Hearing on the Tax Treatment of Health Care

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Hearing on the Tax Treatment of Health Care

U.S. House of Representatives,
Committee on Ways and Means,
Washington, D.C.

The committee met, pursuant to notice, at 10:00 a.m., in Room 1100, Longworth House Office Building, Hon. Kevin Brady, [Chairman of the Committee] presiding.

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*Chairman Brady. The committee will come to order.

Welcome to the Ways and Means Committee hearing on the tax treatment of health care.

It is only fitting that this important discussion falls during Tax Week, a time when Americans are reminded how unfair and overly complex tax policies are hurting workers, job creators and families.

We can all agree Americans deserve better, which is why we are working toward solutions to make our tax code simpler, fairer, and flatter for everyone. Today we will examine proposals to reform the tax code to help all Americans access more affordable health care, including proposals to create a new fair tax credit and encourage greater use of consumer driven health care models to spur innovation and lower costs.

The tax code is full of provisions affecting the quality and the cost and the accessibility of health care for millions of Americans. Currently the tax code contains over a dozen health related tax expenditures, all intended to help more Americans access health care by subsidizing many of the costs.

Unfortunately, using the tax code in this way also can have the opposite effect, increasing premiums and costing taxpayers trillions of dollars in the process. Let us consider the largest health tax expenditure for employer-sponsored health insurance plans, commonly referred to as the employer exclusion.

Congress incorporated this high popular tax break in the tax code decades ago so that employers could attract and keep workers during a time of wage freezes. At the time this provision was created, the labor market and the health insurance market both looked very different.

Today, more than 150 million Americans under the age of 65 get their health insurance through their employer. Our conversation today is about how we can preserve and modernize this important tax incentive at work while also expanding tax benefits to Americans who seek additional health care choices.

And perhaps the crux of this hearing specifically is how can we make this nearly 100 year old tax break more flexible so Americans can have a new, modern option to choose a health plan that fits their needs and can travel with them to a new job, to start their own business, or to raise their family at home.

Some consumers today feel confined by their employer-sponsored arrangement because they are required to choose a plan from options determined by their employer rather than getting to shop around for the plan that best meets their needs.

Others who select health insurance through their employer feel trapped in their current job because they do not want to lose the coverage they like. The tax code compounds those concerns because this pre-tax benefit is tied to the job, not to the person. This approach limits options, is unfair to those who do not get their health insurance through their job, and creates what many economists call job lock.

Additionally, the employer exclusion is a contributing factor to our country's stagnant wage growth. That is because the tax code incentivizes putting a greater share of compensation toward non-taxable health plans and less to taxable paychecks. So as health care costs rise, employers divert increases in salaries to health care at the expense of take-home pay.

Evidence also suggests that the employer exclusion leads to higher health care costs for all Americans. Oftentimes someone who participates in an employer-sponsored health plan does not face the act and increasingly expensive cost of care. This encourages beneficiaries to consume more health services, including services they may not even need, driving up overall costs.

I cannot emphasize enough the employer-sponsored health insureds' market is a vital one. The question we must wrestle with is how we can sustain this option while advancing reforms that make the tax code fair and health care more affordable and flexible for all Americans.

We need bold solutions to tackle this challenge, not in my view, Obamacare's punitive tax on high cost health insurance plans that the law itself has made even more expensive.

We also need to consider expanding consumer-driven health care, the model that empowers consumers, not the government, to unleash the forces of choice and competition to lower costs and increase quality. Yet for many people Obamacare has limited the consumer-driven plans they liked, including health savings accounts and flexible spending accounts.

This committee will continue to protect and expand opportunities for Americans who want to take control of their health care dollars.

I want to thank our expert panel of witnesses for being here today. I look forward to a robust discussion about how we can help all Americans, regardless of employment status, access the affordable, portable, quality health care choices they deserve.

*Chairman Brady. With that I will yield to the distinguished ranking member of the committee, Mr. Levin, for his opening remarks.

*Mr. Levin. Thank you, Mr. Chairman.

And welcome to the panel.

Since the Affordable Care Act was signed into law six years ago, the progress we have seen in health care in this country is undeniable. Twenty million Americans who were previously uninsured now have quality coverage they can afford.

Health care costs are growing at the slowest rate in more than 50 years. Millions of young adults have been able to stay on their parents' plans until age 26, and nearly 130 million Americans no longer have to worry about being denied coverage or charged higher premiums because of preexisting conditions.

Yet despite these gains, Republicans continue to try to cook up ways to destroy the law. There have been 63 votes in the House to repeal or undermine ACA. That is a dangerous prospect on its own. But when it is paired with the fact that Republicans have come forth with no viable comprehensive alternative with which to replace the ACA, that is a recipe doomed to fail.

Take, for instance, the Republican proposal to eliminate or limit the tax exclusion that employers receive when they offer health insurance to employees as part of a compensation package. This would disrupt the employer-based health insurance system that the 155 million working Americans and their families rely on for coverage and likely would result in many employers no longer offering health care at all to employees, and it would leave many, including employees who are older or in poor health, without the ability to find affordable coverage.

Republicans have also proposed expanding the use of health savings accounts, which are associated with health plans that have high deductibles and most often used by wealthier households. HSAs are not an adequate replacement for comprehensive health

care coverage as they can actually lead low and middle income Americans to put off medical care because they simply cannot afford to pay high deductibles or copays.

Repealing the ACA as Republicans want to do would have devastating effects for millions of Americans who use the tax credits that the law offers. The advanced premium tax credit and premium tax credit are integral in making health insurance plans in the marketplace affordable for Americans. Unlike a once a year tax credit, we chose real time tax credits to help hard-working American families afford coverage throughout the year.

Earlier this year, I met a woman who came down with breast cancer. She lost her job and health care coverage. Because of the ACA, she was able to become covered again with health insurance. Her breast cancer reoccurred, and she made clear to us that this new health coverage, as she said to us looking at us straight in the eye, saved her life, saved her live.

Stories like these remind us of just how vital this law is, and for that woman and for millions and millions of people in this country, the Republican alternative has simply been 63 votes to destroy or undermine the coverage that people have received.

Now is the time to keep building on this success, not to start over and risk losing all that we have achieved for millions and millions and millions of Americans.

I yield back.

*Chairman Brady. Without objection, other members' opening statements will be made a part of the record.

*Chairman Brady. Today's witnesses in the panel includes three experts. First we welcome Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute.

Next we will hear from Avik Roy, a Senior Fellow at the Manhattan Institute.

Finally, we will hear from Steven Kreisberg, the Director of Research and Collective Bargaining Services with the American Federal of State, County and Municipal Employees, AFL-CIO.

The committee has received your written statements. They will all be made part of the formal hearing record. We reserve five minutes to deliver your oral remarks.

We will begin today with Mr. Antos. Welcome, and you may begin when you are ready.

STATEMENT OF JOSEPH R. ANTOS, Ph.D., WILSON H. TAYLOR SCHOLAR, AMERICAN ENTERPRISE INSTITUTE

*Mr. Antos. Thank you, Mr. Chairman and Ranking Member Levin and members of the committee. I appreciate the opportunity to talk about this very important issue today.

I am going to focus on the problems created by the way that the tax system subsidizes health insurance and need for Congress to replace the Affordable Care Act's Cadillac tax on high cost, employment-based health insurance with a better approach.

I will first address the tax exclusion.

Premiums paid for employment-based health insurance are excluded without limit from both income and payroll taxes. That reduces the cost of health coverage for the average worker by about 30 percent. In the aggregate the savings amount to more than $250 billion annually.

While the tax exclusion has made workplace health insurance affordable, it has also fueled the rapid growth of health spending, contributed to stagnating wage growth, and is regressive.

The exclusion encourages workers to buy insurance that offers lower cost sharing but higher tax free premiums. That makes consumers less sensitive to prices and promotes the use of medical services, and some of those services may not provide full value to the patient. I think that is the issue. We have waste in our health system. IOM says 30 percent of the money we spend is wasted.

Compensation also has shifted from taxable cash wages to greater health benefits which are not taxed. Between 1999 and 2015, the average employer contribution for family coverage nearly tripled, while wage rates increased by only about half. It is likely that many workers, given the choice, would prefer somewhat lower health benefits for somewhat higher cash wages.

And then finally, workers with higher incomes, of course, benefit the most from the exclusion. The Joint Committee on Taxation found that average savings for tax filers with incomes less than $30,000 was about $1,700 compared to about $4,600 for those with incomes over $200,000. So it is a regressive kind of a tax or kind of a subsidy.

We can restructure the tax subsidy to promote better health insurance choices that will lead to more efficient, higher value care. The subsidy can be made fairer without eliminating the financial incentive employers have to offer health coverage to their employees, and reforms can free up funds to help stabilize coverage for the 27 million who are left uninsured by the ACA.

Unfortunately, the Cadillac tax is not that reform. The 40 percent excise tax on high cost health insurance was intended to offset some of the excessive health spending arising from the tax exclusion. It is levied on employers. It is levied on insurers and other health plan sponsors, and the tax is paid on the cost of a health plan that exceeds certain thresholds.

Even though it is billed as a tax on insurance companies, workers ultimately bear the burden through lower compensation. Moreover, the tax is regressive. The same 40 percent tax is imposed on the production worker and the CEO regardless of how much they are paid in cash wages. They either pay higher premiums or their health benefits are cut back to avoid having to pay the tax. Either way, there is more cost for workers.

The tax will eventually impact everyone with employer coverage. The cost thresholds are indexed to general inflation. Health care costs rise faster than general inflation, and so ultimately all employer health plans will exceed what the ACA considers acceptable levels of health care coverage.

Simply repealing the Cadillac tax, I think, would be a mistake. First of all, you need to find offsetting budget savings.

Second of all, simply repealing would ignore the problems with the tax exclusion and other tax provisions affecting health insurance.

Reasonable reform would repeal the Cadillac tax and modify the tax exclusion to produce both budget savings and better incentives for the health sector. Two generic options, tax exclusion instead of the refundable tax credit or I mean to replace the tax exclusion with a refundable tax credit. Tax credits would break the financial link that motivates employers to offer health insurance and employers to buy it. There still would be a reason for employers to offer health insurance, but the money would not be there from the taxpayer.

Money wages can be expected to increase with the loss of health benefits and firms to drop their own plans, although some firms will continue to offer the benefit because it is a recruitment tool.

A credit would be a fair subsidy. The amount of the credit could be adjusted to account for regional variations in health care cost, for example. There are lots of ways to design it. It can be very complicated, but fundamentally it is a better system.

Alternatively, we could cap the amount of the tax exclusion. That would give employers an incentive to offer lower cost plan options, but would not drive employers to offer only low cost plans. Capping the exclusion is a less dramatic reform than shifting to a tax credit and could be a reasonable compromise that would promote more efficient health plans within the current employer framework.

*Chairman Brady. Thank you, Mr. Antos.

I understand that you can be with us until 12:15 today?

*Mr. Antos. Yes.

*Chairman Brady. Great. Thank you very much.

Mr. Roy, you are up next. Welcome.

STATEMENT OF AVIK ROY, SENIOR FELLOW, MANHATTAN INSTITUTE

*Mr. Roy. Thank you, Chairman Brady, Ranking Member Levin, and members of the Ways and Means Committee. Thanks for giving me the chance to speak with you today about the tax treatment of health care.

In my remarks today I will focus on three areas. First I will discuss how the tax treatment of health care is the central flaw in our health care system.

Second, I will address arguments made by opponents of health tax reform.

Third, I will discuss the principles of sound reform.

Republicans and Democrats may occasionally disagree on health care policy, but we all agree that health care needs to be more affordable. Nearly all of the growth in future Federal spending and thereby future tax increases is driven by health care, in particular, health care inflation, and the high and rising price of health care is the reason we have so many uninsured.

According to the CBO, 98 percent of the long-term uninsured cite the high cost of health insurance as a barrier to coverage. Only six percent cited poor health status, such as a preexisting condition.

The median worker's paycheck has barely increased in three decades, but overall compensation has grown. The problem is that most of the growth in compensation has been eaten up by the rising cost of health insurance. In 1996, the cost of coverage was 11 percent of per capita income. In 2010, it was 19 percent, nearly double.

The high cost of U.S. care originates in 1940s wage control, as you know, and is enshrined in the employer tax exclusion. Hospitals, doctors and drug companies have a powerful incentive to charge high prices here because the exclusion from taxation of employer-based insurance prevents patients from controlling their own health care dollars and thereby holding companies accountable for the prices they charge.

Today the employer tax exclusion, its value in terms of Federal, state and local income taxes and Federal payroll taxes, exceeds $500 billion a year. So it is extremely important to handle reform of the exclusion with great care.

But that is different from opposing reform altogether. If we want to make health care affordable, done properly we have to reform the exclusion. Health tax reform the right way would put more dollars in the pockets of workers rather than insurance companies.

Some opponents of health tax reform say that employer-based coverage protects us from single payer health care. That is manifestly untrue. The rising cost of employer-based coverage has actually been the principal argument for every major expansion of government-run health care in the United States.

Switzerland, by contrast, has a market-based system in which everyone purchases private coverage on their own individually. That system is not perfect, but it has been a far better check on the government. In 2014, the Swiss rejected a referendum to replace their system with single payer health care by a margin of 62 to 38 percent. People like choosing their own plans and will never allow the government to take away that right if they control it.

There are two keys to high quality health care tax reform. The first is that any reform should give workers more options to buy the coverage that they want.

The second is that reform should be enacted gradually. The ACA's Cadillac tax resembles such reform by taxing high value employer coverage, but that tax contains many exceptions and does not deploy the revenue it raises to aid all those who would like to purchase insurance on their own.

The best way to expand health insurance choices for individuals is to truly equalize the tax treatment of employer-purchased and individually purchased coverage. Congress could design a cap that raised an equivalent amount of revenue as the Cadillac tax, gradually phased in over time while also providing tax relief to those who purchase coverage on their own.

There is wide, bipartisan agreement on the utility of refundable tax credits for expanding coverage to the uninsured. The ACA, of course, deploys tax credits for this purpose, but that law has imposed costly mandates on insurers and individuals that have made coverage less affordable for millions, especially those ineligible for subsidies.

Some say that we should offer Americans an identical tax credit to every American with which to purchase coverage, but such a system would necessarily under-subsidize the poor, the sick, and the vulnerable while over-subsidizing the wealthy.

Tax credits for the uninsured should embrace the best of both worlds. They should be means tested to best help those in need. They should apply to health savings accounts and maximize the ability of people to choose the care and coverage that is best for them.

In this way we can achieve the goals that every member of this committee shares: ensuring that every American has access to quality, affordable health care.

Thanks, again, for having me. I look forward to your questions and to being of further assistance to this committee.

*Chairman Brady. Thank you, Mr. Roy.

Mr. Kreisberg, welcome and please proceed.

STATEMENT OF STEVEN KREISBERG, DIRECTOR OF RESEARCH AND COLLECTIVE BARGAINING SERVICES, AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES

*Mr. Kreisberg. Thank you very much, Mr. Chairman, and thank you, Ranking Member Levin. It is a pleasure to be here today.

My name is Steve Kreisberg. I am the Director of Research and Collective Bargaining with AFSCME, a large, public employee union of the United States.

And we do not think we can start talking about the American health care system without talking about the Affordable Care Act. This is an Act that we supported. We have a long history of supporting health care reform and expansion of coverage to all Americans.

Now, as public employees, virtually all of our members have adequate health care coverage, which is a great thing. So a lot of folks have asked us why would we be supporting the expansion of coverage. In the view of our union, this is a fundamental piece of what it takes to be a developed Nation. It is a fundamental part of the American dream, is to have health care so you can go on to achieve your full potential.

The Affordable Care Act for the first time really brings that within reach of virtually all Americans. We have expanded coverage. Ranking Member Levin referred to the figures. Unfortunately, we did not expand it as much as we should have or we intended to because 20 states still refuse to extend Medicaid coverage to their citizens. We think that is a mistake, and we think over time we expect to see further expansion of Medicaid.

But our members are also very much focused on cost, and like the other two panelists before me, we recognize that cost in our system is something that must be addressed.

Under the Affordable Care Act, we have seen a moderation of cost increase year over year. This is a trend that we are pleased to see. Cause and effect are often difficult to determine, but we believe the Affordable Care Act has gone a long way in helping us achieve the cost moderation that everybody seeks.

