FULL COMMITTEE HEARING ON CHALLENGES AND SOLUTIONS TO HEALTH INSURANCE COVERAGE FOR SMALL BUSINESSES

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FULL COMITTEE HEARING ON CHALLENGES AND SOLUTIONS TO HEALTH INSURANCE COVERAGE FOR SMALL BUSINESSES

WEDNESDAY, MARCH 14, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The Committee met, pursuant to call, at 10:00 a.m., in Room 2360 Rayburn House Office Building, Hon. Nydia Velázquez [Chairwoman of the Committee] presiding.

Present: Representatives Velázquez, Jefferson, Shuler, González, Larsen, Braley, Clarke, Ellsworth, Sestak, Chabot, Bartlett, Graves, Akin, Musgrave, Fortenberry, Buchanan and Jordan.

OPENING STATEMENT OF CHAIRWOMAN VELÁZQUEZ

ChairwomanVELÁZQUEZ. Good morning. This hearing on the challenges facing small businesses in providing health insurance coverage is now called to order.

Just about every employer and employee knows there are few issues of greater importance than access to health care. But in today's market, more companies particularly small businesses are finding it difficult to offer health coverage to their employees. The challenge of providing coverage not only undermines the well-being of millions of Americans, it also threatens the growth of small business and our economy.

If the American healthcare system is at a crossroads, small businesses are at its center. Entrepreneurs will tell you that this is the number one issue they face. And unfortunately, this problem is getting worse. Every year, the number of employers offering coverage continues to decrease. According to the Casey Commission on Medicaid and the Uninsured between 2001 and 2005 the number of workers receiving coverage through their employer decreased nearly four percent. More than half of this decline was attributed to companies terminating insurance coverage.

This Committee's goal will be to ensure that healthcare reform does not occur without meaningful consideration of how it impacts small business. Simply put, any reasonable strategy to expand insurance coverage must give serious thought to the challenges faced by small firms.

Today's hearing is the first in a series for the Small Business Committee. We will be looking at ways the Congress can address the problems in the small business health insurance arena. Over

the years, there have been a variety of approaches to reducing the number of uninsured that have been passed into law. We have seen the expansion of the Medicaid program, pools to help high risk populations as well as programs to provide healthcare for those laid off due to trade agreements. However, there have been no meaningful changes to fix the small group market. While states like Massachusetts and California are starting to take action on their own, I believe that there are changes at the federal level that can improve the health insurance market.

A number of committees will be looking at the problem of healthcare coverage in the 110th Congress. My focus is to make sure that the small businesses are part of the debate. We cannot have a discussion on reducing the uninsured without helping the 23 million Americans without health insurance who work at, on or have a family member working at a small business. In my opinion, any solution to America's healthcare crisis can only take shape in light of an open dialogue with all interested parties.

The panel before us will allow the Committee to do that. We must understand the challenges before small business and more importantly, we must understand how the insurance market works.

We have with us today an impressive group of witnesses, well equipped to help us identify the reasons employers are finding it difficult to offer coverage. This is why I am so pleased that representatives from the small business community, healthcare experts as well as the insurance industry are before us today.And I thank all of you for taking time to have this great discussion this morning.

While I know there may be differences of opinion on the best way to solve the problem, I think every one will agree that the current system is broken. I look forward to today's testimony on possible alternatives and practical solutions that may go beyond the particular perspective of the constituency that you represent. My hope is that we can hear about some common ground on the various issues that will help us move forward with meaningful solutions. And now I will recognize Mr. Chabot for his opening statement.

OPENING STATEMENT OF MR. CHABOT

Mr.CHABOT. Thank you, and thank you, Madam Chairwoman, for holding this important hearing on health insurance and healthcare. I want to particular welcome Mike Cavanaugh, President of Queen City Electric in Cincinnati for making the trip to testify before the Committee and I'll be introducing him later. I also want to mention I'm pleased to see a fellow William and Mary graduate, Mr. Stottlemyer from NFIB. We happen to both not only graduate from William and Mary, but played football for that fine college, second oldest in the nation. I happen to be 10 years older, but not 10 years wiser. So glad to have you here, Mr. Stottlemyer as well.

Purchasing health insurance is one of the most costly expenses for small businesses. The National Federation of Independent Business, NFIB, cites the cost of employer-sponsored health insurance as small business owners most pressing problem, greater than taxes or labor costs or even government red tape.

As I visit with small business owners in my Congressional District back in Cincinnati, the cost of healthcare is cited repeatedly

as the most significant challenge for those small businesses and the cost of healthcare is rising. Access to health insurance is also a challenge to small businesses. According to the Small Business Administration, the SBA, employees with small firms are far less likely to have health insurance than those at larger ones. Helping to make healthcare more affordable for small businesses is one of the most important issues this Committee can address and that's one of the reasons that I commend the Chairwoman for holding this hearing today.

We all know that small business is the engine of America's economic growth. According to the Bureau of Labor Statistics from July 2005 to June 2006, small businesses created one and a half million new jobs, 61 percent of all the jobs created in America. Our nation's small businesses and entrepreneurs drive the economy and we need to do all that we can to help keep their costs down, help them stay competitive and encourage their growth.

Association health plans, pool purchasing and reinsurance have been mentioned as ideas to help reduce the cost of health insurance for small businesses. Other suggestions such as implementing new healthcare technology, chronic disease management and aggressive case management have also been advanced as ways to reduce the cost of health insurance and healthcare. With a problem of this magnitude, we must examine all of these options, come up with new ones and work together to address this issue.

I believe that tax relief is also an important way to reduce the overall tax burden and make healthcare more affordable for small businesses. In previous Congresses, I've introduced the Healthcare Affordability Act which would provide every American the ability to deduct 100 percent of the cost of their health insurance, something that larger companies can do, but unfortunately small businesses or individuals are unable to do it at this time. I plan to introduce this bill or similar bill in the near future.

Madam Chairwoman, I appreciate your holding this hearing. I look forward to hearing from our witnesses and to working with you on finding ways to make healthcare more affordable for small businesses and their employees, and once again, thank you for holding this hearing. I yield back my time.

ChairwomanVELÁZQUEZ. Thank you, Mr. Chabot. And our first witness is Mr. Adam Cockey. You will have five minutes. The green light means you can start and then the red light means the time has expired.

Mr. Cockey is the 2007 immediate past chairman of the Business Issues Committee of the National Association of Realtors Board of Directors. The National Association of Realtors represents more than 1.3 million members involved in residential and commercial real estate. Since 2003, Mr. Cockey has been a senior vice president of Prudential Realtors, a real estate firm with 25 offices located in the District of Columbia, Maryland and Virginia. Sir, you can start your presentation and thank you for being here.

STATEMENT OF ADAM D. COCKEY, JR., SENIOR VICE PRESIDENT OF PRUDENTIAL CARRUTHERS REALTORS

Mr.COCKEY. Thank you, Madam Chairwoman Velázquez, and Ranking Member Chabot and Members of the Committee. I am

here representing the 1.3 members of the National Association of Realtors. I thank you for holding this session and appreciate the opportunity to discuss the challenges that the small business community faces with the outlook for health insurance.

I've been in the real estate profession for more than 32 years. I know how hard it is to find health insurance when you have no employer to provide coverage. I also know how hard it is to provide health coverage for employees when you're the owner of the firm.

The real estate sales profession experiences a perfect example of the challenges that the self-employed and small firms face today. You see, real estate agents are self-employed, independent contractors. They are not employees of the offices which they are affiliated. They are independent, legal entities. You might say that they are the smallest of small businesses.

The overwhelming majority of real estate firms are also small, typically having fewer than five employees and like other small businesses, they struggle to provide health insurance to their salaried employees. I'd also note that this struggle is not limited to just the small firms. My firm, Prudential Carruthers, we have 140 salaried employees. Even with what some would consider a less than small number of employees, finding health insurance coverage is a challenge and is expensive, so expensive that in fact, that only 70 of the 140 employees choose to sign up for the coverage. Why do they not? They do not because they find that the coverage is just too expenses on their salary basis.

As a result, most real estate agent employees must find coverage in the individual insurance market, where there is no negotiating and no leverage. For the most part, you basically take or leave whatever coverage is offered at whatever price it is offered. Our firm, as an example, in Year 2005 had an 8 percent increase in insurance. This year, the increase is 21 percent. Over the two years, we've almost had a 30 percent increase in insurance coverage. Consequently, today, more than 28 percent or more than 336,000 of the nation's 1.3 million realtors have no health insurance. If we add family members to the tally, the number of uninsured individuals in realtor households is estimated to be as many as 886,000 men, women and children.

A growing problem. Obviously, realtors are not alone in their struggle to obtain affordable healthcare today and looking at employment trends, we anticipate that we have even more uninsured individuals in the future. Today, as a result of corporate restructuring and job outsourcing, the share of the U.S. workforce that is self-employed, independent contractors, freelance workers, consultants and other nontraditional workers has reached a remarkable level. The General Accounting Office estimates that these workers comprise 30 percent of the American workforce in 2000. Some experts expect that by the Year 2010, 41 percent of the U.S. workforce will be so-called free agent workers.

Without changes in the current health insurance system, we fear this shift in composition of workforce will be accompanied by increases in the number of uninsured. Finding a solution to the insurance problem must become a top priority.

As discussions of a problem must also include discussions of solution, while our organizations and its members are not health insur-

ance experts, let me quickly share some observations. First, any discussion of solutions must address the shortcoming of the national individual insurance market. The market is not serving the needs of the self-employed dependent upon it.

Second, efforts need to be made to define what constitutes a set of core healthcare benefits. Such an effort would be a first step to define an essential set of coverage around which stake regulators could get together. Together, any national or state solution must acknowledge that the cost of providing individuals with total access to all desired health services is far beyond what most individual families and businesses can afford.

And finally, we believe that there is a role for the community, the nonprofit organizations that have not traditionally been involved in facilitating access to insurance for the self-employed and the small businesses.

On that note, I will close, Madam Chairwoman, and again thank you for inviting us. I hope that and I'm happy to answer any questions that you may have.

[The prepared statement of Mr. Cockey may be found in the Appendix on page 40.]

ChairwomanVELÁZQUEZ. Thank you.

Mr.COCKEY. Thank you very much.

ChairwomanVELÁZQUEZ. Our next witness is Ms. Karen Ignagni. She is the President and CEO of America's Health Insurance Plans. American's Health Insurance Plans is the national trade association representing more than 1,3000 health insurance plans.

Thank you.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CEO, AMERICA'S HEALTH INSURANCE PLANS

Ms.IGNAGNI. Thank you, Madam Chair, Mr. Chabot, Members of the Committee. It's a pleasure to be here today to focus on the problems of small business and what can be done with respect to the healthcare challenges in that arena.

We have submitted testimony that focuses on four areas. First, the current state of the small health insurance and how healthcare dollars are being spent there. We have executed the most comprehensive survey to date on that market and we'd be delighted to talk more about the specifics of those results.

Second, an overview of the strategies that our members are undertaking to control healthcare costs, enhance choices, and improve quality.

Third, solutions, specifically targeted to small business to respond to some of the challenges that my colleague, Mr. Cockey, just talked about.

And fourth, our perspective on various legislative proposals, both in Congress now, as the Chair indicated in her opening remarks, as well as things you might think about.

To begin, in November 2006, just a few months, our Board of Directors announced a proposal for expanding access to health insurance coverage for all Americans. The reason I start here is that the problems that small businesses are facing in the healthcare arena are very reflective of the problems that a number of the individuals

who are presently uninsured are facing, and we need to look at broad strategies as well as customized strategies.

Our access proposal includes several elements that would help small business and indeed, Mr. Cockey referred to some of them a moment ago. The Chair and Mr. Chabot referred to some of them and I want to highlight them.

First, our proposal would allow for a new federal performance grant that would allow funding to be made available to states if they meet specific targets to provide a helping hand in expanding coverage.

Second, our proposal for healthcare tax credits would help subsidize the cost of individuals below 400 percent of poverty purchasing health insurance coverage. Many of those individuals from 300 to 400 percent of poverty, which is roughly $60,000 to $80,000 worth of income, are working in small businesses and need that additional helping hand. So we would do that on a sliding scale.

Third, we are very, very supportive of the comments that have just been made about the importance of tax equity. If you are purchasing health insurance on your own in our country now, you need to spend 7.5 percent of your adjusted gross income before you have a dedication. Individuals who are receiving coverage through employers receive their coverage from employers and have that deduction, so we think that's a very important factor.

And because we believe in this principle of tax equity, fourth, we have proposed a new mechanism, a Universal Health Account, that would not prescribe the type of coverage that an individual should purchase, but that it would create a tax vehicle to allow this tax equity to be secured and allow subsidies from the Federal Government, from states, from employers, to flow into those accounts so that individuals would have portability.

Another front, we support steps to modernize the regulatory system. In particular, Mr. Cockey made a very important point a moment ago about the needs for states to create or have a regulatory environment that allows for the purchase of affordable coverage. We have set out two alternatives for states to consider in our access proposal. One in particular goes to this concept that Mr. Cockey referred to which is to establish a basic package of benefits. We know that there are a number of meritorious objectives that underpin state mandates, but they are acting as a barrier for small business who want to do the right thing and provide insurance coverage, but they can't afford to cover everything that is required. We believe in uniform regulatory structures that do provide flexibility for the kinds of customized benefits that we were talking about, but to do that in a uniform way.

And we also believe that it's time to establish an independent advisory commission and a number of the states have been moving in this direction to assess whether or not states should move forward with additional mandates and to look at the mandates that have already been put on the books.

We also believe and I think this has not yet been mentioned, the importance of federal funding for state high-risk pools. There are a number of individuals who are medically uninsurable. There has been legislation, state high-risk pool funding, Extension Act of

2006, which has been enacted, but it needs to be appropriated annually, and this is also a very important part of the structure.

Madam Chair, I've focused primarily in my oral remarks on some of the ideas that I thought the Committee would be particularly interested in, but in the last moment of time I do want to highlight for the Committee that we have provided a whole range of strategies that our members are undertaking to do disease management, to do care coordination, to make the healthcare system more connected, to do personal health records and allow individuals to have the kind of portable effective healthcare coverage that they are very much interested in. We're taking leadership and partnership with a number of organizations and we'd be delighted to talk about all of those issues. I'm sorry to be speaking fast, but I see the red light is on.

Thank you very much.

[The prepared statement of Ms. Ignagni may be found in the Appendix on page 49.]

ChairwomanVELÁZQUEZ. Thank you.

Our next witness is Dr. Gail Wilensky. She's an economist and Senior Fellow at Project Hope, an international health education foundation. She has served in several roles including the immediate past chair of the board of directors of Academy Health and the administrator of the Healthcare Financing Administration.

STATEMENT OF DR. GAIL WILENSKY, SENIOR FELLOW, PROJECT HOPE

Ms.WILENSKY. Thank you, Madam Chair, Mr. Chabot, and Members of the Committee, I am here representing my own views based on my training as an economist and having run Medicare and Medicaid programs and advised Congress through the MedPAC Commission.

You've already heard a number of statements about the general problems in the employer-sponsored insurance market. We are where we are now because of tax laws that have encouraged the provision of health insurance through the under 65 population, through their employers because of the differential treatment of wages and fringe benefits. I'd like to add my support to the notion that we need to make sure there is tax equity so that people who are not getting insurance coverage through their employers, are also able to use pre-tax dollars. There are a variety of strategies that have been proposed. I will support almost any of them if it goes after the major problem of making sure that there's tax equity.

In addition, it's important because fewer employers are offering health insurance coverage and we need a way to have an alternative to reliance on the primary source of insurance through employers. It has some of its own problems, but because it is the way most individuals receive insurance, we have to be very careful as we move forward to make sure we're augmenting employer-sponsored insurance and not destroying it as a basis of insurance coverage, at least as long as we do not have a robust alternative in its place.

When you look at what has been happening with regard to employer-sponsored insurance, it is really the smallest of the first that

is having the most difficulty. We typically make the division under 200 employees as small employer, but when you look at who is offering health insurance coverage, it's only when you get to the three to nine employee firms that you see major difficulties. Although for the 10 to 25, only 73 percent, roughly three quarters of the employers actually offer insurance. Once you get above that number, the numbers are very substantial. Not that it's not a problem, but they are offering health insurance coverage at least, which is something the smallest firms are not doing.

The decline in the variability has been greater for the smallest of firms. The increase in premiums, while not as different as one might have guessed, has again been the greatest for the firms that are less than 9 percent. When you look at averages, you do not see some of the variation that exists, such as Mr. Cockey described. In general, in the last year, insurance went up at a slightly slower rate at about seven percent, but it was three percentage points faster on average for these smallest firms. So again, it appears the biggest problem is for the firms that are 3 to 9, although there are some challenges for firms below 50 employees as well.

The variation in risk, some characteristics about the insurance, about the firms themselves, makes this a more difficult problem to resolve. There's more variability because of the small numbers of employees and they tend not to have their own benefits staff and that means getting the expertise is more difficult. It also means that they pay their costs of getting advice directly through a loading factor and through their insurance broker where big firms tend to do it indirectly through personnel that they have on their firm as benefits managers or through outside consultants. Sometimes the differences are more apparent in terms of where they are being paid, rather than actual differences.

Reinsurance has been mentioned as a strategy and it is one that both small firms and niche insurance companies use. Small firms will turn to reinsurance for stop loss. That is, in order to protect themselves either in the aggregate of having claims that are too large or if one individual has cancer or a major medical event, protecting itself from that kind of a claim. Sometimes niche firms will also use reinsurance as back-end insurance for their own company. This market seems to be functioning pretty well. It does have peaks and troughs. There has been some consolidated. In general, it seems to function pretty well.

There's been some question about whether there's enough insurance offering in the small market. It's quite concentrated, that is, there's usually one very dominant firm, on average, offering about 43 percent of the insurance to small firms, but there are actually a lot of players, on average, 30 to 35 players in all of the states. So it's concentrated; usually a Blue Cross/Blue Shield plan, but there are a lot of niche players as well.

There have been a lot of attempts to try to resolve these issues, guaranteed issue, guaranteed renewability, nondiscrimination, limits on pre-existing conditions. Those usually go after the offerings of insurance and there have been a variety of ways to try to keep the cost down through rate regulation, premium variation limitations. But the sad fact is while there's been some success in terms of coverage offerings, there has been little success in terms of actu-

ally getting the costs down. And it has happened because of an inability to keep purchasing groups together so that they maintain a significant share of the market and they have a sustainable effect. There are a variety of ways to try to go at that. That is the reason that association health plans have been suggested. MEWAs which have somewhat of a checkered history are having a resurgence. The Department of Labor is putting a little more money into their regulations really to know whether or not this is a good strategy.

Figuring out how to promote more stable groups of small employers is clearly the solution. The question of how to do that has a eluded us in the past, but we can't give up. That has got to be the answer for small employers, along with tax equity. And ultimately, you'll forgive my saying this as a health economist, the real solution to lowering or slowing down the growth in health insurance costs is slowing down the growth in healthcare costs. We really desperately need to do that.

[The prepared statement of Dr. Wilensky may be found in the Appendix on page 69.]

ChairwomanVELÁZQUEZ. Thank you. Our next witness is Mr. Todd Stottlemyer. He's the president of the National Federation of Independent Business, the largest advocacy organization representing small and independent businesses in the nation. He became the fifth president of NFIB in 2006. Welcome.

STATEMENT OF TODD STOTTLEMYER, PRESIDENT AND CEO, NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Mr.STOTTLEMYER. Thank you, Chairwoman Velázquez. I thank you for inviting NFIB to discuss the challenges facing small businesses looking for access to affordable and quality health insurance. Throughout your service in Congress, you have championed issues of importance to small business and healthcare has always been one of your top priorities and our members agree. Access and affordability of health insurance remains their number one concern. That is why NFIB believes we must take action now to reach the goal of universal healthcare by increasing access to affordable health insurance.

U.S. workforce is comprised of two distinct categories: big business and small business. When it comes to affordable and available health insurance, the difference between big and small is substantial. In today's health insurance market, the large employer enjoys a market that provides competition, economies of scale and administrative efficiencies. They're also able to obtain relief from the high cost of health mandates. All of these factors improve the affordability and availability of health insurance.

However, the story is different for small business. The cost of their health insurance is significantly more expensive. That is because the small group insurance market lacks competition, bargaining power and administrative efficiencies. The cost is further exacerbated by expenses mandates and the result, according to a 2006 Commonwealth Fund study, on average small businesses pay 18 percent more in health insurance premiums for the same benefits as those in the largest firms.

We strongly believe that health insurance should be accessible and affordable to everyone in the workforce, big or small. NFIB supports a comprehensive approach to help small businesses find affordable and quality health insurance. Our approach has three components: pooling, tax-base incentives, and cost-containment measures.

First, Congress should take steps to develop health insurance purchasing pools for small businesses. Expanding the size of the insurance pool increases bargaining power and decreases administrative costs. This will increase coverage for small businesses. Although action on small business health plans was stymied in the last Congress, NFIB will continue to explore all pooling proposals that can increase the purchase of private health insurance for small businesses.

Beyond pooling, NFIB supports tax-based incentives thatencourage fairness and equality for everyone purchasing health insurance. Rather than continue to rely on a tax system that primarily benefits those who obtain their healthcare in the employer-based system, we need a tax system that offers the same incentives to everyone who purchases health insurance. We're looking at various combinations of tax credits and deductions, all with the same goal in mind, greater access to affordable, quality health insurance.

Sustainable solution must also include cost containment measures designed to make everyone a better consumer of healthcare. Congress needs to take steps to implement health information technology and transparency practices. This will result in consumers being more educated about the cost and quality in the marketplace.

Finally, there are more than 1800 state health insurance mandates on the books. More mandates mean higher cost. We must draw a line in the sand and understand that there's a real difference between what we need and what we want. All mandates are not crated equal. There's a difference in the value of every woman having access to a mammogram and everyone have access to hair transplants or chiropractic services.

Cost-containment measures implemented in tandem with pooling approaches and appropriate tax-based incentives can significantly improve the access and affordability of health insurance for small business.

We must take action now to reach the goal of universal healthcare by increasing access to affordable, private health insurance. The 27 million working uninsured in the small business community can't wait any longer. They need solutions now. Because the longer we wait, the harder the task and the more uninsured population grows.

Universal healthcare does not mean government takes over. It means taking necessary steps to transform the marketplace by injecting choice, competition and value for those services. This will enable more people to purchase private, quality, affordable health insurance that is portable over all phases of your career.

I want to thank you again for holding this hearing today. NFIB very much appreciates your continuing support for small business and we pledge that we are going to do everything we can to increase access to affordable health insurance for America's small businesses, their employees and their families.

Thank you.

[The prepared statement of Mr. Stottlemyer may be found in the Appendix on page 83.]

ChairwomanVELÁZQUEZ. Thank you. Now I will recognize Mr. Chabot to introduce his witness. I believe he's your constituent?

Mr.CHABOT. Yes, he is. Thank you, Madam Chairwoman, and it's my pleasure to introduce Michael Cavanaugh who is the owner and president of Queen City Electrical, Inc. in Cincinnati, Ohio. After a four-year apprenticeship and three years as a journeyman electrician, Mr. Cavanaugh started his own small business. He currently employs 25 people in his business located in Cincinnati's west side and my Congressional District.

