Statement for the Record

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U. S. Senate Finance Committee Roundtable
"Financing Comprehensive Health Care Reform"

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Thank you for the invitation to participate in this roundtable discussion and offer our perspective, on behalf of working women and men, on financing health care reform. The AFL-CIO represents 11 million members, including 2.5 million members in Working America, our new community affiliate, and 56 national and international unions that have bargained for health benefits for more than fifty years. Our members have a significant stake in health care reform as consumers but also, for many, as health care workers or sponsors of coverage.

Through bargaining, our members are among the most fortunate: they have good job-based benefits that help keep care affordable. Yet even the well insured are struggling with health care costs hikes that are outpacing their wage increases and far too many working families increasingly find themselves joining the ranks of the uninsured or under-insured as businesses close or cut back. More than 320,000 Americans lost employer-provided health insurance in March alone, or roughly 10,680 workers a day.[i]

All signs point to a system in crisis. Health care costs too much, covers too little and leaves tens of millions without coverage and many more worried about keeping the coverage they have. Between 1999 and 2008, premiums for family coverage increased 119 percent, three and one half times faster than cumulative wage increases over the same time period.[ii] Workers' out of pocket costs are going up as well, leading to more under-insured Americans who can no longer count on their health benefits to keep care affordable or protect them from financial ruin. Between 2003 and 2007, the number of non-elderly adults who were under-insured jumped from 15.6 million to 25.2 million.[iii] And skyrocketing costs are pushing more workers out of insurance altogether. About 18 million of the 47 million uninsured have household income that exceeds $50,000.[iv]

Future trends indicate far worse conditions. The average cost of a family plan through employer-based coverage is projected to reach $24,000 in 2016, an 84 percent increase over 2008 premiums. At this rate, at least half of American households will spend more than 45 percent of their income to buy health insurance in 2016. [v] By 2017,

health spending is expected to double to $4.3 trillion and administrative expenses are projected to double to $298 billion. [vi] And the implications for our economy are staggering: the Congressional Budget Office has said that unless we take action, health care spending could consume 49 percent of our GDP in 2082, causing wages to stagnate and depressing non-health care sectors of our economy.

No matter how you look at health care, we can no longer afford to not get comprehensive reform done this year. In fact, one study estimates our economy loses between $100 billion and $200 billion each year because of diminished health and shorter lifespan of the uninsured – roughly the range most experts recognize as the upfront cost of comprehensive reform.[vii]

Thankfully, this committee has been consistently leading the call for health care reform that guarantees affordable, high-quality health care for all Americans, noting, like our President, that reform is not only a moral imperative; it is also an economic imperative. Through all the work done last year and with the White Paper released in the fall, this committee has been laying the groundwork to get health reform done.

Our members with health benefits experience everyday what it is like for people with coverage to live in fear of losing it. That is why they are counting on health reform to not only extend coverage to all uninsured Americans but to also lower costs for those who now have it. Comprehensive health reform holds the potential to bring relief to well-insured Americans like many of our members by eliminating the cost shift that results when uninsured and underinsured workers get uncompensated care. And it can provide everyone the security of coverage in the face of continuing and deepening declines in employer-sponsored health benefits.

For all these reasons, we believe the overarching goal of health reform must be to constrain costs: for families, for business and for government at all levels. But we can't constrain costs without covering everyone, and we can't cover everyone without constraining costs.

Key to holding down costs will be inclusion of a public health insurance plan option for all who purchase coverage through an exchange. A public health insurance plan will make coverage more affordable with lower administrative costs. It will also inject needed competition into an imperfect market. And it can help drive delivery system reforms in conjunction with private payers, as Medicare has done with the quality improvement work underway already.

We also applaud the committee for the release last month of an options paper on transforming the health care delivery system. The elements outlined in that paper are essential to increasing value in our health care system – to constrain costs while improving quality. The elements in the options paper will also set us on a path to a more efficient system anchored in continuous quality improvement and scientific advances. Studies indicate that one third of all health care spending is on poor quality care and patients have just a 50/50 chance of getting the right care at the right time. We simply cannot afford to grow the system we have now and it will be especially important to achieve the improvements envisioned in the options paper if we are to bend the cost curve that, if left unchecked, will balloon our federal budget and squeeze out funding for other essential, non-health care priorities. But while these improvements are absolutely necessary to improve the value we get for our spending, they will not be sufficient to fund health care reform

In order to get health reform done, we cannot rely solely on savings in the system; we will need to identify additional revenues. To find those, we agree with the President that health care reform is an urgent national priority that will produce benefits across our economy and improve our future budget outlook; therefore, we should look beyond health care spending to find the revenues needed to fund health care reform. To begin, we support the major elements of the President's budget proposal for more than $600 billion in savings and revenues, half of which comes from savings within Medicare and Medicaid and half of which comes from limiting the itemized deductions for households in the top two tax brackets.