But it is not enough. We all know there is plenty of work to be done, not just with expansion of coverage, but also in cost, and we think the Affordable Care Act and the Obama administration have made a pretty good start in this regard.

The most important aspect of this in our view is the alignment of financial incentives to achieve quality and value in our health care system. We think the problem of cost is on the supply side, not on the demand side, and I think that is very important that you consider the issues in front of you.

I think what Mr. Roy was implying in part is that we need to change consumer behavior, and that will lead to a reduction in our health care expenditures. We do not have faith that that will be an effective solution to our problems. We think that the problem with our health care system is that we do not have a free market and we never had a free market in health care. It does not operate like other markets.

So we need to align incentives from the payers who are not individual consumers for the big ticket items, but through our insurance companies and form our government, and by that we mean that we have to move away from the fee for service system, and I think there is universal agreement that that is probably a wise approach, and we are starting to do those kinds of things right now.

We also feel we need, and this is part of the same approach, to further expand access to primary care and imbed primary care with your other avenues of care so we're not running into specialists uncoordinated from primary care providers.

We also must address prescription drug prices. They are accounting for the large part of our trend in cost increases. Every other developed nation, including Switzerland, regulates prescription drug prices. We do not do so here. We should consider that or some other alternatives to help bring our prescription drugs under control, and we expand on those remarks in our written testimony.

I do want to talk a little bit more about the tax exclusion. The foundation of our health care system right now is employer-based coverage. We believe changes and caps to the tax exclusion undermine that. In fact, we believe changes and caps to the tax exclusion will have the same aberrant results of the excise tax, which the two panelists oppose. So we cannot figure out how you can reconcile the position on tax exclusion with the position they take on excise taxes.

We think both will have the unintended consequence of shifting more cost to consumers. Now, some consumers may prefer high deductible health plans. When you are young and healthy you do. But those very same consumers hope to get old. This beats the alternative.

When they get old, they are going to want more comprehensive coverage. So we are going to see people perhaps enjoy high deductible coverage when they are younger and healthier, but eventually, as age catches up with them, opt into the higher cost plans and the more comprehensive coverage.

That makes no sense. Everybody should have comprehensive coverage from day one to keep our risk pools intact. We believe the high deductible plans are not the effective

way to reform health care. In fact, if you ask your constituents what the problems are with the American health care system, I do not think any of them will say the problem is that they do not pay enough. I think they believe the problem is they pay too much.

Thank you very much.

*Chairman Brady. Thank you, Mr. Kreisberg.

Thank you for the panelists' opening remarks. We will go to the question and answer period, and I will begin with myself.

I said it in the opening. I want to be perfectly clear. Most Americans get their health care at work, more than 150 million Americans. We are going to preserve incentives to get health care at work.

But the world has changed, and the question is: can we create flexibility and expand and make equal that tax incentive so that Americans have more choices?

Mr. Antos, do you believe we can create or modernize that tax exclusion at work in a way that creates flexibility and keep the important incentives for health care at work?

Can we do both?

*Mr. Antos. Yes, I think we can. As I mentioned, if you cap the exclusion, that does not mean you remove completely the tax subsidy through employer sponsored coverage, but what it does do is it discourages the purchase of very expensive coverage that tends to have very low cost sharing and which prevents people from understanding what the cost of health care is.

I mean, the fact is that health insurance through the employer is kind of a mystery to most people. Because the premiums are taken out of your pay, you do not often know what your premiums are, and the employer contribution is also a mystery. People think that it is not coming out of their paycheck.

*Chairman Brady. Yes, and it is.

Mr. Roy, we talked about the tax code being stuck, you know, in the past because it has been 30 years since we have reformed it, but this tax incentive actually first appeared in 1918, got serious 70 years ago, and effectively is stuck there, but workers are not stuck. Many of them change jobs multiple times throughout their life. Many will go home to start a small business. Others choose to want health care individually so they can raise their families.

How in your view is it appropriate to modernize that tax incentive that worked to be able to create that flexibility for workers to live a 21st Century life because, frankly, their lives are different from then when this first got serious seven decades ago?

*Mr. Roy. Absolutely. I would make two points. The first point is that employer-based tax reform or health tax reform is not about having workers pay more. It is actually about workers paying less for their health care. All of these efforts are about making workers paying less for their health care. All of these efforts are about making sure that workers pay less for health care and that health care is more affordable in the future than it is today.

And the second point that I would make is that what is really important, aside from making health care more affordable is putting patients and workers more in control of their own health care dollars. Today those health care dollars are controlled by the government, by employers, by insurance companies, by hospitals, by drug companies. They are not controlled by the consumer, by the worker, by the patient.

And all of our efforts on tax reform are about putting the control back in the hands of that individual and those families.

*Chairman Brady. Well, can I follow up with that? This is sort of my final question. I may have another after that, but this is really about a world where most people are told, "Here is your health care. You will like it. Just take it or leave it, and we will decide what is best for you."

This is about actually giving consumers control, picking a plan that is right for them, not what Washington wants, not what someone else wants, but what they need for their family and their lifestyle. It seems to me in the 21st Century, what we need armed through life is a health care backpack that includes a health plan that works for you and can travel with you whether it is to another job or a home or to start your small business.

You need a health savings account to be able to better afford the day-to-day costs of health care and prevention, and you need easy access to your medical records so you can share that with the doctor or emergency room if you are traveling at the time.

It seems to me that how we modernize, how we get health care to work actually unlocks and creates that flexibility for Americans.

So, Mr. Antos, in your view, what is the best way to modernize this tax incentive at work, and Mr. Roy as well, that creates that flexibility for Americans to control more of their health care plans?

*Mr. Antos. Well, I think the question is: what are the real bounds here? In the sort of ideal world, I think you would definitely go to a tax credit type of a subsidy which would free workers to buy the kind of coverage that they want on the individual market.

That would, of course, require some additional health insurance reforms.

*Chairman Brady. But in that case you would keep the tax incentives that work, but you have an option for the first time really ever, an option to equalize that tax credit and make some choices.

*Mr. Antos. Right. I think the key principle is to make it possible for people, wherever they buy insurance to have the same level of support.

*Chairman Brady. Yes, yes, sort of equal treatment.

Mr. Roy.

*Mr. Roy. Yes, I would agree with my colleague over here, Mr. Antos, and I would add that one of the important things about giving people that choice to buy the health insurance and the health care that makes sense for them is the profound innovation it would trigger in the health care system.

Today in most states, one health insurance company has 80 percent of the market, and that makes it very, very difficult for people even if they do choose their own health insurance to have true choice. But if you actually give people control of those health care dollars again, give it back to them to spend the way they want, you will see profound innovation and competition in not just how health insurance companies have to compete with entrepreneurs, but also how health insurance would be used versus health savings accounts versus urgent care versus all the other things that are out there.

So people should have those choices, and we will not know. We will not be able to anticipate how the consumers, how individuals will decide to use those dollars in the future, but it will be much better than it is today. That we can be very confident of.

*Chairman Brady. Thank you.

Because what we have is not working in the Affordable Care Act. There are a number of people in the Eastern Region. They get cancer under Obamacare, can go to M.D. Anderson for the best cancer cure in the world: zero.

This number of PPOs that are now available, and it was zero, by the way, that are available in our part of the world for families under Obamacare, and I cannot count the numbers of the extra dollars out of pocket that people pay now in the exchanges under the Affordable Care Act that they cannot afford.

In fact, in Texas, half of the people who are supposed to be forced in Obamacare have elected to pay a tax than to go into a health care plan they do not want and cannot afford and cannot see the doctors and get the medicines they want.

So we ought to be thinking about a 21st Century option for the first time ever that recognizes what people need, not what Washington needs.

With that, I will now recognize the distinguished ranking member from Michigan, Mr. Levin, for any questions he may have.

*Mr. Levin. You know, I want to be polite, but let me just say this. I think the Republicans have failed for five years to come up with a plan because there is so much double-talk. You say you do not want to eliminate the exclusion, but then you want to come up with a tax credit and give people control of their health care.

Essentially if you think it through what you want to do is to replace employer-based health care coverage. You do not say that. You kind of modify it. The Cadillac thing, modify it.

So you have been handcuffed because you just talk out of both sides of your mouth constantly. In listening to the two of you, I do not know what your plan would ever be. You say keep the exclusion, but cap it, and then come up with credits. You do not say how much. If it is enough, employers will not provide health care anymore. You are going to destroy the basis upon which we have built.

You can talk about 100 years ago, but this started after the Second World War when employers began to provide health care coverage, and it spawned for the first time most people having health care coverage.

And you talk about Switzerland. I want to say this politely. This is not Switzerland. This is not Switzerland.

Do you favor continuing Medicaid? Yes or no, Mr. Antos?

*Mr. Antos. You say continuing Medicaid?

*Mr. Levin. Yes.

*Mr. Antos. Yes, I favor continuing Medicaid, but with substantial reforms.

*Mr. Levin. You favor continuing it.

*Mr. Antos. Yes. We have to help poor people have access to appropriate health care.

*Mr. Levin. Medicaid provides coverage for more than just poor people.

Mr. Roy, do you favor continuing Medicaid?

*Mr. Roy. Yes. If you want to know all about the details of my own views on health reform and how to achieve universal coverage, I have published them at the Manhattan Institute.

*Mr. Levin. Okay. I understand that. But do you favor continuing Medicaid?

*Mr. Roy. Yes. What we need to do though is dramatically reform Medicaid because right now health outcomes for people enrolled in Medicaid are no better than people with no insurance at all, and that is because the system is so poorly designed.

So reforming Medicaid is essential to providing high quality health coverage for the poor.

*Mr. Levin. So health care under Medicaid is no better than for people with no health insurance at all?

*Mr. Roy. According to the New England Journal of Medicine, which published a study looking at Medicaid enrollees in Oregon, people enrolled in Medicaid showed no better health outcomes than people with no insurance at all.

*Mr. Levin. They were talking about outcomes. That was one study, but that does not mean that people --

*Mr. Roy. There are many other studies.

*Mr. Levin. -- that people who have Medicaid are no better off than people who have no insurance at all.

*Mr. Roy. Well, just to be very clear, I support universal coverage. I support health coverage for the poor. I think we should do it in a very different way.

*Mr. Levin. Mr. Kreisberg, talk a bit if you would about this notion giving people control over their health care.

*Mr. Kreisberg. Well, you know, as I indicated in my statement, the health care marketplace simply does not work the way other marketplaces work. When somebody has a disease, they are often in the hands of their trusted physician who will direct them to a lab for tests, direct them to a hospital for services.

What we have now, we group people, and we group them in insurance plans. We group them in self-insured plans offered by employers. And this grouping mechanism provides the ability to negotiate with the provider. At the time that I am diagnosed with cancer, I am not in a position to start shopping around and negotiating with various hospitals who may or may not even give me the time of day in those negotiations.

Those are the big ticket items in health care. We are not talking about a doctor's office visit when I have the flu. Those are not the issues that are driving our health care cost increases. So we have to start from the premise that consumers are not empowered in a health care marketplace and they will not be regardless of what we do.

I think Mr. Roy talked about the fact that there is a monopoly in some states among insurers. How would one individual be able to negotiate with a monopoly? How does that plan, if you will, deal with the issue of a monopolist?

We are better off with large employers and self-insuring to create some confidence.

*Chairman Brady. Thank you all. The time has expired.

Mr. Johnson, you are recognized.

*Mr. Johnson. Thank you, Mr. Chairman.

Mr. Antos, I have a few questions, but I would ask if you would just answer yes or no.

*Mr. Antos. Sure.

*Mr. Johnson. First, is it not true that about 155 million Americans receive health insurance through their employer?

*Mr. Antos. Yes.

*Mr. Johnson. Next, you stated that the average employer contribution to health care has grown faster than wages, but have health care costs not also grown faster than inflation?

*Mr. Antos. Yes, absolutely.

*Mr. Johnson. Now, you also testified that workers would likely prefer lower health care benefits in exchange for higher wages, but depending on how Congress caps the tax exclusion, could the employee not end up paying even higher taxes?

*Mr. Antos. It is possible. You know, the details do matter.

*Mr. Johnson. Lastly, your testimony cites a study showing that 30 cents per dollar is wasted, which includes increased spending from consolidation. Do you agree that Congress should also address these issues?

*Mr. Antos. I think the health system should address the waste in the health system. That is where the solution is going to be.

Congress can help by passing reasonable laws and HHS can help by interpreting them in an appropriate way through regulation, but ultimately it is up to the health system to solve these problems.

*Mr. Johnson. Well, you know, we always try to pass reasonable laws.

Your answers clearly show that Congress must be very careful though with any changes to employer-provided coverage. The bottom line is that employer health insurance has worked for over 60 years and provides affordable quality insurance to over half of all Americans.

We also cannot lose sight of the importance of promoting free market ideas to reduce cost and increase access, things like FSAs and HRAs and my bill to allow employers to band together to purchase insurance.

I also think this committee should take a serious look at repealing Obamacare's anticompetitive prohibition on physician-owned hospitals.

Mr. Chairman, I yield back.

*Chairman Brady. Thank you.

Dr. McDermott, you are recognized.

*Dr. McDermott. Thank you, Mr. Chairman.

If Tip O'Neill were here today, he would say, "Well, this is another smoke and mirrors hearing. You blow smoke up in the air, hold up a mirror, and let people see whatever you want."

It has been six years since we passed the Affordable Care Act. We hear rumblings from time to time that the Republicans are about to have a replacement plan, somehow achieving the goals of ACA by tearing it apart.

Now, the truth is we will never get a plan out of the Republicans any different than the ACA. In the six years there has not been a coherent plan in spite of all the attempts to repeal and everything else. They never put anything on the table in writing. It is all smoke and mirrors, folks.

There is good reason they do not have a plan. There is no place to go. The few ideas that have floated would create economic and personal chaos. Paul Krugman wrote a piece in the New York Times this week called "Obamacare Replacement Mirage," and I ask unanimous consent to have it included in the record.

*Chairman Brady. Without objection.

[The information follows: The Honorable Jim McDermott]

*Mr. McDermott. And it describes Speaker Ryan's problem precisely. It is that there is no place to go. If you want to cover all Americans and secure financial security and control costs, you have limited options.

One is a single payer system. I support that, but we do not have that. So I am supporting what we have and trying to fix it. That cuts the greed and the insurance industry waste out of the program, the single payer system.

The other alternative is to rely on the existing system, while eliminating abuses in the insurance industry, and that would mean community rating and guaranteeing coverage for consumers with preexisting conditions.

Because a system like that would require insurers to cover sicker populations you need a mechanism to balance the pool of people, and that is where the individual mandate comes in. You cannot have a pool of just sick people in the insurance plan and have the sick ones out here waiting for the day when they can run in and get their insurance. They all have to be in.

Now, if you have an individual mandate, you need to be able to afford the coverage. That is a common sense understanding. So you need to subsidize premiums and you need to reduce cost sharing for lower income people. That is also common sense.

In essence, it is the only reasonable alternative to a single payer system. It looks like the Affordable Care Act, and that is why the Republicans have nowhere to go. They will not fix it. We will not have hearings in this committee about consolidation in health care or on drug prices.

You bring up Switzerland. Switzerland has a highly regulated government system that is run by insurance companies. They negotiate the drug prices in Switzerland. We do not allow the government to negotiate the drug prices in this country because this committee will not have a hearing, will not have a hearing on what is going on with drug prices in this country.

Now, if you want to get rid of the individual mandate and keep in place the issue for people with preexisting conditions, you put the insurance industry into a death spiral. We did exactly that in an experiment in Washington State in the 1990s, and we lost the individual market because you cannot have guaranteed issue and not have some way to save the insurance companies.

Now, if you want to take away American subsidies, that will mean you are going to have financial hardship for everybody, and you will not be able to have insurance because most people cannot afford it without either employer help or government help.

That is what is going on right now in the ACA, and if you want to continue these hollow efforts to repeal the ACA, what you are saying is one of two things. Either you want to replace the ACA with a single payer system -- and I am for that. I will sign up today for that -- or, two, you do not want to provide health care coverage for the American people, for all the American people. You only want it for the financially able American people.

The health savings accounts are for rich people. Poor people do not have those things. They cannot use that because they cannot pay the deductibles.

So you cannot have it both ways, and unfortunately we are having another hearing for this smoke and mirrors business. We will not get it without having adjustments to the Affordable Care Act because that is the Republican program.

