Statement of the
Alliance of Health Care Sharing Ministries
Hearing on Health Care Related Tax Reform
Committee on Ways and Means
U. S. House of Representatives
Washington, D.C.
April 14 2016

The Alliance of Health Care Sharing Ministries (the Alliance) is pleased to offer these comments on behalf of our members on the important topic of health-care-related tax reform.

About the Alliance

The Alliance of Health Care Sharing Ministries (the Alliance) is a tax exempt 501(c)(6) Christian advocacy ministry founded in 2007 by two of the largest health care sharing ministries: Christian Care Medi-Share and Samaritan Ministries International. The Alliance serves the common interests of faith-based ministries that facilitate the sharing of health care needs—financial, emotional, and spiritual—by individuals and families.

I. What Is Health Care Sharing?

A health care sharing ministry (HCSM) is a voluntary, cost-sharing arrangement among persons of similar and sincerely held religious or ethical beliefs, administered by a not-for-profit charity acting as a clearinghouse between those who have medical expenses and those who desire to share the burden of paying for those medical expenses.

- HCSMs serve more than 580,000 Americans, with participating households in all fifty states.
- HCSM participants share more than $500 million per year for one another's health care costs.
- HCSMs strive to be accessible to participants regardless of their income. Shared amounts are a fraction of the cost of insurance rates.
- HCSMs receive no funding or grants from government sources.

Health care sharing helps people with less do more.

II. Health Care Sharing Is Not Insurance

Health care sharing is not insurance but rather a form of benevolent mutual aid in which the

members help each other pay their medical bills in a personal, faith-filled way.

HCSMs are not insurance companies. They do not assume any risk or guarantee the payment of any medical bill- and thus fall outside the purpose and scope of insurance regulation. Twenty-nine states recognize this fact in their insurance code. A thirtieth state, Alaska, has passed similar legislation which the governor is now reviewing.

III. Health Care Sharing Is ACA-Compliant

The federal tax code recognizes health-care sharing as an alternative to traditional health insurance. Health care sharing satisfies the Affordable Care Act requirement that individuals purchase health insurance or pay a penalty-tax. To meet the federal definition, an HCSM must be a long-established, bona fide charity as defined at 26 USC 5000A(d)(2)(B).

The three largest HCSMs (Christian Health Care Mission [CHM], Christian Care Medi-Share [CCM], and Samaritan Ministries International) have received letters of certification as recognized HCSMs from the Centers for Medicare and Medicaid Services, an operating division of the U.S. Department of Health and Human Services.

The IRS has issued Form 8965 along with finalized instructions explaining how members of a recognized HCSM are to report that they qualify for the individual mandate exemption.

IV. Needed Clarifications of the Tax and Regulatory Treatment of Health Care Sharing

Because health care sharing is not health insurance, but does help protect people against excessive medical bills, federal tax and regulatory policies should treat health care sharing ministries as a new category that is neither "health insurance" nor a "health benefit plan" nor a "group health plan" as those terms are defined in federal law. Perhaps the best way to think of an HCSM would be as a "non-traditional medical-expense benefit."

Apart from the exemption from the ACA mandate, federal law has not been updated to reflect the existence of health care sharing. HCSM members and their employers are not yet on a level playing field with traditional insurance in terms of tax treatment. Uncertainties exist that affect current and potential HCSM members. For example, it is unclear whether shared amounts qualify as a deductible medical expense and whether member-to-member assistance, when facilitated by an employer, is excludable from income in the same manner as traditional employer-provided health benefits. We urge Congress to clarify these questions.

Following are several specific issues that the Alliance hopes Congress will clarify in its next tax-reform package.

Issue 1: HSAs for Health Care Sharing Families (Section 223)

Health Savings Accounts (HSAs) offer a vital option for millions of American families. HSAs are not, as some have suggested, a tax haven for the rich. Rather, they can be an additional option for middle and lower class families and the working poor who need help obtaining affordable medical care. HSAs help families save money and promote patient access to preventive and wellness services. They are especially favored by families with members who, due to chronic conditions, must make regular expenditures for medical supplies or treatments. The ability to roll-over and not lose unused savings is an additional benefit that stands only to help those with limited means. HSAs are also a great alternative for small businesses, many of whom cannot afford to provide full health insurance benefits but can afford to put a fixed amount of money (say, $2,500 a year) in an employee's HSA.

Although more than 17 million Americans are currently enrolled in an HSA, health care sharing families are barred from doing so. To qualify for an HSA, a taxpayer must have a high-deductible health plan (HDHP), which by definition is a form of insurance. Health care sharing, as we've seen, is not insurance, and many HCSM members do not want to participate in insurance for religious or ethical reasons. In recognizing the validity of HCSMs in 2010, Congress did not update the HSA section of the tax code (Section 223), an oversight that effectively bars hundreds of thousands of American families from having an HSA.

To correct this oversight, Rep. Mike Kelly of Pennsylvania has introduced H.R.1752, which would make HSAs available to health care sharing families by defining health care sharing assistance to be an HDHP for purposes of Code Section 223. HSAs and HCSMs are naturally complementary, since both promote consumer awareness and involvement in their own health care decisions. They're a "match made in heaven."

The Alliance urges the Committee to pass H.R.1752 and include it in its next tax-reform package.

Issue 2: Deductibility of Health Care Sharing Assistance (Section 213)

The Alliance recommends that the Committee clarify 26 U.S. Code Section 213(d) to recognize health care sharing assistance as a deductible medical expense.

Because of its voluntary, non-contractual nature, it is unclear whether membership in an HCSM qualifies as health insurance for purposes of the medical expense deduction under Code Section 213 ("Medical, dental, etc., expenses"), although it serves a similar function. As a result of this uncertainty, amounts shared via an HCSM may not be able to be deducted as a qualified medical

expense, even though they are medical expenses. The IRS has not spoken to this issue.

The Alliance urges the Committee to remove this uncertainty by clarifying Section 213(d) to recognize health care sharing assistance as a deductible medical expense.

Issue 3: Tax Treatment of Employer Help for Health Care Sharing Assistance (Sections 104-106)

Neither Congress nor the Treasury Department has spoken to the question of how health care sharing should be treated for tax purposes relative to employer-provided health plans. As a result, more than 350,000 HCSM members are uncertain as to their reporting and tax liability with respect to the assistance they may receive for medical expenses from an employer.

The Alliance recommends that the Committee clarify the Code (as, for example, at Section 106) to ensure that employers are able to provide medical-expense related assistance to their employees who are HCSM members on a level playing field with their other employees who are not HCSM members. For example, Section 106 could be clarified to recognize such assistance as a tax-free fringe benefit.

Issue 4: HCSMS and ACA Employer Mandate Penalty (Fines) (Sections 4980D, 5000(b)(1))

The IRS has announced that certain employers who provide a "group health plan" that does not meet all the coverage requirements of the ACA (IRS Notice 2013-54) are liable to an excise tax penalty of $100 per day, per employee. It is unclear whether the IRS will penalize an employer who pays or reimburses an employee's health care sharing amount. In Notice 2015-17, the agency clarified that an "employer payment plan," by which an employer pays or reimburses the health insurance premiums of an employee's individual health insurance policy, is not a compliant "group health plan" for purposes of this provision and is therefore subject to the penalty tax. Although membership in an HCSM is neither insurance nor a group health plan nor an individual health insurance policy, and indeed HCSM membership is ACA compliant, there is a danger that the IRS could sweep health care sharing into the definition of group health plan or an individual health insurance policy for purposes of imposing this penalty. The agency could rely on Section 5000(b)(1), which defines "group health plan" very broadly to include "a plan … contributed to by an employer … to provide health care (directly or otherwise) to [employees]." Such an interpretation would be wrong, since Congress specifically declared HCSMs to be compliant under the ACA.

The Alliance urges the Committee to clarify Section 5000(b)(1) to protect employers from the $100 per day, per employee, excise tax who pay or reimburse an employee's health care sharing amounts. Additionally, it may be prudent for Congress to amend the definition of "group health plan" in the Public Health Service Act (42 USC 300gg-91) to clarify that an HCSM is not a

group health plan.

Issue 5: HCSMs and ACA Employer Mandate Penalty (Formula) (Section 4980H)

The Alliance urges Congress to correct a serious problem in the ACA employer mandate penalty formula that affects companies that employ members of HCSMs. Although by law HCSM members are exempt from the ACA's individual mandate, the employer mandate still applies to employers (including HCSMs in their capacity as employers) whose employees are HCSM members. This creates a serious problem.

Under Code Section 4980H ("Shared responsibility for employers regarding health coverage"), large employers, which are defined as those with 50 or more employees, can be faced with substantial employer-mandate penalties if some or all of their employees rely on an HCSM in lieu of traditional insurance. Those employees are counted toward the 50-employee threshold, even though they have chosen not to receive employer-provided health benefits, and are meeting their ACA individual responsibility by being HCSM members. The employer is liable for penalties through no fault of his own.

The Alliance urges Congress to remedy this inconsistency. The simplest way to do so would be to exempt employees who are members of HCSMs and their participating employers from the employer mandate penalty formula at Section 4980H(c)(2)(B) ("Exemption for certain large employers").

