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United States Senate
Washington, DC 20510

Dear Senator Reid and members of the Senate Democratic Caucus:

In advance of the President's announced visit to the Democratic Caucus meeting today, we want to commend your continued efforts to craft a comprehensive health care reform bill that will ensure quality, affordable health care for all Americans. In your discussions today and in the coming weeks, we want to highlight the severe--although likely unintended--consequences of the proposed excise tax on higher-cost health care plans. The 3.2 million members of the National Education Association strongly agree with the need to pass comprehensive health care legislation. As such, we have devoted considerable time and effort to analyzing the pending proposals to determine their impact on our members, 75 percent of whom are women. We have concluded that the proposed excise tax on higher-cost health plans would severely impact millions of middle class families, including many of our members, as well as potentially spur anti-competitive practices in the health care industry as a whole. For this reason, we emphatically urge the Senate to consider other mechanisms by which to finance the cost of health care reform, such as those passed by the House of Representatives or other progressive ways to ensure that middle class working families do not bear an unfair or disproportionate burden as we attempt to pass this much-needed legislation. We want to underscore again our commitment to working with you in this process to provide real and meaningful data about the proposed excise tax and to encourage further conversations about alternatives.

- **First, around the country, the tax would have a devastating impact on exactly the type of good, comprehensive health care plans that reform should be promoting.** Based on actual plan data for public educators in Clark, Elko, Lyon, and Washoe Counties, Nevada, for example, we have estimated the total taxes that would have to be paid for 17,000 hard-working, middle class educators. The plans would be hit so hard that entire types of health care benefits would undoubtedly be cut, as employers and insurers scrambled to avoid the tax. As the data in this letter indicate, our findings from Nevada are similar to those in other states throughout the country.
- **Second, the tax was conceived based on faulty premises and has been structured in such a way as to defy the realities of the health care marketplace.** As a result, the excise tax will fail to control health care costs, although it *will* cause middle class workers to lose health benefits without compensatory salary increases and may actually exacerbate health care problems in this country. Given the underlying reasons that insurance premiums for one plan can cost more than those for another plan, it is simply illogical to assert that the excise tax is aimed at plans whose benefits are too rich.

Table 1

THE DEVASTATING IMPACT OF THE SENATE EXCISE TAX ON NEVADA’S PUBLIC EDUCATORS			
Estimated Cumulative Taxes Payable in Four Nevada Counties, 2013-2019			
		If Thresholds are Set at \$8,500 and \$23,000 and	
	Number of Participants Included in Analysis	Premiums Increase at 5.5% Per Year	Premiums Increase at 7.5% Per Year
Clark County	9,940	\$13,858,355	\$41,409,343
Elko County	982	\$578,770	\$3,097,650
Lyon County	814	\$7,102	\$1,446,797
Washoe County	5,263	\$30,360,019	\$52,762,094
TOTAL	16,999	\$44,804,246	\$98,715,884
<p>The number of participants included in this analysis are those receiving employee-only or family benefits; it is not the total number of employees receiving benefits in these counties. Where different levels of family coverage are available, this analysis generally uses individual + 4 to define family coverage. Analysis includes medical, dental, vision, and prescription drug coverage. All dollar values are present value, discounted at the assumed inflation rate of 2 percent. Thresholds assumed to increase at 3 percent per year (CPI-U + 1 percentage point).</p>			

- Finally, despite President Obama’s promises that those with employer-sponsored health insurance will be able to keep what they have and that reform would lead to more stability and security for those with employer-sponsored health insurance, the excise tax would lead to large-scale upheaval in our members’ current coverage.** The political fallout from these broken promises would be widespread, as supporters and detractors alike concluded that health care reform was misrepresented to the American people.

The Devastating Impact of the Excise Tax on America’s Public Educators

The National Education Association has examined the impact of the tax on dozens of health plans, both large and small, covering a total of 300,000 educators in 14 states. Everywhere we have sampled plans, we have found that the excise tax would be devastating. Table 2, below, summarizes our state-by-state findings. Even when we raise the thresholds beyond what they are in the current Senate proposal, our results are clear: The excise taxes payable would be so high that increasing cost-sharing in the form of higher copayments, coinsurance, and deductibles would not be sufficient to keep employers under the taxable threshold. Instead, entire classes of coverage would likely be removed—dental and vision benefits could be eliminated altogether. But medical coverage would also have to be scaled back sharply.

The sheer size of the tax burden makes it clear why the Joint Committee on Taxation assumes that the vast majority of the revenue that the excise tax would generate would not come from the tax itself. Instead, the theory is that benefits will be cut back and that, to make up for the loss of benefits, wages would increase, leading to higher income and payroll taxes.

