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## **LEGISLATIVE ALERT!**

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Dear Senator:

On behalf of the AFL-CIO, I am writing to express our strong opposition to the proposed excise tax on higher cost health plans and to correct a number of common misconceptions about this proposal. The excise tax would reduce employer-provided health coverage by \$130 billion in 2019 and result in an average tax increase of over \$1300 for nearly 31 million taxpayers. It would thus violate two fundamental commitments of health reform: that workers should be able to keep the coverage they have, and that their health care benefits should not be taxed. In place of the excise tax, we urge Congress to finance health reform with revenue-raising options that ask the highest-income taxpayers to pay their fair share, along with a robust public option and a strong “pay or play” employer responsibility requirement.

The Senate Finance Committee health care bill would impose a 40 percent excise tax beginning in 2013 on the value of health plans in excess of \$8,000 for individuals and \$21,000 for families (with a three year transition for high-cost states and adjustments for plans with retirees or workers in selected high-risk occupations). Taking projected cost increases into account, these thresholds would affect plans that are valued today at roughly \$6,500 for individuals and \$17,000 for families.

According to the Joint Committee on Taxation (JCT), the excise tax would have an alarmingly broad impact—even within its first decade. The JCT estimates that by 2019 the tax would affect 34 percent of health plans for individuals and 31 percent for families. According to the JCT, 31 million taxpayers would be affected by the tax in 2019, including one quarter of taxpayers with incomes between \$50,000 and \$75,000.

It is critical to understand that *over time* the excise tax would affect lower and lower cost plans—not just “Cadillac” plans—and its reach would extend deep into the middle class. This is by design; it is not an unintended consequence. *Without hitting a broad swath of the middle class, the excise tax would not raise significant amounts of revenue.*

After 2013, the threshold amount at which the excise tax applies would rise at a much slower rate than the expected growth rate of health plan costs, exposing more and more lower-cost plans to the tax. This is why the excise tax would raise such large amounts of revenue—\$201 billion in the first 10 years, with revenues in the following decade projected to rise 10 to 15 percent every year.

The intended effect of the tax is a massive reduction of employer-provided coverage followed by a broad middle class tax increase. It is universally assumed that most insurers and plan administrators would reduce employer-provided coverage to avoid paying the excise tax as soon as they are able to do so. By 2019 the reduction in employer provided coverage would be \$130 billion, according to the Center on Budget and Policy Priorities (based on JCT figures).

The Congressional Budget Office (CBO) and JCT further assume that employers would increase workers' wages to compensate for this enormous reduction in their medical benefit. The Center on Budget and Policy Priorities explains that employers "would put themselves at a disadvantage with other employers in competing for workers" if they failed to raise wages. This is a debatable assumption—especially if unemployment remains high—and does not correspond to the experience of union negotiators in collective bargaining, much less workers in non-union workplaces.

But let us assume a best-case scenario in which employers do not simply cut health benefits for their employees by \$130 billion in 2019, but instead replace the value of those benefits with \$130 billion in higher wages. The result would still be a massive tax increase on the middle class—because health benefits are not currently taxed and wages are. The assumed increase in payroll and income taxes paid by these workers accounts for 81 percent of the revenues raised by the excise tax, according to the JCT. By 2019 nearly 31 million taxpayers would pay over \$1,300 more in taxes every year, on average, as a result of the excise tax. *The excise tax is a backdoor way of taxing workers' health care benefits.*

Reducing employer-provided coverage is not the same thing as "bending the cost curve." The excise tax is not projected to bring down the cost of health care services or national spending on health care within the 10-year budget window in which employer-provided coverage would be eroded, according to CBO and JCT. Instead, the excise tax would simply shift more of the costs of health care onto the backs of workers, who would pay these costs with after-tax dollars. Insurers and plan administrators are expected to reduce plan costs to get under the excise tax thresholds—first by eliminating dental and vision coverage, then by requiring more cost-sharing in the form of higher co-payments, higher deductibles, and higher out-of-pocket maximums, and then by restricting coverage of core benefits.

It is often assumed that making workers pay more for their health care is a good thing because it will get them to stop seeking wasteful and unnecessary care. However, *the enormous waste in our health care system is not driven by consumers.* Eighty percent

of health care spending is for the 20 percent of the population with the most severe health problems; these are not people who demand care because their insurance covers it. Most treatments occur because doctors recommend them, regardless of coverage. *The key to reining in health care spending is to get providers to deliver care in more cost-effective ways.* Increasing out-of-pocket costs for workers may actually lead them to forgo necessary care and make counterproductive health care decisions, driving up national health care spending.

In short, forcing a broad swath of the middle class to pay more in the form of higher taxes, reduced coverage, and higher out-of-pocket expenses would be a travesty of health care reform.

The excise tax would force higher taxes and higher health expenses on workers who have coverage that is by no means “gold-plated” or “Cadillac.” In fact, within one year of implementation, the excise tax would hit the most popular single coverage plan under the Federal Employee Health Benefits Plan (FEHBP). Advocates of the excise tax sometimes compare FEHBP to higher cost plans, citing FEHBP plan costs for the current year and failing to account for annual cost growth between now and 2013. Using a conservative assumption of 6.1 percent annual premium cost growth, the excise tax would hit the Blue Cross/Blue Shield standard option in 2014 for individuals and in 2019 for families. If plan participants have dental and vision benefits, their coverage would be hit even sooner.