Mr. Cavanaugh devotes considerable time and effort in finding a healthcare plan that he can afford to offer his employees and he has been successful. However, he's found this to be a challenging process with limited options available to the small business owner who wants to provide health insurance for his or her employees. A graduate of the University of Cincinnati, Mr. Cavanaugh serves on the Board of Trustees of the Independent Electrical Contractors of Greater Cincinnati, and we welcome you here this morning, Mr. Cavanaugh.

STATEMENT OF MICHAEL CAVANAUGH, OWNER, QUEEN CITY ELECTRIC, INC., CINCINNATI, OHIO

Mr.CAVANAUGH. Thank you, Mr. Chabot. Chairwoman Velázquez, Ranking Member Chabot, and Members of the Committee, thank you for giving me the opportunity to testify today. My name is Mike Cavanaugh as Mr. Chabot said. I'm the president and owner/operator of Queen City Electric in Cincinnati.

Like any small business owner, I started my company for many different reasons. The most compelling thing for me was the prospect of doing things my own way and in a relatively short time after going out on my own, I started to hire other employees to aid in my growing business. From the beginning, I believe that to have a successful business, you must treat your employees well. It's pretty basic, I think. That includes not only a good work environment, but also a full range of benefits, including health insurance, probably one of the most important ones. It's a very expensive proposition, but I feel it's necessary.

How could I as a small business expect to attract and retain the quality people that I'm going to need to grow, if I cannot offer health insurance? Small businesses are at a significant disadvantage because we cannot easily band together to form large pools of insured individuals similar to large companies. As a result, we lack bargaining power. The expense of providing medical coverage is one of the single most important items most small businesses face, in my opinion.

Each year in my company we face the tremendous task of shopping for health insurance. We do this because carriers will not provide fixed rates for longer than one year. So it's an annual process. AS a result, each November, in search of the best overall value, we start working with a couple of local agencies hoping to avoid the annual 15 to 20 percent increases we've seen in rates, historically. We cannot start any earlier than 60 days prior to the expiration

of our current plan, as carriers will not hold rates longer than 60 days. Because each insurance carrier has its own form, we ask each employee to fill out three to five different applications so that we can get quotes from as many different companies as possible. If you can imagine the headache of having all these people fill out these forms, it's very daunting. The process is time consuming and each year we spend hours and hours on the phone asking employees to please get their paperwork turned into the office so we can get our quotes back in a timely manner. This annual process causes a significant waste of time and resources for our business. We'd much rather be making money at what we do best instead of spending time on this.

Once we complete the task of filing out and submitting all the applications, we wait for the companies to respond with their quotes. For some of the companies the quotes provided are not guaranteed rates, but only preliminary rates, because they require additional forms to be filled out by each insured person upon the selection of them as our carrier. So when we evaluate rates from these companies, we keep in mind that they are not necessarily what they may end up being when it's all said and done. Of course the rates cannot be evaluated until a full comparison of the plans can be done. I am fortunate enough in my company to have an office manager who has experience in both human resources and the field of medical administration. Not all small businesses are as fortunate as I am and do not have the luxury of this person working for them. So small businesses typically lack the resources to make informed, educated decisions when selecting health insurance. I was an electrician first and foremost and for me to select the right plan for all my people, it's kind of challenging. We don't always have that expertise. Most small businesses probably don't.

So after a process of applications, evaluations and decisions about the various medical plans, we select one. Much time is spent educating employees on the new plan, discussing coverage, and helping the employees by calling the various providers. Small businesses spend time that they don't have sorting out difficulties created by a myriad of rules and coverage options, all in an effort to provide the best coverage options at the lowest cost.

These issues are very real and time-consuming issues for most small businesses. Nonetheless, we continue to grow and create jobs year after year. The main thing that would surely aid in the efficiency of the entire process, I feel, would be more market competition. If more options were available to the average small business, insurance companies would be more competitive in rates, as well as service. And we all know they can improve in service, with all due respect to that industry.

Please don't mistake these observations I'm made above as an appeal for more government intervention in the way business operates. Rather, consider it an appeal to allow for more open competition in the marketplace. I believe that market forces, in time, can bring efficiency to markets, where government regulations, though well intended, can have the opposite effect.

Thank you again for the opportunity to testify today.

[The prepared statement of Mr. Cavanaugh may be found in the Appendix on page 93.]

ChairwomanVELÁZQUEZ. Mr. Stottlemyer, most small employers generally receive the same tax advantages as large firms for sponsoring health insurance, but they often have too few employees to keep premiums low. Can we relieve some of the current tax burden experienced by small employers to make healthcare and other benefits affordable? And are there mechanisms within the current tax code that could be used to make insurance premiums more affordable and encourage employers to offer coverage?

Mr.STOTTLEMYER. Well, Madam Chairwoman, as I mentioned earlier, we really believe in equality, looking for more equality in the tax system regardless of whether you're a small employer or large employer or you're self-employed. I think the comment was made earlier as it relates to the self-employed, the AGI is seven and a half percent, so you don't have that equitable tax treatment.

We're also looking at different types of deductions or credits that would encourage employers to offer insurance. It would help give them some relief, if you will, for the smaller employers who offer insurance to their employees, if they paid a certain percentage of their premiums. So fundamentally, we're looking at more fairness in the tax code, whether it's large, small or the self-employed, and we think that's very important.

ChairwomanVELÁZQUEZ. Mr. Cavanaugh, can you talk to us about how tax incentives within the code impact your ability to offer coverage?

Mr.CAVANAUGH. The lack of the incentive or incentives? I'm going to be in favor of any incentive in the code, pretty much, any tax break I can get. It would certainly be helpful in my business for a tax break along those lines.

ChairwomanVELÁZQUEZ. Thank you. Dr. Wilensky, do you think there are other ways in which reinsurance can be expanded in the private sector or in the private market to lowering insurance costs? And can you tell the Committee more about the types of reinsurance and the relationship of reinsurers to primary insurers?

Ms.WILENSKY. I will tell you, as I mentioned, there are really two different ways reinsurance works and people sometimes confuse them. The most common and in some ways it would be the most directly relevant to this Committee is when a small firm goes to reinsure against having either in the aggregate large claims or for any individual a large claim. There is a trigger that once an individual's expenses exceed say $50,000, the reinsurance starts, or if in the aggregate, the firm exceeds $500,000 or some preset amount, the reinsurance comes in.

This tends not to be nearly as expensive as the primary insurance because it is less likely. To the best of my knowledge, there is not difficulty in purchasing this insurance. There are a number of reinsurance companies that offer this type of insurance, but it is not the only kind of reinsurance. The other kind of reinsurance tends to go to the small insurance companies, to go to the point of trying to increase competitiveness in the market, that they will go and buy their own back-end insurance so that if the claims against them are too much, they have some protection.

There are cyclical effects that the reinsurance companies report. They have peaks and troughs in their business. When they're in a trough and I think that is happening, has been happening, you get

some that exit and you get some consolidation which means there are fewer that are around. It is also an area where health insurance is a relatively small part for some companies of the reinsurance, but it does not appear to be a problem of too little supply.

I think the problem that is much more significant is the variation in state laws means that some of the bigger players that don't need or don't turn to reinsurance are less likely to come into states because every time they cross a state line, when they are dealing with companies that are not ERISA exempted, they have to face a different set of benefit mandates and different rules with regard to rate regulation and that may be more of the competitive problem of not having enough insurers than a problem in the reinsurance market, as I understand it.

ChairwomanVELÁZQUEZ. Mr. Cockey, a factor that complicates nearly all proposals to expand health insurance coverage is how to deal with risk segmentation in the small group and individual insurance markets. Risk segmentation is especially back for small businesses. I am interested in finding ways to address this problem by spreading risk. Would a small employer purchasing alliance or comparative help prevent risk segmentation?

Mr.COCKEY. Are you saying if they were part of a larger segment, that would—yes, I think that would certainly be some benefit to all because the problem with the small businesses as Mr. Cavanaugh mentioned, I too, have owned my own company for 25 years. The greatest difficulty was trying to find the insurance because we were looked upon at a higher risk because we were the size we were and consequently the revenue from our premiums were not great enough for the insurances to feel that they could cover the potential expenses.

So we went on a search every year to find another company that was going to cover us. So we changed every year. We were with new doctors and new coverage. The sad part about it is when I moved into a larger facility with the Prudential Carruthers group, thinking that would go away that we would have less risk in front of us and looked upon as being a greater opportunity for insurance companies, we are not looked upon any differently.

ChairwomanVELÁZQUEZ. My last question on this round is for Ms. Ignagni. Of the reforms being talked about, one which has begun to receive attention is reinsurance, and the Durbin-Lincoln proposal on the Senate side will have the government act as a reinsurer for the medical expenses of high-cost individuals. I think reinsurance is important to the question of risk. But I'm concerned that a government reinsurance program might not be able to adequately monitor or control that reinsurance and risk adjustment processing.

Do you think that having the government as the reinsurer would work?

Ms.IGNAGNI. I think, Madam Chair, your concerns are warranted and well stated. Having said that, we are looking at a variety of proposals that would allow our members to respond to the challenges we've been talking about today.

And let me give you a couple of examples that go directly to your point. The first job is to encourage small businesses to offer the insurance and then to encourage individuals to purchase it. And

we've been looking at a range of proposals. First, there could be some very targeted, tax strategies to small employers that face disproportionate costs. That would be one way to go at it, number one.

Number two, there could be targeted strategies to small employers that are offering wellness and disease management strategies, again to encourage people to get in early. That's the most affordable time to provide coverage.

Three, subsidies for individuals who are under certain income level to allow them to be able to take it.

Fourth, you could look at the subsidy question, not strictly from the employer perspective, but for individuals who have disproportionate healthcare expenditures. That goes directly to marrying the two questions, one you posed earlier, and the one you posed to me. So we are in the process of doing now having outlined a very broad access proposal for all Americans and the subsections that I talked about. We're also looking at this concept of guaranteeing access and what can be done through pooling mechanisms in the private sector. Our board meets next week and we're going to be having a great deal to say about that after those discussions. So I think we'll be able to offer even more specifics. But the final point here is the issue a number of our members would love to offer more affordable products to small businesses and to individuals. They are simply prevented from doing so because of the tyranny of state mandates. And we have offered very specific proposals on how to address that, not addressing it just for one particular group, but across the board.

I can give you also some data that suggests that the health savings accounts which are new products that we've been allowed to offer under the tax legislation, it has shown that of the small businesses purchasing HSAs for their employees, approximately a third didn't provide healthcare coverage before. So we're hitting a price point. There are other ways to do that, but we are provided— there are barriers because of state mandates.

ChairwomanVELÁZQUEZ. Thank you. I will recognize now Mr. Chabot.

[Mr. González assumes chair.)

Mr.CHABOT. Thank you, Madam Chairwoman, and Mr. Cavanaugh, if I could start with you. I first want to underline the way you concluded your statement. Please don't make these observations outlined above as an appeal for more government intervention in the way business operates. And I can't tell you how much I agree with you in that statement. I hope we follow that recommendation. And then you went on to say "rather, consider it an appeal to allow more open competition in the marketplace. I believe that market forces in time can bring efficiency to markets where government regulations, though well intended, have the opposite effect."

Would the other panel members for the most part, would you agree with that statement in sentiment for the most part? I think I'm observing all nodding in the affirmative. Thank you.

Let me follow up, Mr. Cavanaugh, with another question. You mentioned about your employees and their involvement and getting the forms back and forth and the time consuming nature of that. Once you got the insurance, what are some of the—are there any

complaints that the employees have afterwards about things that they think should be better or things that annoy them, things of that nature? Have things percolated up to your level about that?

Mr.CAVANAUGH. Yes, frequently we—as was alluded to in other comments, we change plans virtually every year in search of more competitive coverage. We have to. So that brings up a whole host of potential problems with networks, doctors being out of network because the insured may have had a certain favorite doctor who is not in the network of the new one. Now that's improving. The networks are pretty large, but there's generally a suspicion of the employer sometimes that we're doing something to lessen their benefits or we're doing it for our own selfish reason, so yes, there are a host of things that arise when we change plans every year. I'd prefer to keep more consistent coverage. So we have to explain these things, different co-pays, all kinds of things; different medications that are not in certain plans and other plans, so yes, there are a host of things.

Mr.CHABOT. And I would assume that as a small business owner that your bottom line is impacted by the health insurance costs, especially as they increase. Would that be accurate?

Mr.CAVANAUGH. Yes, that would be fair to say. Greatly affected. It's one of the largest expenses that we don't have any control over. We don't know what it's going to be either, when we look at our budget for years in the future because we may see a 10 or 20 percent increase. We just don't know.

Mr.CHABOT. And your employees share in the premium costs?

Mr.CAVANAUGH. I pay the majority of it and I've had to ratchet that down. I used to pay 100 percent of the coverage, but it's very difficult, so yes, they do share in the cost.

Mr.CHABOT. And that's pretty common in all the industry, small businesses. I am again noticing the affirmative nods.

If I could turn to you, Mr. Stottlemyer. Relative to the association health plans, how frustrating was it to see for in the last six years the House passed associated health plans five times and then it goes over to the Senate and unfortunately, action not be taken. Not too loaded a question, is it?

Mr.STOTTLEMYER. It was very frustrating and prior to my coming in, I was an employer. I changed healthcare providers three times in the last three years. I had an 18 percent increase from a Blue Cross/Blue Shield. I went to Cigna and United Health. I was a larger small employer, but certainly our membership, those members who belong to NFIB, it's very frustrating because pooling is very important, particularly in states where there's not competition. And bringing them out of those states into a bigger pool, we fundamentally believe creating that competition will help reduce costs. Very frustrating. I'm an optimistic. Yesterday, I was on the Senate side and spent quite a bit of time with several Members talking about pooling, very importantly, and I remain optimistic with the leadership of this Committee and others that we can move the ball forward.

Mr.CHABOT. I certainly hope so. Thank you. Ms. Wilensky and Ms. Ignagni, if I could ask you both just a follow up on the association health plans. What role do you think they ultimately would play, especially if we're able to do some things legislatively up here

in answering the question about how small businesses can deal with the increasing cost of health care in the country.

Ms. Wilensky and then Ms. Ignagni.

Ms.WILENSKY. To the extent they are able to solve the problem that we've not solved to date which is being able to form large, stable grouping mechanisms, they will help small employers have some of the power and market share of large employers.

What will be important is to monitor, if they were to get through the Senate, that they stay stable and some people have suggested that because groups tend to form and then dissolve, rather than stay in these pooling groups, at least in the past, that it might be that there would be some kind of a subsidy for those who remain in a pool, in addition to the natural advantage they gain by being part of a pool. There have been concerns, as you know, raised that these groups won't be subject to the same regulation as they would if they stayed in their own states, but of course, any ERISA-exempted company and some of them are now quite small as a way to get around some of the barriers they feel exist in their own states already have that. So it seems to me this has been an unfair burden to put on small employers that are attempted to gain some of the clout of being a bigger purchaser. If it works, if you can make it happen, it will go a long way to helping these small employers.

Mr.CHABOT. Thank you, Ms. Ignagni, anything you want to add there?

Ms.IGNAGNI. Yes, Mr. Chabot. I think that—I understand completely why small businesses are interested in AHP legislation. But I think with all due respect to that concept there are these larger issues that if we continue to set specific remedies up to meet specific circumstances and not look at the larger picture which is we have a problem with mandates, we need to do a better job in the tax system. We need to deal with these underlying issues, that we do face some risks and I noted that the Congressional Budget Office had done a very good analysis about their concerns that short term, it may solve some problems; long term, we may have a real and more significant problem on our hands.

So our view is to step back to say these problems are real that my colleagues are talking about and to propose remedies to deal with the situation once and for all in a uniform fashion and that's what we're endeavoring to do.

Mr.CHABOT. Thank you. Mr. Cockey, let me conclude with you. I think you had given an example of a company that had 140—

Mr.COCKEY. My company.

Mr.CHABOT. Your company had 140 employees and only 70 took the healthcare that was available. The one thing that came to mind that I was wondering, would some of the people that didn't take it perhaps have spouses that have coverage through their employment?

Mr.COCKEY. Very definitely some did, but the majority of them did not take it because it was not affordable for them. That was the unfortunate part. Those that have spousal coverage, their concern and our concern with that group is that their spouse's employers may start limiting the coverage for family members. So now we

add to a larger number of uninsured individuals. And that's a real risk that we're facing.

Mr.CHABOT. Thank you very much. Thank you, everyone. I yield back.

Mr.GONZÁLEZ. Thank you very much, Mr. Chabot. The chair is going to make sure that I'm next in line. I'm not jumping ahead. I am next. I was next anyway, but the chair will recognize himself for five minutes. And the initial question will be to Ms. Ignagni and Dr. Wilensky, and we can look at the big picture and it's overwhelming, you know, how we bring in and harness and control some of the costs and so on. We can look at tax treatment, on and on. But if we do some of those things, at the end of the day though it still has to be a profitable endeavor for an insurance company to offer the policy itself.

It seems to me that that's basically the thing that we need to address from the outset. How do we make it profitable? It seems to me insurance again is all about risk, predictability. And my experience has been that's the biggest drawback with small businesses it that you can't spread that risk as you can with others.

So first and foremost, I guess, is what could we do, if there was one thing that we accomplish in this first part of the 110th Congress, what piece of legislation would it be addressing against spreading of risk? And is that going to be the association health plans or something similar?

Ms. Ignagni?

Ms.IGNAGNI. I think there's one answer to that and it has a part A and B and I'll be very quick about it, Mr. Chairman. The first is the matter of tax equity that all the witnesses talked about. It's fundamental and very important. Increasingly, people will be purchasing on their own. They're not attached to an employer. Realtors or groups of one is a perfect example of that. That's number one. And number two, as part of that, I think that a very doable thing is to make sure that the high risk pool legislation that was passed is— the appropriations are there to provide this assistance to states who are trying to address the needs of those who are medically uninsurable which could definitely and significantly help small businesses and individuals who are in the market, who have average healthcare risk, but those that do not are finding it very, very difficult to get assistance.

And there are three or four other things, but in the interest of time, I'll start there. I think that's one of the most important things and the other is the state mandates. We are ready to offer customized products to small business, basic packages that we know they want to purchase. They are affordable. They will do disease management. They will do prevention. They will provide catastrophic coverage and we can do it affordably. But we are prevented from doing so. And that ought to be addressed.

Mr.GONZÁLEZ. Thank you. Dr. Wilensky?

Ms.WILENSKY. I'd like to start with the second which is that one of the real barriers has been both the level and the variation in state regulations with regard to mandates and controls over rate variability and offerings, etcetera. It limits the number of insurance companies that will come in and obviously affects also the kind of products that they can offer. Now it's difficult because that

has been traditionally a state function. It has become a more limited state function as firms opt out through ERISA exemption, but it doesn't make it any smaller a problem for those companies that are trying to offer insurance to firms that are not self insuring.

With regard to the risk segmentation, basically the strategy that you can use to resolve that is to try to encourage pooling and to risk adjust. I mean there's not really a better answer than to say once you have predictably higher risks or spenders which will happen any time you have either complex chronic disease individuals or individuals who have predictably higher expenses because of a congenital or other identifiable problem, to pretend like this is not recognizable to the insurance company is to deny the obvious. So the question is can we find ways through risk adjustment by compensating for plans or pools that get an unusual mix in terms of their membership so that they will not try to find ways to exclude or run away from that. You can do it through high risk pools or other reinsurance or tax and transfer payments. But to pretend it's not an issue is not going to resolve the problem and it's something that we need to take on for the small firms, is to offer them a couple of different strategies or to do something through legislation that will allow this risk pooling to occur.

I don't think, with regard to the earlier question that the reinsurance market per se needs to have federal intervention. It seems to be functioning about as well as insurance markets function. So this would be a solution that doesn't have a problem driving it.

Mr.GONZÁLEZ. Well, that's good to hear because we've had that problem regarding other areas of reinsurance and whether we have a federal backstop or not and I know that I'm almost running out of time, but Mr. Stottlemyer, there's always unintended consequences and whenever we consider something, the President proposed something in the State of the Union, right away regarding tax treatment to those individuals, obviously they're paying the premiums for coverage and treating it differently and then you hear, well, that's going to discourage employers from providing health coverage. That's one concern. Association or associated health plans. We hear from the states, oh my gosh, then you're not going to have the quality. You're not going to have the product. And employers let's say in the State of Texas will be offering products that are not as good as was presently considered the minimum under state standards and such. Could you address those two concerns when we attempt to find these remedies?

Mr.STOTTLEMYER. Let me just for a moment put my employer hat back on, when I was an employer. As an employer, I had to offer health insurance because I had to compete in the marketplace for talent. So even if there were changes in the tax code that gave more equity, I wasn't going to walk away from the employer market because I needed to compete for talent. I was day in and day out competing for talent. So I don't think the idea that if we try to level the playing field, if you will, from a tax standpoint that that's going to blow up the employer market. I was an employer and I would not move away from employer health insurance as a former employer.

I do think tax equity is important. The fastest growing part of the small business community today is something called SOHO

businesses, single owner home office businesses. There are 12 to 15 million of these businesses. They also happen to be the most diverse. I mean women, minorities. This is the fastest growing part of this sector of the economy. From a tax standpoint, they're disadvantaged. So we have to look for ways to give equity in the tax market.

The comment was made about association health plans and unintended consequences. Whether it's small business health plans, association health plans, that's really not the issue for us. The issue is pooling. If you get bigger pools, more people into the pool, you can spread risk. And so when you have a state like North Dakota and I don't begrudge in any way, shape or form the Blue Cross/Blue Shield that's there that has 90 percent of the market and they've competed for that and they dominate the market, but there's not competition there.

By allowing businesses, small businesses inside that state to come into a larger national pool, there's going to be competition. So the idea whether age, small business—that's really not the issue. It's pooling. And I think from an economist's standpoint, Dr. Wilensky and others, would—I think it's just common sense that if you create a bigger pool and a stable pool, I agree with that, you need a stable pool and the idea of incentives to keep people in the pool, I think has a lot of validity.

We're never going to be certain. We're going to have to try things because the issue is significant, I think, as we all know. And we're going to have to learn from what we try.

Mr.GONZÁLEZ. Thank you very much. The chair is going to recognize Mr. Bartlett.

Mr.BARTLETT. Thank you very much and in a former life, among other things, I was a small business person and a proud member of NFIB and I had the problem of trying to find health insurance for my employees.

I always have the feeling in a hearing like that no matter how hard we try, what we're really doing is just nibbling at the margins of the problem. There are two fundamental problems that we seem unable to address. The first of these is that the employee ought to own the policy, not the employer. I have no idea why. I think it was because of irrational and perhaps stupid action on the part of the government, wage and price controls and employers had to compete for employees. They couldn't raise wages so they wanted to offer something. I have no idea why they didn't offer mortgage payments or car payments or tuition payments or maybe life insurance, but they settled on healthcare. So here we are. Stuck with it. It is really quite irrational.

If the employee owned the policy rather than the employer a number of really good things happen. First of all, it's totally transportable. If you buy it when you're 18, you carry it with you until your death. And secondly, you're not worrying about pre-existing conditions any more because what 18-year-old has a pre-existing condition? Darn few. You don't need to worry about pooling any more because the pool now is the entire universe of 18-year-olds out there who are buying insurance.