Conclusion

Health care sharing is not health insurance or a health plan. Rather, it is a federally recognized alternative to traditional insurance that has been chosen by hundreds of thousands of Americans to help meet their health care and spiritual needs.

While health care sharing serves some of the functions of traditional health insurance, and should receive similar tax treatment, it is not a "health plan" as traditionally understood and cannot be regulated like an insurance company without destroying its charitable and spiritual character.

To sum up, the Alliance urges the Committee to clarify certain tax issues, ideally in its next tax-reform package:

1. Make HSAs available to HCSM members. (Sec. 223.) (Enact H.R.1752, Rep. Kelly.)
2. Recognize health care sharing amounts as a deductible medical expense. (Sec. 213.)
3. Place health care sharing on a level tax playing field with excludable, employer-provided health benefits. (Secs. 104-106).

4. Clarify that it is not a "group health plan" under federal law.
5. End the inconsistent inclusion of HCSM members in the ACA employer mandate penalty. (Sec. 4980H.)

These changes are needed. Our hundreds of thousands of members look to this important Committee for relief. We are grateful for your help and leadership.

Thank you again for this opportunity to comment on the important topic.

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About the Alliance

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The Alliance is committed to advocacy in the public policy arena on issues of importance to health care sharing ministries. Our mission is to: a) inform legislators of the important work and benefit of health care sharing ministries; b) protect the liberty of our member ministries to practice their religious convictions in health care; c) seek exemptions from mandates requiring our members to purchase health insurance; d) seek exemptions from mandates requiring employers to provide health insurance; e) seek parity with other health care solutions with respect to federal and state tax codes; and f) encourage our member ministries to continue serving their members with this crucial, private sector, charitable solution to challenges in the health care arena.

Contact:
Alliance of Health Care Sharing Ministries
P.O. Box 389
Washington, IL 61571-0389
Office Phone: 888-726-4276

STATEMENT OF THE ALLIANCE TO FIGHT THE 40

ON

EMPLOYER-SPONSORED HEALTH COVERAGE

SUBMITTED FOR THE RECORD OF THE HEARING

ON

"THE TAX TREATMENT OF HEALTH CARE"

BEFORE

THE COMMITTEE ON WAYS AND MEANS

ON

APRIL 14, 2016

Introduction

I. Introduction

The Alliance to Fight the 40 welcomes the opportunity to provide comments for the record of the April 14, 2016 Committee on Ways and Means ("Committee") hearing on the "Tax Treatment of Health Care."[1]

The Alliance to Fight the 40 ("the Alliance") is a broad based coalition comprised of private sector and public sector employer organizations, consumer groups, patient advocates, unions, businesses and other stakeholders that support employer-sponsored health coverage. This coverage is the backbone of our health coverage system and protects over 175 million[2] Americans across the United States. The Alliance seeks to repeal the 40% tax on employee health benefits to ensure that employer-sponsored coverage remains an effective and affordable option for working Americans and their families.

Discussion

II. Background on Employer Sponsored Insurance

[1]Committee on Ways & Means Hearing Advisory: http://waysandmeans.house.gov/wp-content/uploads/2016/04/20160414HL-Advisory.pdf

[2]U.S. Census: https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf Table 1

Over 175 million Americans depend on their employers for health coverage, including retirees, low- and moderate-income families, public sector employees, non-profit organizations and small-business owners. Employer-sponsored insurance is efficient, effective and affordable for working Americans and their families. Employers have numerous incentives to manage costs and improve health outcomes by investing in innovative approaches such as on-site medical clinics, employee wellness programs and other initiatives. Ironically, such innovations would be penalized by the Affordable Care Act's looming 40% tax on employer-provided health coverage, which treats such programs only as expenditures that help to trigger the tax.

Employers also provide valuable assistance to employees regarding their health coverage, including assistance selecting the best health plans, navigating complex claims questions, choosing higher quality providers and other assistance. Changes that undermine or weaken the employer-sponsored insurance market, like the "Cadillac Tax," will force more people to the individual market for insurance, a market that is not as efficient, not as innovative, and that does not provide assistance for individuals to deal with complex claims questions.

Employer-sponsored insurance is more cost-effective than government health insurance programs. A 2014 study of health care expenditures by the American Health Policy Institute found that the federal government is spending nearly three times as much on health care for its beneficiaries as employers are spending to cover their employees.[3] "Employers pay significantly lower health costs per covered life than government programs," partly because of "the significant amount of improper payments that are still made," the study concluded. "Large employers spend considerable time and resources studying trends within their health plans and taking actions to address the underlying causes of what is driving their cost increases," and "have adopted a consumer-oriented approach that more actively engages their employees to seek out high-quality, low-cost health care.… If government policies move people from programs that cost less per individual to ones that cost more per individual, that could mean that we will be spending more on health care than currently anticipated over the next decade.[4]" Similarly, the collective purchasing power associated with employer-sponsored coverage, brings economies of scale that cannot be replicated in the individual market.

As the Committee continues to examine the tax treatment of employer-sponsored insurance, the Alliance hopes that some of the key "lessons learned" from the 40% tax on benefits (the so-called "Cadillac Tax") will inform its policy development. As discussed below, because the employer and employee share of premiums represents a significant portion of the costs that result in triggering the "Cadillac Tax," if the Committee explores options that rely on premium caps or premium thresholds, these proposals may unintentionally cause similar market disruption and harm to working Americans and their families.

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[3] American Health Policy Institute: http://www.americanhealthpolicy.org/Content/documents/resources/AHPI_STUDY_Cost_Per_Covered_Life.pdf.

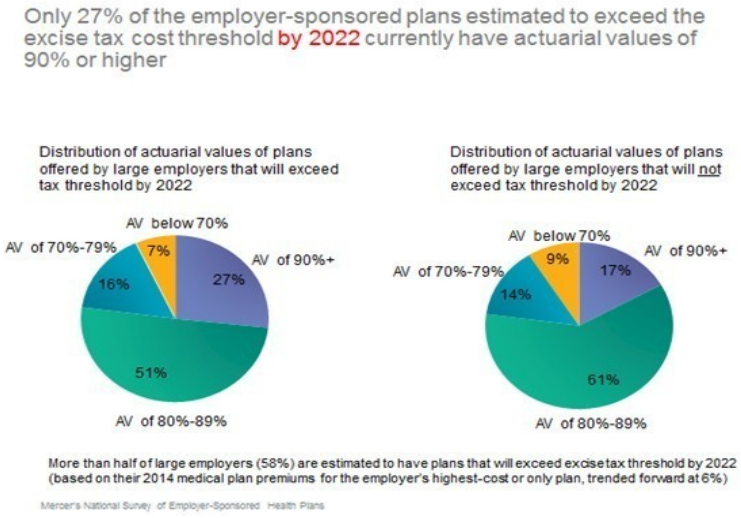
[4] American Health Policy Institute: http://www.americanhealthpolicy.org/Content/documents/resources/AHPI_STUDY_Cost_Per_Covered_Life.pdf

Employer-sponsored benefit plans are the primary source of health coverage for Americans. Even those who hope to increase the portability of health coverage must recognize the efficiency and quality in the existing employer-based health market. We hope that as the Committee explores new policy ideas that those ideas will avoid disrupting the elements of the current system that most agree work well.

III. Repeal the 40% "Cadillac Tax" on health benefits

Impact Far Beyond 'High-Priced' Plans. The ACA's 40% excise tax on employer-provided coverage – whose effective date was delayed from 2018 to 2020 by last year's omnibus spending agreement – would disrupt the health care marketplace by shifting costs to workers and impact all employer plans, contrary to the notion that only "gold-plated" high-value plans would be affected. The tax will apply to plans sponsored by both private- and public sector employers and nonprofit organizations. It penalizes employers that have employees with greater health care needs, workforces with higher numbers of older workers, and employers based in higher-cost areas. The tax will also affect families from all walks of life and in many professions, including low-wage and part-time workers; public servants who protect our safety, like firefighters and police officers; and workers in diverse professions and economic sectors, including retail, education, health care, hospitality, the clergy, and retirees.

The chart graphic displayed here makes clear that it is the population coverage of a plan -- not the relative richness of the benefits -- that determines whether a particular plan hits the tax. A plan in a higher cost area or with older or sicker workers will hit the tax earlier than a much more generous plan in a lower cost area or with a younger work force.