Health reform should include other options that will produce savings for all payers, both public and private, without compromising quality of care. These options would include allowing for greater competition between brand name and generic drugs, for both traditional drugs and biotech drugs, and increasing our investment in comparative effectiveness research in order to give doctors and patients the information they need to make optimal treatment decisions.

Beyond these savings, we urge the committee to consider broader tax reform options, including those put forth by President Obama: increasing the capital gains tax to Reagan era levels; taxing the "carried interest" of private equity managers at ordinary income tax rates rather than at capital gains levels; reforming international tax enforcement and changing rules around deferral of taxes on foreign income, which the Administration has said could raise $210 billion; and eliminating the "Last In, First Out" inventory rules that could raise as much as $60 billion.

Finally, we believe the committee must include an employer requirement to either provide coverage or pay into a fund to make coverage available for their workers, known as "pay or play." There are important policy reasons to do this – to shore up the employer based system, to level the playing field for firms that offer coverage, and to generate the "shared responsibility" that many members of this Congress and the public have recognized will be essential to achieving broadly supported reform. But "pay or play" will also help generate revenues from those firms that opt to "pay" whatever contribution will be required of employers and it will hold down federal costs associated with providing subsidized coverage to low-wage workers in those firms that opt to "play." Without such a requirement, many more employers might eliminate coverage for low-wage workers who would be eligible for subsidized coverage under health reform.

One potential source of funding this committee is considering – capping the current tax exclusion for employer-sponsored insurance, whether by income or benefit amount or a combination of those factors – is, in our view, a step in the wrong direction. We have already noted that we cannot constrain costs without covering everyone. But it

is also the case that we cannot ask people who traded wages for health benefits to pay more for their coverage without undertaking a serious effort to lower costs.

Too often lost in the discussion about capping the tax exclusion is the fact that the cost of coverage reflects much more than the generosity of the coverage. The cost of coverage is a reflection of many factors beyond workers' control: the size of the firm; the demographics of the workforce; whether the industry is considered by insurers to be "high risk;" geographic differences in cost; and whether there are pre-Medicare retirees covered through the same plan.

True cost containment requires a number of elements that we believe are essential to successful reform. First, we need to transform our delivery system from one that rewards better care, not just more care. The options paper presented by this committee makes a significant contribution to that effort. It would also require us to fix our flawed insurance market to prohibit insurers setting rates that effectively discriminate against small firms, older workers, and others deemed too risky to cover. It would require employers to pay their fair share to cover workers, in order to eliminate the cost shift from free riders in our voluntary system. And it would require us to include a public health insurance plan option for everyone purchasing coverage in the exchange in order to make coverage more affordable. A public plan would lower costs for those individuals and firms purchasing coverage in that plan and, through competition, lead to lower costs for coverage in private plans. We believe even large employers should be eligible to purchase coverage in the exchange once it is established and secure, so that the benefits of that price competition can be extended to all purchasers.

I'd like to offer one final note of caution: Congress and the President have indicated that health reform will build on what works and assure Americans that they can keep what they have if they like it. This approach makes enormous sense to us and, in fact, generates broad support from the public. But a cap on the tax exclusion threatens to disrupt the primary source of health coverage and financing for most Americans. Until

we have built a proven, sustainable alternative to employer-sponsored benefits, we should not undertake changes that might threaten that coverage.

[i] N. Kazzi, "More Americans are Losing Health Insurance Every Day: An Analysis of Health Coverage Losses During the Recession," Center for American Progress, May 4, 2009.
[ii] Kaiser Family Foundation and Health Research & Educational Trust Employer Health Benefits 2008 Annual Survey, September 2008.
[iii] C. Schoen, S.R. Collins, J.L. Kriss and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008.
[iv] C. DeNavas-Walt, B. Proctor, J. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2007," U.S. Census Bureau, Issued August 2008.
[v] S. Axeen, E. Carpenter, "Cost of Doing Nothing," New America Foundation, November 2008, accessed at www.newamerica.net
[vi] Centers for Medicare and Medicaid Services, National Health Expenditure Projections, 2007-2017.
[vii] S. Axeen, supra.