

**TAX-RELATED PROPOSALS TO IMPROVE
HEALTH CARE**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

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TAX-RELATED PROPOSALS TO IMPROVE HEALTH CARE

TUESDAY, MAY 17, 2016

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:04 a.m. in Room 1100 Longworth House Office Building, the Honorable Pat Tiberi [Chairman of the Subcommittee] presiding.
[The advisory announcing the hearing follows:]



WAYS AND MEANS

CHAIRMAN KEVIN BRADY

Chairman Tiberi Announces Member Day Hearing on “Tax-Related Proposals to Improve Health Care”

House Ways and Means Health Subcommittee Chairman Pat Tiberi (R-OH) today announced that the Subcommittee will hold a Member Day hearing entitled “Tax-Related Proposals to Improve Health Care.” **The hearing will take place Tuesday, May 17, 2016, in Room 1100 of the Longworth House Office Building, beginning at 10:00 AM.**

Oral testimony at this hearing will be limited to Members of Congress who have either introduced or co-sponsored legislation related to health care policy in the tax code. Members wishing to testify at this hearing should contact the Subcommittee at (202) 225-3943 or Taylor.Trott@mail.house.gov by no later than noon on Thursday, May 12, 2016. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee for inclusion in the printed record of the hearing.

Details for Submission of Written Comments:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select “Hearings.” Select the hearing for which you would like to make a submission, and click on the link entitled, “Click here to provide a submission for the record.” Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, May 31, 2016**. For questions, or if you encounter technical problems, please call (202) 225-3625.

Formatting Requirements:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed,

but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.
2. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.
3. Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available at <http://www.waysandmeans.house.gov/>.

Chairman TIBERI. The subcommittee will come to order. Welcome to the Ways and Means Health Subcommittee Member Day hearing entitled, “Tax-Related Proposals to Improve Health Care”.

Without objection, I would like to recognize our Ways and Means Committee chairman, the Honorable Chairman Kevin Brady from Texas, for an opening statement.

Thank you for joining us today, Chairman.

Chairman BRADY. Well, thank you, Chairman Tiberi, for holding this Member Day hearing, for your leadership on health care issues.

Last week Tax Policy Subcommittee hosted the first Member Day hearing we’ve had in years. Members on both sides of the aisle presented their ideas for improving our current tax system.

We’re continuing that open and transparent process today under Chairman Tiberi with another Member Day hearing focused on a major priority of our committee, health care. We are moving forward with innovative solutions to provide Americans more access, better choices, and greater flexibility in health care.

This hearing is an important opportunity to show the people and families in our districts we’re serious about making our health care system work better for them. A number of provisions in the Tax Code were created to expand health care access and lower costs for the American people. But some of them work better than others, and some may not be working at all. It is our responsibility to take a hard look at the Tax Code, build on what’s effective, and fix what is not delivering results.

We need bold, forward-thinking solutions to ensure our Tax Code promotes the high-quality, patient-centered health care options Americans want and they need. The best way to do that is through an open, transparent, and collaborative process, one that returns

us to regular order and allows Members to advance the priorities of their constituents.

That is what this Member Day hearing of the health care task force is all about. We are coming together to develop innovative legislative solutions and begin moving them to the floor. I am grateful to all the Members and to the chairman and ranking Member who are here today to present proposals. Your participation in this process is invaluable. It is a clear illustration of what we can achieve through regular order.

We are excited to hear about all of your ideas to modernize the Tax Code and improve our health care system.

And so, thank you, Chairman Tiberi, for your dedication and hard work and your leadership of the Health Subcommittee.

Chairman TIBERI. Thank you, Mr. Chairman. And thank you all for joining us today. This is exciting, because today is—the subcommittee is providing a public platform for any and all Members of Congress to discuss bills that they have introduced that modify the way health care is treated in our Tax Code.

Members have put a lot of work into developing and drafting these pieces of legislation, sometimes over years. And this Member Day hearing is their opportunity to share with their colleagues and the American people why these bills are important and why this Committee should take them up.

In addition to my colleagues from Ways and Means Committee I am excited to hear from other Members who serve on other committees who have worked diligently on their own health tax idea, health tax bills. We are committed to working through regular order, and that includes hearing from all those who are working in this space.

So, how is this going to work? Simple. Members will have five minutes to discuss their current health tax legislative priorities. And I would remind Members that they are also able to submit written testimony in support of their legislation.

Thank you again to all the witnesses for taking time out of your busy schedules to join us today, and we look forward to hearing from all of you.

Chairman TIBERI. I will now yield to the distinguished ranking member, Dr. McDermott, for the purposes of his opening statement.

Mr. MCDERMOTT. Thank you, Mr. Chairman and Mr. Chairman Brady. I know it is election season and we have to have hearings like this. I am not sure—I don't know if this is on CSPAN or not, but it is a good time to get some footage of you defending something or other for your campaign commercials. And I really am glad we are holding this. It gives everybody a chance to get up on TV.

The legislating that we will be discussing should be scrutinized carefully. And I hope we can make some constructive conversation today, although I am not sure how much questioning there will actually be. There needs to be tough questions asked at each of these bills.

At the heart of our analysis what must be is a careful examination of what these bills do to the health security of the American people. We must also consider the impact these bills will have on

the sustainability of our health care system. Proposals that undermine the reforms provided by the Affordable Care Act will weaken health security by taking coverage away from working families, and the proposals that carve unnecessary holes in the Tax Code deprive the Federal Government of the needed revenue to make the system sustainable. None of these ideas should get a free pass.

As the Ways and Means Committee, it is our duty to analyze and scrutinize the legislation that comes before us. We can't gloss over the important facts, such as the fact that unpaid-for tax breaks add billions to the deficit, or that political attacks on the ACA undermine health care reform.

Today's hearing is just the first step in what should be an ongoing process. I saw on Sunday's paper that it is now costing people \$2,000 more a year on their hospital bills because of consolidation. We ought to be looking at issues like that, as well.

I hope that it might be even an opportunity to fulfill my Republicans—colleagues' unrealized promise of a return to regular order. Chairman Brady has mentioned it, and I think it is the only way this Congress is going to get back to a functioning stance.

Returning to regular order means we listen to ideas, some good, some bad, and make informed decisions that are the product of careful debate. Holding this Members Day is not enough. It is a nice start, but substantive legislative hearings, markups, amendments, and further debate will allow us to take a hard look at these proposals and find ways to improve them.

There is something that has been missing from the Congress and that this—and for this Committee for some time. I look forward to learning more about the legislation our witnesses will discuss this morning, and I intend to ask tough questions about these ideas. Thank you, Mr. Chairman.

Chairman TIBERI. Thank you, Ranking Member McDermott. Without objection, other Members' opening statements will be made part of the record.

Let's move on to today's first panel of witnesses. And our first panel consists of members of our Health Subcommittee. The three witnesses that will be testifying from our Health Subcommittee are the gentlelady from the second district of Kansas, Ms. Jenkins; the gentleman from the third district of Nebraska, Mr. Smith; and the gentleman from the third district of Minnesota, Mr. Paulsen.

And we will start with ladies first. Ms. Jenkins is recognized for her testimony.

STATEMENT OF THE HONORABLE LYNN JENKINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

Ms. JENKINS. Thank you, Chairman Tiberi, for holding this hearing and allowing me to have an opportunity to speak on H.R. 1270, the Restoring Access to Over-the-Counter Medication Act, legislation that I have sponsored along with our colleague, Representative Kind from Wisconsin.

I was very pleased that the committee decided to mark up this legislation last October, and subsequently reported it favorably out of committee. This legislation still merits more discussion to ensure that we get it across the finish line and into law before the end of the year.

H.R. 1270 would eliminate the unnecessary requirement that individuals have a prescription from a physician in order to purchase over-the-counter medicines with their health savings accounts and flexible spending accounts. Health savings accounts and flexible spending accounts allow individuals and families to make their own health care choices, while simultaneously making them aware of health care costs and giving them incentives to make financially prudent decisions.

And for many years, folks in Kansas and all across the country used these accounts to buy over-the-counter medications, including products such as allergy or cold medicines, antibiotic ointment or pain relievers. The FDA thoroughly and rigorously examines all over-the-counter drugs, also known as OTC drugs, to ensure that they are indeed safe and effective for self-treatment. And in 2002 the IRS designated OTC drugs as qualified medical expenses.

Despite this fact, the President's health care law added a layer of bureaucratic red tape that forces account holders to go to their doctor to obtain a prescription for these OTC medicines before purchasing them with their HSA or FSA. If the patient does not jump through these hoops and still purchases OTC medications with their account, they receive a tax penalty from the Federal Government for making a non-qualified distribution.

This law not only defeats the entire purpose of OTC medications, but it also places a bureaucratic burden on account holders, it clogs doctor's offices with needless visits, it decreases access to OTCs, and it increases health care costs all around. Worst of all, it discourages people from taking control of saving for their health care needs.

H.R. 1270 would roll back this Obamacare tax, help keep costs down, and improve customer choice and access to health care. As we all work towards getting our financial house in order while also ensuring Americans are receiving quality health care, I strongly encourage my colleagues to support this legislation and help bring it to the House floor.

Thank you, Mr. Chairman, and I yield back.

Chairman TIBERI. Thank you, Ms. Jenkins.

Mr. Smith, you are recognized. Proceed for your testimony.

STATEMENT OF THE HONORABLE ADRIAN SMITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Mr. SMITH OF NEBRASKA. Thank you, Mr. Chairman, Ranking Member McDermott, and certainly the subcommittee, for being here today and allowing the opportunity to share ideas.

I introduced a bill as a result of taxpayers facing penalties through no fault of their own through losing—their losing coverage, health care coverage, through the failure of the consumer-operated and oriented plans, or so-called co-ops. And I appreciate, like I said, this opportunity.

My bill would exempt taxpayers from the individual mandate if they would lose health coverage because of the failure of the co-ops in their local area. Under my bill the exemption applies for the remainder of the calendar year for those who lose coverage in the months of January through September, and through the next cal-

endar year for those who lose coverage in October, November, or December.

With co-ops failing and other insurers choosing to pull out of the marketplaces, more than 650 counties, largely in rural areas, are projected to be covered by only one health insurance provider in 2017. This compounds the existing barriers impeding access to necessary, affordable health care for rural Americans.

I would like to ask unanimous consent to include in the record a May 15th Wall Street Journal article titled, "Insurance Options Dwindle in Some Rural Regions."

Chairman TIBERI. Without objection.

[The information follows:]

Insurance Options Dwindle in Some Rural Regions

Some health insurers quit unprofitable markets; ACA exchanges in some areas will have one insurer

<http://www.wsj.com/articles/insurance-options-dwindle-in-some-rural-regions-1463356031>

By
Anna Wilde Mathews and
Stephanie Armour
May 15, 2016 7:47 p.m. ET
[217 COMMENTS](#)

Health-insurance customers in a growing number of mostly rural regions will have just one insurer's plans to choose from on the Affordable Care Act's exchanges next year, as some companies pull out of unprofitable markets.

The entire states of Alaska and Alabama are expected to have only one insurer on the health law's signature online marketplaces next year, according to state regulators. The same is expected to be true in parts of several other states, including Kentucky, Tennessee, Mississippi, Arizona and Oklahoma, state regulators said.

Related

- [Insurers' Losses Deepened on ACA Plans in 2015](#)

So far, more than 650 counties appear on track to have just one insurer on the exchanges in 2017, according to the Kaiser Family Foundation, which is tracking withdrawals as they become public. That would be up from 225 in 2016, when the state of Wyoming, among other areas, already had just one ACA marketplace competitor. Of the counties in jeopardy of having only a single exchange insurer next year, 70% have populations that are mostly rural, said Cynthia Cox, a researcher at the foundation.

Disclosures of new market entries or further pullbacks will change the totals in coming months, Ms. Cox said. Filings in many states aren't yet public, and insurers can tweak their approaches until September.

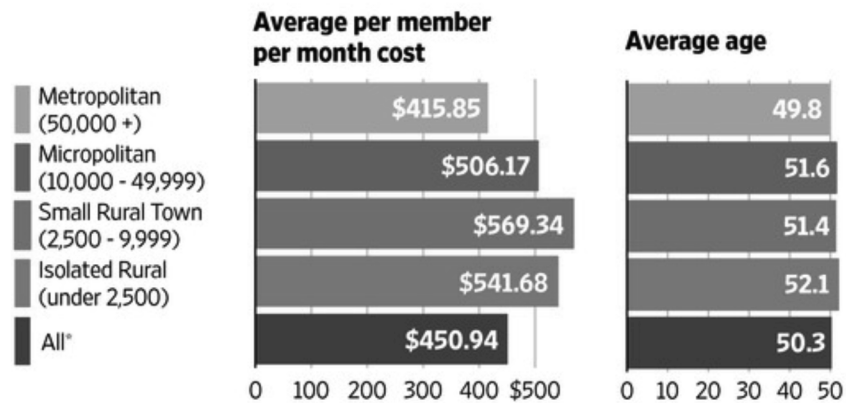
Kori Allen, a bookkeeper in Kodiak, Alaska, this year has an exchange plan from Moda Health Plan Inc., which will pull out of the state's ACA marketplace next year. Ms. Allen, 36 years old, who receives a federal subsidy that helps with her premiums, worries about what will happen when there is only one insurer, Premera Blue Cross, offering exchange products: "It's going to be a monopoly, basically; 'here's the price, take it or leave it.'"

Premera Blue Cross, which had steep losses in Alaska's exchange last year, said it is committed to the market there. "We have been working very closely with regulators and legislators to establish a long-term solution to make the market more sustainable and attract more insurers to the state," said a spokeswoman.

The occurrence of only one insurer in a market poses a challenge for the Obama administration, which has sought to help restrain costs by encouraging competition, and could provide fodder for Republicans intent on dismantling the law. An official with the federal Department of Health and Human Services said that the law has improved the quality of health plans and reduced the number of uninsured in rural and other parts of the U.S. For next year, "we would expect a rise in one-issuer counties," he said, as insurers adjust their approaches. He said the still-new market is evolving toward "stability and success."

A Healthy Mix?

In 2015, consumers in rural regions who got plans through the Affordable Care Act incurred higher health-care costs for insurers than enrollees in large urban areas.



*Weighted average of the four geographic categories

Note: Figures represent adults in 'Silver' plans and are drawn from a database that includes about 2 million enrollees.

Source: Inovalon Inc.

ENLARGE

The federal official said he is "pretty confident" there won't be any areas with no ACA marketplace insurers, but he couldn't completely rule out the possibility.

Indeed, the patchwork of coverage reflects continued instability in the individual insurance market, as companies shift their geographic footprints to avoid areas that have turned out to generate steep losses, and focus on places where they believe they can get their ACA business into the black.

UnitedHealth Group Inc. said last month it would leave all but a handful of the 34 states where it sold exchange plans this year amid losses; Humana Inc. is also pulling out of some areas. Others are sticking around: Anthem Inc. has said it would continue selling exchange plans in its current 14 states. Aetna Inc. will remain in its 15 states and has said it may enter more, and Cigna Corp. plans to extend beyond the seven states where it currently sells exchange plans.

Premiera Blue Cross said all of its subsidiaries would stop selling ACA marketplace plans in a dozen largely rural counties in its home state of Washington. It will also pull out of Oregon, where it has used the LifeWise brand.

Among the challenges: Certain rural counties had fewer, less-competitive health-care providers that weren't willing to strike the payment deals the insurer sought. "In some cases, they have said.... we don't have to negotiate with you," said Jim Havens, a Premiera vice president.

The move will leave two Washington counties with just one exchange insurer next year, according to Washington Insurance Commissioner Mike Kreidler, though its urban areas boast robust competition.

Moda said the Alaska market "requires significant reform in order to be sustainable." The company said it filed with the Oregon insurance regulator to offer exchange plans next year.

A new analysis by Inovalon Inc., a health-technology firm, shows why rural areas are often less inviting for insurers. Using a health-insurance claims database that includes about two million exchange enrollees, Inovalon found that rural residents racked up significantly higher medical costs than urban enrollees in 2015.

"Individuals in less populated areas tend to be sicker" according to the data, said April Todd, an executive at a consulting unit of Inovalon. But the cost gap was also driven by higher expenses at rural health-care providers, she said.

Insurance premiums, which must be approved by regulators in many states, are closely tied to health costs. But a study published last year in the American Journal of Health Economics concluded that having more insurance competitors in the ACA exchanges did tend to bring down prices.

Regulators said they were worried. "When there's more competition, consumers typically are better off," said Mark Fowler, chief of staff at the Alabama Department of Insurance. He said Humana and UnitedHealth will no longer sell exchange plans in Alabama next year, leaving the entire state with just one ACA marketplace insurer, Blue Cross and Blue Shield of Alabama.

In Oklahoma, Aetna has signaled it will join the exchange market next year, replacing the lost UnitedHealth—but has told officials it plans to offer policies only around the urban centers of Tulsa and Oklahoma City, leaving a number of rural counties with just one insurer, said Kelly Dexter, a spokeswoman for the Oklahoma Insurance Department. Aetna said it hasn't made final decisions on what new states it will enter.

Regulators in Kentucky, Tennessee and Mississippi said they each expected to have 50 or more counties with just one insurer on the ACA exchange. All three states said most of the counties were rural.

Mr. SMITH OF NEBRASKA. Thank you. Created under the Affordable Care Act, the 23 co-ops were authorized by the Centers for Medicare and Medicaid Services. They received nearly \$2 billion in federal startup funds, mostly in the form of loans.

However, on December 23, 2014, the Iowa insurance commissioner filed a petition to liquidate CoOpportunity Health, which was providing coverage to nearly 120,000 people across Nebraska and Iowa. In 2015 an additional 11 co-ops discontinued operations. The 11 remaining co-ops also continued to lose money, including Community Health Options of Maine, the only one of these entities ever to have reported a period of profitability.

While taxpayers deserve an accounting of what went wrong with the co-ops, where this money went, and if these loans will ever be paid back, it is not the focus of today's hearing or my testimony. The premise of my legislation is simple: Regardless of one's opinion of the ACA, the facts remain. Consumers were required to purchase health insurance under that law. Many chose to purchase insurance through the state and federal exchanges, and consumers in

13 states who chose co-op plans lost coverage through no fault of their own. Those consumers who made a good-faith effort to comply with the law should not be forced to pay a penalty because the plan they chose ceased operation.

While CoOpportunity is the only co-op to be liquidated in the middle of a plan year so far, experience tells us it may not be the last. Community Health Alliance of Tennessee was in danger of midyear liquidation before HHS permitted it to halt enrollment. And recent reports indicate Community Health Options of Maine may be on the brink of collapse.

I would also like to ask unanimous consent to enter into the record a March 23, 2016 article from the Portland press entitled, "Maine Sought to Put Struggling Health Insurance Co-op Into Receivership."

Chairman TIBERI. Without objection.

[The information follows:]

Maine sought to put struggling health insurance co-op into receivership

<http://www.pressherald.com/2016/03/23/state-sought-to-put-struggling-health-co-op-into-receivership/>

The Bureau of Insurance hoped to stem Community Health Options' losses, partly by ending as many as 17,000 policies, but a federal agency rejected the temporary plan.