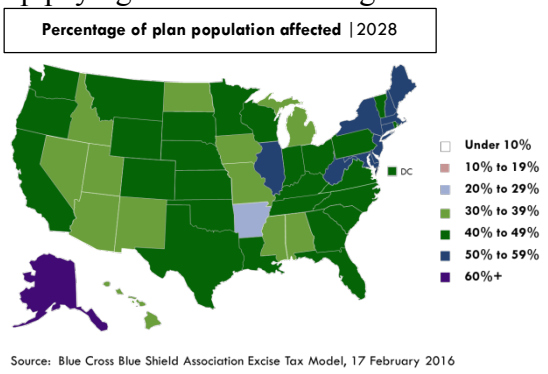
Greater Cost-Sharing. Recent studies by the American Health Policy Institute[5] and Aon Hewitt[6] indicate that significant numbers of employers are modifying their plan designs to avoid paying the 40% tax. Employee deductibles, cost-sharing and co-pays are increasing as employers modify their health plans to avoid triggering the 40% tax. Increasing the amount an employee pays is the main way to decrease the A/V of the plan. Increased cost-sharing will force workers to pay

[5] American Health Policy Institute, "ACA Excise Tax: Cutting Family Budgets, Not Health Care Budgets," October 2015, http://www.americanhealthpolicy.org/Content/documents/resources/AHPI_Excise_Tax_October_2015.pdf

[6] Aon Hewitt, "New Aon Hewitt Survey Shows Majority of Companies Taking Immediate Steps to Minimize Exposure to Excise Tax," October 16, 2014, http://aon.mediaroom.com/2014-10-16-New-Aon-Hewitt-SurveyShows-Majority-of-Companies-Taking-Immediate-Steps-to-Minimize-Exposure-to-Excise-Tax.

more for their health care without a corresponding enhancement of the value of the coverage for which they are paying. In addition, higher cost-sharing leads to lower and middle class insureds unable to actually access their insurance. As deductibles rise, and approach $5,000 or more, many middle income families, who *have* insurance, will not be able to access the medical system due to large out-of-pocket costs. The workers of those employers that contemplate paying the tax can expect their already high share of the premiums to rise even higher. And under the punitive structure of the tax's thresholds, plan features that are designed to promote better health and reduce costs – such as employee assistance plans, on-site health clinics, flexible spending accounts, health reimbursement arrangements, and both employer and employee pre-tax contributions to health savings accounts – are counted toward the thresholds that trigger the tax. Even the cost of preventive benefits such as cancer screenings and immunizations is included, despite the fact that the ACA requires such benefits to be provided with no employee cost-sharing.

Penalizes Employers for Factors Beyond Their Control. The 40% excise tax also unfairly taxes employers for factors they do not control. Employers with higher numbers of workers who have chronic diseases or larger families are disproportionately targeted by the tax, as are employers in specific industries, such as manufacturing or law enforcement. A study by the Economic Policy Institute found that because the tax is focused on high premiums, not high levels of coverage, companies that tend to pay higher premiums – such as small businesses and employers with a high proportion of sick workers – could wind up paying the tax even though their benefits are not particularly generous[7].



Source: Blue Cross Blue Shield Association Excise Tax Model, 17 February 2016

Geographic Disparities. Notably, people who live in higher-cost areas would pay more of the 40% tax for the same level of health coverage than people in lower cost areas. A 2014 report by the benefits consulting firm Milliman found that geography could potentially account for a 69.3% variation in premium. For example, a plan that would cost $9,189 in one area would cost $15,556 elsewhere[8]. The report also demonstrated that the 40% tax's age and gender adjustment features fail to compensate for the impact those factors have on premiums when combined with a high-cost geographic area and/or lower provider discounts.

President Obama's 2017 budget proposal identified the unfair geographic disparity caused by the tax and suggested a modest geographic adjustment. However, geographic disparities are just one of many flaws in the application of this tax. Since, as noted above, many features of employer-sponsored coverage (e.g. on-site clinics, flexible spending arrangements, etc) are included in the tax, tying an adjustment solely to the geographic differences in premiums, alone, does not address the numerous factors that are considered in determining whether the tax is triggered. And the proposal adds enormously to the complexity of calculating the tax. The administration has also requested a study of the impact of the 40% tax on sick

[7] Economic Policy Institute, "Increased Health Care Cost Sharing Works as Intended. It burdens patients who need care the most," May 8, 3013, http://www.epi.org/files/2013/increased-health-care-cost-sharing-works.pdf

[8] Milliman (study prepared for the National Education Association), "What does the ACA excise tax on high-cost plans actually tax?," December 9, 2014, http://www.nea.org/assets/docs/Milliman--What_Does_the_Excise_Tax_Actually_Tax.pdf

workers, but a study will not address the inequitable impact of the tax on plans that are expensive simply because they cover a large number of women, older or disabled employees.

Additionally, because the tax is indexed to the consumer price index, which is lower than health care inflation, every year an increasing number of health plans will be subject to the tax. In fact, 82% of employers already expect their plans will be affected by the tax within the first five years of implementation.[9]

IV. Measures to Reduce Health Care Costs

Instead of trying to raise revenue for the ACA with the blunt instrument of the 40% tax on employer coverage, Congress should focus on strategies to reduce the true cost of health care, such as delivery system reforms. These reforms will require improving meaningful price transparency and enhanced consumer tools and communication. Employers have been driving innovative delivery system reforms, experimenting with accountable care organizations (ACOs) and patient-centered medical homes (PCMH); innovative payment reforms like bundled payments, referenced based pricing and value based purchasing. Efforts related to systematically measuring and reporting quality; reducing health care fraud and abuse; simplifying administrative burdens at providers and insurers; adopting more health information technology; and programs that improve population health through a focus on at-risk populations and those with high needs and high costs offer more hope than tacking a new tax on top of an already costly product.

Administrative costs make up over a third of U.S. health care spending.[10] According to the Institute of Medicine, the United States spends $361 billion annually on health care administration — more than twice our total spending on heart disease and three times our spending on cancer.[11] Implementing the convoluted "Cadillac Tax" will only add complexity, cost and administrative burden to the system.

V. Capping the Tax Exclusion suffers many of the same defects as the "Cadillac Tax"

Capping or eliminating the current employee exclusion of employer-sponsored health benefits from income and payroll taxes, as some have proposed, would amount to a significant new tax on workers. This change would require workers to pay income and payroll taxes on employer-provided applicable coverage above the cap. This is not an effective tool to reduce health care costs in a way that still protects the health care needs of working Americans and their families.

As the Committee examines the tax treatment of employer-sponsored health coverage, the Alliance recommends that it consider key concerns related to lessons learned from the "Cadillac Tax." Because the employer and employee share of premiums represents a significant portion of the costs that result in triggering the "Cadillac Tax," if the Committee explores options that rely on premium

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[9] Towers Watson: https://www.towerswatson.com/en/Press/2014/09/nearly-half-us-employers-to-hit-health-care-cadillac-tax-in-2018-with-82-percent-by-2023

[10] New England Journal of Medicine: http://www.nejm.org/doi/full/10.1056/NEJMsa022033.

[11] National Center for Biotechnology Information: http://www.ncbi.nlm.nih.gov/books/NBK53942/.

caps or premium thresholds, these proposals may unintentionally cause similar market disruption and harm to working Americans and their families. Any new policy proposals should not disrupt elements of the current system that most agree work well.

- **The "Cadillac Tax" increases taxes on middle income families and retirees.** Middle income families and retirees will bear the brunt of the "Cadillac Tax," which increases costs to employees and employers without lowering the actual cost of health care. In order to avoid paying the tax, companies are already being compelled to shift the burden to employees in the form of higher deductibles, increased co-pays and thinner benefits. Proposals that directly tax employees could mistakenly recreate this problem. Joseph Antos, Ph.D., Wilson H. Taylor Scholar in Health Care and Retirement Policy for the American Enterprise Institute, in his testimony before the Committee, pointed out that the "Cadillac tax has serious defects." Antos highlighted that "low-wage workers are disadvantaged by the Cadillac tax" and that "the Cadillac tax will eventually impact everyone with employer coverage."

- **Reducing incentives to participate in employer coverage could increase government spending.** Employers contribute on average about 70% of the cost of employer-sponsored health care coverage. This is a significant benefit to the 175 million individuals receiving employer-sponsored coverage and it reduces the need for government subsidies to help individuals afford health care. Employers are a critical force in the market, negotiating with plans and providers to keep costs down and quality high. Employers also help employees navigate the complex health care system, improving their ability to act as informed consumers and providing them with tools to improve their health such as wellness plans and on-site medical clinics.

- **Taxing health care premiums has a negative impact on women, individuals with high cost health conditions, older workers, families, early retirees and small businesses**. The cost of plans varies greatly based on utilization and the insured population. Consequently the tax is expected to have a punitive impact on employers that cover greater numbers of higher cost populations like women (who actuarially have higher costs), individuals with expensive chronic health conditions or who suffer catastrophic health events, older workers, families, early retirees and small businesses.

- **Taxing health care premiums does not directly affect the unit cost of health care**. While taxing health benefits may decrease plan utilization the "Cadillac Tax" does not address the true costs that comprise the health care delivery process. It also does nothing to improve the actual health of American workers. The majority of health care costs are primarily driven by a relatively small population with high cost health care needs. Taxing their health coverage does not reduce their utilization of health services – it just makes it more expensive.

- **Taxing health care premiums targets families**. The Economic Policy Institute[12] has estimated that a number of proposals to cap or eliminate the exclusion and replace it with tax credits would be "more favorable towards (disproportionately advantages or disadvantages to a lesser degree) single plans over family plans. And, those with family plans will see a higher share of their premiums taxed than their single counterparts."

- **Taxing health care premiums leads to geographic disparities.** As noted above, health care costs vary across the country and within states. This means individuals living in higher cost areas would pay more tax for the same level of health coverage as individuals living in lower cost areas. So curtailing the value of the employee exclusion for health coverage would have the same geographic disparities as the "Cadillac Tax" displays.

