

“The Pressures of Rising Costs on Employer Provided Health Care”

House Committee on Education and the Workforce

Subcommittee on Health, Employment, Labor and Pensions

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March 10, 2011

Thank you Chairman Roe, Ranking member Andrews, and members of the Subcommittee for the opportunity to speak this morning on the pressures of rising costs on employer-provided health care.

I am speaking today as a health policy researcher, a resident fellow at the American Enterprise Institute and co-author of the forthcoming book, “Why ObamaCare Is Wrong for America (to be published later this month). I also will draw upon previous experience as a senior health economist at the Joint Economic Committee, member of the National Advisory Council for the Agency for Healthcare Research and Quality, and health policy researcher at several other Washington-based think tanks.

The subject of this hearing is not a new one, although the economic and policy context in which we examine it has changed and will continue to do so in the years and decades ahead. The two most significant factors are the recent deep recession -- from which both the overall economy and its health sector are slowly recovering -- and the passage and early implementation of the Patient Protection and Affordable Care Act (referred to hereafter as “ACA”) -- from which they may not, without a substantial change in direction.

Roughly 170 million Americans received private health insurance through the workplace in 2009,¹ and the vast majority of those workers and their families, despite periodic complaints, value it very much. However, our largely employer-based system of private health coverage does not work well for everyone -- most notably those workers who lose their jobs. Or who cannot find either new or initial work. Or who cannot afford their share of expensive and rising premiums. Or who need a better balance between lagging wages and rising health benefits costs. Or whose employer simply cannot afford to offer insurance. Millions of people need better options to get more stable and affordable health insurance.

As director of AEI’s “Beyond ‘Repeal and Replace:’ Ideas for Real Health Reform” project, I would be happy to discuss in greater depth a number of better solutions to the continuing chronic conditions

of high costs, inconsistent quality, gaps in access, and misaligned incentives throughout our health care economy. However, the primary focus of my testimony today is, first, to place employer health care cost challenges and assertions about them in perspective. I then will examine the likely effects of the ACA on the future “health” of employer-sponsored health insurance, and very briefly conclude with some suggested policy alternatives.

In brief, we should be more concerned about what is likely to unfold as we approach 2014 and the immediate years afterward than the most recent headlines of the limited-dosage effects of the ACA’s initial year of implementation. It has not provided much short-term help, but still threatens to do more harm later. A number of blame-shifting assertions, statistical mirages, overstatements, and simplistic pet theories should not distract us from the more complex and daunting task of both rethinking the path that the previous Congress took in the ACA and pursuing more robust and realistic routes to sustainable, higher-value health care.

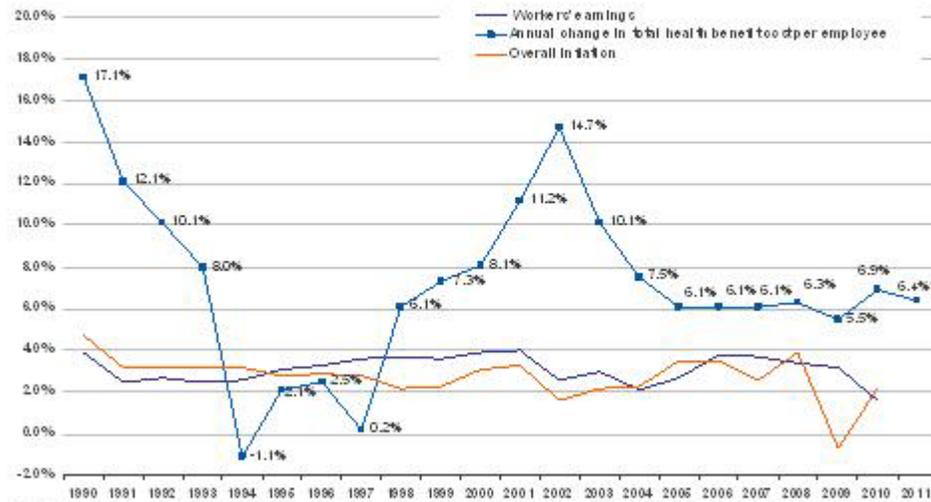
Putting Health Spending Trends in Perspective

Let’s start with a reminder of the health spending context when the ACA was first proposed, debated, and enacted. From calendar year 2007 to 2008, overall national health spending (as measured by the “National Health Expenditure” accounts compiled annually by the Centers for Medicare and Medicaid Services) increased only 4.7 percent. That was the smallest percentage annual increase in the nearly 50 year history of that measure. And then national health spending rose only 4 percent more, in 2009.