We never worry about pooling in life insurance, why don't we worry about pooling in life insurance? It's because it's a competitive

market and this market will not be less competitive if the employee owns the policy rather than the employer.

And the second big problem is that our sick care costs are too high. By the way, I say sick care because we do not truly have a healthcare system. We have a really good sick care system, the best in the world. And if we had a better healthcare system, maybe we'd need a less big sick care system.

There are two big problems with costs in our healthcare system, our sick care system. The first one is that someone else pays the bill. Now if my employer provided a car for me, rather than healthcare for me, I could easily rationalize that I needed an SUV. By the way, I make do with a Prius, but if he was providing the car, I could rationalize I needed an SUV. Employee-owned policies, especially if they're of the healthcare savings plan, would really make the employee more healthcare conscious. He needs to be a careful shopper. If you think about it, sick care costs are the only thing you shop for and never ask the cost. That's because someone else is paying the bill. This is dumb. We need to change that.

The second thing we need to change is litigation. We really need to change that. It's not just a $100,000 premium, it's all of the defensive medicine that's practice by the doctor. And I'm not sure you can get inside the doctor's head to know how much of his medicine is defensive medicine because of enormous risk of insurance. I think this could be solved by when the patient goes to the doctor, there are two paths they can travel. The doctor says Susie, you have a problem. It will cost you $400 for me to fix it, if you will agree to what you call—the kind of insurance you have with—when you have a board that decides the amount of money you get, rather than you go to court? Now if you want to go court, you wouldn't have come to me if you thought I was a quack or a fraud. You're here because you think I'm the best doctor you could go to today. But if you really want to reserve the right to sue me, then you've got to pay $800. I'm not going to ask my other patients to pay for my health insurance costs. Susie, which route would you choose to travel? Ninety-nine plus percent of the time say gee, Doc, I'm here because I trust you. Let's do it because it's cheaper and by the way, the extra $400 comes out of your pocket, Susie. The insurance company is not paying it.

If we did these two things, if we had an employee-owned policy and if we reduced the costs of healthcare by these two rational things, most of the problems we're talking about today would go away. What's wrong with what I just said?

Mr.STOTTLEMYER. The comment about transparency, I think that's exactly right. When I was an employer, one of the important things that I did was I actually had somebody come and it was with a computer and as people enrolled into healthcare, came up and said this is your choice, this is how much it costs, this is how much you pay, and this is how much we pay as the employer. And the first time we did it, people were shocked. They honestly had no idea that I, as an employer, was paying the most significant part of their healthcare costs. So transparency is important. We have to have smarter consumers. I mean if you smoke, the reality is if you smoke, you're using more of the healthcare system.

Mr.BARTLETT. You ought to pay a higher insurance premium if you smoke, if you're overweight or drink. It's the same thing.

Ms.WILENSKY. I don't disagree with what you've proposed, although I would make the choice not just in terms of whether you accept arbitration, but whether or not the physician or the institution follows a certain standard set of patient safety protocols as well. The only difficulty is that while this would be a terrific step in the direction in a lot of issues, the fundamental growth in healthcare spending reflects what goes on in the concentrated spending of the sickest five or ten percent of the population. And they will blow beyond any threshold in the health savings account or major medical account. So learning how to realign financial incentives so that institutions and clinicians are spending smarter, making sure that the kind of information that would help patients and clinicians understand what they're really going to get if they use a new medical technology or procedure, it's a lot more than what you have done because of the huge impact that the five or ten sickest part of the population has on the growth in healthcare spending. But I wouldn't detract from anything that you want to do. I think those are all actually very helpful steps. It just wouldn't solve the problem completely because of concentrations in healthcare spending.

Ms.IGNAGNI. Mr. Bartlett, just a note that we've just ask PriceWaterhouseCoopers to do a study for us to look at how much of the healthcare dollar is going to med-mal, both direct and indirect expenses, 10 cents on every dollars. That's a very significant proportion. And physicians are afraid to practice medicine today. And so I think your point about changing the structure and having a better dispute resolution system is absolutely right on point.

Mr.GONZÁLEZ. Time is up and the chair will recognize Mr. Larson.

Mr.LARSON. Thank you, Mr. Chairman. And I just have a few questions. Certainly we're all acutely aware of the healthcare costs impacting small business and Mr. Cavanaugh's statements are especially poignant, given a visit yesterday by a high school friend of mine, is purchasing a flower shop his father started many moons ago. So he's got a state tax issues he's dealing with, but also the employee's ten people. In 2003, his health insurance premiums went up 13 percent from the year before. In '04, they went up 21 percent from '03. In '05, they went up 14 percent from '04. In '06, they went up 15 percent from '05; clearly putting a tremendous strain on his ability to provide healthcare for his employees, some of whom have been around for 15 years working for him, but again, his father started this business many moons ago. Clearly, he is impacted.

You've given us some thoughts on pools and tax credits. I had a question about that, but I think you all pretty much clearly laid out what your thoughts are on that.

Perhaps for Ms. Ignagni, last year there was some legislation introduced by a lot of folks around here, including a variety of provisions. Can you talk about, well, there was a bill introduced last year that included community rating and it hasn't been discussed at all. Can you discuss community rating and what impact it has, good, bad or indifferent?

[Chairwoman Velázquez resumes chair.]

Ms.IGNAGNI. I think community rating is something that a number of states have tried, for obvious reasons to try to equalize the payment of health insurance costs. So that it's the ultimate pooling mechanism.

What we find in states that have relied on community rating is that the costs are the highest and our study reflects that. We have a very comprehensive study of both the small group and the individual market and it reflects that. This is not to make the point that they're doing the wrong thing. It's the purpose of trying to do the right thing to get everybody in.

A number of states now are looking at whether or not they can do not that broad scale pooling, but target the individuals with the extraordinary healthcare costs. I suspect your high school friend has a couple of people in his business that have very high healthcare costs. Those are the individuals that we could either move to a risk pool or figure out another strategy and we're going to be recommending a series of them very soon, where we could subsidize those disproportionate costs so that it could be more affordable for the employer. Sometimes we don't want to put a complete average and then drive the people with the lowest costs out of the system because that then exacerbates the cost for people who are at the mid-range or the higher range.

So these are the kinds of discussions that we're going through with the idea of recommending some very specific strategies. So all these strategies that have been undertaken have been done for the right reasons, but we want to try and figure out how do you make this all work for everyone and keep everybody in the pool.

Mr.LARSON. Washington State is one of the states with a high risk pool.

Ms.IGNAGNI. Yes.

Mr.LARSON. In fact, we're also one of the states in '93, '94, moved forward on a larger plan in '95, '96, dismantled it all.

Ms.IGNAGNI. Right.

Mr.LARSON. And now the State Legislature is back trying to do all that.

Ms.IGNAGNI. I think this is very important because the lesson of Washington State demonstrates that it's very hard to undertake certain market changes, so-called reforms, absent the goal of universal coverage. If you have everyone in, it's a whole different proposition to figure out what kinds of market reform mechanisms to undertake and I know you're talking about that in Washington now.

Mr.LARSON. Right now, yes. You also mentioned that HSA is one third, in your study, showed one third of the folks who are in an HSA did not have coverage or an ability to purchase otherwise before. Did you look at substitution at all?

Ms.IGNAGNI. We did not look at substitution. We asked small employers and individuals who are purchasing why they purchased it, did they have healthcare coverage prior to this. We found a third of small businesses didn't prior to that point offer health insurance coverage and a slightly higher proportion of individuals who are purchasing hadn't had coverage before. And what that says to us and I know you're struggling with this in Washington and our

health plans are very much involved in that is that once you reach a particular price point for a small business or an individual, they are able to purchase affordably. So now the question is how do you design the structure. For some people, high deductible policies make sense. They'll take advantage of the early intervention. They'll be able to deal with the costs. For others, they want a more scaled down comprehensive package and we think there need to be two alternatives available and that's what we're working toward in the states as well.

Mr.LARSON. And Washington State, either the Senate or the House just passed legislation to allow the offering of a bare bones package.

Ms.IGNAGNI. Exactly.

Mr.LARSON. Dr. Wilensky, in my time remaining, can you address this issue? Have you looked at substitution at all? HSAs, people moving from the current plan to an HSA, substituting one for the other? Or is it too early?

Ms.WILENSKY. It's early. There are two kinds of—the best studies that have done tend to be where the employers have completely switched over so that there isn't a choice between plans. The studies that I have seen report out where there were options, indicate it is a more of a mixed bag than might have been expected, that is, it is not just younger, healthier people that are choosing HSAs. It is more of a mix and that some people with chronic diseases are going into them. Some people are older going into them. But I think it's early to see. It will probably be another two or three years to see if there is a strong segmentation.

The best way to deal with segmentation is to compensate for it. To me, the community rating says pretend you don't know that the very sick patients that are coming in from this one area are going to be average. Think how much better you're of if you are a company that's being paid on the average, but you actually get healthy individuals. And so it's why—I think they're addressing a serious problem, but there are better ways to address it.

ChairwomanVELÁZQUEZ. Time has expired.

Mr.LARSON. Thank you.

ChairwomanVELÁZQUEZ. There's going to be a vote at 11:45 is my understanding.

Mr. Buchanan?

Mr.BUCHANAN. Thank you, Madam Chair, and I thank the panel. I don't even know where to get started on something like this. I've been in business 30 years. I'm new in the House and I've built two good size firms, a thousand employees in my last firm and still have some of that in place, but basically I'm here full time. I chaired our local chamber. I was past last year chairman of the state chamber. I only say all of that because you know, if you put a crisis on a scale of one to ten, this is a ten plus. I mean it's over the top and I know we talked about the tax incentives and I think that's very important, but I remember Mr. Cavanaugh, when he was talking.

In the mid-'80s, I provided all my employees out of Michigan at the time, I'm in Florida now, but in Michigan at the time, I provided everybody full coverage. Now I hate to think when I look at our insurance for a lot of our employees, we're paying the indi-

vidual and sometimes we're paying a little less than that. The coverage kind of comes down. And the pooling of taxes, I'm all for it and I agree because I was at a chamber meeting and I said "why can't we get pooling?" Someone wrote down next to me on a card, I was at the U.S. Chamber, up there for a meeting, two words. I looked over and it said "Blue Cross." But, and I don't know if that's all of it, but that's part of it. But I do want to say one thing, that I'm concerned about and let's say the tax incentive and I think that helps.

I think the pooling helps, but when I met with a lot of doctors when I decided to run for office. And I met with the hospitals. The hospitals aren't making any money. The doctors aren't making any money. I look at our coverage when I go back and take a look at that and what's driving a lot of our costs today is drug coverage, mental health, emotional well being and so even if you put these incentives, a few of these incentives in place and I think they'll help to some extent and we need to do that minimally. When I talk to a lot of the leaders in Florida in terms of the President and Senate and these people that are involved with legislature and trying to figure out what we can do more effectively for small business, and by the way, in the Florida Chamber we had 137,000 businesses, 95 percent were 15 employees or less. But they create most of the jobs.

But when I talked to them they all say, "Vern, nobody has any answers. The drivers are all going the wrong way in terms of the cost, the aging population, this and that." So when we talk about pooling, we talk about taxes, we talk about tort reform, we're the 42nd worse state in the country for frivolous lawsuits, the whole thing on defensive medicine is a big factor. But when you look at all of this, it just seems like what are the answers? I don't know that anybody has any answers. I think this is a start and I guess Mr. Stottlemyer, I'll just start with you. If you want to add anything to what I said from that standpoint, but on the pooling, what's—the second part of that is on the pooling, what's holding that up? Before you address that, can you comment on the first—I just kind of made a lot of general comments, but I'm concerned about the overall direction, the cost to healthcare, all the aspects of healthcare. And like I said, the doctors, the hospitals in our area are all complaining. They're all losing, not making half of what they made 10, 15 years ago, the doctors now. It's partly Medicare and other issues, too. But where is this all going?

Mr.STOTTLEMYER. I think there was the comment and like you, I was an employer for a long time and I too, earlier on, paid much more then had to pay less just because of the cost of insurance going up. I think pooling is important. I don't think per se, I haven't met anybody per se that's against pooling. I think some of the issues last year related to community rating. They related to mandates in the States and those are tough issues. But we, as a society, I think we're going to have to make choices and I was joking with a Senator yesterday, in all seriousness, that I lost some members last year because I came out and said I'm not going to put a mammogram on the same level for every woman in America as chiropractic services or hair transplantation and things like that. Those are mandates in States. To me, it's not the same. It's

more important for me to make sure that every woman in America has access to a mammogram than it is to include chiropractic services. Now I lost some chiropractors. They're no longer members of NFIB. But those are the types of choices that I think we're going to have to make as we go forward, whether it's on mandates, whether it's on community rating including things like smoking, which we all know has—you buy more, if you will, health insurance because you smoke. Those are some of the tough choices as a society that we're going to have to make if we're going to move the ball forward.

Mr.BUCHANAN. I am just concerned if we don't start making those tough choices right now, that this thing is just going to get completely out of hand. Because a lot of people in our area, especially the small employees and employers, they either can't get it or they can't afford to give it.

And I might just ask Mr. Cockey, my son is a realtor. What are the realtors doing? I mean I can't even imagine they can even get insurance or they're paying $1,000 after tax money. We have a lot of relatives in the State of Florida. I'm the only one on the Council who is from Florida, what are realtors doing, I mean, for insurance?

Mr.COCKEY. Some of them are just praying, praying that they don't get sick. Some of them have spousal coverage, again as we mentioned earlier. There is that concern that they'll lose that because the escalation of the other employees' insurance is going up and up. So that's a problem.

And many of them are just not sure what they would do if there's ever a problem. To give you an idea, the average income for a realtor last year, although everyone thinks that if they sold a $1 million worth of real estate, they made $1 million. That's not true. The average income was $36,500. Of that they carry about $6800 to $7000 just in business expenses. So if you take off your taxes and then you reduce that business expense that they have, now you say that you're to pay $12,000 to $15,000 worth of insurance for insurance, they can't do it. They can't pay the insurance after tax. They just cannot do it.

ChairwomanVELÁZQUEZ. Time.

Mr.COCKEY. I'll give you a perfect example of a young lady that works for us. She makes $40,000 a year. She has two children. She's the sole provider for these children. Her current insurance today is $750 a month, plus she pays $100 a month for her coverage for her children, for some medical drugs that they need to take.

ChairwomanVELÁZQUEZ. Time has expired. Thank you.

Mr.COCKEY. So she cannot accomplish life in her present condition.

Mr.BUCHANAN. Thank you, Madam Chair.

ChairwomanVELÁZQUEZ. Mr. Jefferson.

Mr.JEFFERSON. Thank you, Madam Chair. There's been a lot of discussion about tax equity and high-risk pool remedies and issues of stabilizing pools and so on. But I want to zero in on this mandate question, just to ask this panel, what do you suggest that has to be done about that? Everybody identifies it as a problem. States are trying to get after these issues just like we are up here. They

come up with different solutions. Are you suggest that somebody the Federal Government requires some customization of these packages on the state level and if so, how would that be accomplished?

Ms.IGNAGNI. Mr. Jefferson, one of the things that we have proposed is in the context of our universal coverage approach where the Federal Government would be giving the states a helping hand if they achieve specific objectives. One of those objectives would be to set up a regulatory construct that would make it possible for the purchase of affordable healthcare coverage. And we've given two options at a minimum that should be looked at: an actuarial equivalency of HSA coverage or a basic package of benefits which would involve prevention, wellness, a certain number of hospital days, a certain number of physician visits, prescription drugs, catastrophic coverage on the back end. Those are the kinds of packages that individuals can buy affordably, want to buy and that would give them a broad allowance of choice.

Mr.JEFFERSON. How would you limit the states in this, to these provisions?

Ms.IGNAGNI. I would say that if you're doing a broad coverage strategy or in the context of the appropriations, here's one for example, every year you have to appropriate money for the risk pools, so it's sent to states from the Federal Government. As part of that, as a condition of that, you could create the requirement that states create these regulatory corridors. That would be one way to do it. In the context of additional subsidies that would be provided if you—if we move toward a universal coverage proposal, that would be another. But the first would be a very quick thing that could be done right now.

Mr.STOTTLEMYER. Can I add something? We already do that. For those companies that are self-insured under ERISA, they're exempt from state mandates. They're big businesses. The small business is not. State mandates apply to small business. Big companies that are self-insured under ERISA are exempt from state mandates. We're not suggesting that.

I met with John Sefford who is the CEO of the American Cancer Society, the Chief Medical Officer. And one of the things that he talked about, which I liked, is evidenced-based medical mandates, evidenced-based. Things that prevent premature death, prevention, wellness, those types of things. We're going to make some choices. I mentioned earlier about chiropractors. There's nothing wrong with chiropractic services. They're good. But if you're going to get the invincibles, the young people into the pools, you're going to have to charge them less because they don't need everything that somebody who is in a different age or different place in life needs from an insurance standpoint.

Mr.JEFFERSON. Dr. Wilensky, in your testimony you said that at least some place there that there's not much talk about the rise in medical costs, the costs of medical services, generally, as we talk about this issue of the cost of medical insurance. These are certainly joined issues. And that if you're going to actually get after the one you have to figure some way to get after the other at the end of the day, no matter what is said and done here.

Ms.WILENSKY. Right.

Mr.JEFFERSON. Make the point further and tell me how we can get at these things at the same time in order to make sure we actually address them?

Ms.WILENSKY. Healthcare costs have been rising about two to two and a half percentage faster in real terms, that is adjusted for inflation on a per person basis on average for the last 40 to 45 years. If we don't figure out how to change that, we're going to overwhelm the federal budget with Medicare and Medicaid as major entitlements, in addition to overwhelming what's going on in the private sector. And the biggest driver for rising health insurance premiums is what's going on in the healthcare market.

It's not an easy fix, the short answer is no more and pay for it better. Someone, I think Mr. Buchanan, commented his physicians are complaining that they're making as much money under Medicare. The fee schedules have been either frozen by the Congress or allowed to increase very small amounts of 1.5 percent as opposed to the scheduled 4 percent reductions that were in place. But spending, under Part B Medicare, which is where the physicians are, grew 15 percent. It is a huge increase in the volume and intensity of services, some of which are probably needed, many of which are probably very marginal or questionable, some of which may be flat and inappropriate. It's redesigning how we pay for things so that we are rewarding the institutions and the clinicians who do it right, do it right the first time, provide good patient oriented care. It unfortunately requires a lot of change in both the insurance and in the pay structure. So it's not an easy answer, but boy, we better get busy on it.

ChairwomanVELÁZQUEZ. Thank you. Time has expired. Ms. Musgrave.

Ms.MUSGRAVE. Thank you, Madam Chairman, I apologize. I wasn't able to be here earlier and also to the panel, not able to hear all of your testimony. You know, I agree so much with what Congressman Bartlett said about how the employees should own the policy because human nature, we all know we act differently if we know what we have and how we're going to pay for it is a consideration. And I still think and I admire what you did with your employees, Mr. Stottlemyer, but a lot of people still don't know, nor do they care, what something costs. And I really watched in Colorado when I was in the State Legislature about the mandates that came forth every year and every one of them really wasn't going to cost anything. In fact, it was going to save money. You know, we heard that time after time and yet, you know, you get this product that's all loaded up with these mandates.

And I don't know if there's been any discussion before, but Congressman John Shadegg from Arizona had legislation previously that would allow insurance to be purchased across state lines and to me that sounds so reasonable, you know, especially my children, can shop for insurance that was affordable and suited to really fit their needs at this particular time in their young adult life. I would like your response to that and anyone can respond on the panel.

Ms.WILENSKY. Makes sense to me. Again, anything that helps pools and that allows for a way to circumvent some of the barriers that now exist. I do have some sympathy with the issue that Karen Ignagni has raised is that this opens up a bigger door and not just

limiting it to those who are self-insured, to get around some of the costly mandates and helps pooling. We do ultimately have to go back and fix the problem for those that remain for whatever reasons. You do start setting up very unfair playing fields and that will probably come back to have some unintended consequences.

Ms.MUSGRAVE. I also was interested in your remark, 10 cents on the dollar for medical malpractice, and again, I would agree with Mr. Bartlett in that I think that's very hard to calculate, because how do you get into a doctor's head and try to figure out how he or she practices medicine with medical malpractice hanging over them all the time? And you know, they probably don't even know sometimes why they make the decisions they do, but always aware of the fact that they're likely to get shot at when they behave in a certain way. So it's hard to calculate and I would say that 10 cents on the dollar is pretty remarkable, but it's probably higher.

Ms.IGNAGNI. The Department of Health and Human Services has done some very excellent work about the direct costs and the indirect costs and the sum total leads you to approximately 10 percent. You may be right. It may be higher. That's the only—the number that we have is the number that PriceWaterhouseCoopers was able to calculate from data that we know that are reliable than exists. But I think this larger issue that Mr. Bartlett was getting at and that you're getting at now, what is the dispute resolution system that we need to have in our country? Is it through the courts or is there a better way? In the health plan community, we've made a commitment about 10 years ago to be very affirmative about the concept of independent review, third party review. We think that concept could be imported into the med-mal arena as Mr. Bartlett was beginning to go to, in a very productive, affordable, predictable way, so that patients can be protected, but at the same time we don't have these extraordinary costs. If you marry that with the kinds of strategies that Dr. Wilensky was talking about which we have now developed some path-breaking experience and track record and tools with, with respect to changing the way healthcare is paid for in the hospital arena and the physician arena and lining reimbursement up with performance and outcomes, all of these strategies taken together go to Mr. Jefferson's question about how do you get the cost of the system down and do it responsibly so no one feels they can't move into the system.

Ms.MUSGRAVE. Thank you, Madam Chairman, and thank you, panel.

ChairwomanVELÁZQUEZ. Thank you. Mr. Akin.

Mr.AKIN. Thank you, Madam Chair, for fitting me in for a question here. I think this is my Democrat question for the year, but it's a serious one. I understand the cost of medical liability and some percentage there. I understand there's also costs in healthcare that if we could knock down the number of McDonald's french fries that people eat that there's a wellness kind of piece that also a component on Americans living healthier lifestyles and that's actually a pretty good chunk of change. I've heard that some of the insurance people I've talked to have said they think that's even bigger than the liability than the trial attorney piece.

My question, this is my liberal question, my understanding is as much as I'm a pro business guy, that the insurance companies, at

least in some markets, have basically got a lock and a monopoly on medical insurance. They have so tied up the provider systems that there's no one else that can compete with them. And does that mean that we need to take a look at a monopoly kind of practice? And are there some things we should do? First of all, do you agree with the premise, and second of all, how do we do that and still preserve the free enterprise kind of system and approach to healthcare?

Ms.IGNAGNI. Well, in the insurance community, we don't do exclusive contracts. We don't so-call lock up providers. And you see in markets all around the country that insurers move in and out. What's more predictive of whether or not you have a broad number of carriers in a market is what is the state regulatory structure like? How accessible is it? How easy is it to bring new products into the market?

Mr.AKIN. So if there's a state that's got just one insurance company servicing the whole state, such as I think it's—what is it, Iowa? Is that the one that just has one?

Ms.IGNAGNI. I was just in Iowa with four insurers. We were visiting the Governor and the State Legislature, so I can tell you there is not simply one insurer in Iowa. And you find that in virtually every state around the country. So it is a question of what's the regulatory structure. Could we open up and allow plans to offer the range of benefits, the small packages that we've been talking about and have that kind of competition. We've been advocating for that. We have some very specific proposals, but thus far, we haven't been able to succeed in achieving it.