*Chairman Brady. We may need to call on Switzerland to mediate the differences between the committee on health care.

Mr. Tiberi, you are recognized.

*Mr. Tiberi. Thank you, Mr. Chairman.

You know, one of the things I love about this committee and my friends Mr. Levin and Mr. McDermott, and I do believe their hearts are in the right spot, but you never cease to remind me as to why I am a Republican, and I appreciate that a lot.

Because I do care about people. Everybody on this side of the aisle like your side of the aisle cares about people, but it is a challenge for me because Mr. Roy said he is for universal health care. I am for universal health care, and in fact, in my state -- it is probably different in Michigan -- we expanded Medicaid, but I run into people every day when I am back home, whether it is a hospital administrator, whether it is a physician, whether it is somebody on Medicaid or a family member of somebody on Medicaid, who cannot get access to a primary care doctor because the primary care doctor thinks that Medicaid is flawed.

I think that was your point. So, Mr. Levin, Mr. McDermott, to sit up here and say that just because Obamacare passed, everything is well and good and there are no challenges for people, not the rich by the way, is frustrating to me.

Because what Obamacare also did at least in my district, maybe not yours, is that people who were excited about it passing were excited also about the President saying if you like what you have, you can keep it, and I continue to run into people who have not gotten to keep what they had and are paying more and getting less, quite honestly.

I get frustrated up here when every time we have a hearing to try and improve the health care system for patients, for my mom and dad, and we have talked before. Mr. Thompson is looking at me, with respect to this silver bullet of negotiating prescription drugs and how great that is. Well, my dad experienced how great that is not and how wonderful Part D, quite frankly, has been.

I have an aunt who does not have to go to Canada anymore because of Medicare Part D.

So, Mr. Roy, this was supposed to be about the tax exclusion. I have a sister who many years ago had a little boy. He is now going to graduate from Ohio State, Go Bucks, in a couple of weeks, and when he was a little boy, they moved away to Cincinnati, and she came back over the Christmas holiday. He got sick. The former pediatrician gave him a drug to take. During the Christmas holiday she gave him this prescription. He got better, and before New Year's Day, she threw away the prescription.

And I said to her, "What are you doing? If he gets sick again, there is still medication left."

She said, "Do not be so cheap. It costs $3. I will get another prescription."

But the point is, just like what Mr. Brady talked about, she is excluded from the true cost of that drug. My mother-in-law had a stroke a year ago. My wife is a pretty smart person. She is an accountant. Everything was focused on where to go after the hospital for rehab on what insurance covered, not on quality, not on cost. We do not know to this day how much it cost.

Well, thank goodness we had good quality or she had good quality care, but the consumer, the patient because the system is not patient centered. Whether it is a Medicaid patient who cannot get in to see a primary care doc and ends up in the emergency room in Columbus, Ohio, or my mother-in-law who is going to a rehab facility, the patient is excluded from the cost of the care.

How do we get patient-centered care and patients focused on the cost so that there is not over utilization, so that there is more transparency, and all of us know that there is not just some tree in the backyard we are pulling money off of, and we do not have any competition?

*Mr. Roy. The only way to have patient-centered health care is for the patient to control the health care dollars. We do not have patient-centered health care today because employers and insurance companies and the government control the dollar, and that is why we have government centered health care, not patient-centered health care.

I want to bring up a point that was brought up earlier about Switzerland and how it allegedly has regulated prices. What it has is insurance companies that can jointly negotiate prices with hospitals and drug companies, and that is a system that I have written about with Forbes we could have here. All you have to do is have an antitrust exemption for those kinds of negotiations for private insurers in Switzerland or in the United States.

So there are market-based systems elsewhere that we can learn from, but you are never going to have a patient-centered health care system unless the patient is controlling the dollars.

*Mr. Tiberi. And you are for quality health care.

*Mr. Roy. Absolutely.

*Mr. Tiberi. Thank you.

*Mr. Roy. And, again, I have written about this extensively. I would encourage anyone who is interested in a detailed plan on health reform to download it from the Manhattan Institute or the American Enterprise Institute, for that matter.

*Mr. Tiberi. I yield back.

*Chairman Brady. Thank you.

Mr. Lewis, you are recognized.

*Mr. Lewis. Thank you very much, Mr. Chairman.

Thank each one of you for being here this morning.

I would just like to note whether you believe in health care as a right, as a right, in a country such as ours, health care for all. Do you subscribe to that idea?

*Mr. Roy. Is the question addressed to me, sir?

*Mr. Lewis. Any of you.

*Mr. Roy. First let me just say, Mr. Lewis, it is always a pleasure to speak with you. You are a personal hero of mine.

I support universal coverage. I think, like many of your colleagues, a country that is as wealthy as ours should strive to provide quality health coverage for every American.

But the way to do that is to maximize the degree to which individuals are controlling those health care dollars and subsidize through tax credits or refundable tax credits those choices for those who need the help.

*Mr. Kreisberg. Good morning, Mr. Lewis. Yes, our union definitely supports health care as a right. It is really a matter of --

*Mr. Lewis. A fundamental right?

*Mr. Kreisberg. A fundamental right to health care is something that we fully support.

*Mr. Antos. I agree with Mr. Roy. I would also make the distinction between health care and health insurance. Just because you have health insurance does not necessarily mean you are getting appropriate care.

So I think we need to work on both financing and delivery reform.

*Mr. Lewis. But if you accept the idea that it is a right, in a democratic society such as ours.

*Mr. Antos. Yes. I agree with Mr. Roy. I think I probably agree with everyone in the room that everyone should have health insurance, and those who need support to obtain that coverage should get it.

*Mr. Lewis. But do you see the Affordable Care Act as a down payment, as a major down payment for all citizens? It is not perfect.

*Mr. Antos. I am sorry. You referred to the Affordable Care Act?

*Mr. Lewis. Yes.

*Mr. Antos. Well, it is a down payment in a sense, but I would argue for fairly substantial reforms. Certainly the idea of --

*Mr. Lewis. Will you subscribe to the idea that it is a major down payment?

*Mr. Antos. So part of the down payment was to change, and I think it is a very important change, to change insurance rules so that if you have a preexisting condition, that cannot be held against you in terms of access to insurance or premiums. I think that is a good change. I do not see us ever moving back from that.

But as far as the way we are financing it, as far as the complicated way we are making people try to understand what options they have, as far as the restrictions on what insurance must cover, I think those are things that need to be dealt with.

*Mr. Lewis. What would you say to the average person who is receiving health care now that did not have it before? What would you say to them if you get rid of the Affordable Care Act?

*Mr. Antos. Well, I support reforming the law that exists today, and so I would argue that the appropriate reform would, in fact, give everyone access to insurance and give those who need help the most have support from the taxpayer, and that includes the people obviously, most of the people who are signing up on the exchanges.

Most of the people are signing up because they are getting substantial subsidies. The people who do not get substantial subsidies are not signing up, which is a major problem with risk selection in the exchanges.

*Mr. Lewis. Mr. Kreisberg, do you care to respond, sir?

*Mr. Kreisberg. Yes. The first thing I would say is I appreciate that everybody does join in the idea of universal coverage, and I would ask Manhattan Institute and AEI to join AFSCME in going to those other 20 states so we can adopt Medicaid expansion, so that we can really go a lot further in getting to universal coverage.

Because we have 20 states that do not buy into the idea that it is a fundamental human right, and it is a fundamental part of being American to have health care coverage. Because they have that opportunity at no cost to the state, and yet they refused to participate in the Medicaid expansion.

Now, with that said, I think the --

*Mr. Lewis. Is that true in many of the states where the Republicans are governors?

*Mr. Kreisberg. Well, you have these Republican governors, Republican legislatures. You know, I do not want to necessarily make it overly partisan, but it is a partisan issue, I suppose. It is ideological. It is ideological opposition to the idea that we are going to have a government program that addresses a real pressing problem that affects real people.

We know that a child will not reach his or her potential if they do not have health care.

*Chairman Brady. Thank you. All time has expired.

Mr. Smith, you are recognized.

*Mr. Smith of Nebraska. Thank you, Mr. Chairman.

And thank you to our witnesses.

I want to focus on consumerism and health care because I do not think the American people are offended that there is a suggestion that we should have health insurance. It is that the government is forcing people to have insurance coverage that many would find personally objectionable.

And I think it is a good idea to have health insurance. I look back at when I had my first real job out of college. I assumed that the group plan was the best for me. So I did not shop around. I would later learn that I could have saved a lot of money by shopping around, and so I was not the best of consumers then.

And I certainly see policies today that discourage consumerism and certainly discourage, well, prohibit people from exercising what I would call freedom to decide what is the best coverage that would be there for their families or themselves as individuals.

So what can we do to encourage more consumerism? And I do not want to take coverage away.

Another concern that I have, is push to expand Medicaid. All the while we know that it pulls people off of private pay in some cases, and Medicaid provides lower reimbursements to hospitals and doctors, and so it becomes this vicious cycle of who loses, consumers, patients, and drives up the debt and fewer choices are out there.

What can we do to encourage more consumerism? Mr. Roy.

*Mr. Roy. Yes. So, again, I would say that the biggest thing that you can do to encourage consumerism is to have the patient control the health care dollars. The reason why we do not have an Uber for health care or we do not have the kinds of technological innovations that have changed the rest of our economy. Why is that not happening in health care? It is because those things can only happen when the consumer can direct his or her dollars to the health care service that he or she needs.

When the government or the insurance company or large employers control those dollars, then the consumers are not involved in those decisions. So you have to have the patient in charge of the health care dollars and health tax reform, which this committee is considering, is the central key step to achieving that goal.

*Mr. Smith of Nebraska. Mr. Kreisberg, in your previous comments, you were talking about the overall health care issue. Is it possible that there would be a good health care plan that would not be drafted or controlled by the government?

*Mr. Kreisberg. Of course.

*Mr. Smith of Nebraska. What can we do to head in that direction?

*Mr. Kreisberg. Well, I am in a good health care plan that is not controlled by the government. It is in private insurance.

*Mr. Smith of Nebraska. Is it a plan that millions of Americans would not find personally objectionable?

*Mr. Kreisberg. I think the plan that I am in, most Americans would be satisfied with.

*Mr. Smith of Nebraska. Okay.

*Mr. Kreisberg. But I think to be more precise with my answer, Mr. Smith, we need minimum standards for plans just like we regulate who can call themselves a physician. We need people to have adequate coverage because what happens is if I am in inadequate coverage and I now have a dread disease and this plan does not cover me, in our system and in this country, I am not going to die on the streets, and that is a good

thing, but yet I have shirked my individual and personal responsibility to have adequate coverage, and now the rest of you are paying for my health care.

So that is why we have things like an individual mandate and minimum benefits, essential health benefits, so that we can ensure that our plans provide the services that will keep people healthy and treat them when they are sick and they are sufficient.

We cannot just let anything be sold and be told that it is health insurance because when consumers shop for these, they do not know all of the intricacies of that.

*Mr. Smith of Nebraska. But the government should tell people what health insurance is, that individuals themselves should not be able to decide for themselves?

*Mr. Kreisberg. I think they can decide for themselves, but I think we need minimum standards. It is just as we regulate many other things in our society. Individual consumers at a point of sale for health benefits have time and again in the individual market been caught by surprise. This is in the old days before the Affordable Care Act. They have been shocked that their plan did not cover certain services, and then they were sick and they were not covered.

*Chairman Brady. Would the gentleman yield?

*Mr. Kreisberg. Because of a lot of fine print.

*Chairman Brady. If I may, would the gentleman rest?

*Mr. Smith of Nebraska. Yes.

*Chairman Brady. You know, he has made a key point here. You know, if your employer said, "Here are the clothes you will wear in your personal life and here is the car you will drive in your personal life," most of us would say no, but today they say, "Here is the health care you will have in your personal life. Just take it or leave it."

And the point I think Mr. Smith was making was that why can we not give Americans more choice over maybe the most personal spending they will ever make in their lives, and I think that is his point.

With that, let me yield back, Mr. Smith, since I took the rest of your time.

*Mr. Smith of Nebraska. No, I think we want consumers with their providers to be driving the bus, not the heavy handed Federal Government.

Thank you.

*Chairman Brady. Thank you.

Mr. Neal, you are recognized.

*Mr. Neal. A quick comment on the chairman's analysis. I think what he is really saying is that under their plan you would have no car and no new clothes because when you consider that there were 30 million people --

*Chairman Brady. And no jobs under Obama.

*Mr. Neal. No 30 million people -- we are going to take that question up right now, Mr. Chairman -- there were 30 million people without health insurance, at least, and by all objective analysis 20 million people have secured health insurance under the Affordable Care Act.

Now, we all acknowledge that there has been a net gain of about 14 million private sector jobs over the post-recession period, and all of that net gain in employment has been in full-time work. Reform opponents have repeatedly suggested that the ACA is having an adverse effect on jobs. To date there is no evidence that the ACA has had a negative impact on economic growth or jobs, and in fact has moderated health care costs, which is generally accepted.

But, Mr. Kreisberg, based on your experience and analysis, would you address the point that I have just raised? And I am going to give you sufficient time to go through it from A to Z, please.

*Mr. Kreisberg. Sure. First of all, I agree with you. I do not think there is any evidence that the ACA has been, as it has been alleged to be a job killer. First of all, it is a very, very difficult thing to ascertain, cause and effect, and I think everybody will agree with that.

And with all due respect to the CBO, they have been wrong far more than they have been right about everything that they have estimated about the Affordable Care Act, and this is one of those things where they have estimated.

But if you read the CBO report carefully, what you will see is they are not saying that people are losing their jobs. They are saying people are withdrawing from the labor force. There is a reduction of labor supply, not a reduction in labor demand because of the Affordable Care Act, and that is a significant distinction.

What we are seeing is people as they are approaching age 65 but are not yet eligible for Medicare and do not feel that they can work any longer, now they have an option not to work.

We are also seeing on the margins, for instance, people in the Medicaid program maybe reducing hours, which is what CBO has said. We do not know if that is true or not. I think it is really hypothetical, and I think, again, it is very difficult for cause and

effect, and it is almost impossible to do the empirical analysis to validate some of the hypothesis that we have made.

But we do know that after the fact you can look back and we know they have been wrong time and again when it comes to the Affordable Care Act.

So I think when we look at labor market effects we really need to focus on the fact that the Affordable Care Act has probably changed more of the supply factors than the demand from employers. So it is not a job killer in that sense, and I do not necessarily think it is a bad thing if people withdraw from the labor market at the age of 62, 63 or 64.

If one of the problems we have in our society is stagnant wages, perhaps a reduction in supply of people who no longer feel they can work will help create a little bit higher wage growth in this country because you have less supply, and demand should be relatively static.

So I think, you know, this could be one of the things that actually help us as we move forward.

*Mr. Neal. Since we have a minute and 44 seconds, Mr. Kreisberg, we had a conversation earlier about the role that deductibles play, and I thought that your analysis of that was pretty interesting. Could you give us a quick analysis?

*Mr. Kreisberg. Yes. In our view, the high deductible health plans are really not where the action should be, and I think when we talk about how the consumers should control the dollars, we are really talking about more consumer payments, and I touched on this in my statement.

Very, very few people are responsible for most of our health care costs. Those people are profoundly sick. It is not necessarily the same people year after year, but it is episodes of care that drive our expenses.

The high deductible health care system does not get at that. In fact, what we are also seeing with high deductible health care is the trend in health care cost increases actually exceeds those of the other plan designs. So we are not seeing any long-term moderation, you know, from those high deductible health plans.

And ultimately the shifting of costs to consumers and putting, you know, consumers in control of the dollars, we do not see as very effective because the consumer has no ability, none, to negotiate with a hospital. They may be able to choose their provider and maybe some providers provide better rates than other providers, but the idea is that we have insurance companies and self-insured employers who do those negotiations for us, and they are in a much better position to negotiate with those providers because they represent hundreds of thousands or millions of covered lives as opposed to an individual consumer trying to do the negotiation.

So if we are going to drive down costs, we need to keep the groups together. We need large groups, large negotiating bodies, and most importantly, we need to change the incentives in our health care system. We need to align our financial incentives with quality and value.

*Mr. Neal. Thank you, Mr. Chairman.

*Chairman Brady. Thank you, Mr. Neal.

Mr. Reichert, you are recognized.

*Mr. Reichert. Thank you, Mr. Chairman.