Finally, the Congressional Budget Office (CBO) estimated that one alternative, a cap on the exclusion of $7,000 for individual coverage and $17,000 for family coverage, would cause 6 million fewer people to have employment-based coverage than current law.[13]

VI. Conclusion

As the Committee considers different proposals for the tax treatment of health care, we urge lawmakers to seek repeal of the forthcoming 40% excise tax on employer-sponsored health coverage. The tax endangers an employer-based health system that is demonstrably more efficient and cost-effective than other alternatives. The tax will force employees to bear more of the costs of their policies regardless of their ability to do so, a trend that is already emerging as employers prepare for the tax by increasing co-pays and other out-of-pocket expenses. Simply substituting other taxes on employer-sponsored insurance could produce some of the same damaging results, disproportionately affecting retirees, women, older workers, small businesses, and families that have employer-sponsored health coverage. Policymakers should focus on reforms to the health care delivery system as a way to achieve true savings and eliminate waste.

Thank you for the opportunity to share our concerns. We look forward to working with the Committee throughout your policy development.

For more information about the tax, the Alliance to Fight the 40, or this statement, please contact: info@fightthe40.com

[12] Economic Policy Institute : http://www.epi.org/files/2013/increased-health-care-cost-sharing-works.pdf

[13] CBO, "Health-Related Options for Reducing the Deficit: 2014 to 2023," December 2013,page 63, https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44906-HealthOptions.pdf

CAMPAIGN TO END OBESITY
ACTION FUND

April 28, 2016

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth HOB
Washington, DC 20515

The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth HOB
Washington, DC 20515

Dear Chairman Brady and Ranking Member Levin:

The Campaign to End Obesity Action Fund is the nation's leading obesity advocacy organization and convenes leaders from academia, public health, industry, and patient and disease communities to push for needed policy changes to reduce obesity rates in America.

We applaud the Committee on Ways and Means for hosting its recent hearing examining the tax treatment of health care. We encourage the Committee, as part of its deliberations, to consider specific tax policy changes to help combat obesity – the largest driver of rising health care costs in the United States - and, in doing so, save taxpayers billions of dollars.

Nearly 100 million Americans currently suffer from obesity, which costs taxpayers over $200 billion in unnecessary health care costs every year. Left unchecked, some estimates show that obesity rates could climb as high as 50 percent by 2030 and cost taxpayers, employers, communities, and families even more. This is a problem that we can no longer afford to ignore – particularly in economically-disadvantaged communities - and we believe that the Tax Code can and should play an important role in addressing elements of the challenge.

With this in mind, in 2014, 23 leading organizations – from the American Heart Association to Humana to the United States Soccer Foundation – signed onto the attached letter encouraging the Committee to use the Tax Code to "advance cost-effective policies that can bolster healthy lifestyles in key populations and hold promise for halting or reversing the nation's costly and unsustainable obesity epidemic."

It is our hope to work with the Committee on policy changes that will spur private interests to boost access for Americans of lesser means to nutritious food and safe, health-promoting physical activity spaces. These policies can target communities

most at risk for obesity and other chronic diseases in both rural and urban locations that are “food deserts” as well as communities with higher than average rates of physical inactivity. Some examples of such policies could include making the New Market Tax Credit permanent, enacting new incentives for private infrastructure investments or charitable donations of resources to bolster access to nutritious food outlets and safe, health promoting physical activity spaces, as well as creating incentives for employers to provide food and nutrition education to customers.

We appreciate your attention to this important matter and look forward to working with the Committee to advance tax policy proposals that can help ensure at-risk communities have access to the resources they need to enable all citizens to lead healthy lifestyles, reduce obesity and other chronic diseases, and in doing so, create tremendous long-term budgetary savings for all taxpayers.

Sincerely,

Chris Fox
Senior Director, External Affairs
Campaign to End Obesity Action Fund

CAMPAIGN TO END OBESITY
ACTION FUND

January 23, 2014

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Orrin Hatch
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Dave Camp
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Chairmen and Ranking Members:

We are writing to encourage you to use the opportunity presented by ongoing efforts to improve the Tax Code to advance cost-effective policies that can bolster healthy lifestyles in key populations, and hold promise for halting or reversing the nation's costly and unsustainable obesity epidemic.

As you know, the nation's obesity epidemic has the potential to bankrupt the healthcare system. Today, there are nearly 100 million Americans – children and adults – with obesity. American taxpayers spend nearly $200 billion on medical costs associated with obesity each year. Current projections show that, absent major changes, 50 percent of the American population will have obesity by 2030, driving health care costs even further.

There is an important role for the Tax Code in addressing elements of this challenge. Indeed, the Tax Code has long been used to reward priority corporate and individuals' actions which are valued by society and which are likely to yield benefits to the taxpayer base as a whole.

Against this backdrop, we ask you to champion new tax policies that can drive private sector efforts to bolster access among high-risk populations to improved food options and opportunities for safe physical activity. We believe that tax policy should include measures specifically designed to promote the type of infrastructure investments that will help make healthy lifestyles more accessible in communities where they currently are not.

Specifically, we believe that tax policy should embrace new approaches that will:

- Spur private interests to increase access to healthy, affordable foods in economically disadvantaged communities;
- Yield increased access by these communities to safe recreational spaces;
- Support economically disadvantaged individuals specifically for their efforts to adopt health lifestyle choices that are likely to reverse or prevent obesity and other chronic diseases, as well as businesses who invest in tools and resources for these consumers to effect such choices; and
- Be targeted to benefit those individuals and communities most at risk for obesity and other chronic diseases.

We look forward to working with you to advance more specific measures which can fulfill these principles and, in doing so, yield crucial and urgent health and economic benefits for our nation.

Sincerely,
Campaign to End Obesity Action Fund
American College of Preventive Medicine
American College of Sports Medicine
American Council on Exercise
American Heart Association
American Hiking Society
Arena Pharmaceuticals
Change Lab Solutions
Health Education Council, Break Free Alliance
Hepatitis Foundation International
Humana
International Health, Racquet and Sportsclub Association
MEND Foundation
MomsRising.org
NAACP
National Association of Chronic Disease Directors
National Association of County and City Health Officials
National Center for Weight and Wellness
National Coalition for Promoting Physical Activity
National Hispanic Medical Association
Orexigen Therapeutics, Inc.
United States Soccer Foundation
Weight Watchers International

National Association of Specialty Health Organizations
An AAPPO Partner Association
www.nasho.org
NASHO

April 28, 2016

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady,

The National Association of Specialty Health Organizations (NASHO) is writing to voice our support for the current exclusion of the employer-sponsored insurance (ESI) from federal income and payroll taxes. At the April 14 Ways and Means Committee hearing on the tax treatment of health care, the Committee discussed changes to the exclusion, including limiting the amount an employee could contribute to their own health care premiums tax-free. While some argue the exclusion increases the cost of health care, we believe that the exclusion makes specialty health services more affordable and accessible, ultimately improving the health and wellness of employees.

NASHO is a membership organization representing health plans and provider networks that facilitate and support the delivery of specialized health care services. NASHO member organizations provide services to over 250 million Americans. Specialty care includes services such as: behavioral health, chiropractic, complementary care, dental, hearing, pharmacy benefit management, physical therapy, radiology management, vision, ancillary specialty care, and other services that compliments core health care benefits .

The tax exclusion is the foundation for our present employer-sponsored-insurance system. Most people under 65 get their insurance through their employer. Considering the average annual premium costs in 2015 are $6,251 for individual coverage and $17,545 for family coverage, this exclusion provides a significant benefit for many employees.[1]

NASHO is concerned about the unintended consequences of changing the tax treatment of ESI. ESI provides a way to create large pools of individuals in which to spread risk. Without the tax exclusions, employers may decide to stop offering coverage for their employees.

Under proposals that would cap the exclusion, employers would provide less generous coverage to their employees. Employees could face a loss of benefits and increased cost sharing as employers seek to lower their premium costs to come in under the cap. This could result in a loss of specialty health services that:

- deliver preventive services to help keep people well,

[1] Employer Health Benefits 2015 Annual Survey, the Kaiser Family Foundation and the Health Research & Educational Trust.

974 Breckenridge Lane #162 • Louisville, Kentucky 40207 • 502-403-1121 • jroberts@nasho.org

- detect and treat problems early to prevent health care complications and/or comorbidities,
- reduce tertiary care costs,
- support people in behavior change and wellness behaviors,
- control costs by improving the efficiency of services and investing in prevention,
- improve the safety of medications and services, and
- improve overall health outcomes.

Caps based on employer premiums could create inequities for workers that are older, that work in high-cost areas, or that work for small businesses. These employees could face disproportionately higher taxes. Additionally, removing the tax exclusion for ESI would increase the cost of the provision of health insurance and as these costs rise, beneficiaries will look for ways to reduce their spending—potentially eliminating efficient and effective specialty health benefits.

We urge the Committee to consider the impact employees could face when changes to the tax treatment of the ESI are contemplated. **NASHO opposes any policy changes that will limit access to specialty care and urges Congress to preserve the long-standing tax exclusion of employer-sponsored insurance**.

For additional information or questions, please contact NASHO Executive Director Julian Roberts at 404-634-8911.