As for the more narrow measure of the employer cost per employee of employer-sponsored health benefits, the most consistently accurate one over time – Mercer’s National Survey of Employer-Sponsored Plans – indicates that those costs remained in a steady pattern of roughly 6 percent annual increases in the five years from 2005 through 2009, even though the underlying health *care* cost trend was running about 9 percent a year. However, those employer health benefits costs increased 6.9 percent in 2010. Even though the employers surveyed last year expected the health care costs they would face in 2011 to rise another 10 percent, they also planned to make changes in their health plan benefit designs and vendors in order to bring their actual employer benefits cost increases down to 6.4 percent (see Figure 1).

FIGURE 1

Total health benefit cost per employee rises 6.9% in 2010, the sharpest increase since 2004



*Projected

Source: Mercer's National Survey of Employer-Sponsored Health Plans; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April) 1990-2010; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April) 1990-2010.

The Mercer survey includes public and private employers with 10 or more employees. Another longstanding national employer health benefits survey by the Kaiser Family Foundation and the Health Research & Educational Trust (KFF/HRET) examines trends among nonfederal private and public employers with three or more employees. Its most recent annual survey found that average total premiums (both the employer and employee shares) for employer-sponsored coverage increased only 3 percent for single coverage and 5 percent for family coverage in 2010. This reflected a continuation of relatively modest premium growth in recent years.

For 2011, several other national employer health costs surveys have forecasted somewhat higher rates of increase. Last fall, Hewitt Associates predicted that large employers could expect 2011 health care cost increases of 8.8 percent, compared to annual growth rates of 6.9 percent in 2010 and 6.0 percent in 2009 and 2008. Also generally consistent with other forecasts of underlying health cost growth (as opposed to actual health premium cost increases), PricewaterhouseCoopers estimated last June that employers could expect medical costs to increase by 9 percent in 2011.

The above numbers and estimates tell several overlapping stories, with more than a few cautions and limitations. First, employers generally end up paying somewhat less for their health plan premiums than initial health care cost projections would suggest. Particularly in the case of larger employers, they do not accept passively the first set of premium prices quoted to them. They adjust their plan designs (e.g., greater cost sharing), insurance partners, and incentives to employees so that they can afford better the health benefits they ultimately finance either directly (in self-insured plans) or through purchases of fully insured coverage.

Second, it's more informative to focus on percentage increases and relative shares of both the employee compensation dollar and overall economic resources, rather than on nominal dollar amounts, in order to spot any changes in past trends. The persistence of real rates of increase in health spending relative to spending on other goods and services can be less obvious during periods of varying inflation rates.

Third, different employer benefits surveys often reflect somewhat different types of respondents (e.g., large versus small employers), time periods, and methodologies. No single survey tells the complete story, but the better ones all tell us important parts of it despite lesser inconsistencies. Aggregate national average numbers also can obscure substantial variation among different regions, types of purchasers, and insurance product markets. For example, large employers (500 or more employees) experienced a sharper cost increase in 2010 than smaller employers in the Mercer survey, even though they generally have greater advantages in bargaining leverage, risk pooling, benefits administration capacity, and regulatory flexibility. Much smaller employers – particularly in the below-50-employee “small group” market -- consistently face higher insurance premium costs for any given level of benefits, but they purchase “less” and thereby bring down their actual premium expenses. Consumer-driven health plans with greater cost sharing continued to provide health benefits at lower costs, and increased their overall market share (but most notably among the largest employers).