Table Two

THE DEVASTATING IMPACT OF THE SENATE EXCISE TAX ON PUBLIC EDUCATORS' HEALTH BENEFITS ESTIMATED CUMULATIVE EXCISE TAXES PAYABLE, 2013-2019				
State	Entity	No. of Participants in Analysis	Total Estimated Excise Taxes Payable 2013-2019 Assuming Premium Increases of 7.5%	
			Thresholds at \$8,500 and \$23,000	If Thresholds Were \$9,800 and \$25,000
CA	California's Valued Trust ¹	12,603	\$38,469,000	\$23,517,000
	Selected Plans in San Francisco ¹	2,505	\$7,768,122	\$2,154,921
	West Contra Costa County USD ¹	1,153	\$3,743,000	\$1,115,000
CT	Groton Public Schools ²	447	\$9,951,000	\$7,907,000
ID	Nampa School District ³	904	\$971,583	\$147,809
MD	Montgomery County Public Schools ³	19,586	\$65,724,885	\$32,037,381
	Prince George's County Public Schools ³	14,705	\$51,108,000	\$15,461,000
ME	MEA Benefits Trust ¹	22,256	\$113,032,000	\$55,000,000
	University of Maine ¹	3,210	\$18,995,000	\$9,999,000
MN	Rosemount-Apple Valley-Eagan SD ¹	2,266	\$14,747,000	\$8,364,000
NE	Educators Health Alliance ²	19,832	\$43,655,085	\$11,699,189
NJ	School Employees' Health Benefits Prog. ¹	96,200	\$284,766,968	\$120,741,696
NV	Clark County ³	9,940	\$41,409,343	\$16,634,481
	Elko County ³	982	\$3,097,650	\$913,656
	Lyon County ³	814	\$1,446,797	\$155,263
	Washoe County ³	5,263	\$52,762,094	\$34,906,488
NY	United University Professionals ⁴	19,699	\$59,307,693	\$20,496,196
PA	Berks County Consortium ¹	4,056	\$8,350,000	\$2,230,000
	Columbia School District ¹	86	\$665,000	\$342,000
VA	Fairfax County	15,358	\$62,727,171	\$23,912,578
	Powhatan County	398	\$1,154,429	\$307,137
VT	Vermont Health Partnership ¹	8,827	\$31,459,000	\$11,419,815
WI	WEA Trust—Trust Preferred ⁵	29,797	\$401,037,942	\$286,490,142
	14 School Districts in the 7 th Cong. District ⁶	1,456	\$31,935,326	\$24,837,920

The number of participants included in each analysis is not necessarily the total number of people receiving benefits from that plan or through the relevant employer. All dollar amounts are present value, discounted at the assumed CPI-U of 2 percent. Where appropriate, we have already factored into our estimates the Senate's transition rules for high-cost states. ¹Costs for these plans include medical benefits only, not dental, vision, and FSA contributions. As a result, the numbers are much lower than they would be if all benefits were included. ²Costs for this plan include medical and dental benefits ³Costs for this plan include medical, dental, and vision benefits. ⁴Costs for this plan include medical benefits and health care FSA contributions. ⁵Medical benefits only, based on weighted averages of Trust Preferred plans, which are the most popular, but not the only, plans offered by the Trust. ⁶Twelve of the 14 include medical and dental; the others include only medical. The districts are: Cumberland, Chetek, New Auburn, Turtle Lake, Prairie Farm, Cameron, Washburn, Bayfield, Drummond Area, South Shore, Siren, Merrill Area, Tomahawk, and Amery; see Summary Table One and Summary Table Two for detail on these district's plans and the estimated excise taxes that would be generated by them.

The Poorly Conceived Excise Tax

Assumptions on Salary Increases

The National Education Association agrees with the proponents of the excise tax who say that benefits would be cut if the tax proposal became law. This is not an outcome that we should welcome, given the fact that plans of our members do not contain luxurious benefits, such as those found in true “Cadillac” plans of affluent executives. Our extensive experience negotiating contracts and advocating for educators leads us to disagree with the assertion that wages will increase on anything close to the same scale at which benefits are cut. **As you know, states and localities have dramatic deficits they must close, so any cost savings that might be gained from the effect of an excise tax will not be available for salary increases, but will instead be used for budget hole-closing purposes. Further, consistent with our analysis, a new survey from Mercer indicates that only 16 percent of employers would increase wages if they cut health care benefits.**