I would like to echo the statements of the chairman and my colleagues about the value of employer-sponsored health insurance. The current exclusion is an important part of why so many of my constituents enjoy quality health coverage today. Employer-based coverage is not only popular, but businesses in my district absolutely need it.

We have heard today, however, there are some issues surrounding the exclusion. Obamacare took one approach to tackling this through the Cadillac tax, and unfortunately Obamacare got it wrong. It is crude; it is complex; and it's is wrong policy, and there is bipartisan support for its repeal.

So I would like to look further at some of the shortcomings of Obamacare's approach through the Cadillac tax. So, Mr. Antos and Mr. Roy, does the Cadillac tax currently adjust for health care costs that might be higher simply because they are delivered in a place with a high cost of living?

*Mr. Antos. No.

*Mr. Reichert. Same answer, I am assuming?

*Mr. Roy. No. Yes, actually it does. The Cadillac tax is designed to have a certain band in terms of its thresholds based on health costs in a particular area.

*Mr. Reichert. Okay. Well, I do not think it does either. I agree with Mr. Antos. I think Congress might better address though these geographic variations, and there is a variation in cost of living that should be, considered. The cost of health care varies throughout the country.

How might we address these geographic variations in future reforms, Mr. Antos?

*Mr. Antos. It is a difficult question. Obviously part of the solution is to reduce some of the unnecessary regulations that are keeping costs up. States are part of the problem, not part of the solution in many cases.

But beyond that we need to have the kind of coverage that promotes a closer relationship between the consumer and the insurance company. I agree that the consumer is not going to negotiate individual prices with the hospital. That is the job of the insurance company.

But right now the insurance company really does not see the driver of this as their consumers. They are being driven by government regulation and the relationship to employers. So we need to turn that around so the consumers are more in charge in that practical sense.

*Mr. Reichert. Another major concern is that employee contributions to their health care through an HSA are counted toward the cost of care that is measured against the Cadillac tax threshold. Likewise, spending on wellness is also counted.

Can you tell me why? Mr. Roy.

*Mr. Roy. Yes. This is one of the major design flaws of the Cadillac tax, is that it is designed effectively to prevent people from having more consumer-based health insurance plans. HSAs are inhibited by the Cadillac tax. As you noted, wellness programs are somewhat inhibited, and also there are a number of loopholes and exceptions in the way the Cadillac tax applies to different constituencies, different employer groups and different areas of the country.

So it would be much cleaner to have a gradually introduce cap on the employer tax exclusion as some others and we have discussed today so that it is a simple system that applies fairly to everyone.

The challenge is if you heavily vary the tax deduction or the tax exclusion based on particular regions of the country, you might actually have the perverse consequence of rewarding high regulation states that drive up the cost of insurance in their state because they do not face the tax consequences.

*Mr. Reichert. Do you have any idea why it was designed this way?

*Mr. Roy. I was not in the room when the Affordable Care Act was designed, but I understand that various interest groups lobbied for exceptions and changes to the Cadillac tax so that it could serve their interests better.

*Mr. Reichert. Mr. Antos?

*Mr. Antos. So one other aspect of this, I think that the philosophy was that we did not want to have any leakages. So we are going to include these other health related benefits in to count the cost. It was basically trying to keep everything, you know, in the same corral and not have leakages that would have employers, for example, subsidizing health savings accounts more fully.

*Mr. Reichert. Thank you.

I yield back.

*Chairman Brady. Thank you.

Mr. Becerra, you are recognized.

*Mr. Becerra. Thank you, Mr. Chairman.

Gentlemen, thank you for your testimony.

Let me see if I can run through a few areas, and first, Mr. Antos, to you and Mr. Roy. I understand you all have put together the elements of a plan that could be an alternative to the Affordable Care Act. Have you asked that that be placed in legislative writing so we could actually see it as a form of a bill?

*Mr. Roy. There are two plans. There is a plan that Mr. Antos and I collaborated on with some other colleagues that was published by the American Enterprise Institute. I think there were ten coauthors, if that is the plan that you are referring to.

Then there is the one that I published through the Manhattan Institute individually. Neither of those plans has been introduced as legislation or put in legislative language, but our hope is that that may happen at some point.

*Mr. Becerra. Do you have any supporters on the Hill, on the House or Senate side, for either of those two plans?

*Mr. Roy. I think that a lot of the general concepts are being considered in a lot of the working groups that the speaker has organized.

*Mr. Becerra. So we are six years past the enactment of the Affordable Care Act. We were told by those who objected to the Affordable Care Act, didn't vote for the Affordable Care Act, that we need to repeal it, get rid of it, and replace it.

We have yet to see a proposal in legislative language that has been able to garner any kind of support that could pass to replace the repeal of the Affordable Care Act, and I am wondering: can you name any member of Congress who is ready to endorse by submitting your plan into legislation?

*Mr. Roy. What I would say is --

*Mr. Becerra. No, no. Can you name me a member in the Senate or the House who is prepared to endorse --

*Mr. Price. I will volunteer.

*Mr. Becerra. I'm sorry?

*Mr. Price. I will volunteer.

*Mr. Becerra. Okay. So Mr. Price is willing to introduce your plan. So you have got a taker. Will you submit it to Congressman Price so he could submit that into legislative writing?

*Mr. Roy. More than happy to work with Mr. Price.

*Mr. Becerra. So this way we can actually have something to compare because we will need to have the Congressional Budget Office, Joint Tax Committee, everyone do the analysis so we can see what we are talking about. Because until then we are talking apples to oranges. We want to see what your apple looks like. We see what the Affordable Care looks like.

Twenty million Americans today as a result of the Affordable Care Act have health access, health insurance, and I think for those who kept saying that it was going to cost us jobs, in the time that the Affordable Care Act has been in place as a law, we have had close to 1.7 million Americans go to work or go back to work not overall, just in the health care sector. Overall some 14 million Americans have gone back to work.

So it is going to be interesting to see what your plan, once it is scored, out really shows us.

*Mr. Rangel. Will the gentleman yield?

*Mr. Becerra. Certainly, I will yield.

*Mr. Rangel. Dr. Price, I would like to join with you in cosponsoring this fictitious plan that has been out there for six years, and if they can really help the Republicans come up with something, Mr. Roy would you contact my office and Dr. Price's office so that we will get some legislative language to know exactly what you are talking about?

*Mr. Becerra. I am going to reclaim my time. Mr. Roy, you can talk to Mr. Rangel afterwards. I want to reclaim my time so I can ask a couple more questions.

Mr. Antos, Mr. Roy, so I have seen some elements of your plan. High deductible with HSAs, you are trying to make them a little bit more robust. Those are parts of what the plans typically include?

I am not trying to name everything.

*Mr. Roy. You can choose a plan. So the key element is --

*Mr. Becerra. I do not want to get into all of it, but I just want to make sure. It does rely to some degree on high deductible plans?

*Mr. Roy. No, that is not correct.

*Mr. Antos. No.

*Mr. Becerra. Okay. I apologize. Do you support high deductible plans?

*Mr. Antos. As a choice, yes.

*Mr. Becerra. As a choice, okay. And let me ask this. Would you support high deductible plans with access to an HSA, health savings account -- because that typically is the way that they are packaged, right, so you can make the most use of them? -- for seniors under Medicare?

*Mr. Antos. Yes, I think that is a feasible possibility, too.

*Mr. Becerra. Mr. Roy?

*Mr. Roy. Yes.

*Mr. Becerra. Okay. Final question. I think Mr. Kreisberg answered the question about whether you believe health care is a right in this country for Americans. I do not think I heard you say yes or no. If it is not a right, then obviously it is a privilege that we can try to get access to.

Do you believe it is a right?

*Mr. Roy. Let me tell you a story.

*Mr. Becerra. Oh, no, no, no. I do not have time. I have a lot of questions.

*Mr. Roy. Because health care --

*Mr. Becerra. I do not have time for a story.

*Mr. Roy. You have to understand what health care is.

*Mr. Becerra. Mr. Roy, Mr. Roy.

*Mr. Roy. You have to understand what a right is.

*Mr. Becerra. If you do not wish to answer the question that is fine, but I just asked the question. Yes or no?

*Mr. Roy. I refer you to an article I wrote for Forbes called "Yes, Health Care Is an Individual Right."

*Mr. Becerra. Mr. Anthos? Yes or no?

*Chairman Brady. All time has expired.

*Mr. Becerra. Mr. Chairman, if I could just ask him to answer the question.

*Chairman Brady. Mr. Boustany, you are recognized.

*Mr. Boustany. Thank you, Mr. Chairman.

Mr. Chairman, I believe I have the time now.

*Mr. Becerra. Mr. Chairman, could I get just five seconds so that the gentleman could answer?

*Mr. Boustany. Mr. Chairman, I believe I have the time.

*Chairman Brady. I will tell you what. Another member can ask that question or perhaps you could submit the answer in writing.

Dr. Boustany.

*Mr. Boustany. Mr. Chairman, prior to coming to Congress I was a cardiothoracic surgeon, had extensive clinical experience over many, many years, and really got to know our health care system with all of its warts and good things about it at a very intimate level, and now I have had the benefit of serving on this committee and understanding all of the policy ramifications and how we deal with the problems inherent in the system.

And I could certainly talk for hours about this, but I do want to dovetail off of what my friend from California just talked about when he asked a very, I think, artificial question about creating a dichotomy: is it a right or is it a privilege with regard to health care?

Actually it is neither. It is a personal responsibility. Nobody can be responsible for my health other than me because there are different dimensions to health care. Yes, you need all of the care. You need the coverage, but what is missing right now in our health care system today is the fact that individual responsibility and education and information is missing, and that is one of the reasons we do not have a good functioning market in health care.

That is one of the reasons I like HSAs and other patient driven forms of coverage that lead to an informed consumer of health products that gets to where we need to be.

And I was very pleased I heard the testimony before I had to step out for just a moment, and, Mr. Roy, you talked about equalizing the treatment, and that is what has been missing in all of this, is equalizing treatment and letting people decide what is best for them.

You cannot get to high quality, low cost health care without a robust doctor-patient relationship. I can tell you from personal experience, clinical experience expanding over many years in my life both here and in clinical practice we have got to inject personal responsibility into this. Otherwise we cannot save on the front end.

I mean, some of the issues with Medicaid, again, it does not lead to a meaningful doctor-patient relationship. The access is very severely inhibited.

So let us explore this concept a little bit about the injection of personal responsibility. Mr. Roy.

*Mr. Roy. Health care is a right, and what I mean by that is that it is the right of individuals in this country to choose the health care that they want, to choose the health coverage they want, to choose the doctor they want, the nurse they want, the form of urgent care that they need.

Those rights have been abridged by Congress over an 80-year period, and if we believe that health care is a right, then we have to maximize the ability of people to control their own health care dollars, not the government, not insurance companies, not employers.

*Mr. Boustany. Thank you.

Mr. Antos, do you want to comment?

*Mr. Antos. I completely agree with Mr. Roy. The distinction between personal choice and personal responsibility is often overlooked. You need both.

*Mr. Boustany. Thank you.

Mr. Kreisberg, do you want to comment?

*Mr. Kreisberg. Yes. You know, I agree in some respects, but I think where we part ways is this idea of personal responsibility because we also --

*Mr. Boustany. But is not that the American way of doing things?

*Mr. Kreisberg. Well, let me finish please.

-- because we agree with personal responsibility, and I think the approach that my colleagues here take discards personal responsibility because personal responsibility

connotes adequacy of coverage. So the government mandates that we sometimes criticize and rebel against are really just providing a basic standard because if I have inadequate coverage because health care is a right, I am still going to get treated. We have a law. EMTALA will take care of me.

*Mr. Boustany. But it is not the most efficient, high quality way, and the problem that you are overlooking in all of this, coverage does not necessarily equate to high quality care, and that is a fundamental problem in our health care system today because whether it is the Medicaid or Medicare system increasingly those individuals do not have access to a high quality doctor-patient relationship. It is in the emergency room. It is treatment after the fact, much later in the disease process.

I can tell you from years of clinical experience you have got to establish a high quality doctor-patient relationship on the front end. Coverage is important, but there are two sides to that equation. There is what the doctor does and recommends, but there is also the personal responsibility element and informational element for the patient.

And you can have the very best surgeon or physician caring for a patient, but if there is no element of personal responsibility or even diminishment in that level of personal responsibility, you are not going to get a good outcome. So you have to empower individuals, and that fits into our American system of economics, economic freedom, individual liberty, and informed consumers.

That is what is missing in our system.

I yield back.

*Chairman Brady. Thank you.

Mr. Doggett, you are recognized.

*Mr. Doggett. Thank you very much, Mr. Chairman and to each of our witnesses.

Mr. Kreisberg, I believe that you are the first witness to appear in front of our committee in some time to raise the issue of exorbitant pharmaceutical prices. It has been a concern of mine. I think it is appropriate to raise this morning because high pharmaceutical prices are taxing to the American people. In fact, I think they are overtaxing.

Mr. Chairman, I would respectfully ask that we make part of the record a letter sent to you back on November 5th requesting a full committee hearing on prescription drug pricing from ten members of our committee.

*Chairman Brady. Without objection.

[The information follows: The Honorable Lloyd Doggett]

*Mr. Doggett. Mr. Chairman, that letter emphasized the dramatic impact that high prescription drug prices are having on so many American families and the tremendous financial hardship to not only get a diagnosis of cancer or some other dread disease, but to face a prognosis of personal financial ruin for many drug treatment programs that are exceeding $100,000 a year.

It also pointed to the big impact on taxpayers of the increased cost of public health programs in Medicare, in Medicaid, in other programs because of rising prescription drug prices, and while much of the attention back at the time the letter was written centered on an increase on one particular generic drug from $13.50 to $750 overnight, this is not about one pharmaceutical or one type of pharmaceutical.

As you point out, Mr. Kreisberg, in your testimony, this is not just about brand name pharmaceuticals or generics. It is a systemic problem of which there are many aspects, and you pointed to some of the solutions that might be raised.

I would just like to see our committee and this Congress recognize that there is a serious pharmaceutical price problem and begin to look for some answers rather than simply to ignore the problem.

You made reference, Mr. Kreisberg, in your testimony to the work that the AARP, the American Association for Retired People, has done on this. In February of this year, since the November letter that we sent requesting that this committee focus its attention on this matter, AARP put out a report that noted the average cost of a year's supply of a prescription drug has doubled in just the last seven years. It talked about the incredible set of price hikes that have been occurring and referred to a Kaiser Family Foundation study that said that almost half of sick Americans, of people that were not in good health, said they were having serious trouble in paying for their medications.

We see year after year prescription drug prices soaring far in excess of the level of inflation. Among the suggestions that you have made, Mr. Kreisberg, is that we recognize that there is not true competition, that the marketplace does not work for some brand name pharmaceuticals.

I believe there is already a remedy under existing law through a law that was written by Senator Bayh and Senator Bob Dole that would give, when taxpayers have funded the research, would give the National Institutes of Health an opportunity to say if the price has gotten so exorbitant, then we are going to let competition try to bring it down by licensing to competitors.

Do you believe that when taxpayers pay for the research that leads to a new pharmaceutical that we have a stake in the price that consumers will ultimately be charged for that pharmaceutical and that the administration should be asserting its rights?

*Mr. Kreisberg. Yes, sir. I absolutely do believe that if the taxpayers have funded the development of a prescription drug, there certainly should be a fair return to the

taxpayer. I think we have to recognize for those of us who believe in a free market system that one of the biggest interventions and impediments is intellectual property rights. So if we withdrew intellectual property rights, I mean, that interferes with the free market.

Now, no one is advocating that completely because we do need to fund research and development costs, but in the case you are talking about, if the NIH or some other government agency has funded that research and development, certainly the benefits of that should flow to the American people who paid for the research associated with the brand name drug.

*Mr. Doggett. Thank you.

Thank you, Mr. Chairman.

*Chairman Brady. Thank you, Mr. Doggett.

Mr. Roskam, you are recognized.

*Mr. Roskam. Thank you, Chairman Brady, for initiating this hearing.

You know, it is interesting to listen to the back-and-forth a little bit, and let me put this into a little bit of a context. In his opening statement the ranking member talked about a constituent where she said the Affordable Care Act saved her life.

I have a constituent who had a different experience, and her experience was she relied on the President's promises that if you like your doctor you get to keep your doctor; if you like your coverage, you get to keep your coverage, and her experience was as a nine-year breast cancer survivor she found herself very happy with her health care and completely turned around as a result of the Affordable Care Act.