Fourth, although the health sector of the economy appears to exhibit a longstanding ability to grow faster than annual GDP, wages, and non-health areas of government spending, the experience of recent years reveals the substantial effects of a deep recession in slowing the absolute dollar growth of health spending (and health care utilization), if not its relative share of a troubled economy. As a CMS team of health spending actuaries explained in a Health Affairs article, “Although health care spending has grown at a slower rate every year since 2002, the deceleration, or slowdown in the rate of growth, was more pronounced in 2008 and 2009 because of the severe economic recession. In contrast to prior recessions, when there was usually a lag before health care spending growth slowed, the recession that lasted from December 2007 to June 2009 had a more immediate impact on the health care sector.”²

So the illusory “good news” of the last few years might be that the Obama administration can claim at least superficially that it already helped slow down somewhat the growth rate for health care spending, and related health insurance premiums. The “bad news” is we neither can afford, nor should we expect, to rely on a prolonged recession or sluggish economy to keep doing so.

Other Statistical Mirages, Mis-Steps, and Pet Theories versus Longer-Term Trends

There remains a substantial over-supply of theories and explanations for the persistent “excess” growth of health spending and health insurance costs above the rate of annual growth in the rest of the U.S. economy. A number have some limited degree of plausibility, but either their overall impact, duration, or independent effects (or all of the above) tend to be over-stated at best. Recently on the hit list have been such explanations as:

- Excessive profits by ... (chose a sector of the health economy you do not represent)
- Failure to receive more and better-reimbursed health services from ... (choose a sector of the health economy you do represent)
 - Cost shifting (by everyone else)
 - Changes in the insured risk pool (too many healthy people either losing coverage or dropping out of the insurance market, too many sick people staying on employer coverage with enhanced COBRA tax subsidies)
 - Insufficient health coverage and excessive out-of-pocket costs
 - Almost everyone seemingly either has, or is about to suffer from, a chronic and costly health condition

The full list, on both sides of the ideological as well as interest group divides, is of course much longer. It includes a wide assortment of “silver bullets” of health policy reform advocacy that never quite hit their elusive target. But the most predictable common element behind many of the more politically effective ones is that it’s always “someone else’s” fault! A broad consensus has existed for many decades that the small share of health care costs that we individually have to pay most directly are too high. But we appear to be nearing a newer frontier where the limits of what all those “someone else’s” (particularly employers and taxpayers, and even U.S. Treasury creditors) are willing and able to pay are getting much closer in sight, as well.

One of the more pernicious misstatements of health care financing reality is the assertion that our mixed public/private system fails to pay enough of everyone else’s health care bills; hence the need both for more insurance coverage and more comprehensive benefits. However, when one compares out-of-pocket (OOP) health spending to total national health expenditures, one finds that the OOP share in the U.S. continues to decline as part of a long-term trend -- 12.0 percent actual in 2009, 9.7 percent project for 2014, the first fully-installed year of the ACA’s coverage mandates and enhanced taxpayer subsidies. Moreover, the U.S. OOP share of health spending, as of the last comparative figures available from the OECD in 2008 (12.1 percent) was below that of Germany, Canada, and the weighted average of all reporting members, respectively. Despite some apparent growth in the nominal dollar amount of potential cost sharing in certain segments of the private health insurance market, this first-party exposure to some of the costs of care has not yet translated into increases in the share of U.S. health spending that is paid out of pocket.³

Aside from occasional throwaway comments that aggregate health spending is too high and/or unaffordable, the default presumption in many elite health policy circles remains that the actual consumption of care should remain unburdened by the economics of paying more of its full price out of pocket – even at the margin. Early dollar deductibles are resisted as discouraging essential preventive care (as in ... dropping by the doctor's office whenever the first unclear symptom appears, to see if one might be discovered, along with a billing code for it...). Partial cost sharing for larger medical expenses is seen as too punitive and overtaxing the limited abilities of patients to assess more complex tradeoffs. And leaving all the other mid-range types of health care cost decisions subject to cost sharing apparently either would single out the chronically ill too harshly and leave them prone to even greater health problems in the future, or it would jeopardize the underlying financial health of a health delivery system based on opaque cross-subsidies that detach prices from values. Before you know it, not a single dollar of health spending can be left at risk to the dangers of cost sharing.

