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TAKING A CHECKUP ON THE NATION'S HEALTH CARE TAX POLICY: A PROGNOSIS

HEARING

BEFORE THE

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TAKING A CHECKUP ON THE NATION'S HEALTH CARE TAX POLICY: A PROGNOSIS

WEDNESDAY, MARCH 8, 2006

U.S. SENATE,
COMMITTEE ON FINANCE,
WASHINGTON, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senator Baucus.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Welcome, everybody, and particularly to the witnesses who are here, coming a long ways; very busy people whom we have on our witness list today, taking time to be here to help us review public policy and to consider new ideas that are before the committee.

Today, then, we are examining a very important issue. We face a national health care challenge that we must confront. The stakes are very high. Our ability to compete in the global economy and maintain our leadership in the world is, quite literally, at risk with these issues, because of the cost to our manufacturing and services as opposed to what other country manufacturers and services might have. We want to maintain America's leadership in the global economy as well for the workers that benefit from that.

In case anyone has any doubts about this, let me give you just a few figures. As a Nation, we are expected to spend $2.1 trillion on health care this year. That represents 16 percent of our overall economy. Over the past decade, health care inflation has averaged 7 percent. That is three times the inflation rate that we go by generally.

A new report estimates that if we continue on the current path, national health care spending will have increased to $4 trillion by 2015, amounting to 20 percent of the overall economy.* I think we all recognize that this is not sustainable. We have to chart a difference course.

Because of the sheer scope of health care in our economy, many different policy areas intersect. Many of these policy areas fall within the jurisdiction of this committee. Today, we will focus on the impact of our Nation's tax policy vis-à-vis our health care sys-

*For additional information on this subject, *see also,* "Present Law and Analysis Relating to the Tax Treatment of Health Care Expenses," Joint Committee on Taxation staff report, March 6, 2006 (JCX–12–06).

tem. There can be no question that tax policy does, indeed, have a major impact.

Tax preferences for health care are by far our single largest tax expenditure. In 2005, health care expenditures equalled $177 billion. Over the next 10 years, it is estimated that health care tax expenditures will total nearly $2 trillion.

We are used to dealing in big numbers here in this committee, but even in the context of our massive Federal budget, $2 trillion is a staggering amount of money. With the help of our distinguished panel that I will soon introduce, we are going to have an opportunity today to look at our existing tax incentives and to ask a very simple question: are we getting our money's worth?

This is, of course, an important question and one that folks on both sides of the aisle have been too quick to ignore. They have said that the answer is often more tax subsidies. I have been in that situation myself, and even passed legislation along that line.

Instead of charging down that path again, however, we need to take a step back. Too often here in Washington we try to solve problems by throwing more money at them. We want to believe that if we just spend more money or provide more tax subsidies or incentives, whatever you want to call them, our problems will magically disappear. But we also know that, over the long term, these easy solutions have not seemed to solve our problems.

Before we add more tax subsidies, we first should look to see if we can make the incentives that we have today work better. We also need to look at this issue through two different lenses, both from the health policy lens and the tax policy lens.

From a health policy perspective we have to ask, do our current tax incentives make sense? Are they helping to maximize coverage, reduce costs, and improve quality? From a tax policy perspective, we also must ask if our current tax incentives make sense, are they fair, do they help produce good policy results that we ought to expect, and do benefits outweigh the costs?

This is the first time the Finance Committee has held a hearing on health tax issues—we hold a lot of hearings on health issues, but not health taxes issues—since 1994. So, I think we all agree that this hearing is long overdue, or at least Senator Baucus and I do, because we worked this agenda out together.

I hope that this hearing marks the beginning of this committee's work to strengthen our Nation's health tax policy. Among all the facts and figures that I gave at the beginning, there is one more that I should mention, and it is one which we all should pay close attention to.

This is a recent NBC/Wall Street Journal poll. Nearly 9 out of 10 Americans view the issue of health care costs as extremely, or very, important. That puts health care on a par with the war on terror and Iraq.

So, the American people understand we have a problem. They want solutions. This committee has a tradition, I think, of solving some problems. That is why most of us got on this committee in the first place.

On this issue, we must work together. We must give it the serious attention it deserves. A person who helps me with that is Senator Baucus. Go ahead.

**OPENING STATEMENT OF HON. MAX BAUCUS,
A U.S. SENATOR FROM MONTANA**

Senator BAUCUS. Thank you, Mr. Chairman. Thank you, all three, for taking the time to come and share your thoughts with us. I know all of you are very thoughtful people. You have spent a lot of time thinking about this, and you care. I deeply appreciate the time and effort you put into your statements and presentations.

I have read two of your statements. One, Mr. O'Neill's, I thought was very provocative. In fact, after I finished, I went back to my office and said, we need to set these same sort of quality goals for perfection. It is perfection that we are looking for, and so forth.

Mr. Lane, I know you are interested in consumer-directed health care, so I really appreciate that too, and I thank you very, very much.

I ask all of us to push harder than we have been to try to get some results here. I think each day that we delay is another day that means the solution is going to cost more in the future. I just hope that we can find ways to address the real underlying problems facing health care in our country.

My focus is generally on what I just said, but more precisely it is on our country's competitiveness, which is health care as a cost of doing business, in addition to a system where 40-some million are uninsured, a system where health care is not as good as we think that it is. There are just too many errors, just too many mistakes, more than I think most Americans admit and realize compared with other countries.

I have seen data, for example, where the quantity of health care in other countries is greater than the quantity in the United States, although it costs those other countries much less than it costs the United States. We have higher administrative costs in this country than I think we need to have. There are a lot of problems and areas that we can focus on.

But for me, I am now, this morning, going to focus a little bit on competitiveness, that is, the cost of care in doing business. I might say anecdotally, I was over not too long ago at the Jack Welch Technology Center in Bangalore, and I talked to the head man there, Guillermo Willey.

I asked him, why are you here? He said, well, because this is the greatest talent pool for people who work in high technology. I said, where is the next greatest talent pool? It is in China. I said, where is the United States? He said, well, you are kind of down there a little bit.

I said, what do we have to do to really get going, we Americans? He said, well, education is one. We need to make education not quite so expensive, so education is more available, and a higher quality of education. Number two, your health care costs are just too high. I hear it all the time. So that is my focus.

I think addressing high cost and the inadequate coverage of our system is an important part of the answer.

A couple of statistics. Most have heard these, but I think they are worth repeating. General Motors, for example, has become the poster child for high health care costs. Other manufacturers certainly have the same problem, but GM has been kind of a poster child. They spent more than $5 billion on health care.

This year, GM is expected to spend about $6 billion on health care, about $1,500 per car, compared with $500 for Toyota. Negotiated reductions in benefits are expected, however, to reduce GM's cost by about one-third, but that is still far higher than foreign-based competitors.

So we have a problem. We have the highest health care costs in the world, but we do not have the best outcomes. We have more than 45 million Americans with no insurance. There is no silver bullet. I am convinced that improved information technology and pay-for-performance are two important components, but they are just the beginning. There is much, much more that has to be done.

Today we examine a major component of our health care system, tax incentives. The exclusion for employer-provided health care costs is the single largest tax expenditure in the tax code, more than $100 billion a year.

This chart behind me demonstrates that. The red indicates the estimated dollars of tax expenditures for employer contributions for insurance premiums and medical care. It is the highest. The yellow is deductibility of mortgage interest on owner-occupied dwellings.

This crazy blue color, or green, whatever it is, is exclusion of pension contributions and earnings. That is employer-sponsored defined benefit plans. The dark blue is the Child Tax Credit.

This sort of grayish color is exclusion of pension contributions and earnings with 401(k)s. So, by far, the biggest is exclusion of employer contributions for insurance premiums and for health care. And that is just the income tax exclusion. The payroll tax losses are virtually the same, almost has high.

This committee has the responsibility to review the incentives in current law. We need to decide whether the benefits are worth the costs. We need to determine whether changes are necessary, and if so, we need to decide which proposals will improve the system and which will probably do more harm.

We are here today to understand where we are and how the tax code fits into moving forward. It is not an easy task. We hear concerns with the current structure: upside-down benefits, inequitable outcomes. We hear that millions of taxpayers benefit from the system, and that we must be thoughtful and deliberate in changing it.

Tax-based options are clearly one approach, the subject of today's hearings, but a comprehensive solution no doubt will include other options. We should consider building on Medicare or building on Medicaid, or on the Child Health Insurance Program. These existing programs already provide cost-effective coverage for millions of Americans.

The world will not stand still while we consider our options. The global economy, the changing nature of business's relationship with its workers, and advances in medical care mean that what works today might not work tomorrow. Increasingly, our businesses and our workers are asked to be light on their feet, ready for anything in the world that comes their way.

The challenge that faces us is to help employers and workers then to be light on their feet. The challenge is to make health care coverage more affordable, more available, while helping control costs much better than we have. This is a tall order, and it is too

tall for tax incentives alone, but tax incentives, I think, can be a part of it.

In other venues, I have been quite clear about my concerns with the administration's proposed expansion of health savings accounts. I am concerned that the administration's proposals move health tax incentives, not in the right direction, but the wrong direction.

But I want to start this hearing with hope that we can work together to improve the system. We must be conscious of both the value and the flaws of the current system and make sure that we do not lose the good in search of the better, but surely we must search for the better and, in Mr. O'Neill's view, work for the best.

We have a distinguished panel this morning. I look forward to hearing from you all, and thank you very, very much for your contribution. I think it is very helpful.

The CHAIRMAN. Thank you very much, Senator Baucus. I appreciate your help in our getting a very fine panel together. We have, as you have noted, three distinguished and knowledgeable witnesses. Our first witness is the Honorable Paul H. O'Neill. Aside from serving as Secretary of Treasury for a long time, he also has led, for many years before that, as chairman and CEO of ALCOA. Secretary O'Neill's extensive career in government and the private sector has required him to consider Americans' health care policy from multiple perspectives.

I think what Senator Baucus and I appreciate about Paul O'Neill is that he was a person in this town who was always willing to deliver bad, as well as good, news. He has a reputation for being very candid.

One thing we need in this town is somebody who says it like it is, because this is kind of a good news town, Washington, DC is. When you only hear good news, that is why problems do not get solved in this town. So, we appreciate your candidness very much.

Our next witness, Dr. Leonard Burman, is a senior fellow at the Urban Institute, and also co-director of the Urban-Brookings Tax Policy Center. Having served at both the Treasury and the Congressional Budget Office, Dr. Burman has developed considerable expertise in analysis of tax policy.

In 1837, John Deere invented the steel plough, and the company, still in existence, is a leading manufacturer, not only in the United States now, but in the world. Our witness then is Robert W. Lane, chairman of that famous company, Deere & Company. It is an Illinois corporation, but all of their manufacturing is done by Iowans. [Laughter.] It is the leading manufacturing employer of our State, and we appreciate the fine quality they have, but more importantly, the good jobs that they provide.

So, as the world's leading manufacturer of agricultural and forestry equipment around the world, Deere & Company is responsible, of course, for the health coverage of tens of thousands of employees and their families. So, I thank you for joining us.

We will go in the order that I introduced you. So, Secretary O'Neill, would you start out, please?

STATEMENT OF HON. PAUL H. O'NEILL, FORMER SECRETARY OF THE TREASURY, PITTSBURGH, PA

Mr. O'NEILL. Thank you very much, Mr. Chairman. It is a great pleasure to be back in Washington, in these hallowed halls, to have an opportunity to talk about these important subjects.

As you were introducing me, I was thinking, he should just say, "O'Neill is a professional iconoclast." It is what I do, whether I am Secretary of the Treasury or a private citizen. But I must say, it is really an honor to have an opportunity to speak with you. I have a very long prepared testimony; I think it is 26 pages altogether. I would ask that it be put in the record, and then I will just summarize it.

The CHAIRMAN. Can I say, for all of you, we hope you have a longer statement, and we hope that, in 5 minutes or so, you can summarize. Or if my staff gave you another time, whatever that other time was, but normally it is 5 minutes. Your entire statement, for all of you, will be inserted in the record. Yes.

Mr. O'NEILL. All right. Thank you, Mr. Chairman.

The CHAIRMAN. Yes.

[The prepared statement of Mr. O'Neill appears in the appendix.]

Mr. O'NEILL. What I would like to do, because I think this first paragraph is a linchpin for what I want to say to you, I am going to read the first paragraph, and then I am just going to talk concepts. This paper is intentionally full of what I think are important concepts.

American health care policy is in desperate need of reframing and re-thinking, based on a return to first principles. This committee sits at the intersection of policy issues that must be acted on together in order to produce a coherent and workable framework for a better future for Americans, and for America.

Fundamental tax reform, financial security for retirees, and access to medical care for all Americans, in my view, are not separate subjects. In the absence of coordinated policy and legislative action by this committee, I think there is no hope.

So I bring passion to this subject, because I think our future is in the hands of you all and your colleagues. Without some pretty bold strokes, we are going to fail the competitiveness test that Senator Baucus called attention to.

So, let me begin, first, and just say a few words about my notion of fundamental tax reform. If you want to know more about this, when I was Secretary of the Treasury I invited all of the leading thinkers about tax policy in the country to come and prepare papers and advise me and the people, including Pam Olson, who is here today, about how we should think about fundamental tax reform.

It is in a 5-inch binder someplace in a safe, I think, at the Treasury Department. But if you would like to have the benefit of that, maybe they would be willing to give it to you.

My view of fundamental tax reform is this: that our tax system should be used to raise revenue, period. That means no credits, no deductions. It does not mean that we should not create incentives for people to do things. But think about what this country would be like if we said to ourselves, if, for example, we want to induce home ownership, instead of giving people tax credits—which I

would say are, to a degree, inequitable because the value of them depends on your income level, wealth, and the investment you make in a house—how different the world would be, instead of giving people tax credits, if we wanted to induce behavior, we had to write them a check? That would be a different discipline, and I would say an advisable discipline for our country.

Now, to work on the principles of health and medical care, I think we first need to observe a fundamental truth, which is this: the government does not have any money that it does not take away from the people. It is a simple fact of life.

So when we talk about bestowing things on people, we are really talking about taking money away from people and then giving it back to them or someone else in a somewhat different way.

Having observed that all the money comes from the people, even the money that comes from corporations truly comes from the people, because the taxes that corporations collect for us are included in the price of their product. It is not a cost of capital, so if we agree with those principles that the money comes from the people, I think we need to address another question, and it is this. I think we need to ask ourselves the question, when it comes to health and medical care, should there be a basic meaning for Americans when we talk about access? My answer is, yes. I believe all Americans should have access to the health and medical care that they need.

Now, having said that—and couple that with the idea that all the money comes from the people—I believe we should mandate on Americans that they will purchase catastrophic insurance, where "catastrophic" is defined by a combination of income level and wealth accumulation, so that if you are, let us say, a relatively high-income family and you have $100,000 worth of annual income, a catastrophic experience for you is different than it is for someone who has nothing. If you have nothing and you have children and they need to see the doctor, the first dollar is catastrophic.

So, it would really be therapeutic, I think, if we said to all Americans, as an American, you have an obligation to take care of your family's needs, and we are going to require you, as a responsibility of citizenship, to effectively pre-budget catastrophic health/medical care needs.

Then we need to say to them in the most honest way, for those of you who have more, you are going to have to provide income, which will run through the Federal Government, so that we can provide financial support to those who do not have much, or anything, so that they have access to the health/medical care needs that they have as well.

I know that it would take a great act of courage to say it that bluntly to the American people. But I tell you, as I go around the country, I find a lot of people who seem to be interested in the truth these days. I think there is a yearning for "tell us the truth; let us not do any more flim-flam with how we think about and how we run our country."

Now, there is another important aspect to what I have in my testimony. I hope I can engage you in this, because I think you all could really make a big difference if you would get engaged in this subject. This is not an observation from a couple, 3 years now that I have been out of the Treasury.

I have been working on health/medical care issues for the better part of 45 years, coming here to Washington in 1961 as a systems analyst at the Veterans Administration, where they hired me to try to apply the ideas of economics and operations research to the delivery of medical care in the Veterans Administration.

When I was recruited into what was then the Bureau of the Budget, my first assignment was to try to establish a framework for thinking about trade-offs that we make at the Federal level between all the dimensions of the production function for health and medical care, from biomedical research to health/medical care effects that come from interaction with the environment.

So this is not a subject I have recently come to. There is more biographical basis for me making the assertion that I am going to make to you. You can read that for yourself. I believe this, and it is not a casual observation.

If we, today, were able to practice health/medical care intervention at the level of perfection that is possible, we could simultaneously reduce the health/medical care expenses of our society by between 30 and 50 percent, and simultaneously improve medical care outcomes and the health condition of the American people.

This is not trivial, theoretical, academic belief. You will see, I provided some support for this assertion in my testimony. We worked with real hospitals on the ground, sitting in medical wards, to demonstrate that it simply is not true that it is necessary for 1 in every 14 Americans who go into a hospital to get an infection they did not bring with them.

But that is the truth of the matter today. If you or your loved ones go into a medical facility, even the very best medical facilities in the country, the risks of them contributing to your ill health are very substantial. But it is not only about things gone wrong, it is about improving the underlying cost of what we are paying for now in health and medical care.

Again, I have some examples in my testimony of how to attack these problems. I do it from an observation of how systems analysis and the application of the combined ideas of Lean Manufacturing and Toyota Production System, and Six Sigma, and all of that as a body of philosophical thought applied to the real world can produce conditions that are astounding to most people.

I have included in my testimony a chart that shows the injury rate at ALCOA, which is the safest place in the world to work. This is a company in 43 countries, with 140,000 people. It is the safest place to work in the world; not just in the United States, but in all those 43 countries.

Then I have given you a comparison chart to show you that, for health and medical care workers—forget about patients for a minute—the injury rates are 27 times higher than injury rates at ALCOA. It is an unforgivable thing.

But if you go, as I do, and talk to people in some of our great medical care institutions, they do not even know what the facts are about their injury rates, even though people are getting hurt every day by trying to lift people who are 300 pounds without mechanical assistance, or enough other staff to help them do the work. They are being injured by needle sticks and things that they assume are

an inevitable result of delivering health and medical care. None of that is right.

I did not include it here, but I was so busy making news with other things when I was here, nobody paid attention to the fact that, in the 23 months I was at the Treasury Department, we reduced the injury rate by 50 percent.

It was not because we spent an enormous amount of money. It was because the leader cared about the people who worked in the institution and was determined to prove these same concepts apply to everything, everywhere.

Now, one thing that would be enormously helpful—yesterday I was in Princeton to talk to the people at Robert Wood Johnson about this—would be to have a concerted effort in five of our greatest medical institutions, with a team of systems analysts, people trained in these techniques to work in those places to demonstrate what I have asserted, that the opportunity is 50 percent—and it can be captured pretty quickly—so that we have an unambiguous set of propositions that demonstrates how we could get from where we are to reducing our bill from $2 trillion a year to $1 trillion a year. That would really be a beneficial thing for our society.

Now, there are some other things this committee could do that would be enormously helpful, and I know you have struggled with the issue of malpractice insurance. I would assert this. Again, go to first principles.

The idea of medical malpractice has in it the fundamental concept that there are malevolent people out there delivering medical care interventions to intentionally hurt people. I tell you what. I have traveled all over this country. I have been in hospital wards and infirmaries and surgeries. I have yet to find the person who is intentionally hurting other human beings in the practice of medical care. So, I would argue that the fundamental premise of medical malpractice is wrong.

Now, that does not mean mistakes do not happen. I do believe, when mistakes happen, we as a society should pay the economic consequences to the individual who was harmed with this proposition: we should take lawyers out of this whole system and we should have an adjudication board so that when an individual is injured, that adjudication board, with professional medical people, makes awards to compensate for the economic damage.

But, in the bargain, we should say this to medical practitioners. Within 24 hours of an error, it needs to be recorded. It needs to be put in cyberspace, with the circumstances surrounding the injury. There needs to be a root cause analysis that explains how this happened. Then we need to have them say, what changes have you made in your practices so that it goes into cyberspace and every medical practitioner in the country, within 24 hours, has an opportunity to learn from that experience.

One of the things that is an underlying support to what I have given you in my testimony about systems improvement, is the importance of two concepts: real-time problem-solving and transparency.

One of the reasons we do not have transparency in medical care today is because people believe, if they tell the truth, they are going to get their socks sued off, and likely even lose their rights

to practice. So, they have all kinds of incentives not to tell the truth.

Later on, if I have some time, I will give you some illustrations of how deadly that proposition is to the patient population today, because there is no learning from one experience to another.

People are being killed every day because of things we know how to prevent, if we can only share information. So if you all could redesign and eliminate the idea of medical malpractice, it would be profoundly important.

Now, we need one other thing from the professions. We need them to step up to their responsibility to clean out the people who are not capable of doing the things they are licensed to do, and there are some of those. But we cannot get salvation by taking money away through the malpractice insurance system.

We can only get it if the profession will do its job of cleaning up the profession of people who should not be permitted to do surgeries, and then requiring people to share things gone wrong so we can learn, and compensating people who are injured for their economic loss.

There is another thing begging to be done. The reimbursement system that largely flows from the propositions—I helped to create some of this when I was at OMB back in the late 1960s and early 1970s.

The reimbursement system is a nightmare. It induces really undesirable behavior by medical care practitioners by, for example, focusing on the length of stay so that there is a push to get people out of the hospital sometimes sooner than medically indicated.

I will give you a few facts. Of all the people who have bypass surgery in this country every year, 20 percent of them are readmitted to that hospital or another hospital within a month, and about half of them die.

Now, why are they readmitted? Because there is a biological thing that happens after you have bypass surgery. In 6 or 7 days, there is a tendency for the heart to have arrythmia. We know that.

So how do we try to compensate for that? The doctors create a cocktail of medications, send the patient home, with the hope the patient will remember take them in the right order, in the right sequence, at the right time. A lot of patients are not capable of that. So, we have this phenomena that is driven by the reimbursement system, which says the average length of stay for bypass patients is 5.9 days.

Our system, created here in Washington with the best of intentions, induces doctors and hospitals to get people out of the hospital when it is not medically indicated for some significant fraction of people who are discharged anyway because of the financial system. It is really a travesty.

Right now, and I have this in my testimony, the system is so cynical that it kind of envelops the practitioners out there. In Pennsylvania, in 2004, the actual reimbursements to practitioners and hospitals was 28.7 percent of the amounts that were billed. So the billing clerk, who can figure out how to get more complicated, more financially rewarding DRGs—which, again, are created here in Washington—is more important than some of the practitioners, because by manipulating the DRGs, they can get maybe 1 percent

more compensation than their sister hospitals. This is not going to be reformed or refined by private insurance companies. It can only happen if you here do it.

Now, just a couple of other comments, Mr. Chairman. I have included in my testimony an idea that I have been proposing for how we fix Social Security and financial assistance for the retired population, and I will leave that for you to read.

But one more thought. There are 300 million medication errors in the United States every year, and a very large fraction of those begin with unreadable prescriptions.

So I have been on a campaign, as I have traveled around the country, saying to people, you want consumers to begin having an impact? Every American should swear today, and then act on it, that they will never, ever again accept a prescription from a doctor that they cannot read.

The CHAIRMAN. Mr. Secretary?

Mr. O'NEILL. Yes, sir?

The CHAIRMAN. I am going to have to ask you to finish.

Mr. O'NEILL. I am sorry. I am finished.

The CHAIRMAN. Because at 11:30, we have a vote scheduled, and want to go to the other two witnesses. Thank you very much.

Mr. O'NEILL. My pleasure.

The CHAIRMAN. Dr. Burman?

STATEMENT OF DR. LEONARD E. BURMAN, SENIOR FELLOW, URBAN INSTITUTE AND CO-DIRECTOR OF THE URBAN-BROOKINGS TAX POLICY CENTER, WASHINGTON, DC

Dr. BURMAN. Mr. Chairman, Senator Baucus, thank you very much for inviting me.

It is a little bit like déjà vu for me. I actually wrote the testimony for the 1994 hearing when I was on staff at CBO, and I was tempted to just resubmit it and say all those problems are still in existence, they are just worse.

The tax subsidies for health insurance and health care will reduce Federal income tax and payroll tax revenues by over $200 billion. The chart showed $115 billion in income tax revenue losses, but it also undermines the payroll tax base as well.

Almost all the revenue loss is attributable to tax exclusions for employer-sponsored health insurance. Thus, it is no surprise that most Americans under age 65 get their insurance at work. What may be surprising, however, is even with such huge subsidies, more and more people are becoming uninsured, especially the young, those with low incomes, and those who work for small firms.

Some have suggested that the tax subsidies are a significant part of the problem. The subsidies encourage people to get insurance at work, stifling the individual non-group market, and they encourage employers to provide overly generous insurance, since the cost is subsidized.

What is more, the subsidy is upside-down, aiding most those who would purchase insurance under any scenario and providing little aid to those of modest means.

Some have suggested that the best option would be to eliminate the employer exclusion altogether and let the market work its magic. The problem is that the health insurance market just does

not work very well. It is the poster child for what economists call market failures. I have a few examples.

First, the very act of having insurance increases utilization. People spend more when someone else is writing the check. But this causes insurance to be more expensive than it might be.

Second, insurance is most attractive to people who expect to benefit most from it, such as those with chronic conditions. Insurers, thus, have to assume that purchasers have higher costs than average. That means that healthy people get a relatively bad deal from insurance, unless they can align themselves with a large group. This feature of insurance is called adverse selection.

Third, the existence of free, even if inadequate, emergency health care for those with low incomes serves as a deterrent for purchasing health insurance. Why pay if you can get it for free?

Finally, healthy people, especially in the non-group market, can only imperfectly insure against the cost of developing chronic illnesses because premiums for non-group health insurance increase over time for sick people.

Subsidizing individuals who get insurance at work mitigates some of these problems and it exacerbates others. On the one hand, by encouraging individuals to get insurance at work, it reduces the problem of adverse selection because people choose employment for reasons unrelated to health status, and it offers those who work for large firms a kind of renewable insurance. But this pooling works less well for small employers whose costs may be heavily influenced by the poor health status of one, or several, employees.

On the other hand, the tax subsidies encourage over-use of medical services because people do not face the true cost of insurance. As noted, the current tax subsidies are poorly targeted.

On balance, though, despite its failings, the current employer-based system supplies health insurance coverage to almost 70 percent of American workers under age 65. Reforms should build upon that coverage base instead of eroding it.

Because of the rampant failures in the health market, solutions are not simple. The data, however, suggest some obvious directions for improvement. To start, the upside-down tax subsidy should be set right. Currently, the largest subsidies go to those who have a strong incentive to get health insurance, even absent a subsidy, while those for whom health insurance is unaffordable get little or nothing.

A better option would replace the tax exclusion with a refundable credit, targeted at those earning less than the median income. The President has proposed such a subsidy, but it is limited to purchases in the non-group market and so would undermine ESI, which still covers many low-income people.

A better option would be to allow the subsidy for both group and non-group insurance. But this is an important point. Many proposals would level the playing field between ESI and non-group insurance. It sounds fair, but it would cause many people to lose insurance.

For example, a small employer can get the same tax benefits as its employees without going through the hassle and expense of providing ESI but would be sorely tempted to drop insurance coverage, and it would be under strong competitive pressure to do so.

Indeed, the healthiest workers would be happy to take a small increase in wages in exchange for dropping ESI coverage, because cheap, tax-subsidized insurance would exist outside of work.

But left out in the cold would be those who are older or less healthy than average, for whom non-group insurance premiums would be much higher, and low-income people to the extent that they benefitted from cross-subsidization within the firm. It is largely for those reasons that MIT economist John Gruber recently estimated that the President's proposals for expanded HSA tax subsidies would reduce coverage.

Re-targeting the upside-down subsidy is much easier said than done. One option would be to phase out the subsidy at higher incomes. This would reduce the incentive of employers to provide overly generous health insurance, while still providing an incentive for many currently uncovered individuals and families to obtain coverage.

However, it would generate a lot of political opposition. The reaction to the Tax Reform Panel's relatively modest cap proposal is a daunting case in point.

An alternative, although with its own political challenges, would be to come up with a dedicated revenue source, such as a VAT. A more incremental option would be to help small employers to offer health insurance, for example, by providing a refundable tax credit or a direct subsidy to defray the higher administrative costs that small employers, especially those with low-wage work forces, face in purchasing health insurance.

A more far-reaching reform would guarantee that small employers who continually pay at least a certain percentage of their employees' premiums would be able to purchase insurance at large group rates, for example, from a pool similar to the Federal Employees Health Benefit Program.

Finally, I would note that the best option to expand care might be outside the tax system, for example, capping the tax exclusion and using the revenue savings to expand SCHIP or Medicaid, or providing vouchers to low-income households.

That concludes my remarks. Thank you.

The CHAIRMAN. Thank you very much, Dr. Burman.

[The prepared statement of Dr. Burman appears in the appendix.]

The CHAIRMAN. Now, Mr. Lane?

STATEMENT OF ROBERT W. LANE, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, DEERE & COMPANY, MOLINE, IL, ON BEHALF OF THE BUSINESS ROUNDTABLE

Mr. LANE. Good morning, Mr. Chairman, Senator Baucus. I am Robert Lane, chairman and chief executive officer of Deere & Company, and I am pleased to be here on behalf of the Business Roundtable's Health and Retirement Task Force.

Roundtable member companies provide health insurance for 25 million employees and their families. For the third straight year, member chief executives report that their number-one business cost pressure is employee health care costs.

Our companies are looking for tools, tools to help us positively manage rising health care costs and to assure quality health care

for our employees. We believe existing tax incentives should be more focused on consumer-directed options than they are today.

In particular, we are finding that health savings accounts, flexible spending accounts, and health reimbursement arrangements can be efficient tools for our employees to gain considerably more value from their health care dollars.

I want to provide some background information, and then some suggestions for the committee's consideration as you review health care tax policy.

Now, in the past, John Deere has been innovative in managing health care costs through the use of self-insured plans, managed care networks, and disease management programs.

Today at Deere, the annual salaried family premium for our most popular, 100-percent HMO plan, is $12,300. Deere's goal is to more efficiently spend these dollars by improving the value equation, while ensuring our employees remain safe and healthy.

At John Deere, we are creating affordable, sustainable health care benefit plans that encourage our employees to participate, participate actively, in their health care decisions, rewarding them for adopting healthy lifestyles and preventative behaviors, while also providing quality health care insurance protection.

One of Deere's guiding principles is to reform health purchasing processes by changing health care value at the point where most health care consumption decisions are made, at the point of patient care.

Business Roundtable companies believe that our employees, as decision makers, must be given more flexibility to enable them to make smart and efficient health care choices.

At the same time, our companies are committed to remain a partner with our employees, to educate them and coach them about the health care marketplace.

Now, some ideas the Business Roundtable asks the committee to consider are: first, employees, especially those who are challenged with health care expenses in the early part of the year, need to be allowed to coordinate their health savings accounts with the use of flexible spending accounts and health reimbursement arrangements to allow them to budget their expenses over the year.