Sincerely,

Julian Roberts
Executive Director
NASHO

974 Breckenridge Lane #162 • Louisville, Kentucky 40207 • 502-403-1121 • jroberts@nasho.org

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April 13, 2016

The Honorable Kevin Brady
Chairman
Committee on Ways & Means
301 Cannon House Office Building
Washington, DC 20515

The Honorable Sandy Levin
Ranking Member
Committee on Ways & Means
1236 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady and Ranking Member Levin:

Thank you for holding this important hearing about the way in which the federal government utilizes the tax code to improve and provide health care access to many Americans. We appreciate the opportunity to offer written testimony on one aspect of how the tax code impacts health care affordability -- the medical expense deduction. In particular, a recent change for taxpayers under age 65 – and one that is scheduled to impact taxpayers age 65 and over in 2017 – has reduced affordability for those with high health care costs.

In 2013, the income threshold to be able to claim this deduction increased to 10 percent (from 7.5 percent) of income for those up to age 64. The threshold – which has remained at 7.5 percent of income for those 65 and older – is set to increase to 10 percent on January 1, 2017, representing a tax increase on millions of seniors.

AARP, with its nearly 38 million members in all 50 States and the District of Columbia, Puerto Rico, and U.S. Virgin Islands, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

Since the 1940s, Americans with high health care costs have been able to deduct medical expenses from their taxes. For the approximately eight to ten million Americans who annually take this deduction, it provides important tax relief which helps offset the costs of chronic medical conditions as well as long term care. Medical expenses can include amounts paid for prevention, diagnosis, treatment, equipment, qualified long-

term care services, and limited amounts paid for any qualified long-term care insurance contract.

Last September, Rep. Martha McSally (R-AZ), Rep. Krysten Sinema (D-AZ) and others introduced the bipartisan *Halt Tax Increases on the Middle Class and Seniors Act*, H.R. 3590. This legislation, endorsed by AARP in January, would return the income threshold to deduct medical expenses back to the pre-2013 threshold of 7.5 percent of income. Importantly, it would prevent the looming tax increase scheduled for next year on those who are both ages 65 and older and have high health costs.

AARP believes this deduction – with a threshold based on a percentage of income – is truly middle class tax relief. According to 2013 estimated IRS tax data:

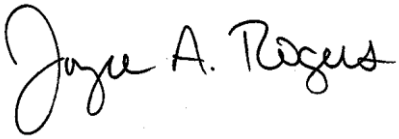
- 73 percent of those claiming the deduction reported income of $75,000 or less;
- 52 percent of those claiming it reported income of $50,000 or less;
- At least 25 percent of all returns claiming the deduction had at least one member of the household who was age 50-64; and
- 56 percent of all returns claiming the deduction had at least one member of the household age 65 or older.

In December 2015, Congress voted – and the President signed into law – delays of the medical device tax, the excise tax on high-cost employer sponsored health plans (known as the "Cadillac Tax") and a tax on health insurance. While these tax delays only indirectly affect consumers, the medical expense deduction is a direct tax benefit that helps millions of moderate income Americans each year.

On behalf of our 38 million members and all older taxpayers, we urge that the scheduled increase in the medical expense deduction be reversed, maintaining the current 7.5 percent of income threshold for those age 65 and older and restoring the previous lower threshold for all Americans.

Thank you for the opportunity to submit written testimony on this important tax issue to improve health care affordability. If you have further questions, please feel free to contact me or have your staff contact Andrew Schwab on our Government Affairs team at aschwab@aarp.org or 202-434-3770.

Sincerely,



Joyce A. Rogers
Senior Vice President
Government Affairs

ERIC The ERISA Industry Committee

The Only National Association Advocating Solely for the Employee Benefit and Compensation Interests of America's Largest Employers

1400 L Street, NW, Suite 350, Washington, DC 20005 • (202) 789-1400 • www.eric.org

Statement by The ERISA Industry Committee re: House Committee on Ways and Means' April 14, 2016 Hearing on the Tax Treatment of Health Care

Chairman Brady, Ranking Member Levin, and members of the Committee, thank you for this opportunity to submit a statement for the record on behalf of The ERISA Industry Committee (ERIC), regarding the hearing on the tax treatment of health care. ERIC is the only national trade association advocating solely for the employee benefit and compensation interests of the country's largest employers. ERIC supports the ability of its large employer members to tailor retirement, health, and compensation benefits for millions of workers, retirees, and their families. ERIC's members provide comprehensive health and retirement benefits to millions of active and retired workers and their families. Preserving and enhancing the employer-sponsored health and retirement systems and the tax incentives that support them are key policy goals of ERIC and its members.

About 175 million Americans currently enjoy health benefits provided by their employer under the uniform, national framework established by the Employee Retirement Income Security Act (ERISA). Most of these Americans receive a generous subsidy from their employers towards their health insurance premiums, and the portion of the premium paid by employees is paid with pre-tax dollars. However, the tax treatment of premiums is only one of the numerous benefits that employees in employer-sponsored plans enjoy.

Trusted, Expert Intermediaries

Plan sponsors serve as a trusted intermediary on behalf of employees. They compare offerings from insurers or third party administrators (TPAs), and select the vendors that best meet the needs of their employees. Employers negotiate on behalf of employees, working to ensure good provider networks, affordable premiums, fair drug formularies, and reasonable cost-sharing. Major employers have staff expertise or engage with external vendors that allow them to ensure high-quality coverage for the lowest price possible. Because employers negotiate on behalf of hundreds or thousands of workers and their families, they are able to maximize the benefits for their employees. In some cases, when an employee's claim is denied, an employer may advocate on behalf of the patient to get them the care they need.

Changes to the tax code that would reduce or eliminate the ability or willingness of employers to sponsor plans would cause these advantages to disappear. Although individuals may be pooled by insurers, they would have no ability to negotiate with insurers. Assertions that managed competition would solve this problem have not been borne out in reality. Individuals lack the expertise of employers in comparing numerous health plans, benefits covered, formularies and prescription tiers, and provider networks. Giving individuals a tax credit instead of preserving the employer-sponsored system would in no way make up for the loss of this trusted, expert intermediary, and would leave most Americans worse off, require them to invest more time and effort in enrolling in health insurance, and would deny them the benefit of strength in numbers. And if someone on the individual market has a claim denied, their only recourse is a government-mandated appeals process.

It is true that there is a subset of people who do not have an offer of affordable health insurance from an employer, are not eligible for subsidized insurance through an exchange, and are not covered by safety net or entitlement programs. Those individuals do face a real disadvantage in not being able to purchase insurance with pre-tax dollars, and Congress should pursue tax equity for them. But Congress should not attempt to offset the cost of this tax change by implementing a tax on the benefits currently enjoyed by 175 million Americans. Congress should also be aware that providing individuals with a tax credit will not replace the value that employers bring to the system.

Pursuing Quality, Value, and Affordability

Employers are at the cutting edge of developing and implementing efforts that increase health care quality, maximize the value of health care and benefits, and improve affordability for employees and their families. Employers pioneered directing employees to centers of excellence and the highest quality providers in order to ensure high quality care. Employers were on the front lines of funding patient-centered medical homes for employees, ensuring they received coordinated care. Employers created incentives for providers to avoid "never events" and to increase medication adherence. Employers have championed consumer-driven health care, and to support that effort, have been consummate advocates for health care cost and quality transparency and health savings accounts and health reimbursement arrangements. Employers took the lead in transitioning to health information technology and e-prescribing. And employers fund fraud prevention efforts to keep premiums affordable for employees.

Employers have engaged in these activities because they have both health expertise and a common interest with employees to ensure employees and their families receive high-quality, affordable care. If employers are removed from this equation, individuals will lose a tireless force advocating for investments of time and money to implement efforts such as these. Providing individuals with a tax credit and transitioning away from the employer-sponsored system will not give them the purchasing power or expertise necessary to demand insurers engage in appropriate efforts to promote more quality improvement and to maximize affordability. Instead, it will deprive Americans of an innovative force that has worked on behalf of employees to maximize quality, value, and affordability for decades.

Care, Not Just Insurance

Many employers go beyond simply financing health insurance, and actually help meet the medical care needs of their employees. Some employers have developed onsite clinics where employees can receive care, and onsite fitness facilities to help employees stay healthy. Others have funded and participated in health information exchanges for their plan employees or telemedicine services to make it easier for employees to access needed care. Others have implemented company-wide electronic health records for employees. Employers help connect employees with vaccines, creating convenience for employees and reducing the rate of transmission of many significant diseases. Employers engage in pandemic preparedness efforts in case their regions experience a medical emergency. And many employers offer comprehensive wellness programs, designed to improve the health of plan employees, in turn helping to control premium costs.

Employers engage in these activities to control costs, to maximize worker productivity, and to benefit employees and their families. They do it because they can and they know it helps. Disrupting the employer-sponsored system will remove the funding and innovation behind these activities, and providing individuals with a tax credit will not fill this gap.

Cadillac Tax by Any Other Name

The Affordable Care Act (ACA) is partially financed through the Cadillac tax (the 40% excise tax on high cost employer-sponsored coverage). The Congressional Budget Office's estimate of the revenue this tax would generate (presumably to offset the costs of other parts of the ACA) is based on the erroneous and baseless assumption that employers will increase employee compensation to offset the cost of paying for health care. There is no evidence that employers will increase pay in lieu of paying health care costs – it is a purely theoretical argument.