For many reasons, we would not expect salaries to increase when health benefits were cut. To begin with, obtaining reliable data on the value of health benefits is difficult or impossible for workers under the best of circumstances, so we cannot assume that employers and employees will be able to fairly exchange health benefits for salary. But even if it was possible to obtain such information, collective bargaining is a very complicated process that can encompass multiple issues at the same time, many of them non-financial, so exchanging health benefits for salary will never be a matter of simple arithmetic. Furthermore, many workers do not bargain collectively at all. In fact, it is against the law for our members to bargain collectively in some states (North Carolina, Texas, and Virginia). And retirees, whose benefits would also be jeopardized by the tax, do not even have a theoretical hope of being compensated for lost health benefits. **Overall, however, no matter how much information or good will might exist, public sector employers throughout the country are facing tight budgets. The assumption that health benefit cuts would necessarily lead to large salary increases completely ignores the realities of the current fiscal crises facing states and localities across the country. It is naïve at best and disingenuous at worst.**

Inaccurate Assumptions Related to What Leads to High Premiums and Why Premium Costs Vary

The excise tax is far too blunt an instrument to rely on to make smart health care policy. Proponents of the tax seem to assume that the chief reason that plans are expensive is because their benefits are too rich. The tax, it might follow, would lead insurance companies, employers, and employees to trim back their benefits to a level that was not over-generous. Indeed, proponents of the tax assert that it will lead to greater efficiency in the insurance market.

It is simply false, however, to assume that when premiums are high, over-rich benefits are to blame. A new report published in *Health Affairs* makes perfectly clear that the excise tax fails to address the real drivers of health care costs appropriately. The *Health Affairs* analysis set out to examine the assumption that high-cost plans are expensive because of rich benefits. It found, in the paper's own words, that "other factors—notably industry sector and the costs of delivering care in the region—are more likely to explain the higher costs of some health plans." Indeed, the study found: "Only 3.7 percent of variation in the cost of family coverage can be explained by benefit design." (Jon Gabel, et. al, "Taxing Cadillac Health Plans May Produce Chevy Results," *Health Affairs* 29, NO. 1 (2010), pp. 1-2).

In reality, premium costs are driven by multiple factors, including the degree of competition in the health care marketplace, the underlying cost of the health services purchased, the size and demographics of the insured group, how and to what degree benefits are used, and state mandates. Holding middle class workers hostage to a taxable threshold when their premium costs are driven by factors outside the control of plan sponsors and plan members is bad policy. The National Education Association's members are more than 70 percent women, and more than 2,200 of our members' employers have fewer than 50 full-time-equivalent employees, according to our most recent data. In addition, close to 500,000 of our members live in rural areas. Such demographics often lead to higher plan costs.

Outside the world of economic theory, it is clear that health care costs vary greatly from region to region and even within a single state. Nonetheless, the excise tax is structured based on the inaccurate assumption that all plans face the same costs. As a result, the tax's structure would have all teachers' plans subject to the same thresholds, regardless of whether it was a small plan with a few members suffering from cancer, or a large plan in a metropolitan area with particularly high physician costs. Yet such factors are real-life drivers of premium costs. When the Government Accountability Office (GAO) examined differences in health care costs for the Federal Employees Health Benefits Program, for example, it found that more than half of the 20 metropolitan areas in the United States with the highest physician costs were in Wisconsin (11 out of the top 20). The state also had two of the 10 costliest metropolitan areas with respect to hospital costs. On the upper end of the scale, Wisconsin's higher-cost metropolitan areas were 40 percent costlier than average metropolitan areas. Thresholds for Wisconsin's teachers, however, will be the same as those in every other state, including the lowest-cost states. (*Federal Employees Health Benefits Program: Competition and Other Factors Linked to Wide Variation in Health Care Prices*, "Government Accountability Office, August 2005, pp. 14 and 56.)

Although the NEA appreciates efforts in the Senate to include transition rules for high-cost states, those rules will not address real and persistent issues related to premium cost variation.

Confusing Premium Costs with Health Care Costs Leads to Bad Health Care Policy

The excise tax is expected to lead to lower health insurance premium costs, as insurers and employers scramble to cut benefits to stay under the taxable threshold. Cutting premiums, however, will do nothing to reduce the underlying cost of health care. One percent of the population is responsible for 18.7 percent of total health care expenditures, while the top 10 percent of the population accounts for 59.5 percent of all expenditures. Health care cost increases are driven in large part by medically necessary services that deal with chronic conditions, heart attacks, cancer, and other medical problems that will not be affected by increasing copayments or even boosting deductibles.

We also know that when consumers are forced to pay more for their health care, they avoid both necessary and elective care. When people suffer from chronic conditions such as hypertension, for example, the research shows that forcing them to pay even modest increases in prescription copayments can cause them to skip doses. This can actually lead to higher overall health plan costs, because preventive medication can be far more cost-effective than dealing with the medical effects of untreated chronic diseases and conditions.