By Edward D. Murphy Staff Writer
emurphy@pressherald.com | 207-791-6465
 Share

A bid by Maine's insurance superintendent to put Community Health Options, the state's only nonprofit cooperative insurer, into receivership and trim its losses by terminating thousands of individual policies was rebuffed by the federal agency that oversees implementation of the Affordable Care Act.

Eric Cioppa, the state's insurance regulator, said his plan to pursue a court order to take over temporary control of the troubled Lewiston-based insurer was approved this year by the board and management of the cooperative. The organization lost \$31 million in 2015 and already has put \$43 million into reserves for anticipated losses this year.

COMMUNITY HEALTH OPTIONS LETTER

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Community Health Options has more than 84,000 policyholders in Maine and New Hampshire. Cioppa said federal officials turned down the takeover plan in February, before he and Community Health Options officials had been able to agree on the number of policies they would have terminated. He estimated that 15 percent to 20 percent need to be dropped to make a significant dent in the co-op's losses.

Cioppa, in a March 14 letter to the Center for Medicare and Medicaid Services, which oversees the Affordable Care Act, complained that federal officials rejected the plan because it would have violated a provision that guarantees that ACA health care policies will be renewed.

A federal rule "shouldn't trump solvency and leverage issues," Cioppa said in an interview with the Portland Press Herald. "This issue isn't going away. We have to figure out a way. The company can't be in this position and I don't think CMS or we want to be in this position again."

If the proposal had been granted, Cioppa said the bureau would have worked with the other two insurers in Maine's health care insurance exchange – Anthem and Harvard Pilgrim – to accommodate the dropped policyholders. The plan was to make sure those policyholders could get comparable coverage and wouldn't have to pay new deductibles or meet out-of-pocket expense limits twice, he said.

SUCCESS, THEN LOSSES, CUTBACKS

Community Health Options was one of 24 co-ops created in the U.S. under the health care act to inject competition into the insurance market, but half of them have failed. The Maine co-op was the only one to make money during its first year of operation, in 2014, when it took in \$7 million more than needed to cover the cost of health care for its policyholders.

But the organization's finances took a turn for the worse in 2015. Even though the co-op doubled its membership, its policyholders, many of whom had been uninsured before, accessed health care at a high rate, running up huge bills.

Related

Pay raises contrast with performance of Maine's health care co-op

The co-op imposed only a 0.25 percent rate increase on premiums last year, and gained so many new enrollees that the total value of premiums collected increased nearly 90 percent over 2014. But its benefits payments grew by 131 percent, leading to the \$31 million shortfall. Also, last year senior management received significant pay raises based on the nonprofit's 2014 performance.

The co-op has since initiated \$11 million in administrative cuts, which include voluntary pay cuts, to help it return to stability. Co-op managers have declined to disclose the specifics of those cuts aside from identifying broad categories of reduced salaries, scaled-back marketing and subletting some unused office space.

Under his proposal, Cioppa wrote in the letter to CMS, his bureau "would have acted to reduce membership, increase capital and thereby better protect the remaining (co-op) members and their health care providers from the risk presented by the type of losses experienced in 2015. Because CMS's decision has precluded my ability to act as proposed, CMS now must share responsibility for the risk of an outcome we all very much hope to avoid."

In a written statement, a CMS spokesman said the agency often works in concert with state regulators to make sure co-ops are financially stable, but it didn't condone Cioppa's proposal because of the guaranteed renewal provision in the ACA.

"With respect to Maine, we proposed and supported several approaches to solving the state's concerns, but do not believe it wise for the state to take actions that would have led to 20,000 people unnecessarily losing coverage," Aaron Albright said.

VOLATILE HEALTH INSURANCE MARKET

Kevin Lewis, the CEO of Community Health Options, didn't respond to a message left Tuesday.

Cioppa, who in December ordered the co-op to stop enrolling customers for individual insurance coverage, said he doesn't want to suggest that the co-op is teetering on collapse, although its losses have placed it under "enhanced oversight" by his office. He said the insurance market is volatile, as the flip from profits to big losses for Community Health Options from 2014 to 2015 reflects. The state has to be vigilant to make sure the co-op doesn't collapse like others around the country, he said.

Cioppa said he would have gone to court, with the co-op's consent, to get the receivership authority he would have needed to terminate the individual policies.

He said the terminated policies would have been chosen randomly. Individual policies are producing the biggest losses in the marketplace, so shedding as many as 17,000 of them should have allowed the co-op to improve its balance sheet, Cioppa said.

The bureau would likely have been able to end the receivership by midsummer, he said.

Cioppa said he and Kevin J. Counihan, CEO of the Health Insurance Marketplace at CMS, have talked since he sent the letter, and CMS and his bureau will continue to work together to help the co-op continue to operate.

Mr. SMITH OF NEBRASKA. Thank you. A recent lawsuit by the Iowa insurance commissioner against the U.S. Department of Health and Human Services over the distribution of corridor funds to CoOpportunity may raise additional solvency concerns and drive liquidation decisions for commissioners overseeing the remaining co-ops.

I would also like to note, while Nebraska and Iowa consumers were provided a special enrollment period to select a new insurance plan, we should not assume one will be provided in the future.

In addition, depending on how quickly consumers choose a new plan during a special enrollment, they may still have uninsured months which could be subject to penalty.

Some consumers who choose high-deductible plans should not be penalized if the best decision for them is to wait until a new plan year, rather than start over on a new deductible, when they have already paid large sums toward a deductible in their previous plan. True fairness would waive penalties for these taxpayers.

Again, I thank you for the opportunity to testify today. My bill is a simple solution which would provide a measure of relief for consumers who follow the law and purchase health coverage, only to lose it through no fault of their own.

I look forward to working with you to improve our health care system. Thank you.

Chairman TIBERI. Thank you. Mr. Paulsen is recognized.

You can proceed with your testimony.

STATEMENT OF THE HONORABLE ERIK PAULSEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. PAULSEN. Thank you, Mr. Chairman, also for holding the hearing today and giving Members the opportunity to share our ideas on how we can improve health care in America.

I want to start by thanking the committee for moving forward last year on my bipartisan legislation to permanently repeal the harmful medical device tax. Congress wisely turned off this tax for two years in January, and we are already seeing the results, because medical technology manufacturers are investing more in R&D, they are creating more jobs, and they are producing more life-improving and life-saving devices. We need to make sure this bad policy doesn't start back up again, and I look forward to working with the committee to permanently end this thoughtless tax.

But I want to spend the rest of my time discussing the legislation that Senator Hatch and I have authorized to expand and improve health savings accounts. When I host telephone town halls and

Congress on Your Corner events and speak with Minnesotans, one of the most common topics that people bring up is health care. Their message is clear: costs are too high, seeing your doctor is too complicated, insurance coverage is too confusing, and patients lack control of their health care decisions.

Minnesotans want to have more choice and flexibility when it comes to health care for themselves and their families. They want to be empowered to shop around for the best quality care at the lower cost, like anything else that they can buy. That is why more than 800,000 Minnesotans have opted for an HSA-eligible health plan. Minnesotans aren't the only ones that are using these accounts. Nearly 20 million Americans now have an HSA-eligible plan, and HSAs should be a central component of a health care—health care in the United States.

Unfortunately, too many Americans are barred from contributing and using these accounts. Furthermore, current law is too restrictive in what types of health care services these accounts can be used for. That is why Senator Hatch and I have introduced the Health Savings Act, H.R. 4469. This bill removes barriers to allow seniors on Medicare, active duty members of the military, Native Americans, and members of health care sharing ministries to save their money in HSAs, where it can grow tax free, and can be used to pay for their medical expenses.

It also expands what these accounts can be used for, including direct primary care, preventative and over-the-counter medications, nutrition and dietary supplements, exercise equipment, physical fitness programs, and membership at a physical—at a fitness facility.

I want to thank Representatives Jenkins, Kind, Boustany, and Kelly for their work on individual pieces of legislation that are included in my larger bill. I support their bills, as well, which they are sharing today.

And in addition to their bills, I would like to highlight two individual parts of my bill that the committee should consider.

While Medicare will pay for much of a senior's health care costs, a study found that an average couple turning 65 will need to find some other way to pay for about \$250,000 of health care costs the rest of their lives, and that is a lot of money. As a result, nearly 20 percent of Americans aged 65 or older are still working. Upon turning 65, most seniors are automatically enrolled in Medicare Part A, which still comes with a high deductible for hospital admission.

What they don't know is this automatic enrollment also terminates their ability to contribute to their HSA, even if they are still working. Allowing seniors to continue to contribute to their HSA will help millions of seniors save for the long-term care costs that are not covered by Medicare. My bill would empower seniors by allowing those enrolled in Medicare Part A to continue to contribute to their HSA.

It would also allow Medicare beneficiaries participating in Medicare Advantage to contribute their own money to their medical savings accounts. Currently, these seniors only receive a contribution from Medicare. Medicare has done wonderful things, Mr. Chairman, to improve the health of America's seniors, and we can help

our seniors even more by increasing the number of tools beneficiaries have at their disposal to pay for their health care costs.

The other provision I would like to highlight is the tax treatment of direct primary care models. Direct primary care is an innovative, alternative payment model offering low monthly membership-based payments for integrated primary care services. Employers and employees both love this setup, because it is cost effective, it keeps patients healthy, and it provides high-quality care.

Unfortunately, the IRS effectively bars you from utilizing direct primary care arrangements if you have a high deductible health plan that is paired with an HSA. And this is simply due to the IRS's outdated definitions that consider these innovative models as a form of insurance. My bill would simply clarify that these are not health plans and would expand who can access these primary care models.

This provision is common sense and has bipartisan support with Senators Cassidy and Cantwell introducing a stand-alone bill.

In conclusion, Mr. Chairman, HSAs are an important way to empower consumers and reduce costs. I would encourage the committee to look at all initiatives, including the Health Savings Act, that will end—be able to expand these innovative and popular accounts. I yield back.

Chairman TIBERI. Thank you, Mr. Paulsen.

Our second panel is—sorry about the competition with the drill, by the way. We are trying to take care of that. The second panel is with us.

We have, representing the entire State of South Dakota, Mrs. Noem. You are recognized for five minutes.

STATEMENT OF THE HONORABLE KRISTI NOEM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH DAKOTA

Mrs. NOEM. Thank you, Mr. Chairman. And I want to tell you how much I appreciate the opportunity to testify today.

If you remember my testimony from last week before the Tax Policy Subcommittee on H.R. 3080, the Tribal Employment and Jobs Protection Act, because it is both a tax and a health care issue. But the reason I am before you today is because the employer mandate in the Affordable Care Act is poised to have a very negative impact on tribal governments, on tribally owned business in Indian Country. And many of the areas that we are talking about are some of the poorest in the country, including several in my home State of South Dakota. The last thing the tribes in South Dakota need is a punitive tax penalty from the Federal Government.

The Federal Government has a trust responsibility to provide health care for Native Americans and for Alaska Natives. This means the Federal Government supports the care of Native Americans through the Indian Health Service and other departments and agencies. For this reason, individual tribal members are exempt from the individual mandate under the ACA.

But only in Washington, D.C., and with hastily-written legislation like the ACA, could you come up with the scenario tribes and their members now find themselves in today. Individual tribal

members are exempt from the individual mandate. However, tribal governments, which primarily employ tribal members, are not exempt from the employer mandate. As a result, tribes must offer coverage or pay a tax penalty for not providing coverage to people the Federal Government is already responsible for caring for.

Moreover, the Federal Government contracts with tribes to provide other vital services in Indian Country, whether it is law enforcement, education, or health care. Imposing the mandate penalty on tribes, which I believe it was never intended to do, will divert limited resource from other areas. As the Rosebud Sioux Tribe in South Dakota wrote to me, "With over 800 employees, estimates show that compliance with this mandate could possibly cost the Rosebud Sioux Tribe in excess of \$6 million annually."

For an already impoverished people residing on a reservation with an unemployment rate that hovers around 87 percent, this could quite possibly mean dissolution of any of the tribal jobs that do currently exist on Rosebud today. It will also result in the reduction in services to our elders and youth and the imposition of severe limitations on various other social programs.

Clearly, tribes are very concerned. And over the past several years they have tried to work with the Treasury Department on a solution. Just last week Treasury had a government-to-government consultation call with tribes from across the country, where it reiterated that it has no authority to exempt tribes from the large employer mandate. While that may be true, Treasury also seems to be unwilling to advocate for a constructive policy solution to this issue.

We owe it to the tribes to provide them with certainty they need to provide for the general welfare and opportunity of their members and exempt them from the employer mandate. This is why I have introduced legislation, and I look forward to working with the members of this Committee to fix this critical situation.

With that, I yield back.

Chairman TIBERI. Thank you. We are pleased that you came to share your information with us today. And obviously, an important member of our Ways and Means Committee.

We are now welcomed by a member of our leadership, our policy chairman who represents the sixth district of Indiana [sic]. Mr. Messer is recognized for five minutes.

STATEMENT OF THE HONORABLE LUKE MESSER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. MESSER. Thank you, Mr. Chairman, and thanks to the entire committee. I appreciate this process today, allowing Members of the body to come forward with legislation and testify and, of course, give a voice to the people we represent.

I rise today in support of what I believe is a modest proposition that will make a big difference for schools all across America. You know, whatever you think of the President's health care law, it wouldn't be fair that we would be paying for that health care law on the backs of schools across this country. And if we really care about our kids, we need to do something about it. And that is what my bill does.

It is called H.R. 769. It is the School Act. And it very simply exempts K through 12 schools, institutions of higher learning, and state and local education agencies from the requirements of the President's employer mandate. The handout that I have before you highlights the impact of this bill—this problem in districts all across this country.

We have had hearings both out in the field and in the Education and Workforce Committee highlighting the very real impact for schools. One witness that testified in the hearing last year said that the President's employer mandate would have a \$4.6 million impact in their school district. I have had districts—or school districts in my congressional district that have shown impacts as high as 300, 400, up to \$1 million dollars.

And of course, the real challenge when this happens in cash-strapped times is that the kids and instruction are being impacted, as well. It is a problem that this Committee knows well, that when the mandate within the law was set at the 30-hour threshold, employers across America were required to push employees below that threshold or release them all together.

We have, as an institution, through the Hire More Heroes Act, the Protecting Volunteer Firefighters Act, addressed this problem for other groups. And I think it is important that we address it for schools.

Thank you, I yield back.

Chairman TIBERI. Thank you for your testimony.

We are joined by the gentleman representing the 11th district of North Carolina. Mr. Meadows is recognized for five minutes.

STATEMENT OF THE HONORABLE MARK MEADOWS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA

Mr. MEADOWS. Thank you, Chairman Tiberi. Thank you, Ranking Member McDermott and members of this Subcommittee for this forum. We had the opportunity just a few days ago to come before a different subcommittee on this same bill, and with Mr. Kelly and Mr. Renacci attending there, and it is refreshing to see the open dialogue, to be able to put forth ideas.

I am asking for your consideration of H.R. 210, which is the Student Exemption Act. Really, the genesis of this particular piece of legislation came from a chancellor of a university in my district. As all of the best ideas typically come from those we represent, this is no exception. And as we look at this particular bill, it is designed to exempt student workers at universities.

One of the byproducts of the Affordable Care Act, not debate the merits pro or con, was to include student workers in the mandate. The university would actually have to provide coverage if they were temporary workers. Well, this had a chilling effect on student workers, as you well imagine, increasing the cost. And actually, under the Affordable Care Act, most students are required to be covered under their parents' coverage up to age 25, or other related activities. And so we actually are requiring them to be double-covered by insurance.

And so, this particular Act is very specific in that it would actually exempt those student workers, it would allow them to actually

work their way through college, instead of having universities cut back on their hours.

We were very encouraged to get endorsements from a variety of associations and institutions of higher learning, typically the type of endorsements that someone with my conservative background would not get. And so, as I look at that, it is something that not only we could find great bipartisan support, but certainly it is one that makes a difference for students, universities, and keeps costs low for those institutions and students who are just trying to work their way through college.

And so, I would ask for your consideration. I thank you for this environment, and I yield back, Mr. Chairman.

Chairman TIBERI. Thank you for bringing that to our attention. We have had students in our district who have experienced that same problem. Thank you.

We are joined by another member of the full Ways and Means Committee, the gentleman representing Northwestern Pennsylvania. Mr. Kelly is recognized for five minutes.

STATEMENT OF THE HONORABLE MIKE KELLY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. KELLY. Thank you, Chairman Tiberi and Dr. McDermott, for giving us this opportunity.

I actually have two tax-related health care bills that I wish to discuss today: H.R. 3678 and H.R. 1752. And both involve making slight modifications to the Affordable Care Act.

But I think the real key is that these are people policies. These are the type of things that people send us here to do for them, and develop policies that actually help people. Too often we are on other sides of the debate and, at the end of the day, neither side wins, but our people lose.

So the first one is the Preserving Access to Orphan Drug Act. Congressman Neal and myself are on this bill. It has eight other Ways and Means sponsors, including you, Mr. Chairman. In short, H.R. 3678 would change the orphan drug exception to the annual fee on branded prescription pharmaceutical manufacturers and importers.

By the way of background, the longstanding policy has been to have laws on the books to encourage the development of orphan drugs to treat Americans with rare diseases. The fact that it is an orphan drug just means it is such a small patient population—and these are rare diseases—that there is generally not a financial incentive. In some cases, there is a financial loss associated with developing these drugs.

Now, when the ACA was being crafted, orphan drug production was exempted from the annual tax on branded drugs. The reason is there is widespread recognition that there are significant costs and challenges in developing these orphan drugs. Therefore, the orphan drug production was supposed to be exempted from the new fee. Yet, in drafting the exemption they tied the exemption to the use of another tax credit, the orphan drug credit, which created a problem. And the problem is that not all companies take this cred-

it. And because of this, they would not be exempted from the new ACA fee.

Now, after passage of the Affordable Care Act, it was discovered that an estimated 41 orphan drugs were ineligible for the exemption. And you can imagine this caused quite a problem. So our legislation seeks to remedy the Affordable Care Act fee issue as it relates to the development of orphan drugs, to ensure that there remains an adequate pipeline of drugs and therapies to help the most vulnerable of patients, many of them children.

Our legislation would exclude all therapies licensed and indicated solely to treat rare diseases at the time of the Affordable Care Act's passage from the annual pharmaceutical fee, regardless of whether the orphan drug tax credit was claimed at that time. This issue has been reviewed by the Ways and Means Committee in the past. In the last Congress Mr. Gerlach introduced similar legislation. That language was incorporated into the Camp tax reform template published by the majority two years ago.

This legislation is supported by the National Organization for Rare Diseases, a coalition that has served Americans who suffer from rare diseases.

Making this minor modification to the ACA will go a long way towards helping Americans today and in the future with those that suffer from rare diseases.

And the second bill is a bill that I have put together with Congressman Dan Lipinski. This is H.R. 1752, the Health Care Sharing Ministries bill. The bipartisan bill right now has 113 cosponsors in the House; 15 of my colleagues on Ways and Means are on the bill, with a majority of members of the Health Subcommittee.

As you know, millions of Americans decline to carry health insurance for religious or ethical reasons. Many Americans cover their medical expenses by becoming members of a health care sharing ministry. Now, this is not insurance, but rather a form of mutual aid. Members help each other pay their medical bills in a personal, faith-filled way.