Mr.AKIN. So you're saying that could be solved at a state level?

Ms.IGNAGNI. Well, no. I actually now, when responding to the previous question, we have some very specific suggestions of what the Federal Government could do to require states to move in that direction.

Mr.STOTTLEMYER. That is one of the reasons why we're for pooling, because it gets you out of the state environment. As I said earlier, I don't begrudge Blue Cross/Blue Shield in North Dakota for having 92 percent of the market. They've worked hard to get that. But if you're in North Dakota, it's very difficult for somebody to come and be successful in that environment. That's just an economic reality. So pooling, in our view, would allow somebody in North Dakota, a small business owner, to get into a national pool. And if you get into a national pool and the national pool is large enough, in our view, it would create more competition and more—

Mr.AKIN. Which you say pooling, you mean AHPs?

Mr.STOTTLEMYER. It could be AHPs, small business health plans, just the fundamental concept of pooling. And I think as Dr. Wilensky said earlier, you have to stabilize the pool. You can't have people come in and out. So I think the idea of some form of tax incentives or incentives to keep people in the pool and I think Karen said that as well, makes a lot of sense. But pooling, fundamentally, if you get a bigger pool, people are going to want to compete for that pool, and it's going to give more competition.

Ms.WILENSKY. If you see a place where there are one or two insurance companies, don't look to the insurance companies, go look to the state regulations, because there's nothing about the nature

of the business that allows those kinds of barriers to be erected. And it's usually something about the requirements that states have put in place that have resulted in that.

Mr.AKIN. Anybody else? Thank you, Madam Chair. That's my last one for the year or so.

ChairwomanVELÁZQUEZ. Thank you, thank you. And I have two or maybe three more questions. I just like for them to be as brief as you can since they're going to call for a vote soon.

Dr. Wilensky, you talked about few criteria that make up health insurance costs. Medical underwriting is used in both the individual and group market to set premiums. However, unlike the individual market, insurers do not review each individual's medical record in the group market, rather, the insurer reviews the entire group's history, taking into consideration it's claim history, demographics and geographic location. Medical underwriting appears to have a significant impact on cost.

I would like to know whether a purchasing pool could successfully implement a community rating mechanism or some alternative to achieve cost savings?

Ms.WILENSKY. The problem that community rating is designed to address is to spread the risks. My belief is the way to better fix the same problem is to risk adjust the groups who have higher expenses coming in through a pooling mechanism or through some kind of subsidy like the high risk pool that Karen Ignagni mentioned.

My problem with community rating per se is you ask people to pretend they can't see that some groups aren't going to be more expensive and to treat them as though they weren't. So the question is how do you compensate if you have somebody who is a complex diabetic or an HIV-AIDS or a disproportionate number of very sick individuals? You need to allow them to come in. You need to compensate either at the individual or the company level those kinds of groups that will experience higher costs. I think it is a more feasible way to keep a group going than to ask people to pretend as though the expenses will be average when they're not going to be.

ChairwomanVELÁZQUEZ. Any other comments? Ms. Ignagni?

Ms.IGNAGNI. I agree with that, Madam Chair. I think that's well stated.

ChairwomanVELÁZQUEZ. Okay. Mr. Stottlemyer, it seems that based on the testimony that we received, your group, NFIB, and AHIP have a different perspective on what a small business health plan will look like in terms of whether or not as AHIP suggests that on groups of 50 or less, should participate in small business health plans. What do you think of that?

Mr.STOTTLEMYER. Well, I hope we support the fundamental concept of pooling and I think we do. I think there's some differences. I think in her testimony talked about a smaller number of employees. I think it was 50 and we would support a larger number of employees, 200, if you will, coming in and the tax incentives could be for even smaller companies. It's not suggesting you'd have to do the tax incentives for a 200-person company. You could split, if you will, those size companies that come into the pool versus where you actually apply the targeted tax incentives. Again, I would hope we would be in favor fundamentally of pooling. We're talking about

bringing people into the pool which is going to ultimately spread risk and hopefully allow cost to be less as well.

ChairwomanVELÁZQUEZ. Ms. Ignagni, are you suggesting that we should limit it to 50 employees or less?

Ms.IGNAGNI. The reason that we made that observation, Madam Chair, is that we have a whole regulatory framework now around certain definitions of small employers, HIPAA, for example.

And so the question is how do you solve this problem as quickly as possible and do it in a way that gets at the problem, but we don't then start creating particular strategies that we have to undo two or three years from now. We saw that with MEWAs and I think that having looked at that experience, we don't want to move down that way in the future. So that's why we've proposed a very specific series of strategies to solve the problem, but not necessarily create those unintended consequences.

ChairwomanVELÁZQUEZ. Thank you. Mr. Cockey, while all small businesses face great challenges in getting health insurance, the self-employed face even greater challenges. They usually pay higher prices and they do not even have the same tax treatment as many of the corporate counterparts.

As an organization that represents many self-employed realtors, can you talk to us about some of the unique challenges that your members face?

Mr.COCKEY. Well, the unique challenge is by the design of our industry and how we earn our money is that we are not salaried employees or guaranteed salary. So the unique part about our business is that our income fluctuates from month to month, so that in good times we have money to pay the bills and in bad times, we have less. So that's the big challenge for us to have a very, very high health insurance program because we don't necessarily have that common income as many employers and employees would have provided. So that's a big challenge for us. Our expenses don't go away for operational side, but our income and revenue truly have dramatic changes. We are now, as an example, the wonderful market that we've been in, we are now in a very serious transition change where the income of many realtors are going to be much, much less and that's going to be a challenge to pay their bills.

ChairwomanVELÁZQUEZ. Thank you. Now Ms. Ignagni, in terms of policies sold to the self-employed, what are some of the reasons these policies tend to cost more than similar policies sold to large firms?

Ms.IGNAGNI. I think the reason, one of the primary reasons, Madam Chairwoman, is the reason that Dr. Wilensky talked about very effectively which is that when you small employers, what you find the reason for higher, disproportionately higher healthcare costs is that you have one or two members of the group with serious catastrophic illnesses. So if we can figure out a way to target those individuals for additional subsidies or the health plan that's covering them for additional subsidies, you can customize that or put them in higher risk pools. There are a number of ways to do it. And as I say, we're going to have quite a number of suggestions very soon, in addition to this. That would be the way to make these policies affordable for small business, to keep people with lower

healthcare costs, not disproportionately raise theirs and be allowed to expand coverage.

I think that the question you asked Mr. Cockey is very—it goes hand in hand with that which is that tax treatment. It's unfair for people who are not attached to a particular employer to have to spend 7.5 percent of their adjusted gross income before they can get a healthcare deduction for their insurance.

ChairwomanVELÁZQUEZ. Dr. Wilensky?

Ms.WILENSKY. There are a couple more reasons that it's expensive. One has to do with the function finding out about the benefits. Mr. Cavanaugh described what he has to go through. If you have some kind of a grouping mechanism, that function can be done for the group, rather than having each individual have to do that. It will become more like having a benefits manager for a large firm. So you ought to have a broader number of people be able to take that fixed cost of figuring out what are the healthcare plans that make sense.

The second thing is that marketing costs are more expensive for very small firms and that also ought to be alleviated, not completely eliminated, but alleviated with pooling, because again rather than have to go to each and every small firm of three or seven or nine employees, you can go to the pool and they will have made those. So in addition to any risk problems, you really will get a spreading of the administrative costs that's now borne in the loading factor that individuals pay through their brokers.

ChairwomanVELÁZQUEZ. Yes, Mr. Chabot. Thank you.

Mr.CHABOT. Thank you, Madam Chair. If it would be okay, I think I'll let Mr. Fortenberry go. He just came in and does have questions.

ChairwomanVELÁZQUEZ. You're recognized.

Mr.FORTENBERRY. Thank you, Madam Chair, and I apologize for missing the majority of the hearing. Thank you all for coming. Obviously, this is a huge concern to all of us. It is a compelling need for us as policy makers to address the issue and to allow, to help overcome any deficiencies in the private market, particularly, so that we can help more people access insurance, health insurance.

I want to give you all a specific example and maybe we can work back towards some of your general comments. I met with a person recently. She's a realtor, an independent agent. She's in her 50s. She was paying something like $1,000 a month for coverage and simply couldn't afford it any more, so she just drops it. Now given the tax treatment of a person in that set of circumstances, her income size, her inability to afford that level of insurance, where are we left for a person like that who would not have an inclination, obviously, to go into the emergency room if something came up and wouldn't have an inclination necessarily to use a community health center, wants to take responsibility but obviously can't deduct costs, as you are pointing out, until they're at 7.5 percent of income and you can't deduct the premium costs. There are, of course, health savings accounts opportunities if that can be combined with some type of extraordinary coverage, but again, I think we're going to have more and more people who are caught in this dilemma who simply don't make the income levels high enough without being able to attach to some group mechanism that they can leverage

down their costs by spreading out the risk or some other form of tax treatment that makes this option more readily available.

Ms.IGNAGNI. We have proposed setting up a universal health account in the tax structure which would provide the same tax treatment that individuals received if they are attached to an employer, but also provide a portable vehicle for subsidies. Some of these individuals may qualify as the states move forward in expanding coverage for state subsidies. Eventually, when Congress moves forward on this question, they may qualify for federal subsidies, but in the interim, there may be some monies that the employers are contributing so you can put all of this into an account and from there they can purchase the proposal that is right for them. But until we address the state mandate question that we've been talking about, the issue of affordable, available coverage for them is one that is a very, very high hurdle, which is why we've put so much emphasis on what should states be required to do by way of regulatory constructs. You couple all these things together and then you can make the programs work. And then our responsibility in the health insurance arena is to make sure that we are reorienting the payment system, we're focusing on outcomes and quality, and there's much very positive news to report.

This is the fourth year where the rate of increase in healthcare premiums has gone down. That almost never happens. It doesn't hit the front pages of any of the national newspapers. If the opposite had occurred, it would.

Mr.FORTENBERRY. But it's still what, 8 to 12 percent, generally in that range?

Ms.IGNAGNI. No, it is seven. It's going down for next year. And that's on average. So if we were to look to the kinds of strategies that we've been talking about today, married with the new set of tools that we're bringing into the market, I'll give you an example. Three years ago, prescription drug expenditures were rising at an annual rate of more than 20 percent. Now it's down to six. Because we've implemented strategies. We've encouraged generic drugs. We've set up tiers. We've done a whole range of things to expand access, but get the cost down. We're doing precisely the same thing now on the physician side and on the hospital side and we're working collaboratively with the healthcare practitioners to set up what should be the criteria for payment.

So all of this is going to flow in a productive way, but we have to get that regulatory construct addressed.

Ms.WILENSKY. The tax treatment is clearly unfair. We have complete agreement that it is unfair to have people who don't get employer-sponsored insurance have to use after tax dollars. Everyone else uses pre-tax dollars.

My other advice is that unless she has major pre-existing conditions that puts her in a very special category, she should go on the Internet and find out what other kind of insurance is available. That seems extraordinarily expensive.

Mr.STOTTLEMYER. Just to add on, the 7 percent, that may be good news, but again, there's a big difference between larger employers and small employers and I'm highly confident that 7 percent is much, much higher for small employers, even this year and next year.

Mr.FORTENBERRY. The market is segmented, basically. Larger employers, the ones who might be tracked or cover the broad numbers of people would be on average seven versus a higher rate of increase and for individuals or small businesses without large risk pools?

Ms.IGNAGNI. We have actually done—we have the most comprehensive survey of the small employer marker. And in the survey and we highlighted some of that in our testimony, you will see the average rates for small employers across the country. In certain states those rates are very, very high because of the issues we've been talking about in terms of the regulatory structure. We can look at the large numbers of carriers in the states. We can look at the competition, but we do know that there are some regulatory challenges. But I'd be delighted, Madam Chair, to provide a full copy of that survey for the Committee, if that would be helpful.

ChairwomanVELÁZQUEZ. Sure. Thank you. Mr. Cockey.

Mr.COCKEY. The thing that you mentioned about your realtor acquaintance, unfortunately, she's one of 336,000 people that are uninsured. Now either they've become uninsured because they can't afford it, never signed up for it to begin with, or they've had to cancel it because now their income has dropped to a point that they can't afford it. She has the ability to deduct that expense as an independent contractor for her coverage, but the unfortunate part is if I don't have the income, the deduction has no benefit.

ChairwomanVELÁZQUEZ. Mr. Chabot?

Mr.CHABOT. Thank you, Madam Chair. I'll be very brief because we have votes on the floor. I'll just conclude with a comment. In my question, Mr. Stottlemyer had mentioned earlier about kind of the frustration with having past association health plans. I believe five times in the past six years, whenever the Senate—and died over there. I've had and many of my colleagues have had similar frustration in trying to address one of the issues that increases the cost and we've talked about that. That's defensive medicine and frivolous lawsuits and medical malpractice suits. So it was frustrating to have passed the Health Act and other pieces of legislation which dealt with that issue as well that passed the House, but then went over and died in the Senate.

Now my party is no longer in control of either House and I'm hoping that my colleagues on the other side of the aisle will have more success in passing such legislation in the Senate than we did.

ChairwomanVELÁZQUEZ. Well, we need the President on board too. It's nice when he says that yes, I support association health plan, but he needs to call—well, when the Senate was in control of the Republicans, he needed to have placed a phone call and asked them to bring that vote forward, that legislation to a vote.

Mr.CHABOT. Maybe we can call him together.

ChairwomanVELÁZQUEZ. I welcome that. Let me thank all of you. This was a great discussion and I can assure you it is an important issue for this Committee. We do understand that in order to tackle the issue of the crisis of healthcare in this nation, we have to address the issue of the lack of insurance for small businesses. This is the first hearing. We will continue with this dialogue and I want to take this opportunity to thank all of you for your participation.

[Whereupon, at 12:05 p.m., the hearing was concluded.]

NYDIA M. VELAZQUEZ, NEW YORK
CHAIRWOMAN

STEVE CHABOT, OHIO

Congress of the United States

U.S. House of Representatives
Committee on Small Business
2361 Rayburn House Office Building
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STATEMENT
of the
Honorable Nydia M. Velázquez, Chairwoman
House Committee on Small Business
Hearing on Challenges and Solutions to Health Insurance Coverage for Small Businesses
March 14, 2007

As just about every employer and employee knows, there are few issues of greater importance than access to health care. But in today's market, more companies, particularly small businesses, are finding it difficult to offer health coverage to their employees. The challenge of providing coverage not only undermines the wellbeing of millions of Americans, it also threatens the growth of small business and our economy.

If the American health insurance system is at a crossroads, small business is at its center. Entrepreneurs will tell you that this is the number one issue they face. And, unfortunately, this problem is getting worse. Every year, the number of employers offering coverage continues to decrease.

According to a Kaiser Commission on Medicaid and the Uninsured, between 2001 and 2005, the number of workers receiving coverage through their employer decreased nearly 4 percent (81.2 percent to 77.4 percent). More than half of this decline was attributed to companies terminating insurance coverage.

This committee's goal will be to ensure that health care reform does not occur without meaningful consideration of how it impacts small business. Simply put, any reasonable strategy to expand insurance coverage must give serious thought to the challenges faced by small firms.

Today's hearing is the first in a series for the Small Business Committee—we will be looking at the ways Congress can address the problems in the small business health insurance arena. Over the years, there have been a variety of approaches to reducing the number of uninsured that have been passed into law. We have seen the expansion of the Medicaid program, pools to help high-risk populations, as well as programs to provide health care for those laid off due to trade agreements. However, there have been no meaningful changes to fix the small-group market

While states like Massachusetts and California are starting to take action on their own, I believe that there are changes at the federal level that can help improve the health insurance market.

A number of committees will be looking at the problem of health care coverage in the 110th Congress; my focus is to make sure that the small businesses are part of the debate. We cannot have a discussion on reducing the uninsured without helping the 23 million Americans without health insurance who work at, own or have a family member working at a small business.

In my opinion, any solution to America's healthcare crisis can only take shape in light of an open dialogue with all interested parties. The panel before us will allow the committee to do that. We must understand the challenges before small business and more importantly we must understand how the insurance market works.

We have with us today an impressive group of witnesses, well-equipped to help us identify the reasons employers are finding it difficult to offer coverage.

This is why I am so pleased that representatives from the small business community, health care experts as well as the insurance industry. While I know there may be differences of opinion on the best way to solve the problem, I think everyone will agree that the current system is broken.

I look forward to today's testimony on possible alternatives and practical solutions that may go beyond the particular perspective of the constituency that you represent. My hope is that we can hear about some common ground on these issues that will help us move forward with meaningful solutions.

Statement of Ranking Member Steve Chabot
House Small Business Committee

Hearing on Challenges and Solutions
in Health Insurance Coverage for Small Businesses

Wednesday, March 14, 2007

Madam Chairwoman, thank you for holding this important hearing on health insurance and health care. I want to particularly welcome Mike Cavanaugh, President of Queen City Electric in Cincinnati, for making the trip to testify before the committee (who I'll be introducing later).

Purchasing health insurance is one of the most costly expenses for small businesses. The National Federation of Independent Business (NFIB) cites the cost of employer-sponsored health insurance as small business owners' most pressing problem, greater than taxes, labor quantity and government red tape. As I visit with small business owners in my Congressional District in the Cincinnati area, the cost of health care is cited repeatedly as the most significant challenge for small businesses. And the cost of health care is rising.

Access to health insurance is also a challenge for small businesses. According to the Small Business Administration (SBA), employees with small firms are far less likely to have health insurance than those at larger ones.

Helping to make health care more affordable for small businesses is one of the most important issues this Committee can address. We all know that small business is the engine of America's economic growth. According to the Bureau of Labor Statistics, from July 2005 to June 2006, small businesses created 1.5 million new jobs – 61% of all the jobs created in America. Our nation's small businesses and entrepreneurs drive the economy, and we need to do all that we can to help keep their costs down, help them stay competitive and encourage their growth.

Association health plans, pool purchasing and reinsurance have been mentioned as ideas to help reduce the cost of health insurance for small businesses. Other suggestions, such as implementing new health care technology, chronic disease management, and aggressive case management, have also been advanced as ways to reduce the cost of health insurance and health care. With a problem of this magnitude, we must examine all of these options, come up with new ones, and work together to address this issue.

I believe that tax relief is also an important way to reduce the overall tax burden and make healthcare more affordable for small businesses. In previous Congresses, I have introduced the *Health Care Affordability Act* which would provide every American the ability to deduct 100 percent of the cost of their health insurance. I plan to introduce this bill (or a similar bill) in the near future.

Madam Chairwoman, I appreciate your holding this hearing. I look forward to hearing from our witnesses, and to working with you on finding ways to make health care more affordable for small businesses and their employees.

Statement of Rep. Jason Altmire
Committee on Small Business Hearing: "Challenges and Solutions to Health Insurance Coverage for Small Businesses"
March 14, 2007

Thank you, Madam Chair, for holding this hearing today on health insurance coverage for small businesses. It is no secret that the current state of healthcare coverage in this country is appalling. More than 46 million Americans lack any healthcare coverage, and more than half of these are self-employed, owners of small businesses, or employees of small businesses. The healthcare situation has reached crisis level, and this hearing today is an important first step in solving the problem.

The current employer-based healthcare system cannot withstand the rapidly rising price of healthcare. Those rising costs disproportionately affect small businesses, which are less capable of absorbing the increase. Small businesses that routinely offered their employees full or subsidized coverage in the past are no longer able to provide any coverage at all. The time has come for real progress on healthcare costs, and I am eager to hear the witnesses' thoughts on how Congress should approach this issue.

Thank you, Madam Chair. I yield back the balance of my time.

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HEARING BEFORE THE

HOUSE SMALL BUSINESS COMMITTEE

ENTITLED

"CHALLENGES AND SOLUTIONS TO HEALTH INSURANCE COVERAGE FOR SMALL BUSINESSES"

WRITTEN TESTIMONY OF
ADAM D. COCKEY, JR.
2007 IMMEDIATE PAST CHAIRMAN
NATIONAL ASSOCIATION OF REALTORS®
BUSINESS ISSUES COMMITTEE

NATIONAL ASSOCIATION OF REALTORS®
MARCH 14, 2007

Madame Chair Velazquez, Ranking Member Chabot and Members of the Committee, thank you for holding this hearing and giving me the opportunity to talk with you about the challenges that face the nation's small business community and especially the self-employed as they search for accessible and affordable health insurance coverage.

My name is Adam Cockey and I am here on behalf of the 1.3 million members of the National Association of REALTORS® (NAR) who are involved in residential and commercial real estate as brokers, sales people, property managers, appraisers, counselors and others engaged in all aspects of the real estate industry. Members belong to one or more of some 1,400 local associations/boards and 54 state and territory associations of REALTORS®. I am the Senior Vice President of Prudential Carruthers REALTORS®, a real estates services firm located here in the District of Columbia, Maryland and Virginia. I am also the 2007 Immediate Past Chair of the NAR's Business Issues Committee.

As a practicing real estate professional for more than 32 years, I know very well how hard it is to find and keep health insurance when you have no employer-provided coverage. I also know how hard it is to find affordable health coverage for your employees when you're the boss.

While the challenges that I, my fellow REALTORS® and other real estate professionals face are shared by the rapidly growing number of small businesses and self-employed Americans who are part of every sector of our economy, I think that the real estate sales professionals' experience is a perfect example of the challenges that the self-employed, small businesses and individuals whose employers cannot afford to offer health insurance coverage face today.

The REALTOR® Experience

You see, the individual real estate agents who helped you buy or sell your home or find that rental unit in the past are not employees of the realty offices with which they are affiliated. They are independent contractors, a separate legal business entity from the real estate company itself. You might say that they are the smallest of small firms.

Real estate firms, the businesses with which these independent agents are affiliated, are likewise small firms which typically have fewer than five salaried employees – a receptionist, office assistant, or, perhaps a transaction coordinator. This is likely even the case for the "name-brand" offices (e.g.

Prudential, Century 21, Coldwell Banker, etc.) in your community since most are independently-owned franchises.

Today, in most states, real estate agents and other independent contractors - your daughter's piano teacher, your hair stylist or even the delivery man who brings your online purchases to your home - are forced to look for insurance in the individual insurance market. This is a market segment where, for the most part, you basically take or leave whatever coverage is offered. There is no negotiating. There is no leverage.

As the result of this industry structure and the current state of health insurance regulations and industry practices, today 28 percent of the nation's 1.3 million REALTORS® do not have any health insurance. In the seven year period of 1996 to 2004, the percent of uninsured NAR members doubled, going from 13 percent in 1996 to 28 percent in 2004. That's over 336,000 uninsured working REALTORS®. By itself, that's an amazing figure. However, if we add the number of associated, and likely uninsured, REALTOR® family members to that total, the total number of uninsured individuals affiliated with the REALTOR® organization is estimated to be as much, if not more than, 886,000 men, women and children.

In the case of real estate firms, few firms offer health insurance coverage to salaried employees. In 2004, only 13 percent of firms offered coverage to salaried workers. In 1996, this percentage was 34 percent, more than double the more recent figure.