Second, HSA contribution limits should be lifted. This is critically important to enable employees to save, save for future health care expenses and not merely drain the accounts year to year.

Third, we support regulatory efforts to permit varied contribution amounts by employers to an employee's HSA when the employee is a low-wage worker or has a chronic illness.

Fourth, Business Roundtable supports legislative changes to allow individuals to carry forward funds in a flexible spending account, or roll funds over into a health savings account.

The current "use-it-or-lose-it" rules cause many individuals to avoid flexible spending accounts or to incur unnecessary care at year-end to avoid forfeiting their money.

These four changes will enhance health care delivery and allow a broader group of individuals to combine the best features of managed care with the positive aspects of individual control over their health spending.

Roundtable companies are not looking to reduce health care benefits. We want to improve on the value that health care dollars can buy. Improving on the value is the only way to assure quality and affordable health care.

We believe that health care expenditures can, and must, be spent more wisely and more efficiently. We ask the committee to focus on additional health care tax incentives directed towards our employees.

Thank you, Mr. Chairman, Mr. Senator, for listening.

[The prepared statement of Mr. Lane appears in the appendix.]

The CHAIRMAN. Thank you very much.

We got a lot thrown at us. [Laughter.] That is a compliment.

Senator BAUCUS. It is not all consistent, either.

The CHAIRMAN. No. No.

I am going to concentrate on some of the negative ramifications of the rising cost of health care. It makes it harder for businesses to manage their costs to compete in the global marketplace.

For more uninsured Americans, because they cannot afford health coverage, and even for those who can afford insurance, it crowds out spending on other important priorities that families have.

Some have suggested that our tax incentives help make health care more affordable because those incentives reduce the after-tax cost of health care. Obviously, others have suggested that the current tax incentives actually increase costs and health care inflation, because the current policy encourages first-dollar coverage and other gold-plated medical benefits.

So I would like your views. This is to all of you, so I will start across the board. I would like your views on this subject. Is one side right, both sides, or neither side? What can we do to align our tax policies with the goals of controlling costs and increasing coverage?

Mr. O'NEILL. Senator, I believe what I said to you in my statement and in my testimony. I really believe using the tax system in the way we do now is a fundamental mistake.

I think, in a way, it provides an opportunity to do things that sound good, but I think often have secondary and tertiary consequences that are actually not so good at all.

To go back to my theme about fundamental tax reform, I noted—and I know you all did, too—that the best estimate today is that our current tax system, which is 10,000 or 11,000 pages, is incomprehensible and we are not collecting as much as $400 billion a year that is theoretically due and owing.

Adding on more refinements for tax benefits in the name of improving the health condition of the American people, I think, is a fundamental mistake. It is not that I want to stop where we are. I want to eliminate what we have done and re-think the proposition about how the American people interact with themselves in the broader context of society.

To me it is really important, because people are very confused by this. There are people who really think Medicare Part D was a gift from the government. I hope you do not mind me saying so, but I think it is, frankly, the worst piece of social legislation in my lifetime. Not because we should not help people.

The CHAIRMAN. Those of us who wrote it appreciate that. [Laughter.]

Mr. O'NEILL. I am sorry. I am in the business of telling you the truth as I see it. I believe that Americans should have access to the health and medical care they need. It is not that I do not want them to have the drugs that they need and require. But I would like for them to have them in a straightforward way, first by asserting to them, those who are of means, you must pay for it, because if you do not pay for it, you are basically electing to consume your money, and when you have a catastrophe in terms of a health requirement, you shift the cost to your neighbors.

If you look at it from a farmer's point of view, if your neighbors ate their seed corn, you would not be to happy to have them coming to you to give them some of your seed corn, because they have a responsibility to provide for their own future, not to consume it and then expect you to cover their responsibility.

So I think it is time for us to say, as Americans, we have rights and responsibilities as an American. Part of your responsibility is to seek to take care of all of your personal and family needs, not just for health and medical care, but for education, and everything else that you do.

For those of you who are unfortunate, and for whatever reason cannot meet the standard of what it means to be an American, the rest of us should bear that burden, and we should bear it happily, with a simple, easy-to-understand, progressive consumption tax, and we could have a very different conversation.

The CHAIRMAN. Dr. Burman?

Dr. BURMAN. I applaud Secretary O'Neill for his efforts to try to get tax reform through, although we probably would disagree about exactly the right way to do it. Within the current tax system, I think, as your question indicated, the current system is really a mixed bag. Without any kind of a subsidy, it is not clear that many people would have health insurance at all.

The problem is this adverse selection problem, that insurers have to assume that people who want to buy insurance are the ones who are sicker than average, and that means that healthy people have an incentive not to buy into the pool, and that pushes the premiums up further.

The good thing that the current system does is, it encourages people to get insurance through employers. In a lot of ways, employers are a good way to pool people together. You choose where you work for reasons other than your health status, for the most part.

So, a company like John Deere or ALCOA has thousands and thousands of employees, a few of whom turn out to be sick, most of them are healthy, and they can all get a relatively good deal on their health insurance.

On the other hand, the unlimited subsidy means that employees will demand more and more generous health insurance coverage. This is the moral hazard problem. So the tax subsidy definitely has contributed to the growth in health costs and in health insurance costs.

There are things you can do about it. One thing, and this is actually the focus of the 1994 testimony, is caps on the tax subsidy.

You want to encourage people to get adequate insurance, but you do not want to encourage them to get Cadillac insurance policies. So, you can cap the subsidy at the cost of a policy like Blue Cross Standard Option, something like that.

In fact, actually, the Federal Government did something very much like that with Federal employees: they paid for the cost of the least expensive options, and you paid for additional costs beyond that.

The other thing, and I think Senator Baucus mentioned this, was that information systems would help a lot. We treat the health insurance and decisions about health care as if people are saying, oh, boy, I can get bypass surgery. The fact is, for most kinds of medical procedures, the price is not really the main factor. It is that you have been convinced that you really need something.

In a lot of kinds of medical procedures, it is really unclear what the costs and benefits are; even if everybody wanted to do the cost benefit analysis and only do things that were economically efficient, a lot of times you don't have the information.

So, investing more in finding out what treatments are effective and which are ineffective, I think, would help a lot.

The CHAIRMAN. All right. Mr. Lane? Then I will call on Senator Baucus.

Mr. LANE. Senator, to your question about whether the tax code is incenting spending, I think, as a practical matter today, it is the amazing expansion of technology and the demographic trends in our country that are going to create enormous pressure on future health care costs.

Basically, employees today, we think, practically understand what it means if they have an umbrella policy which will cover them in all situations for catastrophic problems, like just insuring when you total your car, the car is totally wrecked, and then they will pay for, with their own money, all the expenses up to that point which are more routine, and where they have an opportunity.

For example, I think almost no John Deere employee today knows what an MRI would cost. Many of them have had that prescription given to them or their children, but no one knows because they have a co-pay or deductible.

Under this program, they would all learn what that meant. I do not think they would get more of them. I do not think people would get more than one operation. But I think it does make it more affordable and it does make it possible for them to be engaged.

We have found our employees, as a practical matter—and I believe the employees at the Business Roundtable—that their engagement can make a huge difference. We have a lot of confidence in their practical, common-sense judgment when it is their own money.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Secretary O'Neill, the VA is held up to be a success story. How much of the VA's systems can be applied to the rest of the country?

Mr. O'NEILL. I think it can be applied very broadly. This is of a fairly recent vintage. You all will remember, because I am sure he testified before this committee, Ken Kaiser came to the VA as the chief medical director, with a conviction that health care for vet-

erans should be looked at as the best in the country and not second-class.

I think for a long time there was perhaps the reality that veterans health care was not so good. Ken Kaiser came with a conviction, much like what I have expressed to you, about the possibility, without more money, of creating significantly better outcomes.

I will give you a little illustration from VA Pittsburgh. When we started working with them, and Ken had gotten them started with this, we stopped for a week and observed what was going on in the wards there with regard to hand hygiene policy.

A lot of the infections that people get unnecessarily in hospitals are caused by a lack of adherence by the staff to hygiene policy, so in a week's time we watched what went on 24 hours a day.

What we found was, 40 percent of the nurses and technicians did the alcohol-based scrub, gloving, gowning, masking, as they all knew they ought to, and only 10 percent of the doctors. Ten percent of the doctors. They had the average expected level of infections. We worked with them and did some simple things.

First of all, we asked them, why do you not do this? You are all scientifically trained people, and Semmelweis, in Hungary, demonstrated 150 years ago—it is not like this is new news—that there is a way to prevent transmitting infection from one patient to another. They said, well, the sink is down the hall and we are in a hurry, we are behind schedule. So if we have a white coat on, we do not think we——

Senator BAUCUS. My time is a little short here. So basically, how much of that can be applied?

Mr. O'NEILL. I think almost all of it.

Senator BAUCUS. And what would the effect be in reducing unnecessary health care costs in this country?

Mr. O'NEILL. I think if we just did the things that have already been successful, we have demonstrated in the VA, we could look to bring down the Nation's health care costs bill by 10 to 20 percent. But there is a lot more to do at the VA, as my testimony suggests, and at all of the other medical delivery centers in the country.

I will tell you one fact. A great medical center, you all would know the name and count it among probably the top three places in the country. Their adherence to hand hygiene policy, by their own audited inspection, is 29 percent, in one of the great places in the world to get medical care. So, when you look at how big the opportunity is, it is enormous.

Senator BAUCUS. Now, it is interesting, Mr. O'Neill. When you spoke, there was not much discussion about tax policy, except generally at the top. You said taxes should only be used for raising revenue. But with respect to health care, you did not get much into employer-based exclusions, or HSAs, and all that. Your solutions tend to be more systematic, given the current system.

Mr. O'NEILL. Yes, that is true. I will tell you what. I am fascinated by the fictions that we pick up and we all talk about. I was on the General Motors board for 3 years and got off because I did not think it was fixable, quite a long time ago. [Laughter.]

But the idea that they have $1,500 worth of cost in every year, it is an accounting thing. The truth of the matter is, every employer has to earn enough money in its revenues to cover all of its

compensation costs. General Motors is paying their average assembly-line worker, including benefits, $125,000 a year. That has been an unsustainable proposition for 30 years.

But it is not because they have medical care expenses. It is because their total compensation cost is too high. They negotiated it.

Senator BAUCUS. That is right.

Mr. O'NEILL. They got drawn into it, partly because, in the second World War, when we had wage and price controls, we created this tax incentive for employers to give compensation.

Senator BAUCUS. Right. I know. We all know.

Mr. O'NEILL. I mean, we did it right here.

Senator BAUCUS. We did that. All right.

Now, you said huge savings can be achieved by applying VA-types of systems to all the hospitals and health care providers in the country.

Mr. O'NEILL. Right.

Senator BAUCUS. Second, how much is the solution, in your judgment, the mandatory requirement that everyone purchase health insurance? How important is that to the solution?

Mr. O'NEILL. I think, if you think about this as a Rubik's Cube or something, it is a block, but it is not independent from the other parts.

Again, let me go back to the first paragraph of my testimony. You all sit at the intersection of really critical policy threads that, in my judgment, for too long have been dealt with separately.

I think we need to deal with the tax system, with our ambition and vision for what it means to be an American when it comes to access to health and medical care. For sure, we need to create a system, which I think we could do with a reasonable amount of money, to provide financial security to every American when they get to be 65 years old.

I think you maybe have seen what I have written about that subject. These are things that needed to be treated together, and the things that you can do are to create a framework for the society to realize its potential.

Senator BAUCUS. All right. My time is encroaching here a little bit.

Mr. O'NEILL. Sorry.

Senator BAUCUS. I have a couple, three, quick questions that are all related. How important is it that we in America have an insurance industry and a system of health care reimbursement where there are a large number of health insurance plans tailored to meet lots of different circumstances, giving people lots of choices so they can decide which one seems to make sense for them, but a system where—everything is a double-edged sword as you pointed out in your testimony—a lot of providers try to game the system, try to add the length of stay here, put in a certain procedure in a certain DRG classification to get a little more revenue.

I am struck with your percentage. What, it was 28 percent of the reimbursements billed for in Pittsburgh Hospital is actually received, and the rest is not received. I am leaning to something else, and it is the single-payor system.

How do you get rid of all this, I think, ridiculous, excessive overhead cost that we have in our system, or at least significantly reduce the ridiculous overhead cost that we have in our system?

First of all, I know a lot is paperwork, but how much of it is because of all the numbers of insurance policies we have, et cetera, et cetera, and how important is it to have, on the other hand, all those various insurance policies in this country?

Mr. O'NEILL. Boy, that is a mouthful. But let me do this really fast. I am desperately afraid of the idea of a single-payor system, because I think it reinforces the notion that somehow the Federal Government has a pot of money and it is now going to bestow things on us.

I think it makes a lot more sense to say to Americans, your responsibility as an American is to cover your needs. You are mandated to buy what, for you, is catastrophic protection, and we are going to subsidize catastrophic protection for people who do not have it.

There is a fog around the idea of insurance companies.

Senator BAUCUS. All right, Mr. O'Neill——

Mr. O'NEILL. If I can just say this one thing. Insurance companies that survive do not take any risk. What they do is, they make a market-necessary rate of return on the capital they employ. That is what they do. It is like all business enterprises; that is what they need to do to survive.

So what do insurance companies do? They bill enough premiums to be able to discharge the responsibility for the experienced cost. That is what they do. If they do not collect enough, they raise the premium.

Senator BAUCUS. Well, depending upon their rate of return on their assets, too. That is a key factor.

Mr. O'NEILL. Well, but if you look at industry generally, if you look at the insurance industry specifically, what you will find is the tendency is to——

Senator BAUCUS. With all due respect, you are not answering my question.

Mr. O'NEILL. I am sorry.

Senator BAUCUS. You answered the single-payor part.

Mr. O'NEILL. Right.

Senator BAUCUS. What about the other part? Is our current health insurance system just too complex?

Mr. O'NEILL. It is a disaster. And here——

Senator BAUCUS. And how do you make it more acceptable?

Mr. O'NEILL. Well, going from my notion of a mandate, this requires some really difficult policy choices. In the broadest sense, in my concept, we would have one pool in the country. Every American would be in the pool. It could be run by private companies; that is all right with me.

Now, if you say that, you are really mutualizing the risk for all kinds of people in all kinds of circumstances. In the broadest sense, you could make a public policy case for that. But then come the questions, does that mean we want to mutualize the risk and the cost for people who intentionally damage their own health?

Should we let people have the privilege of a lower cost who are alcoholics and drug abusers and the like, or should we have some

separate pot that we put people in if they are imposing costs on the rest of us that are unfair and unwarranted? So, it is complicated, but ideally, we have one pool for our population.

Senator BAUCUS. I have gone way over my time.

Mr. O'NEILL. I am sorry, I did it.

Senator BAUCUS. That is all right.

The CHAIRMAN. I have one question for the panel. Secretary O'Neill probably has said that there is nothing good about our system, but let us start with the assumption that, with the employer-based system, there is a good deal of good in the sense that most Americans do have health insurance coverage, and the quality of care we receive is as good as any in the world.

As we look at possible reforms, I would like to have you comment on this time-tested edict of "first, do no harm," and what are potential pitfalls that we should be careful to avoid as we look at this? I will start with Mr. Lane, Dr. Burman, then Mr. O'Neill.

Mr. LANE. Mr. Chairman, I think on the question of "do no harm," the current system probably will tend to do harm if we do not make a change, for the reasons you addressed in your opening remarks.

The CHAIRMAN. All right.

Mr. LANE. I think, as has been thoughtfully said here, there probably are some very good things that can be retained. I think that what we like about engaging employees in the program as it has been proposed, and as we are actually doing—this is not theory, we are actually in the middle of coaching and working with our employees today—is that today on the Internet there is an enormous amount of information that is available, potentially available, for employees to really understand more deeply, with their doctor, what their options are and what costs are.

So, probably the status quo would be the more harmful. We are going to keep, in our system, all of our employees covered by insurance. We are not intending to lower the coverage. What we will do is get their engagement, use the information that is available out there, and every one of them will have an understanding and participate with us in trying to spend their money better, which we have seen Americans tend to do when they have their money in their own account, which they can keep if they do not spend. It remains, it stays.

We see that as retaining the good of the umbrella coverage, but involving them in the day-to-day going to the drug store and knowing what a prescription costs. They will pay the full bore, up until their deductible, of every prescription. They will see that.

Today, they do not. The prescription may be $152, but they have maybe a co-pay of $20. We have seen enormous cooperation with our union employees. For example, we work very closely with the United Auto Workers.

We have been successful in working together to retain the benefits for employees, but have their engagement in bringing down the costs of the program and the cost to the company, which then, to your question of harm, allows us to continue to make this part of compensation.

After all, we want a healthy workforce. We want employees. We are in this vicious competitive game worldwide that Mr. Secretary

referred to. In this world, as he has traveled around, we have to compete, just like ALCOA does. We are finding that they are helping us, by their engagement, bring down our costs.

The CHAIRMAN. Dr. Burman?

Dr. BURMAN. I think there are two concerns. Basically, we all agree that there are serious problems with the current system, but I think a lot of people are concerned that you really could make it a lot worse.

One problem is, if policies ended up pushing a lot of people into the individual, non-group market and we did not find a way to solve this adverse selection problem, so the people who were sick actually could not get insurance any more, it seems like that would be a serious setback.

In fact, if a lot of employers drop their coverage and you do not solve the problems in the non-group market, even if you have large subsidies for non-group insurance, the net result could be that fewer people would have insurance, and the ones who really would be hurt would be lower-income people who are sick.

A related concern is about this issue of health savings accounts. The idea behind health savings accounts, I think, is a good one, that you want to give people an incentive to economize. The problem is, with health savings accounts, the incentives can have vastly different effects on people based on their income.

Secretary O'Neill had suggested a kind of catastrophic insurance where the deductible was based on your income. Without that, the idea of maybe a $2,000 annual deductible, which is no big deal for upper-income people, would be a serious burden for lower-income people with chronic illnesses; year after year after year, they would hit the high deductible.

Well, the problem with offering a choice of this high-deductible insurance and the HSA is that it becomes an ideal mechanism for creating adverse selection in the workplace. We know that this can work out badly. In the Federal Employees Health Benefit Program, for a long time, Blue Cross offered a Standard Option and what they called High Option.

The two programs were not that much different, but the High Option was a little bit more attractive to less-healthy workers. OPM did a study and they showed this graph of the premiums, where initially there was a small difference in premiums reflecting slightly more generous benefits in the High Option plan. Over time, the premiums just diverged.

As healthy people opted out of the High Option plan, selected the Low Option, the pool for High Option became sicker and sicker, which moved more and more of the healthy people out, and eventually High Option became infeasible. The people who are paying for it, even if they were really sick, were not getting the benefits they were paying for.

HSAs can do the same kind of thing. The people for whom HSAs are the most attractive are healthy people who have a sufficient income so they can afford the risk of hitting the deductible. Those would be the two risks I would be most concerned about.

The CHAIRMAN. Secretary O'Neill? Then I will call on Senator Baucus. This is my last question.

Mr. O'NEILL. Implicit in the idea of strengthening or refashioning the tax incentives for health/medical care is the idea of transparent information. I wonder if there is anybody in this room who can understand the communications they get from their own health care encounters.

I am flabbergasted to get these three-page forms that have all these numbers on them. At the end of it, it says, "This is not a bill."

Senator BAUCUS. I have had that. I got one yesterday.

Mr. O'NEILL. Really?

Senator BAUCUS. Yes.

Mr. O'NEILL. And then it says, "You may be billed for this amount," whatever that means.

Senator BAUCUS. That is exactly what it said.

Mr. O'NEILL. And then nothing ever comes. The truth of the matter is what I said to you earlier. Pennsylvania is not an exception. Every State in this country is the same: the actual reimbursements are less than 30 percent of the amounts billed. So if you had access to the billing information, you would not know anything. It is just a bunch of numbers on a piece of paper.

And I live in the real world, you know. I really worry about how we can take legislative action here, which I know you, with a great heart and sense about what to do for this country, often take legislative action without going out and walking around to see what it is really like out there in the world.

One experience is amazing to me. At any hospital facility—I beg you to do this—go in and look at what they are doing with HIPAA forms. Have you ever signed a HIPAA form? My question is, did you read it? The truth of the matter is, we have imposed, with the best of intentions for privacy purposes, this enormous regulatory process for HIPAA.

Yet, if you go in, they will not treat you until you initial and sign the form. Do you know what they do with it? They put it in a cardboard box and they send it to Central Storage for 5 years. Do you know what value it has? Zero. It is an imposed cost that we put out there on the system for a noble purpose, but it is part of the $2 trillion, folks.

If I could do one thing, I would cause all economists who have an opinion about these things to go sit in a hospital ward and study the real facts, not the theory about how Adam Smith told us things work, because it is not true.

The CHAIRMAN. All right.

Senator Baucus?

Senator BAUCUS. Yes. I was just going to say——

The CHAIRMAN. I am not sure I agree that everything Adam Smith said was not true.

Mr. O'NEILL. I did not say that. [Laughter.] I did not say that.

Senator BAUCUS. It is interesting. Dr. Burman, you talked about how the Federal Employees Health Benefit Program changed its High Option/Low Option. I am one of those persons. As I was in High Option for a while, I thought, gee, I will get more coverage.

But then I thought, well, I am healthier, several years ago, so it was a lot less expensive, so I opted for Low Option. I wondered why the premiums started getting up a little bit, even though I was in

the Low Option. But you finally explained it to me. I appreciate that.

I would just like, if you would, Dr. Burman and Mr. Lane, to talk a little about HSAs. I have some of the concerns, frankly, Mr. Lane, that Dr. Burman has, that it is going to tend to incent people out of group coverage and may even cause more problems than it solves. It has a very strong initial appeal, choice. We all like choice.

But I personally believe, frankly, there is too much choice in the Medicare Part D drug benefit. In my State of Montana, seniors have to choose from among 47 different choices. It gets a bit complicated, as you might guess.

So do you recognize, Mr. Lane, Dr. Burman's points? And Dr. Burman, do you recognize Mr. Lane's? I am trying to get some understanding here.

Mr. LANE. Sure. Well, we have decided, at John Deere, to introduce HSAs. We have announced this publicly to our employees, to our U.S. salaried employees, and it will begin in 2007 and there will not be a choice. Everyone will participate in them.

Senator BAUCUS. The question, really, is this—particularly if the recommendations by the President are adopted and the limitations are increased very significantly: overall in the United States, the thought is that that will tend to have adverse selection consequences for less-healthy Americans, generally. That is, group coverage will cost more, the more people are moving to HSAs.

Mr. LANE. We actually believe that, with the engagement of every employee in this process, that what will happen is that we will just insure the big, catastrophic events and their engagement will make it possible for people, who today would not choose to be insured, to actually buy just this umbrella coverage, which was available before, but not with the ability to put your own money, pre-tax, into an account that stays if you do not spend it. This is a very attractive new feature, and there are ways to structure it so that the cash flow issues that Dr. Burman mentioned, which are important, particularly at the lower end, will not be an issue.

People who are at the lower end of the wage scale do have issues of, how will they pay for it if the expenses occur early on in the year. But through this FSA recommendation that we just gave in our testimony and other structures, we believe that actually it will engage employees more and they will be more inclined to take the insurance.

Senator BAUCUS. Dr. Burman, do you have any reaction to that?

Dr. BURMAN. Yes. I guess I have just a few other points. One of the attractions of HSAs is that you would think that it would help to restrain the growth of health care costs.

There are a couple of problems. One is that actually, when people are paying for health care out of their own pockets, the evidence from studies like the health insurance experiment in the 1980s was that people are as likely to economize on care that they need as on care that they don't need, so that is really a concern.

The people for whom the cost-control strictures will be most important will be the ones who are low-income people who have a couple of hundred dollars in their HSA and they do not want to blow it out in a year.

The other thing is, the vast majority of medical expenses is incurred by people who are very sick, in the last 6 months of life for people who have chronic illnesses. Those people will not be affected at all by a catastrophic deductible, even at $2,000 or $5,000 a year.

In fact, in some kind of perverse way, health savings accounts might actually encourage some new spending. I read about a company that was offering people credit cards that they could use to pay for their medical expenses out of their HSA. In economic terms, if you have money in the HSA, you want to keep it, because it turns out this is a great retirement vehicle.

But if people are walking around with a credit card and they know they have $5,000 accumulated in their HSA because they have been healthy for a few years, they might say, well, yes, getting the cosmetic stuff for my teeth, or whatever, does not cost me anything. I have the balance in the account. The bottom line is that the effectiveness of HSAs in constraining costs, I think, has been vastly overstated.

The other thing is that HSAs, just like the tax subsidy for employment-based health insurance, are upside-down subsidies. The people who get the most benefit from health savings accounts are the ones in high brackets. If you are in the 35-percent bracket, this is the best tax subsidy for savings that has ever been invented, especially if the President's proposals were enacted. You not only get a deduction at the front end, which is worth 35 percent, but you also save payroll taxes.

As long as you eventually spend the money on medical care—you can pay for some of your retirement expenses or your Medicare premiums when you reach retirement—the money is tax-free forever.

Concern, of course, is that if people switch from putting money in 401(k)s to putting money into health savings accounts because it is a better deal, then they are very vulnerable if it turns out they get sick at some point, if they develop diabetes or something else where they are going to hit the deductible year after year after year. They will reach retirement and they will not have anything in their savings account.

Senator BAUCUS. I appreciate that. One of my concerns, too, I think the estimate is $136 billion, this cost over 10 years. That includes the refundable portion of it. Whereas, raising the limits would cost, on that basis, $136 billion over 10 years. I appreciate this.

The most frustrating part of this, Mr. Chairman, is this is too short. We really need about a whole day to get down to some common understanding and directions on where to go. But it is a start. All three of you are extremely able. We will just have to take, Mr. Chairman, the suggestions that they have all given.

I might say, Mr. Lane, one of my fairly early memories down on the farm was operating a John Deere D.

Mr. LANE. Thank you.

Senator BAUCUS. And going "putt, putt, putt, putt." I will never forget that thing. [Laughter.]

Mr. LANE. Thank you.

Senator BAUCUS. You are welcome.

The CHAIRMAN. I still have one of those Bs and one of those As, and a 620. [Laughter.]

Mr. LANE. Time for a new one, Senator.

Senator BAUCUS. Right. [Laughter.]

The CHAIRMAN. I knew what I was getting myself into.

Just in case you might wonder at other people not being here, the Health Committee has a mark-up today, Judiciary is working on the very important issue of immigration, and then we have lobbying reform on the floor. So I only say that to explain to people that are watching why other people might not be here.

For you folks, though, it is important that maybe people that cannot be here might submit questions for answers in writing, and we would appreciate if you would cooperate with that.

Thank you very much, all of you.

[Whereupon, at 11:30 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Statement of Leonard E. Burman*

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www.taxpolicycenter.org

Before the
United States Senate Committee on Finance

Taking a Checkup on the Nation's Health Care Tax Policy: a Prognosis

March 8, 2006

* This testimony draws heavily on Burman and Gruber (2005). Views expressed are mine alone and do not necessarily reflect the views of any organization with which I am affiliated.

Chairmen Grassley, Ranking Member Baucus, and Members of the Committee:

Thank you for inviting me to share my views on the state of tax policy with respect to health care in the United States. This hearing is extremely timely. Over 45 million Americans under age 65—the overwhelming majority of them in working families—lack health insurance. They are less likely to obtain important preventive screenings while healthy, and they receive lower-quality care when sick.[1] And, the public ultimately shoulders the burden of paying for the medical treatment of those lacking insurance, through either higher taxes or higher health care costs.

The tax system has played an important role in the evolution of the market for health care, and tax reform will inevitably be a part of the solution to the market's problems. Tax subsidies for health insurance and health care will reduce federal income and payroll tax revenues by over $200 billion in fiscal year 2007. Almost all of that revenue loss is attributable to the exclusion from income and payroll taxes of employer contributions to employer-sponsored health insurance. Thus, it is no surprise that most Americans under age 65 get their insurance at work. What may be surprising, however, is that even with such huge subsidies, more and more people are becoming uninsured, especially the young, those with low incomes, and those who work for small firms.

Some observers have suggested that the tax subsidies are a significant part of the problem. The subsidies encourage people to get insurance at work, stifling the individual nongroup market, and they encourage employers to provide overly generous insurance since the cost is subsidized. What's more, the subsidy is upside down—aiding most the high-income families that would probably purchase insurance under any scenario, and providing little aid to those of modest means.

Some, such as former Council of Economic Advisers chairman R. Glenn Hubbard and colleagues, have suggested that the best option would be to eliminate the employer exclusion altogether and let the market come up with cost-effective ways to supply health insurance to the public. But, in an unfettered free market, health insurance is likely to be too expensive for four reasons. First, the very act of having insurance increases utilization. People spend more when someone else is writing the check, but this causes insurance to be more expensive than it might be (a phenomenon known as moral hazard). Second, insurance is most attractive to people who expect to benefit most from it—such as those with chronic conditions and people who plan to have children. Because insurers can only imperfectly match premiums to expected utilization, they have to assume that purchasers have higher costs than the population average. That means that healthy people get a relatively bad deal from insurance—unless they can align themselves with a large group. (This feature of insurance is called adverse selection.) Third, the existence of free—even if inadequate—emergency health care for those with low incomes serves as a deterrent for purchasing health insurance, both because the free care provides a safety net and because uncompensated care raises the cost of care for those with insurance. Finally, healthy people—especially in the non-group market—can only imperfectly insure against the costs of

[1] Hadley (2003) estimates that mortality declines by 4.5 to 7.0 percent for people when they gain health insurance.

developing chronic illnesses, because premiums for non-group health insurance increase over time for sick people.

Subsidizing individuals who get insurance at work mitigates some of these problems and exacerbates others. On the one hand, encouraging individuals to get insurance at work reduces the problem of adverse selection, because people choose employment for reasons unrelated to health status, and also offers those who work for large firms a kind of renewable insurance. But this pooling works less well for small employers whose costs may be heavily influenced by the poor health status of one or several employees. On the other hand, the tax subsidies encourage over-use of medical services because people don't face the true costs of insurance. And, as noted, the current tax subsidies are poorly targeted. The value of a tax exclusion grows with income and is worth little or nothing to those with low incomes, even though they are most likely to be deterred by the cost of insurance.

On balance, despite its failings, the current employer-based system supplies health insurance coverage to almost 70 percent of American workers under age 65. Reform should build upon that coverage base instead of eroding it. Simplistic market-based solutions, though appealing, are likely to come up short. Market reforms that ignore adverse selection, for example, or the fact that a growing fraction of Americans simply cannot afford to pay for health care and meet other basic needs are bound to fail. The best option is to retarget existing subsidies, guarantee that low-income people can afford adequate insurance and that affordable health insurance exists either at work or in a reformed nongroup market, without encouraging excessive spending. And the best option might be one that works outside the tax system.