So we can go back anecdote for anecdote, but I think there is a restlessness that is out there, and it was interesting to listen to you, Mr. Kreisberg, about some of the things that you were pointing out accurately. We have got problems as it relates to primary care.

I do not know if you said this, but I am thinking this. We have got problems as it relates to increased coverage for people, and yet those were all promises that the Affordable Care Act were going to remedy. Remember it was, hey, there is going to be all of this primary care coverage. ERs, you are not going to have to see people, and yet none of that has turned out to be true.

So it was oversold. It has underperformed, and it has created a national restlessness. I would argue a restlessness that cost the majority for the Democratic Party, God bless them, the House of Representatives and it cost them the United States Senate.

And what was interesting about the reconciliation bill a couple of months ago was it was the first time that it became clear to the American public that there is only one office that stands between them and the repeal of Obamacare, and that is the White House. That is really interesting, and it is a long-term trend, and it is a restlessness that the country is articulating.

Now, Mr. Becerra makes a fair point, and his point is that we know you do not like the bill. You have been very clear that you do not like the Act. Where is your replacement? And that is a fair criticism, and it is a fair admonition, and I accept that.

So I think what the chairman is trying to do, and I know what Speaker Ryan is trying to do is to do the prelude work because it has been very clear that the President will not sign something that is orthodoxy for him. So rather than bumping our heads up against the wall, let us instead try and do the robust work now.

It also seems to me that sitting back and listening to the totality of the debate is there is nobody that is really defending how we got here with this large employer-based system, and there is a general recognition that there are two things that are really wrong with our health care system. One is it is too expensive and it is irrationally expensive, and many of the cost drivers are not making anybody healthier.

And the second thing is we as a country are essentially now scandalized by the notion that people with a preexisting condition would not have access to coverage. That bothers just about everybody.

And I think the weakness of the Affordable Care Act was rather than focusing on those two core themes and really attacking those around which there was largely a national consensus, the decision was made, and it is the President's prerogative sine he is the President, to go a different direction.

But I think in our democracy, and I have used this phrase now a couple of times, this restlessness, this level of anxiety; so I am heartened by the notion that today we are talking about how it is going back to wage and price controls after 1945. That is an interesting thing because you can contrast it with other insurance markets, and all three of you agree that we do not have a health care market like we have other markets.

Other insurance markets are completely rational. Why? Because if you have auto coverage, you can change. You can move. It is flexible and so forth, and yet the brokenness that came in as a result of the wage and price controls created a distortion.

So I am listening this morning. I am learning from all three of you in terms of your perspective, and I think that there is something significant that is going to be happening in health care because the country is demanding it. The country with Obamacare has oversold and it has grossly under delivered, and God bless my friends on the other side of the aisle who find themselves in the awkward position of having to defend every bit of it

as orthodoxy when I think if you scratch underneath the surface, they would say, yes, it really does need to be improved.

And there is nobody that wants to go back. That is also a strawman argument. Like let us go back to the old days. There is nobody that wants to do that.

And so I think what the chairman now is trying to do is say let us move forward. Let us have a discussion about it, but I appreciate the historical context in which you are putting all of this.

I yield back.

*Chairman Brady. Thank you.

Mr. Thompson, you are recognized.

*Mr. Thompson. Thank you, Mr. Chairman.

I want to thank all of the witnesses for being here.

A couple of things that were mentioned early on I just want to address right up front, and there was some talk about the government controlled, socialized health care and Obamacare, and it was kind of grouped somewhat together.

I am one of those people who has received my health care from both the government-controlled, socialized health care, and that was when I was in the Army, and now I get my health care, as all members of Congress do, from Obamacare. So I have got a little bit of experience from both.

And I can tell you that I used my government-controlled, socialized health care. I was wounded in Vietnam and spent a lot of time in about five or six different Army hospitals, and as you point out, I did not have a lot of choices with my health care. You show up and you get what they give you, but I got good health care.

But the idea that Obamacare is somehow the same and it truncates your choices I think is a real stretch. We all have choices. We all get our health care through Obamacare, and we have choices in the private sector as to what health care we purchase.

And I would like to ask unanimous consent to have this list put into the record. It is a list of 54 choices that those of us who buy our health care through Obamacare have when we sit down to decide which one it is we are going to purchase, and I think it is important to note that, that we do have those choices, and in this case for those of us on the dais, it is 54, 54 different private sector plans from which to choose.

Mr. Chairman, I would like unanimous consent to have this submitted into the record.

*Chairman Brady. Without objection.

[The information follows: The Honorable Mike Thompson]

*Mr. Thompson. Thank you very much.

I also want to just point out, and it has been said a couple of times, that 20 million more people have health care today because of the Affordable Care Act or Obamacare, and I do not think that can be overlooked.

We know also that because Health and Human Services just let this information out that Medicare saved $473 billion between 2009 and 2014 because of the lower growth rate in health care, and that is significant for all taxpayers and all Americans.

Someone brought up the Tip O'Neill. The other thing that Tip O'Neill said is all politics are local, and in my home state, the local part, the premium growth rate slowed from 2011 when it was at nine percent to four percent last year. That is significant. That means something to people.

And in my district, the uninsured rate went from 15.9 percent in 2012 to 9.8 percent in 2014. That is about 50,000 people in my congressional district who because of Obamacare have access to health care coverage today. They did not have it before. It is good for them, and it is good for taxpayers who were subsidizing any health problems that they had prior to that happening.

And so I think those are all good things. The other thing that I want to mention, as one of the folks on the other side talked about, now they want to do the work. It has been pointed out a number of times we have been doing this for six years, and the only work that has been done by my friends on the other side is to repeal the health care access that people did not have before.

And to say we want to do the work now, it is about six years too late, but I do not think anyone on our side has said that we think it is perfect. We have all recognized there are problems. We have all recognized that we are willing to work to try and fix some of those problems.

We could fix the family glitch. We could work on the advanced premium tax credits so people who live in high income areas are able to get health care similar to those who do not live in as wealthy areas.

Mr. Boustany and I have legislation regarding the health reimbursement accounts. They work. We should not penalize people for using those. What we all want to do is make sure people have health care, and just because one particular access point is not within the law, we should not ignore that. We should figure out how to bring it in the law.

So I would hope that my friends on the other side of the aisle are honest in what they are saying, that this is a means by which we can figure out some of these problems and work it out. We are ready to work together. Let us fix this thing. Let us improve it. Let us find out where the glitches are and close those up.

*Chairman Brady. The gentleman's time has expired.

*Mr. Thompson. Let us stop this nonsense.

*Chairman Brady. Thank you.

Ms. Jenkins, you are recognized.

*Ms. Jenkins. Thank you, Mr. Chairman.

And I thank the panel for being with us today.

One particular issue that I have discussed here in committee before and I would like to bring up in the context of this hearing is that of consumer directed accounts, such as health savings accounts and flexible savings accounts. These types of structures allow individuals to make their health care choices while incentivizing them to be financially prudent with those decisions.

And in Kansas, along with the whole U.S., these accounts are increasing in number every year. For example, in 2010, there were about 82,000 HSAs in Kansas, and in 2015 there were over 134,000 accounts, an increase of over 60 percent.

Mr. Antos, are you familiar with the President's health care law and what they did to HSAs and could you just summarize for us quickly?

*Mr. Antos. Well, the ACA severely cut back the allowed contributions that can be made and made other limitations, and obviously, the Cadillac tax further penalizes these.

As the health benefits consulting industry knows, the easiest thing to lop off if you are faced with that is an HSA.

*Ms. Jenkins. Yes, and did it not require that you have to have a prescription now if you want, an over-the-counter prescription to use one of those accounts?

*Mr. Antos. Yes.

*Ms. Jenkins. Limiting these types of structures or accounts, as Obamacare does, does not help keep health care costs down. If more Americans were empowered to manage their own health care decisions and had more skin in the game, when it came to their health care cost decisions, then what would you predict the impact to be on our health care spending, Mr. Roy?

*Mr. Antos. So -- oh, I am sorry.

*Ms. Jenkins. Mr. Antos, go ahead.

*Mr. Antos. Just quickly, that the added complications will only make it more difficult for consumers to operate in the way that we would like them to do, which is efficiently.

*Mr. Roy. It would reduce costs and increase choice and increase quality and increase patient service, customer service. Customer service is lacking so much in our health care sector because the patients do not control the dollars. The government, the insurance companies, and the employer do. So everyone orients and caters to them, not to the patient.

*Ms. Jenkins. Thank you.

*Mr. Roy. So one thing that is important I want to mention because it has been raised a number of times by one of my colleagues here is this idea that consumers are incapable of making health care choices, that if you are unconscious because you have had a stroke, well, you cannot choose your hospital.

That is true. That is the proper role of health insurers, to negotiate those prices and those networks on your behalf. But there is an enormous ecosystem of health care choices that we can make on our own, the choice to which eye doctor you go to or who you get your primary care from, whether to get knee surgery in your state or a neighboring state from a low priced center or higher quality center.

There is an enormous range of choices that can be opened up to patients to make for themselves, and there can be no doubt that they will make those choices better than the government or their employer.

There was a study done last year that showed there is enormous price variation for common procedures that all of us often use, but we have no transparency into how much those procedures cost because none of us are in control of our own health care dollars.

So the more patients are in control of their own health care dollars, those prices will come down massively because providers will have to compete for patients' business instead of the other way around.

*Ms. Jenkins. Great point. One particular limit in Obamacare that obviously has me concerned is the over-the-counter drugs. They were designated as qualified medical expenses by the IRS in 2002, yet Section 9003 of the Affordable Care Act mandated holders of tax preferred accounts, like FSAs and HSAs, seek a doctor's prescription in order to be reimbursed for purchases of these OTCs.

How does requiring a script for products the FDA, has already determined safe and effective for over-the-counter use and the IRS has determined to play a key role in health care delivery, improve customer choice and access to health care?

*Mr. Roy. This is one of the least rational provisions of the ACA. It forces you to go to a doctor to obtain a medication that is available over the counter. That is the kind of thing that drives up health care cost, and it was solely done as a revenue raising measure to pay for the ACA's coverage expansion.

That would be a great example of something that this committee could do something to reform.

*Ms. Jenkins. Great. Thank you.

I yield back.

*Chairman Brady. Thank you.

Mr. Larson, you are recognized, and after your questioning, we will go two to one to balance it out.

*Mr. Larson. Thank you, Mr. Chairman.

And I want to thank our witnesses here today as well. As always these are great discussions.

Reuters noted almost six years ago and several other institutions follow that there is, on average, somewhere between 700 to $800 billion annually in waste, abuse, fraud, and a system as it currently existed that is not capable of lowering cost.

Today's discussion seems to have been a little bit all over the place, but nonetheless, as a number of my colleagues have pointed out, I hope as a committee we can get beyond this notion of for the 63rd time we are going to repeal the Affordable Care Act. It has been six years, and the Act is not going to be repealed, and as many on our side have said, it needs to be improved. There are many on our side that would have preferred a single payer act that as, Mike Thompson pointed out, in the military he got pretty good service with that and very efficient service, I might add, as well.

But because of the advance of technology and science and innovation and all the things that entrepreneurialism can bring, you would think that we would even be able to do better because we are Americans. And yet what happens is rather than us sitting down collectively and coming up with a program and a system that is better, for six years we have heard, "We are going to repeal it," instead of, "okay, you guys. We are going to sit down with you and that plan that Mitt Romney submitted in Massachusetts that you then submitted that we called Obamacare, we are going to work together to make sure that we produce the most efficient outcomes on behalf of patients and people."

Those people cannot have individual responsibility if they are sunk at the bottom and have no means or capability or accessibility to do so. But collectively, just like we did when David Camp said, "Let us get together and work. Let us go into the subcommittees that require us to examine what aspects of health care we can do to help the patient out."

I note that companies like the Aetna, Mark Bartolini may be one of the most progressive and interesting entrepreneurs in the country talking about patient-centric care and making sure they meet the patient at the household and making sure they are doing everything for the patient there to avoid stays in the hospital that cost money; to care for the patient at that level and to do so that will combine both the best that all public health has to offer, meaning governmental public health and common sense solutions along with entrepreneurial, science and technology.

I hope, Mr. Chairman that that is ultimately what we can get to. This is nonsense. This is why the public hates us. We are having a light beer discussion here: tastes great, less filling. Repeal Obamacare.

No, Obamacare has done a lot for people. The public says, "A pox on all your houses. Fix the problem for us."

Today, frankly, you have a solution. I was happy to see Mr. Becerra say it and see Mr. Price join, that the bill will be submitted. The people will be able to look at it. At least that is a start.

This nonsense, this ongoing thing that we are going to repeal Obamacare for the 63rd time drives people crazy. They are concerned about their health and their well-being and want to make sure that it is there for them, and frankly, Mr. Chairman, I hope we can quickly get to a position where the capable people on this committee can sit down with one another and come up with solutions.

Do you want to know why the general public is so upset with us? It is because we do not do a thing. Six years, you do not like Obamacare? Fine. What is the solution? The solution resides within this room and with the American people. Let us sit down and get it done instead of this light beer commercial that we are having.

*Chairman Brady. Thank you.

Mr. Paulsen, you are recognized.

*Mr. Paulsen. Thank you, Mr. Chairman.

And I also want to thank our witnesses for being here this morning.

I actually want to just focus some of my time on some of the reforms that are needed particularly on the patient-centered ideas. We heard some other comments already about lowering costs, and I want to address some inaccuracies that were mentioned by some of

my colleagues, Mr. Levin and Mr. McDermott, regarding health care savings accounts and that only wealthy people use these accounts.

It is important to note that according to IRS data, the IRS, only 20 percent of HSA account holders have family incomes below $50,000. So these are, you know, below $50,000 incomes, and 83 percent of HSA account holders live in neighborhoods with median incomes below $75,000, 83 percent of those account holders, and only two percent of account holders actually even spend or contribute up to the amount of the maximum amount you can contribute to an HSA, which is like 6,550 bucks for a family.

Clearly, if wealthy people are taking advantage of it, are using it, why would they not contribute up to the maximum amount if it was some tax shelter.

And finally, just to mention, 24 percent of Americans, that is like a quarter of the population across the country, have an HSA or an HRA eligible insurance plan that they can participate in, which is actually a really, really big number.

I personally think we need to go more in that direction because people appreciate the choice, the flexibility when it comes to making sure that they can use health care for themselves or for their families. From a consumer perspective, they want to be able to shop around for the best quality care at the lower cost just like they can shop for anything else.

And it is probably one of the reasons why there is such a high percentage of Americans now, 20 million, that are using HSAs actively. In Minnesota, you know, we have a population just over five million people, but 800,000 people have opted now for some health savings account eligible health plan, which is a big number.

And I just really believe, and I think we are hearing some more conversation in some of your testimony today as well, that these HSAs should be a central component of health care; that these accounts give more people more choice on how to use their health care dollars, control over the care that they receive, and ultimately they are going to be smarter consumers.

And I will just say also I have introduced legislation, the Health Savings Act, with Senator Hatch in the Senate that will expand the use of these HSAs and make sure that people are able to lower their costs. The bill would allow more people to access these accounts, including seniors who are on Medicare, active military personnel and active military members, Native Americans who are enrolled in Indian Health Services, and members of health care sharing ministries.

And I will just say off the bat after I introduced the bill, positive comments are coming in from some of my constituents. I hear from Aaron who said, "This is a great idea. I love my HSA as it makes me into a health care consumer."

Robert put out, I think, on Facebook saying, "Thanks for taking this common sense step to help defray our health care expenses."

And then finally Ed responded in saying, "Why are these not available for seniors already?"

So I think this is moving in a positive direction, and also with the bill will make sure that we are going to be expanding what the accounts can be used for, as Ms. Jenkins had mentioned, for instance, but we will be able to include preventative care prescription drugs. Health insurance premiums will be included, over-the-counter medications without that doctor's prescription, physical fitness programs, wellness, nutritional supplements, and membership fees for innovative direct primary care models.

So clearly these accounts can be a key solution for everyone who is dealing with higher health care costs. You know, Mr. Roy and Mr. Antos, I know you have written a little bit about this as well. You have talked about it. Anything else you want to share about the importance of these accounts and how we should make this a highlight of the reforms where we are trying to go?