Health care sharing ministries operate similarly to other religious-based mutual aid societies that have existed for over 100 years. This is just basically what we do in this country. Our country has such an open heart, and our faith-based people feel that they have an obligation not just to themselves, but to each other.

Now, the issue is that uncertainties exist with respect to the appropriate savings treatment of these arrangements with regard to the health savings accounts and deductibility. In recognizing health care sharing ministries in the Affordable Care Act, Congress did not update the HSA section of the code, Section 223, that effectively bars hundreds of thousands of American families from having a health savings account. Because of its voluntary, non-contractual nature, membership in a health care sharing ministry probably does not qualify as health insurance for purposes of the medical expense deduction under the Tax Code, although it serves a similar function.

Now, I believe Congress needs to clarify the Tax Code on these questions to that end. I have introduced legislation to correct this problem. H.R. 1752 would treat membership in a health care sharing ministry as coverage under a high-deductible plan.

Mr. Chairman, thank you for allowing us to be here today. I think when people see what is going on, they say, "This is the Congress that we have always thought should be there. This is the Congress that the founders put together. This is the Congress that actually works in solving problems for the people." I don't care how they are registered; they are all Americans, and we got to take care of them, and we can.

Mr. Chairman, thank you. I yield back.

Chairman TIBERI. Thank you, Mr. Kelly.

And I would like to thank the four of you for your testimony today. You are more than welcome to get on with your day, appreciate you being here, and we will go to the next panel.

And one of those panelists is here, so I will introduce the first person in our next panel. Representing the seventh district of California, Dr. Bera is recognized for five minutes.

Thanks for being here.

STATEMENT OF THE HONORABLE AMI BERA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. BERA. Thank you, Mr. Chairman. I appreciate the opportunity to talk about this issue, H.R. 4217. It is to amend the Internal Revenue Code of 1986 to determine eligibility for health insurance subsidies without regards to amounts included in income, by reason of conversion to a Roth IRA.

This bill came to me and this idea came to me through a constituent, Larry. Larry was not yet eligible for Medicare, and decided to purchase health insurance through California's online exchange, Covered California. Because his only income in 2014 was through Social Security, Larry qualified for a tax credit to help him pay for his health insurance premium.

Larry was also proactive in preparing for retirement, and decided to transfer money from his traditional IRA to a Roth IRA. Because that is a taxable event, Larry paid the income tax on that money. However, at the end of the year, Larry found out that Covered California viewed that transition as income, and determined he was not eligible for any premium assistance.

Additionally, they required that Larry repay the full value of his advanced tax credit for the past year, over \$7,000. Now, that is not appropriate. We shouldn't be punishing people who are saving for retirement. Larry never saw any of this income as new money in his pocket. It remains in his retirement account. Asking someone who is living solely on Social Security to pay over \$7,000 is unreasonable and unfair.

The challenge is, because of the inflexibility of the Tax Code, the IRS and Covered California have no choice but to follow the law. My bill is simple. For the purposes of calculating premium assistance, IRA conversions would not be included in gross income.

Regardless of how you feel about the Affordable Care Act, we should not be punishing seniors who are doing the right thing to save for retirement.

Chairman TIBERI. Thank you for your testimony today.

Mr. BERA. And Mr. Chairman, I have got a——

Chairman TIBERI. Okay.

Mr. BERA. I have got a second bill here.

Chairman TIBERI. You have got three minutes, go ahead.

Mr. BERA. H.R. 4832, the Health Savings Protection Act. This is a bill that I was honored to again work with a fellow doctor, Dr. Boustany, on, a common-sense health care fix.

The so-called Cadillac tax was well intentioned to bring down the cost of health care, but it is a blunt tool. I have serious concerns about how it might affect the costs that are passed through to employees, especially in high-cost states like my home state, California.

While I was happy to see a delay included in the recently-passed spending bill, more has to be done. That is why Dr. Boustany and I introduced the Health Savings Protection Act.

As it stands right now, when the Cadillac tax goes into effect, employees' personal contributions to their health savings accounts will be counted towards the calculation of the tax, and the dollar value of their overall health benefit. This was not the intention of the Cadillac tax. This will discourage responsible Americans from saving for their health care needs, and threatens to eliminate HSA. Employers simply won't offer the option to open a HSA if it could threaten to trigger the 40 percent tax. And if they do, we all know the excise taxes almost always surface as pass-throughs. The employees will ultimately be left footing the bill.

We should be doing more to encourage savings for unexpected health expenses. That is why we introduced this simple bill to preserve health savings accounts and protect workers from seeing increases in health costs. The bill would exclude any employee contributions from triggering the Cadillac tax.

I want to thank Dr. Boustany for his hard work on this bill, and hope that we can come together to give families the certainty they need. Thank you.

Chairman TIBERI. Thank you for joining us today. We are now going to turn to a member of the subcommittee, fellow member of the subcommittee representing the fifth district of California.

Mr. Thompson is recognized. Please proceed.

STATEMENT OF THE HONORABLE MIKE THOMPSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. THOMPSON. Thank you, Mr. Chairman, and thank you for providing this opportunity today. I am going to talk about legislation that I have introduced with my colleague and my friend, Congressman Boustany from Louisiana.

Our bill is bipartisan and it is bicameral. It has got more than 85 cosponsors in the House, and it is endorsed by dozens of small businesses and small business organizations across the country. Our bill would allow small businesses with fewer than 50 employees to offer health reimbursement arrangements, HRAs, accounts that employees could use to buy health insurance in the individual market, or to pay for qualified health expenses if they are already covered.

Right now small businesses are subjected to a \$100-per-person-per-day fine for offering HRAs to their employees, because an HRA doesn't meet the requirements for group health plans. The businesses that we are talking about don't even have to offer any type

of health coverage to their employees. There is no requirement for small companies of 50 or fewer people to provide health insurance. These are businesses that offer HRAs because they are looking for a way to support their workers.

HRAs are a critical retention and attrition tool that puts small businesses that may not have the resources to negotiate employer-sponsored coverage on a level playing field with their larger competitors. We shouldn't be penalizing responsible business owners who are going above and beyond for their employees.

Small businesses drive job creation and grow our economy. We should be going out of our way to help them support their employees and focus on what they do best, running their business.

And this is working. These small businesses are providing health care for their employees. This penalty takes that away from them. And I am proud to join my friend in trying to resolve this issue.

And I yield back, Mr. Chairman.

Chairman TIBERI. Thank you, Mr. Thompson. We are now joined by another member of the Ways and Means Committee, a leader on health care issues representing the third district of Louisiana.

Dr. Boustany, you are recognized. Please proceed with your testimony.

STATEMENT OF THE HONORABLE CHARLES BOUSTANY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA

Mr. BOUSTANY. Well, thank you, Mr. Chairman, and it is great to see everybody on the dais there. And I want to thank my friend and colleague, Mr. Thompson from California, for describing out bill, H.R. 2911, which would give small business relief from this onerous penalty.

If you recall, going back into the last Congress I questioned Secretary Lew about this penalty, and Secretary Lew admitted that this was a serious problem for small businesses. And the Administration actually put these penalties on hold for almost a year. But now they have come back, and we are hearing from small businesses across the country about this onerous \$100-per-day-per-employee penalty, which is penalizing small businesses that are trying to do the right thing, provide health insurance for their employees.

So this is a carefully crafted bill. It has got bipartisan support in both the House and Senate. And I certainly hope that we can move forward to a formal committee markup of the bill.

I have two other bills I would like to highlight. And again, I thank my colleague, Mr. Thompson, on this. But H.R. 928 is repealing the health insurance tax. For more than five years and three congresses I have been proud to introduce legislation to repeal the Affordable Care Act's annual tax on health insurance providers. And as the committee is well aware, the health insurance tax will generate \$156 billion in revenue between 2017 and 2026, according to CBO estimates, a cost that will be borne entirely on the backs of everyday Americans through increased premium costs and out-of-pocket expenses.

Mr. Chairman, we continue to see the cost of health insurance premiums and deductibles rise precipitously, while the portion of

health care costs our insurance plans actually cover has declined. Americans are struggling, struggling to afford coverage at all. We could provide some relief by simply repealing this onerous tax. This would be very helpful to small businesses and families, and I hope we can work with the committee to see this pathway on this.

We were able to put the tax on hold this year for this in the PATH Act, but it is going to bounce back. And we are projected to see massive hikes in premiums in every state, as a result of this tax. I am hopeful we can do something on it.

And lastly, I also—I have another bill that I have cosponsored with my friend from California, Mr. Thompson, a bipartisan bill, H.R. 3539, Reinvigorating Antibiotic and Diagnostic Innovation Act.

I want to highlight this bipartisan bill because we have got problems today with resistant bacteria and resistant infections at hospitals that no antibiotic treatment is available for them. Bacteria tend to change over time. They evolve and develop this resistance, and they lead to these horrible infections, sometimes after surgery, sometimes just de novo infections. And what our legislation would do would be to establish a tax credit for up to 50 percent of the clinical development of expenses to incentivize the development of two components necessary to making progress to reducing these very virulent infections.

First, new diagnostic tests for initial and expedited identification of the underlying bacterial or fungal infection. We need this because delay, even by 24 hours, can cause deaths in a hospital, and certainly extensive morbidity. So rapid detection and rapid understanding of the underlying features of these infections is very important.

And secondly, developing antibiotic and antifungal medications that treat these serious life-threatening infections for which there is currently no reliable medical course of action for recovery.

Mr. Chairman, this two-pronged approach to jumpstart new innovation in antibiotics, antifungal medications, and diagnostics will not only help to tackle the critical and growing problem of medication resistance, antibiotic resistance, but it also will help preserve medical innovation and those industry jobs here in America. This is also a big source of cost in our hospitals today. And so this is a very small step, very important step, I believe, in spurring innovation.

So I look forward to working with the committee to advance this legislation as well, and I yield back my time. Thank you.

Chairman TIBERI. Thank you, Dr. Boustany, for your testimony today.

We are now joined by the gentleman from Utah representing the second district.

Mr. Stewart, you are recognized for five minutes. Thanks for being here.

**STATEMENT OF THE HONORABLE CHRIS STEWART, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF UTAH**

Mr. STEWART. Thank you, Chairman. And to other Members of the Committee, thanks for the opportunity to come and talk to you about a bill that I have been working on for nearly two years, H.R.

868, Veterans TRICARE Bill. And let me explain just very briefly what it does.

If you are a veteran, like myself, and you ever opt in to an HSA account, it terminates your TRICARE from that moment forward, and there are disincentives to do something that many people recognize is efficient for themselves, for their family. They can build an asset through the HSA. In many cases, it is a great option for their family. But they are disinclined to do that because they lose their TRICARE, their veterans benefit, after that.

This simply allows an off-on switch so that someone like myself could maybe opt in to an HSA for, you know, a period of time, maybe when it is offered through my wife's employment or through my own and, you know, 5 years or 10 or 20 years later, when that phase of my life is complete, to opt back in to the TRICARE program.

It has broad support, bipartisan support, 92 cosponsors. It is about a 60–30 split between Republicans and Democrats. I believe there was something like 12 members of this Committee that have signed on on this, a number of subcommittee chairmen. We originally sponsored the bill with our Democratic cosponsor, Tulsi Gabbard, who is a strong supporter of the bill.

It is also supported by many outside organizations that deal with veterans or veterans issues: The National Guard Association; Airline Pilots Association. Not surprising that many of them are former veterans who would like to take advantage of HSAs offered through their employment but, again, don't because they are afraid of losing that benefit. The Association of the U.S. Navy is a supporter of this, as well.

So, support among veterans groups, professional groups, very simple, very little cost, and we would just ask your support. I mean, honestly, it is a little frustrating to me that for two years we have been trying to do this very simple bill with bipartisan support that helps our veterans, and haven't been able to do that. So we look forward to the committee taking this up, and your support.

And with that, Mr. Chairman, I yield back.

Chairman TIBERI. Thank you for bringing that to our attention today.

We are now joined by two more Members. I will first recognize in order of coming the gentlewoman representing the first district of Washington State. Ms. DelBene is recognized for five minutes.

STATEMENT OF THE HONORABLE SUZAN DELBENE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Ms. DELBENE. Thank you, Mr. Chairman and Ranking Member McDermott and Members of the Subcommittee. I really appreciate the opportunity to testify today on my legislation to improve the small business health insurance tax credit.

As a former businesswoman and entrepreneur, I know firsthand that when small businesses and start-ups get the tools and the opportunities to succeed, America's economy is stronger. And in my home state of Washington there are over half-a-million small businesses. They comprise 98 percent of all businesses and employ nearly 1.3 million workers, more than half of the state's private

sector workforce. Helping small businesses thrive is an important way to grow our economy across the country.

From the businesses that I have met with, I have heard repeatedly how important health coverage is to recruiting and retaining great employees. Whether it is Bramble Berry in Bellingham, or Frost Doughnuts in Mill Creek, they all want to provide quality coverage, but often find it is too expensive, too complicated, or there are too few options that are available to them.

In fact, according to the Small Business Majority, 70 percent of small business owners who don't offer health insurance to their workers say it is because they can't afford to do so. These business owners just want a little bit of help. And the Affordable Care Act took an important step in addressing this problem. It created a tax credit to help small businesses afford the cost of health coverage for their workers and their families.

Unfortunately, the ACA small business tax credit isn't working as well as it was intended. Too many businesses are either ineligible for the credit or discouraged by the complexity of its requirements. In 2012 the Government Accountability Office found that only 170,000 small employers had claimed the credit, a fraction of the up to 4 million businesses that were estimated to be eligible by federal agencies and small business organizations.

To help small businesses compete and grow, Congress should make the tax credit more accessible to employers, and available for a longer period of time. That is precisely what my legislation would do. Among other changes, the Small Business Tax Credit Accessibility Act would raise the maximum size of businesses that are eligible for the credit from 25 to 50 employees. It would increase the number of years for which a small business can receive the credit from two to three consecutive years, and eliminate eligibility requirements that are unnecessarily complex and discourage businesses from claiming the credit.

This proposal will go a long way towards ensuring that more small businesses can provide health coverage to their workers, while continuing to compete and grow in a still-fragile economy.

I am grateful to have been able to partner with Congressman Kind on this effort, along with Senators Koon and Merkley, who have introduced companion legislation in the Senate. It enjoys broad support among industry, small businesses, and health care organizations, including the National Association of Health Underwriters, the National Grocers Association, the National Retail Federation, Third Way, and Small Business Majority. I urge members of this Subcommittee to support it.

Members of Congress have a responsibility to be good stewards of public policy by keeping our laws updated and making adjustments, when necessary, to ensure that they work in the real world. This is a common-sense bill that will offer meaningful help to entrepreneurs and workers across the country, and I look forward to working with Members of the Committee from both sides of the aisle to move it forward.

Thank you so much for the time, and I yield back.

Chairman TIBERI. Thank you for joining us today.

We are now joined by the gentlelady representing the sixth district of New York. Ms. Meng is recognized for five minutes.

STATEMENT OF THE HONORABLE GRACE MENG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Ms. MENG. Thank you, Chairman Tiberi, Ranking Member McDermott, and our distinguished Members of the Subcommittee. Thank you for the opportunity to share my proposals with you. I am here today to discuss H.R. 3117, the Fund Essential Menstruation Products, or FEM Products Act of 2015.

Before I get to my legislation, I want to share just how important access to affordable feminine hygiene products is. Access to these products is a serious and ongoing need for women and girls in the United States. When women are able to purchase quality safe and affordable feminine hygiene products, we are able to continue on with our daily lives at work, at school, and in our communities with minimal interruption.

According to a Feeding America survey from 2011, people across the country at all income levels listed these products as “items that cannot be foregone or easily substituted.” When women do not have access to sanitary feminine hygiene products, we are forced to substitute cheap materials, and this can cause some serious health problems.

Unfortunately, this happens every day in the United States. This is a real issue in New York City, so much so that the YMCA of Greater New York began providing these products to young women and girls in order to make sure that these girls actually stayed in the programs and stayed in school. The YMCA now provides these products as part of the first aid kits at many of their programs across our city. Feminine hygiene products are also among the most requested items at food pantries and homeless shelters in New York City.

But this is not just an issue for low-income or homeless women and girls. Women make up 50.8 percent of the U.S. population. And in an average lifetime, a woman will use about 10,000 tampons or pads, 2 of the most common types of products. Purchasing these products is a continuous and costly expense for women that women must bear for much of our lives, from when menstruation begins at about age 12 to the time of menopause at approximately 54 years of age. Many women will spend at least \$7,000 over the course of our lives.

Now, different population of women and girls face different barriers, in terms of access to affordable feminine hygiene products. I introduced H.R. 3117 to help women and their families to mitigate the costs of purchasing these products. This bill will also add feminine hygiene products to the list of items that can be purchased with funds in an FSA, flexible spending account.

An FSA allows for individuals to place up to \$2,550 of their income in an untaxed account where the money currently can be used for certain medical expenses like bandages, crutches, and prescription medications. It only makes sense to include tampons, pads, and other feminine hygiene products, as well.

I also plan to introduce legislation that would create a refundable tax credit for feminine hygiene products for individuals who regularly use them. I am currently in discussion with advocates and industry experts to best determine yearly expenses. And I will scale

the tax credit accordingly. It would cover low and middle-income individuals and families, and there would be no limit to the number of dependents who can claim this credit. A family with three teenage daughters or a same-sex female couple should receive a credit in accordance with their real costs.

I have already spoken at length about the great need for assistance in this area. A tax credit would help families afford these costly items and ensure that women and girls can continue to lead their lives without worrying about this basic health care need.

My efforts are part of an international movement to make these products more affordable through common-sense tax policy. Currently, 40 out of the 45 states that have a sales tax charge these products as luxury items. The sales tax is affectionately known as the Tampon Tax. In the past year, legislation to remove the tax has been introduced in seven states, including my home state of New York, where it has already passed both houses of the state legislature, and is awaiting the governor's signature. On the international stage, Canada got rid of this tax last year, and the United Kingdom has engaged in a heated debate over the issue for the past year, as well.

This is a complicated issue, because different populations of women and girls face different barriers in terms of accessibility and affordability. As Members of Congress, we should ensure that women and girls have access to safe quality and affordable feminine hygiene products, however we can. Thank you.

Chairman TIBERI. Thanks for your testimony.

We are now joined by the gentlelady from the second district of Arizona.

Ms. McSally, you are recognized for five minutes.

STATEMENT OF THE HONORABLE MARTHA MCSALLY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA

Ms. MCSALLY. Thank you, Chairman Tiberi and Ranking Member McDermott, for hosting this important hearing to discuss tax-related proposals to improve health care, and for the opportunity to discuss legislation I introduced earlier this Congress.

Much attention has been given to taxes that pay for the Affordable Care Act, such as the medical device tax or the Cadillac tax. But buried in the Affordable Care Act is a lesser-known tax increase that is already hurting middle-class families, and is about to hit seniors. My bill, H.R. 3590, the Halt Tax Increases on the Middle Class and Seniors Act, protects seniors from this tax hike and rolls it back for middle-class families.

Health care costs are already high. Since 2005, costs have risen faster than inflation every year except 2008. Additionally, the trend towards rising health insurance deductibles is leaving people exposed to increasing out-of-pocket expenses. We should be working to reduce this burden, not making it worse. But that is not what this hidden tax hike in the Affordable Care Act would do.