The above represents only a slight exaggeration of the ambitions and presumptions of the ACA's coverage mandates, cost sharing limits, and expanded health spending subsidies through future health benefits exchanges, which are either imposed on employer-sponsored coverage or will directly affect its future. If left unchanged and fully implemented, they would push most Americans to believe they can and should spend even higher relative shares of other people's money. This in turn will aggravate the longstanding economic effects of distorted spending incentives and substantial dead-weight losses when re-routing greater shares of the economy through public financing mechanisms.⁴

Before examining both the likely short-term and long-term effects of the ACA on employer health care costs, overall health spending trends, and the larger economy, let's first remember some broader points about what really matters in improving the value of the health care we receive (i.e., delivering better health outcomes at lower costs).

- Although the ACA emphasizes expanded insurance coverage, redistribution and expansion of public subsidy payment streams, and scapegoating private insurers for a host of partly real but broadly exaggerated misdeeds, the overwhelming component of current health premium costs and their future rates of growth is comprised of ... the underlying cost of health care as currently delivered in far from optimally effective or efficient ways. And it has failed to provide a clear, consistent, feasible, and sustainable route to address that problem.
- Producing better health outcomes and improved population health is driven much more by factors well beyond the supply and cost of medical care. Our longstanding political biases in health policy continue to neglect this crucial point. Despite a handful of fledgling initiatives in less-noticed sections of the overall legislation, the ACA's overwhelming focus remained on politically controlling private health insurance more tightly, rearranging public subsidies for health care financing predominantly for political and re-distributional reasons, and then jerry-rigging the complex contraption to meet daunting political and budgetary scoring needs by whatever means necessary to ensure narrow passage last March.

- Although our health care system still manages to perform admirably in many respects despite the many public policy handicaps under which it continues to operate, its costs continue to exceed its value and this increasingly crowds other important private and public needs. We cannot afford to continue to neglect necessary spending and investment in a number of NON-healthcare sectors of our society.
- The employer-sponsored portion of private insurance will continue to provide a vital role in our health care arrangements. It remains much more creative, accountable, sensitive to workers' preferences, and value-conscious than the growing share of the health care marketplace dominated by politically-administered care and coverage. But the small employer portion of the health coverage market needs better tools and options. In an increasing number of cases, traditional small-group coverage is less and less financially viable. Nor is it a consistently satisfactory option for small business employees and their employers. The ACA failed to solve those problems, largely because it was pursuing a broader political agenda. Rethinking and restructuring a much different version of health benefits "exchange" options for some, but not all, of those people currently in the small employer, as well as individual, portion of the health insurance market, remains essential.
- Improved choice, competition, and value in health care arrangements still will have to be driven by more transparent, accountable, and decentralized private markets, rather than top-down political edicts. Real health care reform is not a public versus private either-or proposition, but we have overloaded the operational circuits of our political system and overfed its appetite for private resources. Rebalancing the mix necessarily must begin with repeal of many core components of the ACA, but it cannot end short of equally difficult but necessary reforms to replace them.

Assessing the ACA's Effects on Employers and Employees

In the very near term, the ACA has only done modest damage to employer-sponsored health coverage. Its main provisions were delayed for a number of years in a staggered "time-release" schedule of implementation due to political, economic, and administrative considerations. Employer coverage mandate penalties, crowd-out competition from highly-subsidized state health benefits exchanges and expanded Medicaid coverage, and more binding requirements for (plus actual definition of) essential health benefits, remain a number of years away ("après 2013, le deluge"). So, because the ACA actually has provided very little in tangible first-year "benefits," it also has imposed only modest immediate costs and complications on most employers. Early projected estimates of the increased employer premium costs of initial mandates for offering group health insurance coverage to dependent "children" (up to age 26) of covered adults range in the one- to two-percent range. Premium cost increase estimates for the early prohibition on lifetime coverage limits, as well as the gradual phasing out of annual coverage limits, were equally modest. The less-noticed fact was that most employer group policies already had rather generous coverage limits, and hence they were largely unaffected by this "mandate." Of course, every two- to three-percent "average" increase in premium costs can be

more problematic for profit-squeezed small employers already operating on the margin, let alone those who are at the high-cost end of those broad cost-estimate averages.