In the rest of my testimony, I summarize the latest data on who has health insurance and who doesn't, outline the various tax subsidies that exist for health insurance, examine how those subsidies affect the market for health insurance and employment, and briefly comment on some reform options.

Summary Data and Historical Trends

Most working-age Americans and their families receive health insurance through employers. According to the March 2005 Current Population Survey (CPS), 156 million non-elderly Americans (61 percent) in 2004 received primary health insurance coverage from either their own or a family member's employer (see figure 1). Of the 39 percent without employer-sponsored insurance (ESI), almost half were uninsured and most of the rest were enrolled in a public health plan (including Medicaid, Medicare, or a program sponsored by the Department of Veterans Affairs).[2] Only 5 percent of Americans under age 65 were covered by private non-group insurance in 2004.

The number of non-elderly people who lack health insurance has grown dramatically over the past two decades. In 1987, fewer than 32 million reported no source of health insurance (see figure 2). After a temporary reversal in the late 1990s, when a tight labor market and moderate growth in health insurance premiums caused more employers to offer health insurance,

[2] VA insurance includes CHAMPUS, CHAMPVA, and any government-sponsored military health insurance plan.

the declining trend in insurance coverage resumed in 2000. By 2004, more than 45 million individuals under age 65 had no health insurance, according to the CPS.[3]

The uninsured are disproportionately young, poor, and working in small firms (see table 1). Only 12 percent of workers between ages 55 and 64 were uninsured in 2004, but nearly 27 percent of workers between ages 18 and 34 lacked health insurance coverage. Workers in poor households are much less likely to have insurance coverage than those with modest or higher incomes. Over half of poor workers (those in families with incomes below the federal poverty level) and about 40 percent of near-poor workers (those in families with incomes up to twice the federal poverty level) lacked insurance in 2004. In contrast, only 23 percent of workers with incomes between two and three times the federal poverty level and 6 percent of those with incomes greater than four times the federal poverty level were uninsured.

Small firms are much less likely than larger firms to offer health insurance. In 2004, about 52 percent of workers at firms with fewer than 25 employees were covered through their own or their spouse's employer; 33 percent were uninsured. In contrast, 78 percent of workers at firms with more than 1,000 employees were enrolled in an employer-sponsored health insurance plan, while 14 percent remained uninsured.

Although much of the disparity between small and large firms probably stems from the higher premiums charged to small groups, another factor is the difference in income levels between workers at small and large firms. Employees at small firms often earn less than employees at large firms, and so are less likely to have health insurance coverage for that reason. Indeed, Nichols et al. (1997) found that high-income workers at small firms in 1993 were more likely to be offered ESI than low-income workers at large firms.[4] Nonetheless, workers at every income level were much more likely to be offered insurance by a large employer than by a small one.

While few people rely on non-group health insurance plans for primary coverage, those without access to ESI are much more likely to do so. Non-group coverage is especially important to workers in small firms. Nearly 8 percent of workers in firms with fewer than 25 employees were covered by non-group coverage. For workers in firms with 100 or more employees, the figure was 3 percent.

There are also significant differences in coverage between adults and children: children are much more likely to be insured. While 20 percent of adults lacked health insurance in 2003, less than 12 percent of children did. (Burman and Gruber, 2005) This pattern holds across

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[3] The two lines on the figure reflect an inconsistency in the data series. Starting with the March 2000 CPS, which collected data for 1999, interviewers asked respondents who did not report any type of health insurance whether they were, in fact, uninsured. Of the 42.1 million persons who did not report health insurance coverage prior to the verification question, 3.1 million responded that they were not uninsured and did in fact have health insurance coverage (Nelson and Mills 2001). This reduces the number of uninsured in 1999 to 39.0 million. Again, in 2001, 3.5 million people who did not report having insurance said that they were not uninsured in response to the verification question. Based on this evidence, the number of people without health insurance in 1987 was likely under 30 million rather than the 31.8 million reported.

[4] In addition, lower-income workers are less likely to accept an offer of health insurance than those with high incomes because they cannot afford to pay their share of the premium.

income levels. Poor children are about half as likely to be uninsured as poor adults. Even among higher-income households, adults are more likely to be uninsured than children. Several factors explain this dichotomy. First, few childless families qualify for Medicaid, regardless of income, and State Children's Health Insurance Programs (S-CHIP) cover some children ineligible for Medicaid. Second, at higher incomes, families with children may value health insurance more than childless households do. Third, childless non-elderly adults are probably younger on average than those with children. As mentioned, younger adults are much less likely to have insurance.

Current-Law Treatment of Employer-Sponsored Insurance

The tax law provides substantial subsidies for employment-based health insurance. Employer contributions to employee health insurance are treated as nontaxable fringe benefits and are not considered part of total compensation for both income tax and payroll tax purposes.[5] However, if the employer contribution does not cover the entire premium, the employee pays for the remainder out of after-tax dollars. In other words, the tax exclusion applies only to the employer's share of the premium. But employees with access to flexible spending accounts (FSAs) may be able to pay their share out of pre-tax dollars.[6]

Employers may purchase insurance for their employees or provide insurance themselves (i.e., self-insure—typically, in a plan managed by a third-party administrator). Section 105 of the Internal Revenue Code sets out nondiscrimination rules for benefits provided by self-insured plans. These rules aim to prevent highly compensated managers from providing generous tax-free benefits for themselves that are not available to the rank-and-file workers.[7] The Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured plans from state mandates and health insurance premium taxes that apply to third-party insurers.

Section 125 of the Internal Revenue Code allows employers to set up so-called "cafeteria plans" for administering certain employee benefits. A cafeteria plan allows employees to choose to receive part of their compensation either as cash wages or as one or more nontaxable fringe benefits, including health insurance. Flexible spending accounts are similar to cafeteria plans. They allow employees to set aside a fixed dollar amount of annual compensation to pay for out-of-pocket expenses for medical and dental services, prescription drugs and eyeglasses, and the employee's share of the cost of employer-sponsored health insurance. An FSA is financed through regular salary reductions. Any amount unspent at the end of the year is forfeited to the employer.[8] Employees pay no income or payroll taxes on the medical-related benefits paid

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[5] See Lyke (2006) for an excellent summary of current-law tax provisions and proposals related to health insurance.

[6] These employees tend to be at larger firms. FSAs are discussed later.

[7] In contrast, no nondiscrimination rules apply to the provisions of commercially purchased health insurance. The Tax Reform Act of 1986 included a new Section 89, which sets out nondiscrimination rules for employee health and welfare benefits, but the new restrictions raised a firestorm of protest among business interests and others and were repealed in 1989.

[8] Treasury Notice 2005-86 allows employees a grace period of up to two and a half months beyond the end of the calendar year to submit charges for reimbursement under a health FSA if the employer permits.

through a cafeteria plan or FSA. As a result, employees with access to such plans may pay for all or most of their medical costs with pre-tax dollars.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amended ERISA to require employers with 20 or more employees who provide health insurance (whether self-insured or not) to allow participants and other beneficiaries (i.e., family members) to purchase continuing coverage for at least 18 months after it would otherwise cease for any reason, including termination, death, or divorce. Employers can charge covered employees up to 2 percent more than active employees for continuation of coverage.

The Trade Adjustment Assistance Reform Act of 2003 created a 65-percent refundable tax credit for health insurance purchased by workers certified by the Department of Labor as having lost their jobs due to foreign competition. Workers covered by a pension taken over by the Pension Benefit Guaranty Corporation also qualify.

Most individuals who purchase their own insurance directly, whether through COBRA or not, cannot deduct the cost. However, individuals may deduct the portion of premiums they pay for health insurance plus other medical expenses that exceed 7.5 percent of adjusted gross income (AGI). In addition, starting in 2003, the self-employed could deduct their health insurance premiums from income tax (though not payroll tax).[9]

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a four-year pilot program to make Medical Savings Accounts (MSAs) available to a limited number of people who are self-employed or work for small firms. The Medicare Prescription Drug Improvement and Modernization Act of 2003 renamed MSAs Health Savings Accounts (HSAs) and made them available to workers regardless of firm size. To qualify, individuals must be under age 65 and covered by a high-deductible health insurance plan, either offered at work or purchased in the non-group market. The deductible must be at least $1,050 for single coverage and $2,100 for family coverage. The maximum deductibles in 2006 are $2,700 and $5,450, respectively.[10] Employer contributions to an employee's HSA up to the deductible are excluded from taxable income for both income and payroll tax purposes—just as contributions to ESI are. Individuals' contributions to an HSA are deductible for income tax purposes.[11] Individuals 55 to 64 may make additional "catch-up" contributions of up to $700 in 2006.[12] Balances in an HSA may be withdrawn to pay for qualifying medical expenses without penalty; non-medical withdrawals are subject to income tax, and withdrawals made before age 65 are subject to an additional 10 percent penalty. Unspent balances in an HSA can accumulate tax-free.

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[9] Before 2003, self-employed people could only deduct a portion of their health insurance premiums.

[10] The deductible limits are indexed for inflation.

[11] If the individual contributions are made through a cafeteria plan, they are also excluded from income for payroll tax purposes.

[12] The catch-up contribution limit phases up to $1,000 by 2009. The concept of a catch-up contribution was implemented for individual retirement accounts and defined contribution plans in the Economic Growth and Taxpayer Relief and Reconciliation Act of 2001, based on the logic that women had to make additional contributions to catch up for the time spent out of the labor force. This is a dubious justification for a provision that mostly benefits men, but its application to HSAs is truly puzzling since their ostensible purpose is to offset unusually high medical expenses, not provide another retirement savings vehicle.

These supplemental tax subsidies for health insurance are small compared with the exclusion for employment-based health insurance. They will reduce income tax revenues by an estimated $13 billion in fiscal year 2007. In contrast, the employer exclusion will reduce income tax revenues by between $102 and $147 billion in the same year.[13] Including payroll taxes, the total revenue loss could exceed $200 billion per year.[14]

Health Insurance Market Failure

One of economics' great insights is that, under certain circumstances, unfettered free markets can produce the most efficient (though not necessarily the fairest) outcomes. As Adam Smith noted, however, the invisible hand operates only if a number of conditions are met. *And virtually all of the conditions for market efficiency fail in the market for health insurance.*

For example, market efficiency requires that buyers and sellers have complete product information. Yet lack of information is an endemic problem for both suppliers and consumers in the health insurance market. Insurers have only a limited ability to determine the health status—or actuarial risk—of any individual. So a health insurance company that sets a fixed price for individuals in a particular class is most attractive to those with the highest risk. Thanks to this so-called adverse selection, the average insurance purchaser is riskier than average, which raises the insurer's costs and forces premiums to rise. Higher premiums then drive out lower-risk individuals, and the "death spiral" continues. If adverse selection is severe enough, a market might even disappear (Rothschild and Stiglitz 1976).

Medical care is a unique commodity—when people become sick, they'll do almost anything to get well. And because information on the effectiveness of various therapies is often lacking, physicians trying to provide the best care possible may prescribe tests or treatments even without evidence that they will lead to improved health. Aside from any moral or ethical objections, this lack of information renders cost-benefit analysis nearly impossible for the physician or patient. That means that healthcare decisions are often made with little regard for cost (Aaron 1991). This price-blindness may be a virtue for the ill, but it is a vice from an economic perspective.

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[13] The official government estimates are done for Congress by the Joint Committee of Taxation (JCT) and for the administration by Treasury's Office of Tax Analysis (OTA). Their estimates for the deduction for medical expenses and for health insurance premiums of the self-employed are similar, but their estimates for the exclusion from income tax of ESI diverge markedly. OTA estimates that the latter provision will reduce revenues by $147 billion in fiscal year 2007; JCT estimates a $102 billion revenue loss. The JCT estimates are smaller because they assume that, absent the tax exclusion, individuals who itemize deductions would be able to deduct the part of their health insurance premiums that, combined with other medical expenditures, exceeds 7.5 percent of AGI. OTA does not account for this offsetting deduction because it would logically require an increase in the tax expenditure estimate for the itemized deduction for health expenditures. Note that tax expenditure estimates are different from revenue estimates because, by convention, they do not take into account most behavioral responses or interactions with other tax expenditures. See Office of Management and Budget (2006) and JCT (2005).

[14] Payroll tax revenue losses are more than half of the income tax revenue cost. (See Burman et al. 2003.) Thus, conservatively, the payroll tax expenditure would be at least $76 billion, based on Treasury numbers, or $51 billion, based on JCT's estimates. This yields a range of $153 to $223 billion or more for the combined revenue loss.

Insurance gives individuals an incentive to use too much health care because they have to pay only a fraction of the cost (the deductible and coinsurance). They will demand medical procedures until the marginal benefit to them equals their out-of-pocket expense.[15] Fully-insured individuals may consume care until its marginal benefit is nil. To counteract this tendency, many insurers rely on managed care schemes that limit unnecessary medical expenditures.

But how much of the cost of medical care is due to this moral hazard that arises from the low net-of-insurance price of insured care? Newhouse (1992) argues that the lion's share of growth of health expenditures stems from advances in medical technology, not moral hazard. He concludes that overzealous efforts to limit moral hazard could do more harm than good if they reduce the incentive for medical innovation.

So-called free riders create another classic market failure. Because hospitals generally do not turn away very sick people who need care, the incentive to purchase insurance is diminished, especially for people who have little wealth to protect. So a small part of the health cost incurred by insured people and taxpayers is the cost of providing care for other individuals who did not provide for their own insurance—that is, those who choose to "free-ride" (Olson 1982).

Finally, full economic efficiency requires the existence of complete markets against not only current, but also future, risks. But it is virtually impossible to insure fully against future illness. Individuals cannot generally contract for health insurance at fixed rates, or under fixed terms, for more than one year in advance. While individuals can buy policies with rates determined by the experience of a subscriber group who purchased at a certain time, adverse selection makes such pools too expensive for healthy members over time. Members of the pool who turn out to be healthier than average can find insurance elsewhere with lower premiums. As the healthiest drop out, those who become sick and remain in the pool end up paying very high premiums. Thus, even in a set pool, insurance costs are based on health status in the future as well as when the policy is purchased (Hall 2000a).

The 1996 Health Insurance Portability and Accountability Act requires that all non-group insurance be renewable, but there is no limit on annual premium increases. Some states attempt to regulate premiums in the non-group market, but insurers can often find ways to circumvent such regulations (Hall 2000b).

Inability to renew on favorable terms may also arise in the employer market because premiums are underwritten. A large employer group partially solves this problem by continually refreshing the pool with healthy members who participate in the group for reasons largely unrelated to health status. Small employers, however, may be even more vulnerable to poor health outcomes than individuals in the non-group market are.

Effects of Current Tax Subsidies

The federal government spends $200 billion or more a year on tax incentives for employer-sponsored health insurance. Those incentives encourage employees to participate in health

[15] The marginal benefit is net of non-pecuniary costs, such as pain and discomfort, and other costs, such as lost time from work.

insurance plans, reducing adverse selection and free riders. At the same time, the subsidy prompts employees to demand more comprehensive health insurance than they would if they had to pay the full price. More comprehensive insurance exacerbates moral hazard (Congressional Budget Office 1994). The tax incentive thus contributes to high health care costs.[16] Combined with state laws and courts that put pressure on insurers to provide more and more benefits, health insurance costs in the small group and individual markets climb out of reach of low- and moderate-income households.

Health Savings Accounts are intended to mitigate the moral hazard problem by encouraging individuals to make more cost-conscious healthcare decisions. But HSAs may exacerbate the problem of adverse selection because the high-deductible plans will be most attractive to healthy individuals.

Similarly, there are both advantages and disadvantages to tying health insurance to employment. The main advantage of subsidizing ESI is that employment is a natural way to pool health insurance risks since people choose employment for many reasons other than their expected use of health care. Employment pooling works best for large firms, but Pauly and Herring (1999) claim that even relatively small groups can effectively pool most risks.

Another advantage with large groups is that administrative and marketing costs are lower (Monheit, Nichols, and Selden 1995). Collecting premiums as a part of payroll processing is less expensive than direct billing. Collecting insurance premiums, either explicitly or implicitly as a part of payroll processing, may also be an especially effective way to encourage participation because individuals like to break up large expenses into small, automatically collected pieces (Thaler 1992). Also, participation rates are higher if the choice facing workers is framed in terms of opting out rather than opting into an insurance plan. Large groups also have bargaining power to lower costs when dealing with insurers and providers. And, to the extent that workers can count on long-term employment with an established firm, ESI may provide more protection against premium increases than does the individual market.[17]

But ESI has drawbacks as well. It is an imperfect pooling mechanism. In a small firm, if one person gets sick, average costs can jump. Also, ESI provides limited renewability at best. People can lose their jobs or employers can decide to drop coverage—for example, because of

[16] Indeed, Steuerle (2004) argues that, by pushing up the price of medical services and insurance, the tax subsidy actually reduces the number of people with insurance.

[17] An actuarially fair premium for a long-term health insurance contract would be one that does not vary over time in response to *unexpected* changes in health status. The long-term health insurance contract could allow premiums to vary with age to reflect the normal increase in health expenditures that accompanies aging, much as term life insurance contracts call for increasing premiums with age to reflect higher expected mortality risk. Initial premiums under such a contract would probably be higher than those in the current individual market because they would provide insurance protection not only against the health care costs incurred during that year, but also against increased premiums due to unexpected declines in health status. (A mitigating factor, however, is that long-term insurance might be more attractive to people who are healthier than average because they would value the insurance against future declines in health status.) As discussed earlier, individuals may find that their non-group health insurance premiums increase over time if they turn out to be sicker than average, even if they were healthy when they first purchased insurance (Hall 2000a). However, as discussed later, it may not be feasible for any single insurer to offer an actuarially fair premium schedule set for periods longer than one year because of adverse selection among individuals covered by such insurance.

unacceptably large premium increases.[18] Although no better mechanism for pooling or renewability currently exists in the individual market, such a mechanism might have arisen were it not for the large tax subsidy for ESI. For example, if they were subsidized, professional associations, unions, or religious institutions might also offer group health insurance policies to their members, much as they do with life insurance (Pauly and Herring 2001).

Finally, the subsidy for ESI amplifies the advantage of large firms over small ones as payers for health insurance. To see why, imagine a world without a tax exclusion for ESI. Many large firms might still offer health insurance even without a tax subsidy because of their advantages in pooling and lower administrative costs. Few if any small firms would. Now, after a tax exclusion is introduced, taxes fall for employees of firms that offer health insurance, but not for employees of other firms. Firms that do not offer health insurance now would face pressure from their employees to offer this valuable tax-free fringe benefit, and many would do so, but their compensation costs would increase relative to the large firms because, for a given package or benefits, health insurance is more expensive for small firms. The higher benefit costs place smaller firms at a competitive disadvantage. Effectively, the tax exclusion for ESI is a differential labor subsidy that is most valuable to large firms. It distorts the allocation of labor in favor of large firms and reduces production efficiency because workers who might be more productive at small firms are induced to shift to large firms by the tax subsidy.

The subsidy for ESI also creates other production inefficiencies. It gives employers an incentive to outsource low-income and younger workers (who would not value the insurance as much) and distorts workers' decisions about work and retirement (CBO 1994).

For all its imperfections, however, ESI covers almost 70 percent of American workers. Although some analysts believe that a better mechanism would arise if there were no ESI, there is a risk that major tax changes could significantly reduce insurance coverage. Removing or reducing employers' incentives to sponsor health insurance would have mixed effects on coverage. Although some young, healthy people might be induced to acquire coverage in the individual non-group market under a different set of incentives, the loss of ESI could be particularly devastating to old and unhealthy workers who would face prohibitively high health insurance premiums in the private non-group market.

Thus, the conundrum: almost 45 million Americans lack health insurance. Subsidizing the purchase of private non-group insurance for those who cannot obtain it at work seems a natural remedy. But subsidizing private non-group insurance makes employment-based insurance less valuable to those who could enroll in subsidized private insurance. Some employers will stop sponsoring health insurance if their workers do not demand it. Certainly, not all the workers at those firms would purchase non-group coverage. Others may increase the employee share of premiums or increase the cost-sharing requirements under the company health insurance plan (i.e., provide less generous insurance). Depending on how employers respond, a new coverage initiative could ultimately reduce the number of people with health insurance.

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[18] HIPAA requires insurers to offer insurance to terminated employees who have exhausted their COBRA coverage, but insurers can and do charge much higher rates for HIPAA customers. For example, CareFirst (Blue Cross-Blue Shield) charges a markup of about 80 percent for HIPAA coverage in Virginia compared with otherwise identical underwritten policies (http://www.carefirst.com, March 6, 2006).

Who Benefits from the ESI Subsidy?

The current tax exclusion for employment-based health insurance benefits some workers more than others. Clearly, the exclusion does not help uninsured workers. Even among workers with employer-sponsored coverage, the benefits of the tax exclusion vary widely. Individuals in low tax brackets—mostly low-income people—get little or no benefit from the tax exclusion. Those—mostly higher-income families—with more generous coverage, such as family coverage or insurance with low deductibles, benefit more because the premiums for their health insurance policies are higher.

For three reasons, the subsidy for ESI most benefits those with high incomes. First, because the subsidy is provided in the form of an exclusion from income, it is most valuable to those who face high marginal tax rates. Second, those with low incomes are much less likely than people with higher incomes to be in jobs that offer health insurance. Third, lower-income people who do get health insurance at work tend to get less generous coverage than those with higher incomes do and their employers tend to pay a smaller share of the premium.

The value of the tax exclusion increases with income

Earning compensation in the form of health insurance rather than wages produces indirect tax benefits. It can reduce both income tax and payroll tax liability. For example, people in the 15 percent federal income tax bracket save $150 in income taxes for every $1,000 of wages converted to employer contributions toward health insurance premiums. They save another $76.50 in Social Security and Medicare payroll taxes. In most states, they also pay less state income tax. So the combined value of income and payroll tax exclusions can reduce the overall cost of health insurance by 25 percent or more for middle-income families.

The value of the tax exclusion increases sharply with income because income tax rates rise with income. The Tax Policy Center estimates that almost 31 percent of households were exempt from income tax filing or were in the zero tax bracket in 2005.[19] Most of them did not save anything in federal income taxes from reducing their taxable wages.[20] Another 15 percent were in the 10 percent bracket and 34 percent were in the 15 percent bracket. The income tax exclusion is worth 15 cents on the dollar or less to those households. Only about 20 percent of households were in the 25 percent or higher tax bracket.

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[19] Table T06-0054, available at www.taxpolicycenter.org/estimates. In 2005, 14.4 percent of tax filing units (generally, households) did not file and another 16.2 percent filed but were in the zero tax bracket (meaning that they had zero taxable income after claiming deductions).

[20] Some people in the zero bracket who receive ESI may benefit from the exclusion of employer-sponsored health insurance from taxable income. Some people's incomes are below the filing threshold simply *because* their health insurance premiums are excluded from income. For example, an individual earning $8,200 in 2005 had no taxable income. However, if her employer stopped contributing $2,000 toward health insurance and instead increased her wages by that amount, she would have positive taxable income and owe $200 in income tax (before any credits). Note, though, that few people at this income level receive ESI (see table 1). There are also families in the 10-percent and higher tax brackets that would receive no benefit from the tax exclusion because nonrefundable tax credits such as education and dependent care tax credits offset all their income tax liability.

The Tax Price of Health Insurance

The tax price of health insurance to employees measures how taxes alter the price of health insurance.

The tax price of ESI is 1 - *as*, where *a* is the share of the premium paid by the employer and *s* is the subsidy rate for ESI. Thus, if there are no tax subsidies ($s = 0$) or the employee pays the entire premium ($a = 0$), the tax price is 1. If *s* is 0.5 and *a* is 1, the tax price is 0.5. The lower the tax price, the less expensive health insurance is after tax savings are subtracted. If the employer pays 50 percent ($a = 0.5$), the tax price increases to 0.75. Thus, the smaller the share paid by employers, the higher the tax price.

The lowest-income taxpayers receive no benefit from the income tax exclusion and only a small benefit from the exclusion of Medicare payroll taxes.[21] The exact amount of savings depends on whether workers or employers ultimately pay the employer's portion of payroll taxes. Most economists believe that workers pay the tax indirectly because wages are lower than they would be if the employer weren't paying for health insurance. To see why wages are lower, suppose an employer is willing to pay $20,000 to a particular worker before considering taxes. If the employer has to pay payroll taxes at a rate of 7.65 percent, the employee now costs more than he or she is worth to the employer. Either the employee will not be hired or retained, or compensation would have to decline to $18,579 or less to make the employee attractive to the employer. (Payroll tax on $18,579 is $1,421, so the total after-tax cost of the employee is $20,000.)

At least in the long run, employees are likely to pay the cost of the employer portion of payroll taxes in the form of lower wages. The exception to this rule would be situations where compensation is not set freely in a competitive labor market. An obvious example would be workers earning the minimum wage whose employers are prevented by statute from passing along payroll taxes (or most other labor expenses) in the form of lower wages.[22]

In 2005, the subsidy created by the exclusion from income and Medicare payroll taxes was worth about three cents on the dollar to the roughly 30 percent of households who were non-filers or in the zero tax bracket in 2005 (see figure 3). That is, the after-tax "price" of the portion of health insurance provided by employers was 97.1 percent of the pre-tax price for employees in the zero tax bracket. If employers cannot lower wages to offset their payroll tax costs, the employee's tax price would be close to 99 percent of the pre-tax price of health insurance.

Employees in the 10 percent income tax bracket pay a tax price of 87.3 percent, those in the 15 percent bracket pay 82.4 percent, and those in the 25 percent tax bracket face a tax price of 72.5 percent. The 0.4 percent of tax filing units in the highest 35 percent tax bracket face a tax price of 62.6 percent. Put differently, the richest 0.4 percent of tax filers get subsidies 12 times bigger than the poorest 30 percent get.

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[21] They would also save on Social Security payroll taxes, but that saving comes at the expense of lost benefits at retirement, a significant factor for low-income workers, as discussed later. Very low income workers may also save unemployment insurance taxes, but those savings also come at the expense of lost potential benefits.

[22] This is one reason small firms and those with low-wage workers are less likely to offer ESI.

The issue is a bit more complex in the case of Social Security taxes. If we include savings in Social Security taxes, the tax price faced by low-income workers would fall from 97.1 percent to 85.8 percent of premiums. Social Security benefits, however, are highly progressive, so reduced future benefits are likely to offset much or all of a low-income person's payroll tax savings. Feldstein and Samwick (1992) estimate that the lifetime effective Social Security tax rate (including both payroll taxes and benefits) for employees with low covered earnings was negative in 1990. That is, the present value of future benefits more than offsets the tax paid for people with very low earnings. If employees understand that their current taxes will produce a valuable future benefit, then it may be inappropriate to treat Social Security payroll contributions as a tax for lower-income people.[23] So workers with low lifetime incomes may view the tax savings from health insurance as conveying no benefit at all since they sacrifice more than a dollar of retirement benefits for every tax dollar saved now.

The connection between Social Security benefits and taxes is weaker for higher-income people. For them, it might be more appropriate to treat Social Security payroll taxes as a pure tax. If so, someone in the 15 percent federal income tax bracket faces a tax price for health insurance of as little as 72 percent of premiums. In the 25 percent tax bracket, the price is under 63 percent. For very high income taxpayers, the price can fall near 50 percent, but most primary earners in the 35 percent tax bracket do not pay Social Security taxes on the margin, so the 63 percent tax price is more appropriate.[24]

Effective tax subsidy rates

The tax exclusion for ESI provides a subsidy for health insurance that varies both among individuals and among firms. An individual gets no benefit from the tax exclusion if his or her employer does not offer health insurance. Even if the employer offers insurance, the employee may not be eligible for it because he or she works part-time. The subsidy rate generally depends on the percentage of the health insurance premium that is paid for by the employer. One exception is if the employer offers employees access to a flexible spending account, which allows employees to pay for their own share of premiums with pre-tax income. For employees with access to ESI, the overall size of the subsidy is governed by the amount of the premiums, and the subsidy rate depends on their income and payroll tax rates.

Virtually all factors that lead to high subsidy rates on health insurance increase with income. Burman et al. (2003) estimated effective subsidy rates by income in 1998.[25] As noted, the likelihood of having employer-sponsored insurance coverage increased dramatically with

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[23] Feldstein and Samwick (1992) point out that many individuals with low covered earnings were not in fact poor, but earned most of their income working for state and local governments that were exempt from the Social Security payroll tax.

[24] On the other hand, phantom taxes caused by the phaseout of itemized deductions and other provisions can increase the effective tax rate for upper-middle- and upper-income taxpayers. However, since these taxes are obscured by the complexity of the tax law, it is unclear that they would affect most taxpayers' decisions (Burman and Gale 2001).

[25] These estimates are the most recent available to my knowledge. They would tend to overstate subsidy rates at all income levels except the bottom (which is generally not subject to income tax) because of the income tax rate reductions enacted in 2001 through 2003. However, the basic picture of a tax subsidy that increases with income and premium costs that decrease as a share of income is still accurate.

income. Only 11 percent of families with incomes below $10,000 had health insurance through their job, compared with over 80 percent of families with incomes above $40,000. Lower-income families were less likely to work in jobs that offered health insurance coverage (Cooper and Schone 1997). Even if their employer offered it to full-time employees, low-income people are more likely to work either part-time or part-year, and therefore be ineligible for health coverage.

Accordingly, the value of the tax exclusion also increases dramatically with income. Among families with employer-sponsored health insurance, the premiums for those with incomes below $20,000 averaged less than $2,800 in 1998 (Burman et al. 2003). Average premiums more than doubled for families with incomes above $75,000. Higher-income families average higher premiums because they are more likely to be covered by multiple policies and have family rather than self-only coverage. Indeed, the average family size for those with incomes below $20,000 is about 1.9, compared with 3.1 for those with incomes above $75,000. In addition, lower-income families are more likely to have coverage for less than a full year because of part-year employment.[26] The average employer premium share also increased with income, from 66 percent for families with incomes less than $10,000 to 79 percent for families with incomes of $200,000 or higher.

Finally, as discussed earlier, the benefit of any tax exclusion is greatest for high-income families because the income tax is progressive. That is, excluding a dollar of income from tax is worth much more to someone in the 35 percent tax bracket than to one in the 10 percent or 0 percent tax brackets.

Putting all these factors together, the picture is of a tax subsidy that overwhelmingly favors middle- and upper-income households. Families in the lowest income group received an average tax subsidy (including both income and payroll taxes) worth 9 percent of their premiums in 1998, compared with a subsidy of 33 percent of premiums for the highest-income group.[27] Consequently, while high-income families on average receive ESI worth three times as much as that received by low-income families, it only costs 2.3 times as much after tax savings are considered. (Note, however, that lower-income employees may receive some indirect benefits if employers subsidize their premiums to induce participation and to the extent that employer-based health insurance is less expensive than nongroup insurance.)