Currently, the IRS allows Americans with high health care costs to deduct certain out-of-pocket expenses from their taxes. Before 2013, individuals could deduct out-of-pocket medical costs that exceeded 7.5 percent of one's adjusted gross income, or AGI. The Affordable Care Act changed that for Americans under the age of 65

by increasing that threshold to 10 percent of an individual's AGI, effectively raising taxes on middle-class Americans.

To make matters worse, the same tax is scheduled to hit Americans 65 and older, starting on January 1, 2017. Though it has not received much attention, the medical expense deduction means a great deal to some of the most vulnerable Americans. According to the IRS, more than 10 million people use this deduction; 87 percent of them earn less than \$100,000 a year.

The average family taking advantage of this deduction makes just over \$58,000 a year, and has seen an income tax increase of several hundred dollars per year since the threshold was raised for those under 65 in 2013. This deduction is extremely important for low- and middle-income Americans who have already spent thousands in out-of-pocket medical costs, and they can't afford another shock to their wallets.

The same goes for seniors, many of whom already live on fixed incomes and struggle to make ends meet. Currently, seniors make up 56 percent of all claimants of the medical expense deduction. If the threshold is raised in January 2017, many seniors who have saved for their entire lives and have carefully planned for retirement will suddenly be faced with hundreds of dollars in extra taxes on top of the out-of-pocket medical costs they already pay.

That is why I introduced H.R. 3590, a bipartisan bill to stop this tax increase for seniors and roll it back for those under 65. The impetus to this legislation came to me from one of my constituents from Green Valley, Arizona. His name is Loren Thorson. Tragically, Loren passed away earlier this year, but he knew the importance of raising awareness of this tax hike, and was committed to doing what he could to stop it.

In closing, I want to thank the 14 cosponsors, including Congresswoman Lynn Jenkins, a member of this Subcommittee, as well as Congressman Bob Dold and Jason Smith, members of the full committee, and the various groups that are supporting this legislation, to include the AARP, Americans for Prosperity, 60-Plus, Americans for Tax Reform, the Association of Mature American Citizens, and the National Taxpayer Union.

I encourage the committee to consider my bill, and I look forward to working with you to protect seniors and the middle-class Americans from this tax hike that they just cannot afford.

Thank you.

Chairman TIBERI. Thank you, Ms. McSally. You were last, but not least. Very good, I appreciate that. And I would like to thank all our colleagues for appearing before us today, and appreciate all the time and work you and your staff have done to put time into these bills.

Last month our committee started a robust conversation about how we can modernize the Tax Code to deliver the high-quality, affordable, portable health care options Americans deserve and expect. And I am happy we had the time to pursue regular order today and make a public record of efforts that can help us achieve that stated goal.

Please be advised that Members will have two weeks to submit written questions to be answered later in writing. Those questions and your answers will be made part of the formal hearing record.

Without objection, the subcommittee stands adjourned.
 [Whereupon, at 11:06 a.m., the subcommittee was adjourned.]
 [Member Submissions for the Record follows:]

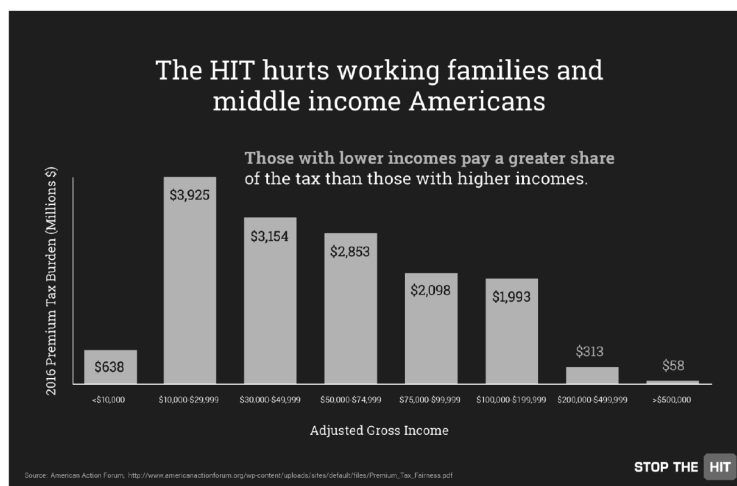
Rep. Charles W. Boustany, Jr. 1

**Statement for the Record
 Charles W. Boustany Jr., M.D.
 Ways & Means
 Member Day Hearing on Tax Legislation
 May 17, 2016**

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We can help small businesses with the rising cost of coverage by repealing the health insurance tax (HIT). This tax was included in the Affordable Care Act (ACA), and is directly resulting in the increased price of health insurance coverage for employers and workers.

Small businesses from across the country have been calling on Congress to provide permanent relief from the HIT, and have even gone so far as to create a Stop the HIT coalition to further these critical efforts. The coalition recently released data showing how lower- and middle-income workers are paying a greater share of this tax:



Congress provided temporary relief from this tax in 2017, and small businesses took notice. The National Federation of Independent Businesses applauded this relief saying: “A suspension of the HIT is a step in the right direction for small businesses and employees who bear the brunt of paying this tax on their healthcare benefits.”

Unfortunately, however, this temporary relief is just that, temporary. As a result of the dire consequences the HIT will have on further increasing the already-skyrocketing cost of health insurance coverage to Americans, I am proud to have introduced H.R. 928 to fully and

permanently repeal the ACA-imposed HIT. As of today's hearing, H.R. 928 has 235 bipartisan House cosponsors in support of fully repealing this onerous tax on the health insurance coverage American families need. Furthermore, the HIT stands as a direct contradiction to the purported goal of the ACA in providing affordable health insurance coverage options for Americans and their families.

Our job creators and working Americans deserve permanent relief from this unnecessary tax, and for these reasons I stand with my 235 bipartisan House colleagues in urging swift consideration and passage of this legislation.



Rep. Charles W. Boustany, Jr. 2

Statement for the Record

Charles W. Boustany Jr., M.D.

Ways & Means

Member Day Hearing on Tax Legislation

May 17, 2016

As the lead Republican sponsor of H.R. 1218, the Personal Health Investment Today Act (PHIT Act), I would like to submit the following statement in the Congressional Record for the Member Day Hearing on Tax Legislation, May 12, 2016.

H.R. 1218 expands the IRS definition of qualified medical expenses to include physical activity as a form of prevention. This additional inclusion places individuals back in control of their own personal health, and allows them to choose how to spend their own hard-earned dollars as it relates to maintaining a healthy lifestyle. The ability to direct such funds would extend to pre-tax medical accounts to help reduce the incidence of chronic, preventable diseases.

I am proud to have introduced this bill alongside Congressman Ron Kind (D-WI), the leading Democratic sponsor of this initiative. Together, we have been working collaboratively on the proposal while finding ways to bring attention to its merits and the benefits to today's working families, adults and seniors.

Each year, our country spends billions of dollars on treating the health consequences that result from chronic medical conditions, many of which could be mitigated through physical activity. It is time for Congress to pass meaningful legislation that provides tools to encourage preventive healthcare and reverse the critical strain on our nation's healthcare delivery system. The PHIT Act is a bi-partisan solution that has, thus far, garnered the support of 77 House co-sponsors, including eight members of the Ways and Means Committee.

Research has consistently indicated substantial, positive health benefits are disproportionately attributed to individuals in a more physically active population. Likewise, better health status also results in positive economic benefits to both individuals, as well as our health system at large.

More specifically, a recent Cooper Institute study that utilized Medicare claims data found individuals who are physically fit at the mid-life point showed a 40 percent reduction in subsequent annual healthcare costs, as compared with those of their peers who were less physically active. These findings could mean an average annual cost savings of \$5,242 for men and \$3,694 for women. Moreover, the Robert Wood Johnson Foundation issued a study finding that children who remain inactive are more likely to be inactive adults, whom are then six times more likely to have inactive children. The statistics are staggering and, with the help of the PHIT Act, we can reverse the cycle.

Thank you for the inclusion of my statement and considering H.R. 1218 as part of the May 12 Hearing Record. I look forward to working with my colleagues on this and many other meaningful legislative proposals to expand consumer choice and keep Americans healthy.



Rep. Charles W. Boustany, Jr. 3

Statement for the Record

Charles W. Boustany Jr., M.D.

Ways & Means Member Day Hearing - Tax Legislation

May 17, 2016

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As the lead Republican sponsor of H.R. 4832, the Health Savings Protection Act, I would like to submit the following statement in the Congressional Record for the Member Day Hearing on Tax Legislation, May 12, 2016.

The Affordable Care Act created a new excise tax on certain high-cost health care plans provided by employers, commonly referred to as the Cadillac Tax. While the purported purpose of this tax was to discourage employers from offering health insurance plans with overly robust health benefit coverage, we now know that the tax will impact many employer-sponsored health plans in a manner that simply incents the employer to reduce the range of health benefits covered by the employer-sponsored plan.

Even more concerning than the behavioral consequences the Cadillac Tax will have on employer-sponsored health coverage, the Internal Revenue Service has interpreted the intent of this provision to also include the dollar value of employee contributions to Health Savings Accounts (HSA) and Flexible Spending Arrangements (FSA). Ultimately, this means an employees' hard-earned money that he or she chooses to set aside as "savings" for their own future health spending needs, is treated as an employer contribution to the overall value of the health plan, subject to the Cadillac Tax. This is beyond troubling given that we should be encouraging Americans to save for their own future health needs. For all these reasons, I am proud to have joined with my colleague, Dr. Ami Bera, to introduce the bipartisan Health Savings Protection Act (H.R. 4832).

HSAs and FSAs are two savings vehicles that provide a means for employees to contribute their own dollars on a tax-preferred basis, specifically set aside to cover any future qualified health expenses they incur. While recent studies show nearly 103.5 million Americans benefit from consumer-directed health savings accounts like these, this figure is actively being accelerated as employers increasingly move toward offering high-deductible health plans to their employees. High-deductible health plans are less costly to the employers as a result of shifting more of the out-of-pocket cost burden to the employee themselves, making the ability of the employee to contribute their own money on a pre-tax basis to health-specific savings accounts even more critical to ensuring Americans are prepared for their own health costs incurred.

In addition to the general benefit to employees of saving for their own health expenses, the mechanics of these accounts also has organic benefits. More specifically, the ability for certain health-related savings accounts to accumulate contributions over time, as well as the feature of automatic deduction and deposit of these contributions from employee paychecks directly into the health-related savings account, ensures a reliable budgeting tool that is particularly beneficial to lower-income employees.

In light of the inclusion of HSA and FSA employee contributions in the calculation of the Cadillac Tax, research out of the American Health Policy Institute has shown that employers are substantially less likely to even offer the additional benefit of an HSA or FSA account to their employees as an option, as elimination of this benefit is the easiest way to avoid triggering the Cadillac Tax penalty.

There has never been a worse time to disincentivized use of health-related savings accounts for Americans and their families. In fact, a recent survey from the Employers Council on Flexible Compensation (ECFC) found the median household income for an FSA participant is \$57,080 and for an HSA participant is \$57,660. For all these reasons, Dr. Bera and I have introduced the Health Savings Protection Act (H.R. 4832) to exempt employee pre-tax contributions from calculation of the Cadillac Tax. If enacted, this legislation would ensure there are no adverse consequences to employers choosing to offer these critical savings vehicles that allow employees to afford the increasing out-of-pocket health expenses they are presently faced with.

I want to thank my colleague, Dr. Ami Bera, for joining me in introducing this vital legislation that will ensure Americans and their families have an avenue to save pre-tax dollars for their future health care expense needs.



Rep. Randy Hultgren

Statement for the Record

**Tax-Related Member Proposals to Improve
Health Care**

**House Committee on Ways and Means
Subcommittee on Health**

**The Honorable Randy Hultgren (IL-14)
Member of Congress**

May 17, 2016

Chairman Tiberi and Ranking Member McDermott, thank you for the opportunity to provide testimony before the Health Subcommittee. Since its passage six years ago, the Patient Protection and Affordable Care Act (ACA) has been a misnomer. For too many Americans, the ACA has failed to live up to its promise of more affordable, more accessible health care. For people in my home state of Illinois and its 14th Congressional District, the pendulum has swung in the opposite direction, carrying with it higher insurance premiums, unattainable deductibles, and fewer plan choices by way of a consolidated marketplace. This post-ACA reality is pricing families out of sufficient insurance – under the law, the underinsured population has doubled to 31 million, or fully one quarter of insured people.¹ The ACA is covering Americans in name only, and the federal government is not living up to the promises it made the American people.

Policy makers have long been after an alternative to the ACA, a comprehensive platform that creates more competition in insurance markets, allows insurers to compete across state lines, reforms caps and rollover rules on health savings accounts, and establishes a more modest premium tax credit system for low-income individuals. These are worthwhile proposals and objectives, but in the time it continues to take Congress to debate and legislate such ideas, states are suffering. American families are watching their premiums and their deductibles increase every year with no tangible hope for change because there is not yet a functional, achievable way out of the ACA. States are stuck.

Stories from My District

In the summer of 2015 I organized a Community Leadership Forum on Health Care in Illinois's 14th Congressional District. I solicited the ideas, concerns, and advice of insurers, employers, hospitals, providers, patients, and caregivers regarding the local impact of a sweeping overhaul of our nation's health care system called the ACA. Their message was clear – the centralization of national health care and insurance planning has precluded the market from improving access by relieving all players of rising costs. It became abundantly clear to me that the best ideas in health care come from its practitioners and its participants, that while we continue to pursue comprehensive reform in Washington we

¹ Sarah Ferris, "Study: 'Underinsured' population has doubled to 31 million," *The Hill*, May 20, 2015. <http://thehill.com/policy/healthcare/242584-study-underinsured-population-has-doubled-to-31-million>

should rely on our laboratories of democracy for some free-market test runs. Out of that effort was born a legislative solution to the ills of the ACA.

H.R. 3352, the State Health Care Options Act

The State Health Care Options Act (State Options) expands Americans' access to affordable health insurance options through state innovation. The bill offers states facing daunting rate, deductible, and out of pocket cost increases a parachute – a mechanism that would allow them the flexibility to immediately, inventively address rising health insurance costs and diminishing plan options. State Options gives states the opportunity to chart their own course away from centralized control and regulation of health care and coverage and toward a more free-market approach that better suits the insurance, care, provider, and patient needs characteristic of their unique populations.

The ACA already gives us a place to start. State Options revamps Section 1332 of the law to streamline and expand the process and parameters for the provision's state innovation waivers. The process that the U.S. Department of Health and Human Services (HHS) laid out and reaffirmed in its final rulemaking presents states with barriers to these waivers that are all but insurmountable. In March 2011, just two months after the inauguration of a new Congress, the Centers for Medicaid and Medicare Services (CMS) announced rules pursuant to Section 1332 – the quietly announced proposed regulations elicited only 27 public comments, and the final rules included a series of Herculean tasks including: state-passed legislation authorizing a waiver request; a 10-year, revenue-neutral budget plan; and an offering of exhaustive state resident data, including age, income, health expenses, and health insurance status of state residents.

While ACA supporters in Congress paid lip service to a waiver option and process in statute, CMS made it functionally impossible for states to access this important tool, for which there is a great deal of legal precedent. For example, after *No Child Left Behind*, states were left with federal standards to improve and assess their unique school systems. Forty-five states, including Illinois, said they could do it better, and the U.S. Department of Education let them try. The administration gave state educational agencies the flexibility to request waivers for 10 provisions of the law and implement plans to improve outcomes for their students and teachers.

The federal government overreached when it came to our children's education, and states were rightfully granted a way out. State Options replicates this effective model to include state ACA waivers in statute, allowing applicants to simply select a waiver, the approval of which is only contingent on waiver-specific information provided to HHS. This information includes:

- The years for which the waiver will be effective.
- The ACA provisions the state intends to waive.
- An assurance that the state will report annually to HHS on progress made with respect to affordability, access, and transparency.
- An assurance that the state will effectively take over for a state or federal exchange with respect to collecting health information and certifying health plans for the purpose of determining subsidy eligibility.

Additionally, whereas states could not be approved for a 1332 waiver until 2017 under the ACA, State Options allows state applicants to notify HHS of their intent to opt out of certain allowed provisions of the law immediately upon passage of the bill.

Health Flex Waivers

Under State Options, states that apply for an innovation waiver would have two clear options for health care and insurance flexibility, and the authority of HHS to limit state ingenuity would be scaled back significantly.

The health flex waivers included in State Options are functionally the same opt-out mechanisms described in Section 1332 of the ACA, sans the prohibiting application and approval requirements. States that select the health flex waiver option are able to opt out of all provisions articulated in Sections 1301, 1302, and 1303 of the ACA – most prominently the benchmarks and services that currently comprise an essential health benefits package and certify that a coverage option is a qualified health plan. At its most basic level, the health flex waiver allows a health insurance market in a state to offer basic or catastrophic health plans made unlawful by the ACA.

The health flex waiver system also allows states to opt out of the ACA's plan rating mechanism, replacing a multi-layered system of tiers with one that more

simply identifies which plans include more benefits than average, which plans offer standard coverage, and which basic plans cover catastrophic medical events. States with health flex waivers are able to offer insurers the leeway to develop a larger buffet of coverage options and consumers the flexibility to purchase a plan without paying for benefits they do not need or want.

Exchange Waivers

Instead of or in addition to a health flex waiver, states are able to opt out of the ACA's exchange requirements. States with an exchange they established themselves could dismantle the existing marketplace and open up other purchasing channels for consumers. Residents of these waiver states would then be able to buy a health plan through an agent or broker, on a private exchange, or directly from an insurer.

Under State Options, exchange waiver states assume responsibility for certain exchange functions, including serving as the certifying entity for health plans. States are offered subsidy eligibility information from HHS and the Department of the Treasury for the purpose of calculating premium assistance credits and cost-sharing arrangements. On matters of health insurance cost assistance and product standards, the state takes the role of the federal government as the certification and regulatory hub in these presumably more diverse, decentralized insurance markets.

Additionally, State Options creates a new "no lock-out provision." Because these states will have shaken off the rigid framework and regulation that comes with reliance on an exchange, people who buy insurance in these exchange waiver states are able to fluidly move in and out of plans should they experience changes to their income, employment status, and/or health. Consumers should not be locked into a health plan with only one opportunity each year to make a change.

Health flex waivers and exchange waivers are neither mutually exclusive, nor are they a package deal – states interested in opting out of certain ACA provisions may freely choose one, the other, or both.

Health Insurance Subsidy Reform

The existing income threshold for federal health insurance subsidy eligibility under the ACA is 400 percent of the federal poverty level. Based on 2014 federal poverty guidelines, a family of four making \$95,400 is eligible for a premium subsidy this year. Because the U.S. Census Bureau routinely updates this national benchmark based on the Consumer Price Index, the federal poverty level rises with inflation. With respect to insurance subsidies, this meant that the eligible income for a family of four increased by \$1,600 between 2014 and 2015. If we allow this trend to continue, the ACA will be subsidizing coverage for two-parents families with two children with a combined six-figure income by 2018.