*Mr. Roy. You have made a lot of great points, Mr. Paulsen. One I would emphasize in what you alluded to is that health savings accounts have the potential to transform health coverage for the poor. Imagine if we took the cost sharing subsidies that are on the ACA and converted those into health savings account deposits. That means if you are sick, you can use that HSA deposit to pay off your deductible, but if you are healthy and you stay out of the hospital, that HSA can accumulate and roll over and generate compound interest, and over time that person who today is low income with negative net worth can actually have a positive net worth, pass that nest egg off to their children, and you actually can transform the entire economic trajectory of that family and future generations of that family.

So that is the power of health savings accounts. They can do more for poor people than any other approach to health reform.

*Mr. Paulsen. Mr. Antos, anything else to add in the final seconds?

*Mr. Antos. Well, we have a long way to go.

*Mr. Paulsen. Right.

*Mr. Antos. But beyond that, yes, absolutely. A properly funded system that includes HSAs with smarter regulation so that people can actually buy the kind of coverage that they need will take us a long way.

*Mr. Paulsen. Thank you.

*Chairman Brady. Thank you.

Mrs. Black, you are recognized.

*Mrs. Black. Thank you, Mr. Chairman.

And I thank all of the panelists for being here today. This is a very important topic obviously, and I think my colleague from Illinois used a great word, "restlessness," that we feel restlessness by the people and especially the people in my district as I hear from them about health care and about the uncertainty and all of the things that go along with it.

So I as a health care practitioner for over 45 years being a nurse and having seen that pendulum go from here to here and now back maybe toward the middle, I just wrote down four things that I think are the key pieces of this.

One is choice. One is access. One is portability, and the other is affordability. So I want to go through each one of those just very briefly and talk about choice, which has certainly been a topic here within the panel today.

And one of the things I can tell you is that the Affordable Care Act has not helped with choice in my district. It has limited the number of insurance companies that actually participate in the Affordable Care Act. So I have constituents who tell me, "I really like my doctor. I cannot go to my doctor anymore. I cannot go to my physical therapist. I cannot go to this, that or another." So choice has really been limited, although it has been lifted up as, you know, like the panacea that has solved everything.

The affordability piece on that is folks will tell me, "Yes, I have a subsidy that helps me pay my premium, but do you know what? I cannot afford my deductible. I cannot afford my copay." So do they really have insurance? No, they do not.

I also know that it has driven the cost up in the private sector. People are telling me now every day, and I am not exaggerating when I tell you every day in my office we get a call or an email about how their insurance has been affected by what has happened most recently with the Affordable Care Act.

So the portability piece and the access.

So let me go to my question before I run out of time. Mr. Roy, I want you to answer this for me. What happens if a person currently with employer-sponsored insurance loses their job? Can they keep their plan?

*Mr. Roy. Well, they can have COBRA for 18 months, but it is very difficult to transfer that coverage to individually purchased insurance. There is a gap in the transition. They do not have the ability to protect the exact plan they had before.

*Mrs. Black. So that brings up a really good point. They have COBRA, and I have constituents who are in this situation. Let us just say that the employee does get the

COBRA, but their benefit value for their plan was $3,000. That is probably even low considering what insurance really costs today. But does that employee get to take that benefit with them while they search for a new job and take that $3,000 so that they can help pay their COBRA?

*Mr. Roy. I do not believe so. I mean, I think it depends. Joe might know the answer to that.

*Mrs. Black. Mr. Antos? I think the answer clearly is no. At least that is what I am learning from my constituents.

So you have that insurance, but it is not really portable because you cannot afford the COBRA. Many people will tell me, "I cannot afford the COBRA. Yeah, it is there. It is a benefit for me, but I cannot afford it."

So we put them into a difficult situation where they had employer-sponsored insurance, but they do not really have an option there when they leave because it is really not portable.

So for all the benefits of the employer-sponsored base system, which there are many, and I am not at all saying they are not, but one great drawback is if this employee loses their job, then he or she loses support for the purpose of their health care insurance.

If we were to design from scratch a health insurance system, then how would you mitigate against this profound loss?

Mr. Roy, do you want to answer that?

*Mr. Roy. Yes. You know, one analogy that was made earlier or one comparison that was made earlier today was between auto insurance and health insurance. I think that is a really great way to think about what health insurance should look like.

We do not expect auto insurance to pay for our gasoline or our oil changes or our wiper fluid. We expect it to protect us against catastrophic and financial loss if our car gets totaled, if it gets stolen, if it gets cracked, we get into an accident.

That is what health insurance should be. Health insurance should protect every American from bankruptcy due to medical bills, but the moment we expect it to dominate all of our health care choices is the moment that it becomes too expensive.

And to your point, we do not ask our employer to sponsor our car insurance for us. That would be completely irrational, and similarly, it would make a lot more sense for individuals to have the ability or the option to choose their own health insurance.

Now, there are arguments for employer-sponsored health insurance. It should continue because there is a certain scalability. If you have a large group with 300

employees, the ability to purchase health insurance that is more affordable for that population is greater sometimes than if you purchase it for your own.

But that should not just be about large employers or even small employers. That should be your church group. That should be a professional association. That should be any group of people that wants to get together to pool their risk and pool their options.

*Mrs. Black. So there are other options out there which we should be speaking about, and just to conclude, if you have somebody who is on the Affordable Care Act, they really do not have a lot of choice either, and that is not portable either because if they want to take those subsidies that they get from the Federal Government and purchase something outside of the system that they are required to use, they do not have that choice either.

*Mr. Roy. Let me make an analogy there. You know, the choices in the Affordable Care Act are you can buy a car from GMC or Honda or Ford or Toyota so long as it is a green pickup truck.

*Mrs. Black. My time has expired. More than my time has expired. Thank you.

*Chairman Brady. Thank you.

Mr. Pascrell, you are recognized.

*Mr. Pascrell. Thank you, Mr. Chairman.

This is the first time I have ever heard anybody testify and compare one's health to one's automobile, and I would just like to note perhaps when we get to that point which should not be covered in terms of your own health. I think people have some debate over that.

That is exactly what got us into trouble from the very beginning. The fact is, sir, that we cooperated after Plan D was defeated, the very prescription drugs you are talking about here. We cooperated, even those of us, myself included, who voted no against that plan. We voted. We sat down and worked out, and then finally when we got ACA, we changed the law so that we would not have that gap where people were paying premiums and not getting any benefits.

We can do this. So this is about myth. I take Mr. Larsen, my brother here. You know, he talked about light beer. This is the age of mythology. There are now two ways about it.

Yesterday we had the mythology of blaming the IRS for everything except the weather, and then when we found out they are the people we can most rely upon in government and we looked at the Treasury Department, which had the lowest tax

delinquency rate in the Federal Government, and guess where we were. They are 1.2 percent, and we are 5.1 percent, and the general public is eight percent.

This is about myth. That is what it is about, and we are going to dispel that myth between now and November. Let us make it clear. We are not going to be the foolish folks that ran away from this after they voted for it in 2010. Those days are over. They are done.

A conversation, if it produces a plan at all that is centered around idea that we know will not provide the same level of consumer protections that the ACA will do, will not result in as many people getting coverage and will not help balance risk pools. We have not even talked about that today, have we? And which is key to keeping premiums down is what we should be discussing rather than trying to tear down what is the law.

Sixty-three times, how many times can we do this? Obviously maybe 100. There is no cap.

Let me ask this to you, Mr. Kreisberg. We have yet to hear about a concrete alternative. By the way, we not only do not have an alternative plan. We do not have what we are going to do in the transition period when we tell the 20 million new people who have insurance, "Wait, because the new plan is on the way. It is in the mail."

So this alternative, one of the favorite centerpieces when talking about the alternative to the ACA is that they would allow people to buy insurance across state lines. Every state had a different insurance commissioner. Every state has different insurance lines. You hear these presidential candidates talk about why can we not go across the state. They should know the facts, unless they are talking without them knowing what the system is, like immigration. If you do not know what the system is now, how can you criticize it and say let us have reform?

Allow people to buy insurance across state lines. That is the fix, generally without any regulatory role for the Federal Government. With a policy like that, what kind of impact would that have on the consumer, sir?

*Mr. Kreisberg. Well, it would have virtually no effect on rates. I think there have been a number of studies that, you know, since the Affordable Care Act has been adopted, we have essential minimum benefits across state lines now from the Federal Government.

There are a number of state benefit mandates which those states are entitled to enforce within their own states, and we have always supported that. We have always opposed interstate sales because we think it is a violation of states' rights in this particular regard.

So we do not think it has right now much of an impact on rates. We think it is adverse to consumers. We think you lose regulatory oversight. You may have some difficulties

with reserve requirements that insurance companies are allowed to hold, and ultimately I do not think it serves any productive purpose at this time.

*Mr. Pascrell. One final question. The last myth we have time for today, and that is it is a job killer. Now, I have seen data from different universities, Labor Department. I cannot find that. Would you help me?

*Mr. Kreisberg. Sir, it is not a job killer. It is not a job killer whatsoever.

*Mr. Pascrell. Well, then spell it out.

*Mr. Kreisberg. As I indicated before, even CBO has said that it is really a matter of labor supply. People may now have the ability to get insurance outside of their workplace and withdraw voluntarily from the labor market as opposed to employers laying off employees because of the Affordable Care Act.

*Mr. Pascrell. Thank you.

I yield back.

*Chairman Brady. Thank you.

Mr. Kelly, you are recognized.

*Mr. Kelly. Thank you, Chairman.

What I am going to start off with is the actual purpose of the hearing, and so the purpose of this hearing is to learn about the different health care tax expenditures in the tax code and determine those in need of reform, and I think as so often, everything gets lost in the translation.

So when we talk about tax expenditures, what we are talking about is the government giving up anticipated revenue to subsidize, and each of you is here today representing a certain agency. You are all either 501(c)(3)s or 501(c)(5)s, right? Those are nonprofit organizations. By definition in the tax code, you pay no taxes.

Each of you for the organizations that you work for have health care supplied by those people. You do not have to pay for it. The question today was about who pays for this because we talked initially, and I may be wrong on this, Chairman, about 150 million people being covered by employee-sponsored insurance. Part of the Patient Protection and Affordable Care Act is how are you going to pay for it? Because we always worry about how are you going to pay for it.

So let us say all of a sudden employers said, "We are just not going to do it anymore." You would lose 150 million who are paying for their own insurance to begin with, right?

Now, is it true that we are talking about a loss of revenue, tax revenue here? This is what we are talking about of all the different tax codes right now, right? This is money that will not be garnered by the Federal Government.

And so we are saying that in some cases we have to subsidize those plans for people who cannot pay for them. I just want to read to you. "A subsidy is a sum of money granted by the government or a public body to assist an industry or business so that the price of a commodity or service may remain low or competitive."

My question to each of you: who supplies the money for the subsidy?

*Mr. Kreisberg. In both cases it is the worker, right? You, Mr. Kelly, had said that --

*Mr. Kelly. I am with you. It is okay, Mr. Kreisberg. Mr. Roy, I will come back to you. I will come back to you. I understand, but who pays for the subsidy?

*Mr. Roy. If you are talking about the --

*Mr. Kelly. I am talking about subsidies.

*Mr. Roy. The advanced premium tax credit on the Affordable Care Act exclusions?

*Mr. Kelly. I am talking where does the revenue for the subsidy come from?

*Mr. Roy. It comes from the taxpayers.

*Mr. Kelly. Taxpayers.

*Mr. Antos. Right, from the taxpayers.

*Mr. Kelly. It is all generated by hard-working American taxpayers. It is not generated by the government. The government looks at every single dollar we make and says, "We are going to allow you to keep a fractional part of what you earned."

The government says to every hard-working American taxpayer, "We are going to allow you a portion of each dollar that you earned."

The government will take from taxpayers the amount of money they need to run programs and say, "We will use it better because we know how to use it better, but you will supply it." Am I wrong on that?

*Mr. Roy. No.

*Mr. Kelly. Okay.

*Mr. Roy. And one thing about the employer tax exclusion that is --

*Mr. Kelly. I am running out of time, Mr. Roy, and I do not want to get a lecture, but the purpose of this meeting was to talk about tax expenditures and capping what an employer is allowed to deduct.

I happen to be in a private business. I have always provided health care for my people. Now I am being told that you are not going to be able to deduct that as a cost of doing business because you have actually gamed that in order to avoid paying taxes.

Yes, excuse me. And, by the way, the people that receive that benefit, they should be taxed on that because that was actually revenue.

We are trying to adopt some source of revenue from hard-working American taxpayers again. All of this stuff is being driven by taxes.

*Mr. Kreisberg. It is not to raise taxes. It is actually to lower taxes and increase out-of-pocket --

*Mr. Kelly. Mr. Roy, do you pay taxes on your health care plan?

*Mr. Roy. Yes, I do.

*Mr. Kelly. Do you really?

*Mr. Roy. Absolutely.

*Mr. Kelly. Okay. It is provided by the agency you work for.

*Mr. Roy. We all pay taxes.

*Mr. Kelly. You pay wage taxes.

*Mr. Roy. Our taxes pay for the cost of our health care system.

*Mr. Kelly. Okay. I get that part. I get that part. Listen. I understand that world. I get that part.

The reality of it is it comes from people who go to work and earn income and companies that are profitable. That is where the taxes come from, and the other part of it is we get it from printing money or borrowing money, which, by the way, we have every single taxpayer sign on because they are cosigners on that debt.

But the purpose today was to talk about different health care expenditures, and I am just submitting to you that we are forgetting the most important part of this, and that is the people that provided the revenue. There is nobody here that says they do not want health care for people. The question is how do you pay for it.

And at the end of the day, it is going to be by Americans.

*Mr. Roy. Let them make that choice.

*Mr. Kelly. And there are going to be some that can afford their own, some that cannot. I get that whole part of it, but we are going to change the tax code in order to collect more revenue, and when the government says they are losing revenue, what they are actually saying is, "Mr. and Mrs. Taxpayer, you are going to get to keep more of your own money. It is going to stay in your pocket. You can decide how to spend it."

That is what it is about. It is about a loss of tax revenue. That is all this meeting is about. All the rest of it is political talking points or election year talking points. It is not about the issue which we have all been addressing, and that is: how do we pay for this? And the answer is every hard-working American taxpayer is going to contribute to it.

My question, and it always comes down to the same thing. I love the fact that as an employer I have been able to do things for the people that I work with, but I do not think I should be held to only using that as a tax. Then the people you give it to should be taxed for it. We are looking at a cap on what employers are allowed to deduct as a cost of doing business.

I would submit to you there is a heck of a lot more to running a business --

*Chairman Brady. All time has expired.

*Mr. Kelly. Thank you. I yield back.

*Chairman Brady. Mr. Renacci, you are recognized.

*Mr. Renacci. Thank you, Mr. Chairman.

I want to thank the witnesses for being here.

It is interesting. I said this yesterday. The American people, if they wanted this, they would get very frustrated, and as my friend Mr. Larsen said, they get frustrated, but it is not because we are talking about ACA. They get frustrated because we are talking at each other instead of listening, and that is the problem.

We need to listen to our witnesses. We need to listen to the people we represent.

So I am going to go back. I am glad that Mr. Kelly got us back on track as to what the hearing was about.

You know, employers cover, according to the CBO, 63 percent of health care through an employer-sponsored plans. You guys would agree with that, right?

*Mr. Roy. The worker is paid that because it is part of the worker's overall compensation.

*Mr. Renacci. I understand, but employers are covering --

*Mr. Roy. When an employer hires someone, the cost of their overall compensation is calculated.

*Mr. Renacci. We are going to get to that. We are going to get to that.

So employers, in fact, cover 155 million people through employer-sponsored health care. I think, Mr. Antos, you said yes to that.

So I go back in the district and I talk to my employers. I talk to my employees, too. Do you know what my employees say? They say, "I do not want the responsibility of trying to find my own health care. It is complicated. I like the idea of an employer covering my health insurance."

And by the way, I have hired many employees, and do you know what they say? "I want a good wage," and you hire them for a good wage, and then you give them health insurance. So the health insurance does not stop me from paying them a good wage.

You guys are saying that it is reducing. They do not come in there saying, "I am only going to work for this and you should pay me more because of health insurance." Most of them love that we are covering health insurance.

So they say to me, when I talk to the employees, "We do not want to be burdened with trying to select. We like the idea of the employer doing this. We like the idea of the employer covering everything. We like the idea of being part of a bigger plan because I cannot do it on my own." That is the other thing they say.

