ERIC The ERISA Industry Committee
Driven By and For Large Employers
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Senator Orrin G. Hatch
Chairman, Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch,

Thank you for the opportunity to provide input as the Senate Finance Committee takes up the issue of health reform. The ERISA Industry Committee (ERIC) looks forward to working with you to enhance the health care system to promote affordability, quality, and accountability throughout the system. It is encouraging to see your work to advance the use of health savings accounts (HSAs) and Flexible Spending Accounts (FSAs), as ERIC is committed to advancing value-driven insurance designs and promoting value throughout the system. That, in conjunction with tax relief in the health care space, including importantly, repeal of the so-called "Cadillac" tax, will provide significant benefits to the 178 million Americans who receive health insurance through an employer.

The ERISA Industry Committee is the only national association that advocates exclusively for large employers on health, retirement, and compensation public policies at the federal, state, and local levels. ERIC members sponsor benefits, voluntarily, to many millions of Americans, and hope that health reform will present an opportunity to relieve the burdens that raise costs and drain resources from plan sponsors, as well as to improve the regulatory structures that can help foster the best coverage and care for workers. We believe that the Finance Committee can help in three key ways: improving consumer-driven options for Americans, reducing health care taxes, and improving public sector programs to focus on value.

Improving Consumer-Driven Health Options

Today, most major employers offer consumer-directed health options for employees, often pairing a low-premium (high-deductible) plan with a beneficiary-controlled account like an HSA, FSA, Health Reimbursement Arrangement (HRA), or the like. These plan designs help employees to be smart shoppers for health services, and put them in the driver's seat when it comes to controlling utilization and promoting savings. But significant improvements could be made, which would lead many more employers and employees to migrate to consumer-directed plans, and lower costs and improve health care quality.

Currently, annual contributions to HSAs are capped at $3,400 for an individual and $6,750 for a family, which limits employees' ability to save for out-of-pocket health care expenses, and exposes them to taxation on health care costs in excess of the contribution limit but below the annual out-of-pocket limit.

Under the House-proposed American Health Care Act of 2017, the annual limitation on contributions to HSAs would be aligned to match the annual out-of-pocket limits. This would allow workers to save more and make consumer-directed health plans more attractive. The House bill would also eliminate the Affordable Care Act's (ACA's) annual limit on FSAs, returning those plans to their pre-ACA state of utility.

Another issue related to the HSA and FSA contributions is the current law that allows spouses to make catch-up contributions only to accounts in their own name, rather than to a joint account. This treatment of spouses is illogical when considering that health expenses in a marriage are typically shouldered by both spouses. The House legislation would fix this error, as well as provide a grace period for those who enroll in an HSA-qualified insurance plan but take a little more time to establish the actual bank account that constitutes the HSA.

Another important issue relates to over-the-counter (OTC) medications. Under the ACA, HSA and FSA funds are prohibited from being used to purchase OTC medications unless they are prescribed by a medical provider. This prohibition is counterproductive because it requires people to see a doctor to acquire an OTC medicine using their designated health funds, and we urge the Finance Committee to reverse it. Allowing consumers to use their health accounts to purchase OTC medicines for treatment of common ailments such as seasonal allergies or colds can help prevent unnecessary visits to a physician and assist in lowering the cost of health care in America.

Congress should also ensure that all categories of excepted benefits can be offered to an employee who enrolls in a high-deductible health plan paired with an HSA, such as vision, long-term care, or disability insurance. Under current law, enrollment in certain supplemental products that qualify as excepted benefits would prevent an employee from contributing to an HSA, and this should be fixed in order to abide by the original intent of HSA rules, which was to confine major medical plan enrollment for HSA contributors to high-deductible plans, rather than PPOs or other more comprehensive coverage – not to wall them off from fringe benefits like hospital indemnity or cancer-only benefits.

Further, current rules prevent qualified high-deductible health plans from offering first-dollar coverage for certain preventative services, especially prescription drugs that can prevent dangerous episodes by keeping chronic illnesses managed. These rules should be updated to ensure that those enrolled in HSA-compatible plans can benefit from first-dollar coverage for prescription drugs and other medical products and services that are likely to prevent or reduce catastrophic episodes later.