The bottom line is that the subsidy is not at all targeted to those who most need help paying for health insurance. Health insurance premiums were 40 percent of income for the poorest households in 1998, but their subsidy rate was less than 10 percent (see figure 4). Those with incomes over $200,000 received subsidies equal to one-third of premiums even though premiums would amount to only 3 percent of their income without a subsidy.

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[26] It is probably also true that higher-income people demand more generous health insurance coverage from their employers than their lower-income counterparts, just as higher-income people are more likely to drive a Lexus than a Chevy. Unfortunately, I am not aware of any evidence on the quality and comprehensiveness of health insurance plans offered by employers to employees at different income levels.

[27] The measure of the tax subsidy shown here reflects both the federal income tax and the payroll tax, and applies to premiums only. It does not consider any worker premiums paid on a pre-tax basis or other pre-tax contributions made to a flexible savings account, each of which will also favor higher-income workers relative to lower-income workers.

Conclusion and Policy Options

The government provides $200 billion or more in annual tax subsidies for employment-based health insurance. Consequently, over 60 percent of Americans under age 65 are insured through an employer. (Americans age 65 and over are primarily covered by Medicare.) However, there are significant gaps in coverage, especially among small firms and low-income workers. Current tax subsidies are poorly suited to addressing those gaps because they favor higher-income workers and large firms that face the lowest insurance costs.

Because of the rampant failures in the health market, solutions are not simple. The data, however, suggest some obvious directions for improvement. To start, the upside down tax subsidy should be set right. Currently the largest subsidies go to those who have a strong incentive to get health insurance, even absent a subsidy, while those for whom health insurance is unaffordable get little or nothing. A better option would replace the tax exclusion with a refundable credit targeted at those earning less than the median income.

The President has proposed such a subsidy, but it was limited to purchases in the nongroup market, and so would tend to undermine ESI, which still covers many low-income people. A better option would be to allow the subsidy for group and nongroup insurance. The President's proposals would also deal with a fundamental limitation of traditional tax subsidies—they come too late to help cash-constrained families pay for services. Those proposals would advance the credit based on prior year income and allow the credit to be transferred directly to insurers. Allowing the credit to be also transferable to employers who provide health insurance would be a significant improvement.

Rearranging the upside-down subsidy is much easier said than done. One option would be to phase out the subsidy at higher incomes. This would reduce the incentive of employers to provide overly generous health insurance, while still providing an incentive for many currently uncovered individuals and families to obtain coverage. However, it would generate a lot of political opposition. (See the reaction to the Tax Reform Panel's relatively modest cap proposal.) An alternative (not without its own political challenges) would be to come up with a dedicated revenue source, such as a VAT. (Some portion of VAT revenues could also be dedicated to another looming health crisis, the exploding unfunded costs of Medicare and Medicaid as the baby boomers reach retirement.)

A more incremental option would be to help small employers to offer health insurance—for example, by providing a refundable tax credit (or direct subsidy) to defray the higher administrative costs that small employers face in purchasing health insurance. A more far-reaching reform would guarantee that small employers who continually pay at least a certain percentage of their employees' premiums would be able to purchase insurance at large-group rates, for example, from a pool similar to the Federal Employee Health Benefits Program.[28]

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[28] It is important that purchasing reforms not become a new avenue for adverse selection in the health insurance market. For example, CBO (2000) estimated that a proposal to allow so-called Association Health Plans to skirt certain state regulations, including community-rating requirements, would save an average of 13 percent in premiums for employees in the plans, but at the expense of other (less healthy) employer groups, which would pay an average of 2 percent more in premiums because of unfavorable selection.

Some options, however, could undermine the current system of employment-based health insurance without dealing with the endemic problems in the nongroup market. For example, former Council of Economic Advisers chairman Glenn Hubbard and colleagues recently suggested that the best option would be to eliminate the employer exclusion altogether and let the market come up with cost-effective ways to supply health insurance to the public. The President's Advisory Panel on Tax Reform recommended limiting the employer exclusion and allowing individuals to get the same tax benefits in the individual nongroup market as they can get through employment-based coverage. And the President has proposed a major expansion of tax subsidies for health savings accounts (HSAs), including income tax deductions and payroll tax credits for individuals who purchase the companion high-deductible health insurance plans.

These proposals would likely reduce insurance coverage—at least over the short- to medium-term. While it is possible that an unfettered free market might develop institutional arrangements to deal with the problem of adverse selection (and the other health insurance market failures) over time, nobody knows how those mechanisms would work and they might not exist. Meanwhile, a small employer who can get the same tax benefits as her employees without going through the hassle and expense of providing ESI would be sorely tempted to drop insurance coverage. Indeed, the healthiest workers would be happy to take a small increase in wages in exchange for dropped ESI coverage because cheap tax-subsidized insurance would exist outside of work. Left out in the cold would be those who are older or less healthy than average, for whom nongroup insurance premiums would be much higher, and low-income people to the extent that they benefited from cross-subsidization within the firm. It is largely for that reason that Jon Gruber (2006) recently estimated that the president's proposals for expanded HSA tax subsidies would reduce coverage. And, even if the subsidies caused coverage to increase, it would be at great cost per new worker covered.[29]

Other more far-reaching options, such as an individual mandate with vouchers sufficient to help low-income households afford health insurance, might achieve universal or near universal coverage, but analysis of those options is beyond the scope of this hearing.

[29] See Burman and Gruber, 2005, for example.

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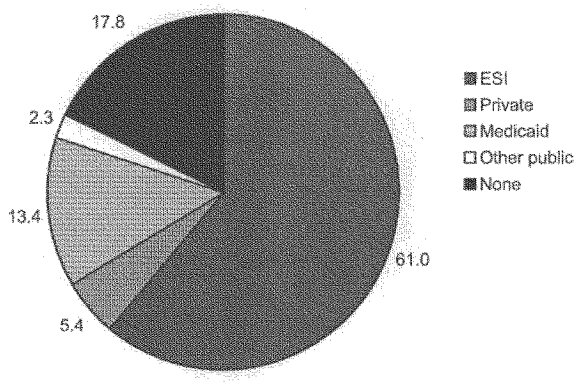
Table 1. Primary Source of Health Insurance for Workers Age 18 to 64, by Demographic Category, 2004

	Workers (millions)	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other	
Total - Workers	**143.0**	**69.6%**	**5.7%**	**4.4%**	**1.2%**	**19.1%**
Age						
18-34	**52.6**	**59.1%**	**6.7%**	**6.7%**	**0.9%**	**26.7%**
35-54	**70.8**	**75.5%**	**4.7%**	**3.3%**	**0.9%**	**15.5%**
55-64	**19.7**	**76.7%**	**6.5%**	**2.3%**	**2.7%**	**11.8%**
Worker's Annual Income						
<$20,000	**44.4**	**46.0%**	**8.0%**	**9.6%**	**1.7%**	**34.6%**
$20,000-$39,999	**46.9**	**72.6%**	**4.8%**	**3.1%**	**1.0%**	**18.5%**
$40,000+	**51.7**	**87.2%**	**4.5%**	**1.1%**	**0.8%**	**6.4%**
Family Poverty Level						
<100%	**12.6**	**20.2%**	**9.7%**	**18.0%**	**1.3%**	**50.8%**
100-199%	**22.1**	**42.1%**	**7.3%**	**10.0%**	**1.6%**	**39.0%**
200-299%	**23.6**	**66.3%**	**5.7%**	**3.5%**	**1.3%**	**23.2%**
300-399%	**21.6**	**78.9%**	**5.4%**	**1.9%**	**1.0%**	**12.9%**
400%+	**63.0**	**87.3%**	**4.4%**	**1.0%**	**1.0%**	**6.4%**
Work Status						
Full-time/Full-year	**99.1**	**76.6%**	**4.2%**	**2.5%**	**0.8%**	**15.8%**
Full-time/Part-year	**18.9**	**54.6%**	**6.3%**	**8.8%**	**1.7%**	**28.6%**
Part-time/Full-year	**13.3**	**55.7%**	**11.1%**	**6.0%**	**2.0%**	**25.1%**
Part-time/Part-year	**11.7**	**50.3%**	**10.6%**	**11.6%**	**2.5%**	**25.0%**
Business Size (# Workers)						
Self-employed	**13.2**	**47.6%**	**19.4%**	**3.6%**	**1.8%**	**27.7%**
<25	**29.7**	**51.9%**	**7.7%**	**6.0%**	**1.4%**	**33.0%**
25-99	**16.7**	**69.5%**	**4.5%**	**4.2%**	**0.9%**	**20.9%**
100-499	**16.3**	**75.2%**	**3.3%**	**4.7%**	**0.8%**	**16.0%**
500-999	**6.0**	**79.4%**	**2.3%**	**4.1%**	**0.6%**	**13.7%**
1000+	**40.0**	**77.6%**	**3.3%**	**4.4%**	**0.9%**	**13.7%**
Public Sector	**21.0**	**86.2%**	**2.4%**	**2.8%**	**1.6%**	**6.9%**
Race/Ethnicity						
White (non-Hispanic)	**99.7**	**74.7%**	**6.4%**	**3.4%**	**1.2%**	**14.3%**
Black (non-Hispanic)	**15.5**	**63.6%**	**3.5%**	**8.1%**	**1.5%**	**23.4%**
Hispanic	**18.9**	**48.8%**	**3.2%**	**6.9%**	**0.7%**	**40.4%**
Asian/S. Pacific Islander	**6.5**	**70.1%**	**6.9%**	**3.7%**	**1.0%**	**18.3%**
Am. Indian/Alaska Native	**0.7**	**50.4%**	**3.7%**	**11.4%**	**1.2%**	**33.2%**
Two or more races	**1.7**	**64.0%**	**6.9%**	**5.8%**	**2.2%**	**21.1%**

Source: Catherine Hoffman, Alicia Carbaugh, Hannah Yang Moore, and Allison Cook, *Health Coverage in America: Data Update 2004*. November 2005. The Kaiser Commission on Medicaid and the Uninsured. Available at: http://www.kff.org/uninsured/upload/Health-Coverage-in-America-2004-Data-Update-Report.pdf,

Note: Medicaid includes S-CHIP. Other includes other public insurance (mostly Medicare and military-related).

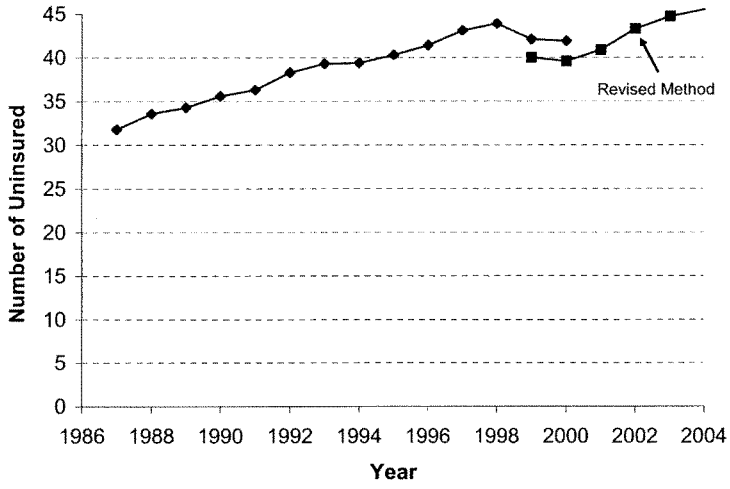
Figure 1. Primary Source of Insurance for Non-Elderly Americans in 2004



Source: Health Coverage in America: Data Update 2004. November 2005. The Kaiser Commission on Medicaid and the Uninsured. Available at: http://www.kff.org/uninsured/upload/Health-Coverage-in-America-2004-Data-Update-Report.pdf, accessed 3/06/06.

Note: Medicaid includes S-CHIP. Other includes other public insurance (mostly Medicare and military-related).

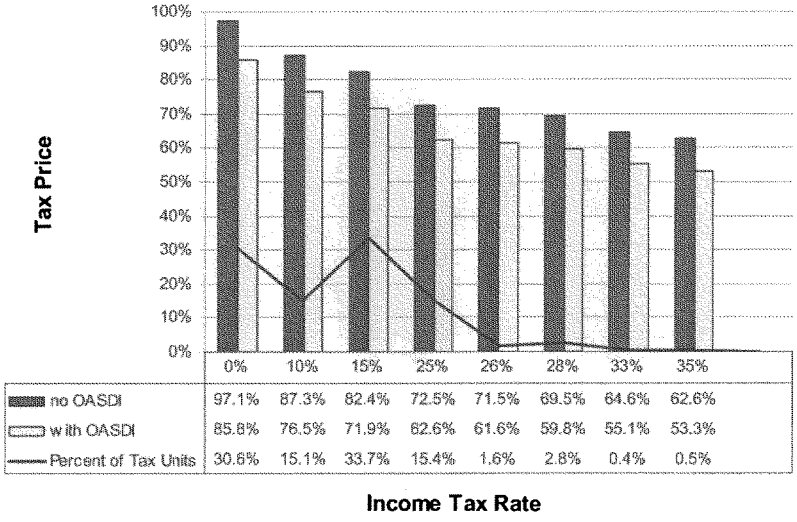
Figure 2. Non-Elderly Uninsured, 1987–2004, in Millions



Source: Paul Fronstin, Employee Research Benefit Institute (EBRI), "Sources of Health Insurance and Characteristics of the Uninsured," December 2000; and Catherine Hoffman, Alicia Carbaugh, Hannah Yang Moore, and Allison Cook, Health Coverage in America: Data Update 2004. November 2005. The Kaiser Commission on Medicaid and the Uninsured. Available at: http://www.kff.org/uninsured/upload/Health-Coverage-in-America-2004-Data-Update-Report.pdf, accessed 3/06/06.

Notes: Revised estimates include as insured those who did not report having insurance on the CPS but then said that they were not uninsured in response to a verification question, which was not asked before 1999.

Figure 3. The Tax Price of Health Insurance, 2005

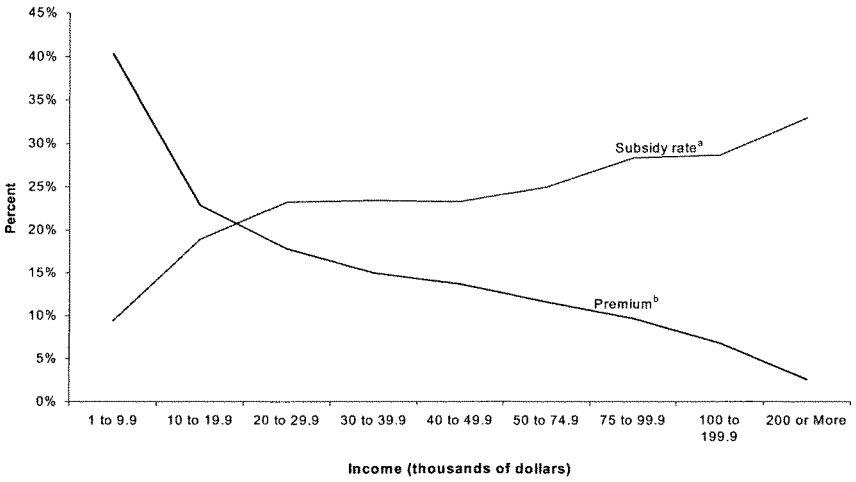


	0%	10%	15%	25%	26%	28%	33%	35%
no OASDI	97.1%	87.3%	82.4%	72.5%	71.5%	69.5%	64.6%	62.6%
with OASDI	85.8%	76.5%	71.9%	62.6%	61.6%	59.8%	55.1%	53.3%
Percent of Tax Units	30.6%	15.1%	33.7%	15.4%	1.6%	2.8%	0.4%	0.5%

Sources: Tax Policy Center Table T06-0054 and author's calculations.

Note: 26 percent bracket is an AMT rate only; 28 percent bracket includes both regular tax and AMT rates.

Figure 4. Health Insurance Subsidy Rate Compared with Premium Burden, by Income, 1998



Source: Leonard E. Burman, Cori E. Uccello, Laura Wheaton, and Deborah Kobes, 2003. "Tax Incentives for Health Insurance." Tax Policy Center Discussion Paper No. 12. Washington, DC: The Tax Policy Center.

[a] The subsidy rate is defined as the tax subsidy as a percent of premiums.

[b] The premium burden is calculated as the pre-tax premium as a percent of after-tax income.

Responses to Questions for the Record From Dr. Leonard E. Burman
March 8, 2006

From Senator Hatch:

Mr. Burman, you mentioned in your testimony that health insurance in a free market would likely be too expensive. One of the reasons you cited was that the very act of having insurance increases utilization. Is not this one of the reasons why Health Savings Accounts, with a high deductible insurance policy, can reduce health care costs?

A: The high deductible health plans HDHPs associated with HSAs are intended to reduce the incentive for over-spending on health care by making consumers more conscious of the cost of medical care. The concern about HSAs is that they would exacerbate another potentially more important problem in the health insurance market—adverse selection. Since healthy people will tend to be drawn to the HDHPs, premiums for conventional low-deductible insurance will eventually climb out of reach. And, for lower-income people especially those with chronic illness the high deductibles will represent a tremendous burden. This problem might be solved by increasing the deductible in HDHPs with income, as proposed by Martin Feldstein and Jonathan Gruber. Under that scheme, low-income people would face very low (or even zero) deductibles, whereas those with very high incomes would face very high deductibles (much higher than allowed under current law).

From Senator Snowe:

1: I would like to get your thoughts about how to address the crisis that faces small businesses when it comes to purchasing quality, affordable health insurance. This isn't a new crisis. We've now experienced double digit percentage increases in health care premiums in four of the past five years. Nearly 46 million Americans are uninsured, and, according to the Employee Benefit Research Institute, approximately 60 percent of whom work for a small business.

Study after study tells us that the smallest businesses are the ones least likely to offer insurance and most in need of assistance. According to the Kaiser Family Foundation, only 47 percent of the smallest employers, those with 3 to 9 workers, offer health insurance as a benefit. In contrast, 98 percent of larger businesses, defined as those with 200 or more workers, offer health insurance as a benefit.

Given this data, I believe there is a clear need to find practical and achievable solutions to solving the small business health insurance crisis. I believe that we can help through tax incentives.

Given that the tax code already allows a tax deduction for health care costs, what is keeping small businesses from offering health insurance and what additional policies can Congress enact to provide the most meaningful assistance to small businesses? Would it make sense to provide small businesses with a tax credit to cover employees as you referred to in your testimony?

A: Small employers face three primary barriers to offering health insurance: (1) They have to pay much, much higher loads (or commissions) for insurance than large employers (on a per employee basis); (2) They tend to have lower-income workers, which means that health insurance premiums can be a very large share of compensation; and (3) Their premium costs can skyrocket if one or two employees (or family members) become sick because they have a small group across which to pool risks.

Tax incentives could help here, but market reforms are also very important. One option that health experts have suggested is to create something like the Federal Employees Health Benefits Program that any individual or small employer could buy into with very low loads. I think the state of Massachusetts is implementing something like that as part of its plan to expand health insurance coverage.

Tax credits for offering coverage, especially to low-wage workers, could offset some of the disadvantage small employers face relative to large employers. They could serve as a nice complement to a market reform that would make insurance more affordable for small employers.

2: Small businesses face numerous barriers to providing their employees with quality, affordable health insurance. One primary reason is that there is virtually no competition in the state small group insurance markets. Last year, along with Senators Bond and Talent, I requested that the Government Accountability Office (GAO) study this issue.

The GAO report, released last November, shows a significant consolidation in the state insurance markets. The five largest carriers now have more than 75 percent market share in 26 states (up from 19 in 2002) and more than 90 percent market share in 12 states (as opposed to 7 in 2002). Insurers face almost no competition, which leaves small businesses with few–if any–health insurance coverage options and with a non-existent ability to affect the price of insurance.

What recommendations can you suggest for opening up the small group insurance market to encourage greater competition, lower prices, and provide small businesses with additional coverage options? Or, how can we use the tax code to incentivize more insurance companies to compete in the small group market, and to provide products and services in new and evolving markets?

A: My expertise is in tax policy rather than health economics so I do not have much authority to speak to the issue of insurance market competition. I think using a vehicle

like FEHBP to pool many small employers and require insurers to compete to offer products in the pool could be a helpful reform.

From Senator Baucus:

In your testimony you mentioned the potential inequitable tax effect that HSAs could have on lower-income uninsured individuals, and you mentioned that high-deductible plans individuals must buy with HSAs will be more attractive to healthy individuals. Do you think individuals with significant health care needs and chronic conditions are disadvantaged by HSAs as compared with employer-sponsored coverage? If so, why?

A: I do. HSAs work best for healthy individuals, especially those with high incomes, because they can expect to accumulate large balances over time, contributions are deductible, and the income earned in the HSA accumulates tax-free. Those with chronic illnesses like diabetes, however, can expect to spend more than the HSA deductible every year. On balance, they will be paying much more for health care than they did with traditional insurance, because they save less in premiums than the difference in deductible between HDHP and traditional insurance. This is probably not a problem for high-income people who have adequate income and other savings to be able to pay the deductible every year, but it can be devastating to lower-income people for whom even a $2,000 deductible can unaffordable.

From Senator Rockefeller

Questions 1 and 2 – Inability of Tax Proposals to Promote Health Insurance Coverage

1: The President's fiscal year 2007 budget includes two main proposals allegedly aimed at increasing health insurance coverage–individual tax credits and the expansion of Health Savings Accounts (HSAs). Based on your analyses, how many currently uninsured Americans do you estimate each of these initiatives will cover? What is the basis for your estimates?

A: The best analysis to my knowledge of these new tax incentives was done by MIT economics professor Jonathan Gruber. He estimated that the combined effect of the two policies would be to reduce the number of people with health insurance coverage by 600,000. Almost 9 million people would lose employer-sponsored insurance, of whom 4.5 million would gain coverage either in the individual nongroup market or through Medicaid. The remaining 4.4 million would become uninsured. Another 3.8 million previously uninsured people would gain individual nongroup health insurance under the proposal.

Gruber estimates that the two pieces of the President's proposal have opposing effects. The expansion of HSAs, which makes tax subsidies in the nongroup market as attractive as insurance offered by employers, reduces insurance coverage on net by 1.5 million because many employers drop coverage and only some of those who lose ESI purchase nongroup health insurance. The targeted individual tax subsidy, by itself, would reduce the number of uninsured by a net of 1.4 million. For the two proposals together, Gruber predicts a net reduction of 0.6 million (more than the sum of the two pieces) because of interactions.

Although Gruber does not say so in this analysis, it is also likely that the people who would gain health insurance coverage under the President's proposal would be healthier on average than those who lose it. The reason is that healthy individuals whose employers drop coverage will have no problem finding affordable nongroup coverage, whereas those with chronic illnesses will have to pay much higher premiums. Also, the high deductibles in HDHPs make them very unattractive to lower-income workers.

I should note that these estimates are highly uncertain and rely on a number of assumptions that are open to debate. In my view, the long-term risk is mostly in the direction of even less insurance coverage. I believe that the President's proposals—especially tax credits and deductions for HDHPs—would eventually make employer sponsored insurance a thing of the past for all but the very largest employers. (Some would argue that this is inevitable anyway, but it is clear that these proposals would hasten the demise of ESI.) Many of the people who lose employer coverage are likely to become uninsured unless we can find a way to deal with the failures in the market for nongroup health insurance that I outlined in my testimony.

2: According to the Kaiser Family Foundation, the average annual premium paid for single individually-purchased coverage was $1,786 and $3,383 for family individually-purchased coverage in 2003. And, individual policies often have deductibles as high as $5,000 and require excessive out-of-pocket expenditures. Given these factors, how effective do you think a refundable health insurance tax credit of $1,000 for individuals and $3,000 for families would be at reducing the ranks of the uninsured given rapidly rising health care costs?

A: Not very. Most people who would be eligible for the proposed credits are poor and have little or no savings. Gruber estimates that, on balance, 1.4 million people would gain insurance coverage from the refundable credit. That is a tiny fraction of the 45 million Americans who lack health insurance coverage.

Question 3 – Health Coverage Tax Credit (HCTC) Affordability

I think the HCTC program is a good example of what happens when you use the tax code to try and expand health insurance coverage–people do not get the health coverage they need. Don't you agree that, unless the federal government provides a sizeable premium subsidy, health coverage through the tax code will be largely unaffordable?

A: Yes, but Congress may also want to consider other more cost-effective alternatives. One problem with tax credits is that households do not receive them until they file a tax return, long after the premiums are paid. The President proposes to address this problem by making the credits transferable to an insurer, but it is not clear that this would work. A better option, especially with limited budgetary resources, could be to expand public programs that are already serving low-income families such as Medicaid and S-CHIP.

From Senator Schumer:

Mr. Chairman, our inquiry today is focused on how our nation's tax policy can best promote the accessibility and affordability of health care. One step that many employers in both the private and public sectors have taken to expand health coverage is to offer health benefits to the domestic partners of their employees. Ironically, when they do so, they and their employees face income and payroll tax burdens that do not exist for other sorts of employer-provided health coverage. Specifically, the value of such benefits is taxable income to the employee and both the employee and employer owe payroll taxes that are not owed on other employer coverage. This additional tax hit deters some employees from making use of the coverage and poses both financial and administrative burdens for employers.

I have introduced bipartisan legislation with Senator Smith -- S. 1360 -- that corrects these tax inequities when employers voluntarily offer domestic partner coverage. I am hopeful that our legislation could be included in any health tax legislation this committee prepares this year.

Dr. Burman, do you think it makes sense to impose these additional income and payroll tax burdens on the employees who make use of this coverage and on the employers who voluntarily provide it? Don't we want a tax regime that will encourage employers to extend health coverage and encourage employees to use such coverage?

A: Yes. In my personal view, the most straightforward solution would be to allow same-sex partners to marry and to treat them the same as other married couples, which in some cases would involve higher taxes (marriage penalties) and in others (like this one) would involve tax savings. Given that most states do not appear ready to take this step and given the prohibitions in the Defense of Marriage Act, which defines marriage for federal purposes as a legal union between a man and a woman, S. 1360 seems like a good second-best approach and justifiable as a matter of equity. Whatever merits there are to subsidizing health insurance coverage among traditional married couples would seem to apply with equal force for domestic partners. Employers who voluntarily cover domestic partners of their employees are expanding access to health insurance and should presumably be encouraged. My only caveat is that I am assuming that the legislation has some way for the IRS to monitor the legal status of domestic partners.

Business Roundtable

Testimony of Robert W. Lane
Chairman and Chief Executive Officer of Deere & Company
Before the Senate Finance Committee
"Taking a Checkup on the Nation's Health Care Tax Policy: a Prognosis"
March 8, 2006

Good morning, Mr. Chairman, Senator Baucus and other members of the Committee. I am Robert Lane, Chairman and Chief Executive Officer of Deere & Company. I am very pleased to be here today on behalf of Business Roundtable, an association of 160 chief executive officers of leading U.S. corporations with $4.5 trillion in annual revenues. I am here today as a member of the Roundtable's Health and Retirement Task Force.

Some 10 million people work for Roundtable member corporations – with John Deere accounting for more than 47,000 employees. Counting employees and their families, Roundtable companies provide health coverage for about 25 million Americans. Business Roundtable's public policy priorities are to ensure a vibrant economy and a competitive workforce. These priorities go hand-in-hand with our goals of promoting a healthier workforce, strengthening the health care marketplace and improving the value of our health care spending.

I first would like to congratulate Congress for creating health savings accounts – a tool that has the potential to truly impact the rising cost of health care in America. Health Savings Accounts provide a way for our employees to gain considerably more value from their health care dollars.

However I am here today to point out that we believe the use of health savings accounts will not become widespread as Congress intended without some small but important enhancements. HSAs have the potential to dramatically impact how employees spend their health care dollars. However, they need to deliver the same value to the employees of large and small businesses alike in order to have a positive impact on our health care system.

Today I would like to provide some background information and then suggest four recommendations that would position health savings accounts to become a powerful tool for individuals as they continue to seek the most prudent way to spend their health care dollars.

Health Care Value

Soaring health care costs are harmful to our nation's economic health and our ability to be globally competitive. At Deere, the annual salaried family premium for our most popular 100% HMO plan is $12,300. This represents a significant benefit cost as well as value to all of our employees, and especially for lower paid employees. Deere has been innovative in managing health care costs through the use of self insured plans, managed care networks, and disease management programs in order to provide this level of benefits to our employees.

In a December 2005 Business Roundtable survey, CEOs cited health care costs as corporate America's number one cost pressure (42%) for the third year in a row. This topped energy costs (27%) and litigation costs (9%). Likewise, families across the country are looking for ways to deal with rising medical bills.

Improving health care value does not rest with any single stakeholder. To the contrary, everyone involved in our health care system – employers, insurers, doctors, consumers and the government – must find and help institute reforms that improve the value of health care expenditures. The key strategy for achieving this is to embrace policies that will make the health care system more efficient while keeping patients safe and healthy. That is why I am here today.

The success we had in the 1990s using managed care plan designs was due to the efforts of insurers, doctors and employers. Largely overlooked in the managed care plan designs were the preferences and decisions of patients. During the last two decades the managed care plan designs insulated the patients from the cost of health care services largely due to the very modest copayments and nearly 100 percent coinsurance plans.

As a result, we have seen greater patient demand for more services, prescriptions and higher levels of technology with little understanding of cost, benefit or value of these services. Roundtable CEOs, for example, believe we can improve the value of health care and improve the system by empowering consumers with price and quality data; helping our employees take more control of their and their families' health care decisions; improving patient safety; and transforming the system through the use of technology. Business Roundtable companies provide health benefits because it is cost effective to deliver a portion of the employee's compensation in this manner, creating an employee value proposition which encourages health insurance enrollment and leads to a healthier, productive workforce.

Of these objectives, I want to emphasize that one of the most important steps toward transforming our health care system is harnessing the power of our

employees as consumers of the system. At Deere we have some very simple guiding principles:

1. To create affordable, sustainable health benefit plans that encourage all employees to participate actively in their health and health benefits;
2. To reform the health purchasing process by changing the health care value equation at the point at which most health care consumption decisions are made – the point of care by the patient;
3. To support a benefit design which encourages and rewards employees for adopting healthy lifestyles and behaviors to have a greater impact on the future of health care benefits; and
4. To provide insurance protection.

I'm here today to address health care tax policy in the context of these overarching objectives – all of which place the employee consumer in the center. There are three areas of tax policy that affect health care: the taxability of premiums and health care expenditures; tax credits for the uninsured and dislocated workers; and the development of consumer directed health products, like Flexible Spending Accounts (FSAs), Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs). One of the critical tax code provisions that Congress needs to examine is expanding the availability of these consumer-directed plans – placing the employee as decision maker regarding what is best for them.

Consumer-Centric Health Plans

These plans – FSAs, HRAs and HSAs – have promoted greater engagement and understanding by our employees in purchasing health care services. The newest, Health Savings Accounts, is an example of health care reform guided by principle and good public policy. HSA plans seem to combine the best of managed care (networks, credentialed providers, outcomes reporting) with the aligned interests of the indemnity plan designs, while providing the much needed insurance protection. Business Roundtable believes that HSAs are a powerful tool to improve the value and quality of care that Americans have come to expect out of our health care system.