State Options reduces this threshold to 300 percent of the federal poverty level for individuals and families who obtain coverage through a plan issued in a waiver state. Subsidy eligibility is capped at \$35,310 for individuals and \$72,750 for a family of four to ensure that the availability of this important federal financial assistance is concentrated among the truly needy.

Affordability Standards

The ACA currently exempts from the individual mandate and its financial penalty anyone who is unable to find a ACA-compliant health insurance coverage in his/her home state that is less than eight percent of his/her household income for that taxable year, effectively creating a new benchmark for affordability. The problem with this measure is that health care costs are increasing considerably, and as this trend continues, more and more Americans will be spending more than eight percent of their annual income on insurance premiums and out-of-pocket costs. The ACA's only "solution" to this cost dilemma is to relieve these individuals of a penalty should they decide to forego insurance coverage altogether. This "fix" means more uninsured people, not more affordability.

Before the ACA passed, it was possible in each state to find and purchase a health plan at or below 6.5 percent of that state's median household income. To ensure that waiver states are outpacing the ACA with respect to affordability, they must guarantee the availability of at least one health plan that provides a basic level of coverage for which an enrollee's required contribution does not exceed 6.5 percent of the median household income of residents in that state for the most recent taxable year.

Transparency Standards

Because state and federal exchange applications often limit their questions to age, location, income, and gender, consumers who experience a dramatic premium, deductible, or out-of-pocket cost increase are left in the dark about the impetus for the price jump. State Options requires the issuer of health plans in waiver states to make available information about the demographics of the population enrolled in their plans, the utilization of health care services by these customers, and any other pertinent factors that may serve as a justification for premium levels – including any premium increases – under the plan.

Closing

While Congress continues its laborious work to repeal and replace the ACA with a system that is affordable, accessible, and sustainable, we can do something now to keep states from waiting on us.

The realistic, accessible ACA waivers offered by State Options and the new parameters for attaining them give states genuine flexibility to tackle their unique health care and insurance problems. State Options is a parachute that gives Americans a way out of an upward health care cost and coverage spiral, a solution to health insurance market monopolization, and a clear exit from the broken ACA system more broadly. States have independently produced and tested successful approaches to countless national problems – health care should be no different.



Rep. Lynn Jenkins

Health Policy Subcommittee Hearing on Member Health-Tax Proposals:

For The Record - Congresswoman Lynn Jenkins

I would like to note that I am cosponsor of the following bills, and emphasize my support for them:

- H.R. 879 – Ax the Tax on Middle Class Americans' Health Plans Act, sponsored by Rep. Guinta
- H.R. 2911 – The Small Business Healthcare Relief Act, sponsored by Rep. Boustany
- H.R. 3678 – The Preserving Access to Orphan Drugs Act of 2015, sponsored by Rep. Mike Kelly



Rep. Kenny Marchant 1

**Statement for the Record by Kenny Marchant (TX-24)
Member of the Ways & Means Subcommittee on Health
Tax-Related Proposals to Improve Health Care May 17, 2016**

Statement of support for H.R. 3678, the Preserving Orphan Drugs Act of 2015

Chairman Tiberi, Ranking Member McDermott, as a member of the Ways & Means Subcommittee on Health, I am pleased to provide the following statement in support of H.R. 3678, the Preserving Orphan Drugs Act of 2015.

I am an original cosponsor of H.R. 3678, which is a bi-partisan solution spearheaded by Congressman Mike Kelly, with the support of Chairman Pat Tiberi and Representatives Richard Neal, Diane Black, George Holding, Charles Rangel, Lynn Jenkins, and Devin Nunes. I support H.R. 3678, the Preserving Orphan Drugs Act of 2015 in order to help Americans with rare diseases. These ailments and the effect they can have on families have always been a focus of this committee, and this legislation is consistent with our tradition.

In an October 2015 letter, the National Organization for Rare Disorders (NORD) wrote to then Chairman Ryan in support of the Kelly-Neal-Black legislation. NORD explained that the Affordable Care Act unintentionally created an imbalance for rare disease therapies, and that H.R. 3678, if enacted, will correct that imbalance.

As this subcommittee and the full committee consider legislation related to healthcare and tax in the remaining days of this Congress, I look forward to working with you and our colleagues to move this bipartisan legislation forward.

Mr. Chairman, Again I thank you for calling today's hearing. As you examine tax-related policies to improve health care, I support the inclusion of H.R. 3678 as part of the agenda. Thank you for including my statement and considering the Preserving Orphan Drugs Act of 2015 as part of today's hearing.



Rep. Kenny Marchant 2**Statement for the Record by Kenny Marchant (TX-24)
Member of the Ways & Means Subcommittee on Health
Tax-Related Proposals to Improve Health Care May 17, 2016****Statement of support for H.R. 1218, Personal Health Investment Today Act (PHIT Act)**

Chairman Tiberi, Ranking Member McDermott, as a member of the Ways & Means Subcommittee on Health, I am pleased to provide the following statement in support of H.R. 1218, the Personal Health Investment Today Act (PHIT Act).

H.R. 1218 expands the IRS definition of qualified medical expenses to include physical activity as a form of prevention. This allows consumers to invest in their own personal health, and choose how to spend their own hard earned dollars as it relates to maintaining a healthy lifestyle. The ability to direct such funds would extend to pre-tax medical accounts to help reduce the incidence of preventable chronic diseases.

The PHIT Act is a bi-partisan solution spearheaded by Congressmen Charles Boustany, M.D. (R-LA) and Ron Kind (D-WI). They have been working tirelessly on finding affordable solutions to help today's working families, adults and seniors practice good preventative healthcare. Each year, our country spends hundreds of billions of dollars on treating chronic medical conditions. It is time for Congress to pass meaningful legislation that encourages steps to stay out of the hospital and reverse the strain on our nation's healthcare delivery system. Research indicates long term economic benefits to more active population.

The Cooper Institute, based in Dallas, Texas, found significant long term savings to the Medicare program when individuals are physically at mid-life. For instance, a 40 percent reduction in annual healthcare costs were realized, resulting in an average savings of \$5,242 for men and \$3,694 for women based on Medicare claims data. Moreover, the Robert Wood Johnson Foundation issued a study finding that children who remain inactive are more likely to be inactive adults, whom are then six times more likely to have inactive children. The statistics are staggering and together, with the help of the PHIT Act, we can reverse the cycle.

Mr. Chairman, I thank you for calling today's hearing. As you examine tax-related policies to improve health care, I support the inclusion of H.R. 1218 as part of the agenda. Thank you for including my statement and considering the PHIT Act as part of today's hearing.



Rep. Richard E. Neal**Richard E. Neal
Ways and Means Health Tax Member Day
STATEMENT FOR THE RECORD
May 16, 2016**

Mr. Chairman, I write in support of HR 3678, *The Preserving Access to Orphan Drugs Act*, which Representative Kelly and I introduced last year. This legislation provides a simple correction to the Affordable Care Act to guarantee that all orphan drugs be exempted from the bonded annual pharmaceutical fee contained in this landmark legislation, consistent with the original intent of the legislation.

The ACA exempted orphan drugs from the pharmaceutical fee so that remedies for rare diseases would not be unduly burdened by this cost. This is an extension of well-established federal policy that recognizes that bringing drugs to market to treat rare diseases is challenging because of the limited demand. These drugs are enormously important to the patients who need them, and the federal government has long partnered with the rare disease patient community to knock down barriers to innovation in this sector. When the Congress exempted orphan drugs from the pharmaceutical fee, several classes of drugs that had not utilized the Orphan Drug credit were overlooked. This distinction discriminates against many beneficial therapies.

This legislation removes that distinction and restores orphan drugs as a policy priority to protect a patient community that depends on investment and innovation despite their limited numbers. This bill is simple, sensible and long overdue, and signals our continuing institutional commitment to innovation, quality of treatment, and guaranteeing that no Americans fall through the cracks of our healthcare system.



Rep. Joe Courtney

COMMITTEES:
ARMED SERVICES
SUBCOMMITTEES:
Ranking Member—SUPPORT AND
PROTECTION FORCES
PEACEKEEPERS
EDUCATION AND THE WORKFORCE
SUBCOMMITTEES:
HIGHER EDUCATION AND WORKFORCE TRAINING
HEALTH, EMPLOYMENT, LABOR, AND PENSIONS



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May 17, 2016

The Honorable Kevin Brady
Chairman, Ways and Means Committee
1102 Longworth HOB
Washington, D.C. 20515

The Honorable Sander M. Levin
Ranking Member, Ways and Means Committee
1139E Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady and Ranking Member Levin:

Re: Statement for the Record from May 17, 2016 Members Day on Health-Tax Bills

Thank you for taking the time to hold this Member Day on health-tax related legislation. I would like to take this time to speak on a topic that many of you are already familiar – the so-called Cadillac Tax.

As you know, part of the *Affordable Care Act* included a provision that was inserted by the Senate that levies a 40% tax on high-cost health insurance plans that cost over \$10,200 for singles and \$27,500 for families. One of the main goals of the *Affordable Care Act* was to make health insurance more affordable for everyone. The Cadillac Tax, unfortunately, does the exact opposite. Though I understand that the true intent of this provision was to tax true “Cadillac” plans, such as those on Wall Street and K Street, but instead this tax is going to hit teachers, police officers, government workers, cancer patients, and families. That is, those with Ford Focus plans.

This provision has been the source of concern and opposition since debate over the health reform bill. Notably, during the House-Senate negotiations over the final form of the bill in 2010, over 190 members joined me expressing our serious opposition to the tax. Our efforts resulted in a delay in the implementation of the tax to 2018.

Since then, a growing coalition of stakeholders from labor to business, health insurers to health advocacy groups, have kept up the drumbeat against the tax. With their support, and the backing of a majority of congress in favor of repeal, implementation of the tax was again delayed, this time to 2020, through last year’s *Bipartisan Budget Act of 2015*, otherwise known as the Omnibus.

While delay has eased the pressure to a degree, the fact remains that many employers, particularly those that face negotiations over long term contracts, remain highly concerned about the tax. Some, I am sure, believe that we have ‘fixed’ the problem by delaying implementation

and modifying the tax with Administration-proposed changes. The truth is that for those negotiating health benefit plans, 2020 is now -- and proposed changes are not enough.

A variety of studies and surveys on employer behavior have shown that employers are downgrading the value of health plans offered to workers in order to make sure that their total costs fall well below the thresholds as to not trigger the tax. This means increased cost-sharing requirements through higher deductibles, higher copays, and less services fully covered for families across the country. So, though we successfully delayed the tax by two years, and the Administration offered a few modifications to the tax in order to correct perceived issues, these actions fall woefully short of fixing the underlying problem.

An April 2016 report released by Milliman analyzed the extent to which Administration proposals to modify the tax will change the perceived outcome of tax implementation. The report found that the changes do little to change the disproportionate impact that the tax will have on those who live in higher-cost geographic areas, those who happen to be female, older workers, and those who work in more physically demanding occupations.

In addition, a *CancerCare* Patient Access and Engagement Report was released in May 2016 that examines a number of factors patients experience while living with cancer. Of particular relevance is part of the study that addresses the financial and insurance concerns of patients and families. This study confirms many of the startling realities that I have been referencing all along -- one third of survey respondents reported that in order to afford treatment, they cut back on things like groceries, transportation, missed bills, and choose to become delinquent on rent and mortgage payments.

It is important to note that this trend is not just relevant to cancer patients. Workers across the country have already been affected by employers downgrading their health insurance plans to avoid the tax. These hard working citizens are being forced to choose between every day essentials, and going to see their primary care physicians for small health issues, that can easily turn into acute illnesses if not addressed in a timely manner. In addition, those with chronic conditions are also skipping doctor appointments, and not adhering to medically-prescribed treatment regimens because they find medical care and the necessary prescriptive drugs and devices too expensive.

For these reasons, I am here today to remind this Committee of my bipartisan legislation, HR 2050, the *Middle Class Tax Benefits Repeal Act of 2015*. The legislation has 186 bipartisan cosponsors here in the House, and Senate versions (S. 2045 and S. 2075) have 37 bipartisan cosponsors between them. In addition, the Senate voted 90-10 during December 2015 Omnibus deliberations to repeal the Cadillac Tax altogether.

With the broad support of legislators from both sides of the aisle, and both sides of the Hill, in partnership with stakeholders from across the American spectrum -- including Fortune 500 companies, towns and municipalities, patient advocate groups, organized labor, economists, and everyone in between -- we can alleviate the burden of this tax. I urge my colleagues on the committee to work with me to complete the repeal of this unworkable provision.

Thank you for the opportunity today to speak to the Committee on behalf of workers across the country who should not be penalized for things that they cannot control -- like where they live, how old they are, if they are male or female, and if they choose one occupation over another. I hope that we can work together as Democrats and Republicans to alleviate this burdensome tax once and for all.

Sincerely,



JOE COURTNEY
Member of Congress



Rep. Bill Huizenga

STATEMENT FOR THE RECORD OF REP. BILL HUIZENGA

House Ways and Means Committee

Member Day Hearing on “Tax-Related Proposals to Improve Health Care”

May 17, 2016

Chairman Brady and Chairman Tiberi, I appreciate you holding this hearing and affording me the opportunity to share with the Ways and Means Health Subcommittee my tax-related proposal to improve health care.

In an age where a patient’s right to make their own health care decisions is seemingly under constant attack and health care costs are skyrocketing, it is crucial that Congress explore ways to build a stronger free-market health care system and improve access to affordable care. H.R. 975, the Health Freedom for Seniors Act is a bill that I introduced to expand and strengthen Health Savings Accounts (HSAs), empower more Americans to save money for their own health care, and save taxpayer dollars.

HSAs are savings accounts for qualified medical expenses. Deposits made to an HSA are not subject to an income tax at the time of deposit, and the money in an HSA can be used tax-free to pay for qualified medical expenses. HSAs encourage individuals to save for their future medical expenses and incentivize them to play a more active role in making medical decisions. Currently, seniors eligible for Medicare are prohibited from establishing HSAs, limiting their freedom to make health care decisions. My legislation would change that.

Nearly 18 million Americans are covered by an HSA; however, 55 million more are prohibited from taking advantage of the benefits an HSA provides because they have Medicare coverage. The Health Freedom for Seniors Act fixes this problem by allowing HSA-eligible seniors to contribute to HSAs.

In addition, the Health Freedom for Seniors Act would actually incentivize seniors to contribute to HSAs. Under current law, seniors aged 70 and one-half are forced to begin taking annual distributions from their retirement accounts, such as IRAs and 401(k) plans. My proposal provides seniors the opportunity to roll their required minimum distributions from their retirement accounts tax-free into an HSA.

This approach has been endorsed by Americans for Tax Reform, FreedomWorks, 60 Plus Association, HSA Coalition, American Bankers Association, National Taxpayers Union, and the Small Business and Entrepreneurship Council.

It is time to empower seniors to plan and save for future medical expenses, while strengthening the influence and decision-making they have over their own treatment and care. The Health Freedom for Seniors Act finally gives seniors that opportunity.

Again, I would like to thank the Ways and Means Committee for hosting this Member Day and I appreciate your consideration of my proposal.



[Public Submissions for the Record follows:]

American Society of Clinical Oncology



American Society of Clinical Oncology

Julie Vose, MD, MBA, FASCO
President
American Society of Clinical Oncology

Statement prepared for:
House Ways and Means Committee
Subcommittee on Health

Implementation of *Medicare Access & CHIP Reauthorization Act of 2015* (MACRA)
May 11, 2016

The American Society of Clinical Oncology (ASCO) is pleased to submit this statement in connection with the hearing entitled, "Implementation of *Medicare Access & CHIP Reauthorization Act of 2015* (MACRA)." ASCO is grateful to the Ways & Means Committee, particularly to this subcommittee, for their work to develop MACRA. We provided extensive feedback to you during development of the legislation, which we publically supported and promoted.

The collaborative environment you created resulted in overwhelming bipartisan support in both the House and Senate. As a part of the provider community, we appreciate this important step toward a more rational payment system and feel ownership over this as well. ASCO will continue to work with you and CMS to ensure this legislation works for oncology providers and their Medicare patients.

The emphasis on quality and value that underpins MACRA is entirely consistent with ASCO's mission and work. For more than a decade, we have been focused on the delivery of high quality, high value care for every patient with cancer. Our longstanding performance measurement system, QOPI, is a qualified clinical data registry, which has a high degree of support and participation among our members. It is even beginning to penetrate international practices. We also are well on the path to building a rapid learning system for oncology, called CancerLinQ, which we believe will revolutionize cancer care. We are hopeful that these important systems can thrive under MACRA.

We support MACRA's emphasis on value over volume. ASCO is focused on the cost of cancer care and what it means for patients with cancer. We have developed a wide range of education and related tools that support and encourage patient-physician conversations about the cost of their care. We also have a robust portfolio of clinical guidance for physicians, including a value framework designed to inform and support shared decision-making and the selection of high value care options.

CMS Proposed Rule

CMS released a proposed rule on April 27, 2016, setting out potential regulations for implementation of two pathways for professionals to satisfy MACRA's requirements, the Merit Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). While ASCO is still reviewing the 962 page rule, a few of our initial impressions are outlined below. We look forward to sharing our written response to the proposed rule with the Committee once it is finalized.

The Merit Based Incentive Payment System (MIPS)

MACRA established MIPS as the default physician payment system to replace the SGR-based physician reimbursement system. MIPS will provide positive and negative payment adjustment to physicians based on their performance across four performance categories. The performance categories are:

- The Quality Performance Category
- The Resource Use Performance Category
- The Clinical Practice Improvement Activity Performance Category
- The Advancing Care Information Performance Category

With the exception of the Clinical Practice Improvement Activity (CPIA) performance category, the new performance categories are based heavily on existing CMS quality and value improvement programs.

Resource Utilization

ASCO has weighed-in with CMS on a number of areas in implementation of specific importance to oncology. Although we support the transition to value-based payment, we remain concerned that the MIPS methodology for measuring resource utilization could unfairly penalize an oncologist who provides medically necessary care with high-costs that are outside of the oncologist's control. Currently, CMS assesses resource use through the Value-Based Payment Modifier (VBM), which is too blunt of an instrument to protect and promote high-quality oncology care. To be successful in implementing MACRA, policymakers must learn from and avoid the mistakes made in implementing the VBM.

The treatment of cancer is clinically complex and highly specialized, creating many factors that must be considered to accurately evaluate medical oncology resource use in a way that protects the interests of patients. There are more than 120 different types of cancer (and through advances in molecular diagnostics, this list is growing), and the most appropriate treatment option for a particular patient often involves the administration of a multi-drug regimen. In many instances, the selection of the most appropriate anticancer drug for an individual patient is based on the fact that there is a single molecular entity without any clinically equivalent substitute that provides a clear clinical advantage for the individual. In these common scenarios, the medical oncologist is left with little flexibility to reduce drug utilization costs by selecting lower cost alternatives. It is counterproductive to achieving the highest quality of care for a patient to force a provider to choose one therapy over another solely due to costs that are set outside of the oncologist's office.

