MAKING HEALTH CARE REFORM WORK FOR SMALL BUSINESS

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MAKING HEALTH CARE REFORM WORK FOR SMALL BUSINESS

Thursday, September 18, 2008

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

The Committee met, pursuant to call, at 10:37 a.m., inRoom 1539, Longworth House Office Building, Hon. Nydia M. Velázquez [Chair of the Committee] Presiding.

Present: Representatives Velázquez, Gonzalez, Cuellar, Ellsworth, Chabot, and Fortenberry.

Chairwoman VELÁZQUEZ. Good morning, I call this hearing of the House Small Business Committee to order. Last month, the Census Bureau came out with what appeared to be good news for our Nation's uninsured. In the year between 2006 and 2007, the number of people without health care decreased from 47 million to 45.7 million, but while that may have seemed to be an encouraging drop, the reality is that is simply not a growing crisis. In fact, the decline was the result of expanded government programs like Medicare and Medicaid, not increase access to affordable private insurance.

Despite a modest update in coverage, our country's health care concerns are deepening. Within the entrepreneurial community alone, 20 million men and women are uninsured. Since the year 2000, small business premiums have jumped more than 80 percent. As a result, millions of entrepreneurs and their employees have been forced out of the market. Clearly health care remains a serious problem for the small business community. Already this committee has held more than a dozen hearings on the issue.

In July, in helping to introduce bipartisan legislation called the CHOICE Act, which included a number of provisions designed to make health care affordable for small firms. In this morning's hearing, we will continue to explore the various coverage challenges facing entrepreneurs and discuss options for reforming the current system. By definition small firms have fewer employees and less capital than their corporate counterparts. Accordingly, they have less clout and bargaining power with big insurance companies. As a result providers are not as compelled to offer competitive small business rates, leaving entrepreneurs with fewer options.

In addition to a lack of choices, small businesses are forced to foot the bill for insurance companies hide administrative costs. Because of the unique nature, small business coverage tends to be more specialized, providers pour a great deal of money and manhours into micro targeting entrepreneurs. These expenses are ultimately reflected in increased premiums. These steep administra-

tive costs, unlimited provider options have made health care a small business nightmare.

Universal coverage will be the best way to insure that every entrepreneur and small business employee is covered. That said, any overhaul of the current system will have to be carefully orchestrated. At present, there are a number of potential means for doing so, they include allowances for personal tax incentives, mixed private public insurance groups and public coverage. But in order for any of these approaches to be viable, they must take a number of key provisions into account. They must be capable of not only easing administrative burdens and creating more choices, but also of eliminating the current systems complexity.

Any move to repair our broken health care system will have to strike a delicate balance. It must be cautious without being wavering, it must be resolute without being reckless, and most importantly it must be universal without being one-size-fits-all. This is particularly true for our entrepreneurs whose businesses represent 50 percent of the workforce in a myriad of diverse industries. While small firms may be diverse in their unique interests they are united in their need for health care. A need which must be met not just for the sake of our 26 million small businesses, but for the sake of America's 45.7 million uninsured and the country as a whole.

[The statement of Chairwoman Velázquez is included in the appendix on page 26.]

I would like to take this opportunity to thank the distinguished members of the panel in advance for their testimony, and I yield to Ranking Member Chabot for his opening statement.

Mr. CHABOT. Thank you, Madam Chair, for yielding. And I want to thank you for holding this important hearing this morning and welcome the panel. I would like to thank each and every one of the witnesses who have taken the time to provide this committee or will shortly their testimony this morning. And I want to especially welcome a fellow Cincinnatian, Jim Eckstein, who I will introduce briefly later.

The cost of health insurance in general is rising faster than inflation, while the percentage of individuals without health insurance unfortunately continues to rise. Today, more than 47 million Americans are without health insurance. For small businesses and their employees soaring health costs are a critical issue. The cost of health insurance continued its 20-year reign as the number 1 issue worrying small business owners according to the FIB.

Roughly 63 percent of all uninsured workers are either self-employed or work for firms without more than 100 employees, in other words, fewer than 100. And that estimate is by the Employee Benefit Research Institute. According to the National Small Business Association, in 2007, only 47 percent of businesses with fewer than 500 employees offered health insurance. That was down from 58 percent about 10 years ago.