Several other claims of early deliverable benefits from the ACA remain overstated, if not even more questionable. The initial implementation of minimum medical loss ratio (MLR) mandates for fully-insured coverage that began this year will have a more disruptive coverage impact in the individual than in the small group market (80 percent of premiums must be paid out in medical benefits by insurers in both markets, under rather complex rules for calculating compliance with that threshold). However, the initial enforcement of the MLR rules threatens to squeeze out or reduce the valuable services of many insurance agents and brokers, and discourage private insurers' investments in useful ancillary services that do not meet more narrow ACA-enabled regulatory definitions of payments for "medical benefits" – rather than leave it up to small employers and their covered employees to determine whether they are worthwhile as part of an overall package of insurance benefits. Moreover, the exaggerated effort to paint insurers' "excessive" administrative costs as a key component of high and rising insurance premiums flies in the face of the formers' relative share of those premium dollars as well as recent trends in their rate of growth. In general, administrative costs (including profits) for private insurers have been growing less rapidly than overall private premiums since 2003, as calculated by CMS in its annual National Health Expenditure account estimates (decreasing from 13.67 percent in 2003 to 11.15 percent in 2009).

Another "feel good" exercise of short-term political posturing under the ACA involves initial provisions for enhanced federal and state review of private insurers' premium rate filings. Although HHS does not have full power to deny proposed rate hikes, it has issued regulations enabling it to ask for more information to "justify" them, slow down requests for their approval by state regulators, and enhance the ability of the latter to block, reduce, or delay them further under state law. However, the long history of prior approval mechanisms for proposed insurance rate filings at the state level indicates that regulators may temporarily suppress rates but cannot keep them below the levels needed for insurers to pay claims and earn a reasonable economic rate of return on their capital.⁵

In a similar vein, the ACA claims to ensure that insurers in the employer group market eventually will be prohibited from denying coverage for employees with more costly pre-existing conditions (but not before 2014). Actually, earlier provisions of federal law under HIPAA (enacted in 1996) already provided similar protection in the group market for current and new employees with evidence of qualified continuous insurance coverage, apart from longstanding guaranteed renewability practices in most of the private insurance market in any event.

Early interpretation and enforcement of ACA's prohibition on lifetime insurance coverage limits for so-called "mini-med" health benefits plans reveals a different short-term "duck and cover" strategy by the current administration, when faced with bad publicity and substantial political pressure to reverse course in regulatory policy. Initially, a handful of high-profile or politically savvy companies offering such lower-cost, limited-benefits health plans to their lower-wage and/or shorter-tenured workers were granted short-term "waivers" from the new rules implementing the ACA's ban on lifetime benefits caps. But as public criticism of both the selective waivers and the jeopardy remaining for other

providers of mini-med coverage increased, the trickle of waivers turned into a gusher of subsequent exemptions until almost all of that sub-market had received short-term relief by the end of last month (HHS recently reached the magic “1040” mark in the number of waivers granted).

The above rounds of early ACA implementation reveal the overly broad regulatory discretion granted to the HHS secretary in many hastily- and poorly-drafted sections of the law, as well as a short-term political strategy to push for tighter regulation unless and until it meets substantial resistance, at which point the administration’s regulators may pull back temporarily. (One-year waivers and creative re-interpretations of ambiguous legislative language provide little assurance regarding later years). The more important objective is to avoid substantial political controversies on less essential ACA provisions that might threaten to undermine the implementation of much more important and far-reaching ones after the 2012 election cycle completes its course.