Philosophically, we need to agree on the role of the employee and in terms of deciding their health and health care. Why? Because HSAs put health care consumers back in the driver's seat to select the health care benefits that they want and need, and therefore have the potential to be transformational for the American health care system. At Deere we speak of a shared responsibility with employees to manage their health and health benefits. I use the words "potential to be transformational" because we cannot transform our health care system without the active participation of Americans. And we should acknowledge, as Americans, we are not likely to support a system of the government or health insurance companies deciding what is best for our own families. While the initial take-up rate for these types of consumer directed products is small, **more needs to be done to make these plans more attractive to large employers and their employees if we are going to have a meaningful impact on provider reporting, outcomes and patient engagement**.

To that end, Business Roundtable seeks your support for the following four changes to reduce the tension between rising health care costs and our current competitive business environment. If we fail to bring about an improvement in health care value, then the impact may be felt in a variety of ways – from the limiting of covered services, loss of employer provided health care which will have the greatest impact on the lower paid employees, and even a loss of American jobs, both in the manufacturing and service sectors.

As I stated earlier, health savings accounts are a powerful tool and Business Roundtable seeks these changes to increase the use of these accounts to the benefit of employees across the country.

First – Coordination with Existing Plans

A significant disincentive is the inability of our employees to use widely available flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs) in conjunction with their HSA. Employees often have concerns about how to pay for their out-of-pocket health care expenses if insufficient amounts are available under the HSA, especially early in the year when they are responsible for the deductible. The FSA may solve the budgetable concerns of our lower paid employees since they can have access to the entire FSA amount – while budgeting the expense over the entire calendar year. Without coordination of these accounts, employees may be left to scramble for the payment of a maintenance prescription or the delivery of their child in January without the ability to pay under an HSA alone.

In addition, employees have a familiarity with the rules and requirements and use of an FSA and HRA. As we all seek to encourage employees to become better

consumers, consumers need flexibility to use FSAs & HRAs in conjunction with the HSA. Many employees today have FSA and HRA accounts – they have experience with them. Business Roundtable strongly encourages the Committee to support legislation to permit these funding programs to be coordinated. We support the changes that are included in H.R. 4511, the "Flex HSAs Act" introduced by Representative Cantor (R-VA). Included with my testimony is a letter of support by Business Roundtable, as well as by the Coalition on HSA Coordination. The changes in this legislation would address the two most important obstacles to widespread adoption by our employees of these new plans: 1) ability to budget the deductible expense over the entire year; and 2) ability to save dollars beyond the deductible to prepare for future unpredictable medical expenses.

Second – Contribution Limits

We support lifting the current contribution limits to an HSA so that individuals and employers could budget up to their out-of-pocket expense into their health savings account. This is a critically important change if we expect Americans to be able to succeed at managing unexpected health care expenses and not merely drain their accounts with their expected health care costs from year to year. After all, isn't the policy intended to encourage employee engagement and planning?

Third – Contribution Amounts

Business Roundtable supports regulatory efforts to permit employers to vary contributions to employees' HSAs when an employee is a low-wage worker or has a chronic illness. The Department of Treasury is reviewing comments on a proposed rule to permit such flexibility – we believe this is a necessary change to ensure that these plans can better address the special needs of these workers.

Fourth – FSA Rollover

Business Roundtable also supports legislative changes to permit a limited carry forward of up to $500 in a flexible spending account (FSA) or a rollover into a health savings account (HSA). Today, the current FSA "use it or lose it" rule causes many individuals not to participate in FSAs or to incur unnecessary care at year end to avoid forfeiting their money. Allowing employees to carry forward these amounts aligns with the principle of consumerism. We urge the Senate Finance Committee to support a $500 rollover of these expenses as contained in the House-passed version of the Pension Protection Act of 2005 (H.R. 2830).

Other Health Care Priorities

Now that I've covered various aspects of tax policy, let me spend just a moment on the broader priorities of Business Roundtable on the health care front.

The CEOs strongly support other efforts to empower workers to become better consumers – including greater access to information on cost and quality data, more efforts aimed at disease prevention and disease management, and arming the health care system with 21st century information technology.

Business Roundtable believes that the disclosure of information is an important tool to help American consumers transform our health care system. We want to give our workers access to information about the cost and quality of health care services and the institutions, providers and suppliers who deliver that care. While private sector disclosure of price and quality data is occurring, we believe that the Centers for Medicare and Medicaid Services (CMS) should release 100% of the Medicare claims database.

This is essential to measuring cost efficiency and compliance with nationally-endorsed clinical guidelines by providers and suppliers.

And we support legislation to create a health information technology system with uniform interoperability standards. We must improve and deploy the health care system's information technology sooner rather than later. This is one change that can save administrative costs and greatly improve the delivery of health care services.

Conclusion

As a representative of Business Roundtable and my company, John Deere, I appreciate this opportunity to encourage the Committee to evaluate the tax code and its implications on health care tax policy. We believe Congress must continue to address rising health care costs and their effect on large and small employers' ability to offer quality, valuable health care benefits.

Health savings accounts are a very important option – and we believe they will increase consumers' access to quality health care services. Expansion of consumer-centric accounts is critically important in moving toward a system where we combine the best features of managed care with the positive aspects of individual control over health spending choices, enabling our workers, businesses and nation to remain competitive.

We look forward to working with the members of this Committee as you move forward on these issues.

Business Roundtable

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December 13, 2005

The Honorable Eric I. Cantor
U.S. House of Representatives
329 Cannon House Office Building
Washington, D.C. 20515

Dear Congressman Cantor:

On behalf of Business Roundtable, I am writing to express our support for your legislation entitled the "Flex HSAs Act." Business Roundtable is an association of chief executive officers of leading corporations with a combined workforce of more than 10 million employees and $4 trillion in annual revenues, which provide health care coverage to approximately 25 million Americans.

Business Roundtable applauds all aspects of this legislation, in particular the provisions that would permit the coordination of Health Spending Accounts (HSAs) with Flexible Spending Arrangements (FSAs) and/or Health Reimbursement Arrangements (HRAs) by allowing them to be used in conjunction with low premium health care plans. This important change will allow employers and employees to coordinate these programs and permit employees the best possible options for themselves and their families. Innovation and flexibility are critical aspects of the employer-sponsored health care system, and this legislation moves in the right direction to permit greater options available to meet employees' needs.

Thank you for your leadership in working to modify key elements of the law to permit greater flexibility and coordination of consumer-centered health plans. We look forward to working with you to pass this important legislation.

Sincerely,

John J. Castellani
President, Business Roundtable

The Coalition on HSA Coordination

Where Personal Health & Financial Security Come Together

AHIP

CIGNA

Deere & Company

General Motors

Fidelity

Financial Services Forum

IBM

Medtronic, Inc.

Metavante

National Association of Manufacturers

Target

Textron

UnitedHealth Group

Watson Wyatt

The Coalition on HSA Coordination

The Coalition on HSA Coordination was created in 2005 to examine the issues underlying the expansion and strengthening of HSAs. Recognizing the impact of HSAs on small businesses and the uninsured, the Coalition pairs the experience and leadership of many of America's large employers to explore the real-world potential for HSA coordination.

Since their creation in 2003 by the Medicare Modernization Act, HSAs have already lessened the healthcare burden for individuals and many small business owners. An eHealthinsurance study showed that while premiums for employer-sponsored health insurance have been rising steadily since 1996, (an 11.2% increase in 2004 alone), average premiums for individual HSA-qualified high-deductible plans dropped 19% in the first 6 months of 2005. These changes result in real savings for American families. A recent nationwide poll (Source: Mellon Financial Corp) shows that the number of employers offering HSAs could more than quadruple in 2006. These trends of consistent savings and dramatic growth hint at the potential of HSAs in the years to come.

But more can be done to increase the strength and effectiveness of HSAs for all consumers. If more coordination and integration were allowed between HSAs and other individual accounts – such as flexible spending accounts (FSAs) and health reimbursement accounts (HRAs) – more employers and employees could enjoy the full benefit of a shift to HSAs and high deductible health plans (HDHPs). To be truly transformational, HSAs must be widely available and popular among all segments of the working population.

In December 2005, the Coalition was an active participant in the introduction of the 'Flex HSA' bill. Sponsored by Rep. Cantor, the 'Flex HSA' bill will promote greater adoption of HSAs by lifting the "lesser of the deductible" limitation and allowing coordination of HSAs with flexible spending accounts and health reimbursement arrangements. By allowing the coordination these accounts, HSA users can reduce their total annual costs, saving both the employee and employer from double-digit increases in monthly premiums.

With the President's commitment to expand HSAs in his State of the Union address, 2006 promises to be a productive year for medium- to large employers seeking to lower health costs while providing employees with greater control over their healthcare choices.

Questions for the Record
Senate Finance Committee
Mr. Robert W. Lane
On behalf of Business Roundtable

From Senator Hatch:

1. Mr. Lane, you mentioned in your testimony the importance of encouraging and rewarding employees for adopting healthy lifestyles and behaviors. I also believe this is a key component to helping us control health costs. What are some of the best ways to encourage and reward in the corporate setting? Can you think of ways the tax code might be used to encourage taxpayers to adopt healthier lifestyles?

Answer: I believe we need to align the interests of the employer and employee in the management of the employees' health and health care benefits. HSA plans, combined with a high deductible health plan, provide us with many options, as employers, to encourage health promotion/disease prevention efforts.

At Deere, our plan improves the coverage of preventive care – we pay 100% of those costs and they are not subject to any deductible or other employee cost. This is a good example of paying for the right behaviors.

We are also providing programs to address employee lifestyles. Deere recently began offering the American Cancer Society Tobacco Cessation program. The program has been well received with actual enrollment exceeding our expectations. Deere also provides employees with the **Live**Well **Work**Well program providing important resources such as stress and substance abuse counseling.

We could do more. There are chronic illnesses that we know compliance with treatments will reduce costs and potential for additional complications associated with the disease. For example, individuals with diabetes who follow their physician's ordering for testing and treatment will reduce their long term costs dramatically, this also reduces costs that would be borne by the entire employee group. If employers could make differential HSA contributions to individuals based upon employer defined compliance with specified treatment protocols, a good investment benefiting the individual and the whole group would result.

2. Mr. Lane, you offered four suggestions to increase the attractiveness of Health Savings Accounts. Could you place these in order of priority as to which would give us the most bang for the buck?

Answer: First, there should be first dollar coordination with flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), and health savings accounts (HSAs). This coordination is especially important for employees who are lower paid or who have chronic illnesses. It helps them budget their personal expenses over the entire

year, as well as providing them the opportunity to save for other future, largely unpredictable medical expenses.

Second, HSA contribution limits should be increased. For employees affected by chronic illnesses, many times they may spend their entire HSA account balance on current year medical expenses without having the opportunity to build HSA dollars to handle their future medical expenses. As employees have a greater role in their own health and health care benefits, we need to increase the limits to provide success and saving opportunities for all employees.

Third, the Department of Treasury should permit varied contribution amounts by employers to an employee's HSA when that employee is a low-wage worker or has a chronic illness.

Fourth, FSAs should be changed to allow individuals to carry forward funds or roll funds over into a health savings account. Current "use it or lose it" rules cause many individuals to avoid flexible spending accounts or to incur unnecessary care at year-end to avoid forfeiting their money.

These four changes will enhance Health Savings Accounts.

3. Mr. Lane, what do you say to critics of Health Savings Accounts who say that these accounts appeal only to the young and healthy and leave the sicker and older in the insurance pools and thereby increase insurance costs for everyone else? What about the criticism that some have stated that many consumers are not capable of understanding the complex world of health care and should not be expected to navigate it?

Answer: HSAs are not just for the healthy and wealthy – they do strive to develop a shared responsibility of the employer and employee. HSAs strive to balance the insurance protection of the group with the personal responsibility and control of the individual. A number of surveys suggest more than 20% of families have incomes below $30,000 per year that are enrolling in HSAs. HSAs offer affordable health care insurance protection for lower wage households.

HSA principles do not abandon the concept of insurance protection that is the value needed by unhealthy and lower paid workers. Yet, HSAs allow these same workers to budget, plan and save for their own personal healthcare costs combined with insurance coverage.

From Senator Baucus:

1. You testified that Deere plans to implement a new HSA-based coverage arrangement for all employees in 2007. Why are you providing only one coverage option instead of allowing employees a choice among HSAs and more comprehensive coverage options? Do you have any concerns about a risk of adverse selection if a choice is offered?

Answer: Deere has four guiding principles in offering coverage:

1. To create an affordable, sustainable health benefit plan that encourages all employees to participate in their health and health benefits;
2. To reform the health purchasing process by changing the health care value equation at the point at which most health care consumption decisions are made – the point of care by the patient;
3. To support a benefit design that encourages and rewards employees for adopting healthy lifestyles and behaviors to have a greater impact on the future of health care benefits, and;
4. To provide insurance protection.

The HSA best accomplishes these principles. The Deere HSA plan design delivers the same benefit value while encouraging healthier lifestyles. HSAs fundamentally recognize the importance of all stakeholders in the management of health care – the employer, insurer, and the medical provider, and now to an equal extent, the employee or patient. These principles apply to all employees; yet continuing to offer a 100% managed care plan as an option merely allows individuals the opportunity to largely pay their portion in the form of a premium deduction from their paycheck with no incentive to understand their lifestyle decisions and the value of medical treatments. At Deere, we are changing the health care value equation not the value of health care.

2. What range of benefits will be provided under the Deere plan? Will you require first-dollar coverage for preventive services? Will the high-deductible plan cover maternity services? Please share a description of anticipated covered benefits under the Deere plan if one is available.

Answer: Deere will pay 100% of preventive care – this will not be subject to the deductible. Providing these benefits encourages the right behavior. Attached is a copy of our two plan designs.

From Senator Rockefeller:

Questions 1 and 2 – Inability of Tax Proposals to Promote Health Insurance Coverage

1. The President's fiscal year 2007 budget includes two main proposals allegedly aimed at increasing health insurance coverage – individual tax credits and the expansion of Health Savings Accounts (HSAs). Based on your analyses, how many currently uninsured Americans do you estimate each of these initiatives will cover? What is the basis for your estimates?

Answer: Business Roundtable has not evaluated or studied the impact of the President's proposals' impact on the uninsured. However, to the extent uninsured find themselves without health insurance due to high premiums, HSA plans do make it more affordable to have the health insurance protection needed by all American families. Studies have

indicated that 30-37% of the HSA owners today were previously uninsured. This is good evidence that HSA plans are solving a portion of the issues causing Americans to go without health insurance.

2. According to the Kaiser Family Foundation, the average annual premium paid for single individually-purchased coverage was $1,786 and $3,383 for family individually-purchased coverage in 2003. And, individual policies often have deductibles as high as $5,000 and require excessive out-of-pocket expenditures. Given these factors, how effective do you think a refundable health insurance tax credit of $1,000 for individuals and $3,000 for families would be at reducing the ranks of the uninsured given rapidly rising health care costs?

Answer: Business Roundtable does support providing tax credits for low-income individuals and families who have no health insurance. It is important, as you note, to ensure that we start working on ways of reducing overall health care costs so that health insurance coverage is affordable.

3. Health Coverage Tax Credit (HCTC) Affordability: I think the HCTC program is a good example of what happens when you use the tax code to try and expand health insurance coverage – people do not get the health coverage they need. Don't you agree that, unless the federal government provides a sizeable premium subsidy, health coverage through the tax code will be largely unaffordable?

Answer: Business Roundtable has not evaluated the values that these programs should include in order to ensure that they can provide low income individuals with private health insurance coverage. We will evaluate this issue and respond at a later date. However, we understand that in order to make a health insurance tax credit achieve its goal, it will have to be sufficient to purchase coverage for low-income families.

From Senator Schumer:

1. Mr. Chairman, our inquiry today is focused on how our nation's tax policy can best promote the accessibility and affordability of health care. One step that many employers in both the private and public sectors have taken to expand health coverage is to offer health benefits to the domestic partners of their employees. Ironically, when they do so, they and their employees face income and payroll tax burdens that do not exist for other sorts of employer-provided health coverage. Specifically, the value of such benefits is taxable income to the employee and both the employee and employer owe payroll taxes that are not owed on other employer coverage. This additional tax hit deters some employees from making use of the coverage and poses both financial and administrative burdens for employers.

I have introduced bipartisan legislation with Senator Smith – S. 1360 – that corrects these tax inequities when employers voluntarily offer domestic partner coverage. I am hopeful that our legislation could be included in any health tax legislation this committee prepares this year.

Mr. Lane, a substantial number of leading American corporations, including Citigroup, Corning, Dow, General Mills, and Hewlett-Packard to name just a few, have endorsed the Smith/Schumer bill. The list of endorsing companies includes many Business Roundtable member companies. And I know how important it is to business to be able to structure their benefit plans in a way that maximizes their ability to recruit and retain talented workers. Has the Business Roundtable had a chance to look at the Smith/Schumer bill and is this legislation something you would support?

Answer: Business Roundtable has not taken a position on this legislation. I am aware, however, that a number of Business Roundtable companies provide domestic partner benefits and certainly these companies would prefer that there not be tax penalties associated with extending health coverage in this way. We will look at this legislation and get back to you with any comments or issues.

JOHN DEERE EMPLOYEE BENEFITS - 2007 HEALTHCARE BENEFIT SUMMARY

Plan# 0246 **UHC CarePlus** **www.uhc.com** **1-888-JDEERE1**

Benefit	In-Network	Out-of-Network
Annual Deductible	$1,250 for single and $2,500 for family per calendar year	$2,500 for single and $5,000 for family per calendar year
Maximum Out-of-Pocket Expense Does not include dental, vision, or charges in excess of reasonable and customary.	$2,000 for single and $4,000 for family per calendar year	Unlimited
Physician Services – General		
Office Visits	80% of allowed covered charge *	50% of allowed covered charge*
Hospital Visits	80% of allowed covered charge*	50% of allowed covered charge*
Surgical Procedures		
Office	80% of allowed covered charge*	50% of allowed covered charge*
Outpatient	80% of allowed covered charge*	50% of allowed covered charge*
Inpatient	80% of allowed covered charge*	50% of allowed covered charge*
Maternity Care	80% of allowed covered charge* (For employee and spouse only) (Dependents are not eligible)	50% of allowed covered charge* (For employee and spouse only) (Dependents are not eligible)
Allergy Testing	80% of allowed covered charge*	50% of allowed covered charge*
Allergy Injections	80% of allowed covered charge*	50% of allowed covered charge*
Physician Services – Preventive**		
Preventive Exam	100% of allowed covered charge	50% of allowed covered charge*
Mammograms	100% of allowed covered charge	50% of allowed covered charge*
Pap Tests	100% of allowed covered charge	50% of allowed covered charge*
Well-Child Care	100% of allowed covered charge	50% of allowed covered charge*
Immunizations	100% of allowed covered charge	50% of allowed covered charge*
Screenings	100% of allowed covered charge	50% of allowed covered charge*
Cholesterol		
Osteoporosis		
**Based upon U.S. Preventive Services Task Force (USPSTF) guidelines.		
Hospital Services		
Inpatient Care	80% of allowed covered charge* Pre-notification required - 1-888-JDEERE1	50% of allowed covered charge* Pre-notification required - 1-888-JDEERE1 Failure to pre-notify will result in a $300 benefit reduction
Outpatient Care	80% of allowed covered charge*	50% of allowed covered charge*
Emergency Room **Emergency Ambulance**	80% of allowed covered charge* 80% of allowed covered charge to nearest facility*	
Skilled Nursing Care	80% of allowed covered charge* Pre-notification required	50% of allowed covered charge* Pre-notification required
Home Health Care	80% of allowed covered charge* Pre-notification required	50% of allowed covered charge* Pre-notification required
Hospice	80% of allowed covered charge* Pre-notification required	Not covered
Durable Medical Equipment	80% of allowed covered charge*	Not covered
Prosthetic Devices	80% of allowed covered charge* $20,000 benefit limit per calendar year	Not covered
Physical/Occupational/Speech Therapy	80% of allowed covered charge* Maximum 60 combined treatment days per calendar year in- and out-of-network	50% of allowed covered charge* Maximum 60 combined treatment days per calendar year in- and out-of-network
Cardiac or Pulmonary Rehabilitation	80% of allowed covered charge* Maximum 36 days per calendar year in- and out-of-network	50% of allowed covered charge* Maximum 36 days per calendar year in- and out-of-network
Chiropractic Services	Not covered	Not covered
Imaging and Laboratory Services	80% of allowed covered charge*	50% of allowed covered charge*

Deductible applies. Allowed charge means, in order, contracted rates, reasonable and customary charges and billed charges.
This is a summary only. If there are differences between this summary and your plan documents, your plan documents will take precedence.

JOHN DEERE EMPLOYEE BENEFITS - 2007 HEALTHCARE BENEFIT SUMMARY

Plan# 0246 **UHC CarePlus** **www.uhc.com** **1-888-JDEERE1**

Benefit	In-Network	Out-of-Network
Organ Transplants	80% of allowed covered charge* Must be approved by UHC	Not covered
Mental Health Services		
Inpatient Care	80% of allowed covered charge* Maximum 45 days per calendar year	Not covered
Outpatient	80% of allowed covered charge* Maximum 20 days per calendar year (Must triage through United Behavioral Health – 1-888-JDEERE1)	Not covered
Substance Abuse Services		
Inpatient Care	80% of allowed covered charge* Maximum 45 days per calendar year	Not covered
Outpatient	80% of allowed covered charge* Maximum 35 visits per calendar year Maximum of 140 visits per lifetime (Must triage through United Behavioral Health –1-888-JDEERE1)	Not covered
Prescription Drugs 31-day supply 90-day supply for maintenance drugs (Mail order program is available)	**Participating Pharmacy** 80% coinsurance for Tier 1 drugs* 50% coinsurance for Tier 2 drugs* 35% coinsurance for Tier 3 drugs* All subject to a $100 per 31-day supply maximum after deductible is satisfied	Not covered
Hearing		
Audio Exam	80% of allowed covered charge up to a maximum reimbursement of up to $70*	50% of allowed covered charge up to a maximum reimbursement of up to $70*
Hearing Aid	80% of allowed covered charge up to a maximum reimbursement of up to $500 per ear*	50% of allowed covered charge up to a maximum reimbursement of up to $500 per ear*
	Hearing benefit – once every 36 months – combined in- and out-of-network.	Hearing benefit – once every 36 months – combined in- and out-of-network.
Vision Care	**Participating Spectera Provider**	
Eye Exam	100% of allowed covered charge after $5 copayment	$43.70 maximum reimbursement
Single Vision Lens	100% of allowed covered charge after $10 copayment	$35.00 maximum reimbursement per pair
Bifocal Vision Lens	100% of allowed covered charge after $10 copayment.	$52.50 maximum reimbursement per pair
Trifocal Vision Lens	100% of allowed covered charge after $10 copayment	$70.00 maximum reimbursement per pair
Lenticular Vision Lens	100% of allowed covered charge after $10 copayment	$87.40 maximum reimbursement per pair
Frame	100% of allowed covered charge after $10 copayment	$24.80 maximum reimbursement
Contact Lenses	100% of allowed covered charge after $50 copayment	$52.50 maximum reimbursement per pair
	Exam, lenses and frame – once per 24 months – combined in- and out-of-network	Exam, lenses and frame – once per 24 months – combined in- and out-of-network
	Children 16 years and younger – exam and lenses – once per 12 months – combined in- and out-of-network	Children 16 years and younger – exam and lenses – once per 12 months – combined in- and out-of-network
Dental Services	Services provided through UnitedHealthCare	
Coordination of Benefits	Non-Duplication of Benefit	

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JOHN DEERE EMPLOYEE BENEFITS - 2007 HEALTHCARE BENEFIT SUMMARY

Plan# 0247 **UHC CarePlusMAX** **www.uhc.com** **1-888-JDEERE1**

Benefit	In-Network	Out-of-Network
Annual Deductible	$2,150 for single and $4,300 for family per calendar year	$4,300 for single and $8,600 for family per calendar year
Maximum Out-of-Pocket Expense Does not include dental, vision, or charges in excess of reasonable and customary.	$2,150 for single and $4,300 for family per calendar year	Unlimited
Physician Services – General		
Office Visits	100% of allowed covered charge *	50% of allowed covered charge*
Hospital Visits	100% of allowed covered charge*	50% of allowed covered charge*
Surgical Procedures		
Office	100% of allowed covered charge*	50% of allowed covered charge*
Outpatient	100% of allowed covered charge*	50% of allowed covered charge*
Inpatient	100% of allowed covered charge*	50% of allowed covered charge*
Maternity Care	100% of allowed covered charge* (For employee and spouse only) (Dependents are not eligible)	50% of allowed covered charge* (For employee and spouse only) (Dependents are not eligible)
Allergy Testing	100% of allowed covered charge*	50% of allowed covered charge*
Allergy Injections	100% of allowed covered charge*	50% of allowed covered charge*
Physician Services – Preventive**		
Preventive Exam	100% of allowed covered charge	50% of allowed covered charge*
Mammograms	100% of allowed covered charge	50% of allowed covered charge*
Pap Tests	100% of allowed covered charge	50% of allowed covered charge*
Well-Child Care	100% of allowed covered charge	50% of allowed covered charge*
Immunizations	100% of allowed covered charge	50% of allowed covered charge*
Screenings	100% of allowed covered charge	50% of allowed covered charge*
Cholesterol		
Osteoporosis		
**Based upon U.S. Preventive Services Task Force (USPSTF) guidelines.		
Hospital Services		
Inpatient Care	100% of allowed covered charge* Pre-notification required – 1-888-JDEERE1	50% of allowed covered charge* Pre-notification required – 1-888-JDEERE1 Failure to pre-notify will result in a $300 benefit reduction
Outpatient Care	100% of allowed covered charge*	50% of allowed covered charge*
Emergency Room **Emergency Ambulance**	100% of allowed covered charge* 100% of allowed covered charge to nearest facility*	
Skilled Nursing Care	100% of allowed covered charge* Pre-notification required	50% of allowed covered charge* Pre-notification required
Home Health Care	100% of allowed covered charge* Pre-notification required	50% of allowed covered charge* Pre-notification required
Hospice	100% of allowed covered charge* Pre-notification required	Not covered
Durable Medical Equipment	100% of allowed covered charge*	Not covered
Prosthetic Devices	100% of allowed covered charge* $20,000 benefit limit per calendar year	Not covered
Physical/Occupational/Speech Therapy	100% of allowed covered charge* Maximum 60 combined treatment days per calendar year in- and out-of-network	50% of allowed covered charge* Maximum 60 combined treatment days per calendar year in- and out-of-network
Cardiac or Pulmonary Rehabilitation	100% of allowed covered charge* Maximum 36 days per calendar year in- and out-of-network	50% of allowed covered charge* Maximum 36 days per calendar year in- and out-of-network
Chiropractic Services	Not covered	Not covered
Imaging and Laboratory Services	100% of allowed covered charge*	50% of allowed covered charge*

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Plan# 0247 UHC CarePlusMAX www.uhc.com 1-888-JDEERE1

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Outpatient	100% of allowed covered charge* Maximum 20 days per calendar year (Must triage through United Behavioral Health – 1-888-JDEERE1)	Not covered
Substance Abuse Services		
Inpatient Care	100% of allowed covered charge* Maximum 45 days per calendar year	Not covered
Outpatient	100% of allowed covered charge* Maximum 35 visits per calendar year Maximum of 140 visits per lifetime (Must triage through United Behavioral Health –1-888-JDEERE1)	Not covered
Prescription Drugs 31-day supply 90-day supply for maintenance drugs (Mail order program is available)	**Participating Pharmacy** 100% coinsurance for Tier 1 drugs* 100% coinsurance for Tier 2 drugs* 100% coinsurance for Tier 3 drugs*	Not covered
Hearing		
Audio Exam	100% of allowed covered charge up to a maximum reimbursement of up to $70*	50% of allowed covered charge up to a maximum reimbursement of up to $70*
Hearing Aid	100% of allowed covered charge up to a maximum reimbursement of up to $500 per ear*	50% of allowed covered charge up to a maximum reimbursement of up to $500 per ear*
	Hearing benefit – once every 36 months – combined in- and out-of-network.	Hearing benefit – once every 36 months – combined in- and out-of-network.
Vision Care	**Participating Spectera Provider**	
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Dental Services	Services provided through UnitedHealthCare	
Coordination of Benefits	Non-Duplication of Benefit	

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Paul H. O'Neill

Invited Testimony

United States Senate
Committee on Finance

The Honorable Charles E. Grassley, Chairman

March 8, 2006

Mr. Chairman and Members of the Committee:

It is an honor to be asked to testify before this distinguished body on an issue of such vital interest to the future of our Republic. American health care policy is in desperate need of reframing and rethinking based on a return to first principles. This committee sits at the intersection of policy issues that must be acted on together in order to produce a coherent and workable framework for a better future for Americans and America. Fundamental tax reform, financial security for retirees and access to medical care for all Americans are not separate subjects. In the absence of coordinated policy and legislative action by this Committee, there is no hope.

There are three primary imperatives.

First, stop tinkering at the margins of a variety of ill-defined problems with tax policy. Refocus finance policy simply and powerfully on the biological human need at the core of all of this: ensuring that every American has access to health care services, equitably and efficiently. To do so, I would pass a law mandating every American to purchase a base level of health care coverage. Those that have a certain level of income and wealth must not only carry coverage, but through a simplified, fundamentally reformed tax system, provide financial support to help those who don't have the means to fully finance their own coverage. This step would pierce several myths that serve to obscure our path forward in healthcare finance. These include the notion that the government creates social benefits from some magic pot of money that it doesn't first take from the people. A second paralyzing myth is that employers provide health care benefits, rather than the reality that they take dollars that would otherwise be available for compensation and act as a rather inefficient and increasingly spotty pass-through for insurance benefits. If we enacted my approach, the resources to pay for health care stay attached to the people who generate them, insurance assumes its proper role as a spreader of the financial risk associated with uneven distribution of illness and incidents, and society can succeed in ensuring equal access to health care services for every American, which is the entire point. (To make this work, the insurance market must again be required to perform its

social purpose – spreading the financial risk that is associated with the uneven distribution of illness and injuries, rather than remain the risk-avoidance industry that policymakers have allowed it to become.)

My second set of recommendations flow from the truth that achieving full access to health care for everyone in society is in part a function of how much health care costs. Unless we get more value from each dollar we invest, we are unlikely to achieve access for every American. On this front, the evidence is increasingly clear that if health care providers performed at the theoretical limit of organizational performance, we could reduce the costs of care by 30%-50%, while substantially improving outcomes. Yet, the federal government has only tip-toed toward the ideas and approaches to capture value on this scale that have been demonstrated in every field of human endeavor. I am proud to say that we had success of this scale during my time as CEO of Alcoa, and that I have been part of early demonstrations that this is possible in health care. To achieve those 30%-50% gains across the country, this body should ensure that health care performance goals are set that are worthy of this nation, and that the conditions of transparency and accountability necessary for rapid learning and improvement are fully in place for the quality of care, for the cost of care, and for learning from "things gone wrong" (safety).