It's also interesting to note that the percentage of uninsured REALTORS® is almost double that of Americans as a whole. In 2004, for example, the percent of the U.S. population without health insurance coverage was estimated to be 15.7 percent compared with the REALTOR® percentage of 28 percent.[1]

When asked why they are uninsured, the overwhelming majority of uninsured REALTORS® – 84 percent – indicate that unaffordable health insurance premiums were the cause. Given the structure of the real estate sales industry, it is not unexpected that real estate professionals would be sensitive to premium costs. Like all self-employed and/or independent contractor workers, real estate licensees have no employer who subsidizes health insurance premiums, no guaranteed monthly income and significant

[1]Carmen DeNavas-Walt, Bernadette D.Proctor, and Cheryl Hill Lee, U.S. Census Bureau, Current Population Reports, P60-229.*Income, Poverty, and Health Insurance Coverage in the United States: 2004*, U.S. Government Printing Office, Washington, DC, 2005.

monthly business expenses that continue even in those months when there is no sale, and therefore, no income.

These factors make it difficult for real estate licensees to afford monthly premiums that can easily reach $1200 or $1400 per couple or family. Many of our members report that their monthly insurance premiums now exceed their home mortgage payments.[2]

When we consider the sources of coverage for those members who are insured, we believe that it is a given that the percent of uninsured REALTORS® will continue to increase in the coming years. Among those who have health insurance coverage, REALTORS® are most likely to obtain their coverage from their spouse's employer (25 percent). We expect this source of coverage to decline in future surveys as more and more employers reconsider whether to continue to offer insurance coverage to employee's spouses and dependents. We anticipate that many may be forced to drop coverage for employees' families.

Survey results indicate that group plans provided coverage for 23 percent of the NAR membership.[3] In the past, the typical NAR member with group coverage was typically an agent for whom real estate was a second career and had health insurance as part of their retiree benefits. Today, however, group coverage is also likely to be held by either a new agent who continues to work two jobs as they transition from a prior career or an established agent who takes a second job simply because that job provides the agent with health insurance benefits.

We believe that in the future, group coverage also will be a declining source of insurance coverage for real estate professionals. Those in real estate as a second career may not continue to have health benefits from an earlier job, as retiree insurance benefits become a thing of the past for a new generation of workers. For those working two jobs – real estate sales and a second job that provides benefits - there comes a point when choices have to be made as to which job offers the worker the mix of job fulfillment and benefits that are essential to a healthy life. For those who cannot do without health insurance, real

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[2] One Aurora, Colorado member shared his not uncommon experience during a 2006 Capitol Hill visit – a 93 percent increase in health insurance premiums between 2003 and 2006 for his family of 5. As he put it, *"I have only been able to continue this coverage because of a nest egg and not because of the income from my fledgling business. Unfortunately, I am now in a position where I must pursue employment with a company that has group health care because I can no longer afford these healthcare expenses."*

[3] A review of detailed survey results indicates that this figure may be an overestimate of the true "group" coverage percentage.

estate is likely not to be the final choice. It is clear from the calls, emails and survey comments that our staff receive that this is already a choice which many of our members face today.

The Need for Solutions

Finding solutions to the problem of the uninsured must become a top priority for this nation. It is a problem that affects over 46 million Americans today. More than half of these individuals are self-employed or the owners and employees of small businesses. [4] These small firms are widely recognized as the largest source of new American jobs and much of the technological innovation from which our economy has benefited. We believe that without change, problems with the availability and affordability of health coverage will increasingly threaten what has been a major source of job growth and innovation in this nation.

The share of the U.S. workforce that is self-employed has reached a remarkable level. This is a result of an extended and continuing period of corporate acquisitions, outsourcing and downsizing, as well as a series of technological and communication advances. Corporate reorganizations have "offered" many formerly employed professionals the opportunity to go into business for themselves following layoffs. For some workers, the opportunity is a welcomed one; for others, it is the only options. Technological and communication advances have loosened the geographic bounds that have tied workers together in a central location or large firm and made it possible to work independently.

The Ford Foundation, for example, estimated in 1999 that the number of freelance, independent contractors and temporary workers totaled 37 million individuals.[5] More recently, the General Accounting Office (GAO) estimated that 30% of the American workforce in 2000 was comprised of these "non-traditional" workers.[6] By way of comparison, the GAO estimated that manufacturing employment totaled 18 million workers in 2000 while an additional 20 million worked for some level of government.

Some have estimated that by 2010, 41% of the US workforce will be what David Pink has labeled "free agent" workers.[7] In this new world, will a health coverage system based on employer- provided health

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[4] Employees Benefit Research Institute, "The Working Uninsured: Who They Are, How They Have Changed, and The Consequences of Being Uninsured," EBRI Issue Brief No. 224 (August 31, 2000).
[5] Elena Cabrel, "Building Safety Nets for the New Workforce," Ford Foundation Report (Spring/Summer 1999).
[6] General Accounting Office, "Contingent Workers: Incomes and Benefits Tend to Lag Behind Those in the Rest of the Workforce," report no. HEHS-00-76 (June 30, 2000).
[7] David H. Pink, *Free Agent Nation*, (New York: Warner Books, 2001).

insurance be even less successful at providing American workers with access to affordable care than it is currently? Without changes to the existing system, we think so.

Solutions: Observations and Considerations

As is always the case, a discussion of a problem must also include some discussion of solutions. While our organization and its members are not the insurance experts, we would like to share with you some observations and considerations that we believe are important.

Attention to the Individual Market. America's health insurance delivery system is primarily an employer-based system. In 2003, for example, only 5.3 percent of non-elderly Americans had individual coverage; by contrast, 69.5 percent had employer-provided coverage[8]. It is not unexpected, therefore, that much debate has focused the problems facing employer-provided insurance plans or those who cannot work (e.g. the elderly, children, etc.). We feel very strongly, however, that any discussion of solutions to the insurance crisis must address the current shortcomings of the nation's state-based individual insurance markets. These markets are not serving the needs of the population that is dependent upon them.

While we are not experts, we have come to understand the challenges that must be faced in reforming of the individual market. The question we now are asking is whether or not the nation's system of state-based coverage for individuals has outlived its ability to effectively pool risk on the scale that is necessary to offer an affordable product. Are there ways of expanding the pool without creating unintended consequences; are there ways in which more competition can be encouraged in those state markets with few active companies; and how do we best incentivize individuals to participate so as to minimize adverse selection?

Given the share of the U.S. population that is currently self-employed and the growth of this segment of the workforce that is projected for the coming decades, it is imperative that the problems facing individual insurance markets be addressed. Any discussions to address the situation should also include each of the key constituencies that will be impacted by any recommended changes. We would hope, therefore, that any future discussions include representatives of the self-employed and small firms.

[8] Kaiser Family Foundation, *Health Insurance Coverage in America, 2003 Data Update*, November 2004, Table 1, p.28, at http://www.kff.org/uninsured/7153.cfm

Define a Set of Core Health Care Services. Lacking any guidelines or agreement as to what constitutes a set of core health care services, states have established benefit mandates that vary widely in the type and number of required services. One estimate puts the total number of state mandates at more than 1800.[9] Many states have 40, 50 or more mandates.[10]

The lack of uniformity and complexity in state mandates has increased the administrative costs of regional or national insurance programs, contributed to the withdrawal of insurers from states where they had once operated and created a barrier to efforts by national or regional non-employer groups to develop affordable and uniform national insurance programs tailored to the specific needs of their small business and self-employed members.[11]

Late last year the U.S. Citizens' Health Care Working Group delivered its final report to the Congress and the President. Created as a part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Working Group was charged with providing for a nationwide public debate about how to go about improving the health care system to provide every American with the ability to obtain quality, affordable health care coverage and developing an action plan for Congress and the President to consider as they work to make a health care system that works for all Americans.[12]

In a comment letter on the group's interim recommendations, NAR has expressed its support for the Working Group's recommendation that efforts be made to define what constitutes a set of core health care services. We believe that such an effort would be a first step to defining an essential set of coverages around which state regulators could coalesce and begin to build a more uniform set of mandates that would allow for large pools and more competition in the marketplace.

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[9] Council for Affordable Health Insurance, "HEALTH INSURANCE MANDATES IN THE STATES, 2006", Washington, DC, 2006.

[10] *Ibid.*

[11] Since most large companies can choose to avoid state mandates by self-insuring under the Employee Retirement Income Security Act (ERISA), which exempts self-insured companies from state oversight, these mandates and their associated apply only to those health insurance policies controlled by state health insurance laws, i.e. typically policies purchased by small businesses and individuals.

[12] NAR's members participated in many of the Working Group's community meetings held across the country. NAR hosted a Working Group community meeting for its members during the NAR legislative conference on May 16, 2006, in Washington, DC. In addition, NAR submitted comments on the Working Group's interim final recommendations. NAR's letter may be accessed at http://www.realtor.org/small_business_health_coverage.nsf/docfiles/L-06Aug-chcwg.pdf/$FILE/L-06Aug-chcwg.pdf

Acknowledge Resource Limitations. In addition, as much as we all would like to be able to have unlimited access to health services, we believe that it is important that any national or state solution acknowledge that resources – family, business and government resources - are not unlimited. NAR's average real estate sales agent member made $37,600 in 2005 and spent an average of $6,800 in business expenses to earn that income, leaving roughly $2566 a month to cover mortgage, taxes, insurance, food, clothing, children's expenses, etc. What can we rationally expect this individual to pay for health insurance coverage?

Tax Treatment of Health Insurance Premiums. Many proponents of health insurance reform advocate for more favorable tax treatment of health insurance premiums. While NAR has no broad policy that is applicable to these recent proposals, we would comment that favorable tax treatment of health insurance premiums should not be seen as the sole solution to the problems facing the uninsured. We speak from experience.

Since 2003, independent contractors have been able to fully deduct the cost of health insurance premiums. This tax change was one for which we advocated successfully and it has helped to make health insurance more affordable for REALTORS® who had sufficient income to pay the premiums or newly available to those who had "almost" had the necessary funds.

However, as the percentage of members uninsured indicates, tax deductibility has not been a complete solution for those who still find premiums more than marginally out of their reach or have been denied coverage. As one member very succinctly put it, "If I don't have the money to pay the premiums each month, I can't take advantage the deduction or a tax credit." Despite this experience, NAR continues to evaluate proposals as they arise and is open to exploring ways in which an alternative or additional tax treatment could help a larger proportion of our uninsured members.

A Role for Non-Traditional Partners. There are any number of community and non-profit organizations that have not traditionally been involved in facilitating access to health care but which could serve a valuable role in meeting the needs of the nation's small businesses, the self-employed and individuals if existing regulatory barriers could be overcome. Among the array of

organizations which have been established to serve a particular membership and could play a facilitating role are professional or trade associations, like the NAR.

Trade associations have a long tradition of serving their members personal and professional needs. Member service is why these organizations exist and they are uniquely positioned to meet their members' needs. When it comes to designing a member health insurance program on a national or regional basis, however, the complexity of our state-based system of insurance regulation presents an insurmountable obstacle to trade organizations. The administrative burden of offering a nationwide insurance program that meets the mandate and rating requirements of the fifty states and four territories has been insurmountable, even for an organization as large as NAR.

While some individuals argue that this approach has been tried before (e.g. MEWAs) and experience has found them subject to abuse, we believe that those earlier structures did not provide clear regulatory authority nor did they sufficiently limit the types of groups that could offer the insurance programs. We believe that with careful crafting there are ways to make use of these tried, tested but untapped groups.

Conclusion

I would like to close and let you know that finding a solution to the health insurance access problem is a priority issue for the small business community and the National Association of REALTORS®. Just as our 2007 NAR president, Pat Combs pledged in her remarks earlier this year before the Senate Health, Education, Labor and Pension Committee's first health roundtable, NAR stands ready to do whatever we can to assist you in your efforts to address this very important and growing problem.

Thank you for giving me the opportunity to share my thoughts. I am happy to take any questions.

Testimony on

Health Insurance Coverage for Small Businesses

by

Karen Ignagni
President and CEO
America's Health Insurance Plans

Before the
U.S. House Committee on Small Business

March 14, 2007

I. Introduction

Madam Chairwoman, Mr. Chabot, and members of the committee. I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national trade association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of products in the commercial marketplace – including health, long-term care, dental, disability, and supplemental coverage – and also have demonstrated a strong commitment to participation in public programs.

We appreciate this opportunity to testify on the health care needs of small businesses and their employees. Our members share your commitment to improving health care choices for small businesses and bringing costs under control for all Americans. We look forward to working with you to identify workable strategies to achieve these goals.

My testimony today will focus on four areas:

- The current state of the small group health insurance market and how health care dollars are being spent;
- An overview of the strategies health insurance plans are implementing to control health costs, enhance choices, and improve quality;
- Solutions for helping small businesses offer quality, affordable health insurance coverage to their employees; and
- Our perspectives on legislative proposals in Congress.

II. Overview of Small Group Market and Health Care Spending

The discussion of this issue should begin with a close evaluation of the options that currently are available to small employers in the health insurance market. At the same time, it also is important to focus on the causes of rising health care costs and how health insurance premium dollars are being spent. AHIP has released two reports over the past 14 months that provide important information about the current state of the small group health insurance market and the factors contributing to rising health care costs.

The Current State of the Small Group Health Insurance Market

In September 2006, AHIP released a report[1] providing comprehensive information on premiums, choices, and benefits in the small group health insurance market. This report outlined survey findings based on premium and benefit data from more than 650,000 small groups covering 7.2 million workers and dependents. To date, it is the largest and most comprehensive survey of the small group market.

The survey provides useful information about the affordability of health insurance coverage for small businesses and their workers. Nationwide, the survey found that the average premium for small group health insurance in 2006 was $311 per month ($3,730 per year) for single coverage and $814 per month ($9,770 annually) for family coverage.

The survey also found that premiums for small group health insurance vary significantly from state to state. For example, premiums for single coverage are below the national average of $311 per month in Virginia ($246 per month), Arizona ($281), Missouri ($292), and California ($296). By contrast, premiums in New York ($419), Connecticut ($404), Massachusetts ($392), and Louisiana ($373) are well above the national average.

These state-by-state variations can be attributed to several factors, including demographics, the variety of health insurance plans available and the types of products chosen, the cost of health care services in the state, premium taxes and assessments, and the degree to which private premiums reflect cost shifting driven by the uncompensated costs of caring for the uninsured or underpayments from low reimbursement rates paid by some state Medicaid programs.

Additionally, regulation of the small group market can affect premiums in at least two important ways:

- First, states that do not allow rates to vary by health status generally have higher average rates. In these states, small firms with relatively healthy employees are not eligible for any health-status related premium reductions, and they may choose to forgo coverage. As a result, average rates tend to rise for firms remaining in the small group pool.

[1] AHIP Center for Policy and Research, *Small Group Health Insurance in 2006: A Comprehensive Survey of Premiums, Consumer Choices and Benefits*, September 2006

- Second, states that allow self-employed individuals (i.e., "groups of one") to purchase coverage in the small group market also may see increases in average rates. In these states, self-employed individuals may delay purchasing insurance until they need health care services and can then obtain coverage on a guaranteed-issue basis at rates regulated under the state's small group rules. Those who are generally healthy and have low costs may choose to remain uninsured.

Other key findings of AHIP's survey indicate that most small business employees with health insurance are covered by preferred provider organizations (PPOs) and health maintenance organizations (HMOs), while high-deductible health plans (HDHPs) combined with tax-free Health Savings Accounts (HSAs) are quickly establishing a presence in the small group market.

Among small group enrollees, 57 percent had PPO coverage last year and 39 percent had HMO coverage, often with a point-of service (POS) option. Approximately 4 percent of enrollees were covered under HDHP/HSA plans, which are proving to be a valuable option for many small employers who are offering health benefits for the first time and for many individuals who were previously uninsured. A separate AHIP survey[2], released in March 2006, found that 33 percent of companies offering HSA products through the small group market previously did not offer health coverage and, additionally, that 31 percent of persons covered by HSA products in the individual market previously were uninsured.

Factors Contributing to Rising Health Care Costs

A second report analyzed in greater detail the improving outlook for growth in health care costs, as noted in recent years by the Centers for Medicare & Medicaid Services (CMS) and private researchers. Specifically, the causes of rising health care costs and how health insurance premium dollars are being spent are examined by a report[3] AHIP released in January 2006. This report, prepared by PricewaterhouseCoopers, indicates that health insurance premiums are growing at a reduced rate, despite increased utilization and higher costs, while health insurance plans' tools and techniques are easing increases in drug costs.

Focusing on the 8.8 percent premium increase that was measured between 2004 and 2005, the report found that 43 percent of this increase could be attributed to higher utilization of services. The trend toward increased utilization was fueled by factors such as increased consumer demand,

[2] AHIP Center for Policy and Research, *January 2006 Census Shows 3 2 Million People Covered by HSA Plans*, March 2006
[3] PricewaterhouseCoopers, *The Factors Fueling Rising Healthcare Costs 2006*, January 2006

new and more intensive medical treatments, defensive medicine, the aging of the U.S. population, and unhealthy lifestyles. The report also concluded that price increases exceeding the rate of general inflation accounted for 30 percent of the premium increase and were impacted by consolidation among hospitals and other providers, increased costs of labor, and higher priced technologies.

Other findings show that 86 cents out of every premium dollar goes directly toward paying for medical services. Embedded within the 86 cents are the costs of medical liability and defensive medicine, which are estimated to be ten cents of the premium dollar. Of the remaining premium dollar, five cents goes to consumer services such as prevention, disease management, care coordination, investments in health information technologies and health support, provider support, and marketing. Six cents goes to costs associated with government payments, regulation and claims processing, and other administration. Health insurance plan profits comprise three cents of the premium dollar.

While noting that systemic challenges are putting upward pressure on costs, the report found promise in emerging private sector initiatives. It emphasized that efforts by health insurance plans to promote incentives for quality performance (pay-for-performance), transparency of information to assist consumers with decision-making, and consumer engagement to adopt healthy lifestyles have the potential to mitigate future cost increases and address some root cost drivers. It further suggested that efforts to assess the emergence of new technologies and public reporting of quality measures would improve accountability throughout the health care system.

III. Private Sector Cost Containment and Quality Improvement Initiatives

Health insurance plans have been working aggressively to improve quality and control costs, while also meeting consumer demands for choice, through a variety of innovative strategies and initiatives. These efforts are making a difference, as evidenced by CMS data that was discussed in a February 2007[4] article published by *Health Affairs*. This article, authored by a team of CMS economists and actuaries, reports that national spending on private health insurance premiums increased by a projected 4.8 percent in 2006 – marking the fourth consecutive year in which premium growth decelerated – and that overall national health care spending slowed to a projected increase of 6.8 percent in 2006 (also the fourth consecutive year of declining growth).

[4] *Health Affairs*, Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact, February 2007

The following are several areas where health insurance plans are working to improve the quality and affordability of health care for small businesses and other consumers.

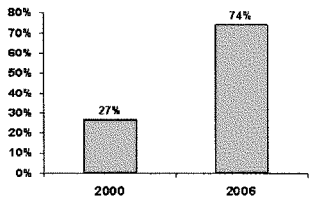
Pharmacy Benefit Management

Health insurance plans use a wide range of pharmacy benefit management tools and techniques to reduce out-of-pocket costs for members and improve quality by reducing medication errors. These tools and techniques include:

- programs that encourage the use of generic drugs;
- step therapy programs that promote proven drug therapies before moving to newer, different treatments that do not necessarily result in better health outcomes;
- negotiated discounts with pharmacies that participate in a plan's network;
- disease and care management techniques that include evidence-based guidelines to encourage the use of the most appropriate medications;
- appropriate use of mail-service pharmacies; and
- "tiers" for various categories of drugs – generic, preferred brand name, and non-preferred brand name – to promote the use of more cost effective drugs (see table below).

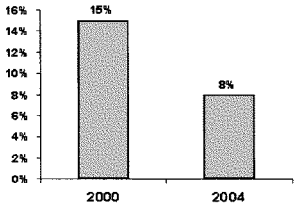
Prescription Drug Tiers Are An Effective Strategy in Controlling Health Care Costs

Percent of covered workers with three or more tiers of cost sharing for prescription drugs, 2000 to 2006



Employer Health Benefits, 2006 Summary of Findings, The Kaiser Family Foundation and Health Research and Education Trust

Annual percent change from previous year, prescription drug costs, 2000 to 2004



Prescription Drug Trends, June 2006 The Kaiser Family Foundation

The success of these strategies is clearly evidenced by the PricewaterhouseCoopers report's finding that prescription drug spending increased 8.6 percent in 2005, following several years of double-digit increases. The report credited health insurance plans' prescription benefit tools and techniques with helping to slow drug spending.

The application of these tools and techniques in the Medicare Part D prescription drug program also has highlighted their effectiveness. According to CMS[5], beneficiaries who previously did not have drug coverage saved an average of $1,200 in 2006 by enrolling in Part D plans. The value offered by Part D plans also can be seen in the lower-than-expected premiums that beneficiaries are paying. CMS has reported that beneficiary premiums in 2007 will average $22 a month if enrollees remain in their current plans. This figure is 46 percent lower than the $41 monthly premiums that previously were projected for 2007.

A number of research studies have reinforced that these tools and techniques are controlling costs in public programs. As we noted earlier, CMS has reported data showing a slowdown in recent years in both overall national health care spending and private health insurance premiums. CMS economists and actuaries noted in a recent *Health Affairs* article[6] that a significant factor in this slowdown is that private health insurance payments for prescription drugs increased by 5.8 percent in 2005, compared to an average annual increase of 16.7 percent during 1994-2004. The authors suggest that "the proliferation of tiered-copayment benefit plans" has been a key factor in the slowdown in prescription drug spending in recent years.

Moreover, the Government Accountability Office (GAO) reported in January 2003 that pharmacy benefit management techniques used by health plans in the Federal Employees Health Benefits Program (FEHBP) resulted in savings of 18 percent for brand-name drugs and 47 percent for generic drugs, compared to the average price customers would pay at retail pharmacies. Another 2003 study, conducted by the Lewin Group for the Center for Health Care Strategies, found that Medicaid managed care plans reduced prescription drug costs by 15 percent below the level states would otherwise have experienced under Medicaid fee-for-service programs. Plans achieved these savings by performing drug utilization review, establishing pharmacy networks, and encouraging patients to take the most appropriate medications.

AHIP's members also are taking steps to improve patient safety and reduce the risk of medication errors. Health insurance plans have created pharmacy information systems which, as

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[5] Centers for Medicare & Medicaid Services, *Part D Medicare Prescription Drug Benefit Fact Sheet*, January 2007
[6] *Health Affairs*, National Health Spending in 2005: The Slowdown Continues, January/February 2007

a matter of standard practice, alert pharmacists when the combination of two or more of a patient's medications could lead to an adverse drug reaction. Software that plans use in their pharmacy networks is programmed to identify hundreds of potentially harmful drug interactions, including those that could occur due to the patient's age or gender. When the system recognizes a dangerous combination of drugs or contraindications, an on-screen alert is sent to the pharmacist who can then call the patient's doctor to find a safer alternative.

Evidence-Based Medicine

Health insurance plans are working aggressively to promote evidence-based medicine. This term refers to the widespread adoption in everyday clinical practice of treatments and therapies that are consistent with the latest scientific evidence on what works best and reduces the number of inappropriate services that do little or nothing to improve patient care.