Then I go to the employers, and I ask them, and do you know what they say to me? "Congressman, that big wet blanket the government keeps throwing on top of us, you are raising our costs for health insurance. You are raising our cost," which has shown for the last couple of years with the Affordable Care Act and other ways, "and now you want to cap it and cut it at the top. You want to hurt us again."

That is not fair to the employer. It is not fair to the employee. We have to go back to what the basis is. If we went to those 63 percent and asked them are they happy they are covered with health insurance, they would say I bet you they are happy they are covered with health insurance.

So here is my concern. We know health care costs are going up. We want to capitate it and say, "Mr. Employer, you can pay it, but anything above that is going to be a tax increase to you because we are not going to have it as a deduction." That is a problem.

So the only way, in my estimation, and this is what drives me crazy, and I now come to you Mr. Roy. You keep saying an employer-sponsored plan does not give the employee choice, but I would ask you this. Are there not employer sponsored plans that give and could give employees a choice over their health care decisions, if structured properly?

*Mr. Roy. So there are a couple of points to make in response to that. The first is that --

*Mr. Renacci. I do not have a lot of time.

*Mr. Roy. -- nobody is talking about tax increases. People are talking about letting patients control those dollars themselves, increasing their take-home pay, and letting them --

*Mr. Renacci. I know that, but let us get back to it.

*Mr. Roy. -- decide what they want to fund.

On the issue of choice for health insurance plans --

*Mr. Renacci. If the plan is structured properly.

*Mr. Roy. -- employers can decide whether to offer one plan or two plans or three plans, but should workers not have the choice to choose between their employer-sponsored plan and 100 different plans that are out there independent of their employer?

*Mr. Renacci. They can do that right now. They can do that right now.

*Mr. Roy. It is much harder for them to do that because the inequities in the tax code made that much more expensive.

*Mr. Renacci. They can do that right now, but I guarantee if you talk to the employees, and you see this is what happens. The American people get frustrated with us in Congress because they want us to listen to them. They do not want to make those decisions. They like the idea of selecting a plan that their employer gives them, and they definitely do not want to have somebody come to us and say, "This is what we think is best for you."

They know what is best for them. They want us to represent them. That is what is so frustrating, but that is what is great about these hearings because I do like to hear some of your thoughts, and I have listened.

The next question I have, Mr. Antos: will more people lose their employer-sponsored plan if we cap the employer exclusion?

*Mr. Antos. More people will move off of employer-sponsored plan, but let me clarify something.

*Mr. Renacci. Wait a minute. Will they lose --

*Mr. Antos. What you and Mr. Kelly said I believe is incorrect, which I do not think anybody is proposing that the employer's ability to take off their top line legitimate costs of doing business, which includes their contributions to all forms of compensation for employees, nobody is talking about capping that or eliminating that in any way.

What we are talking about is limiting what the employee can essentially exclude form his income taxes, but it is not going to affect the employer.

*Mr. Renacci. That is even worse.

*Mr. Antos. Thank you.

*Mr. Renacci. Now you are going to add taxes to the employee. Again, if the American people hear what you just said, they are going to be really upset.

I yield back.

*Chairman Brady. The time has expired.

Mr. Davis, you are recognized.

*Mr. Davis. Thank you very much, Mr. Chairman.

And I, too, want to thank all of our witnesses.

Newsweek has an article written March 3rd titled "How Obamacare May Lower the Prison Population More than Any Reform in a Generation." It was written by Elijah Wolfson. Toni Preckwinkle, who is president of the Cook County Government, second largest county in the country with one of the largest jails in the country, responded to that article by writing a letter to the editor, and here is what President Preckwinkle wrote.

She said, "I commend Newsweek for recognizing the vital connection between Obamacare and safer communities." She went on to say that in November 2012, Cook County was granted a Medicaid waiver that has already allowed us to provide health insurance to over 86,000 low income residents, including 2,600 formerly detained individuals.

Mr. Chairman, I would ask that both of these articles be inserted into the record.

*Chairman Brady. Without objection.

[The information follows: The Honorable Danny Davis]

*Mr. Davis. Since we have not seen any alternative to what is often called Obamacare, except a national health plan, preferably single payer, let me mention a few of the accomplishments and benefits our country has experienced from the Affordable Care Act.

Twenty million people have gained health insurance coverage who did not have it. The gains since 2013 have been the fastest and most rapid since the decade following the creation of Medicare and Medicaid. The uninsured rate is below ten percent for the first time in the history of this country. The uninsured rate among young adults, ages 19 to 25 has fallen by 52 percent through the third quarter of 2015.

We know that states that expanded their Medicaid programs have seen rapid gains in health insurance, much more than those states that have not. Millions more workers are now protected against unlimited out-of-pocket spending.

Since the Affordable Care Act became law, health care prices have risen at the lowest rate in 50 years. Hospital readmission rates have fallen sharply since the passage of Obamacare. The private sector has added jobs every month since the Affordable Care Act became law.

Thanks to the Affordable Care Act an estimated 20 million people have gained health insurance, and for the first time in history nine of ten Americans have health insurance.

Among African American adults, the uninsured rate declined by 53 percent. Among Latino adults the uninsured rate dropped by 27 percent. The gains for women have been rapid, and among young adults has dropped 47 percent.

It prohibits coverage denials and reduced benefits and protects 129 million people who have some type of preexisting health condition. More than one million Illinois residents have obtained health insurance coverage, and on March 22nd of this year, the Department of Health and Human Services announced that Medicare spent $473.1 billion less on personal health care expenditures between 2009 and 2014 than previous spending trends would have indicated.

Mr. Kreisberg, let me ask you: have you heard of, seen anything or know of anything that would do a better job of meeting the health needs of our country than that?

*Mr. Kreisberg. I do not think there is anything in the current dialogue today, Mr. Chairman, given where the American people are that would do a better job than what the Affordable Care Act has done in terms of expanding coverage.

As I said earlier, I do not think we have met the full potential, and I think we do need to work on fully implementing the Medicare expansion provisions of the Act so we can bring some of the benefits that you have described to more people.

*Mr. Davis. Thank you very much.

I yield back.

*Chairman Brady. Thank you.

Mr. Meehan, you are recognized.

*Mr. Meehan. Thank you, Mr. Chairman.

And I appreciate the panelists here today. I wish they had a chance to actually answer questions instead of being lectured to because I guess this is hearing.

But in any event, look. I thank you for your work, and I know one thing. When I go back in my district and I talk to my employers, Obamacare is not working to them, and the frustration level is the highest I have ever seen. Eight percent costs per year in increase, but I also have questions about how we work this system.

So I am going to ask four things if you can address them as best you can. If we are going to do some sort of a cap, and it is designed to make it more available to everyday people, not just to the benefit of the more wealthy members in that; so if we try to create caps, how do we keep the young, healthy employees inside that system?

My second question is: if we are going to create a tax system that does some kind of a refundable tax credit, how do you deal with people or families that do not currently have access to employer-sponsored programs?

And what do you do with those who have an income level below, you know, the 300 percent?

A third question that my colleague talked to: how do you make consumers understand what to buy when they have a doctor tell them they are sick? First they are sick. It is a hard time to make a lot of choices.

Second, you do not understand what you are buying. You are being told you have got to get this test.

And then the last question. I have thrown a lot at you if you have it. I am anxious to hear us make this, but how do you know that employer is not going to keep the savings themselves and not pass it on in the form of wages that will increase?

A lot of questions, but if you can, help me.

*Mr. Roy. Those are all great questions. I think you have asked the right questions.

So on the issue of whether the employer will keep the money or raise wages, the economic literature is overwhelming in indicating that there is an exact one-to-one correlation because it is overall compensation that the employer thinks about, and it is a competitive market, right? If you want to retain those workers and not lose them to a competing firm, you have got to pay them what the market is paying them.

So if health care costs go down, the cost of insuring your workers goes down. That gets returned to workers in the form of higher wages. So we can be optimistic about that.

On the question of patient choice and how if you got to the doctor you do not actually know. The doctor says you are sick. How do you deal with that? It is a classic problem in health care.

There is a flip side to that, which is a lot of times you as a patient know a lot more about why you are sick and your family history and your background than the doctor does who is just glancing at your chart, has forgotten a few things. Your medical records are all over the place.

So there is asymmetry in both directions, and the more the consumer is in charge of his own health care dollars, the more that doctor has an incentive to be really responsive to that patient and that patient's needs and that patient's unique medical history, and that is what our current system works against.

And so if I missed anything that you have addressed, please.

*Mr. Meehan. Well, no, I asked two other questions. I want to know about young, healthy employees. How do you keep them in if we cap this system?

*Mr. Roy. Right. So the issue of whether the young, healthy employees will withdraw from employer-based care and go off and shop on their own, you could see that to some degree, but you could also see that a lot of people stay, and the reason why they would stay in the employer-based system is because of the economies of scale that come from a large employer or even a smaller employer purchasing health insurance in bulk for a group of its employees and having that negotiating power that comes with that versus being an individual shopping for coverage.

So I think employers should retain some confidence that they have a lot to offer to that employee, and they can provide other incentives to say, "Hey, you know, we want you to stay in our risk pool. Here are some other things that we can offer you that if you brought insurance on your own, maybe you would not get as good of a deal."

*Mr. Meehan. Okay. I wish we had time for follow-up questions, but I wanted to get my fundamental questions answered, and the last one was: how about a refundable tax credit for somebody that is not in an employment situation?

*Mr. Roy. That is essential. So if you only have a nonrefundable tax credit, then people who do not have income tax liabilities, they cannot get the financial assistance they need. So refundable tax credits are a very important part of equalizing the tax treatment of health care.

*Mr. Meehan. Mr. Antos, have you got any response or any thoughts on any of those issues?

*Mr. Antos. Well, one other aspect has to do not just with wages, but also with people being able to keep their jobs. You know, there are many margins of adjustment that employers face, and by giving more flexibility to the system we will not only have people with higher wages, but in some cases when there are loose labor markets, when the labor markets are not doing well, the people will less likely be laid off.

*Mr. Meehan. Thank you. I appreciate that.

*Chairman Brady. Thank you.

Mr. Holding, you are recognized.

*Mr. Holding. Thank you.

Mr. Roy, in your testimony you stated that reform should give workers more choice to purchase the kind of health coverage that is affordable for them and their families, but you know, unfortunately many of the new requirements of Obamacare made employer-sponsored coverage increasingly unaffordable, with higher deductibles, premiums and cost sharing. Employees are also presented with fewer choices as we have discussed when it comes to employer coverage.

So rather than dictating exactly what benefits must be offered, would it make more sense to allow employers to provide a defined contribution to their employees so that they can shop around and find the products that meet their needs a little bit better?

*Mr. Roy. Absolutely. That would be a tremendous innovation in the delivery of health insurance in the employer market. You have a defined contribution that they can then say, "Look." Let us say it is $5,000. If I want to spend $6,000, then I can do that with my additional funds. If I like the $5,000 health insurance plan, let me buy whatever we want.

There is an intermediate way of getting there, which is private health insurance exchanges that some large employers like Walgreens are using to say, "We are going to give you this much money. Buy whatever health insurance among these ten plans that are on the exchange."

There are a number of people working on improving that modality for delivering health coverage to the employer market.

*Mr. Holding. Well, defined contributions are pretty common practice in the world of pensions.

*Mr. Roy. Yes.

*Mr. Holding. But not health benefits. So is there something in the tax code or Federal law that treats defined contributions differently than defined benefit plan?

*Mr. Roy. Yes. Unfortunately, if you just give them the money to buy whatever health insurance they want, it does not qualify for the employer tax exclusion, except in these private exchange contexts where you can convert it in a certain way.

With the self-insured population you have a little bit more flexibility than through the conventional employer tax exclusion.

*Mr. Holding. So do you think that treating defined contributions in the same way we do defined benefits under the tax code would help to make the health care costs more manageable and predictable for employers, employees and employers?

And similarly, do you think it would give employees more flexibility in their insurance coverage?

*Mr. Roy. Absolutely, and you know, there has been a lot of concern expressed today about if you reform the employer tax exclusion, would that disrupt coverage in the employer market for those who prefer it, and one of the best ways to ensure that employer-based health coverage continues to be robust is to give employers exactly the option that you are describing, to say, "Do you know what? We are going to get out of the business of picking the health insurance plan for you, but we are going to be allowed to have a defined contribution which then you can use to shop for coverage that you want," because that is a benefit that employees would love to have and would loath to give up.

*Mr. Holding. Now, importantly, on the flip side do you think this would create incentives for insurers to compete for this business? Correct?

*Mr. Roy. Absolutely.

*Mr. Holding. And competition ultimately would drive costs down because your insurers are competing, correct?

*Mr. Roy. It would drive costs down. It would also improve quality and customer service because, again, insurers would have to compete for your business.

*Mr. Holding. Thank you.

Mr. Chairman, I yield back.

*Chairman Brady. Thank you.

Mr. Dold, you are recognized.

*Mr. Dold. Thank you, Mr. Chairman.

And I want to thank our witnesses again for your time, and I, too, join my colleague, Mr. Meehan, in hoping that this could have been more question and answer to hear from you as opposed to taking the short period of time really more for speaking at you.

I will kind of try to get to some questions, but I will tell you as a small business owner the frustration level that is out there not only amongst the employers, but amongst those looking and seeking to provide insurance for their families is extremely high. They are frustrated largely because as an employer, and I am a small employer, we see our premiums and have seen traditionally year after year, even before the Affordable Care Act, they would rise up pretty significantly, sometimes 44 percent a year, and yet certainly as someone that runs a multi-generational business, we consider the people that we work with part of our family.

And honestly, that is where that trust comes in because many, especially in these small businesses that are out there, they trust the people that they have been working with for ten, 15, 20 years and trying to provide or make the choices that they believe would be best.

As we look at the flexibility which I think is absolutely critical, I think we are also getting away from the idea that what our goal should be is that we want quality care for everyone, and we want to make it as affordable as possible, more recently we have seen premiums go through the roof. Deductibles have gone sky high, and so for a family of four, it would not be uncommon for them to pay $2,500 a month in premiums and have a deductible of $12,000-plus.

So for that family of four, they are paying, you know, 20-some odd thousand dollars of insurance before they get dollar one of coverage.

And we have done a masterful job of actually disguising the costs of health care, right? How much does it cost to go to the pediatrician? Well, I will tell you some people say it is just $20. No, no, that is the copay.

And so really what we have done is we have taken consumers completely out of the equation, and what we really need to be focused on is how do we enable that competition.

And the other thing that I would argue, we would like to have the flexibility for employees not to feel trapped into a job because if I leave I am going to lose my health coverage and, therefore, I potentially might not be able to have that coverage as I move forward for my family, and that is really terrifying, obviously, for those that have family members that have great need.

I am reminded of a study that was done up in Wisconsin. Hospital A had a knee replacement. It was $57,000 for the knee replacement. Hospital B, three miles down the road, not far and still basically right there in the neighborhood, was $38,000.

Now, we associate better care with $57,000, and yet what was amazing was better outcomes actually happened at the hospital for $38,000. My point is: should we not know that? Should we not be able to get that data out there and drive more people to the hospital that is doing it for $38,000?

Mr. Antos, what happens to the hospital that is doing it for $57,000?

*Mr. Antos. They are making a lot more money.

*Mr. Dold. Well, but what happens to them if we are able to figure out that the hospital three miles down the road is doing a --

*Mr. Antos. Well, if there is actually usable consumer information about their cost and the quality of the services, what is going to happen is that it is going to drive the expensive hospital to revamp the way it does its business. It is going to drive the hospital to talk to their doctors about how you manage care.

*Mr. Dold. Ultimately what we are trying to focus on in this hearing is what can we be doing with regard to our tax code to make better decisions, and frankly, we do not want to talk about an increased tax on hard-working taxpayers. We want to encourage those employers to be able to continue to do it.

Because I would argue as a small business person, we want to make sure that we are able to attract and retain good people. But I do believe that we have to come up with a mechanism that provides that flexibility for employees, for those hard-working taxpayers to say, "I have good quality care," regardless of where they are working and for those even that are not working.

And that is where I think that refundable tax credit really has to come into play.

Can you talk to us about what we can really be doing in terms of focusing on that flexibility, so we do not have the job lock, as it were, Mr. Roy?

*Mr. Roy. Yes. So as both of us described in our prepared remarks, if you gradually cap the taxable exclusion away that is revenue neutral so that it would involve no tax increase on any worker relative to what current law is. You give people the flexibility to opt out if they want to and shop for coverage on their own.