I'll provide details on these conditions later in my testimony. But let me highlight one recommendation to jump-start the nation. I would immediately fund a study of five outstanding American hospitals that systematically details how all of their operations are performing when measured against perfection, and indicates the process problems that create the gaps between the current performance of any particular process and the ideal. Since 1999, when the Institute of Medicine pierced our national complacency regarding the safety and performance problems that afflict our hospitals, the industry and policymakers alike have seemed paralyzed about what to do to close the gap. The type of "Total Value Opportunity Study" I describe is a tool used often in private enterprise to map how to actually gain safety, quality and cost improvements of the scale we need, and I believe it could provide the missing "connective tissue" for health care.

My third imperative is to embrace the connections between solving this problem and solving the other social dilemmas that rest squarely in the lap of this Committee. For example, I have advocated a "return to first principles" approach to solving the Social Security shortfall, in the *Los Angeles Times*, and in numerous speeches and interviews. Here is the basic premise. If we invested $23,000 on the day each American child was born and allowed the magic of compounding to do its work, when that child turned 65 years old they would have an annuity in excess of $1,000,000 to support their life needs. This assumes a very conservative 6% annual rate of return. The level of income such an annuity would throw off (in excess of $80,000 per year) would give real meaning to the idea of financial security for every American retiree by providing completely for all of their needs, including health care, food, clothing, shelter and transportation.

In short, if this body commits to stop trafficking in fictions with the American people, and commits to anchor finance policies to the most economically efficient ways to produce value, you have a chance to transform the vast and certain human pain associated

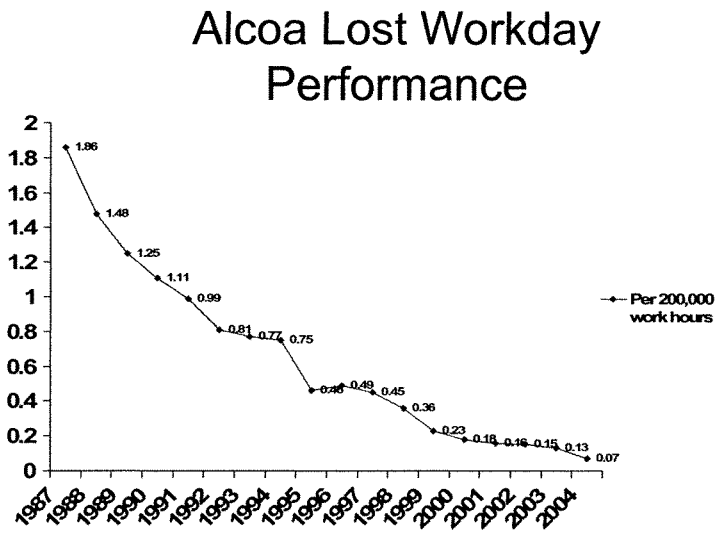
with our present social dilemmas into American success stories that will be recognized for generations.

* * *

Before elaborating on the conditions necessary to capture the 30%-50% value that is presently being lost in health care activities, let me provide some background on my standing to address the topic.

Many of you know that my involvement and interest in health and medical care spans more than four decades. Early in my career, at the Veterans Administration, I created some of the first systems analysis models to help optimize the health care that our veterans received. At the President's Office of the Budget, I helped create an analytic system for considering what investments could give the federal government the most return for its dollar in actually improving health care outcomes. I was also responsible, with some of you and your predecessors, for implementing a few of the major health care programs that have done so much good for the American people, but have also had such significant unforeseen consequences.

After leaving the Ford Administration, I set out to test in the private sector the ideas that I believed could lead to the creation of great value across any dimension of human activity – great social value, great human value, and great economic value. In my second assignment, as CEO of Alcoa, I got the chance to put my ideas fully into practice. I committed myself and the company to the notion that we could become the best at everything we did by committing ourselves to becoming the first injury-free workplace in the world. Much like this Committee may be doing at this moment, Wall Street scratched its head for years at the notion that human values, safety performance and financial success could somehow be connected. Yet, as we progressed toward our goal of complete safety, we gained the human bonds and the deep skills at understanding and improving our processes that every one of our people applied to transform us from a threatened company in 1987 to an increase of 800% in market value by 2000, an increase that was sustained through the bursting of the economic bubble. We did become the safest company to work for in the world, despite the presence of tremendous hazards in the workplace, and the fact that we were more than 120,000 people working in more than 30 countries, many with terrible health and safety records. Today, Alcoa's lost workday rate is more than twenty-seven times smaller than the average American healthcare institution. What I understood – and Wall Street didn't – is that it is people that produce value in any enterprise, and that people will respond to a set of values and proven ideas and principles to produce unbelievable increases in performance.



As Alcoa flourished, I felt that I had proven my hypothesis regarding what ideas would create true social value across very complex enterprises, in any discipline. The sector in our society that was obviously crying out for rapid improvement was health care. Accordingly, in 1998 I joined other leaders in Pittsburgh to create the Pittsburgh Regional Healthcare Initiative, one of the most ambitious efforts to radically improve the performance of the health care system in the United States. We set out to eliminate healthcare-acquired infections and medication errors within three years. What we did

achieve was notable – a more than 65% drop in central-line associated blood stream infections, widespread sharing of information on medication errors, and stronger community learning systems in heart surgery, among other areas.

But while many in Pittsburgh were satisfied with this rate of improvement, including our largest hospital system and academic medical center, I was not, because they were not comprehensive or embedded as new ways to think and work in the DNA of the organizations. I believe we need three to five health care institutions where the leaders are determined to use the ideas of systems analysis in every aspect of their enterprises to act as model sites for the rest of the nation to learn what it will really take to solve our health care crisis on a sustainable basis. Accordingly, a year ago I and a few associates founded a small enterprise named Value Capture to partner with just a few health care CEOs around the country to help them achieve these results. We are working with Richard Salluzzo, MD, CEO of the Wellmont Health System in Eastern Tennessee, and Cliff Orme, the CEO of LifeCare Hospitals of Pittsburgh, and considering engagements with several others. In working with these determined leaders, we have yet to observe a process that could not be improved by a minimum of 50%.

Having provided this background, here are more detailed recommendations for my second imperative: how the federal government can create the conditions necessary to capture 30%-50% better return on our investments in health care through the applications of systems principles to health care operations.

1. Set national performance goals at the limit of what is theoretically possible, focusing on safety and quality, and pursue them with vigor.

Unfortunately, the federal government rarely sets performance targets at all, let alone setting them at the theoretical limit of human attainment. The result of not insisting on the elimination of fundamental problems with the performance of the healthcare system is more of the same, or worse. For example, there are clear reasons that the appalling healthcare-acquired infection rate – affecting approximately 1 in 12 people admitted to the hospital -- has been steady or increasing for decades. The only common database that comes close to a shared learning system for these infections has been the Centers for Disease Control's NNIS system, which due to lack of mandate and budget constraints has covered less than one-tenth of the nation's hospitals. Within that database, infection types constituting more than 50% of the total number of infections that occur in hospitals are not counted at all. Unsound "cost benefit" reasoning is used to justify this exclusion. This is a sorry state of affairs. Yet, if the federal government were to say that we are determined as a nation to eliminate healthcare-associated infections within five years, and make sure each leader in the system, from the head of Medicare to each hospital CEO, were held accountable for establishing the urgent and comprehensive learning systems necessary to make rapid progress, the glaring inadequacies of our present efforts and thought processes would be quickly surfaced and flushed out of the system. I'd like to stress the importance of carefully structured accountability. National goals that are just slogans are useless, even dangerous.

I strongly recommend focusing national performance goals on safety and quality measures, despite the fact that driving out waste to make healthcare access affordable is an integral objective. Health care organizations to date have reacted to cost pressures by driving themselves by goals unrelated to the quality of their care. Measures derived from perverse financial incentives, such as "average length of stay," dominate the industry. These goals are not rooted in human biology and healing, the very point of the healthcare system. Accordingly, focusing on them threatens to destroy value rather than create it, by creating incentives for behaviors unassociated or disassociated from healing. In addition, the healthcare workforce is much less motivated by cost savings than they are by improving care for patients, and by their own safety. This reflects the truth we demonstrated at Alcoa; give people goals that they find motivating, and they will apply the skills they learn in pursuit of them to every aspect of their work lives, including the financial aspects of the enterprise.

I also strongly urge you to set our nation's goals at perfection.

Most organizations make the mistake of establishing arbitrary benchmarks to define success. It is particularly glaring that benchmarking accepts a certain level of error or poor quality as "normal" when it comes to basic safety for patients in our health care system. If our goal would be to have "just" 4% of patients contract an infection while they're in the hospital to be cured, who among us will volunteer to be among the 4%? First in Pittsburgh, and now with a few health systems around the country, we're aiming at the "theoretical limit" of perfection, healthcare systems with zero hospital-acquired infections, zero medication errors, and the world's best patient outcomes in clinical areas like cardiac surgery, diabetes, depression, and obstetrics. We think those goals defuse defensiveness and blame, and keep people pushing forward. The question isn't whether we are "good" or "bad." It is, "What's the next step toward perfect?" It also drives one toward thinking, "How could we be sure this is done right every time?"

Finally, one reason most organizations don't set perfection as the goal (and so don't try to reach it), is that they believe that it costs too much to address the last few percentage points of error. This doctrine is enshrined by economists as the "law of diminishing returns" and also afflicts notions of federal spending priorities. Unfortunately, it's untrue and dangerous. The best organizations understand that excellence comes from getting really good at making improvements and solving problems "on the shop floor." They know that as they get toward zero defects, their progress tends to accelerate because they have built the capability and support systems for their staffs to excel.

Is progress on this scale possible in health care? Yes. Our associate Rick Shannon, MD, Chief of Medicine at one of Pittsburgh's largest academic medical centers, Allegheny General Hospital, has created a profound case study. Under his leadership, the ICUs he controls used systems principles to reduce one type of infection rate by 95%. How long did it take? Less than 90 days. How long has it been sustained? For more than two-and-a-half years. The approach has now spread to the hospital's other ICUs, and several other infection types. The financial impact on the hospital has been profound. To date, the efforts have saved the institution more than $2 million. We see similar gains being

realized across a number of systems problems with our current partners at LifeCare and Wellmont Health System in Tennessee. And Pittsburgh has shown that even with basic levels of cooperation and learning, infection rates will quickly fall by more than 60%.

The elimination of these problems is possible everywhere. But it won't happen everywhere until this government, led by this Committee, insists on it.

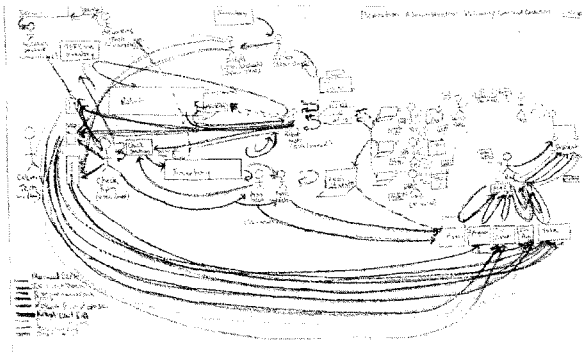
Once safety and quality goals are set, transparent reporting on progress down to the level of specific institutions is a useful accelerant. The early efforts of CMS to publicize health system performance across a few measures should be radically expanded. A few farsighted institutions are far ahead of the pack on recognizing that comprehensive disclosure of performance is helpful to the fulfillment of their mission. I would urge you to examine the safety and quality reporting of the Norton Health Care System in Kentucky at www.nortonhealthcare.com for an example.

2. Commission a national Total Value Opportunity Study

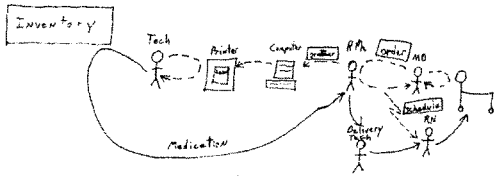
I specified in the introduction to my testimony that a "Total Value Opportunity" study at five of the nation's leading health care institutions could ignite actual progress toward safety and quality goals across American health care by providing a much more concrete picture of where in specific health care processes much greater value can be captured, and specifying the "real world" improvements in the processes that would capture that value. By doing the study at acknowledged centers of excellence of various types (academic health centers, community and rural health systems), the results could not be dismissed. Experts trained in systems analysis (six sigma, lean manufacturing, Toyota Production System, activity-based costing) would be paired with medical authorities to conduct the study, which could be accomplished within 6-9 months of work at each institution.

To give you a sense of the picture that such a study would paint, here are process diagrams showing a) a typical hospital medication process, from the time the physician writes the order to the time the medicine is actually delivered to the patient; b) a far simpler, safer and more efficient "target condition" imagined by staff at the same institution.

The Current Condition



Target Condition



- Same pathway for all medications.
- All medications prepared/delivered 1 hr. prior to administration time.

And here are two slides summarizing the clinical and financial implications of dramatic improvements in another process, infection control, produced by Dr. Shannon at Allegheny General Hospital in work that is an early prototype for the type of study I have proposed. The national study should associate each possible process improvement with resource consumption and finance implications:

	Traditional Approach FY 03	PPC Approach FY 04 Year 1	PPC Approach FY 05 Year 2	PPC Approach FY 06 (7 months) Year 3
ICU Admissions (n)	1753	1798 (+45)	1829 (+76)	1094
Atlas Severity Grade	1.9	2.0	2.1	2.2
Age (years)	62 (24-80)	62 (50-74)	65 (39-71)	64 (56-76)
Gender (M/F)	22/15	3/3	4/7	1 / 2
Central lines employed (n)	1110	1321* (211)	1487* (377)	1518*
Line-days	4687	5052*	6705*	6072*
Infections	49	6*	11*	3*
Patients Infected	37	6*	11*	3*
Rates (infections/ 1000 line-days)	10.5	1.2*	1.6*	0.49*
Deaths	19 (51%)	1 (16%)*	2 (18%)*	0 (0%)*
Reliability (# of lines placed to get 1 infection)	22	185*	135*	506*

The Losses Attributable to CLABs* are Staggering

- **Average reimbursement: $64,894**
- **Average Expense: $91,733**
- **Average Loss from Operations: -$26,839**
- **Total Loss from Operations:-$1,406,901**
- **Average Age: 56 years**
- **Average LOS: 28 days (5-86)**
- **Only three patients were discharged to home!**

*** Central-line associated blood stream infections**

3. Create a National Commission on Health Care Payment with two charges: A) End the profound cynicism of the healthcare pricing system; B) Fix the payment system to eliminate disincentives to "do the right thing."

Once we have a map of the way forward, making sure that how we pay for healthcare services helps us and doesn't hurt us is the next step. I would give a National Commission on Health Care Payment six months to produce action recommendations to Congress and the President necessary to solve the dysfunctions in how we bill and reimburse for health care services.

A. A destructive pricing and billing system:

Health care is the only industry that keeps two sets of books as a matter of course. The set of bills that are sent out by hospitals and others are a fiction. Contracts with insurers pay only a fraction of the listed price. Unless, that is, you don't have insurance. In that case, you're asked to pay full price. In Pennsylvania in 2004, hospitals were reimbursed 28.7 cents for every dollar they "billed." This was the exact rate of reimbursement they expected.

In addition to raising obvious issues of equity, this creates terrible problems on at least two other fronts. First, it consumes enormous resources throughout the system in a shell-game that destroys value rather than creating it. Hospitals are obsessed with exploiting loop-holes in their contracts with insurers and the federal government to "optimize" revenue, producing ever-more complicated and fictitious pricing schemes and "black box" financing systems that not only profoundly distract health care managers from actually delivering a better product, but actually add complexities and distortions that interfere with care. For example, across the country, efforts to optimize revenue from radiology services have produced Byzantine billing codes that are overwhelming to the physicians that order them and the nursing floors that enter the orders, and so produce innumerable dropped and confused orders that are changed in radiology departments, producing frustration and negative impacts on patient care.

Second, in my experience, if you ask people to work every day in organizations where major facets of their work are fictions, it has a corrosive effect on the whole enterprise. If we are not forthright about something as fundamental as what we charge and why, it eats at our sense of excellence and integrity.

I don't understand how the health care professions themselves can live another year with the current system. And if you have not yet read the current issue of *Health Affairs*, which includes two devastating articles on the current state and evolution of the hospital pricing system, I commend it to you and suggest that after reviewing it you as stewards of our national interest will not be able to live another year with the current system.

The President's push for transparency of health care pricing for consumers deserves strong support. Properly driven, the scrutiny that would follow disclosures would be extraordinary, and the broken health care pricing system couldn't withstand it.

B. Eliminate disincentives to "do the right thing" in our reimbursement systems.

The failures of the health care payment system to reward health care providers for doing the right thing for patients, or performing at better levels than their competitors, are many. I'll point to just two fronts for rapid action.

First, the unsustainable pace of health care cost increases is driven in large part by the increasing burden of chronic diseases such as diabetes on the American population. Today chronic disease accounts for 75% of all health care costs, according to the Institute of Medicine and the Centers for Disease Control and Prevention. In turn, combating chronic disease effectively requires much more effective primary and preventive care. Yet, if you look at our payment systems, you will see that we are paying hundreds of millions of dollars every year for patients to undergo advanced procedures – many of which have been proven by the literature to be "washes" in whether they sustain life – while paying very poorly for effective primary care that would have helped stay the progression of the disease in the first place. A recent in-depth story by *The New York Times* identified what drives this sad state of affairs. A primary cause is the reluctance of commercial health insurers to provide effective preventive and chronic care benefits for diabetics, for fear that they will attract a disproportionate share of persons with diabetes. The insurance market exists to spread financial risk efficiently, yet we have allowed it to evolve in ways that insurance companies are allowed to avoid risk, with terrible impacts on human suffering.

It doesn't have to be this way. Over the past five years, the Veteran's Administration shifted its resources sharply toward primary care. They held their cost of care constant per patient at a time when general healthcare costs increased 50%, and dramatically raised the quality of care provided to veterans (a quality which sharply exceeds the performance of the rest of the American health care system). In Pittsburgh, the VA increased primary care for diabetics and has seen a corresponding 38% reduction in foot amputations. Will Medicare, private insurers and large health care purchasers have the guts to follow the VA's lead? Surely this panel can see that they do.

Second, while the intellectual infrastructure to "pay for performance" is evolving, the government's and private market's embrace of this ability has been tepid at best. The quality incentive programs that exist are typically less than 1% of annual revenue for a hospital, when hospital CEOs will tell you that at least 5% would be required to "get their attention." The Medicare/Medicaid program has launched a few payment experiments for physicians and hospitals, but they generally don't put enough revenue on the table to shift behavior. My staff can find only one physician group in the United States where it is possible for a doctor to make 30% more income by performing at the highest possible levels in the quality of care they provide their patients. The scale and scope of our so-called pay for quality efforts should be immediately and radically expanded.

4. Prejudice the health care system toward truth telling.

Rethinking our approach to medical malpractice is more important than the amount of assets it involves would suggest (perhaps 2% of direct health care spending). It should be a priority because the current system inhibits rapid learning from mistakes, which is the fastest and only way to radically improve all that ails our health care delivery processes.

Again, it is helpful to me to think of problems in terms of first principles. The first principle of health care for me is that patients should get the best possible quality of care, and should be absolutely safe. That means that when things go wrong, these incidents need to be exposed and learned from, immediately, so that they won't be repeated. Putting in place systems to speed the open flow of information about errors, poor outcomes and solutions was an important component of how aviation, nuclear power and Alcoa became safe enterprises.

It turns out that despite physicians' and hospitals' fears of lawsuits, openness about errors is what patients want most. A growing body of research and experience show that when something goes wrong, patients and their families want to feel like they've been leveled with, receive a full apology, and be assured that actions have been taken to prevent the same problem from happening to someone else. They are less likely to sue if they get those things than if they do not.

Two forces can be meshed to radically advance safety, quality, and efficiency. First, health care needs a "blame free" error learning system that can help health care workers learn from errors almost instantly across the country. Congress last year passed enabling legislation to create a national error reporting system that could fulfill this goal. I say "could" because a critical design decision remains. It is critical that in the current regulation-writing phase, the learning system be structured to allow every health care professional to be able to access and learn from it on an around-the-clock "real time" basis, at the granular level of each incident (with measures taken to protect the privacy of patients and anonymity of particular institutions, of course). It will be the tendency of bureaucrats, experts, and lawyers to restrict access to the database to a very few, who will scan for problems and issue periodic safety bulletins. Unfortunately, this approach doesn't work to produce safety in any complex organization or endeavor. Each individual actor knows the nature and risks of their work and workplace the best, and holding them accountable for learning and allowing them to learn on a constant, specific basis is the proven way to make them capable and responsible for creating safety in their own work.

To make this system truly powerful for eliminating injury, however, requires turning the current medical malpractice system on its head. Congress should create a genuine economic incentive under medical liability laws for caregivers to use the error reporting system for learning and rapid application. Here is what I propose. If mistakes are reported to the learning system and the patient within 24 hours of discovery, and measures to prevent the error from happening again are installed within a week, payments

to the patient could be limited to their economic damages with some basic adjustments for fairness. And those payments should be made by society, not individual providers. If an error isn't reported promptly to the patient and the national learning system, however, the provider could be subject to treble damages. This suggestion is something of a political inconvenience in the current political battle over medical malpractice in which neither side is proposing the right balance of relief and responsibility. But evidence across a number of domains – including worker safety on a national basis and my own experience at Alcoa – suggest creating the right incentives and disincentives for learning are necessary to set the conditions for rapid, steady, sustainable improvements in safety. And I do think this could be a "break through" approach to medical malpractice that moves us beyond the current stale posturing that is so tiresome to the American people and, I believe, each of you.

* * *

To conclude, I want to reiterate the three major imperatives that face this committee in health care. First, stop tinkering at the margin of incorrectly characterized problems with tax policy, and attach the responsibility and resources for achieving equitable access to health care to each individual American. Second, deploy the proven ideas and principles of systems analysis to make it possible to capture the 30%-50% improvements in value per dollar invested in healthcare that are clearly possible. Third, use the same "return to first principles" approaches to address the other critical dilemmas facing this committee, such as Social Security and an inequitable, unworkable tax system, and you will see mutually-reinforcing improvements in the social and financial condition of the American people.

It has been a privilege to share these prescriptions and the experiences that inform them with this Committee. Appendices with additional details on my recommendations follow. I would be happy to answer questions and continue the discussion as you move forward to address our most urgent national problems.

Appendices:

1. Total Value Opportunity Proposal-Senate Finance Committee
2. Healthcare Issue Brief: Transforming Medical Malpractice
3. "Truth in Medicine," Paul H. O'Neill, *The Washington Post*, December 24, 2004
4. "What Health Care Can Be," Paul H. O'Neill, *Healthcare Financial Management*, June, 2005
5. "A New Idea for Social Security," Paul H. O'Neill, *Los Angeles Times*, February 15, 2005.

Appendix 1

TOTAL VALUE OPPORTUNITY PROPOSAL –
SENATE FINANCE COMMITTEE

CORE IDEA OF THE PROJECT:

The Institute of Medicine reports and a wide range of other studies and reports have highlighted things gone wrong in the U.S. health and medical care sector. The evidence consistently suggests that major improvements in patient outcomes and the health care status of Americans could be achieved while reducing costs by 30-50%. However, while there is a great deal of activity in response to these findings there is not much evidence of a significant improvement in patient outcomes, and cost increases continue unabated. Why?

Policy makers react to the aggregate evidence by seeking one or two major "levers" to radically improve the quality, safety and efficiency of care. But the problems of complex systems such as American health care delivery can not be solved by edict. At the local level, practitioners believe their error rates are small, regrettable but largely inevitable, within the national norms, and that they are under compensated and underappreciated for what they do. They are opposed to transparent identification and sharing of things gone wrong because of perceived legal risk. Many see waste and aggravation in things they are required to do – filling out insurance forms, for example -- but not many see opportunities for quality improvements and cost saving in things they believe they can control.

Both groups – policymakers and practitioners – would be guided toward more constructive action by the creation of a compelling "business case" for the application of

quality ideas and principles in the health and medical care sector by specifying and quantifying the financial value associated with:

- Errors (e.g., extended stays associated with wrong medications or wrong procedures. Cost of injuries to staff; lost work days and restricted work)
- All repair activity (e.g., time spent clarifying illegible or incomplete medication and other doctors' orders)
- All non-value added activity (e.g., time spent searching for needed materials - - medications, equipment, supplies)

RELEVANCE OF THE PROBLEM AND PROPOSED INNOVATIONS:

The current problems of safety, quality and waste in the American health care system directly harm tens of millions of Americans each year and indirectly harm the interests of every American. The failure of policymakers and executives to understand how to address safety, quality and cost problems should now be the central focus in this arena. Practical, powerful diagnostic techniques proven to speed radical improvements in other large, complex, high risk industries could be used to address this gap.

APPROACH AND METHODOLOGY:

Select and work with five high reputation hospitals to document the difference between current patient outcomes and cost performance and the potential results if the care process eliminated errors and the waste associated with system design inefficiencies.

Assemble a team of analysts with successful experience in using and deploying the ideas of systems analysis, six sigma, lean manufacturing, the Toyota Production System and activity-based costing. Over a period of twelve months, analyze all major pathways in the patient care process to produce the project objective.

INTENDED CHANGES IN HEALTH CARE:

To provide the operational facts that are needed to press for accelerated improvement in American health and medical care, by:

- Creating a greater public sense of urgency to change health care by showing specifically where value is being lost and providing a better set of tools to help the public understand how it might be accomplished.

- Providing health care executives a map of their core processes that highlights the problems that embed error and waste in the system, and provides targeted tools to help the executives eliminate those causes.

- Strengthening the will and fact base of policy makers and corporate purchasers to:

  -- Overhaul reimbursement systems to successfully reward value creating care.

  -- Recognize the areas in which well-intended rules and regulations are impeding progress toward safe and perfect care, and remove those impediments.

Appendix 2

Healthcare Issue Brief: Transforming Medical Malpractice

Prepared by:
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If the purpose of the medical malpractice system is to provide a powerful incentive for health institutions and providers to eliminate error, the system has failed. Based on Lucien Leape's scholarly work, over 300 million medication errors occur each year. The Institute of Medicine estimates that between 50,000 to 98,000 deaths per year are attributable to medical errors. There are countless other measures of total system failure including never-ending streams of falls, empty oxygen tanks, and unmet patient needs. These errors also have a steep economic cost, building rework and instability into the system and driving a substantial portion of the growth in health care spending.

When people who are injured are asked what they want of the system, the most common responses are:

1. To receive an apology for the harm that occurred.
2. To be told exactly what happened, immediately and with complete honesty.
3. To be assured that everything has been done to guarantee that the same problem won't victimize anyone else, and;
4. To receive full compensation for lost wages and medical costs.

Apart from failing to prevent harm, the current medical malpractice system fails to deliver any of these outcomes desired by victims of error. A simple analysis reveals why.

The malpractice system functions on the assumption that, if the punitive damages for harm are great enough, doctors, nurses, and hospitals will make every effort to avoid error. There are two fundamental problems with this logic. First, people working in health care are already doing everything they know to avoid errors, but the way the system is designed makes errors inevitable. Secondly, the people who are running health care organizations are functioning without the commodity they most need to solve these problems, information about the real root causes of these system errors.

The current medical malpractice system actually impairs the ability of health care leaders to offer patients the thing they most want, error-free care.

There is a rough parallel to this problem in the evolution of the worker's compensation system. By the early 1900's, thousands of workers were killed or maimed each year by industrial systems that were not designed for safety. As a direct result, businesses were bearing enormous legal costs defending themselves against numerous lawsuits. It led to a crushing insurance burden. Between 1911 and 1940, as the problem became a crisis for both workers and businesses, they agreed to legislative compromises in every state that addressed many of the system problems from a safety and a cost perspective. Government required employers to buy insurance to offset the economic burden of medical costs for people who were hurt and could not work through the workers compensation system. In exchange for this reduction in legal exposure, companies were required to share information about every incident so that all employers could avoid similar events.

We propose a similar system for medical malpractice, upgraded based on current learning and technology. The federal government (or state governments as an at-scale laboratory) would set up a fund to pay the economic damages for patients harmed by the health care system in exchange for mandatory reporting of everything gone wrong and systemic actions to remedy problems that could cause harm. In return for this protection from liability, anyone failing to report an incident would be liable in the regular court system for treble or quadruple damages. Reporting could take place in a national, real-time database designed to make it easy for anyone to share problems in the system with the potential to cause harm. Additionally, anyone could look to this database to learn from root cause solutions shared there.

This system would allow people to reduce the medical malpractice problem by preventing recurring errors at their root rather than focusing on the financing. Most importantly, this proposal would remove blame from the culture and free health care systems to expose and learn from their mistakes in the pursuit of perfect patient care.

The Value Capture Policy Institute is a non-profit organization dedicated to advancing state and federal policies that create the conditions for every human need to be met without waste or error. For more details on this proposal or to schedule time to learn more about how to eliminate medical malpractice, please call Geoff Webster at (412) 553-1197.

Appendix 3

washingtonpost.com

Truth in Medicine

By Paul H. O'Neill

Friday, December 24, 2004; Page A17

If the president and Congress want to accomplish something truly important over the next four years, how about this: a fundamental change in the playing field for health care.

I have a few suggestions. They are based on 40 years of work on health care policy and operations, including my current role as leader of a community effort in Pittsburgh to set the world benchmark for safety, quality and efficiency in health care delivery. My thoughts are also based on leading a major company, Alcoa, to become the world's safest place to work.

First, the government should create powerful incentives for medical care providers to immediately tell the truth about errors and poor outcomes -- tell it to patients, families and colleagues around the country. The purpose is not to punish but to learn rapidly from mistakes, something that is required in any high-risk, high-performing industry. The benefit won't just be safer, clinically superior health care but less expensive health care. Why? Because safety is realized only when organizations focus on their customers and constantly improve the quality and efficiency of the processes that serve them.

Today we don't report and disclose even the tip of the iceberg of things gone wrong in health care, dooming ourselves to repeat the mistakes, without ever rooting out the broken processes that are producing them in the first place. For example, the nation's leading researchers estimate that less than 1 percent of medication errors are identified.

To address the issue, we ought to have society assume the cost of things gone wrong, in the interest of creating a genuine learning system. Victims of errors would be paid fair compensation, and doctors would not have to pay for malpractice insurance. But if doctors didn't openly and immediately detail errors or poor outcomes to patients and to a national learning system, they would be subject to large, personal financial penalties or loss of license.