Our leadership in the movement toward evidence-based medicine is a response to growing concerns that variation in medical decision-making has led to disparities in the quality and safety of care delivered to Americans. Over the past decade, the Institute of Medicine (IOM) has focused the nation's attention on the critical need to improve health care quality and patient safety, coordinate chronic care, and support evidence-based medicine. A 1999 IOM report[7] found that medical errors could result in as many as 98,000 deaths annually. Another study[8], conducted by RAND, found that patients received only 55 percent of recommended care for their medical conditions.

Additional studies indicate that Americans frequently receive inappropriate care in a variety of settings and for many different medical procedures, tests, and treatments. Such inappropriate care includes the overuse, underuse or misuse of medical services. Studies also show that patterns of medical care vary widely from one location to another, even among contiguous areas and within a single metropolitan area – with no association between higher intensity care and better outcomes.

The Dartmouth Atlas of Health Care[9] documents wide variation in the use of diagnostic and surgical procedures for patients with coronary artery disease, prostate cancer, breast cancer, diabetes, and back pain. For example, the rates of coronary artery bypass graft (CABG) surgery

[7] "To Err is Human," Institute of Medicine, 1999
[8] "The Quality of Health Care Delivered to Adults in the United States.," Elizabeth A. McGlynn, RAND, June 25, 2003
[9] Center for the Evaluative Clinical Sciences, Dartmouth Medical School, *The Dartmouth Atlas of Health Care*, "The Quality of Medical Care in the United States: A Report on the Medicare Program," 1999

were found to vary from a low of 2.1 per 1,000 persons in the Grand Junction, Colorado hospital referral area, to a high of 8.5 per 1,000 persons in the Joliet, Illinois region. The *Atlas*' findings[10] reveal wide variation in hospital care and outcomes for chronically ill Medicare patients. For example, the length of hospital stays varied – depending on a patient's geographic location – by a ratio of 2.7 to 1 for cancer patients and by a ratio of 3.6 to 1 for congestive heart failure patients.

To promote evidence-based medicine, our members are working with physician groups to increase the use of quality technology assessment and clinical practice guidelines that help clinicians make decisions about the most appropriate course of treatment for patients with a specific disease or symptoms. Furthermore, AHIP has collaborated with the Agency for Healthcare Research and Quality (AHRQ) and the American Medical Association to establish a National Guideline Clearinghouse – www.guideline.gov – which is a web-based resource that gives patients and providers access to the latest medical evidence on effective treatments and technologies. The National Guideline Clearinghouse provides access to both summaries and the full text of clinical practice guidelines, an electronic forum for exchanging information on best practices, and a tool that allows users to generate side-by-side comparisons for any combination of two or more guidelines.

Comparative Effectiveness Research

To help advance the adoption of evidence-based medicine, we strongly support federal funding for comparative clinical effective research. Research that compares the relative effectiveness of existing versus new medical therapies that are designed to treat the same condition will yield valuable information for ensuring that patients consistently receive treatments based on more definitive evidence and for learning how certain drugs and devices work for various populations.

This important research also will help us achieve greater efficiency and value throughout the health care system by helping to eliminate unnecessary or ineffective treatments. At a time when rising health care costs are a serious concern for all Americans, it is important for our nation to vigorously pursue these opportunities for improvement. An aggressive research agenda – backed with increased federal funding for AHRQ – is urgently needed to take bolder steps toward the development of an evidence-based health care system.

[10] Fisher, E., *Health Affairs,* October 7, 2004

Disease/Care Management

Virtually all health insurance plans have implemented disease and care management programs to improve the coordination and quality of care for patients with diabetes, asthma, congestive heart failure, and other chronic diseases. These programs improve patient outcomes and satisfaction – and help control costs – by ensuring that these patients receive effective care on an ongoing basis so they can avoid emergencies and unnecessary hospitalizations.

Research studies have demonstrated that these programs are effective. For example, a study published in *Medical Care*[11] evaluated the impact of a heart disease management program on hospital service utilization, as well as the potential costs savings over and above the cost of delivering the program. This randomized controlled study included 443 women aged 60 or older with diagnosed cardiac disease who were seen by a physician approximately every six months. The results demonstrated that hospital cost savings exceeded program costs by a ratio of nearly 5 to 1. Moreover, program participants experienced 46 percent fewer inpatient days and 49 percent lower inpatient costs than the control group, while no significant differences between the two groups were reported in emergency room utilization.

Transparency

Health insurance plans are working with other public and private stakeholders to promote greater transparency and value-based competition throughout the U.S. health care system. This effort is focused on empowering small business employees and other consumers to be more actively engaged in making decisions – based on reliable, user-friendly data – about their medical treatments and how their health care dollars are spent.

To meet this challenge, AHIP and its members are working through a broad-based coalition – known as the AQA – to develop uniform processes for performance measurement and reporting. Those processes are ongoing, and would *first,* allow patients and purchasers to evaluate the cost, quality and efficiency of care delivered, and *second,* enable practitioners to determine how their performance compares with their peers in similar specialties. This effort now involves more than 125 organizations, including physician groups, hospitals, accrediting organizations, private sector employers and business coalitions, and government representatives.

[11] Wheeler, J. (2003). Can a disease self-management program reduce health care costs? The case of older women with heart disease. *Medical Care.* 41(6): 706-715.

The AQA has approved 121 clinical performance measures for the ambulatory care setting, many of which are being incorporated into provider contracts. In addition, a standard tool designed by AHRQ to measure patient satisfaction in the ambulatory care setting has been approved for use by consumers. The clinical performance measures approved by AQA include new sets of measures for practitioners in the areas of cardiology, dermatology, hematology, rheumatology, clinical endocrinology, ophthalmology, oncology, emergency medicine, radiology, neurology, gastroenterology, geriatrics, as well as measures for surgery, cardiac surgery, and orthopedic surgery. These measures represent an important first step in establishing a broad range of quality measurement and helping to give consumers the information they need to make informed health care decisions.

With support from CMS and the AHRQ, the AQA has implemented a pilot program in six sites across the country to combine public and private sector quality data on physician performance. This pilot program is testing various approaches to aggregating and reporting data on physician performance, while also testing the most effective methods for providing consumers with meaningful information they can use to make choices about which physicians best meet their needs. Ultimately, we anticipate that the results of this pilot program will lead to a national framework for measurement and public reporting of physician performance, which is an important step toward advancing transparency and providing reliable information for consumer decision-making.

Value-Based Purchasing

Many health insurance plans are redesigning their payment models to reward health care providers for delivering high quality care. Paying for quality is a promising strategy for improving overall wellness and advancing evidence-based medicine, thereby reducing unnecessary hospitalizations and emergency room use, and improving efficiency – which in turn will lead to better health outcomes and greater value. This is a significant change in a system that historically has paid providers the same amount, regardless of the quality of care they deliver, and actually has served to incentivize misuse and overuse of health care services.

Under these new payment models, many health insurance plans are offering financial rewards to physicians in the form of increased per-member-per-month payments or non-financial rewards in the form of public recognition, preferential marketing, or a reduction in administrative requirements. Additionally, some plans are beginning to redesign provider networks and offer consumers reduced co-payments, deductibles, and/or premiums for using providers deemed to be of higher quality (based on select performance measures).

AHIP's members are committed to working with stakeholders across the health care community, particularly health care professionals who work on the frontlines every day, to develop and improve incentive programs and an overall strategy that accounts for the quality of care delivered to patients.

Health Information Technology

By implementing health information technology, our members are helping consumers make well-informed decisions about their health care, while also achieving greater efficiencies and cost savings throughout the health care system.

In November 2006, AHIP's Board of Directors endorsed a set of recommendations calling for the industry to implement steps to standardize health plan-based personal health records (PHRs). The Board's recommendations, developed in partnership with the BlueCross BlueShield Association, will facilitate both information-sharing between consumers and caregivers and portability when a consumer changes health plans. The recommendations address several key priorities: (1) standardization of the data shown in a PHR; (2) approval of a technical standard for transferring PHR data when a consumer changes health plans; (3) planning for long-term maintenance of the standard; and (4) a timeframe for industry-wide implementation of the standards.

In addition, health insurance plans have developed a wide range of other health information technology initiatives, including secure websites that allow their members to quickly locate information about their benefits, check the status of claims, contact member services, or learn about preventive care, drug interactions, disease management, and other health issues. Other plans have created on-line pharmacies that allow enrollees to refill their prescriptions and access information about their medications. Another strategy implemented by a number of companies provides opportunities for members to receive health information from doctors and nurses through websites and e-mail. Our members also are implementing information technology to improve claims processing, offer better customer service, decrease administrative costs, and enhance their overall efficiency.

AHIP and its members are strongly committed to developing an interconnected health care system – based on national, uniform standards – that improves the delivery of care, enhances health care quality, and increases productivity.

Generic Biopharmaceuticals

We also support efforts to improve the availability and affordability of safe and effective generic biopharmaceuticals. In February 2007, AHIP's Board of Directors approved a statement expressing support for legislation that would provide an expedited means of bringing safe and effective generic biologics to the market. Our statement outlines three key principles to guide these legislative efforts: (1) promoting the timely market entry of generic biologics; (2) ensuring that generic biologics are comparable to brand-name products in safety, quality, and efficacy; and (3) providing a mechanism to allow the review criteria to keep pace with innovation in biologics.

We applaud Representatives Henry Waxman and Jo Ann Emerson for recently introducing bipartisan legislation, H.R. 1038, that would accelerate approval by the Food and Drug Administration (FDA) of generic versions of life-saving biological products. For millions of health care consumers, this legislation offers the hope of significant cost savings and greater access to advances in biotechnology.

Post-Market Surveillance

Consumers also would benefit from an increased focus by the FDA on post-marketing surveillance to evaluate the long-term effects of prescription drugs, biological products, and medical devices. As the population ages and as more Americans are afflicted with multiple chronic diseases, this is becoming an increasingly important priority.

Recognizing that the FDA already has committed significant resources to pre-market testing of drugs, biologics, and devices, we believe the agency should take the additional step of requiring manufacturers to conduct selected post-market studies of their products. This should include situations where safety concerns have not been raised, to determine if the drug, biologic, or device is safe, effective, and fulfilling its intended purpose.

IV. Solutions for Helping Small Businesses Offer Quality, Affordable Health Insurance Coverage

We appreciate the need for decisive action to help small employers. In fact, failing to take any action at all would be the most expensive outcome for the entire health care system – including small businesses – due to the cost shifting that is associated with uncompensated care for the

uninsured. Therefore, as the committee considers legislative options to address the concerns of small employers, we would like to offer a number of promising solutions to meet this challenge while also addressing the broader issue of the uninsured.

AHIP's Access Proposal

In November 2006, AHIP's Board of Directors announced a proposal for expanding access to health insurance coverage for all Americans. Our proposal includes a comprehensive set of policy initiatives that would expand eligibility for the State Children's Health Insurance Program (SCHIP) and Medicaid, enable all consumers to purchase health insurance with pre-tax dollars, provide financial assistance to help working families afford coverage, and encourage states to develop and implement access proposals.

AHIP's access proposal includes several elements that have significant potential to assist small businesses and their employees:

- Our proposal for a new Federal Performance Grant would provide $50 billion to assist the states in expanding access to coverage. These funds could be used to support a wide range of innovative initiatives, including reforms targeted to help small employers.

- Our proposal for a health care tax credit would help working families with low incomes secure health insurance for their children. This proposal would help eligible employees contribute to the cost of employer-sponsored coverage, thus reducing the number of workers who forego such benefits because they cannot afford to pay their share of the premium. Another advantage is that tax credits could prompt more small businesses to offer employee health benefits. The Employee Benefits Research Institute (EBRI)[12] has reported that among small employers that do not offer employee health benefits, 71 percent would be more likely to seriously consider offering health benefits if the government provided assistance with premiums.

- Our proposal for universal health accounts would allow all individuals to purchase any type of health care coverage and pay for qualified medical expenses with pre-tax dollars. This is an important step toward achieving greater equity in the tax treatment of health insurance for all consumers – regardless of whether they purchase coverage on their own or receive it through their employer. Our proposal also calls for federal matching grants for contributions

[12] Employee Benefit Research Institute, *Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey*, January 2003

made by working families to the health accounts, which also could be used to pay the employee share of employer-sponsored coverage.

- At the state level, we have outlined a set of principles for states to consider as they discuss access reforms. One idea that has significant potential to help small businesses is our suggestion that states should allow product flexibility so health insurance plans can offer a wide variety of affordable products. If states establish minimum benefit requirements for purposes of determining an appropriate level of coverage or eligibility for premium subsidies, we have suggested that such requirements should allow health insurance plans to offer policies that do not include all mandated benefits. Small employers would be well-served by regulatory structures that create opportunities for more affordable products.

AHIP envisions that these initiatives – along with our proposals to improve SCHIP and Medicaid – would expand access to health insurance coverage to all children within three years and 95 percent of adults within 10 years. AHIP's members are working aggressively to build support for these proposals. At the same time, AHIP is an active member of the Health Coverage Coalition for the Uninsured (HCCU), which is also calling for broad reforms to expand health coverage to the uninsured. Through the HCCU, we are working closely with a diverse coalition that includes Families USA, the Chamber of Commerce, AARP, the American Medical Association, the American Hospital Association, and other national organizations.

Regulatory Reforms

We support steps to modernize and maximize the effectiveness of the regulatory system for the health insurance marketplace. Action in the following areas would improve value for consumers, including those working for small businesses.

- **Encourage choice with uniform rules in the small group market.** A common set of rules would encourage competition, enhance consumer choice, and provide greater predictability for employers. The solution is not to waive all requirements for particular groups, but to establish an appropriate and consistent framework for all participants to ensure that small employers have maximum options to meet their needs. This means that the federal and state governments need to work together to encourage "best practice" regulation. In recent years, this movement to uniformity has been addressed in draft legislation – known as the State Modernization and Regulatory Transparency (SMART) Act – that would promote uniformity in plan processes, particularly internal and external review of coverage disputes, speed-to-

market, and market conduct standards.

- **Encourage prompt product approval and consistency in regulatory processes.** Steps should be taken to ensure that states adopt a mechanism by which health insurance plans can bring innovative products to the market in a timely manner. Ideally, the federal government should encourage states to be forthcoming regarding their standards for policy rate and form filing requirements and to abandon unwritten "desk-drawer rules." This ultimately will create oversight mechanisms that allow companies to provide consumers with the products they need in a timely manner.

- **Establish an independent advisory commission to evaluate the impact of mandates on health care costs and quality.** Such a commission could advise policymakers on the safety and effectiveness of proposed and existing mandated health benefits, and assess whether proposed mandates result in improved care and value. The commission's findings also could inform public program coverage and decision-making to ensure that evidence-based standards are applied consistently in Medicare, Medicaid, and other public programs.

Funding for State High-Risk Pools

AHIP strongly supports federal funding for state high-risk pools to cover individuals who do not have employer-sponsored coverage and suffer from grave or chronic health conditions. These pools have proven to be highly successful in ensuring that individuals who have unusually high health care costs can obtain the coverage they need at more affordable rates. It is important, however, for states to develop high-risk pools that have a broad base of funding – going beyond assessments on health insurance premiums – so that purchasers of health insurance, including both individuals and small employers, do not bear a disproportionately large burden in funding the pools.

We applaud Congress for enacting the "State High Risk Pool Funding Extension Act of 2006." As you know, this law authorizes $75 million annually, for fiscal years 2006 – 2010, to help states cover the operational costs of high-risk pools. Now it is important for Congress to provide the full appropriations that this new law authorizes for state high-risk pools. This is one of the next steps that should be taken as part of a long-term strategy for strengthening our nation's health care safety net.

V. Our Perspectives on Legislative Proposals in Congress

We appreciate the committee's interest in developing and advancing legislation to create affordable health care options for small businesses. We are particularly pleased that the debate is moving beyond association health plan (AHP) proposals and entering a new era in which other alternatives will be considered.

As these alternatives evolve in the coming weeks and months, we are eager to engage committee members in a dialogue about potential solutions for helping small employers. We recognize that some members of Congress are interested in exploring pooling arrangements or health care subsidies for small businesses. Also, in previous years, others have proposed a Small Employers Health Benefits Program (SEHBP) that would be modeled after the existing FEHBP program for federal employees and retirees.

Recognizing that the SEHBP bill is innovative in its use of tax credits, rating flexibility, and financial incentives, we believe this legislation is a worthwhile contribution to the congressional debate on coverage options for small employers. At the same time, based on our review of last year's bill, we do have concerns that the proposed program might run the risk of fragmenting the small group insurance market by allowing small employers with a healthy workforce to opt out of the state small group market and, instead, purchase insurance under a different regulatory system. This fragmentation would lead to higher premiums for small employers whose workers are older, less healthy, and more likely to incur health care costs. To promote affordable coverage options for all employers, it is important to share risk by maintaining a mix of healthier-than-average people and less-healthy-than-average people all in a single pool.

As Congress considers solutions for meeting the health care needs of small employers, we will be evaluating legislative proposals based on whether they meet several core principles: (1) making health insurance more available and affordable for small employers; (2) establishing a fair marketplace with a level regulatory playing field that allows all players to operate under the same rules; and (3) building on, rather than disrupting, positive progress in the current market. With these principles in mind, we stand ready to work with committee members to explore legislative options for helping small employers.

Association Health Plans

Recognizing that AHPs have been an important part of this debate over the past ten years, we want to take this opportunity to discuss our concerns about legislative proposals that would

establish special rules and exemptions for national and regional AHPs. We believe such proposals would lead to higher health care costs and more uninsured Americans.

In order to fully understand the implications of the AHP legislation, it is important to focus on the fact that most states have adopted some variation of the National Association of Insurance Commissioners' (NAIC) model regulating rates in the small group market. The NAIC model limits rate variations – to no more than 25 percent above or below the average rate – for similar employer groups based on claims experience or health status. Moreover, this model limits annual rate increases for any one group to 15 percent on top of the rate increase applied to all groups.

The AHP legislation lacks this protection against wide rate fluctuations. That is, there is no limitation on what a group could be charged relative to similar groups based on health status or claims experience. The resulting rate swings would make small groups more vulnerable to catastrophic costs and make business planning less predictable.

While low rates initially may seem attractive to small businesses with a healthy workforce, if one of their workers developed a significant illness, they would face a rate hike from the AHP the following year. Ultimately, the result would be a market in which a shrinking portion of healthy businesses would be covered by the AHP while businesses whose workers have significant health needs would be driven out of the AHP.

These concerns are reinforced by the Congressional Budget Office (CBO), which has reported [13] that AHPs would make health insurance less affordable for the vast majority of small businesses. According to CBO's analysis, 82 percent of small business employees would pay higher premiums under AHPs. This should be a major concern for all committee members.

We also urge the committee to consider the implications of allowing only certain entities – AHPs – to be exempted from state regulations. Congress should not create an unlevel playing field by granting special regulatory rules to specific entities that have little or no experience in the group and individual insurance markets. Federal legislative efforts should instead focus on creating consistent rules that address the affordability of health insurance coverage for all workers and their families.

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[13] Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts,* Jan. 2000.

Yet another serious concern is that preemption of state law for AHPs could repeat the problems of the late 1980s and early 1990s. The experience with Multiple Employer Welfare Arrangements (MEWAs) exposed thousands of individuals to unpaid medical bills and left them with no health insurance protection. To avoid repeating this history, we urge Congress to consider alternatives to AHP legislation.

Small Business Health Plans

As you may know, there has been an effort in the Senate over the past two years to develop legislation authorizing Small Business Health Plans (SBHPs). This legislation has focused on three key areas: (1) rating requirements for the small group market; (2) low cost plans/mandate relief for the group and individual markets; and (3) harmonization of process standards in the group and individual markets.

While we support the overall goal of this legislation – making health coverage more affordable for small employers – we have expressed our concerns about several significant issues:

- **Mandate Relief:** The bill's proposal for a "Benefit Choice Standard" would allow SBHPs to offer a lower cost plan option that is not required to comply with state benefit, service, or provider mandates as long as a comprehensive plan option is also made available. We are concerned that this approach would create an environment that would promote adverse selection among groups. Groups that do not envision requiring costly health care services would be likely to opt for the lower cost plan, while groups expecting high health care utilization would be inclined to select the comprehensive option. This outcome would almost certainly drive up premiums for the more comprehensive plan, ultimately pricing many small employers out of the market. Additionally, the bill would provide preferential rules for SBHPs, allowing them to offer lower cost plans three months earlier than other entities providing coverage to small employers within a state. We believe the timeframe for offering such plans should be consistent across the board for all entities, to ensure that there will be vigorous competition in creating high quality, affordable options for small employers.

- **Favorable Treatment for Franchises and Existing AHPs:** The bill would provide existing AHPs and franchises with an exception from formation and certification requirements that apply to other entities. To promote a level playing field, we believe all players in the SBHP market should be required to conform to the same requirements, regardless of when they were formed.

- **Participation of Large Groups:** We believe the bill should clarify that only groups of 50 or less may participate in SBHPs, recognizing that small businesses have the greatest difficulty affording health care coverage for their employees and that large businesses generally are in a better position to offer affordable health care coverage to their employees. Additionally, limiting SBHPs to groups of 50 or less is necessary for consistency with HIPAA and other federal laws regulating insurers and health plans, and administrative consistency and efficiency for insurers.

While we recognize that the SBHP legislation has not been introduced in the House, we wanted to ensure that the committee is aware of our views on this proposal.

VI. Conclusion

Thank you again for providing us this opportunity to testify on this important legislative priority. AHIP and our member companies share your strong commitment to meeting the health care needs of small employers and their workers. We look forward to working with the committee to develop legislative solutions for meeting this challenge.

House Committee on Small Business

"Challenges and Solutions to Health Insurance Coverage for Small Businesses"

March 14, 2007

Statement by Dr. Gail Wilensky

Madame Chairwoman and Members of the Committee: Thank you for inviting me here to testify about the current state of health insurance coverage in the small employer market. My name is Gail Wilensky. I am currently a senior fellow at Project HOPE, an international health foundation that works to make health care available to people around the globe. I have previously directed the Medicare and Medicaid programs as the Administrator of the Health Care Financing Administration, now known as the Center for Medicare and Medicaid Services and chaired the Medicare Payment Advisory Commission. I am here today to share my views on the current state of the employer-sponsored insurance market, particularly as it affects small employers, based on my training as an economist and my experiences in these and other relevant positions. My testimony reflects my personal views and should not be regarded as reflecting the views of Project HOPE.

My testimony reviews why employer-sponsored insurance is such an important source of coverage for most Americans, the trends in employer-sponsored insurance over time, particularly as it relates to small firms, the effects of small group insurance reforms and how reinsurance can affect small employers.

The Role of Employer-Sponsored Insurance

Most health insurance coverage for the under-65 population comes from employer-based insurance. As of 2004, some 161 million people or 63.5% of the under-65 population had such insurance. There are several reasons that so much insurance comes through the workplace but one of the most important reasons relates to the tax treatment of fringe benefits in general and health insurance coverage in particular.

Under current law, employer contributions to employer-sponsored insurance do not count as taxable income to the employee. This general tax treatment is true of all fringe benefits but unlike most other fringe benefits, there is no limit on the amounts that can be excluded from the employee's income. For the employer, the contribution is also a deductible business expense but so is the rest of the compensation package, that is, wages. Thus, it is the tax treatment of employer-contributions as it affects the employee that has made this form of fringe benefit so attractive to employees. To employers, it has become an important strategy in recruiting and retaining employees. In addition, the ability for employers to group employees and thereby pool risk has made insurance less costly when provided by employers and thus, further enhanced its attraction.