Congress and CMS must not assume that variations in resource needs among patients and medical oncology providers will "average out" over time. It is common for medical oncologists to specialize in treating particular types or sub-types of cancer. There are some physicians and many oncology practices that specialize in treating the most complex—and often most costly—oncology patients. In some of those instances, there will be significant differences in resource consumption compared with other providers. We are especially concerned that if resource use measurement does not account for these clinical differences, CMS may inadvertently unfairly penalize practices and create access barriers for patients with complex and molecularly unique forms of cancer. Congress and CMS should take this situation into consideration for any process used to measure resource use in oncology and should not implement such a process until there is confidence the methodology will adequately protect quality and access to care for patients with these complex illnesses.

Given the factors described above, and because drug pricing is outside of the control of treating physicians, ASCO recommends that Congress and CMS adopt a more nuanced approach for evaluating oncology resource use. We urge Congress to work with CMS to exclude the use of raw drug expenditures in resource use determinations. Instead, CMS should assess drug resource use by evaluating adherence to evidence-based, value-based medical decision-making. ASCO endorses the use of high-quality clinical pathways in oncology as a mechanism to assess the provision of such care.

Appropriately designed clinical oncology pathways are detailed, evidence-based treatment protocols for delivering quality cancer care for specific patient presentations, including type and stage of disease. Clinical oncology pathways are a tool that can be used to appropriately align incentives for cancer patients and providers for resource use assessment in

cancer care. Pathways are being used by an increasing number of private payers to ensure evidence-based, value-based care for cancer patients. Used in this way, clinical oncology pathways can enable oncologists, payers, and patients to provide assurances that patients are receiving clinically appropriate therapies without unnecessary costs, including drugs. Oncology pathways balance the considerations of clinical efficacy, safety, toxicities, cost, and scientific advances, including the growing personalization of therapy based on molecular diagnostics.¹ Simply put, clinical pathways help to ensure that the right patient gets the right drug at the right time. Since compliance with appropriately designed oncology pathways define optimal care, medically appropriate concordance with pathway programs that have been developed and peer-reviewed by oncologists should be considered a major quality indicator.

In addition to drug costs, ASCO has serious concerns that CMS is failing to implement adequate risk adjustment to assess resource use in a way that fairly addresses differences in resource use among oncologists. Cancer care is incredibly complex and growing more so with each passing year, and the costs of cancer care are highly variable depending on a patient's diagnosis, cancer stage, molecular markers, geographic access to care, comorbidities and other clinical factors. In light of these complexities, it is imperative that CMS develop a risk adjustment methodology that will be specifically used to address cancer care. Traditional administrative claims data alone are insufficient to provide a desirable risk-adjustment methodology.

We urge Congress to provide oversight in this area to ensure that medical oncologists are not subject to unfair resource use measurement due to the clinical complexity of the patient populations they serve.

Quality Reporting

Ensuring that quality reporting is based on a provider's day-to-day practice is essential for MIPS to become a useful tool for quality improvement. While we are pleased to see that CMS would use quality measures that are included in the final MIPS quality measure list *and* quality measures that are used by Qualified Clinical Data Registries (QCDRs), we are concerned with some of the uncertainty surrounding the process for approval of QCDR measures. The proposed rule would require CMS to approve QCDR measures that are non-MIPS measures on a measure-by-measure basis before providers can report QCDR measures in lieu of reporting MIPS measures. There are currently no measure sets for medical oncology or radiation oncology under the MIPS measure list. Under the proposal, we could only speculate whether

¹ Zon RT, Frame JN, Neuss MN, Page RD, Wollins DS, Stranne SK, Bosserman LD. American Society of Clinical Oncology policy statement on clinical pathways in oncology. *Journal of Oncology Practice*. 2016 [epub ahead of print].

CMS would exercise its oversight over QCDR measures in a restrictive or timely manner. The CMS verification process should be implemented in a way that embraces the use of QCDRs to improve patient care and should not in any way slow the continued use of existing, robust QCDR measures or slow the adoption of new QCDR measures.

We thank Congress for its continued support of QCDRs by requiring their inclusion in MIPS. For more than a decade, ASCO has offered its members the ability to participate in the Quality Oncology Practice Initiative (QOPI), which is designated as a QCDR and focuses specifically on measuring and assessing the quality of cancer care. Congress should ensure that CMS does not weaken the protections in MACRA that exempt quality measures developed for use in a QCDR from many of the measure development process requirements that other MIPS measures will be required to undergo. This exemption is of critical importance because it will give QCDRs, like QOPI, the flexibility to innovate and develop quality measures that are clinically relevant to specialty practice.

We urge Congress to work with CMS to improve quality reporting in cancer care by promoting the use of quality measures that are important to patients and have meaningful impacts on the day-to-day practice of oncology. Failure to promote clinically relevant quality reporting will continue the “check-the-box” reporting attitude of many providers toward the Physician Quality Reporting System (PQRS) used by Medicare today.

Finally, it is essential that Congress continue to support the implementation of group quality reporting in QCDRs. The promotion of group reporting is critical for oncology, since individual oncologists will rarely have enough cases, within any given cancer diagnosis, to report data that is statistically valid and representative of practice patterns and overall performance.

Clinical Practice Improvement Activities (CPIA)

The creation of the clinical practice improvement activities category offers an opportunity for CMS to encourage providers to engage in activities that can meaningfully improve the quality of care they provide. ASCO supports an attestation-based system that allows providers and groups to attest to participation in activities that meaningfully improve the quality of care they deliver to achieve the full clinical practice improvement activity score. We strongly support that the proposed rule has recognized several aspects of QCDR participation as a CPIAs; however, we urge Congress and CMS to ensure that important activities such as ASCO’s QOPI Certification and provider participation in clinical trials should also be included in the proposed list.

Under the proposed rule, several of the listed CPIAs may interest oncology providers, such as participation in and use of data reported to a QCDR, participation in payment reform models sponsored by the CMS Innovation Center, and longitudinal and episodic care management.

Meaningful Use of Certified Electronic Health Records Technology

MACRA requires CMS to evaluate providers based on their meaningful use of certified EHR technology. Under the proposed rule, CMS has renamed the EHR meaningful use program: “The Advancing Care Information” and made it a performance category. Consistent with recent CMS directives, the Advancing Care Information (ACI) would move to a year-long reporting period, aligning with the other performance categories under MIPS.

Additionally, although the proposed rule would eliminate the clinical decision support and computerized provider order entry objectives from the program, the proposed rule would maintain most of the required measures and objectives in place for 2016. It would score MIPS clinicians and groups on measures and objectives that correlate to Stage 3 Meaningful Use.

For the first time, the proposed rule would allow for group reporting of ACI and would also allow for reporting through qualified registries and QCDRs. This is an important improvement over the Meaningful Use program.

We thank the House for passing *H.R. 6, the 21st Century Cures Act* which included a provision to encourage EHR interoperability. Continued efforts are needed to address the lack of widespread interoperability in the current health IT ecosystem and to alleviate administrative burdens of the meaningful use program prior to requiring full compliance with the meaningful use program to avoid adverse reimbursement consequences. Until widespread interoperability is achieved and the regulatory burdens associated with participation in the meaningful use program are lessened, Congress and CMS should not subject providers to penalties based on systemic problems that they had no role in creating.

Alternative Payment Models (APMs)

MACRA allows a second option for reimbursement through APMs. Participation in an Advanced APM would allow physicians to opt out of MIPS and receive an additional bonus over and above what is negotiated for a specific APM model.

ASCO's Alternative Payment Model

ASCO is encouraged by MACRA's strong emphasis on alternative payment models, and particularly the acceptance of those developed by physicians. ASCO has been developing and refining an APM for oncology since 2010. Our model, the Patient Centered Oncology Payment Model (PCOP), would fundamentally restructure the way oncology is paid for and better align payments with the patient services that are critical to delivering quality care.

PCOP was developed by a dedicated group of ASCO volunteers, who met once every two weeks for two years. The group included medical oncologists from diverse practice settings, seasoned practice administrators, and experts in physician payment and business analysis. ASCO used data from the National Practice Benchmark for Oncology and interviews with a sample of oncology practices to estimate the amount of time and money oncology practices are currently spending to deliver services to oncology patients—services that are not adequately supported by existing fee-for-service payments for office visits and infusions.

This model would also test many of the policy alternatives that have gained visibility recently, including bundled payments and episode based reimbursement. ASCO has estimated that PCOP would achieve savings for the Medicare program, while providing the necessary resources for oncology practices to provide high-quality, high-value cancer care. By matching payment more closely with actual care delivery, practices can organize care in a way that helps patients avoid expensive hospitalizations and unnecessary tests and treatments.

We believe that PCOP will qualify as an APM under MACRA because it meets the stated criteria in the law: includes quality measurement, requires more than nominal financial risk, requires the use of certified EHRs, and includes financial incentives. The Center for Medicare and Medicaid Innovation (CMMI) has its own model for oncology, the Oncology Care Model (OCM), which some have argued should suffice as the only oncology-specific APM. However, CMS should ensure that multiple oncology-specific APMs are available, including PCOP, to ensure that CMS explores multiple approaches to reforming oncology reimbursement. We believe that Congress intended to foster innovation and experimentation to reform Medicare reimbursement when MACRA was passed and that testing multiple approaches in oncology is preferable, given its clinical complexities.

ASCO is grateful for the pathway outlined in MACRA for physician developed APMs. CMS intends to keep the Physician Focused Payment Model Technical Advisory Committee (PTAC) process separate and independent. We are aware the PTAC is just forming, and we are hopeful it provides—as you intended—a meaningful opportunity for review and approval of high quality APMs like ASCO's PCOP, however we are concerned that there is still no assurance

the PTAC will review and recommend models to be tested as new payment models by CMS. In fact, CMS proposes to maintain CMMI's flexibility "to test models when it believes that it is the right time to do so, taking into account other models it is currently testing..." As part of demonstrating the criteria above, CMS proposes that payment models must address how it is different from current Medicare payment methodologies, and why the payment methodology cannot be tested under current payment methodologies. If this pathway does not work as intended, we hope that Congress will intervene and establish a clear pathway for implementation of APMs recommended by the PTAC.

Preparing Our Members for MACRA

In closing, we want to make the Committee aware of work ASCO is doing to prepare its membership to be ready for MACRA implementation. ASCO is using all the communications vehicles we have available to educate and inform our members about MACRA's ongoing implementation. We hope that oncologists can be among the best prepared specialists in the nation. While our hopes remain high that multiple APMs will be available for oncology, we know that many, if not most, of our US members will be in MIPS. To that end, we are encouraging participation in Meaningful Use, PQRS, and ASCO's own QCDR.

We've held full day seminars at our office in Alexandria, VA, nationwide webinars, presentations at state society meetings, and presented at ASCO's annual meeting so that all of our members have an opportunity to receive training on MACRA implementation. We have recruited a dedicated committee of ASCO's highest committee leadership to work on implementation and view it from broad perspectives. Additionally, we've conducted practice readiness assessments at individual sites to help practices understand what steps they will need to take ahead of MACRA implementation.

When appropriate, we will share APM information and help prepare our membership for all APMs available in oncology.

We know that there is much work ahead and we stand ready to work with Congress and CMS to ensure successful implementation of MACRA. We look forward to working together.

* * * * *

Thank you for your leadership on passage and continued oversight to ensure successful implementation of MACRA. We look forward to continued work with you and your staff to ensure that Medicare beneficiaries have access to oncology services moving forward. Please contact Kristin McDonald at Kristin.McDonald@asco.org with any questions.

The Organized Dentistry Coalition

Submission For The Record

Submitted by The Organized Dentistry Coalition

To House Ways and Means Health Subcommittee

Regarding hearing on 5/17/2016:

Member Day Hearing on “Tax-Related Proposals to Improve Health Care.”

On behalf of the undersigned dental organizations, representing a majority of the clinical professionals in the field of dentistry, we welcome the opportunity to submit a statement for the record regarding the May 17, 2016 Ways and Means Health Subcommittee Member Day Hearing on “Tax-Related Proposals to Improve Health Care.”

As you know, a Flexible Spending Account (FSA), also known as a Flexible Spending Arrangement, is a tax-free spending account, usually funded through voluntary salary reduction agreements between employees and employers, which allow consumers to pay for qualified out-of-pocket health care costs. As you are also aware, the Affordable Care Act (ACA) put new restrictions on FSAs by imposing a \$2,500 (increased to \$2,550 in 2015) annual cap on an individual's contribution to an FSA.

We believe this restriction on consumer health care spending has been a major step back for consumers at a time when out-of-pocket costs for health care have never been higher. Even more limiting, the ACA states that unused FSA funds set aside in one year will be inaccessible under a "use-it-or-lose it" policy. (This provision was amended in 2013 allowing families to rollover \$500 to the next calendar year. This was an improvement, but it doesn't completely eliminate the "use it or lose it" concern that many have about the current plan.)

Out-of-pocket costs for “traditional” medical insurance easily exceed the current \$2,550 annual cap. When you factor in the rising costs of deductibles, co-pays and prescription medication; this inflexibility forces some patients to forgo necessary care, including dental care. According to the 2015 Milliman Medical Index, consumers spent an average of \$4,065 for out-of-pocket expenses in 2015.¹ This is nearly double the amount consumers are allowed to save under the current FSA restrictions. In the current health care environment, hundreds of thousands of Americans – many of whom have middle-class incomes and are without access to dental insurance – rely on medical FSAs to cover rising out-of-pocket health care costs.

Many dental procedures, even for those with dental insurance, require out-of-pocket expenses for consumers. Many common and necessary dental procedures such as dental implants, a set of braces, a root canal, or even

the extraction of an abscessed tooth require out-of-pocket spending. By restricting consumers to save only 50 percent of what they can expect to spend out of pocket, we are forcing them to make critical medical decisions based on what they can afford, not on what is medically necessary.

However, these uncomfortable and potentially dangerous decisions could be avoided if we just allow consumers to save more of their pre-tax dollars for health care expenses. One legislative approach which would allow consumers to drive their own health care spending is being sponsored by Rep. Steve Stivers and Rep. Michelle Lujan Grisham, the RAISE Health Benefits Act (H.R. 1185). Under H.R. 1185, families and individuals will be able to:

- *Save more by increasing the annual FSA cap to \$5,000 per year from the current \$2,550;*
- *Add an additional \$500 to the FSA savings cap for each dependent above two dependents;*
- *Better prepare for expected and unanticipated health care costs by carrying over unused funds and eliminating the IRS's onerous "use it or lose it rule."*

This common sense legislation would be a huge step in the right direction and we would strongly encourage the Committee to include this legislation as it considers tax-related proposals to improve health care.

The undersigned organizations appreciate the opportunity afforded by Chairman Tiberi and Ranking Member McDermott to provide this statement and we thank you for your commitment to finding solutions within the tax code to help improve the health care system. Should you have any questions or need further information, please do not hesitate to contact Ms. Jeanne Tuerk of the AAOMS Governmental Affairs Department at 847/233-4321, or jtuerk@aaoms.org.

Academy of General Dentistry
 American Academy of Oral and Maxillofacial Pathology
 American Academy of Pediatric Dentistry
 American Academy of Periodontology
 American Association of Endodontists
 American Association of Oral and Maxillofacial Surgeons
 American Association of Orthodontists
 American Association of Women Dentists
 American College of Prosthodontists
 American Dental Association

¹ 2015 Milliman Medical Index, <http://www.milliman.com/uploadedFiles/insight/Periodicals/mmi/2015-MMI.pdf>

Michael G. Bindner, Center for Fiscal Equity

**Comments for the Record
United States House of Representatives
Committee on Ways and Means
Health Subcommittee**

**Member Day Hearing on Tax-Related Proposals to Improve Health Care
Tuesday, May 17, 2016, 10:00 AM**

**By Michael G. Bindner
Center for Fiscal Equity**

Chairman Tiberi and Ranking Member McDermott, thank you for the opportunity to submit these comments for the record to the House Ways and Means Committee. As usual, we will preface our comments with our comprehensive four-part approach, which will provide context for our comments.

- A Value Added Tax (VAT) to fund domestic military spending and domestic discretionary spending with a rate between 10% and 13%, which makes sure very American pays something.
- Personal income surtaxes on joint and widowed filers with net annual incomes of \$100,000 and single filers earning \$50,000 per year to fund net interest payments, debt retirement and overseas and strategic military spending and other international spending, with graduated rates between 5% and 25%.
- Employee contributions to Old Age and Survivors Insurance (OASI) with a lower income cap, which allows for lower payment levels to wealthier retirees without making bend points more progressive.
- A VAT-like Net Business Receipts Tax (NBRT), which is essentially a subtraction VAT with additional tax expenditures for family support, health care and the private delivery of governmental services, to fund entitlement spending and replace income tax filing for most people (including people who file without paying), the corporate income tax, business tax filing through individual income taxes and the employer contribution to OASI, all payroll taxes for hospital insurance, disability insurance, unemployment insurance and survivors under age 60.

Proposals along these lines have long been a part of our standard package of health care reforms. We have long advocated a conversion to catastrophic insurance with a medical savings account to pay for appointments and drugs, although we have always suggested a third element – a Medical Line of Credit to bridge the gap between the current MSA balance at the catastrophic deductible. The MLC would also pay for services, including acupuncture and reproductive health that may not be covered or coverable under catastrophic insurance.

Under our standard tax reform proposal, catastrophic policies would be purchased by all employers (and certain self-employed) as an offset to the Net Business Receipts Tax/Subtraction VAT. While this raises the tax rate, the lack of any tax subsidy would doom private insurance and deny most families medical care. Likewise, the Health Savings Account would be provided by employers, but would be a deduction rather than a credit. Medical Lines of Credit would be funded entirely by employees with no tax advantage – as under our plan most employees would not pay any income taxes.

Personal experience with cardiac care (luckily a succession of false alarms) showed that, while this approach makes economic sense, it does not jibe with how doctors operate. There is no price schedule in the waiting or exam rooms to compare costs for proposed procedures or tests. Health care is not a normal good. While it responds to market pressures, some care cannot be limited by them.

I also came to the conclusion with the passage of health care reform – and the electoral rejection of the health care reform above which was not far from what Senator McCain proposed in his 2008 run (and which was not even mentioned as the Republican alternative in the Obamacare debate) – that Americans like their comprehensive insurance. Most importantly, while the Medical Line of Credit is essential for complete health care, its inclusion essentially short circuits any decision to shop for care.

If the McCain approach cannot pass, will the Affordable Care Act survive the test of time (it has certainly survived all attempts to repeal it)? Possibly. The key concept, that people in marginal jobs deserve the same tax subsidies that corporate employees get is sound. Those parts that fulfill that need, which originated in the Heritage Foundation (which even now clamors for repeal) are also worthy.

What is less defensible are the higher non-wage income taxes used to fund it, although no bill which just repeals these will survive a Budget Act point of order in the Senate (regardless of House Rules) nor would the political optics look good. Repeal would hurt too many Americans, so expansion of the tax (along with a rate cut) with some form of consumption or payroll tax— such as the one proposed by Senator Sanders in his single payer plan (or by Mrs. Clinton during her husband’s health care reform effort). In our proposal, the consumption tax used would be the NBRT/Subtraction VAT.

The main danger to the Affordable Care Act is ease of entry and exit. If it is too easy to get in, then people will wait until they are sick to sign up. After they are well, any plan will stop coverage if you stop sending in your monthly premium check. If enough people do that, rates go up and the cycle goes down. This eventually leads to a collapse in the system that can be fixed in one of two ways – give everyone cheap and mandatory health care or place health insurers into bankruptcy, like General Motors and Chrysler, and reorganize them into a single-payer system (without any congressional action). Had the leadership laid out this scenario, it might have stopped the Affordable Care Act – and insurance companies would have most assuredly stopped contributions to the GOP.