At Alcoa, the first principle I had to ingrain throughout the company was this: Every person was responsible for sharing details of things that went wrong, immediately, so that we didn't have to learn the same lesson over and over again. We are far from that standard in health care, but if we stop fighting the wrong battle over medical malpractice, we can get there. Our objective should be to get lawyers out of the medical system, not to cap the money they are taking.

Second, the president should appoint a commission with a tight deadline to redesign the health care reimbursement system with the goal of making it pro-patient. Today, in many

corners of even our most significant federal payment systems, we still pay clinicians and facilities for activity, not for the quality of the job they did for the patient. The way to use payment to drive improvement is beginning to emerge in a few experiments around the country, but the status quo will prevail unless the president puts his weight behind rapid change.

We also need a better map of how to achieve dramatic improvements in cost and quality. The federal government should start the mapmaking by commissioning a detailed, three-month analysis of the nation's leading hospitals to fully document not only the cost of errors but also the wasted time, effort and resources embedded in much of health care delivery. Such a study could be accomplished for $10 million and would make the case for change in a management framework that couldn't be ignored. The team of experienced industrial engineers and health care leaders I work with in Pittsburgh has yet to encounter a health care process that could not provide higher quality at half the current cost.

That map can be brought to life if the government then joins with a single major medical complex that declares its intention to be the best in the world -- measured by objective data -- at every single thing it does. Across the American health care landscape, improved performance has occurred only in parts of organizations. When we have a place that's "done it," we'll have a model that others can see and learn from. We'll also have taken away the age-old excuse that "nobody's done it, so how can we?"

Apart from these federal priorities, the industry itself has its own set of solemn obligations to act on. The 30 to 50 percent of national medical care spending that is currently paying for waste and errors can be captured only through deliberate action at the local level. With the health care industry and the government playing their parts, hundreds of billions of dollars can be freed up. This would make it easy to solve the so-called "access" problem of uninsured Americans and still leave large amounts for other important needs.

The writer was secretary of the Treasury in 2001-2002.

Appendix 4

COMMENTARY

Paul H. O'Neill

what health care can be
an expanded role for financial leaders

Glimmers of changes to healthcare governance, policy, and financing are on the horizon. How can you be a driver of change?

AT A GLANCE

- Patients should receive safe, high-quality health care.
- Healthcare financial executives need to participate in problem solving, and one problem they need to take on is the structure of finance and payment.
- There are no magic bullets. Healthcare financial executives should be champions of change.

In Pittsburgh and in other places around the country, we have helped hospital leaders perform thousands of hours of observations of nurses, unit clerks, custodians, physicians, supply clerks, and other front-line staff working. The story is always the same: Roughly 40 percent to 50 percent of the staff's time is spent on truly value-added work. About 50 percent to 60 percent is spent working around problems that occur and recur, day after day. In other words, 50 percent of the time and cost is wasted.

In a recent one-hour observation of four staff members at a fine health system, 81 problems occurred in meeting a patient's needs. For only one problem was a solution attempted that might have prevented it from happening the next day to the same patient and staff member, let alone others across the organization and the country. Only one problem was reported in the institution's formal incident reporting system, where it will end up as a data point on a monthly risk management report full of information that is not useful for understanding what happened or how to prevent a recurrence.

This is how we have designed the system. We have conditioned front-line staff to work around problems rather than participate in solving them, and we have assigned quality and risk management functions to small teams of people who can't possibly support effective problem solving across the organization. We sit around in endless meetings with the wrong people trying to create and impose the wrong solutions. Does it surprise us that 50 percent to 60 percent of the potential value of your institutions' resources is being wasted every day?

How can you begin to capture that value? By restructuring approaches to problem solving and process improvement to involve everyone in the organization in three areas of activity geared toward solution:

- Identifying everything that goes wrong
- Rapidly investigating causes and implementing experiments as close to the front line as possible to prevent recurrence
- Openly sharing learning

There are no magic bullets or secret solutions here, just models that have been proven to work in organizations that handle complexity and risk very well. As a point of comparison, Alcoa's 131,000 employees across 43 countries arguably work with much more risk in their industrial production environment than American healthcare workers. Yet today, their lost workday rate of 0.07 per 200,000 work hours is 27 times safer than the rate for the average American hospital.

Paul H. O'Neill serves as nonexecutive chairman of Value Capture LLC, Pittsburgh, which provides support for leaders of healthcare institutions who are determined to radically improve the safety, quality, and efficiency of their care. He was a founding co-chair of The Pittsburgh Regional Healthcare Initiative. He serves as a director at the National Quality Forum, RAND, Eastman Kodak, and Celanese, among others. He is a senior adviser to The Blackstone Group, New York.

O'Neill served as the 72nd Secretary of the U.S. Treasury from 2001 to 2002.

O'Neill was chairman and CEO of Alcoa from 1987 to 1999, and retired as chairman at the end of 2000. During that time, Alcoa became the safest corporation to work for in the world and increased its market capitalization by 800 percent. Before joining Alcoa, O'Neill was vice president from 1977 to 1985 and then president from 1985 to 1987 of the International Paper Company.

He worked as a computer systems analyst with the U.S. Veterans Administration from 1961 to 1966 and served on the staff of the U.S. Office of Management and Budget from 1967 to 1977. He was deputy director of OMB from 1974 to 1977.

Questions or comments about this article may be sent to him at poneillpa@aol.com.

What Can Healthcare Financial Executives Do?

What does any of this have to do with financial staff in hospitals? In most places, regrettably, not much. In my experience, people trained in finance and accounting are inclined to think in systems terms if they are permitted to do so. Yet I know of no place in the nationwide healthcare system where there is a full-fledged activity-based costing system that links costs to outcomes—work that can and should be done by the financial staff. When was the last time someone from the financial staff in your institution visited a medical floor for several hours to understand the near chaos of the work process and the things gone wrong, and developed the authority of knowledge required to participate with the staff in designing a system for continuous improvement?

How many of your hospitals have a system that identifies every medication problem in real time and takes action to find the root cause? And does something about the root cause, in real time? How many financial staffs have calculated the wasted money spent in dealing with illegible prescriptions and physicians' orders to target that waste for elimination? Some financial staff may need additional training to do this work, but others are already well equipped.

At one hospital, we helped the staff do an activity-based costing analysis of the inputs and revenues derived from patients who developed central line associated bloodstream infections (CLABs) in their medical intensive-care units. Management had assumed that since these patients generated large outlier payments, the institution was at least breaking even on these train wrecks. The facts were that on a fully loaded basis, the institution had lost $10 million per year on just three classes of infections, because the

> Does it surprise us that 50 percent to 60 percent of the potential value of your institutions' resources is being wasted every day?

costs of providing the care far outstripped the outlier payments. They'd also killed 40 percent of those CLAB patients (that is, 17 people). Happily, we also helped them drop the rate of CLABs in their medical ICUs by more than 90 percent in 90 days, so these savings—human and financial—were not theoretical.

To emulate those results, healthcare leaders must begin to ask themselves these kinds of questions every day, and relentlessly act on them:

> How do we know if we are getting each patient exactly what she or he needs?
> How do we know if something we expect to happen doesn't (or something we don't want to happen does)?
> How do we know if our people are able to solve that problem to its root?
> How do we know if our people have made an improvement?
> How do we know if they are able to learn from others—across the building and community and nation- instantaneously?

At a broader level, financial staff and their bosses need to take on the structure of hospital finance and payment. There is no other industry that keeps two sets of books as a matter of convention. Last year, Pennsylvania hospitals were paid 30 cents for every dollar billed - the exact level they expected. In my experience, asking a large segment of your employees to

> Hospital CFOs should be the internal champions of moving toward well-designed pay-for-performance payment systems.

carry out a function every day that is a cynical fiction has a corrosive effect on an organization. If this is false, employees wonder, what else is? It also further obscures the ability of managers to effectively link inputs with outputs in their decision making.

Hospital CFOs should also be the internal champions of moving toward well-designed pay for-performance payment systems. At too many hospitals and health systems, I hear rhetoric supporting a link between payment and quality of service, but then learn that the same leadership has negotiated fiercely with payers to take pay-for-performance off the table and arrive at a global annual expected budget based on increased case rates.

And I do not understand how healthcare financial officers can tolerate formal processes for mitigating the risk of lawsuits that are profoundly counterproductive. The current system of secretive peer review inhibits rapid learning from mistakes and symbolizes the dysfunctional structures and approaches to things gone wrong in health care.

We are seeing the glimmers of changes to healthcare governance, policy, and financing that will make it easier for financial officers to use their extraordinary training to drive the provision of safe, high-quality medical care.

It's helpful to me to think of problems like this in terms of first principles. The first principle of health care for me is that patients should get the best possible quality of care, and it should be absolutely safe. That means that when things go wrong, the "things" need to be exposed and learned from, immediately, so that they won't be repeated.

It turns out that despite physicians' and hospitals' fears of lawsuits, openness about errors is what patients want most. A growing body of research and experience at places such as the U.S. Naval Medical Center and Kaiser Permanente show that when something goes wrong, patients and their families want to feel like they've been leveled with, receive a full apology, and be assured that actions have been taken to prevent the same problem from happening to someone else. They are less likely to sue if they get those things than if they don't.

Financial Leaders as Champions of Change

The financial community might champion two policy changes to advance these concepts. First is the implementation of a "blame free" error learning system that can help healthcare workers learn from errors almost instantly across the country (enabling legislation is stalled in Congress). Second is the creation of a genuine economic incentive under medical liability laws for caregivers to use the system. If mistakes are reported to the learning system and the patient within 24 hours of discovery, and prevention measures are installed within a week, payments to the patient could be limited to their economic damages with some basic adjustments for fairness. Those payments should be paid by society, not healthcare providers. In other words, no malpractice insurance. (The workers' compensation system is somewhat of a prototype.) However, if an error isn't reported promptly to the patient and the national learning system, the provider should be subject to treble or quadruple damages. This suggestion is something of an inconvenience in the current political battle over medical malpractice, but I suggest it will lead to profoundly more benefit for your institution than any of the "solutions" currently on the table.

At the end of the day, the first examples of true excellence in American health care will be those institutions whose leaders make it crystal clear through their daily actions that they are determined to realize their values by ensuring that every staff person, regardless of rank or station, can successfully contribute to getting each patient exactly what he or she needs. Excellence is possible where leaders act on the faith that the organizational benefits of being driven by clearly established values will outweigh any loss sustained from telling "big admitters" to take their business elsewhere if they refuse to comply with safety precautions or the short-term cost of a necessary safety fix.

We are seeing the glimmers of changes to healthcare governance, policy, and financing that will make it easier for financial officers to use their extraordinary training to drive the provision of safe, high quality medical care. Realizing what is possible requires you to be leaders, not accepters of the status quo.■

Appendix 5

COMMENTARY

A New Idea for Social Security

By Paul H. O'Neill
Paul H. O'Neill was Treasury secretary in the Bush administration from January 2001 to December 2002.

February 15, 2005

The debate over what we should do, if anything, with the Social Security system is heating up. A political campaign-style assault has already begun; in the weeks and months ahead, prepare to be buried in markedly different versions of the truth.

If you are like me, you hunger for something better from the political class. How about a new idea to offer financial security for each American when he or she reaches retirement age? Here's one way.

If we decided as a society that we were going to put $2,000 a year into a savings account from the day each child was born until he or she reaches age 18 — and if we assume a 6% annual interest rate — each child would have $65,520 at age 18. (The worst return for a 25-year investor in the stock market from 1929 before the crash to 2004 was an average of 6% a year.) With no further contributions, again with a 6% interest rate, those savings would grow to $1,013,326 at age 65.

If we began to do this now, the first-year cost would be $8 billion; that is $2,000 times the roughly 4 million children born each year. The second year would cost $16 billion and so on until we were contributing $2,000 per year to a savings account for every child from birth until age 18. When fully implemented, the cost would be $144 billion per year. To put this $144 billion per year into context, this year's combined spending for Social Security and Medicare will exceed $750 billion.

What this plan would do is "pre-fund" for the needs of old age. It solves the long-term financing problem for both Social Security and Medicare, allowing for the gradual replacement of programs like Supplemental Security Income and Medicaid and food stamps and housing aid for those over age 65. To make this work, the savings account money would need to be invested — my suggestion would be through so-called index funds. The administrative costs would be practically nothing because there's no need for a huge separate tax collection bureaucracy; the money would come from the general revenues of the U.S. government.

To be clear, this is a decision for our society to make. The U.S. government is just the instrument to bring it into effect. There are two crucial facts that distinguish this idea from traditional Social Security. The savings would be owned by the individual, and every person would have an account. (Everyone born before the plan went into effect would remain under the current Social Security system.)

Equal coverage for every American is an important part of this concept. Traditional Social Security does not provide equal coverage. For example, stay-at-home spouses get a smaller "dependent's" benefit, and some Americans are not covered at all. In effect, this would be a new birthright for those fortunate enough to be born here.

You might ask, "Can we afford it?" My answer is, in a federal budget of more than $2 trillion, we can certainly afford it. In an economy that will be upward of $12 trillion this year, we can afford it. By the time this plan was fully implemented, we would be living in an economy of $20 trillion. We can afford it.

Some may say, "This is a terrible idea because more illegal immigrants will come here to get this benefit for their children." I say hogwash. The question suggests we should make our country a less desirable place in order to reduce illegal immigration. The proposition is absurd.

Some will argue that this prospective gift from society will reduce the incentive to save. There are two answers to this concern. First, as this idea is implemented, we will be saving because the money to pay for this will be coming from our taxes. Let me say this directly: This is savings. Second, maybe you know some 20-, 30- or 40-year-olds who would scale back their quest for current income because of some prospective annuity at age 65. I don't know any of those people.

This is a clear and straightforward concept. Why haven't we done something like this?

Over the last 30 years, both political parties seem to have stopped generating truly new ideas. And political mechanics have taken over in place of the visionaries who thought up Social Security in the first place.

If we could put this idea in place to begin ensuring old age financial security for future generations, it would reshape the action we need to take now to meet our obligations under the current Social Security system. Are there any politicians listening out there?

STATEMENT OF SENATOR ROCKEFELLER
SENATE FINANCE COMMITTEE
MARCH 8, 2006

Mr. Chairman, thank you very much for holding this hearing. Our federal government currently provides tax breaks worth well over $100 billion each year to try to expand health care coverage. Yet, it has been quite some time since this Committee examine the effectiveness of those tax incentives and discussed other ways to help more Americans afford health care.

Most Americans currently receive their health insurance through an employer-sponsored plan. And that is a testament to the value of the tax preferences available for employer-sponsored health care. I am quite suspicious of proposals that seek to expand health care coverage by focusing on coverage purchased in the individual market. In fact, many of these proposals seem likely to ultimately expand the ranks of the uninsured.

Our experience with the Health Care Tax Credit -- which is available to those eligible for trade adjustment assistance -- is illustrative of the problems with providing tax breaks for individuals to purchase health insurance. We have seen very low take up rates among those eligible, because, even with a tax subsidy, individually purchased health insurance is often unaffordable. The evidence also suggests that consumers are intimidated and confused by the products available in the insurance market.

It seems to me that President Bush's signature health care initiative, Health Savings Accounts (HSAs), suffers from the same deficiencies as the Health Care Tax Credit and more. Analyses show that HSAs, while providing a lucrative tax shelter to high income individuals, are likely to actually increase the number of uninsured individuals.

As the employer-provided health insurance system is undermined, fewer workers will have access to such coverage and will still be unable to afford coverage in the individual market. It also seems that individuals who do manage to maintain health insurance by switching from an employer-sponsored plan to an individually-purchased plan will end up with significantly lower quality coverage.

I am also concerned that, as proposed by the president, HSAs would essentially provide a new tax shelter for savings that may actually undermine employer-provided *retirement* plans such as 401(k)s.

I look forward to hearing from today's panelists about how we can actually increase the availability of quality health care for working Americans. And I hope that each panelist will specifically address the president's HSA proposal, since it seems likely that that will be this administration's primary health care focus this year.

Thank you, Mr. Chairman.

STATEMENT OF SENATOR GORDON H. SMITH
U.S. Senate Finance Committee
"Taking a Check-Up on the Nation's Health Care Tax Policy: A Prognosis"
March 8, 2006

Thank you, Chairman Grassley and Senator Baucus, for providing the Finance Committee with an opportunity to receive an update on how well our existing health care and health coverage tax benefits are meeting the needs of both employers and individuals. This is a timely and important hearing, and I hope it marks the start of Congress' commitment to a thorough and thoughtful discussion of how to reduce the number of uninsured in our Nation.

Tax incentives are a powerful tool that we have at our disposal to support and expand access to health care coverage. They are one of the primary reasons our Nation's employer-based health insurance system has evolved to cover nearly one out of every three noninstitutionalized Americans. We should take note, however, of the increasingly clear signs that the present system may be weakening. Over the past several years, the portion of the Nation's population lacking consistent health coverage has grown to 15.6 percent. This trend coincides with a steady decline in the number of individuals who receive health coverage through their employer.

Clearly, the Nation's once stalwart employer-based health insurance system is under strain, and I believe we must begin to evaluate how effective and equitable our existing health care tax policies are for individuals and businesses alike. With the Federal Government spending an estimated $190 billion in health care related tax expenditures each year, we owe the American people a thorough review of these policies. More and more employees face the risk of losing their employer-sponsored health insurance coverage as rising health care costs erode employers' associated tax benefits. Clearly, we cannot continue down the path we are on without seriously reconsidering the existing structure of our benefits system.

As Congress continues to discuss the tax code as a means to provide access to health insurance coverage, I think it is important we recognize that tax-based solutions may not be helpful to everyone. Many of those who currently lack health coverage are low-income and may suffer from serious health problems. Their limited resources may not be sufficient to purchase an insurance policy that would enable them to take advantage of available tax deductions or credits. Additionally, the tax benefit they would receive may not be large enough to incentivize them to purchase a policy, even if they could afford it. That is why Congress must consider alternative forms of coverage, especially those that target the low-income uninsured and those who may suffer from chronic health conditions.

There are many revisions and expansions of current tax policies that Congress could enact to promote more equitable distribution of benefits and improve access to health insurance coverage. This is especially true in regards to providing more options for small businesses. Nearly one-third of all uninsured Americans are employed by firms with fewer than 25 employees. Because small businesses cannot achieve the same economies of scale larger employers receive in purchasing health insurance, they are unable to take

advantage of many of the benefits available in the current tax code. While they are technically able to deduct their share of premium costs as a business expense, they often face unaffordable premiums in the small group market that prevent them from being able to purchase coverage for their employees. Congress should improve existing health care tax benefits to encourage greater coverage among small businesses and consider other alternatives to make health insurance more affordable.

Congress can also enhance the effectiveness of the existing employer premium deduction by allowing it to apply to benefits provided to domestic partners and other family members. Many employers in both the private and public sectors have already taken the initiative to provide such coverage to their employees. By the end of 2004, 45 percent of Fortune 500 employers offered health coverage to domestic partners, a 10-fold increase from 1995. When such coverage is offered voluntarily, both employers and employees face income and payroll tax burdens that do not exist for other employer-provided health benefits. Specifically, the value of these domestic partner benefits is treated as taxable income to the employee and triggers payroll tax liability for both the employer and the employee.

The additional taxable income that employees experience due to this oversight in existing law result in Federal income taxes that total thousands of dollars annually. These unanticipated taxes deter many employees from adopting the coverage for their partners. Given the growing number of uninsured Americans, I believe this inequity needs to be reversed as quickly as possible to promote increased access to employer-based health coverage.

Senator Schumer and I introduced the Domestic Partner Health Benefits Equity Act to address this very problem. The legislation would apply the general and beneficial tax rules regarding employer health coverage (*i.e.*, that such coverage is not taxable income to the employee and is not treated as wages for payroll tax purposes) to coverage of any individual who is an eligible beneficiary under the employer health plan. The bill does not mandate that employers offer domestic partner health coverage, it simply provides for a more equitable application of the existing premium tax deduction that is the foundation of our Nation's employer-sponsored health insurance system. I believe this small change to existing law will provide employers the incentive to expand health benefits to a greater variety of beneficiaries, a step that will further drive down the number of uninsured.

Extending access to long-term care insurance is another need that could be met by building upon health care deductions currently included in the tax code. Recently, I filed the Long-Term Care Trust Account Act of 2006, a bill that creates a new savings vehicle that will support the purchase of long-term care insurance and care. The concept is similar to several existing savings vehicles, including HSAs, IRAs, and Coverdell Education Trusts. Long-Term Care Trust Accounts will allow loved ones and individuals themselves to fund their long-term care needs on a tax preferred basis. The accounts will give a tax credit to incentivize people to save for their long-term care premiums until they believe it is proper to purchase insurance. The accounts will also allow the purchase of care when a person needs long-term care services. I hope this legislation will receive quick consideration by Congress as one of the many options that should be made

available to individuals to help them prepare for the health care they will need as they grow older.

Congress should explore creating a new catastrophic deduction by separating certain existing medical expenses deductions and move them "above the line." A new threshold should also be set, one that more realistically reflects the distribution of out-of-pocket health care expenses incurred by individuals with extraordinary health events. This small change would provide much-needed relief from the financial burden of catastrophic health costs by expanding the benefits to those individuals who do not itemize their deductions. The existing medical expenses deduction could then be revised to allow more individuals to deduct premium costs for insurance purchased in the individual market.

Flexible Spending Accounts (FSAs) are another option to provide protection against health costs that receives generous tax benefits under existing law. FSAs allow employees to defer cash compensation for use as reimbursement for qualified health care costs. Many Americans have taken advantage of FSAs through employer cafeteria plans in order to offset out-of-pocket costs for medical care and medical supplies not covered by their health insurance. However, they are not functioning as well as they possibly could. Their effectiveness is limited by the requirement that accumulated FSA balances be forfeited if they are not used for qualified expenses typically by 2½ months after year-end.

I believe Congress needs to provide greater flexibility in the administration of FSAs, especially in terms of defining qualified expenses and rolling-over unspent savings to future years. Last year, Senator Conrad and I filed the Retirement Savings and Security Act of 2005 which includes a provision that would allow employees to transfer up to $500 per year in unused health FSA amounts to a defined contribution plan or IRA. This will encourage more Americans to use their FSAs as well as encourage increased savings for retirement. I believe we should also explore expanding the scope of reimbursable expenses to include supplies and other services that promote healthy behaviors. FSAs have the potential to be an incredibly effective tool to help individuals better prepare for out-of-pocket health expenses, and I am hopeful we can consider enacting some of the proposed FSA reforms before the end of this session of Congress.

While many of my proposed reforms to our existing health care tax policies may come with a cost, I believe the long-term benefit of investing in people will certainly be worth it. Congress faces an enormous challenge in meeting the varied needs of the uninsured, and it is a challenge that can be met only by considering a broad range of new initiatives to expand health coverage options. There is no "one size fits all" solution we should be working toward. The tax code represents just one of many tools available to us as we begin crafting solutions to this problem, and I hope my colleagues realize that as well.

I hope this hearing marks the beginning of a constructive dialogue on the issues facing the Nation's health care system as a whole. Thank you, Chairman Grassley and Ranking Member Baucus, for organizing today's hearing. I look forward to working with you both as we explore options to improve the effectiveness of the Nation's health care tax policies and improve accessibility to affordable health insurance coverage.

Senator Olympia J. Snowe
Senate Finance Committee
Hearing on Health Care Tax Proposals
March 8, 2006

Mr. Chairman, thank you for holding this most important hearing to examine health care tax incentives. I also thank our witnesses for testifying today. I am looking forward to hearing their thoughts and ideas about using the tax code to help reduce the nearly 46 million uninsured Americans and to improve and expand existing coverage options.

Before I make my remarks, I would like to mention that I am pleased that Senator Enzi is today marking up AHP legislation in the HELP Committee. Last year, I introduced the Small Business Health Fairness Act (S. 406), which would allow small businesses to pool together through Association Health Plans (AHPs), to provide uniform health insurance products to their employees at lower costs. I firmly believe that AHPs, also known as "Small Business Health Plans," will play a crucial role in reducing the ranks of the uninsured in this country, at nominal cost to the Federal government. The Senate must take up–and pass–small business health plans legislation this year, to provide small business with some relief from escalating health care costs.

But small business health plans are only one solution. Today, our focus is on ways to use the tax code to help solve our Nation's health care woes. I think we can all agree that additional solutions will be required to address the complex problem of rising health care costs. Health insurance premiums have risen by double-digit percentage levels in 4 of the past 5 years, far outpacing wage gains and inflation.

From my perspective, as Chair of the Committee on Small Business and Entrepreneurship, I think our focus ought to be on: (1) encouraging more small businesses to provide health insurance to their employees and (2) injecting more competition into dysfunctional State small group markets.

Plain and simple, Mr. Chairman, small businesses face a crisis when it comes to securing affordable, quality health care for their employees. There are now nearly 46 million uninsured Americans. According to the Employee Benefit Research Institute (EBRI), it is largely employees at small businesses and the self-employed who are uninsured. Of the working uninsured, who make up about 83 percent of the total uninsured population, EBRI reports that 60.6 percent either work for a small business with fewer than 100 employees or are self-employed. What this tells me is that any solution to the health care problem must be targeted to our Nation's smallest businesses.

Interestingly, study after study bears out this conclusion. According to the Kaiser Family Foundation's Employer Health Benefits 2005 Annual Survey, only 47 percent of the smallest employers, those with 3 to 9 workers, offer health insurance as a benefit. In contrast, it is only at the largest businesses, those with 200 or more workers, that coverage is nearly universal: 98 percent of large businesses now offer health insurance as a benefit.

Small businesses in my home State of Maine have it particularly bad. The Maine Center for Economic Policy (MECEP) recently reported a 15 percent average premium increase for small businesses in Maine over the past 3 years. The MECEP report also highlighted several other alarming trends: Half of the Maine small businesses surveyed raised deductibles over the past 3 years. Over one quarter have either increased co-pays or reduced benefits coverage, or have delayed pay raises to cover increased costs. Eight percent of Maine small businesses have dropped health coverage entirely.

Meanwhile, there is no meaningful competition in the small group market, and coverage and affordability are real problems. In May 2005, along with Senators Bond and Talent, I requested that the Government Accountability Office (GAO) study this issue. The GAO report, released last November, shows a significant consolidation in the State insurance markets. The five largest carriers now have more than 75 percent market share in 26 States (up from 19 in 2002) and more than 90 percent market share in 12 States (as opposed to 7 in 2002). Insurers face almost no competition, which leaves small businesses with few–if any–affordable coverage options.

Again, the clear take-away from all of these statistics is that legislation is badly needed to (1) encourage small businesses to offer their employees health insurance and to (2) inject much-needed competition into dysfunctional State small groups markets. I believe that we can use the tax code to address these issues, and I am currently developing legislation that I hope to introduce in the near future.

I look forward to working with Chairman Grassley and my colleagues on the Finance Committee to write comprehensive legislation to reduce the number of uninsured. Although I believe that assisting small businesses and reforming the small group insurance market will be part of a solution, I recognize that many other proposals will need to be part of an overall package. I hope we can get started on legislation as soon as possible, as individuals and small businesses in Maine and across the country repeatedly tell me that health insurance is their number one issue of concern.

Thank you, Mr. Chairman.

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Presented to the Committee on Finance
United States Senate

Taking a Checkup on the Nation's Health Care Tax Policy: A Prognosis

Hearing of March 8, 2006

The American Society of Pension Professionals & Actuaries (ASPPA) appreciates the opportunity to submit our comments to the United States Senate Committee on Finance on the President's proposals regarding health savings accounts (HSAs). ASPPA's comments, developed by an ASPPA HSA Task Force, are focused on their impact on employer-provided health care coverage and emphasize whether the proposals will make the HSA/HDHP (high deductible health plan) option more attractive to employers. These comments also address the impact the proposals might have on retirement plan savings.

Section I identifies some of the key objections and hurdles that employers face when making decisions regarding the HSA/HDHP design. Identifying these issues helps one evaluate the impact of the President's proposals, which is found in Section II. Section III addresses the potential impact the proposals might have on retirement plan savings.

All employers are sensitive to the costs of providing health coverage. Each employer generally falls into one of the four categories below. The needs and concerns of employers in each category vary, which results in potentially different impacts for each of them.

(1) Employers who refuse to offer any health coverage regardless of the cost.

(2) Employers who do not currently offer health coverage but might be willing to do so if the costs are reasonable.

(3) Employers who already offer non-consumer driven health care coverage.

(4) Employers who already offer some form of consumer driven health care coverage other than HSAs [*e.g.,* health reimbursement arrangements (HRAs) or health care flexible spending accounts (health FSAs)].

I. Reasons Employers Do Not Implement HSA/HDHP Options

A. Employers' Problems with the HDHP Products

- HDHPs may not be available to employers (*e.g.*, some states mandate certain coverage that precludes HSA eligible HDHPs).

- There may not be a sufficient premium decrement for switching to a HDHP, which is of particular importance to those employers currently offering traditional coverage. If there is not a significant premium decrease in switching to an HDHP, then a larger portion of the total health care cost is borne by either the employer or is shifted to employees. Presumably, premiums for HDHPs will stabilize over time due to market forces.

B. Problems with Employee Education/Moral

- Employee education and moral is a problem for employers who consider switching from traditional health coverage to an HSA/HDHP model. Larger employers may be able to offer employees a choice of benefit plans. Smaller employers do not have that flexibility. For them, a drastic switch to an HSA/HDHP may be viewed as a significant reduction in benefits. In particular, the elimination of the ability to offer a co-pay option (*e.g.*, for prescriptions and medical office visits) is a huge hurdle to overcome. Not having a co-pay option can be particularly problematic when attempting to attract workers where competitors continue to offer traditional health plan coverage.

- The rules regarding the tax treatment of HSAs are too complicated and fraught with traps (*e.g.*, an individual may be ineligible for an HSA if the individual's spouse is covered by a traditional health FSA). Also, it requires individuals to be responsible for determining the deductibility and tax-treatment.

- The monthly determination of the HSA contribution limit prevents a smooth transition to an HSA/HDHP model. An employee's coverage changes to an HDHP immediately, yet the HSA contribution limit is a month-by-month determination.

C. Loss of Employer Control

- Many employers have a paternalistic approach in providing benefits to employees. Once amounts are deposited into an employee's HSA, the funds can be spent for non-medical expenses. Even though such a withdrawal will result in adverse tax consequences, if the funds were attributable to employer contributions, it still results in a gain to the individual.

- The inability to control the funds results in a reluctance on the part of an employer who seeks to pre-fund an individual's HSA so that there are adequate funds should a large medical expense be incurred.

II. Impact of the President's HSA Proposals

A. Provide an Above-the-line Deduction and Income Tax Credit for Purchase of HSA-Eligible Insurance

The proposal would make available an above-the-line deduction (available regardless of whether a taxpayer itemizes deductions) for premiums for high-deductible health insurance policies. A high-deductible policy is a policy that would qualify the individual to have an HSA, but the individual does not have to actually maintain an HSA. The deduction would be available if the individual does not have employer-provided coverage. In addition, individuals covered under a high-deductible policy would be allowed a refundable credit of the lesser of (1) 15.3 percent of the premium or (2) 15.3 percent of the individual's wages subject to employment taxes.