The excise tax would force higher taxes and higher health costs onto workers whose plans have high costs for reasons that have nothing to do with “gold-plated” benefits. Research has shown that health plans are more likely to meet the excise tax thresholds if they cover a higher share of older workers, workers in high-cost geographical regions, or workers with poor health status. The actuarial consulting firm Milliman concludes, “Whether someone hits the [excise tax] ceiling is not so much driven by benefit richness as it is by age, gender, profession, health status, and the geography of the covered population.”

Union plans especially are affected by these factors. Union workers are older than non-union workers. They are also concentrated in high-cost states: 16 of the 20 states with the highest health costs have above-average rates of union coverage. Union workers are concentrated in occupations with high incidence rates of work-related injury and illness that result in lost time from work. And with regard to 10 self-reported chronic diseases, union members have a 10 percent higher chronic disease burden, on average, due to their older age.

For example, the Steelworkers represent workers at a small manufacturer of name-brand sporting goods where layoffs due to international competition have left a highly skilled workforce whose average age is over 60 and who average 40 years of experience. Family coverage cost almost \$21,000 in 2007. This was 40 percent more

than the average for a similar USW group with the same plan, simply because of the age and health conditions of the group.

Union health plans are not “gold-plated.” The Medical Expenditure Panel Survey (MEPS) shows that union members are 3 percent more likely to be in an HMO plan than non-union members. The AFL-CIO’s review of a sample of affiliate health plans shows that these plans do not cover services that are medically unnecessary—such as botox, cosmetic surgery, or yoga classes. Their provisions for co-pays, deductibles, and co-insurance vary, but are roughly comparable to—or slightly lower than—the FEHBP Blue Cross Blue Shield standard option. They do have out-of-pocket caps that are significantly lower than FEHBP.

For steel workers at a particular firm operating in Pennsylvania, Ohio, Illinois, and Indiana, coverage currently costs \$6,689 per year for individual coverage and \$17,507 for family coverage. In 2013, costs are projected to be \$8,286 for individuals and \$21,688 for families.

For telecommunications workers in popular plans across 43 states, benefits average \$6,800 for individuals and \$17,800 for families. In 2013, costs are projected to be \$8,400 for individuals and \$22,000 for families.

For CWA retirees in these same plans, costs are much higher: \$9,100 for individuals and \$22,400 for families today, and projected to be \$11,200 for individuals and \$27,700 for families in 2013.

For thirty eight multi-employer firms covering 1,000 or more people in various industries (construction, transportation, retail food, janitorial) across all regions of the country, a survey by the Segal benefits firm found that, for individual coverage, 24 percent of the plans would be subject to the tax in 2013, rising to 71 percent in 2022. For family coverage, 18 percent of the plans would be subject to the excise tax in 2013 and 66 percent in 2022.

For public workers in Illinois, benefits in the largest plan have costs of \$8,580 for individuals and \$19,908 for families in 2009, rising to \$10,832 for individuals and \$25,134 for families in 2013.

It would be perverse to force working families to pay for health reform with higher taxes, reduced coverage, and higher out-of-pocket health care expenses instead of asking households with the highest incomes to pay their fair share. Tax cuts since 2001 have disproportionately benefited the richest five percent of Americans, and the wealthiest one percent will have received over \$700 billion from the Bush tax cuts over the 2001-2010 period. The top one percent also reaped two thirds of the income gains from the 2001-2007 economic expansion, so it makes sense to ask the wealthiest households to help finance this urgent and long-neglected national priority.

There are numerous revenue-raising alternatives to the excise tax. One would be an income tax surcharge that would effectively require the wealthiest one percent to give back some, but not all, of the Bush tax cuts. Another alternative would be the President's proposal to limit itemized deductions for the very wealthy, which would affect only the top 1.3 percent of taxpayers. Another alternative would be to apply the Medicare payroll tax to unearned income; 73 percent of the tax would be paid by the wealthiest one percent of taxpayers, and over 90 percent would be paid by the wealthiest 5 percent.

It would be especially perverse to force working families to pay for health reform through higher taxes, reduced coverage, and higher out-of-pocket health care expenses without including two critical reforms that bring down costs: a robust public option and a "pay or play" employer responsibility requirement. A robust public option would save \$110 billion over 10 years in the tri-committee House health reform bill. The requirement that employers provide health coverage or pay into a common fund to finance coverage would raise over \$160 billion over 10 years in the tri-committee bill.

Finally, it should be noted that the excise tax is wildly unpopular. This week's Washington Post poll shows that 61 percent of the public is opposed, which is consistent with other survey findings.

One of the principal goals of health care reform should be to guarantee quality affordable health care for working families. The excise tax would do just the opposite. It would raise taxes and health care costs for workers, including some of the most vulnerable workers: workers in firms with older employees and firms with employees that have poor health status.

There is a right way and a wrong way to pay for health care reform. The excise tax is the wrong way. The right way is through shared responsibility: asking all but the smallest businesses to contribute, and asking people who earn more than \$250,000 per year to pay their fair share.

Sincerely,

A handwritten signature in black ink, appearing to read "W. Samuel", written in a cursive style.

William Samuel, Director

GOVERNMENT AFFAIRS DEPARTMENT