And also if they change jobs, they own their own health insurance plan just like with auto insurance. Your auto insurance does not change when you switch jobs. It is your auto insurance, your life insurance, et cetera.

The same with health insurance. It should work the same way. You should be able to transition. You should be able to continue your coverage, and it should not have to be sponsored by the employer to do that.

And one mechanism to do that and integrate it into the employer-based system is what we were talking about just a minute ago, which is to have a defined contribution at the employer level, which then the individual can take and use to buy the insurance and keep the coverage as he changes jobs.

*Mr. Dold. I would love to hear the responses, but my time has expired, Mr. Chairman.

*Chairman Brady. Thank you, Mr. Dold.

*Mr. Dold. Thank you.

*Chairman Brady. Mr. Rangel, you are recognized.

*Mr. Rangel. Thank you, Mr. Chairman.

And let me thank the panel for your patients and indulgence in coming here to share with us.

Mr. Roy, you know, facetiously Dr. Price and I said we will adopt your policy, but I will be serious to find out is it at all possible for you to present the plan that you have to us for us to look at?

And how soon could we get it?

*Mr. Roy. I would be happy to do it at any time that is convenient to you and your office, Mr. Rangel, at any time that you on your committee or anyone in the Congress.

*Mr. Rangel. Can you send it to us directly? And then I would arrange with Dr. Price and others to be able to discuss it because it pains me to have struggled so long for expansion of health care to find people that would be anxious to repeal it and not to have a plan to suggest how the vacuum will be filled.

*Mr. Roy. Absolutely, and you know what I would say, Mr. Rangel, is that I have reached out many times to Democrats both in the --

*Mr. Rangel. No, no, no.

*Mr. Roy. -- House and in the Senate.

*Mr. Rangel. You do not have to reach out any further.

*Mr. Roy. It sometimes is very difficult.

*Mr. Rangel. You also are a journalist, right?

*Mr. Roy. Say that again?

*Mr. Rangel. You are a journalist as well?

*Mr. Roy. Yes.

*Mr. Rangel. You can prepare the press release now that I have said that I am anxious to see what is on your mind because with all of the activity on the floor to repeal the Affordable Care Act, I have not seen an alternative, and you are prepared to show that to me.

Now, you are not a health care provider, are you?

*Mr. Roy. No. I am a --

*Mr. Rangel. But you are considered an expert in delivery of health care, are you not?

*Mr. Roy. Well, I will defer to this committee that invited me here as to whether I have expertise or not.

*Mr. Rangel. Well, you have provided this advice to Governor Mitt Romney, have you not?

*Mr. Roy. I was an advisor to Mitt Romney in the past, year.

*Mr. Rangel. And as well as Rubio. You advised him.

*Mr. Roy. Yes.

*Mr. Rangel. And Nick Perry?

*Mr. Roy. Yes, sir. And so in addition to an expert in health care, you also could be considered political analyst in terms of providing political advice as relates to health care. Is that true?

*Mr. Roy. I provide policy advice, not political advice.

*Mr. Rangel. But you have given a lot of policy advice to outstanding Republican politicians, right?

*Mr. Roy. I am happy to give policy advice to anyone who asks, and it is mostly Republicans.

*Mr. Rangel. I know you would. You do get paid for giving advice, do you not?

*Mr. Roy. No, I was a volunteer on --

*Mr. Rangel. Have you ever been paid to give advice?

*Mr. Roy. Have I ever been paid to give policy advice?

*Mr. Rangel. Policy advice as relates to health care.

*Mr. Roy. Well, I am an employee of the Manhattan Institute. So I do research on policy.

*Mr. Rangel. So what I am saying is of course, you would welcome giving advice. No Democrat ever accepted your services.

*Mr. Roy. But I would be eager to provide that.

*Mr. Rangel. Okay. Now, what group did you mention, the Financial Institute? Are you with them now?

*Mr. Roy. The Manhattan Institute for Policy Research. That is the nonprofit think tank.

*Mr. Rangel. Are you with them now?

*Mr. Roy. Yes. I am a senior fellow with the Manhattan Institute.

*Mr. Rangel. Did you ever work for J.P. Morgan?

*Mr. Roy. I did many years ago, yes, before I started working in health care policy.

*Mr. Rangel. And when you went to work for health care policy, did you form or become partner in a firm called Tarea Funds?

*Mr. Roy. No, I was not a partner in Tarea.

*Mr. Rangel. Were you a part of Tarea?

*Mr. Roy. I was an outside consultant. I worked with some of their individuals.

*Mr. Rangel. So you gave advice to Tarea?

*Mr. Roy. I was a consultant, yes.

*Mr. Rangel. Does consultant mean giving advice to them?

*Mr. Roy. Sometimes, yes.

*Mr. Rangel. And is Tarea a hedge fund organization?

*Mr. Roy. No.

*Mr. Rangel. Do they advise a hedge fund organization?

*Mr. Roy. No, they mostly advise companies, such as biotechnology companies that are trying to develop new therapies.

*Mr. Rangel. Have you been described as an advisor to hedge fund investors?

*Mr. Roy. Yes, I have sometimes given advice to investors as I give advice to policy makers and other people who are --

*Mr. Rangel. But since your specialty is in health care, would you have concentrated in giving investment advice or policy advice to hedge funds that are concerned with providing health care? That is where your expertise is.

*Mr. Roy. I am not sure I understand the question. If the question --

*Mr. Rangel. I am trying to connect you with hedge fund providers. That is what I am trying to do.

[Laughter.]

*Chairman Brady. That has become clear, Mr. Rangel, yes.

*Mr. Rangel. And so I do not know what it is. What part of my question is it that you do not understand?

*Mr. Roy. So after I --

*Mr. Rangel. Hold it. You are not a doctor. You are not a health provide --

*Mr. Roy. I worked as an investor.

*Mr. Rangel. Please, just one minute.

*Mr. Roy. Sorry.

*Mr. Rangel. You are not a doc. You see, you took my time away, but perhaps the chair might afford you some time to separate yourself from hedge fund investors as relates to health care.

*Mr. Roy. My policy advice is entirely independent of my previous career as an investor in the health care system.

*Chairman Brady. Thank you.

Mr. Roy is an acknowledged expert and credible witness on health care reform. We welcome your attendance today.

Mr. Rice, you are recognized.

*Mr. Rice. Mr. Kreisberg, you work for a big public sector labor union, correct?

*Mr. Kreisberg. Yes, sir.

*Mr. Rice. And you do design work and consulting, I guess, for their health plans?

*Mr. Kreisberg. For the staff health plan?

*Mr. Rice. For whatever health plan they have.

*Mr. Kreisberg. I have collectively bargained health plans covering hundreds of thousands of workers.

*Mr. Rice. How many of those workers are covered under the Obamacare exchanges?

*Mr. Kreisberg. I am sorry. I am having a little bit of trouble --

*Mr. Rice. How many of those workers are covered under the Obamacare exchanges?

*Mr. Kreisberg. The ones that I negotiated for are not in the exchanges, but other members of ours are in the exchange.

*Mr. Rice. What percentage would you say?

*Mr. Kreisberg. Of our members in the exchanges?

*Mr. Rice. Yes, yes.

*Mr. Kreisberg. I would probably say five percent, if that high. Excuse me. We do have more in the Medicaid expanded coverage program.

*Mr. Rice. Do you think if you moved all of your members to the exchanges that that would increase their satisfaction with their health care coverage or decrease it?

*Mr. Kreisberg. I believe it would decrease their satisfaction.

*Mr. Rice. The Cadillac tax, you know, you are sitting here saying that you like the Affordable Care Act, but you do not want your members on it.

*Mr. Kreisberg. That is not what I said.

*Mr. Rice. Okay. Well, explain it to me then.

*Mr. Kreisberg. Well, for many of the people who are covered in the health care exchanges, they had coverage in the individual market, which was not working well at all or they had no coverage at all. So we believe the Affordable Care Act health care exchanges are very positive things for those members.

But we are a firm believer in the traditional employer-sponsored insurance, which our members are fortunate enough to normally be able to access.

*Mr. Rice. All right. Well, Jonathan Gruber testified that when he was helping design the Affordable Care Act that the Cadillac tax was specifically designed to increase the cost of employer provided insurance over years and thus force everybody into the exchanges, and what I am asking you is if the Cadillac tax works as Mr. Gruber designed it and forces all of the employer-provided health insurance to become so expensive that people cannot do it and all of your members are transferred onto the exchanges. Are they going to be happy with that or are they going to be disappointed?

*Mr. Kreisberg. Well, first of all, I think Gruber is wrong.

*Mr. Rice. Well, he designed the plan.

*Mr. Kreisberg. Some controversy over that, but he is wrong in terms of what would happen. What would happen, I would argue --

*Mr. Rice. Excuse me. Mr. Roy, is Gruber wrong or is he right?

*Mr. Roy. Is Gruber wrong about what specifically?

*Mr. Rice. That the Cadillac tax was designed to make employer-provided health insurance more and more expensive so that people would eventually be forced onto the exchanges?

*Mr. Roy. I do not believe he said that the Cadillac tax would make health insurance more expensive and that people would go on the exchanges. I do not believe he said that.

*Mr. Rice. Employer-provided insurance.

*Mr. Roy. I think he has stated that the Cadillac tax was designed, because it is back-loaded in terms of the way it appears, as the way it comes in, that would be less transparent.

*Mr. Rice. It was back-loaded so that people will not figure it out until years later. He said the American public was too stupid to figure it out.

*Mr. Roy. Its convoluted design was what he was celebrating because people would not understand how it worked.

*Mr. Rice. It does not apply until 2018, and then it is indexed based on inflation, not on inflation in health care cost.

So, Mr. Antos, moving to you, that would result in employer-provided health insurance becoming more and more expensive, correct?

*Mr. Antos. Absolutely right. In fact --

*Mr. Rice. And it would force people onto the exchanges, correct?

*Mr. Antos. Well, it might force them out of insurance altogether.

*Mr. Rice. So, Mr. Kreisberg, coming back to you, when the health insurance that you collectively bargain for and that you provide to your population becomes so expensive that you cannot collectively bargain for it anymore because of the Cadillac tax and your guys get moved back onto the Obamacare exchanges, are they going to be happy with that?

*Mr. Kreisberg. Well, what would happen is that the health plans that they are in would change so they would fit under the cap. We would not necessarily lose our coverage. We would still probably have a --

*Mr. Rice. But you would lose your benefits.

*Mr. Kreisberg. -- but it would be less valuable.

*Mr. Rice. I am sure they would be happy with that.

*Mr. Kreisberg. They would not be happy with that, which is why we oppose the excise tax.

*Mr. Rice. Over half the American population is covered by employer health providers. A large part is covered by Medicare. A large part is covered by Medicaid. Poor people are covered by Medicaid. Retired people are covered by Medicare.

Most of the rest of the people are covered by employer-provided health insurance, and they really like it, right? Is the Affordable Care Act not an attack on employer-provided health insurance?

*Mr. Antos. Well, former White House official Ezekiel Emanuel argued that the Cadillac tax would pave the way towards eliminating the employer market altogether.

*Mr. Rice. Thank you.

I yield back.

*Chairman Brady. Thank you.

Mr. Reed, your final question?

*Mr. Reed. Well, thank you, Mr. Chairman.

You are at the end, and I guess this is the penalty for showing up late, and I take responsibility for having the last five minutes.

First, I just want to make sure this is clear, and I was offended by my colleague on the other side of the aisle who referenced that somehow the Republican agenda is to take away health care for people in America. That is just not accurate, and our committee is better than that, and I will talk to that member personally to make sure that we always raise our discourse.

Because I think what is here between us on both sides of the aisle is a recognition that the health care system is not working in America, and that we have to get to the issue of health care cost in particular.

And I understand that the heart of this conversation today is about employer-sponsored health care, and it is a big change if we go down the path of removing that exclusion in the tax code, and I am very concerned about that. But I am willing to put all options before us to have a wide open debate in order to make sure that we are attacking the fundamental problem, and that is health care cost and accessibility for our fellow American citizens.

That being said, we are six years into this experiment with the Affordable Care Act, Obamacare. So let me ask you a question. Who has been to the doctor in the last 60 days on the panel?

[Show of hands.]

*Mr. Reed. Anyone else?

How much did it cost?

*Mr. Roy. I do not know.

*Mr. Reed. You do not know, right?

*Mr. Roy. Well, because it was covered by insurance, and I do not really get a bill that explains to me how much it cost.

*Mr. Reed. So each of you had indicated that you have insurance through your employer. What did you pay last month for that insurance?

*Mr. Roy. I do not know.

*Mr. Reed. Mr. Kreisberg, do you know?

*Mr. Kreisberg. The insurance plan that I am covered in, my employer pays for it. It costs probably about $2,500 a month.

*Mr. Reed. How much does it cost you?

*Mr. Kreisberg. I do not pay a premium.

*Mr. Reed. You are 100 percent covered by your employer.

*Mr. Kreisberg. Yes.

*Mr. Reed. And it is approximately how much by your employers?

*Mr. Kreisberg. Approximately I would believe somewhere about 23 to --

*Mr. Reed. You would guess, right?

*Mr. Kreisberg. -- 23 to $2,500 a month. Yes, I am guessing.

*Mr. Reed. You are guessing.

*Mr. Kreisberg. An approximation.

*Mr. Reed. Does that not illustrate the point? You are three leading experts testifying before the U.S. House of Representatives' Ways and Means Committee. Is this not the point?

*Mr. Roy. Absolutely, and it is a question I often ask.

*Mr. Reed. You do not know. You do not know the answer to that fundamental question, and does that not in a large part drive the problem we are facing in America's health care?

*Mr. Kreisberg. I think your conclusion is wrong from the point you are trying to make.

*Mr. Reed. The lack of transparency by you as an expert not knowing the cost, not knowing how much it cost you in the system is not causing the problem or at least contributing?

*Mr. Kreisberg. No.

*Mr. Reed. Would you concede it contributes to the problem?

*Mr. Kreisberg. The problem is not what can consumers know about cost. The problem is what the costs are. As you are trying to point out, the cost --

*Mr. Reed. Hold on. Mr. Kreisberg, hold on. I waited two and a half hours to have this time.

*Mr. Kreisberg. Yes.

*Mr. Reed. This is the issue. There are in my mind two tools that we can use to control costs: market pressure driven by people or government mandate driven by D.C. Are there any other tools out there that you can think of?

I see a bunch of noes across the table here, right?

*Mr. Kreisberg. Yes.

*Mr. Reed. What we are trying to do is to say to the American people we stand on the side of you. We stand on the side of a market. Now, you may not agree that it could work in the health care industry, and there are going to be situations where a true market does not exist in health care. I get that.

But our fundamental tool that we are trying to use is market driven pressure to drive the cost down. The other side when they celebrate the Affordable Care Act they are saying government is going to drive those costs down. I am concerned about that as well as the hundreds of millions of people across America that say if a government can tell you how we are going to drive that cost down in a personal transaction such as health care, that is an extensive, big government type of power being exercised over us.

So I am open to try to empower individuals to have that market-based pressure giving them their money in an employer-based situation. I have great concerns about it. I will be perfectly honest with you because we have all become accustomed to it, but I do understand the power of what that would represent.

Is that not what we are trying to do by recognizing the exclusion and saying if we give that power to the employee, that they may be in a better position to determine and put that market pressure on the system to drive the cost down?

Is that what we are trying to get to, Mr. Roy?

*Mr. Roy. I thought you laid it out beautifully.

*Mr. Reed. Well, thank you.

As we end on that, I yield the balance of my time, and thank you to the entire panel for that exchange.

*Chairman Brady. Thank you.

We would like to thank our witnesses for appearing before us today.

The question is as we preserve the incentives for employer-sponsored health care, can we update this tax incentive, provide more options in the 21st Century world to workers at work or those who want health care outside their work in a way that works for their family and their lives.

And we have had great testimony and very constructive dialogue today. I appreciate the witnesses.

Please be advised I would like to submit for the record an analysis from the Congressional Budget Office that shows that drug price savings are not obtained by negotiating with Medicare.

[The information follows: The Honorable Kevin Brady]

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

With that, again, thank you for being here. The committee stands adjourned.

[Whereupon, at 12:56 p.m., the Committee was adjourned.]

Questions for the Record

Public Submissions for the Record