The Excise Tax Fails to Factor in True Retiree Health Care Costs and State Legal Protections for Retiree Health Benefits

The excise tax will hit retirees hard. NEA appreciates that retirees will be subject to higher thresholds, and that pre-Medicare and Medicare-eligible retirees' benefit costs can be considered together for purposes of determining premium costs that count toward the thresholds. These provisions would clearly help retirees, but retirees between the ages of 55 and 65 typically have health care costs 30 percent to 80 percent higher than average costs. The increased retiree-specific thresholds will fall far short of accommodating this cost differential for retirees. As a result, retiree health care plans will be subjected to even greater pressure to slash benefits than many other plans. In addition, many retiree plans for public educators do not cover Medicare-eligible retirees at all, so blending the premium costs for pre-Medicare and Medicare-eligible retirees would not be an option. We must also point out that retiree health benefits in some states are constitutionally protected, so while those benefits would not be cut, the tax would add seriously to public sector deficits, as plan costs exceeded the thresholds by more and more every year. Finally, in at least one state, state law permits changing retiree health benefits for public educators only once every five years. In this case, given the need for benefit-cutters worried about the thresholds to anticipate premium cost inflation, this law would make it virtually impossible for insurers, employers, and employees to change the plan's benefits to stay under the thresholds without gutting the plan.

The Way the Tax Will Be Calculated and Attributed to Benefit Providers Will Lead to Concentration in the Health Insurance Industry and Penalize Even Low-Cost, Efficient Benefit Plans

We believe too little attention has been paid to the severe impact the proposed excise tax will have not only on the middle class, but also on the potential anti-competitive practices that will become a byproduct of this legislation if it is passed in its current form. An examination of the way the tax will be calculated and attributed to benefits providers, however, shows other serious problems with the tax. An excise tax will have to be paid for any employee for whom the sum cost of all relevant health benefits exceeds the applicable dollar threshold. In practice, employers often offer benefits through different companies—one for medical insurance, another to manage pharmacy benefits, a third to provide dental coverage, and a fourth to administer a health care flexible spending account program, for example. If there was a tax to be paid, each one of these providers would pay a share of the tax in proportion to the cost of the benefits they provided.

As a result, highly efficient, low-cost benefit plans or administrators—exactly the ones the tax's proponents champion—would be taxed based on the cost of other providers' health benefits over which they have no control and which could have relatively high costs for completely legitimate reasons. Insurance companies offering medical or dental benefits could be taxed solely because of the flexible spending account decisions made by individuals, even if medical and dental benefits would have been under the threshold on their own.

Another adverse consequence of the way the tax would be attributed to benefits providers is that competition in the insurance market would be likely to decrease, as companies stopped offering stand-alone medical, dental, vision, or prescription drug plans. Insurance companies would not be likely to expose themselves to a tax based on another insurance company's benefits, and they would chafe at paying a tax on the benefit plans they offered simply because an employee chose to make a contribution to a health care flexible spending account. As a result, insurance companies would be likely to insist that employers use their company for all types of benefits rather than seek the best individual medical, dental, vision, or prescription drug plan. Employers would lose the ability to shop

for the best deal from among insurance companies, even though the ability for employers to carve out different types of benefits is an important tool in keeping costs down, because it provides for greater competition and allows employers to more precisely identify the providers that meet their needs in a cost-effective manner. In short, the way the excise tax is currently constructed would likely lead to more consolidation in the health care industry, not less.

Conclusion

It is deeply troubling to us that this devastating policy is being pursued despite its predictable impact on middle class workers, its serious and destructive conceptual defects, and promises by many lawmakers that those with employer-sponsored insurance would not face the kind of turmoil that will result from the tax. As you will recall, the proposal to tax health care benefits was a powerful part of the presidential and congressional debate in 2008, and we believe Americans strongly indicated then what their preference was about that idea.

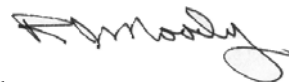
We stand solidly for comprehensive health care reform, but we also stand firmly opposed to the proposed excise tax on higher-cost health plans. We understand the challenge of finding sufficient revenue to pay for this needed legislation; however, we know there are other ways to finance the cost of quality, affordable health care for all Americans. We urge you to more thoroughly examine these alternatives, as well as the analysis we have done and will continue to do on a state-by-state basis.

We thank you for your consideration of our views on this very important issue.

Sincerely,



Kim Anderson
Director of Government Relations



Randall Moody
Manager of Federal Advocacy