The low-cost system with catastrophic care would operate as above (and would hopefully include the Medical Lines of Credit). Single-payer care would be funded by the NBRT/Subtraction VAT. Such a tax is superior to the payroll tax proposed by Senator Sanders because it would hit profit. The upper-income payroll taxes for non-wage income would repealed and incorporated into the NBRT.

Under Single-Payer, we propose an additional option. Firms that provide direct health care, such as automobile manufacturers, would not pay for third party coverage at all. The cost of the coverage provided would be an offset to the NBRT.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Contact Sheet

Michael Bindner
Center for Fiscal Equity
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Health Subcommittee

**Member Day Hearing on Tax-Related Proposals to Improve Health Care
Tuesday, May 17, 2016, 10:00 AM**

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears:

This testimony is not submitted on behalf of any client, person or organization other than the Center itself, which is so far unfunded by any donations.

Letter

May 31, 2016

Dear Chairman Brady and Ranking Member Levin,

As the Ways and Means Committee considers legislation regarding health care policy in the tax code, I urge the Committee's consideration of legislation to repeal the Affordable Care Act's 40 percent tax on certain health care benefits.

As you may know, this provision of the Affordable Care Act, commonly referred to as the Cadillac Tax, places a 40 percent excise tax on employer-sponsored health care benefits that exceed an annual limit of \$10,200 for individuals and \$27,500 for self and spouse or family coverage. This tax covers not only health insurance premiums, but other forms of health benefits such as, Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs). While the thresholds for the tax will be indexed based on the Consumer Price Index- Urban (CPI-U), it is important to note that the cost of health care has traditionally risen much faster than CPI-U.

Additionally, the thresholds established in the provision do not account for the age of the consumer or the difference in the cost of healthcare throughout the country. This tax is likely to result in fewer benefits and higher costs for low- and moderate-income families, retirees, and the self-employed, both as the threshold begins to cover more employees and as employers begin to look for ways to avoid the tax completely. In my home state, the tax is estimated to cost each of our municipalities millions of dollars each year.

These are just some of the reasons I believe the Committee should consider H.R. 879, *the Ax the Tax on Middle Class Americans' Healthcare Act*, the first repeal of this tax in both the House of Representatives and the Senate. This legislation would fully repeal the 40 percent excise tax, and ensure that hard working Americans and their families have access to high quality, low cost health care. H.R. 879 has 129 cosponsors and has garnered support from various interest groups and stakeholders across the political spectrum.

While I was pleased that H.R. 2029, the Consolidated Appropriations Act of 2016 included a 2-year delay of the tax, I believe a full repeal of the tax must be considered prior to the new implementation date. Hundreds of millions of Americans will be affected by the tax in the first years alone, and the numbers will only increase. Without a full repeal of this tax, we will see an increase in income taxes, higher state and local taxes, reduced benefits for middle class Americans, and a loss of jobs as employers try to combat the cost of the tax.

I want to thank the Committee for its consideration of H.R. 879 as it evaluates certain health care policy in our tax code.



Healthcare Leadership Council



STATEMENT FOR THE RECORD

House Ways and Means Committee
Health Subcommittee

Implementation of Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

May 11, 2016

Dear Chairman Tiberi and Ranking Member McDermott:

The Healthcare Leadership Council (HLC) appreciates the opportunity to submit a statement for the record regarding the hearing entitled, "Implementation of Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)." We applaud the subcommittee for focusing on ensuring that we properly implement these important reforms to the Medicare program.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century health system that makes affordable, high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, biotech firms, health product distributors, pharmacies, post acute care providers, and information technology companies – advocate measures to increase the quality and efficiency of healthcare through a patient-centered approach (attached is a list of our members).

In 2015, as part of our National Dialogue for Healthcare Innovation (NDHI) initiative, HLC convened leaders of healthcare organizations, patient advocacy organizations, federal government officials, and academic health policy experts to build consensus on a broad spectrum of steps necessary to strengthen health system value and enable health innovation to have a greater positive impact on the entirety of the healthcare continuum.

NDHI participants came to the conclusion that healthcare in the U.S. can be significantly improved by focusing on improvements that are readily achievable via legislation,

regulation, or voluntary actions by various health system players. Positive health system transformation does not require a wholesale remaking of health delivery structures, but rather the enabling and acceleration of patient-centered innovation.

Attached is our final report detailing the findings of this seminal group of leaders. Many of these recommendations are directly relevant to ensuring the success of MACRA and also to achieving the goals set by the Department of Health and Human Services (HHS) of tying 50% of fee-for-service Medicare payments to quality or value through alternative payment models, such as Next Generation Accountable Care Organizations (ACOs) or Medical Home Models by the end of 2018.

As our healthcare system shifts from fee-for-service to value-based models evaluated through outcomes, NDHI finds that some laws and regulations that were once important to the healthcare system may no longer be applicable or may inhibit transformation efforts in unintended ways. Once payment and outcomes are aligned, there is less need for government regulation on process, since consumers and healthcare organizations share healthcare goals and responsibility for achieving them. Laws designed to prevent anticompetitive behavior, for example, now sometimes hinder the coordination needed for the best patient care.

NDHI participants have focused on two of the primary fraud and abuse laws – the Federal Anti-Kickback Statute and Physician Self-Referral (Stark) Law – and prioritized options that should be pursued to better support innovative payment and delivery reforms for organizations participating in alternative payment models. These options include:

- Requiring the HHS Secretary to review and assess the Federal Anti-Kickback Statute and Stark Law as well as the Civil Monetary Penalties (CMP) Law (expansion of current MACRA requirements) in the context of health system transformation, specifically addressing whether the laws create unnecessary barriers to new integrated care models and whether these laws are effective in limiting fraudulent behavior. Changes identified through this assessment may yield opportunities to amend fraud and abuse laws to foster healthcare arrangements that promote increased quality and lower costs.
- Granting the HHS Office of the Inspector General (OIG) and Centers for Medicare and Medicaid Services (CMS) broader flexibility and discretion to develop exceptions and safe harbors to the Federal Anti-Kickback Statute and the Stark Law consistent with current health policy objectives (e.g., increased efficiency and quality, decreased cost).

- Expanding the waiver for patient incentives under the Medicare Shared Savings Program (MSSP) to all demonstrations under the auspices of the CMS Center for Medicare and Medicaid Innovation (CMMI). The current waiver gives ACOs the flexibility to encourage preventive care and patient compliance with treatment regimens without facing CMP due to beneficiary inducements. Current law only authorizes the waiver of the program integrity laws for CMMI demonstrations, but CMMI has largely issued guidance regarding such waivers on a case-by-case basis. While this information helps to ameliorate the concerns of would-be participants in CMMI demonstrations, concrete assurances in the form of prospective, bright line waivers could spur greater confidence and participation. Additionally, CMS should expand these permissions (such as the ability to waive copays) to private sector ACOs, which operate with the same incentives as those in CMS demonstration programs.

Please find more analysis and further options to address the current federal fraud and abuse legal framework – to make it more compatible with value-focused, integration-oriented health system transformation – in a 2016 report on value and innovation available at www.ndhi.org.

On behalf of HLC, I applaud you for your bipartisan work to support alternative payment reforms. We are committed to educating members of Congress and the public about the need to align incentives and shift to value-based care models – provided that these models allow the flexibility for participants to innovate in their quest to provide the highest quality, highest value care.

We stand ready to assist and support your efforts.

Sincerely,



Mary R. Greal
President

Attachment

Susan DeVore - Chair
President & CEO
Premier healthcare alliance

Fran Soistman
EVP, Government Services
Aetna

Steve Collis
President & CEO
AmerisourceBergen

Rolf Hoffmann
SVP, US Commercial Operations
Amgen

Susan Salka
President & CEO
AMN Healthcare

Joseph Swedish
President & CEO
Anthem

Anthony Tersigni, EdD
President & CEO
Ascension

Jonathan Bush
Chairman, President & CEO
athenahealth

Joel Allison
CEO
Baylor Scott & White Health

Gregory Henderson, M.D., Ph.D.
President
Bio-Reference Laboratories

J. D. Hickey
CEO
BlueCross BlueShield of Tennessee

Everett Hoekstra
Sr. Vice President & CFO
Boehringer Ingelheim USA

George Barrett
Chairman & CEO
Cardinal Health

Neil de Crescenzo
CEO
Change Healthcare

Toby Cosgrove, M.D.
CEO & President
Cleveland Clinic Foundation

Tim Ring
Chairman & CEO
C. R. Bard

Alex Azar
President, Lilly USA
Eli Lilly and Company

John Finan, Jr.
President & CEO
Franciscan Missionaries of Our Lady Health System, Inc.

Jack Bailey
President, US Pharmaceuticals
GlaxoSmithKline

Neil Kurtz, M.D.
President & CEO
Golden Living

Dennis Murphy
President & CEO
Indiana University Health

Jennifer Taubert
Company Group Chairman, North American
Pharmaceuticals
Johnson & Johnson

Jonathan Scholl
President, Health and Engineering Sector
Leidos

Susan Turney, M.D.
CEO
Marshfield Clinic Health System

William Butz
CEO
Maxim Healthcare Services

John Noseworthy, M.D.
President & CEO
Mayo Clinic

John Hammergren
Chairman, President & CEO
McKesson Corporation

Omar Ishrak
Chairman & CEO
Medtronic

Barry Arbuckle, Ph.D.
President & CEO
MemorialCare Health System

Robert McMahon
President, U.S. Market
Merck

Anna Mohl
Regional Business Head, North America
Nestlé Health Science Medical Nutrition Business

Steven Corwin, M.D.
CEO
NewYork-Presbyterian Hospital

Mark Neaman
President & CEO
NorthShore University HealthSystem

Fabrice Chouraqui
President
Novartis Pharmaceuticals

Jesper Hoiland
President
Novo Nordisk, Inc.

Cody Phipps
President & CEO
Owens & Minor

Albert Bourla, DVM, Ph.D.
Group President, Vaccines, Oncology and
Consumer Healthcare
Pfizer

Jez Moulding
President North American Pharmaceuticals
Sanofi

Chris Wing
President & CEO
SCAN Health Plan

David Chernow
President & CEO
Select Medical

Tim Scannell
Group President, MedSurg &
Neurotechnology
Stryker

Tom Skelton
CEO
Surescripts

Ramona Sequeira
President
Takeda Pharmaceuticals U.S.A.

Jason Gorevic
CEO
Teladoc

Barclay Berdan
CEO
Texas Health Resources

Curt Nonomaque
President & CEO
Vizient

Alex Gourlay
President
Walgreens

James Chambers
President & CEO
Weight Watchers International

Jaideep Bajaj
Chairman
ZS Associates

Letter

April 12, 2016

The Honorable Kevin Brady
Chairman
Committee on Ways & Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Sander Levin
Ranking Member
Committee on Ways & Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Pat Tiberi
Chairman, Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Jim McDermott
Ranking Member, Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Charles Boustany, M.D.
Chairman, Subcommittee on Tax Policy
Committee on Ways & Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Richard Neal
Ranking Member, Subcommittee on Tax Policy
Committee on Ways & Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Committee Chairmen and Ranking Members:

The undersigned organizations encourage your prompt consideration of the Small Business Healthcare Relief Act (H.R. 2911) as leaders on the Committee on Ways and Means. This important legislation would protect small businesses from punitive fines for helping employees with health care costs and restore the ability to provide a flexible and valued benefit.

Soaring health insurance premiums have thwarted the ability of many small business owners to provide, and their employees to obtain, health coverage. From 2010 to 2015, premiums for small firms increased 25 percent, from an average monthly family premium of \$1,104 to \$1,385.¹ Similar, if not greater, premium increases are expected to continue in the years ahead.

To provide much-needed relief, we support allowing employers to provide employees with a defined financial contribution toward the cost of health care coverage. Under this approach, employers could provide employees with a set dollar amount to use on a tax-preferred basis when purchasing health care coverage.

Historically, many small business owners directly paid for or reimbursed employees for medical care and services through an employer payment plan, such as a Health Reimbursement Arrangement (HRA). However, the Affordable Care Act (ACA) requires that all group health plans meet certain benefit requirements, such as first dollar coverage of preventive services and no annual dollar limits on essential health benefits. Because HRAs are reimbursement

¹ "2015 Employer Health Benefits Survey," Kaiser Family Foundation, Sep 2015. <http://kff.org/health-costs/report/2015-employer-health-benefits-survey/>

arrangements, they violate these rules according to the Internal Revenue Service (IRS) and are therefore unlawful on a stand-alone basis.

As a result, since July 1, 2015, small businesses who do not offer a group health plan with the HRA face \$100 per day, per employee fines. That totals \$36,500 annually per employee up to \$500,000 in total, or 18 times more than the \$2,000 employer mandate penalty for larger employers who do not provide any coverage. Affected small businesses are trying to help their workers, but the IRS says their effort violates ACA requirements.

Many small business owners and employees are not aware of the prohibition, meaning this upcoming tax season could trigger surprising audits and costly penalties. For example, a small business owner who has been offering an HRA to his or her four employees since July 1, 2015, will owe the IRS \$220,000 by the end of this year. Small employers, who want to help employees, simply cannot afford financial punishment of this magnitude. As a result, employees will lose their employer-provided health benefits and pay more for health care.

We strongly support the Small Business Healthcare Relief Act (H.R. 2911), which currently has 77 bipartisan cosponsors, including 28 House Ways & Means Committee members. This critical legislation would allow small businesses with fewer than 50 employees to offer employer payment plans and HRAs to employees for the payment of premiums or qualified medical expenses associated with insurance coverage without facing outrageous fines.

Thank you in advance for your consideration of our request for a prompt mark-up of this bipartisan, responsible small business health care bill. We look forward to working with you to address employer payment plans and account-based plans, such as HRAs, which provide small businesses with important and necessary relief from rising health costs.

Sincerely,

Air Conditioning Contractors of America
 American Horticulture Industry Association – AmericanHort®
 American Dental Association
 American Farm Bureau Federation
 American Independent Business Coalition
 American Rental Association
 American Subcontractors Association, Inc.
 America's Business Benefit Association, Inc.
 Associated Builders and Contractors, Inc.
 Associated General Contractors
 Auto Care Association
 Communicating for America, Inc.
 Council for Affordable Health Coverage
 Door Security and Safety Professionals
 Evolution1 Inc. – a WEX Company
 Family Business Coalition
 Global Cold Chain Alliance

Healthcare Leadership Council
Heating, Air-conditioning & Refrigeration Distributors International
Independent Community Bankers of America
International Association of Refrigerated Warehouses
International Franchise Association
Insurance Benefits & Advisors, LLC
Mid-America Lumbermens Association
Mountain States Lumber and Building Material Dealers Association
National Association of Electrical Distributors
National Association of Home Builders
National Association of Manufacturers
National Association for the Self-Employed
National Association of the Remodeling Industry
National Association of Towns and Townships
National Association of Wholesaler-Distributors
National Christmas Tree Association
National Club Association
National Federation of Independent Business
National Grange
National Lumber and Building Material Dealers Association
NPES, The Association for Suppliers of Printing, Publishing, and Converting Technology
National Restaurant Association
National Retail Federation
National Small Business Association
Northeastern Retail Lumber Association
Padgett Business Services
Pet Industry Distributors Association
Promotional Products Association International
Retail Industry Leaders Association
Saturation Mailers Coalition
Secondary Materials and Recycled Textiles Association
Service Station Dealers of America and Allied Trades
Small Business & Entrepreneurship Council
Small Business Council of America
Small Business Legislative Council
Small Business Majority
Society of American Florists
Southern Consumers Alliance
The Latino Coalition
Tire Industry Association
U.S. Chamber of Commerce
Western Equipment Dealers Association
Window and Door Manufacturers Association
Zane Benefits



Natural Products Association



1773 T St, N.W. Washington, D.C. 20009
 (202) 223-0101, Fax (202) 223-0250
 NPAinfo.org

May 16, 2016

The Honorable Kevin Brady
 Chairman
 U.S. House Committee on Ways & Means
 Washington, DC

The Honorable Sander Levin
 Ranking Member
 U.S. House Committee on Ways & Means
 Washington, DC

Dear Chairman Brady & Ranking Member Levin,

The Natural Products Association (NPA) would like to thank the Committee on Ways and Means for holding its Member Day Hearing on "Tax-Related Proposals to Improve Health Care." The NPA appreciates the opportunity to offer comments and to reiterate its strong support for the Health Savings Act of 2016 – H.R. 4469.

Founded in 1936, the NPA is the nation's largest and oldest non-profit organization dedicated to the natural products industry. NPA represents over 1,400 members accounting for over 10,000 retail, manufacturing, wholesale, and distribution locations of natural products across the country, including foods, dietary supplements, and health/beauty aids. The association supports a strong grassroots network of members and consumers passionate about products that contribute to healthy lifestyles.

NPA encourages the House Committee on Ways and Means to swiftly consider and pass H.R. 4469 which would change the status quo and allow Americans to use their Health Savings Account (HSA) and Health Flexible Spending Account (FSA) dollars on nutritional and dietary supplements.

Well over half of Americans already safely use supplements on a daily basis to help balance their diet and ensure they are getting the vitamins they need. This key component to a healthy lifestyle, however, is not supported by any organized healthcare plans.

The Health Savings Act would make necessary changes to dietary supplement coverage, allowing families to lead healthier lives, provide more freedom in Americans' personal healthcare choices, and lower overall healthcare costs.

We are grateful for your continued leadership on these important issues and welcome a constructive dialogue that furthers our shared interests in protecting the business interests of NPA members and dietary supplement consumers across the country. We thank the Committee for the opportunity to submit this letter.



1773 T St, N.W. Washington, D.C. 20009
(202) 223-0101, Fax (202) 223-0250
NPAinfo.org

Sincerely,

A handwritten signature in black ink, appearing to read "Dan Fab".

Daniel Fabricant, Ph.D.
Chief Executive Officer and Executive Director
Natural Products Association

A simple horizontal line.

Statement**Comment for the Record****“Tax-Related Proposals to Improve Health Care”****Ways and Means Health Subcommittee Member Day Hearing**

I would like to thank Ways and Means Health Subcommittee Chairman Tiberi, Ranking Member McDermott, and their subcommittee colleagues for holding an important hearing on May 17th regarding tax-related proposals to improve health care in the United States.

I bring to the Committee’s and Subcommittee’s attention the urgent need to enact H.R. 2061, the Equitable Access to Care and Health Act law. I sponsored the EACH ACT along with my Democrat colleague from Massachusetts, Congressman Keating, and we are joined by 21 bipartisan members of the Ways and Means Committee, 176 of my House colleagues, and 35 bipartisan members of the Senate.

The Each Act ensures that the religious conscience exemption in the Affordable Care Act is appropriately and fairly tailored. Regardless of one’s opinion of the broader health care law, the current religious conscience exemption is overly narrow and, therefore, inaccessible to those Americans who rely on religious, non-medical health care services, which are not covered by the ACA-compliant plans sold on the exchanges.