Reduce the Health Care Tax Burden

In order to truly simplify, streamline, and reduce the country's tax burden, it is essential that the onerous taxes created by the ACA be repealed. As you may be aware, the ACA constituted a $1 trillion dollar tax increase. Many of these taxes landed squarely on the middle class, but the most dangerous tax in the ACA was the 40% "Cadillac" excise tax on high-cost employer-sponsored health insurance plans. The Cadillac tax incentivizes employers to drop coverage or significantly reduce benefits, while also shifting significant costs to employees. The Cadillac tax is actually a tax on everyone because the tax's design and indexing ensure that after a requisite amount of time, every health plan is a Cadillac plan. This tax will inordinately disadvantage women, seniors, low-income families, the disabled, and traditional employers with diverse workforces. While it may not be tenable to include full repeal of the Cadillac tax

in a first draft of reconciliation legislation, we urge you to first delay the Cadillac tax as long as possible within the legislation, to cosponsor the "Middle Class Health Benefits Tax Repeal Act of 2017" (S. 58), and then to support an amendment on the Senate floor to completely eradicate the Cadillac tax. We strongly urge you to oppose any efforts to create a new tax on American workers' health benefits - whether by imposing a cap on the tax exclusion for employer-sponsored health insurance, or by any other means. We also urge Congress to take action to eliminate the gateway to taxation of benefits: the requirement that the value of employer-sponsored health insurance be listed on employees' W-2s.

The current tax code, pursuant to the ACA, also levies other significant burdens on employers. For instance, under the ACA, employers are required to report unnecessarily comprehensive amounts of information about their health plans, beneficiaries, and employees to the IRS. The information is burdensome and costly for employers to obtain, and creates administrative encumbrances and expenses to compile and submit said data in a format acceptable to the IRS. Further, in the most recent reporting year, the IRS struggled to process these reports in a timely manner, making employers' timely compliance pointless. We encourage you to eliminate these reporting requirements and ease this administrative burden, to the greatest degree permissible under Senate rules. Final legislation should eliminate the employer shared responsibility requirements to the greatest degree possible as well, allowing employers once again to engage in shared decision-making with employees on how best to compensate them, and how best to design health insurance benefits that meet beneficiary needs. No funds should be allocated to the IRS for the purposes of fining employers pursuant to the employer mandate or related reporting requirements.

ERIC supports efforts to reduce other ACA taxes as well, including taxes that are levied on the health care industry but that have been confirmed by the Congressional Budget Office to be passed on to consumers. As you know, employers pay on average about 80 percent of employees' health care costs, and these unnecessary taxes are costing resources that could otherwise be put to use supporting employees' health care needs.

Driving Value through Public Sector Plans

ERIC member companies are committed to work with government leaders to advance value-based care because it will result in improved clinical outcomes and better health for Americans, as well as lower costs for consumers, employers, and taxpayers. To achieve this, the public and private sectors will need to work together. To obtain value, consumers need to be well-informed about cost, quality, and outcomes, which requires transparency. In the same way, health care providers need information to compare their performance with that of their peers in order to improve their own practices. These measurements need to be standardized so that the information can be analyzed in significant ways and made publicly available. We encourage you to support the creation of aggregated databases that pool the collected data from various sources, including treatment data from clinics and hospitals, as well as insurance claim information. Much of this information is now merely reported on a voluntary basis from health plan claims data, and clinical data is rarely captured. With the right information, meaningful cost and quality tools, like cost of treatment calculators, can be created and made available to consumers to make better-informed decisions.

To further the value-based agenda, appropriate financial incentives will need to be implemented. Private sector stakeholders have seen positive outcomes from pay-for-performance and value-based purchasing

initiatives, and exceptional outcomes in public programs should be rewarded accordingly. Medical providers should be free to provide the best treatment to their patients, and regulatory relief that permits treatment innovation will encourage providers to seek the best outcome rather than numerous tests and procedures which are financially lucrative, but may not be in the best interest of the patient. It is important to provide strong financial incentives to hospitals that provide high-quality care and reduce avoidable readmissions and hospital-acquired conditions and to the providers that make that possible. Last Congress' MACRA legislation moved the ball forward in this regard, but Congress should continue down this road, increasing the amount of Medicare reimbursement that is reliant on quality and efficiency, as well as insuring that while providers can make more money by providing high-quality services, they also experience financial risk in the case of providing poor quality care.

Conclusion

Thank you for considering the perspective of large employers as you take up health care reform. We are eager to work with you to improve the health care system, reduce the tax burden, improve consumer-directed health options, and drive value throughout the health care sector. Please contact James Gelfand, Senior Vice President for Health Policy, at (202) 789-1400 or jgelfand@eric.org for more information or if ERIC can be of further assistance.

Sincerely,

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