The Cadillac tax has virtually the same effect as capping the employee exclusion for employer-provided health care, but it was cleverly tailored to appear not to undermine employer-sponsored plans. However it is characterized, though, capping the exclusion for employer-sponsored health insurance would have the same negative impact on employers and employees as the Cadillac tax and create the same administrative burdens applying to the tax. Both are counterproductive policies that undermine the one part of the health care system that has worked.

Employers are deeply concerned about the Cadillac tax because of its virtually unimaginable complexity as well as the fact that it does not tax "generous" plans; rather, it penalizes plans that are expensive because they cover individuals in high-cost areas, have high percentages of older, sicker people, and/or have a large gender imbalance, among other factors. In addition, although the threshold for the Cadillac tax is indexed, it is indexed at a lower rate than the rate at which medical costs actually increase. Thus, in practice, although a significant number of plans will be subject to the tax when it begins, over subsequent years it will touch all employer-sponsored insurance. This is likely to have the same impact as capping the exclusion for employer-sponsored care; it will lead to a massive disruption in this type of health insurance, causing many workers and their families to lose the many significant benefits of employer-sponsored health plans.

In other words, support for capping the exclusion is the equivalent of supporting the Cadillac tax, and both have the potential to significantly disrupt or end the employer-sponsored health system. Without employer-sponsored insurance, 175 million people would be likely to seek health insurance through exchanges, which are ill-prepared to deal with such a large influx of new customers, in addition to other problems that members of this Committee have frequently pointed out about ACA exchanges.

Go With What Works

While there is concern that individuals who obtain health coverage directly rather than through an employer do not receive the tax benefit afforded those in employer coverage, it is inappropriate to implement policies that risk dismantling the employer system in order to "raise" revenue to spend on pursuing equitable treatment for those without employer coverage.

Separately, for decades, academic economists have advocated for an end to the employer-sponsored system, which has and continues to work well for 175 million Americans. Their reasoning relies on purely theoretical assumptions, and the solutions they develop in order to help a relatively small number of people would have outsized negative consequences on a majority of Americans. Perhaps because they know how unpopular it would be to simply abolish the tax-favored status of health insurance benefits, some advocate for policies that would have the same effect, albeit in a less visible fashion. They assume that consumer pressure and competition would lead to all the same innovations and improvements that

employer involvement as plan sponsors has achieved, but conveniently overlook the fact that employers and individuals do not have the same leverage. They assert that the current system is unfair and creates "job lock," even though those who do not have an offer of affordable employer coverage may be offered generous premium support, and virtually every major employer does offer health insurance benefits. They claim that the employer-sponsored system is regressive, even though it is the only non-government system that offers individuals uniform benefits, and pays most of their premiums, no matter where they work, where they live, or where they receive medical care.

Instead of exploring ways to undermine the employer-sponsored system, we urge Congress to consider ways to improve health care for all Americans, such as advancing consumer-driven options like Health Savings Accounts, improving quality and transparency for patients, and ensuring innovation for more therapies to treat and cure Americans.

Above all, instead of threatening the employer-sponsored system, we urge Congress to strengthen it by reducing onerous rules and regulations that inhibit the ability of employers to offer high-quality health care to their employees and their families. Congress should consider eliminating administratively wasteful and unnecessary reporting requirements on employers, assuring employers that their ability to offer onsite medical care, meaningful wellness programs and health savings accounts will not be threatened, and ensure that employers are incentivized to offer generous benefits and full-time positions to Americans by defining the work week as 40 hours. And most of all, instead of doubling-down on the dangerous Cadillac tax, Congress should repeal it.

Conclusion

Thank you for this opportunity to submit testimony on this important issue. ERIC stands ready to work with Congress to enact legislative changes that will strengthen the employer-sponsored system, improving health coverage, cost and quality for the 175 million Americans who currently receive health insurance through employers. If ERIC can be of further assistance, please do not hesitate to contact James Gelfand, Senior Vice President for Health Policy, at jgelfand@eric.org or (202) 789-1400.

NATIONAL ASSOCIATION OF WORKSITE HEALTH CENTERS

Statement by the National Association of Worksite Health Centers re:
House Committee on Ways and Means on
the Tax Treatment of Health Care

On behalf of the National Association of Worksite Health Center (NAWHC), I'm pleased to submit to you our organization's views and recommendations related to how employer onsite and near-site health and wellness centers ("clinics") should be treated under the Affordable Care Act's provisions related to applying an excise tax on employer health benefits over specific threshold amounts.

The Chicago-based, NAWHC (www.worksitehealth.org) is the nation's only non-profit association supporting employer-sponsors of onsite, near-site, mobile health, pharmacy, fitness and wellness centers. It assists employers in exploring this benefit strategy and in developing and expanding the capabilities of onsite centers to integrate all worksite primary, acute, behavioral health, occupational health and chronic care services and wellness programs.

We conduct educational programs, networking and benchmarking activities, while serving as an advocate for the employer-sponsors of worksite health centers. NAWHC also provides online resource materials on worksite health and fitness centers, on-site pharmacies and wellness centers at www.worksitehealth.org.

Overview of Worksite Health Activities

It's important for the Committee to understand that even before the ACA was passed, employers of all sizes offered a broad array of services to workers:

- Treatment of injuries
- Occupational health
- Identification of risks
- Prevention of illness
- Health education
- Chronic disease management
- Wellness programs
- Primary care
- Health coaching
- Ancillary services, such as pharmacy, lab, therapy, dental and other services

Since the 1930's, employers, especially manufactures, began providing first aid or occupational health clinics to address worksite injuries and accidents. These have now evolved to address the high cost, fragmentation and limited resources of various communities health care systems, as well as the needs of covered populations.

The Value and Prevalence of Employer Health Clinics

Employers have found that an onsite center offers a vehicle to integrate, enhance and increase the coordination of care and the engagement of workers in employer-sponsored health-related services and programs.

Today, around 30% of public and private employers offer some form of onsite, near-site or mobile health services to employees, dependents, retirees and others. While many vendors recommend at least 1000-1500 employees in a single location to support center, many employer-sponsors of centers have smaller populations. Centers range from one day a week operations, led by Nurse Practitioner or Physician Assistant, to 5-7 day a week centers, open evenings and weekends, primarily staffed by physicians.

Worksite health centers are not limited to large employers or manufacturers or those in rural locations. We find employers as small as 100 workers, in all industries and communities ,have found value in offering onsite care.

Employers find onsite or near-site clinics help them and their workforces deal with a variety of key problems and challenges, including access to care, having to leave work for extended time to get care or services, lower productivity, high out of pocket costs for community providers, high use of emergency rooms for non-emergency conditions and lack of time to address health problems.

While many employers who have clinics locate them onsite, an increasing number use near-site clinics, mobile vans, telemedicine or even physician visits to the worksite to provide easily accessible services. Over 60% offer services at no or minimal cost to employees.

Regardless of the model used, employers find these clinics meet their financial, health and wellness objectives, lowering the need for outside high cost services, increasing the health of the workforce, enhancing productivity levels, reducing absenteeism, all while providing a benefit that is highly regarded by employees.

Onsite Clinics and the Excise Tax

As we look at the ACA and its relationship and impact of employers, it seems clear to us that that the law seeks to achieve the Triple Aim of reducing costs, improving patient experiences and improving the health of populations. Employer onsite clinics were developed and are successful in achieving these same objectives.

The excise tax was intended to reduce costs in the health care system by having employers reduce or eliminate high cost- Cadillac- benefits. Clinics accomplish this reduction of costs by offering workers improved access to convenient no or low cost services, reducing the need for expensive emergency room care for non-emergency conditions.

We believe that employers who sponsor clinics should be incentivized to expand and offer more clinics, not penalized which will discourage their growth and use.

COBRA and legislators at its passage never contemplated the evolution of onsite clinics from basic first aid to what they are today. Subsequently, the old language defining "clinics" should not be barrier to how onsite clinics have evolved or taxed.

If clinics are subject to the excise tax, this may significantly undermine the progress employers have made in reducing costs and improving the health of their workforces. It will discourage expansion of these accessible, affordable and integrated medical settings.

Recommendations for Clinic Services to be Excluded from the Excise Tax

There are a number of services offered thru clinics that are either government mandated or represent a very small percent of the total cost of care that should be excluded from the excise tax calculation. These include the following:

1. Any service required by federal, state or local laws or intended to protect the safety and health of workers, i.e. OSHA, workers comp and occupational health services

2. Low cost, insignificant services: allergy shots, minor injuries, accidents, immunizations, tobacco cessation, weight loss, prenatal services, condition monitoring-wellness programs – such as those provided in retail clinics

3. Primary care services, which represent a small amount -less than 5% - of an employer's total health care costs. The ACA doesn't tax local providers for these services, so neither should employer clinics be taxed

4. Clinic services offered at fair market value, which should not be strictly defined, as each community has its own levels of cost for care

5. Clinic utilities and other expenses provided in an employer's normal course of business when the medical facility is housed in an employer's building and such services and costs cannot be separately identified as specific to the clinic.