In order to comply with the current law, these hard-working Americans, many of whom I proudly represent in the 13th district of Illinois, are required either to pay for medical health insurance that does not cover the religious health care they actually use or pay significant tax penalties for not doing so. For many Americans, this adds up to many thousands of dollars in penalties paid since 2014 because of their religious beliefs.

The EACH Act importantly protects and promotes religious liberty and fairness by making sure the ACA’s religious conscience exemption covers any individual American who “relies solely on a religious method of healing, and for whom the acceptance of medical health services would be inconsistent with the religious beliefs of the individual.”

Thankfully, I am not alone in working to ensure that this much-needed, bipartisan solution makes it across the finish line and into law as soon as possible. I was very pleased when the Committee marked up H.R. 2061 last September and reported it favorably out of committee. The full House passed H.R. 2061 under suspension of the rules by voice vote shortly thereafter. Unfortunately, it has stalled in the Senate, and this despite broad bipartisan consensus and careful review by the Senate Finance Committee staff, the Obama Administration, and key stakeholders.

The EACH act is an urgent and eminently doable piece of legislation that solves a real tax problem faced by Americans of faith across the country. I strongly encourage my colleagues in the House and Senate to deepen their support of this important legislation and enact it into law as soon as possible. We have both the opportunity and the responsibility to act now to protect religious freedom, equity, and the rights of conscience. I urge you to join me in passing the EACH Act into law this year.

Thank you again for the opportunity to raise such an important issue. I commend the Chairman for his commitment to find real solutions that modify the way health care is treated in our tax code.



Church Alliance



**STATEMENT FOR THE RECORD
OF
THE CHURCH ALLIANCE**

**FOR THE MEMBER DAY HEARING
ON
“TAX-RELATED PROPOSALS TO IMPROVE HEALTH CARE”**

**BEFORE
THE U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH**

MAY 17, 2016

Chair: Ms. Barbara A. Boigegrain
1901 Chestnut Avenue, Glenview, Illinois 60025 • <http://church-alliance.org>
(847) 866-4200 • Barbara_Boigegrain@gbophb.org

The Church Alliance would like to thank Ways and Means Health Subcommittee Chairman Pat Tiberi, Ranking Member Jim McDermott, and the distinguished members of the Subcommittee for holding its hearing on tax-related proposals to improve health care in the United States.

The Church Alliance is a coalition of chief executive officers of thirty seven (37) denominational benefit boards (see addendum for complete list). The Alliance's members reflect a diversity of beliefs, including mainline Protestant denominations, two branches of Judaism, and Catholic schools and institutions. The members of the Church Alliance share a common purpose: to provide health care and pension benefits to more than 1 million clergy, church lay workers, and their dependents.

The Church Alliance wishes to bring to the Committee's attention the urgent need to address the treatment of church health plans under the Patient Protection and Affordable Care Act ("ACA"). Specifically, we urge Committee members to work together to ensure that individuals enrolled in and small employers offering church health plans are treated equally under the law.

Church Benefits Plans.

Church benefit plans are generally multiple-employer in nature and may cover thousands of church employers throughout the country, many of which are small churches located in rural communities. Having a program maintained by one central benefits organization serving multiple church employers helps provide efficiency, continuity and consistency of employee benefits for the many ministers who may move from one church or church-related organization to another within a denomination.

The benefits provided by church benefit boards or church associations may be mandated by the denomination or may be chosen one church at a time. Over the years, church denominations have organized themselves in a variety of ways reflecting their own theological beliefs and forms of church polity (the operational and governance structure of a denomination).

Church Health Plans.

Many church health plans have been in existence for over 50 years. Most denominations offer a nationwide plan (often on a self-funded basis), which allows clergy families the comfort and security of career-long, portable, comprehensive medical coverage, on an affordable basis. In addition, workers who move from one church to another typically can continue coverage under the denominational health plan.

In addition, because church health care plans are national in scope, these plans are able to take advantage of "economies of scale," allowing individual churches and members of the clergy to purchase health care coverage for less than it would cost to purchase similar coverage through the small group or individual insurance markets. This approach has allowed thousands of small churches, many in rural or disadvantaged areas, to provide meaningful health care benefits to clergy and lay employees.

Because each denomination has a unique polity that reflects its theological beliefs, each denomination also has a different level of authority and control over its individual churches as employers. As a result, in some denominations, the church plan is mandatory for all

church employers; in other denominations, the national plan can control only plan design and administration, but not the eligibility and participation rules or employer contributions toward the employee's cost of coverage.

The Problem.

The Patient Protection and Affordable Care Act (ACA) made significant changes to our nation's health insurance industry. ACA has had a significant impact on individuals in church health plans, which have been carefully designed over the years to reflect theological beliefs and forms of church polity.

More specifically, the availability of premium tax credits in exchange plans and small business health care tax credits for employers purchasing plans through a small business exchange (SHOP), and their unavailability in church health plans, have created a number of problems for members, small churches with limited financial resources, and the nationwide health plans sponsored by such churches (referred to as "denominational health care plans"):

Individual Members

Health plans depend on the ability of an insurer to cover health care expenses with premiums and cost-sharing. Age and health distribution are therefore vital to the financial health of a plan. This is because younger individuals, who tend to utilize fewer health services, cross-subsidize sicker, older members.

The lack of access to subsidies in a denominational health care plan creates an imbalance in church health plan risk pools because younger, healthier individuals may leave church health plans to purchase subsidized coverage on the Exchange.

Small Churches

Many churches meet the definition of a small business because they employ fewer than 50 full-time employees. However, under current law, small churches that participate in denominational health plans do not qualify for the small business tax credit because the ACA limits the credit to those insurance plans purchased through a SHOP. Unfortunately, church health plans cannot be offered on these exchanges because church plans are closed to non-church employees. As a result, many small churches are faced with the difficult decision whether to maintain participation in a health plan designed specifically for the denomination, or to terminate participation, either switching to a SHOP plan and potential small business tax credits, or foregoing employer-provided health coverage completely, enabling qualifying church employees to take advantage of the subsidies offered in the exchanges.

Denominational Health Care Plans

With individuals foregoing denominational health care plan coverage in favor of exchange coverage and subsidies, and with small churches ceasing sponsorship of such plans in order to obtain the small business health care tax credit available with a SHOP plan, the long-term viability of denominational health care plans is at risk. In addition, adverse selection resulting from healthier individuals moving to exchange coverage may create a "death spiral" for the national denominational plans, placing their viability at even greater risk.

Potential Solutions.

We urge Congress to ensure that individuals continue to have access to denominational health care plans. Below are several proposals to address this issue:

- **Help Individuals Afford Coverage.** Clergy and lay church employees are not highly compensated individuals, and need assistance affording health coverage. The Church Alliance supports a policy approach that would treat church plan members similar to those individuals obtaining exchange coverage. Such an approach could include extending existing individual tax credits to qualified church plan members.
- **Promote Individual Choice.** Individuals should have the freedom to choose the health coverage that works best for themselves and their families. The Church Alliance supports a policy approach that will allow individuals to stay in church health plans while maintaining access to important tax credit benefits.
- **Help Small Business Provide Coverage to Employees.** Many smaller churches do not have the financial resources to provide health coverage to their employees. The Church Alliance supports a policy approach that would eliminate the incentives for small churches to choose SHOP plans over denominational health care plans. Such an approach could include extending the existing small business tax credit to qualified small churches participating in church health plans.

Thank you again for the opportunity to raise this important issue. The Church Alliance commends the Subcommittee for its commitment to finding solutions to improve the treatment of health care under the tax code.

Addendum

CHURCH ALLIANCE

Acting on Behalf of Church Benefits Programs

CHURCH ALLIANCE MEMBERSHIP

Evangelical Lutheran Church in America	Evangelical Presbyterian Church
Association of Unity Churches	General Conference of Seventh-Day
Associate Reformed Presbyterian Church	Adventists
United Methodist Church	Mennonite Church
Christian Reformed Church in North	Reform Pension Board
America	National Association of Free Will Baptists
Reformed Church in America	Evangelical Covenant Church
Community of Christ	Presbyterian Church (U.S.A.)
Presbyterian Church in America	Evangelical Free Church of America
International Church of the Foursquare	Young Men's Christian Association
Gospel	Christian Brothers Services
United Church of Christ	Church of God Benefits Board
Church of the Brethren	Lutheran Church-Missouri Synod
Wesleyan Church	Baptist General Conference
Wisconsin Evangelical Lutheran Synod	Joint Retirement Board for Conservative
American Baptist Churches	Judaism
Christian Church (Disciples of Christ)	Christian Churches Pension Plan
Southern Baptist Convention	Episcopal Church
Free Methodist Church of North America	Churches of God, General Conference
Board of Pensions of the Church of God	Church of the Nazarene
	Unitarian Universalist Association

WageWorks

WageWorks' Statement for the Ways & Means Committee Record May 17, 2016

WageWorks is pleased to submit the following statement for the Committee's hearing record for the Subcommittee on Health's Member Day hearing on "Tax-Related Proposals to Improve Health Care," held on May 17, 2016. We thank Chairman Pat Tiberi and distinguished Members of the Subcommittee for holding this hearing to consider changes to the tax code's treatment of health insurance.

WageWorks is the nation's leading provider of tax-preferred employee benefits, including millions of consumer-directed health care accounts. On behalf of our public and private employer customers, we administer health savings accounts (HSAs) and health flexible spending arrangements (FSAs) for more than four million account holders and, including family members, an estimated ten million covered lives. HSAs and FSAs help hardworking Americans meet their rapidly growing out-of-pocket health care costs and empower them to become better consumers of health care. It should thus come as no surprise that these accounts have been shown to help bend the cost curve.¹

The Affordable Care Act (ACA) preserved HSAs and FSAs at established annual contribution levels. However, the ACA's excise tax on high cost employer-sponsored health coverage—more commonly known as the "Cadillac tax"—threatens to undermine consumer-directed health care by categorizing employees' own pre-tax contributions to HSAs and FSAs as employer-sponsored coverage, and thus, including these employee contributions in the calculation of the Cadillac Tax. Specifically, although the statutory language limits the Cadillac tax calculation to "the amount of *employer* contributions,"² a legal fiction developed by the IRS treats employees' salary-reduction contributions as if they were made by the employer.

These circumstances led the Congressional Budget Office to predict in 2010 that HSAs and FSAs would be first on the "chopping block."³ And, despite the short-term delay of the Cadillac tax's effective date, these predictions are already proving true as many employers are eliminating or limiting employees' ability to contribute to an HSA or FSA.⁴ For example, a recent survey of employers found that almost a quarter of employers (22.9 percent) are already changing contribution amounts to consumer-directed benefits in order to avoid initial Cadillac tax liability.⁵ This disturbing trend is manifesting because employers do not typically control the amount each employee contributes, and the corresponding tax liability. Moreover, employers are forced to calculate, and assess, the Cadillac tax on an employee-by-employee basis, given the

¹ See, e.g., Amelia M. Haviland et al., *Do "Consumer-Directed" Health Plans Bend the Cost Curve Over Time?* NAT'L BUREAU ECON. RESEARCH, Working Paper No. 21031, at 26-27 (Mar. 2015).

² I.R.C. § 49801(d)(2)(C) (emphasis added).

³ Jenny Gold, 'Cadillac' Insurance Plans Explained, KAISER HEALTH NEWS, Jan. 15, 2010, available at <http://kaiserhealthnews.org/news/cadillac-health-explainer-npr/>.

⁴ TEVI D. TROY & D. MARK WILSON, AMERICAN HEALTH POLICY INSTITUTE, ACA EXCISE TAX: CUTTING FAMILY BUDGETS, NOT HEALTH CARE BUDGETS 3 (2015).

⁵ NEIL MRKVICKA, ET AL., INTERNATIONAL FOUNDATION OF EMPLOYEE BENEFIT PLANS, 2016 EMPLOYER-SPONSORED HEALTH CARE: ACA'S IMPACT 33 (2016).

amount of each employee's election, which is creating an enormous disincentive for employers to continue to offer these important benefits.

In a bipartisan and bicameral fashion, Members of Congress have recognized that indirectly limiting access to consumer-directed health care was not a goal of the ACA, and the problem should be corrected. Republicans and Democrats have come together to introduce and cosponsor legislation that would ensure that employee HSA and FSA contributions are not treated like employer contributions and swept into the Cadillac tax, including the Health Savings Act of 2016 (S. 2499 / H.R. 4469), the Preserving Consumer Health Accounts Act (S. 2698), and the Health Savings Protection Act (H.R. 4832).

We thank Representative Ami Bera for coming before the Ways and Means Committee to urge consideration of the Health Savings Protection Act, which he introduced jointly with Representative Charles Boustany. As Congressman Bera explained, this legislation would correct the anomaly in section 4980I of the tax code and exclude employees' own contributions to their HSAs, FSAs, and medical savings accounts (Archer MSAs) from the Cadillac tax.

According to a recent Kaiser Family Foundation analysis, high-deductible health plans (HDHPs) have grown significantly in recent years, from 10 percent of enrollees in 2006 to more than 40 percent in 2015.⁶ Over this same time period, copays and other out-of-pocket costs have also substantially increased. It is only fair that American workers be allowed to access the tax benefits that were specifically designed to help them pay for these out-of-pocket costs. The alternative is a steep, albeit indirect, tax increase for working families.

An analysis of the millions of accounts administered by WageWorks demonstrates that consumer-directed health care is a squarely middle class benefit. We found that median household income for both our FSA and HSA-holders is less than \$60,000, with more than two-thirds of households earning below \$70,000. These are households that would likely qualify for cost-sharing subsidies if they ended up getting coverage through a health insurance Exchange. So, while the ACA subsidizes out-of-pocket costs for households at these income levels that are enrolled in Exchange plans, the Cadillac tax threatens to prevent employees at the same income levels from using their own personal accounts to pay for these expenses. A recent Commonwealth Fund report found that future increases in cost-sharing for employer-based plans will be greater than for Exchange plans, primarily because cost-sharing increases in the exchange plans are based on constant actuarial values.⁷

It is important to point out that due to a variety of statutory restrictions, many Americans who are enrolled in HSA-Qualified plans are precluded from contributing to HSAs and must instead rely on FSAs to meet their deductibles and other out-of-pocket expenses. For example, employees whose plans may have high deductibles, but where the plans offer certain first-dollar coverage (such as telehealth services that provide more than just preventive care), render employees

⁶ Liz Hamel et al., *Survey on Non-Group Health Insurance Enrollees, Wave 3*, KAISER FAMILY FOUNDATION POLLING, 20 May 2016, available at <http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/>.

⁷ Jon Gabel, et al., *Changes in Consumer Cost-Sharing for Health Plans Sold in the ACA's Insurance Marketplaces, 2015 to 2016*, 2 THE COMMONWEALTH FUND (May 2016).

ineligible to contribute to an HSA. As a result, the only account-based plan that is available to pay for out-of-pocket expenses is an FSA. Similarly, other employees who have high out-of-pocket costs due to chronic health care needs, may enroll in a PPO-type plan where the employees by definition are not covered under an HSA-Qualified plan (and therefore, may only contribute to an FSA). HSAs are also unavailable to employees in HSA-Qualified HDHPs who are age 65 or over, eligible for government programs like TRICARE, or share a household with an FSA-holder, among other circumstances. It is thus imperative that HSAs, as well as FSAs, continue to be treated equitably under the tax code.

WageWorks commends the Subcommittee and Full Committee for its continued attention to provisions of the tax code that have both direct and indirect consequences on the health care that Americans receive. We hope that reforming broken parts of the tax code, including impediments to accessing consumer-directed health care, like HSAs and FSAs, will be addressed as part of this process, if not sooner. Therefore, we urge enactment of the Health Savings Protection Act as well as legislation to repeal or substantially reform the Cadillac tax. The Cadillac tax looms large for American businesses and their workers, so this Congress should repeal or reform it now to ensure that it does not eliminate important programs, like consumer-directed health care.



Yoga Alliance



Statement for the Hearing Record

Tax-Related Proposals to Improve Health Care

House Ways and Means – Subcommittee on Health

May 17, 2016

Barbara Dobberthien

Executive Director and Chief Operating Officer

Yoga Alliance

Submitted: May 31, 2016

Statement submitted on behalf of Yoga Alliance, a nonprofit 501(c)(6) membership association.

Statement for the Record

Chairman Tiberi, Ranking Member McDermott, and Members of the Subcommittee on Health:

I am writing on behalf of Yoga Alliance, the yoga community's largest nonprofit membership association, representing over 73,000 yoga teachers and schools. We appreciate the opportunity to share this testimony as you consider legislation related to health care policy in the tax code.

As you examine a variety of legislative proposals, we urge your consideration of and support for H.R. 1218, the Personal Health Investment Today ("PHIT") Act, bipartisan legislation that would enable Americans to use pre-tax medical accounts to pay for physical activity expenses, including expenses related to yoga. This legislation represents a key path forward in our ongoing national effort to promote health and well-being and simultaneously reduce health care costs via prevention.

Currently, a pre-tax medical account like a health savings account ("HSA") or a flexible spending account ("FSA") may be used to reimburse medical expenses to treat illnesses or other medical conditions of an account holder or covered beneficiaries. The PHIT Act would expand the definition of tax-free medical expenses covered by HSAs and FSAs to include "qualified sports and fitness expenses," allowing an individual taxpayer to claim up to \$1,000 per year for physical activity expenses or joint filers to claim up to \$2,000 per year. Easing the financial burden of engaging in physical activity will encourage increased and sustained physical activity among American adults and children, which, in turn, will reduce health care costs related to obesity and sedentary lifestyles.

Under the PHIT Act, "qualified sports and fitness expenses" are those expenses paid for the sole purpose of participating in physical activity, including expenses related to facility memberships, participation or instruction in physical exercise or activity programs, and equipment used exclusively for physical exercise or activity. For the yoga community, passage of the PHIT Act would enable many more Americans to access yoga classes, and with it, the associated health and wellness benefits of yoga practice.

According to the 2016 *Yoga in America Study*,¹ there are currently 36.7 million U.S. yoga practitioners, up from 20.4 million in 2012. Further, practitioners report that the top reasons for starting yoga are flexibility, stress relief, general fitness, improvement of overall health, and physical fitness, all benefits that stave off chronic conditions associated with a lack of physical activity. Given that approximately one-third of all survey respondents to the *Yoga in America Study* indicated they are likely to practice yoga in 2016, legislation that would make this activity more affordable – like the PHIT Act – would incent these individuals to maintain their practice and reap the health benefits for themselves and the health care cost savings for our country. Of course, the PHIT Act would not only afford greater access to yoga, but also support greater involvement in numerous physical activities for all Americans.

A top priority of most health care reform initiatives is to slow spending without compromising care. Measures like the PHIT Act that encourage and expand access to physical activity and that provide accompanying health and wellness benefits will be a vital component of any solution to lower health care

¹ Yoga Journal and Yoga Alliance, *Yoga in America Study* (2016), available at www.yogaalliance.org/2016YogaInAmericaStudy.

costs and promote healthy living. For this reason, we ask that the Ways and Means Committee consider the PHIT Act promptly and that the Committee's members support this bipartisan legislation.

Thank you for your attention to legislation related to health care policy in the tax code and common sense solutions for our nation. We would be pleased to answer any questions you may have, and would appreciate any opportunities to be of further assistance to your Committee.