Despite this attraction, there have been a lot of criticisms about reliance on employer-sponsored insurance. In a mobile economy like the U.S., it makes disruptions in coverage almost inevitable whenever individuals change their place of employment. In addition, the contributions by employers, while part of the worker's compensation

package, tends to make employees think someone else's money is being used to buy insurance, which leads employees to want more than they might if they thought of it as "their" money. Also, the current tax-treatment of employer contributions encourages the purchase of more insurance than would occur if wages and taxes were treated comparably and more insurance contributes to the rapid rise in health care spending, which in turn makes health insurance more expensive. However, because it is the source of so much insurance coverage, even many of its critics are concerned about declining patterns of employer-based coverage in the absence of a robust alternative. This concern, as well as the concern about "excess" insurance is one of the rationales for the proposal in the President's budget that would eliminate the current employee tax exclusion for employer-sponsored insurance and replace it with a new deduction for individuals who purchase health insurance.

Trends in Employer-Sponsored Insurance

The percentage of the under-65 population covered by employer sponsored insurance has been gradually declining over the last two decades. In 1984, the percentage covered by employer related insurance was 69 percent; by 2004 the percentage had declined to 63.5. As is frequently the case, the issues underlining the decline are more complicated than a simple decline would suggest because numbers combine the net outcome of firms offering insurance, eligibility for insurance and take-up rates of coverage. Also, the patterns are different for larger firms, defined as those over 200 than for smaller firms

and while more variable for firms with fewer than 50 employees, the decline has been particularly noticeable for firms with fewer than 10 employees.

For the larger firms, offer rates remain very high—98%-99% of such firms offer health insurance. Most of the change associated with employer-sponsored insurance for this group is related to the percentage of the premium that the employer pays and the structure and cost of the benefits offered. Most of any decline in enrollment among larger firms is related to the increasing costs to employees rather than its availability.

For small firms, offer rates vary substantially by size of firm. The stability of the offer rate has also varied. As of early 2006, 92% of the firms with 50-199 workers offered insurance, 87% of firms with 25-49 workers offered insurance, 73% of firms with 10-24 workers offered insurance but only 48% of firms with 3-9 workers offered insurance. The decline from the end of the previous decade was also greater for the smallest group: from 56% in 1999 to 48% in 2006. Five percent fewer firms with 50-199 workers also no longer offered coverage in 2006, compared to 1999. For the other firm sizes, the percentages started and ended at about the same place although there was some movement in offer rates during the intervening years. Thus, the decline and the relatively low percentage of firms offering insurance is much more of an issue for firms employing 3-9 workers than for other small-sized firms.

The characteristics of the workers also affect offer rates. The most important characteristics affecting offer rates are the income level of the employees, the percent that

are full-time workers and the extent that employees are unionized. In general, the higher the income, the greater the percent that are full-time and the greater the proportion of workers that are unionized, the more likely the firm is to offer insurance coverage.

Not all employees are eligible for coverage. In general, coverage is not available for part-time or temporary employees and there may also be some waiting period for newly-hired workers.

Enrollment rates also vary. The most commonly given reason for not enrolling, irrespective of firm size, is the financial contribution required by the employer. On average, 52% of employees who are eligible but decline say that cost is the reason they don't participate. This is especially a concern for family coverage where employers, contribute on average, less than they do for single coverage.

Offer Rate Decisions by Employers

The decision as to whether to offer insurance coverage for a smaller employer is more complicated than for a larger employer where almost all offer insurance, largely because of the favorable tax treatment for employees described earlier and the easier ability of large employers to have specialized employees who focus on competitive pay packages and benefits. The mix of cash and fringe benefits offered in part depends on the competitiveness of the particular labor market, whether competing employers are offering

coverage and sometimes whether most of the workers in a firm are secondary workers, where the primary worker may already have coverage.

Small employers have some added challenges. The smallest firms are unlikely to have a benefits staff, and may not have much expertise in the complex world of benefits. The cost of insurance is also an issue. About 80% of employers who don't offer insurance say the cost of insurance is the main reason. Furthermore, premiums have been increasing at a somewhat greater rate for smaller firms than for large firms although this is another area where averages can mask important differences. Costs for employers with fewer than 200 employees increased one percentage point faster than those with more than 200 employees from 2004 to 2005. In the latest year, however, the spread was a little larger—8.8% for firms with 3-199 employees versus 7% for firms with more than 200 employees. But like the offer rate, the largest differences were between the smallest firms and other firms—small and large. Firms with more than 50 employees had rates of increase just above or just below 7% whereas the increase for workers between 25 and 49 workers was 9.6% and 10.5% for firms with 3 to 9 employees.

In addition to somewhat higher costs and rates of increase, the value of the insurance may be less for small firms. Several studies including one by the U.S. General Accounting Office (now called the Government Accountability Office) report that coverage purchased by smaller firms frequently requires more cost-sharing from employees or may exclude certain benefits. The reasons are several but an important one is related to the lack of a benefits specialist in most small firms. Instead of having in-house benefits

personnel or outside hired benefits expertise, most small firms use insurance brokers to provide similar functions but this increases the cost of the insurance purchased or at least changes how the firm pays for it. The administrative cost of insurance purchased through the assistance of a broker will have the broker's cost built into the premium whereas large firms may pay this cost as a labor cost or as part of outside consulting costs.

The risk profile for small employer groups is also more variable because the average costs of a small group is less predictable than the costs of a large group. In addition to variability, insurers worry about adverse selection in which plans may find themselves getting a disproportionate number of predictably sick patients which causes the plan costs to increase relative to other plans.

Insurers typically engage in a variety of strategies to avoid adverse selection including requiring a certain percentage of eligible employees to participate before they will insure a group. Some plans may also require medical underwriting which means reviewing the claims history and health status of potential enrollees. However some states and certain Federal laws limit a plan's ability to vary the amount different groups can be charged and also to limit the ability of a plan to deny coverage to various groups. Some insurers (and some self funded plans) attempt to protect themselves against the possibility of very high cost plans through reinsurance.

Reinsurance is a term that can be used in at least two different ways. One is as a reference to stop-loss policies that are typically written for small firms that wish to self

insure. These firms understand that large claims could be financially devastating to the firm and "reinsure" to protect themselves against large claims, either at a per person level or in the aggregate. A second type of reinsurance is when small niche companies, such as some of the ones that offer insurance in the small firm market, buy "back-end insurance", also as a means of protecting themselves against very large claims. This type of reinsurer therefore typically works behind the primary insurer.

The reinsurance market appears to function reasonably well although it is somewhat cyclical, subject to peaks and troughs in capacity, with availability diminishing when in periods of trough. Some stop-loss companies have reputedly pulled out of certain states because of state requirements that they regard as too stringent but it is not obvious that there is a supply problem. There has been some consolidation here as elsewhere in the insurance market.

Health Insurance Regulation

States have the primary responsibility to regulate insurance and many have introduced legislation to influence the provision of insurance. Some states require plans to guarantee both the issuance and the renewability of insurance plans. Most states require that coverage include certain benefits. Many states regulate premiums in some way. The purpose is to increase access to insurance in general, to make it more affordable and to insure coverage of certain benefits. Despite what are good intentions, there is some indication these same regulations can serve to increase the cost of insurance and/or limit

the number of insurers who are interested in providing insurance in their state and thus have serious unintended consequences.

Two different Federal laws have had the most important impact on insurance regulation. ERISA (Employee Retirement Income Security Act) enacted in 1974 provides oversight of employee benefit programs. In health care, however, it's most important provision is the "preemption provision" which exempts self-funded (aka self-insured) employer plans from state regulations. HIPAA (Health Insurance Portability and Accountability Act) provides rules regarding portability, pre-existing condition exclusions, nondiscrimination, guaranteed issue and renewability.

Small-Group Market Reforms

Many of the states have passed legislation to increase the availability and affordability of insurance to firms with fewer than 50 employees. Some of the legislation was passed before HIPAA but HIPAA allows states to enforce their own reforms as long as the states' requirements exceed those of HIPAA.

Guaranteed issue, guaranteed renewability, nondiscrimination, limits on preexisting conditions exclusions and portability requirements increase the potential availability of health insurance coverage in the small group market but do not address issues of cost. These provisions may also affect the number of insurance companies that decide to do

business in a state since the other alternative for an insurance company is not to offer coverage in a state that has too many onerous requirements.

A recent survey by the GAO, however, suggests that there are many licensed insurance carriers providing insurance to the small group market in most states although the markets appear to be quite concentrated. According to a 2005 report, the median number of carriers was 28, ranging from a low of 3 in Rhode Island to a high of 75 in Georgia. The market share of the largest carrier is very significant—about 43%, with a range from 19% in Texas to 93% in North Dakota. In most of the markets, this largest carrier was a Blue Cross and Blue Shield carrier. The markets have also been increasing in concentration, with the share of the largest carrier increasing by 10 percentage points from the survey done in three years earlier.

Most states have some form of rate regulation that determines how much premiums can vary from group to group. Many states have adopted regulations relating to premiums increases and adjustments that are based on a model issued by the National association of Insurance Commissioners.

The net result of all of these efforts towards small group market reform has not been encouraging. According to a study that was done by researchers at the Agency for Health Research and Quality (AHRQ) using data from the 1987 National Medical Expenditure Survey (NMES) and 1996-97 Medical Expenditure Panel Survey (MEPS), these reforms have had little impact on either offer rates or enrollment rates.

Some states have been concerned about the potential affects of state-mandated benefits on the cost and therefore, the availability of insurance in the small firm market and have exempted small firms from the state-mandated benefit laws in their state. Large firms can avoid state-mandates by being self-insured, which almost all of them are in any case. The true costs of mandates are difficult to assess but to the extent that they reduce the number of small firms offering insurance coverage, which they undoubtedly do, the unintended consequence of this form of consume protection is quite serious.

Group purchasing cooperatives reflect a different type of strategy that allows small firms to join together to gain some of the advantages of larger firms. Many states have passed laws that allow some kind of purchasing cooperative for the purpose of purchasing insurance in order for small firms to be in a better position to negotiate lower premiums and expanded coverage options. Unfortunately these state-regulated cooperatives have also had little impact on the small-group market. They have been able to expand the options available to small employers but they haven't been able to lower costs. The primary reason is that they have not been able to achieve significant, sustainable enrollment numbers which is necessary if their presence is to be felt.

Multiple Employers Welfare Arrangements or (MEWA's) are another strategy that allows groups of employers to collectively provide insurance benefits. The have had an unfortunately checkered past and have been associated with instances of both fraud and insolvency. They are under different and tighter supervision by the DOL as a result of

HIPAA and now include more than 3 million participants. It is too early to know whether tighter regulation had made MEWA's a more viable and attraction option for small employers.

The Federal government has proposed several strategies to allow for small employers to improve their purchasing power. Two proposals at the Federal level include association health plans (AHPs) and HealthMarts. AHPs would allow small firms to band together across state lines to purchase insurance which could also increase their numbers and thus power and also provide some protection against state regulation. HealthMarts are clearinghouses where employers and employees within a geographic area can go to buy health insurance. Concern has been raised about AHP's that they would allow groups of small employers to be shielded from small-group reform laws and also rating rules but of course, no more so than self-insured companies. Whether the AHP's would really enable the groups of small employers to negotiate lower rates is another matter.

Conclusion

Employer-related insurance continues to be the main source of insurance coverage for the under-65 population although its availability has been eroding over time. Offer rates and enrollments as well as premium increases have been more problematic for the smallest firms, those between 3 and 9 employees but in some areas, also for firms with fewer than 50 employees.

Insurance is primarily regulated at the state levels with many different requirements regarding premium rates, allowed variations in premium rates and their rates of increase, mandated benefits and so forth. Two important pieces of Federal legislation also effect employer-sponsored insurance: ERISA and HIPAA. The major effect of HIPAA has been to allow larger employers to self-insure and thus operate outside many of the state requirements.

Various attempts have been made to help small employers gain some of the advantages of larger firms. These have included allowing them to band together for the purchase of insurance coverage or exempting them from state mandated benefits. Thus far, these strategies have been more successful at expanding the types of options offered than they have been at lowering the cost of the insurance. Insurance to small employers is inherently more expensive because many of the functions provided by insurance brokers to small firms are provided by benefits managers or outside consultants in large firms and also more variable because of the smaller numbers of lives covered. These problems are particularly acute for the smallest firms, those with fewer than 9 employees.

Strategies that allow small employers to effectively band together to gain market share should work if the can be made more stable. Experimentation with these types of strategies needs to continue until we figure out what works. Strategies that encourage states to adopt more uniform provisions regarding rates, benefits, offerings, etc, would also make it more likely national companies would find it more attractive to offer policies to smaller firms and would help.

Ultimately, however, the most important way to lower the cost of health insurance is to slow down, if not lower, the cost of health care. It is critical that the United States devote more serious attention to this issue--for the sake of small firms, large firms, the Federal budget and the country as a whole.

TESTIMONY BEFORE THE UNITED STATES CONGRESS
ON BEHALF OF THE

NATIONAL FEDERATION OF INDEPENDENT BUSINESS

NFIB
The Voice of Small Business®

Testimony of Todd Stottlemyer
National Federation of Independent Business

before the

House Committee on Small Business

on the date of March 14, 2007

on the subject of

Challenges and Solutions to Health Insurance Coverage for Small Businesses

On behalf of NFIB, I want to thank Chairwoman Velazquez for inviting me to discuss the unique challenges facing small businesses ability to access affordable health insurance. As the voice of the leading small business association, nationally and in all fifty states, NFIB is uniquely positioned to talk about this issue.

I would like to focus on three areas. First, identifying the barriers to small business health insurance. Second, offering a multi-pronged approach to increasing access and affordability. And third, explaining why NFIB believes it is critical to take action now.

Defining the problem

The ever increasing cost and lack of availability of health care might be a new topic to many – but not to the 27 million working uninsured in the small business sector. Nor is it a new problem for America's small businesses – all of whom struggle to afford health insurance. NFIB members represent both of these communities.

For two decades the cost of health insurance has been the top concern of our members. In 2004, two-thirds of those asked said health-care costs were the most critical problem they faced.

The small business community pays, on average, 18 percent more in health insurance premiums for the same benefits as those in

the largest firms, according to a Commonwealth Fund-supported study published in 2006.

Why? The answer is four-fold: a lack of competition, a lack of bargaining power, a lack of administrative efficiencies and expensive mandates.

There is inadequate competition among insurance carriers in the small-group market. A recent GAO report found that in 2004, in a typical state, the largest insurer had 43 percent of the market for small group coverage, up from 33 percent in 2002. In nine states, the largest carrier — a Blue Cross and Blue Shield company — had more than 50 percent. In fact, in North Dakota a Blue Cross Blue Shield carrier had over 90 percent of the market. With few options in the small-group market, the smallest employers and employees are held captive to premium increases because there really is nowhere else for them to go.

The next problem is lack of bargaining power. Due to their size, small businesses are unable to spread risk across a larger population (as large businesses and unions are able to do) and end up with far less bargaining clout. The result of few options and even less bargaining power is higher prices.

Third, increased costs are also linked to a lack of administrative efficiencies. According to a 2001 GAO report, about 20 to 25 percent of

a small employer's premiums are dedicated to administrative costs. Similar administrative costs for a large employer average about 10 percent. These costs include things such as marketing and billing functions – non-health functions. High administrative costs often make health insurance prohibitive for the smallest of our nation's businesses.

Finally, an abundance of mandates further drive up the cost of health insurance. Today, there are more than 1,800 state health insurance mandates on the books, an increase of about 600 since the early 1990s. More mandates mean higher costs. While a single mandate may increase prices by less than 1%, once all the mandates in a state are totaled - about 40 for most states - they can quickly escalate the cost of coverage. The result? There will be an increase in the number of people who decide the price tag is just too high and forgo insurance altogether – an outcome that is the opposite of what we are all working to achieve.

<u>A Roadmap to Better Health</u>

NFIB supports a comprehensive approach to helping small businesses find affordable and quality health insurance. Our approach has three specific steps: pooling, tax-based incentives and cost containment measures.

First, Congress should take steps to develop health insurance purchasing pools for small businesses. Increasing the size of the pool increases the clout and bargaining power among small businesses. This helps decrease cost and increase coverage.

In previous Congresses NFIB has aggressively urged the enactment of legislation to permit Small-Business Health Plans. Although action in the Senate was stymied in the last Congress, NFIB and the small-business community remain focused on achieving a pooling-based solution. NFIB will continue to explore all pooling proposals that are designed to significantly increase the purchase of private health insurance for small business employers, employees and their dependents.

Beyond pooling, NFIB will look to tax-based incentives that will encourage fairness and equality for all purchasing health insurance.

Today, we have a tax system that allows employers to enjoy a full deduction for the cost of health care they purchase for their employees. Employees with employer-provided health care enjoy the same tax benefit because they can exclude the full cost of their health care from their taxable income. Unfortunately, for those who cannot receive their health care in the employer-based market, their tax benefit is greatly limited.

Rather than continue to rely on a tax system that primarily benefits those who obtain their health care in the employer-based system, we need a tax system that offers the same incentives to everyone purchasing health care.

Today, the fastest growing segment of small business is the Single Owner Home Office (SOHO) business. Not only are they the fastest growing part of the economy, but the most diverse as well. For the past two decades women-owned firms have continued to grow, and 81 percent of women-owned firms have no employees. It is clear that our tax system needs to reflect these changing demographics in order to benefit everyone in the workforce.

NFIB is considering several different tax proposals that provide incentives for small businesses to provide health care. We are looking at various combinations of tax credits and deductions, all with the same goal in mind: allowing Americans to gain greater access to affordable health insurance.

Finally, a sustainable solution must include cost containment measures designed to encourage a greater degree of personal responsibility.

As a former small-business owner, I always made a point of making sure my employees understood the financial value of their benefits. I wanted them to know that we valued them as individuals,

and believed strongly that investing in their health care was an investment in the future success of the company. I also believed in educating them about how their prevention, wellness and lifestyle choices influenced all of our health care costs. This practice encouraged them to become personally vested in the decisions they made about their health care.

We must broaden that knowledge to the larger population. To that end, it is important that steps be taken to increase the availability of information associated with cost and quality of health care so we can all become better customers and consumers.

Encouraging individuals to be more informed health care consumers can be achieved by implementing a more transparent health care system that makes information on cost and quality more readily available. We can flip open the latest issue of C*onsumer Reports* to find information on performance, reliability and affordability for automobiles, but not for health services and providers. To use health-care dollars wisely, one needs to have access to information about the quality of doctors and hospitals and the cost of a procedure. Similarly, steps can also be taken to improve health information technology (IT) so we can put tools in place that allow us to more efficiently manage medical information. Both transparency and health IT can increase

efficiency and improve the long-term affordability of our health care system.

Finally, no discussion about cost containment is complete without focusing on mandates. If we have any hope of addressing costs, then we must draw a line in the sand and understand there is a real difference between what we want and what we need. All mandates are not created equal. In our minds there is a difference in the value of every woman having access to a mammogram, and everyone having access to hair transplants.

These cost-containment measures, implemented in tandem with pooling approaches and appropriate tax-based incentives can significantly improve the access and affordability of health care for the small-business community.

<u>Why Action is Necessary Now</u>

In just the first few months of 2007, many different ideas have been unveiled to address the complex issues impacting America's health care delivery system. Some have advocated for tax credits, others for more government involvement, and still others for scrapping the employer-based system altogether.

Many of these ideas have merit. But to be perfectly blunt, the largest portion of the nation's uninsured population – small business – can't wait any longer. They need solutions now.

NFIB believes we must take action now to reach the goal of universal health care by increasing access to affordable health care. This does not mean that the government takes over. But it does mean taking necessary steps to transform the marketplace by injecting choice, competition and value for those services. Those actions will result in a climate that enables more people to purchase private, quality, affordable health insurance that is portable for all phases of your career.

A universal approach to addressing the health care cost crisis is not easy to achieve. It will require people sitting down together and hammering out ideas that are bound to lead to robust and passionate debates. NFIB welcomes the challenge of working with lawmakers and others from the business and advocacy communities to craft meaningful solutions that ensure we address the crisis we are facing – now, not later. Because the longer we wait, the harder the task and the more the uninsured population increases.

Thank you again for holding this hearing today. NFIB appreciates your support for small business and we share your commitment to taking timely and significant action to address the health care cost crisis that is plaguing America's small businesses. Working with you and others, NFIB pledges to do all that it can to increase access to affordable health insurance.

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House Committee on Small Business

"Challenges and Solutions to Health Insurance Coverage for Small Businesses"

March 14, 2007

Statement by Mike J. Cavanaugh of Queen City Electric

Chairwoman Velázquez, Ranking Member Chabot, and Members of the Committee, thank you giving me the opportunity to testify before you today. My name is Mike Cavanaugh, and I am the owner and operator of Queen City Electric in Cincinnati, Ohio.

Like any small business owner, I started my company for many reasons. The most compelling thing for me was the prospect of doing things my way. In relatively short time after going out on my own, I started to hire other employees to aid in our growing business.

From the beginning, I believed that to have a successful business one must treat its employees well. This includes not only a good work environment but also a full range of benefits, including health insurance. This is very expensive, but I feel necessary. How could a small business expect to attract and retain the quality people that it needs to grow if it cannot offer health insurance? Small businesses are at a significant disadvantage because we cannot easily band together to form large pools of insured individuals similar to large companies. As a result, we lack bargaining power. **The expense of providing medical coverage is one of the single most important items most small businesses face.**

Each year in my company we face the tremendous task of shopping for health insurance. We do this because carriers will not provide fixed rates for longer than one year. As a result, each November, in search of the best overall value, we start working with a couple of local agencies hoping to avoid the annual fifteen to twenty percent increase in rates. We cannot start any earlier than sixty days prior to expiration of our current plan, as carriers will not hold rates for longer than sixty days. Because each insurance carrier has its own form, we ask each employee to fill out three to five different applications so that we can get quotes from as many different companies as possible. This process is time consuming. Each year we spend hours on the phone asking employees to please get the paperwork turned in to our office. **This annual process causes a significant waste of time and resources for our business.**

Once we complete the task of filling out and submitting all the applications, we wait for the companies to respond with their quotes. For some of the companies the quotes provided are not guaranteed rates, only preliminary rates because they require additional forms to be filled out by each insured person upon the selection of them as our carrier. So when we evaluate rates from these companies we keep in mind that the rates are not necessarily what they may end up being when all is said and done. Of course the rates cannot be evaluated until a full comparison of all the plans can be done. I am fortunate to have an office manager in my company who has experience in both human resources and the field of medical administration. Not all small businesses are as lucky and many do

not have the luxury of this person working for them. **Small businesses often lack the resources to make informed, educated decisions when selecting health insurance.**

After the process of applications, evaluations and decisions about the various medical plans, we select one. Much time is spent educating employees on the new plan, discussing coverage, and helping the employees by calling the various providers. **Small businesses spend time that they don't have sorting out difficulties created by a myriad of rules and coverage issues all in an effort to provide the best coverage options at the lowest cost.**

These issues are very real and time-consuming issues for most small businesses. Nonetheless, we continue to grow and create new jobs year after year. The main thing that would surely aid in the efficiency of the entire process would be more market competition. If more options were available to the average small business, insurance companies would be more competitive in rates as well as service.