6. Onsite services provided as a stand-alone plan, subject to COBRA

7. Onsite service by an outside health care provider, where the employer only offers space

8. Behavioral health, EAP services provided as part of an employer's drug/alcohol programs

We would also propose two alternative approaches to excluding clinics and their services:

- Exempt the cost of services up to a certain amount, such as annual covered life $750 a year or 10% of the existing excise tax; or
- Exempt clinic services that paid for thru an employer's health plan, which is already to be taxed, as this would result in double taxation, but still exclude the items in 1-8 above for the tax calculation of an employer's plan.

I would be pleased to provide additional information or insight into any of the above background or recommendations, either via email, on the phone or in person.

Thank you for your consideration of our perspective and recommendations.

Sincerely.

Larry S. Boress
Executive Director

April 12, 2016

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

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

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

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

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

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

Dear Committee Chairmen and Ranking Members:

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

Soaring health insurance premiums have thwarted the ability of many small business owners to provide, and their employees to obtain, health coverage. From 2010 to 2015, premiums for small firms increased 25 percent, from an average monthly family premium of $1,104 to $1,385.[1] Similar, if not greater, premium increases are expected to continue in the years ahead.

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

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

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

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

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

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

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

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

Sincerely,

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

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

HR POLICY ASSOCIATION®
The Association of Chief Human Resource Officers

April 14, 2016

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
U.S. House of Representatives

Dear Chairmen Brady:

HR Policy Association welcomes the opportunity to provide a statement for the record to the Committee on Ways and Means regarding the hearing on the tax treatment of health care. HR Policy is the lead organization representing chief human resource officers of more than 360 of the largest corporations doing business in the United States. The member companies provide health care coverage to over 20 million employees, dependents and retirees, and collectively spend more than $106 billion annually on health care in the U.S.

Private sector employers strongly urge Members of the House Ways & Means Committee to carefully consider any changes to the tax treatment of employer-sponsored health benefits that may adversely impact employees and employers. Providing tax credits for purchasing individual coverage should not come at the expense of those who receive health care through their employer.

According to the Congressional Budget Office, limiting the tax incentives for employment-based health care benefits would increase the financial burden on some people with substantial health problems, and employees in firms in areas with above-average health care costs would be more likely to see their taxes increase.

Instead of discussing policy changes that could potentially increase taxes on employees, Congress should repeal the Affordable Care Act's 40 percent excise tax on high-value employer-sponsored health care benefits. The threat of the tax, which is scheduled to take effect in 2020, is continuing to undermine benefits employees greatly value, and limiting innovative approaches to health and wellness that are reducing, rather than driving, national health expenditures.

Sincerely,

Daniel V. Yager
President and Chief Executive Officer

Statement for the Record
U.S. House of Representatives
Ways and Means Committee

Regarding
Tax Treatment of Health Care

April 14, 2016

Submitted by:
The National Association of Health Underwriters

National Association of Health Underwriters
1212 New York Avenue, NW
Suite 1100
Washington, DC 2005
(202) 595-5060
(202) 747-6820 Fax
www.nahu.org

Chairman Brady,

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefit specialists. Our members service the health insurance policies of millions of Americans and work on a daily basis to help individuals and employers purchase, administer and utilize health insurance coverage that best fits their needs and budgets, and service this coverage on a year-round basis. NAHU appreciates the opportunity to provide written testimony for the House Committee on Ways and Means hearing on "The Tax Treatment of Health Care," and we would like to take this opportunity to encourage the committee's support for the continuation of the "employer exclusion."

The employer exclusion is used to reference the tax benefit that excludes employer-provided contributions toward an employee's health insurance from that employee's compensation for income and payroll tax purposes. This exclusion makes employer-provided health coverage an attractive form of compensation for workers. According to a new poll from Accenture, three-quarters of workers see health benefits as a "vital reason" for continuing to work for their employers, and one-third would quit if their employers stopped offering insurance. A similar percentage said they wouldn't work as hard if their benefits disappeared.[1]

Employer-sponsored coverage is the bedrock of private insurance coverage in the United States. According the Bureau of Labor Statistics, about 175 million Americans have employer-sponsored coverage and are statistically more likely to maintain coverage year after year.[2] Providing coverage through employers or other group arrangements offers controlled entry and exit in the health insurance market, which ensures the spreading of risk, federally guaranteed consumer protections like portability rights, the ease of group purchasing and enrollment, and the economies of scale of group purchasing power. In addition, it is a means for employers to provide equitable contributions for their employees.

Several recent health insurance and tax-reform proposals have suggested eliminating or capping the tax exclusion provided to individuals who have employer-provided group coverage and perhaps substituting it for some other tax preference. Capping the exclusion for employees would degrade the benefit and serve as a tax increase for middle-class Americans. Eliminating the exclusion would mean that most of the advantages of employer-provided coverage would no longer exist: No longer would there be a potent means for spreading risk among healthy and unhealthy individuals; employers and individuals would lose many group purchasing efficiencies; workers would be less likely to have their employer as an advocate in coverage disputes; employers would be less likely to involve themselves in matters of quality assessment and innovation; and employers could suffer in terms of worker productivity and labor costs because employer-sponsored insurance leads far more workers to purchase health insurance than they would on their own. Some employers would not meet participation requirements for group coverage so the entire workforce would lose employer-sponsored coverage. This shift might seem minor, but it could compel employers to stop providing health insurance, according to the

[1] http://www.plansponsor.com/Health-Insurance-Critical-for-Retaining-Employees/
[2] https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf, Table 1

Congressional Budget Office and the Joint Committee on Taxation.[3] Companies will expect their employees to secure affordable coverage in the individual market. For many people, particularly older and lower-income workers, that may be impossible, even with the implementation of the Affordable Care Act.

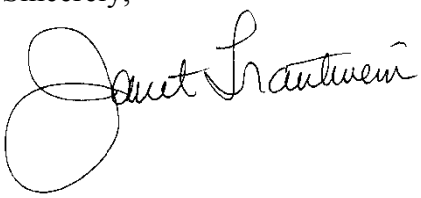
One plan would eliminate the tax exclusion for employer-provided health insurance, preventing companies from purchasing coverage with pre-tax dollars, and instead provides individuals with a tax deduction of $7,500 a year for buying insurance. Families would receive a deduction worth $20,500.[4] These types of tax deductions would encourage young, healthy workers to forgo employer-sponsored insurance because they could purchase cheaper plans elsewhere. Employers would be left with an older, sicker risk pool, thus higher costs – if the can get group coverage at all. As costs escalate, even the most generous employers may quit offering health insurance altogether. De-linking coverage from employment like this would make health insurance more expensive and less accessible, thereby contradicting the objectives of the Affordable Care Act.

Adding to the threat to employer-sponsored insurance is the increase in cost to the employers. In a recent survey, almost 90 percent of businesses reported that their costs had increased because of the law.[5] Employers are responding by laying off workers, making full-timers part-time so the mandate doesn't apply or dropping coverage altogether. In all three cases, the result is fewer people with employer coverage.[6] [7] [8] [9]

Getting businesses out of the healthcare business would be a mistake. We urge you to maintain the system that has worked for Americans for decades, and preserve employer-sponsored health coverage through the continuation of the employer exclusion.

NAHU sincerely appreciates the opportunity to provide these comments and we look forward to working with you as you continue to make improvements for health insurance consumers and employer-sponsored coverage. If you have any questions, or if NAHU can be of further assistance to you, please feel free to contact me at 202-595-0787 or jtrautwein@nahu.org.

Sincerely,



Janet Trautwein
CEO, National Association of Health Underwriters

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[3] http://www.cbpp.org/research/health/republican-study-committee-health-plan-would-likely-result-in-many-more-uninsured
[4] http://eba.benefitnews.com/news/health-care-reform/republicans-propose-controversial-aca-fix-eliminating-employer-exclusion-2746596-1.html
[5] https://www.ifebp.org/bookstore/aca2014/Pages/default.aspx
[6] http://news.investors.com/politics-obamacare/090514-669013-obamacare-employer-mandate-a-list-of-cuts-to-work-hours-jobs.htm?fromcampaign=1
[7] http://www.help.senate.gov/imo/media/doc/Webb.pdf
[8] http://healthaffairs.org/blog/2014/06/04/repeal-and-replace-the-employer-mandate/
[9] http://www.mlive.com/business/west-michigan/index.ssf/2015/01/affordable_care_act_prompting.html

Statement
of the
U.S. Chamber
of Commerce

ON: **"The Tax Treatment of Health Care"**

TO: **The House Ways and Means Committee**

FROM: **Randel K. Johnson, Senior Vice President**
Labor, Immigration, & Employee Benefits,
U.S. Chamber of Commerce

DATE: **April 28, 2016**

The Chamber's mission is to advance human progress through an economic, political and social system based on individual freedom, incentive, initiative, opportunity and responsibility.

The U.S. Chamber of Commerce is the world's largest business federation representing the interests of more than 3 million businesses of all sizes, sectors, and regions, as well as state and local chambers and industry associations. The Chamber is dedicated to promoting, protecting, and defending America's free enterprise system.