ASPPA recommends that the President's proposal be modified to provide that the income tax deduction and credit be available for any portion of a HDHP premium that would otherwise be paid by a taxpayer on an after-tax basis, regardless of whether the insurance is obtained in the individual insurance market. Many employers provide health coverage, but do not pay the entire cost of such coverage. The employee-paid portion would be paid on an after-tax basis unless the employer permits the payments to be made pre-tax through a premium conversion feature of a cafeteria plan (*i.e.,* an IRC §125 plan). Not all employers, however, offer cafeteria plans.

If adopted as proposed, those employees who must pay a portion of employer-sponsored coverage on an after-tax basis would be at a disadvantage to those individuals who obtain HDHP coverage in the individual insurance market. If an employer provides an employee a cash subsidy for individual market insurance (to take advantage of the tax incentives), then some employees will elect to keep the cash rather than obtain coverage. The likely result would be a reduction in the number of individuals who have health coverage.

B. Increase HSA Contribution Limits and Provide a Refundable Income Tax Credit to Offset Employment Taxes on HSA Contributions Not Made by an Employer

The maximum annual HSA contribution limit would be increased to the out-of-pocket limit under the corresponding high-deductible health insurance policy (current law generally caps the HSA contribution limit at the policy's deductible amount). For 2006, the statutory maximum out-of-pocket limit is $5,250 for self-only coverage ($10,500 for family coverage). In addition, individuals making after-tax contributions to an HSA would generally be allowed an income tax credit equal to the lesser of (1) 15.3 percent of the premium or (2) 15.3 percent of the individual's wages subject to employment taxes.

ASPPA recommends that this proposal be adopted. The ability to only contribute up to the deductible has been a concern because the total out-of-pocket expense is the amount at risk to individuals. Accordingly, this proposed change would alleviate that concern, which would make HSAs more attractive to both employers and individuals.

C. Provide a Refundable Tax Credit to Lower-Income Individuals for the Purchase of HSA-Eligible Health Insurance

Individuals under age 65 would be allowed to claim a refundable income tax credit equal to 90 percent of premiums paid on a high-deductible health insurance policy. The amount of the credit would also be limited by the maximum credit amount per covered family member of $1,000 per adult and $500 per child for up to two children. The maximum credit available to any taxpayer would be $3,000. The maximum credit would begin to be reduced (phased out) at between $15,000 and $25,000 of taxable income, depending on the number of individuals covered by the policy. In addition, the tax credit could be claimed on the taxpayer's tax return or in advance. Eligibility for the advance credit option would be based on the taxpayer's prior year tax return. Individuals claiming the credit in advance would reduce their premium payment by the amount of the credit, and Treasury would reimburse the health insurer for that amount. Taxpayers would be eligible only if they do not participate in a public or employer-provided health plan. Eligible health insurance plans would be required to meet minimum coverage standards, including coverage for high medical expenses. In addition to private health plans, individuals would be able to purchase insurance through private purchasing groups, state-sponsored insurance purchasing pools and state high-risk pools.

ASPPA recommends that this proposal be modified to increase the phase-out limits and to permit the credit regardless of whether the taxpayer participates in individual market insurance or employer-sponsored coverage. The proposal in its current state would have no impact on making HDHPs more attractive to employers, and it would likely have little or no impact on making HDHPs more attractive to the affected taxpayers.

D. Make Other Statutory Changes to Improve HSA Administration

Qualified medical expenses that can be reimbursed by an HSA would be expanded to include premiums for the purchase of non-group HSA-eligible plans. In addition, the reimbursement of the expenses by an HSA established no later than the date for filing the return for that taxable year would be excludable from income. Moreover, employers would be allowed to contribute existing HRA balances to the HSAs of the same employees.

ASPPA recommends that this proposal be adopted. It will make HSAs more attractive to all individuals. The ability to contribute existing HRA balances to the HSAs of the same employees may be attractive to employers currently providing HRAs. Many HRA sponsors, however, will not take advantage of such a provision due to loss of control over how the funds are spent as well as the resulting funding obligation (the majority of HRAs are unfunded, and contributing balances to an HSA would require funding).

ASPPA also recommends that the proposal be modified to permit participants in a qualified IRC §401(k) or 403(b) plan to make a one-time transfer of their elective contribution, up to $10,000, to an HSA.

E. Improve the Health Coverage Tax Credit

The proposal would make a number of modifications and improvements to the Health Coverage Tax Credit (HCTC) that was created under the Trade Adjustment Assistance

(TAA) Reform Act of 2002. Under current law, the HCTC is a refundable tax credit equal to 65 percent of the cost of qualified health insurance paid by eligible individuals, including certain recipients of TAA benefits and certain individuals between the ages of 55 and 64 who are receiving pension benefits from the Pension Benefit Guaranty Corporation (PBGC). The proposal would modify the HCTC by subjecting state-based HCTC coverage to rules more like HIPAA. The proposal would also permit spouses of HCTC-eligible individuals to claim the HCTC when the HCTC-eligible individual becomes entitled to Medicare coverage, if the spouse is age 55. The proposal would also make a number of technical clarifications to the HCTC.

ASPPA recommends that this proposal be adopted; however, it will have little or no impact on making HSAs more attractive to employers.

III. Impact of the President's HSA Proposals on Retirement Savings

Some commentators have suggested that the President's proposals will have a detrimental impact on retirement plan savings. Under the current rules, HSAs can serve as a powerful savings tool whereby all amounts contributed are not subject to taxation. The President's proposals will make the HSA an unprecedented savings tool. The tax credit being proposed will permit HSA contributions to be made without being subject to payroll taxes. The credit, coupled with higher contribution limits (up to $10,500 if the HDHP is family coverage), will serve as a huge incentive for individuals to establish HSAs. The HSA contributions may very well be in lieu of retirement plan contributions.

Consider an individual who has $5,000 of income to save. If the amount is deferred into a 401(k) plan, then it is subject to federal payroll taxes, but is not subject to federal income taxes. Any distributions from the 401(k) plan would be subject to federal income taxes. On the other hand, if the contribution is made to an HSA (assuming the out-of-pocket maximum under the HDHP is at least $5,000), then the contribution is not subject to income taxes or payroll taxes. If a distribution is made from the HSA for a qualifying medical expense, it will be entirely tax-free. If a distribution is made for a non-qualifying medical expense, it would be subject to taxation—which is the same treatment that would apply if the distribution were made from the 401(k) plan. Thus, if the amount of money that an individual has to save is limited, the HSA would clearly be the better alternative.

The issue is whether the HSA is meant to serve as a retirement savings vehicle in addition to a health plan. The HSA has preferable tax treatment and is not subject to nondiscrimination and coverage rules that apply to a qualified plan. Whether small business owners will decide to forego a qualified retirement plan in lieu of an HSA is speculative. There is a distinct possibility, however, that over time, HSAs will be touted as a retirement savings plans. This goes beyond the intended purposes of HSAs, which is to implement the consumer-driven health care concept and ensure that there are adequate funds to meet the out-of-pocket medical expenses that one might incur under a HDHP.

ASPPA recommends that limits be put into place to curtail the use of HSAs as a retirement savings plan. As stated above, ASPPA supports the increase in the HSA contribution limits and the tax credits. An approach that would help ensure that HSAs are not viewed as retirement savings plans would be to prohibit contributions once the value of the HSA has

reached a certain threshold. For example, if an HSA balance is at least $100,000 if filing jointly ($50,000 for individual coverage) as of December 31, then no additional contributions may be made to the HSA in the following taxable year.

* * *

ASPPA HSA TASK FORCE

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Statement for the Printed Record of a Hearing, "Taking a checkup of the nation's health care tax policy: a prognosis" on March 8, 2006, before the U.S. Senate Committee on Finance

Mercer Human Resource Consulting (Geoffrey Manville, 202-263-3957)

March 21, 2006

The Honorable Charles Grassley
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510

The Honorable Max Baucus
Ranking Democratic Member
Senate Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510

Re: Employer strategies for health cost management

Dear Chairman Grassley and Ranking Member Baucus:

Thank you for the opportunity to submit for the hearing record key findings from Mercer Health & Benefits LLC's 2005 National Survey of Employer-Sponsored Health Plans. We applaud your leadership in working to strengthen our nation's health care system and hope that our survey findings on employer strategies for coping with the high costs of health care will help advance your important work. We agree that making health coverage more affordable and more available, while controlling costs, is critical to the economic security of American workers and to the global competitiveness of American businesses.

A key tactic employers used to control their 2005 health care costs was cost-shifting, our survey found. Looking ahead, however, employers say that the key to health costs management will be involving workers and their dependents in their own health and health care decisions. The two strategies that respondents said will be the most significant in their organization over the next five years are care management and consumerism. Five years ago, care management and consumerism were the province of only the very largest employers; today, they are being embraced by employers of all sizes. The survey results show that employers are adopting a wide range of consumerist and other cost-management strategies as they work to make high-quality, affordable health care available to workers and their families.

We have attached several excerpts concerning consumer-directed health plans from our report on the findings of the *Mercer National Survey of Employer-Sponsored Health Plans 2005*.

Because of employer-provided health benefits, many Americans now enjoy health care coverage that they might not otherwise be able to afford. We recommend that Congress and the Administration, employers, and employees join together to recognize the important role that employer-provided health benefits play and can continue to play in solving this country's health care policy challenges.

Mercer Human Resource Consulting stands ready to assist the Committee – through information sharing, policy and technical analyses, and in whatever other ways would be helpful – in its ongoing efforts to improve our health care system.

Sincerely,

Mercer Human Resource Consulting (Geoffrey Manville, 202-263-3957)

Attachment

Attachment

Here are excerpts concerning consumer-directed health plans from the report on the findings of the *Mercer National Survey of Employer-Sponsored Health Plans 2005.*

About Mercer's 2005 National Survey of Employer-Sponsored Health Plans

The random sample used for the *National Survey of Employer-Sponsored Health Plans* includes private employers and government agencies that have 10 or more employees.

For private employers, we used the D&B database, drawing a sample stratified in eight size categories. The survey is an enterprise survey, meaning that only one response per employer is accepted even if the employer has multiple work sites or establishments. For government agencies, we used the *Census of Governments,* drawing random samples of state, county, and local governments.

A weighting scheme was used to combine the results and create one database. Results may be projected to all employer health plan sponsors with 10 or more employees. The sample was composed and weighted to permit projectable data breakouts for the four census regions. The larger size groups were oversampled but weighted to reflect the proportions of firms nationally. Although we discuss some findings based on industry group in the analysis, the sample was not stratified by industry, and readers are advised to use industry data judiciously.

The results in this report are based on the responses of 2,122 employers that sponsor health plans. In the Overview, we present general findings for the entire surveyed population. Because health benefits vary greatly on the basis of employer size, we also examine results separately for large and small employers. We divide the two groups at 500 employees because our survey shows that plan characteristics change most dramatically at this point. The balance of the report looks at results for large employers only.

Overview

Top cost management strategies for the future

Employers were asked how significant each of six different cost-management strategies would be to their organizations over the next five years. "Scaling back benefits or cost-shifting" received the lowest scores, with just 21 percent of all employers saying this strategy would play a significant or very significant role over the next five years. The two strategies that the most employers say they will focus on are consumerism, defined as "promoting informed and responsible spending by employees for health care," and care management, a range of programs designed to improve employee health, including disease management.

More than a third of all employers (34 percent) said consumerism will be significant or very significant to their cost management efforts over the next five years, while 32 percent said care management will be significant or very significant. Many employers see these strategies as two sides of the same coin. Care management programs require the active involvement of employees in improving their health, while consumerist strategies engage the employees in managing health care cost.

Consumerism and CDHPs

Employers implemented a range of consumerist strategies in 2005. Two-fifths of all employers now provide employees with a Web site with information on provider quality and cost, and 17 percent provide a tool to help employees select the plan that will best meet their needs based on expected health care utilization.

Some of the nation's largest employers took the step of implementing a consumer-directed health plan (CDHP). Among very large employers (20,000 or more employees), CDHP offerings rose sharply, from 12 to 22 percent. Otherwise, CDHPs saw only modest growth. Only 2 percent of small employers — those with 10–499 employees — offered CDHPs in 2005, and only 5 percent of large employers — those with at least 500 employees — offered them. Enrollment in CDHPs also remained low. Nationally, just 1 percent of all covered employees enrolled in CDHPs. Among large employers, when a CDHP was offered alongside other medical plans, on average 16 percent of employees chose to enroll in it.

Small employers' lack of interest in CDHPs was a surprise. The first CDHPs incorporated health reimbursement accounts (HRAs), which required an employer contribution. When health savings accounts (HSAs) were created by the Medicare Modernization Act of 2003, a type of CDHP account that does not require an employer contribution, proponents said HSAs would expand access to coverage by providing a less expensive option for small employers that might not otherwise offer coverage. This theory did not pan out in 2005: use of CDHPs by employers with 10–499 employees reached only 2 percent, while the percentage offering any form of health plan dropped from 65 to 63 percent. It may be that the cost difference wasn't enough to prevent some small employers from dropping coverage, given that a third of those offering PPOs already require an individual deductible of $1,000 or more. The more complex plan design may also be a deterrent; most small employers have limited resources to focus on benefit programs.

However, survey results suggest we will see a significant increase in CDHPs — especially HSA-based CDHPs — over the next few years. Growth should be strongest among small employers: 9 percent say they are very likely to offer an HSA-based CDHP in 2006, and 5 percent, an HRA-based CDHP. However, these figures should be taken more as an expression of strong interest than as a projection. In 2004, a much higher percentage of small employers said they were likely to offer a plan in 2005 (12 percent) than actually did so (2 percent). Survey respondents complete the survey in the late summer, when many small employers have not yet finalized plans for the upcoming year; very large employers, which solidify plans earlier in the year, are better able to provide accurate predictions for the upcoming year. Among employers with 20,000 or more employees, CDHP offerings are likely to rise to 29 percent in 2006, with 7 percent offering HSA-based plans and 21 percent offering HRA-based plans.

Employer Strategies for Health Program Management

Consumerism

Grounded in the belief that the lack of normal consumer economics is an important factor behind high health benefit cost in the US, consumerism is a number of strategies intended to promote greater employee involvement in health care decision making. Many health plan designs, particularly the copayment feature commonly used in HMOs and for in-network PPO services, provide little incentive for members to consider cost in their health care decisions. In addition, information on the cost and quality of specific health care providers, which consumers would need to make appropriate decisions, is not readily available. Over half of all large employers (55 percent), and 71 percent of those with 20,000 or more employees, say that promoting health care consumerism will be a significant or very significant part of their health care strategy over the next five years.

For most employers, the first step has been to provide their employees with information, such as access to online information on health conditions and on provider cost and quality. More than a fifth (21 percent) provide a plan selection tool that allows employees to input expected health plan utilization (this rises to 47 percent among employers with 20,000 or more employees, which are the most likely to offer multiple medical plans). In fact, 83 percent of all large employers say they took one of these actions to promote consumerism in 2005.

Adopting a consumer-directed health plan indicates a strong commitment to consumerism. Under a CDHP, an employee spends money from his or her individual account to pay for routine health care expenses; serious illness or injury is covered by a high-deductible (or catastrophic) insurance plan. These plans are only a few years old and still evolving. Two types of accounts are associated with the plans: a health reimbursement account, or HRA, which is funded solely by the employer and offers a great deal of flexibility in terms of plan design, and the health savings account, or HSA, which was created by federal legislation and does not require an employer contribution but is more limited. Just 5 percent of large employers offered an account-based CDHP in 2005, up from 4 percent in 2004. However, many more say they are likely to offer one in 2006 or 2007.

These plans were more common among the very large organizations that typically provide employees with a choice of plans: among employers with 20,000 or more employees, 22 percent offered a CDHP, up from 12 percent in 2004 and 9 percent in 2003. The majority of employers sponsoring HRA-based CDHPs believe that the plan is meeting their most important objectives (59 percent) and that the reaction of employees enrolled has been more positive than negative (61 percent) — although it should be noted that only 34 percent have conducted an employee satisfaction survey. Detailed information on CDHP plan design is provided on pages 27–30.

Consumerism vs. other medical plan types

PPOs and HMOs together account for 85 percent of total enrollment, with the PPO clearly dominant and the HMO continuing to play an important role as an alternative health care delivery model. In this section we discuss three other types of medical plans, each with low enrollment but at different phases of their evolution. Consumer-directed health plans are clearly poised to grow in the near term, while enrollment in POS plans, the hot new plan of the early nineties, continues to fall. Traditional indemnity plans are all but extinct, used mostly to cover employees outside the area of a managed care network.

In a year in which many large employers reduced the number of medical plans offered, the CDHP was the only type of medical plan to grow in prevalence. However, in 2005 these plans remained concentrated among the largest employers, and predictions for their growth — including those made by respondents to our 2004 survey — proved overly optimistic. Just 2 percent of all employers with 10 or more employees offered a CDHP, and just 1 percent of all covered employees were enrolled in one in 2005.

On the other hand, the employers that did add a CDHP in 2005 were some of the nation's largest. As employer size increases, so does CDHP prevalence, reaching 10 percent among employers with 5,000–9,999 employees and 19 percent among employers with 10,000–19,999 employees. The fastest growth has been among employers with 20,000 or more employees; offerings of CDHPs among this group jumped from 12 percent in 2004 to 22 percent in 2005.

The survey results suggest that offerings of CDHPs will grow sharply in 2006 among employers of all sizes. Eleven percent of small employers (including those already offering a CDHP) said they were "very likely" to offer a CDHP in 2006; if even half actually do so, it will still be a sizable increase. Very large employers will continue to add plans over the next two years, although at a somewhat slower pace. A total of 29 percent of employers with 20,000 or more employees are likely to offer a plan in 2006, and 31 percent are likely to do so by 2007.

HRAs versus HSAs

CDHPs include one of two types of employee-controlled accounts: a health reimbursement account (HRA) or a health savings account (HSA). With an HRA, only the employer contributes funds; with an HSA, an employer contribution is optional, similar to a 401(k) plan. In 2005, the majority of large employers offering a CDHP used an HRA, while the majority of small employers offering a CDHP used an HSA.

HSA-based plans are likely to gain ground in 2006. Large employers that said they were very likely to offer a CDHP in 2006 were split nearly down the middle in terms of HRAs and HSAs: 8 percent said they were very likely to offer an HRA-based plan, while 7 percent were very likely to offer an HSA-based plan. Three-fifths of all large employers said they would be more likely to offer an HSA if regulations were changed to permit unspent FSA balances to be rolled over in the HSA; 57 percent said they would be more likely to offer an HSA if they could coordinate the HSA with the FSA so that employees could spend the FSA funds first.

CDHP enrollment

Over four-fifths of large employers offering a CDHP in 2005 offered it as an option rather than as a total replacement. Among these employers, enrollment averaged 16 percent of eligible employees. Among very large employers (20,000 or more employees), which tend to offer a greater variety of plans, enrollment averaged 8 percent. Neither enrollment figure has changed significantly from 2004.

A small number of survey respondents have offered an HRA-based CDHP since 2003 and provided three years of enrollment statistics. Among these 28 employers, average enrollment rose each year, from 16 percent to 19 percent to 22 percent. (Because of the low number of responses, this result is not weighted and represents only the respondents providing data.) While this is too small a sample to draw broad conclusions, the enrollment pattern seems typical for a new product.

CDHP sponsors were asked how much help employees required with the CDHP compared to other medical plans, both during open enrollment and afterward. Almost two-thirds said employees require more assistance (about a fourth said much more). More than one-quarter (27 percent) said that employees have a lot of difficulty deciding whether they will receive better or worse coverage under the CDHP than under another plan. Only 10 percent said employees have no difficulty.

CDHP cost, contributions, and design

The average cost of CDHP coverage was $5,714 per employee in 2005. This figure includes employer contributions to the HRA or HSA account. This is 12 percent lower than the average PPO cost per employee ($6,518), and 14 percent lower than the average HMO cost ($6,658).

Employee premium contribution requirements are more liberal for CDHPs than for either PPOs or HMOs. Nearly a fourth of large CDHP sponsors (23 percent) and nearly half of small sponsors (47 percent) required no contribution for employee-only coverage. This compares to 13 percent and 41 percent of large and small PPO sponsors, respectively. Average contribution amounts in a CDHP were lower as well. Among large employers, the cost for employee-only CDHP coverage was $57 per month, compared to $78 per month for PPO coverage. The cost for family coverage was $206 for a CDHP and $290 for a PPO.

In HRA-based plans, the median deductible for employee-only coverage was $1,250 and the median employer account contribution was $750, leaving a "gap" of $500. By comparison, the median in-network PPO deductible was $300. The median individual out-of-pocket maximum was also somewhat higher in CDHPs than in PPOs — $2,500 compared to $1,960 (including the deductible).

HSA-based plans clearly offer leaner coverage. Over a third of large employers make no contribution to the account. Among those that do, the median contribution for employee-only coverage was $100. The median deductible was $1,200, and the out-of-pocket maximum was $3,500.

Employer objectives and employee satisfaction

When asked to rate the importance of a number of possible program objectives, large HRA sponsors were most likely to select "reducing cost over time" and "promoting consumerism" as very important objectives. More than half (58 percent) agreed that their most important objectives have been met, though only 1 percent strongly agreed. Asked about employee reaction to the plan, 11 percent said it was strongly positive, and another 50 percent said it was more positive than negative.

-END-

NCLR
NATIONAL COUNCIL OF LA RAZA

TAKING A CHECKUP ON THE NATION'S HEALTH CARE TAX POLICY: A PROGNOSIS

Submitted to:
The U.S. Senate Committee on Finance

Submitted by:
Janet Murguía
President and CEO

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March 8, 2006

On behalf of the National Council of La Raza (NCLR), – the largest national Hispanic civil rights and advocacy organization in the United States – I submit this statement to you for the hearing entitled "Taking a checkup on the nation's health care tax policy: a prognosis." NCLR serves all Hispanic nationality groups in all regions of the country and is an umbrella organization with nearly 300 Affiliate organizations, through which NCLR reaches millions of Latinos each year. NCLR is not a direct service organization, but instead works to make macro-level changes in the Hispanic community. During the past decade, NCLR, through its Washington, DC-based Policy Analysis Center, has focused on efforts to improve equity within the health care system by raising the quality of health care for Latinos and other Americans. NCLR's primary health policy emphasis has been on restoring access to Medicaid and the State Children's Health Insurance Program (SCHIP) to legal immigrants whose eligibility was restricted as a result of enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (P.L. 104-193). However, as the health disparities for Latinos and other racial and ethnic groups continue to grow, NCLR is focused on comprehensive transformation of the health care system, which will enable Latinos and all Americans to have access to adequate health care.

Population Trends in the Latino Community

The decennial Census reported that from 1990 to 2000, the Latino community grew by almost 60%. Currently, there are more than 41 million Latinos in the U.S., making up 14% of the total U.S. population. While data show that the general U.S. population is aging, Latinos remain a relatively young group, with a median age just under 27 years old.[1] In addition, Latinos compose a significant and growing part of the U.S. economy, with the highest participation in the U.S. labor force.[2] At the same time, incomes for Latinos continue to lag behind many of their racial and ethnic counterparts, principally due to low wages and earnings. The average per capita income of Latinos is $14,106 per year, which is only 56% of the per capita income of non-Hispanic Whites.[3] More than one in five (21.9%) Latinos are in poverty and face numerous threats to their well-being. If work supports such as health insurance are not bolstered, future productivity may be hindered.[4]

Health Status Among Latinos

The Latino population currently faces a number of significant health challenges. The most recent National Healthcare Disparities Report concluded that more than half of measured health care access and quality indicators have worsened for Hispanics, when compared to non-Hispanic Whites.[5] Latinos continue to experience disproportionately high rates of diabetes, heart disease, asthma, and HIV/AIDS among other serious health conditions. Young Latinos, who account for one in every five children in the U.S., struggle with these and other serious health risks, including alarming rates of obesity, teen births, mental illness, and depression. Latinos' limited health care coverage undoubtedly plays a role in their poor health status and inhibits their access to consistent, quality health care.

Health Coverage in the Latino Community

Widespread uninsurance within the Latino community has had enormous impact on the ability of Latinos to access health care.[6]

Despite their high work participation rates, Hispanics are more likely to lack health insurance than any other group of Americans; for example, one in three (33%) Latinos in the U.S. is uninsured, compared to 20% of non-Hispanic Blacks and 11% of non-Hispanic Whites. Similarly, 21% of Latino children lack health insurance, a rate nearly twice that of any other group.[7] Recent data from the Agency for Healthcare Research and Quality (AHRQ) also noted that 44.3% of Hispanics experienced at least periodic uninsurance throughout the year, which makes it difficult to receive consistent quality care and to choose appropriate health care options.[8] There are several reasons why this occurs:

- Low-income families are more likely to go without health insurance. Approximately 43% of low-income Latinos below 200% of the federal poverty level are uninsured.[9]

- Employer-based insurance continues to be the primary source of health coverage for non-elderly persons in the U.S. However, Latinos are far less likely to have employer-based health insurance, because it is not offered in their work setting or is cost prohibitive. In 2004, only 39.8% of non-elderly Latinos had employer-based health insurance compared to nearly seven in ten (68.9%) non-Hispanic Whites.[10]

- Public health insurance programs, chiefly Medicaid, are a major source of health coverage for Latinos. However, there are still Latinos who are unable to access these programs because of cultural and linguistic barriers that prevent enrollment as well as legal restrictions to immigrants enacted in 1996.

Health insurance coverage options that enhance access to and quality of health care for Hispanics are surely needed.

Health Savings Accounts and the President's Proposal

President George W. Bush proposes the expansion of Health Savings Accounts (HSAs), a move he says will help address rising health care costs. HSAs are tax-advantaged health care accounts to which individuals with high deductible health plans (HDHPs) can contribute to cover the costs of unreimbursed health care expenses. His proposal expands the structure of HSAs by providing a greater subsidization of HSA contributions. Specifically, the President proposes: increasing the contribution limit to the out-of-pocket maximum for HDHPs and a refundable income tax credit to offset employment taxes on non-employer HSA contributions, providing an above-the-line deduction and income tax credit for HSA-eligible non-group health coverage as well as a refundable credit of 15.3% of contributions to an HSA (to offset certain payroll taxes), and providing a refundable tax credit to lower-income individuals for the purchase of HSA-eligible health coverage.[11]

The new tax incentives governing high deductible insurance policies and HSA contributions are estimated to reduce revenues by $156 billion over ten years.[12] However, HSAs are a relatively small portion given overall spending for health care. The President's Advisory Panel on Federal Tax Reform notes that for 2006 alone tax benefits for health care will amount to 12% of all federal income tax revenue, of which a large proportion is attributable to the employee exclusion for employer-provided health insurance and medical care, an estimated $126 billion.[13]

Principles of Reform

NCLR is highly skeptical that health tax incentives are the sole, or even most important, element of a health care reform strategy to increase Latino access to quality health coverage. However, as the dialogue on health tax incentives moves forward, it should be a top priority to include communities who are uninsured and have much at stake in this debate, including Latinos. NCLR urges the Senate Committee on Finance to consider the principles below:

Effective health care expansions will:

- Reduce existing health care coverage gaps between Latinos and other Americans. The primary goal of health tax incentives should be to ensure improved opportunities for individuals to access quality health care.

- Provide affordable access to health care. Any proposal should facilitate low-income individuals' access to health care coverage.

- Ensure that Latinos have an equal opportunity to exercise an informed choice to participate in expanded health care programs. New health care options should increase the transparency within the health care system. Further, resources should be dedicated to ensure that Latinos, and other underserved communities, can become connected to these programs.

- Ensure equity in health care coverage. Health care expansions should not make Latinos and other Americans vulnerable to adverse selection or other phenomena that expose them to increased health care costs or compromise their access to quality care.

In particular, health care tax incentives should not:

- Undercut existing health care coverage for Latinos. Health care expansions should build upon systems that provide coverage, not erode them. Congress should not offset expansions of health tax incentives by cutting programs that are proven to connect people to health care such as Medicaid and the State Children's Health Insurance Program (SCHIP). Further, efforts to expand tax incentives should be designed in ways that address the high rate uninsurance for Latinos by bridging the disconnection between Latinos and their employers.

- Displace other Latino health care and tax priorities. Congress should ensure full support of the many effective programs that already address health disparities and promote Latino access to health care. Furthermore, Congress should immediately approve legislation that would increase health care coverage for Latinos, such as the "Immigrant Children's Health Improvement Act" (H.R. 1233, S. 1104).

- Increase the federal deficit. The Congressional Budget Office (CBO) estimates that the total federal budget deficit will persist through 2006 and reach $336 billion. As noted above, the President's proposal would increase the deficit, and there currently is

insufficient information about how it will achieve cost savings in the provision of health care services.

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[1] U.S. Census Bureau, Current Population Survey, *Race and Hispanic Origin*, March 2002. Available online at: http://www.census.gov/population/pop-profile/dynamic/RACEHO.pdf
[2] U.S. Census Bureau, Bureau of Labor Statistics, *Employment and Earnings*, January 2006. Available online at: http://www.bls.gov/cps/cpsa2005.pdf
[3] U.S. Census Bureau, Current Population Survey, *Income, Poverty, and Health Insurance Coverage in the United States: 2004,* August 2005. Available online at: http://www.census.gov/prod/2005pubs/p60-229.pdf
[4] *Ibid.*
[5] Agency for Healthcare Research and Quality (AHRQ) *2005 National Healthcare Disparities Report.* Available online at: http://www.qualitytools.ahrq.gov/disparitiesreport/2005
[6] AHRQ, *op cit.* Uninsured Latinos are less likely than other Americans to have a primary care doctor or have an ongoing relationship with a doctor. A U.S. Census study noted that more than two-fifths (43%) of Latinos had not seen a doctor in the past year.
[7] U.S. Census Bureau, Current Population Survey, *Income, Poverty, and Health Insurance Coverage in the United States: 2004,* August 2005. Available online at: http://www.census.gov/prod/2005pubs/p60-229.pdf
[8] AHRQ, *op cit.*
[9] Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2004 Data Update*, November 2005.
[10] *Ibid.*
[11] Department of Treasury, *General Explanations of the Administration's Fiscal Year 2007 Revenue Proposals*, Washington, DC: Government Printing Office, 2006. Leonard Burman, *New Healthcare Tax Proposals: Costly and Counterproductive*, Tax Analysts: Tax Notes, February 13, 2006.
[12] Leonard Burman, *New Healthcare Tax Proposals: Costly and Counterproductive*, Tax Analysts: Tax Notes, February 13, 2006.
[13] President's Advisory Panel on Federal Tax Reform, *Report of the President's Advisory Panel on Federal Tax Reform,* U.S. Government Printing Office, November 2005.

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