Please don't mistake these observations outlined above as an appeal for more government intervention in the way business operates. Rather consider it an appeal to allow more open competition in the marketplace. I believe that market forces, in time, can bring efficiency to markets, where government regulations, though well intended, have the opposite effect.

Thank you for the opportunity to testify.

Statement of
Women Impacting Public Policy

Submitted to
House Committee on Small Business

"Challenges and Solutions to Health Insurance Coverage for Small Business"

March 14, 2007

Women Impacting Public Policy (WIPP) is pleased to submit testimony on the challenges and solutions to health insurance coverage for small businesses. WIPP is a bipartisan public policy organization representing well over a half million women and minorities in business nationwide, including 47 organizations as well as individual members.

The hearing, "Challenges and Solutions to Health Insurance Coverage for Small Business," touches on our members' number one issue – affordable and accessible healthcare. First, WIPP would like to thank the Chair and Ranking Member for their support of Association Health Plan (AHP) legislation in previous Congresses. Second, we appreciate your holding this hearing to find a solution to the rising cost of health care for small businesses. Action on this vital issue is essential to the continued economic growth of small business.

We all know the statistics, but the fact remains that of the 46.6 million uninsured Americans, 60 percent are employed by a small business or a dependent of someone who is employed by a small business. This nation cannot and should not sustain such a staggering number of Americans without health insurance. Without preventive care and quality healthcare, which insurance provides, our nation's healthcare bill will continue to rise at record levels.

Every year, WIPP conducts an annual Issues Survey to its members. WIPP members are asked to rank policy issues and give input on policy issues. We formulate our policy based on the response from our members. We are still in the stage of getting preliminary results, but we see a significant shift among our members on the healthcare

issue. In past polls, our members have identified national trends before the rest of us do, so I would like to share with the Committee preliminary results of WIPP's 2007 survey.

There are really two significant policy shifts we found on the healthcare questions in this survey. One, our members have shifted their thinking with respect to employer sponsored healthcare. When we asked the question: "Do you believe that businesses (either large or small) should be the main provider of healthcare coverage for their employees?" a majority said "no." Our members do not believe health insurance should be the sole responsibility of employers—they believe the conversation around healthcare needs to shift to individuals. When asked the question, "a proposal pending in Congress would allow uninsured individuals to shop for health insurance across state lines. Do you believe this proposal would result in providing more individuals with health coverage?" 64 percent said "yes." This, we believe, is affirmation that changes have to occur to make the individual market strong enough to sustain the shift to individual coverage.

The second policy shift reflected in our survey was a willingness by WIPP members to consider a number of different healthcare proposals being discussed in the Congress. When a question described the proposal by Senators Lincoln and Durbin, clearly stating that small businesses could opt-in to the pool and the insurance would be provided by private insurers, preliminary results overwhelming supported that proposal (84 percent).

When our members were asked whether states should require everyone to carry health insurance, either by their employer or by themselves, with state programs to assist those who fall below a set income level, 42 percent said "yes" and 39 percent said "no."

Small businesses who have operations in multiple states (even if it is one employee) will find navigating multiple state requirements difficult.

This policy shift, from employer to individual, introduces a different way of viewing health insurance and how to obtain it. President Bush, in his State of the Union speech, proposed a shift from employer sponsored healthcare to individual healthcare by proposing that a tax deduction be made available to individuals as well as employers. We note that states like California and Massachusetts, who are grappling with how to insure their residents, are proposing the responsibility of obtaining insurance lie with the individual.

Having said that, the individual market, as it exists today, is not strong enough to sustain a wholesale shift. According to the Kaiser Family Foundation, in 2005, only 5 percent or 14 million Americans are insured through the individual market. A 2005 survey conducted by the Commonwealth Fund, examined the experience of adults ages 19 to 64 in the individual insurance market compared with adults with employer-based coverage. Compared with adults with employer coverage, adults with individual market insurance give their health plans lower ratings, pay more out-of pocket for premiums, face higher deductibles, and spend a greater percentage of income on premiums and health care expenses

The only solution for small businesses and their employees, as we see it, is to strengthen these two markets. One is achieved by encouraging individuals to purchase insurance—thus increasing the size and strength of the pool. The second is to strengthen the small business market by increasing the bargaining power of a small business. That involves establishing large pools that can negotiate better prices with the insurers and the

reason behind WIPP's support of the creation of Small Business Health Plan (also referred to as Association Health Plans) for many years. Another proposal, providing additional tax incentives to employers to offset the exorbitant price of premiums, would also be helpful to small businesses.

The healthcare solution has many tentacles such as using technology to centralize medical records, limiting medical malpractice and instituting healthy employee programs to reduce medical claims. WIPP members are open to discussion of a variety of Congressional proposals. While we do not believe universal healthcare- run by the government as opposed to the private sector – is a good solution, we are open to ideas on how best to increase the buying power of individuals and small businesses for their healthcare.

We are not as presumptuous as to suggest that we have the solution. But we live with the problem every day. We believe that it is a reasonable request from the over half million women-owned businesses we represent, that Congress take action to ensure that small businesses can offer healthcare to their employees at reasonable rates or make it possible for employees to obtain individual insurance at rates they can afford.

When large employers and small employers are saying the system is broken, when 46.6 million Americans are without health insurance, it is time for the federal government to adopt changes which can make the small business and the individual market work.

AARP STATEMENT FOR THE RECORD

ON THE

HEALTH INSURANCE FOR SMALL BUSINESSES

SUBMITTED TO THE

HOUSE COMMITTEE ON SMALL BUSINESS

March 14, 2007

Washington, D.C.

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On behalf of AARP's 38 million members we thank you for holding this hearing on health insurance for small business. With 47 million Americans uninsured and 17 million of them working for small businesses,[1] it is appropriate to explore why small business is significantly less likely to offer health insurance than large employers. A 2006 study by the Kaiser Family Foundation/HRET cites the cost of health insurance as the main reason that small employers do not offer health benefits to workers. As shown in the following table, slightly above average increases in health care costs – about 10% – could cause 7% of small employers to drop coverage. This is daunting given that the Kaiser Family Foundation/HRET finds health care premiums rose 8.8% on average in 2006 for small employers.

Potential Small Employer Reaction to Increase in Health Insurance Costs				
If Cost Increased:	Continue to Offer Current Coverage	Change Coverage	Drop Coverage	Don't Know
5 percent	70%	23%	3%	4%
10 percent	46	42	7	4
15 percent	25	54	15	5
25 percent	12	59	22	6
Source: EBRI/CHEC/BCBSA 2002 Small Employer Health Benefits Survey				

AARP members include both small business owners and employees of small business. Both care about the ability of small businesses to cover the health insurance needs of their workers. There is a real need for policies that enable small businesses to offer coverage even with rising health care costs. AARP wants to work with Members of Congress to find viable solutions. But we must also avoid approaches that create greater problems or end up lessening access to care.

[1] Paul Fronstin, Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2006 Current Population Survey (EBRI October 2006), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_10a-20061.pdf from Figure 11 where a small employer is defined as the self employed plus employers with 0 to 99 employees.

Tax credits

Tax credits or other subsidies for small businesses to provide their employees with health insurance is one approach. Under these proposals, a small employer would receive a subsidy for low-income workers if the employer paid a portion of the premium cost for the employee. One example of a state that is successfully using subsidies is the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC).[2] Under the O-EPIC program, Oklahoma subsidizes up to 60% of the premium cost for employees below 185% FPL who work at small businesses. The state contribution amount is funded through a state cigarette tax and a Medicaid match is provided by the federal government.

Association Health Plans (AHPs)

Starting small business risk pools within a state is also a potential way to help small businesses purchase affordable health insurance. These cooperatives exist already in a number of jurisdictions such as New York City, New Mexico and Ohio,[3] and are regulated by the state Departments of Insurance. They allow small employers to group together as they would in a multi-state AHP and buy health insurance, usually from a variety of carriers.

Some view association health plans (AHPs) as a pooling solution to the health care costs of small business. By pooling together the purchasing power of multiple small employers, some believe that the AHP group can use bargaining power to obtain better benefits at a lower price. In some instances, AHPs could also be exempt from state requirements designed to protect consumers. AARP views AHPs as potentially harmful, especially to older and less healthy

[2] See the O-EPIC website at http://www.oepic.ok.gov/. See also the State Coverage Initiatives website at http://statecoverage.net/oklahomaprofile.htm.
[3] See http://www.healthpass.com/ for New York City, http://www.nmhia.com/ for New Mexico and http://www.cose.org/products/benefits/healthinsurance.asp?level1Seq=30&level2Seq=2#a for Ohio.

employees, as employers will have a financial incentive to discriminate against them.

Federal insured AHPs preempt state insurance laws, including laws on rating and underwriting. Without these laws in many states, insurers can use demographic characteristics (e.g., age or gender) and health status to set rates for the AHP. When a new small business wishes to join the AHP, the insurer looks at the average age and health status of the employer group to set its rate. If the average age of the group is significantly increased by having an older worker or two, the price charged to the employer to enter the AHP is set much higher than it otherwise would be (than if the state rating laws applied). So, by hiring younger workers, small employers can keep their average age lower and thus their cost of insurance under the AHP lower. If a small employer has the choice of hiring a younger worker versus an older worker, an AHP gives the small employer an incentive to hire the younger worker in order to keep health premiums low.

Self-insured AHPs pose even more problems than insured AHPs. In addition to the rating issue and potential for age discrimination, State Departments of Insurance would have no oversight of self-insured AHPs. The US Department of Labor (DOL) would be left to enforce valuable consumer protections such as grievance and appeals procedures and oversight of marketing practices. DOL does not have the resources or the technical expertise to perform these enforcement functions. Also, DOL would be left to ensure the financial solvency of self-insured AHPs – a function DOL has never performed.

Health Savings Accounts

Many see health savings accounts (HSAs) combined with high deductible health plans (HDHPs) as a solution to the small business health care crisis. An AHIP industry study found that 510,000 people in small groups were covered in such plans in January 2006. This was 16% of total lives in such plans and up from

147,000 the year before. HSA/HDHPs may be more attractive to small businesses. For instance, an EBRI study found people in HDHPs were more likely than those in more comprehensive plans to be sole proprietors or to be employed in small businesses.[4]

HSA/HDHPs are not the magic solution to the problems of small business owners' health care costs. AARP does not view HSA/HDHPs as a promising market approach to providing adequate, affordable coverage to a significant proportion of consumers who now lack access to health insurance. Reasons for this potentially include:

- Low-income people may find themselves underinsured for routine expenses that cost less than the high deductible and forgo services;
- Individuals forgo preventive care and potentially cost the health care system more later with acute illness that could have been prevented; and
- Risk segmentation in insurance markets could cause a price split between HDHPs and more comprehensive products – making premiums for comprehensive products unaffordable.

As the HSA industry grows, AARP hopes that products will become more consumer friendly and truly drive cost-conscious behavior. For instance, HSA/HDHPs can be improved by adding real-time information that clearly delineates what services count toward the deductible. Exempting a broader array of preventive care from the deductible would help people with chronic conditions. Also providing comparative effectiveness information on treatments can help consumers select the most cost-effective services for their health care dollar.

[4] "The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey 2006: Early Experience with High-Deductible and Consumer-Driven Health Plans," Employee Benefits Research Institute (December 2006).

Health Marts

Others see purchasing individual policies across state lines – a sort of Health Mart – as a solution to the small business health cost crisis. Health Marts would permit employers to avoid state mandated benefits that often contribute to higher health insurance premiums. By buying an out of state policy, employers in states with mandates can obtain bare bone policies that cost less. Consumer protections provided in-state would be lost, while consumer protections from out-of-state would be more difficult to enforce.

For instance, if a resident of Massachusetts bought a Maine individual policy, the Maine Department of Insurance would be responsible for enforcing Maine's laws in Massachusetts. Conceivably Maine regulators could find themselves enforcing their laws in all 50 states. Not only does Maine not have the resources to enforce its laws so broadly, it's not clear that Maine would have the authority to enforce its laws in other states. This situation would leave small businesses – and their employees – in the lurch if something went wrong with their out of state policies.

Conclusion

AARP believes that all Americans should have affordable coverage for quality health care. Addressing the large number uninsured who are employed in small businesses is an important component in reaching this goal. No one solution exists to the small business health crisis. We recognize that the public, through government, has a role to play in ensuring that people have access to public or private coverage, and that the financial responsibility for health care is one shared by government, employers, and individuals. We believe that government should help subsidize the cost of coverage for those with low incomes, and should fully finance coverage for the poor. We look forward to working with you to solve the health care coverage problem for small businesses.

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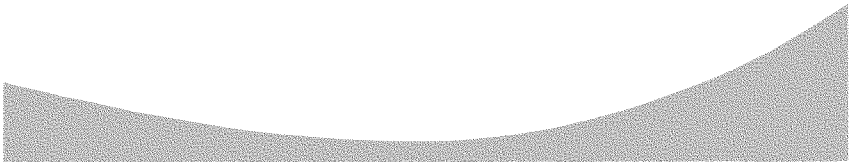
Written Testimony Submitted by

The National Association for the Self-Employed

House Committee on Small Business
"Challenges and Solutions to Health Insurance Coverage for Small Businesses"

March 14, 2007



Introduction

The number of Americans living without health coverage rose in 2005 to 46.6 million, an increase of almost 16 percent over the previous year. In a 2005 survey, the National Association for the Self-Employed (NASE) found that a majority of micro-business owners (51.1%) say they do not have nor offer a health insurance plan for themselves or their employees. The smallest companies are most impacted, with only 13.8% of companies that grossed less than $50,000 annually having health insurance compared to 70% among those grossing more than $500,000 yearly. Thus, the NASE which represents over 250,000 micro-businesses (ten or less employees) supports efforts to improve our health care system by making coverage more affordable and easier for individuals to both understand their options and manage their costs.

Access to Affordable Health Coverage

A key step forward to increase access to quality, affordable health coverage is to level the playing field for the self-employed by removing current inequities in the tax code that make the purchase of health coverage more costly. At present, the self-employed are not able to deduct the cost of their health insurance premiums for the purposes of self-employment tax (payroll taxes). While 100 percent deductibility of health insurance premiums has phased in, it does not solve this tax inequity. Sole proprietors are required to pay two types of taxes on their annual tax returns: income tax and self-employment tax. One hundred percent deductibility relates only to income tax and not self-employment tax. Thus, the self-employed still pay self-employment tax on their health insurance premiums.

All employees who receive compensation from employers pay FICA taxes. FICA comprises Social Security (6.2 percent) and Medicare (1.45 percent) taxes. Employers are required to withhold from gross compensation 7.65 percent for FICA. In addition to the FICA withheld from the employee, the employer is required to "match" the FICA withholding. Therefore, the employee and employer contribution for FICA is 15.3 percent of compensation (subject to applicable annual limits). The self-employed pay FICA at a rate equivalent to employees and employers, 15.3 percent. FICA tax for the self-employed is called "self-employment tax."

All other business entities such as C corporations receive a deduction for health insurance premiums as an ordinary and necessary business expense for all employees including owners. Employees and the owner pay for their health insurance premiums pre-tax therefore they are not subject to FICA taxes. However, sole-proprietors (Schedule C filers) do not receive this "business deduction" for health insurance premiums. The premiums are not paid with pre-tax dollars and are exposed to self-employment tax. Accordingly, the sole proprietor(s) pays this tax (15.3 percent on self-employment income up to $86,000) on his/her insurance premiums. Sole proprietors are the only business entity that does not receive a full deduction of health care costs.

The most recent Kaiser Family Foundation study indicated that the self-employed pay on average $11,480 for family health coverage. Because they cannot deduct these premiums as an ordinary business expense, they are required to pay $1,756.44 in additional taxes that no other business entity must pay. This is money that our members tell us they would use to reinvest into their business, hire part-time assistance, or utilize to offset the rising premium costs they face each year so they may hold on to their coverage a little longer. Equity must be the first step towards creating a fair and affordable health care system.

[For more information, please visit www.setaxequity.org]

The Working Uninsured

With the number of working uninsured rising every year, the NASE supports proposals for targeted health care tax credits to assist the self-employed and micro-businesses in purchasing health insurance. Tax credits would assist owners and individuals employed in businesses that do not have employer-sponsored health plans to access health insurance. Over 60% of our nation's uninsured working for small businesses or the dependents of workers in small business, health tax credits would facilitate a large portion of our uninsured gaining access to coverage.

An effective tax credit must be advanceable, which allows eligible individuals to receive their credit every month, rather than in a lump sum at the end of the year to let them buy coverage without incurring extensive costs during the year. The credit should also be refundable which allows individuals subject only to payroll taxes and do not pay income tax to be eligible to receive the credit as a refund from the Internal Revenue Service. This would permit lower income workers who do not owe income taxes to receive the full value of the tax credit. The credit could be used to purchase coverage through the individual or group market, to buy into state purchasing pools, or to join an insurance pool in the private sector or one established by a state for high risk patients.

Only health care tax credits would allow the self-employed to purchase insurance policies they own and control. The individual maintains choice of insurance carriers from which to purchase coverage, of doctors, and of services he/she wants covered. Tax credits do not impose a one-size-fits-all standard, but instead seek to enable and empower individuals to choose the policies and features that most appeal to them and for micro-business owners, work best for their business.

Health care tax credits are a more cost-effective method of insuring workers who are able to pay some (but not all) of the cost of their health insurance. While most tax credit proposals would provide a maximum individual subsidy of $1,000, the cost of insuring an individual through Medicaid is roughly twice that amount (Source: Kaiser Commission

on Medicaid and the Uninsured, January 2005). A targeted tax credit can provide quality coverage to low- and middle-income families and self-employed individuals at a more modest cost.

[For more information, please visit the Coalition for Affordable Health Coverage at www.cahc.net]

Transparency and Technology in the Health Sector

In order for individuals, families and business owners to make informed choices regarding their health coverage, they need accurate information on both price and quality of service providers. Micro-business owners are responsible for every aspect of their business. In all facets of their business, accurate and timely information is key to their decision making process and a crucial factor to their success is their ability to manage costs. However, under our current health care system, micro-business owners are unable to access the important information they need to make the best decisions, leaving many confused, frustrated, and hindered in their ability to select the best health coverage choices for their business, their employees and their family.

The first step should be assisting micro-businesses owners in learning the basics of health coverage options available to them. The majority of self-employed individuals are not human resource specialists nor do they have an HR department to rely upon. They are navigating the health system with little to no experience in selecting a benefits plan. Congress must utilize federal programs such as Small Business Development Centers and Women Business Centers and encourage trade and professional associations to educate small business on health coverage. Encouraging transparency of price and quality information on services from providers, hospitals, insurance carriers, etc. would give micro-business owners and their employees the information they need to make smart health choices.

In addition, to alleviate some of the overhead costs faced by doctors that is many times is passed on to patients in the form of higher fees, the NASE feels that Congress should facilitate and expedite the use of technology in medical offices. We live today in an electronic era, yet the majority of medical providers still use paper medical records. Implementation of electronic medical records would alleviate burdens such as high costs, medical errors, and administrative inefficiencies to our health care system. We are aware that the Department of Health and Human Resources through the Agency for Healthcare Research and Quality is working on implementing a national health information technology program to improve our current health care system. However, we feel more needs to be done to assist doctors in this transition.

Increased Funding for High Risk Pools and SCHIP programs

The NASE supports the expansion and increased funding of state high risk pools to assist in providing coverage for those with pre-existing conditions and chronic illnesses that often are unable to attain insurance in the marketplace. Established over 25 years ago, high-risk pools operate in 33 states and covered more than 181,000 people as of June 2004. High risk pools fulfill a valuable role in our health system by moderating the insurance market and keeping costs down for all individuals. Yet, high risk pools still allow those with extensive health needs to gain access to coverage. These pools should be supported and encouraged by Congress.

Additionally, the NASE supports the reauthorization of the State Children's Health Insurance Program (SCHIP) which assists children from low-income families to gain access to health coverage. We believe it is essential for all children under the age of 18 to have access to health care. As part of the reauthorization efforts, we would like a simpler process for states to voluntarily use SCHIP dollars to subsidize such employer-sponsored coverage. Many parents of SCHIP-eligible children have access to employer-sponsored health insurance coverage but cannot afford their portion of the dependent premiums. It is important to encourage these parents enroll their children in SCHIP, and

use these dollars to pay for their portion of their employer-sponsored insurance to increase the number of families covered together under private-market plans.

Conclusion

The National Association for the Self-Employed strongly supports continued efforts to find proactive solutions to address the root causes of skyrocketing health costs while also increasing understanding and active participation in our health care system. The self-employed and micro-business community continues to be the backbone of our nation's economy and immediate action must be taken to alleviate the massive health cost burden laid at their feet in order to ensure their survival.

Removing Barriers to Small Employer Health Care
Hearing of the
House Committee on Small Business and Entrepreneurship
Wednesday, March 14, 2007
Written Testimony
Submitted By
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We offer our thanks to Chairwoman Velázquez, Ranking Member Chabot and all of the committee members for the opportunity to offer written testimony regarding the availability and affordability of health insurance for small business owners. Professional Photographers of America is joined in submitting these comments by the other organizations comprising the Alliance of Visual Artists: Society of Sport and Event Photographers, Commercial Photographers International and the Student Photographic Society. Together with our affiliates, we represent some 30,000 photographers and their families. PPA is the oldest and largest trade association for professional photographers; our members are engaged in all facets of photography and imaging.

Photographers are among the smallest of small businesses. While there are some exceptions, the vast majority of professional photography studios are quite literally "mom and pop" operations. According to a survey of our members conducted in March 2005, the average photography studio has 2.04 full-time and 1.1 part-time employees a number that includes the owner of the business. Only one of the 555 studios surveyed had more than 50 full-time employees; 98% of photographers surveyed had less than 10 fulltime employees.

It is no secret that the health insurance market for small businesses is in critical condition. The current system simply does not work. Small businesses are restricted from banding together across state lines to develop health insurance programs; despite the fact that larger corporations and many labor unions already have that capability. In many states there are few competing plans and small businesses are, by their nature, often restricted from spreading the cost and the risk of medical plans over a large pool.

Small businesses, with few employees and little market leverage or expertise in insurance matters are at the mercy of insurance companies in negotiating policies and rates In businesses, such as professional photography, with heavy competition and narrow profit margins the cost of insurance often becomes a luxury that must be sacrificed

Research indicates that only 34% of professional photographers have coverage through their business, 9% are uninsured and 6% are insured through a government program (Medicaid, Medicare, etc.) Fifteen percent of professional photographers rely on a second job in order to obtain health insurance. The remainder obtain health insurance through a spouse's employer (33%) or through their photography employer (2%) Of those with coverage through their own business, 45% saw double digit premium increases this year – with a significant number (12%) seeing increases over 20%.

Our members are entrepreneurs and are not interested in a handout. Instead, we are simply asking for the opportunity to be consumers in a competitive health insurance marketplace that offers the same multi-state economies of scale that are available to large employers and some unions under existing federal law. While no legislative proposal in this area will ever satisfy all of the interested parties, the fact remains that something must be done to address this issue. Otherwise, there will come a day when it is impossible for small business owners to provide health insurance for their employees; and we believe that day is drawing near.

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