However, the unpredictability of what will be enforced and how it will be interpreted leaves many employers frozen in uncertainty in their health benefits planning, when not fearing the worst and finding their expectations met. The best illustration of the latter involves last year’s expansive interpretation of the ACA’s seemingly straightforward rules for grandfather protection from several of its new rules for employer health plans that were already in existence on the date of the law’s enactment. By the time HHS had re-interpreted the conditions for such grandfathering far more narrowly, most employer plans concluded they were likely to lose it once they made even modest adjustments in their “grandfathered” plans. Even federal regulators acknowledged that by 2013, only about one in five small employers and one-third of large employers will remain grandfathered. The impact of the new grandfathering rules was less in terms of the additional obligations and costs to which employer plans would become subject (most of them have decided to live with those burdens as the price for making other necessary cost-reducing changes in the health plans). Rather it was the latest unforeseen construction of a new set of hoops (mostly restrictions on any significant changes in cost sharing and benefits structure) through which they would have to jump if they still wanted to “retain” the protection from a lesser set of regulatory hassles and burdens (primarily involving no cost sharing for coverage of “preventive” health benefits) that the law had previously promised them on its face. Large employers generally shrug and make the economic and political tradeoffs as the price of doing business in a highly political and sometimes arbitrary regulatory environment. Smaller employers are more likely to be on the receiving end of new regulatory costs that they are proportionately less able to foresee, finesse, and finance.

Still ahead for the employer community are uncertainties in how the ACA’s rules for such largely-uncharted definitions and details of “essential benefits” and “state benefits exchanges” will be written and then interpreted in practice. The reasonable fears in the employer community are that those benefits will be biased toward more generous and less affordable levels, and that the exchanges ultimately will be designed to capture a much greater share of current employer coverage, penalize them for it, and then trap those new “beneficiaries” in much more highly regulated and restrictive insurance plans that only look “private” initially but eventually gravitate toward more of an expansion of Medicaid-like public coverage over time.

Added on to this menu of bitter-tasting items are various new taxes that nibble away further at the affordability of employer coverage and the profitability of the enterprises that must finance it. Higher Medicare payroll taxes, including those imposed on a new category of “unearned” income, will hit not just the “rich” but a significant number of successful small business owners operating either as sole proprietors or in subchapter S corporate structures. New taxes on insurance premiums, medical devices, and on prescription drugs will add up as they are passed through to the end-user consumers of health care in the form of higher insurance premiums and out-of-pocket care costs. A particularly obnoxious Form 1099 tax reporting requirement that would devastate many small businesses with new paperwork burdens remains widely unpopular but not yet fully repealed by the current Congress.

In isolation, few of the initial burdens under the ACA for employers are likely to determine decisively whether most employers continue to offer health insurance. But over time they amount to a steady drip-by-drip political form of water torture that can eventually reach critical mass and push a much larger share of employers to reconsider their involvement in offering health insurance coverage.

Former football coach Bill Parcells once said, “They want you to cook the dinner, at least they should let you shop for the groceries.” The ACA sets in motion the temptations to impose stronger doses of a highly politicized and tightly regulated regime of health insurance in which employers are increasingly going to be asked first to pay for health insurance groceries selected by Washington regulators and then to cook and serve them according to recipes concocted by the previous Congress and at HHS.

The potential economic damage ahead posed by the ACA to employers is not limited just to the future cost of health benefits they will face or their decisions whether to offer or drop coverage. The structure of future penalties for failure to comply with the employer mandate to provide coverage, which begins in 2014, will send out additional economic disincentive signals that tell different categories of business owners that they may need in some cases either to grow slower, hire fewer workers (particularly lower-wage earners), pay them less, pay them more, restructure firms to be smaller or have a different payroll structure, outsource more operations, rely on more capital and less labor, or mix and match all of the above as the latest rules, ambiguous enforcement guidance, and the surrounding health policy terrain requires them to pay more attention to volatile health care politics and less to business operations. Some of the key economic disincentives include the need to stay below the 50-employee threshold for the upcoming employer coverage mandate penalties, to juggle the tradeoffs between higher average wages versus lower cost health benefits versus a larger employer share of health benefits premium payments – to limit penalties for employees declining “unaffordable” coverage, or to keep payrolls lower and smaller in pursuit of temporary and narrowly- defined small business tax credits for health coverage costs, Far too many employers will feel like they have left the difficult challenges of recent private health insurance markets, only to be trapped in a more complex maze where almost all the choices could go wrong but must be weighed again and again to determine which is the “least bad” one at the moment.

It is in this larger context that the “lure to leave” the many political and regulatory landmines of ACA-style employer coverage could reach a tipping point if and when we reach the years shortly after

new subsidized health benefits exchanges have become established without crashing (no small feat!). Despite a host of uncertainties ahead, such exchange-based insurance coverage (as envisioned quite optimistically in the ACA) might seem like a great deal to many workers, particularly lower-wage employees whose premiums would be more heavily subsidized by taxpayers than under the current tax exclusion for employer-sponsored insurance.