More than 96% of Chamber member companies have fewer than 100 employees, and many of the nation's largest companies are also active members. We are therefore cognizant not only of the challenges facing smaller businesses, but also those facing the business community at large.

Besides representing a cross-section of the American business community with respect to the number of employees, major classifications of American business—e.g., manufacturing, retailing, services, construction, wholesalers, and finance—are represented. The Chamber has membership in all 50 states.

The Chamber's international reach is substantial as well. We believe that global interdependence provides opportunities, not threats. In addition to the American Chambers of Commerce abroad, an increasing number of our members engage in the export and import of both goods and services and have ongoing investment activities. The Chamber favors strengthened international competitiveness and opposes artificial U.S. and foreign barriers to international business.

The U.S. Chamber of Commerce ("Chamber") welcomes the opportunity to submit this statement for the record following the April 16, 2016, hearing of the House Ways and Means Committee on "The Tax Treatment of Health Care." The Chamber is the world's largest business federation representing the interests of more than 3 million businesses of all sizes, sectors, and regions, as well as state and local chambers and industry associations. The Chamber is dedicated to promoting, protecting, and defending America's free enterprise system.

More than 96% of Chamber member companies have fewer than 100 employees, and many of the nation's largest companies are also active members. We are therefore cognizant not only of the challenges facing smaller businesses, but also those facing the business community at large.

Besides representing a cross-section of the American business community with respect to the number of employees, major classifications of American business—e.g., manufacturing, retailing, services, construction, wholesalers, and finance—are represented. The Chamber has membership in all 50 states.

The U.S. Chamber of Commerce has long advocated for meaningful health care reform. After convening a cross section of our member companies in 2012, our Health Care Solutions Council articulated a commitment to: "achieving greater value in health care, as measured by more affordable coverage options and greater access to higher-quality, prevention-oriented care, leading to better population health and sustainable U.S. health care costs. By prioritizing efforts to improve the employer-sponsored health system which covers millions of Americans, we will use these solutions to drive system-wide changes."

As an organization, we remain committed to preserving and improving the employer-sponsored system where in 2014 over 175 million Americans received their health care coverage.[1] The employer-sponsored health care system is not only where the majority of Americans receive private health care coverage, but it is also where innovation in benefit and plan design are advancing, where chronic disease management and population health efforts are improving productivity and wellbeing, and where unnecessary health care costs are being reduced. Further, recent surveys show that this benefit remains paramount to employees. Millions of Americans like the plans that they have through the employer-sponsored system.

- Eighty-eight percent of workers report that employment-based health insurance is extremely or very important, far more than for any other workplace benefit.[2]

- More than one in five workers report accepting, quitting or changing jobs because of the benefits, other than salary or wage level, that an employer offered or failed to offer.[3]

- Eighty-five percent of workers take the health insurance coverage they are offered through their employer.[4]

[1] http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf Table 1, page 5, 2014 column.
[2] Views on the Value of Voluntary Workplace Benefits from the 2015 Health and Voluntary Workplace Benefits Survey, Employee Benefits Research Institute, November 2015 Volume 36, No. 11, page 3
[3] Ibid
[4] Ibid, page 7

Beyond being the coverage of choice, there are many ways that employer-sponsored coverage benefits employees and employers.

- Economies of scale allow for lower premiums and costs when purchasing coverage as a group because administrative costs are lower.

- Employers spend less money paying for health coverage than the federal government. An American Health Policy Institute study found that employers spent $3,430 on health care per person in 2012; government programs spent $9,130.

- On average, employer-sponsored coverage costs less than coverage on the exchange. The cost of health plans in the individual market surged past those for employer-based plans in 2015. Monthly costs per covered member in the individual market reached an average of nearly $500 in October 2015 compared to $460 monthly for employer-based plans, according to data from S&P Dow Jones Indices. A year earlier, by contrast, the average employer-based plan was nearly 6 percent more expensive than the average individual plan.[5]

- Job satisfaction and worker morale are strongly correlated with benefits satisfaction – more than 54 percent of those who are extremely satisfied with their benefits are also extremely satisfied with their current job.[6]

As you evaluate health care reform alternatives, we wish to emphasize three important messages regarding the importance of employer-sponsored health care system. First, over **175 million** Americans are enrolled in employer-sponsored coverage. A recently released report from the Employee Benefit Research Institute says this number has grown. We urge you to protect ERISA and employer-sponsored coverage.

Second, we urge you to repeal the Affordable Care Act's (ACA) 40% excise tax on high-cost plans and preserve the longstanding tax treatment of employer-sponsored coverage for employers and employees alike. There is no direct evidence that changing the tax treatment of these benefits will result in savings. Instead, a change in the tax treatment of employer-sponsored benefits is likely to have an adverse effect, especially on those employers who have an older workforce, or a workforce with employees and family members who have chronic illnesses, or employees who live in high - cost areas of the country. Additionally, the political challenge of replacing the ACA will not be eased by creating a de facto tax increase for many employees.

Finally, we believe that greater innovations in employer-sponsored coverage may continue to help to reduce health care spending. Employers are adopting new strategies to improve the delivery of health care and are empowering employees and their families with more tools to help them avoid chronic illnesses that can be prevented. Some are providing employees with on-site or access to mobile or nearby clinics to receive routine screening services, while others are driving greater performance in their provider networks – all advancements that we believe improve each and every community where employees live. Employers have crafted workplace wellness, disease management, and care coordination programs to improve the health of their employees. These

[5] http://www.pnhp.org/news/2016/april/costs-in-individual-insurance-market-skyrocketing

[6] Views on the Value of Voluntary Workplace Benefits from the 2015 Health and Voluntary Workplace Benefits Survey, Employee Benefits Research Institute, November 2015 Volume 36, No. 11

programs offer another way to advance our country's evolving health care approach beyond simply treating diseases and caring for the sick to improving health and maintaining wellness. These workplace wellness programs give people tools to identify their risk factors, improve their health, modify unhealthy behavior and stay well both in the workplace and at home.

We support your efforts to strengthen the individual market where many people buy health care coverage, but not at the expense of the employer system that is highly valued by the majority of Americans who receive their health coverage through employers today. Any forthcoming health care reforms must take into consideration the vital role of the employer-sponsored system in facilitating the innovation and creativity that is happening in the private sector offering of health care coverage. As the foundation of our health care system, we support flexibility for our nation's employers as they continue their commitment to providing innovative, sustainable and high-value care for all Americans.

The Chamber thanks you for taking the time to hold this important hearing on the tax treatment of health care. We look forward to working with you as you continue to examine this important issue. Please do not hesitate to contact us if we may be of assistance in this matter.

Randel Johnson
Senior Vice President
Labor, Immigration & Employee Benefits
U.S. Chamber of Commerce

Statement for the Hearing Record

The Tax Treatment of Health Care

House Committee on Ways and Means
April 14, 2016

Barbara Dobberthien
Executive Director and Chief Operating Officer
Yoga Alliance

Submitted: April 27, 2016

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

Statement for the Record

Chairman Brady, Ranking Member Levin, and Members of the House Committee on Ways and Means:

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

As you examine this important issue, we urge your consideration of and support for H.R. 1218, the Personal Health Investment Today ("PHIT") Act, bipartisan legislation that would enable Americans to use pre-tax medical accounts to pay for physical activity expenses, including expenses related to yoga. We believe that this legislation represents a critical component of our ongoing national effort to promote healthy lifestyles and to reduce health care costs via prevention.

Currently, pre-tax medical accounts, namely health savings accounts ("HSAs") and flexible spending accounts ("FSAs") may be used for reimbursement of medical expenses to treat illnesses or other medical conditions experienced by account holders or covered beneficiaries. The PHIT Act would expand the definition of tax-free medical expenses covered by HSAs and FSAs to include "qualified sports and fitness expenses," allowing an individual taxpayer to claim up to $1,000 per year for physical activity expenses or joint filers to claim up to $2,000 per year. This means that the PHIT Act will provide an incentive to ease the financial burden of engaging in physical activity. In turn, the increased physical activity that the PHIT Act encourages will reduce health care costs related to obesity and sedentary lifestyles.

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

Specifically, according to the 2016 *Yoga in America Study*,[1] there are currently 36.7 million U.S. yoga practitioners, up from 20.4 million in 2012. In addition to practicing yoga, practitioners are also significantly more involved in other forms of exercise such as running, cycling, and weightlifting than non-practitioners. Further, practitioners report that the top reasons for starting yoga are flexibility, stress relief, general fitness, improvement of overall health, and physical fitness. These are all benefits that stave off chronic conditions associated with a lack of physical activity. Of course, the PHIT Act would not only afford greater access to yoga, but also support greater involvement in numerous physical activities for all Americans.

Health care costs in the United States are skyrocketing, and a top priority of all health care reform initiatives is to slow spending without compromising care. For this reason, measures like the PHIT Act that incentivize and expand access to physical activity and accompanying health and wellness benefits will be a vital component of any solution to lower health care costs and promote healthy living. For this reason, we ask

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

that the Ways and Means Committee consider the PHIT Act promptly and that the Committee's members support this bipartisan legislation.

Thank you for your attention to the tax treatment of health care in the United States and common sense solutions for our nation. We are available to answer any questions you may have, and would appreciate any opportunities to be of further assistance to your Committee.