As written in the law, however, these generous subsidies are officially limited to families earning between 100 percent and 400 percent of the federal poverty level, who do not receive qualified health insurance from their employers or from public programs such as Medicaid and Medicare. But many employers will face substantial economic incentives to reconsider continued offers of health coverage to their workers. A complex set of employer mandate penalties would loom large, with their amounts varying depending on the size of a firm and traded off against the net gains from eliminating direct health benefits costs, paying higher wages, and competing differently in labor markets.

The tilted playing field for tax subsidies for workers at the same income level inside employer health plans versus purchasing coverage in the exchanges appears far from politically sustainable, despite the temporary legislative “firewalls” constructed in the ACA to minimize such crossovers. If and when they begin to break down, two related effects would topple the superstructure of ACA’s tenuous combination of more, but not unlimited, taxpayer financing of health care financing and reasonably predictable access to various types of (largely mandatory) “private” insurance coverage. As sketched out most notably by former CBO director Douglas Holtz-Eakin, the federal budgetary implications of this employer coverage meltdown alone would be explosively unaffordable. Whether market-based forms of private insurance would be sustainable under this vastly rearranged landscape also seems questionable, at best.

The massive uncertainties and confusion ahead under the ACA for employers and their workers are already mounting, after less than one year. Much grimmer reality could bite even before its full mandatory coverage and expanded subsidies roll out in full force in 2014. The sheer difficulty of understanding, anticipating, and maneuvering through the complex and shifting regulatory terrain of the ACA and ObamaCare will be difficult for any business firm. It will be particularly challenging for smaller firms still struggling to survive during challenging economic conditions. Many of the misguided economic signals sent by the ACA to the business community encourage slower, rather than faster, economic growth; economic paralysis amidst the search for clear and consistent regulatory analysis; and fewer opportunities for better-paying jobs.

We still have time to pull back before testing the temperature of the water for the lead group of health policy lemmings nearing the edge of the cliff. A short list of changes in direction would include a stronger focus on responsible choice and competition in health care markets; more neutral, limited, and transparent taxpayer subsidies for health care spending by most Americans (augmented to provide special enhanced protection for the most vulnerable low-income and high-risk portions of the population); real steps toward meaningful information transparency; and realignment of incentives to reward better health care choices and higher-value health care delivery.⁶

Thank you again for the opportunity to present this testimony. I look forward to your questions.

¹ As calculated under Current Population Survey methods by the Census Bureau last year. Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, Current Population Reports, P60-238 (Washington, D.C.: U.S. Government Printing Office, 2010), table C-1.

² Anne Martin, David Lassman, Lekha Whittle, Aaron Catlin and the National Health Expenditure Accounts Team, "Recession Contributes to Slowest Annual Rate of Increase in Health Spending in Five Decades," *Health Affairs* 30:1 (2011):14.

³ For an earlier examination of this issue, see Thomas Miller and Rohit Parulkar, "Out of Pocket Theory for Health Spending Cutbacks Is 'Clueless,'" *Health Affairs Blog*, September 24, 2010, available at <http://healthaffairs.org/blog/2010/09/24/out-of-pocket-theory-for-health-spending-cutbacks-is-clueless>

⁴ See, for example, Martin Feldstein, "How Big Should Government Be?" *National Tax Journal* 50:2 (1997): 197-213; and Christopher J. Conover, "Congress Should Account for the Excess Burden of Taxation," Cato Policy Analysis no. 669, October 13, 2010.

⁵ See Scott E. Harrington, "Regime Change for Health Insurance Regulation: Rethinking Rate Review, Medical Loss Ratios, and Informed Competition," American Enterprise Institute, December 2010, available at <http://www.aei.org/paper/100163>.

⁶ See, for example, James C. Capretta and Thomas P. Miller, "The Defined Contribution Route to Health Care Choice and Competition," American Enterprise Institute, December 2010, available at <http://www.aei.org/paper/100164>.