Our current system of health insurance and health care is financially unsustainable and threatens the health and finance security of small businesses and, most importantly, their employees. Large employers, unlike small businesses are able to spread risk more broadly among their workers and enjoy economies of scale that

keep administrative costs employer than is true in the small business community.

When a large employer self insures its health benefits are not subject to State insurance laws and regulations because it is not defined as insurance. This, along with the broad risk spreading and low per-person administrative cost confers a considerable cost advantage over similar benefit plans in a small group or individual markets for insurance.

Health care insurance reform should make the market for health insurance more competitive resulting is greater access to quality care. Health care policy reforms should balance the competing goals of access to quality, affordability, and predictability and consumer choice.

Madam Chair, I look forward to working with you on this important issue. And I want to commend you for your hard work and the attention that you focused on this very important issue over the last 2 years. As you have indicated we have had a number of hearings. I know that you appreciate, as I do, the importance of this to the small business community, so thank you for holding this important hearing, and I yield back the balance of my time.

[The statement of [The statement of Ranking Member Chabot is included in the appendix on page 28.]

Chairwoman VELÁZQUEZ. Thank you. Thank you, Ranking Member Chabot. I welcome our first witness, Ms. Linda J. Blumberg, she's a principal research associate of the Health Policy Center in the Urban Center. The Center analyzes trends and underlying causes of changes in health insurance coverage, access to care and the use of health care services. Prior to joining the Urban Institute, she served as a health policy advisor at the Office of Management and Budget.

Ms. Blumberg, you have 5 minutes. When you see the green light to start and the red one means that your time has expired.

STATEMENT OF LINDA BLUMBERG, PRINCIPAL RESEARCH ASSOCIATE, HEALTH POLICY CENTER;

Ms. BLUMBERG. Thank you.

Madam Chairwoman, Ranking Member Chabot and distinguished members of the committee: Thank you for inviting me to share my views on health insurance and strategies for health reform that affect small businesses and their workers. While I am an employee of the Urban Institute, this testimony reflects my views alone and does not necessarily reflect those of the Urban Institute, its trustees or its funders.

In brief, my main points are as follows. Small employers face substantial disadvantages relative to large employers when providing health insurance to their workers. These problems can largely be summarized as higher administrative costs of insurance, limited ability to spread health care risk, and a workforce with lower than average wages. All of these problems must be addressed if insurance coverage is to increase significantly among workers in small firms.

Fixed administrative costs make it inefficient for insurers to sell coverage to small employers. The per person price of buying insurance for a small group of individuals will always be higher than

buying those same benefits for a large group. Allowing small employers and individuals to purchase coverage through organized purchasing pools such as the type developed in Massachusetts with their connector, State or Federal employee health benefit plans, public programs, or other such group purchasing entities is an approach that could provide small employers and individuals with an avenue for more efficient purchasing. Such purchasing entities should also be structured to guarantee workers without employer offers access to a source of comprehensive insurance coverage and they constitute 70 percent of uninsured workers .

With regard to the second problem facing small employers, the limited ability to spread risk, small employers tend to have workforces with greater variance in year-to-year health care costs than large employers, a shear consequence of small numbers. Strategies are available to more broadly spread the risk associated with small group and individual purchasing. These include mandating that all individuals have insurance coverage, regulating premiums such that dollars are moved from healthier risk pools to sicker ones, or directly subsidizing health care costs of those with high medical needs. Such approaches could make coverage more affordable and accessible for workers in small firms. Strategies that would tend to further segment the risk of small firm workers, such as proposals to federally license association health plans, or to increase coverage in existing non group insurance markets. These segmenting strategies might lead to some savings for the healthy, but would do so at increased cost to the unhealthy, leading to no expected change in insurance coverage.

The third general problem, that small employers tend to have lower wage workforces than large employers, means expansions of insurance coverage will require significant income-related subsidies to make coverage affordable for many uninsured workers. Because employers largely finance insurance by paying lower wages to their workers, expecting low-income workers to voluntarily seek out that type of trade off is not practical.

Subsidies should be targeted according to workers' incomes in order to ensure that the bulk of government assistance goes to those in greatest financial need. Once one accepts that substantial subsidies will be required to expand coverage significantly, a host of design issues come into play. These include: defining what families at different income levels can afford to contribute to the cost of their medical care, including protecting the unhealthy from excessive out-of-pocket costs; mechanisms for making voluntary participation in insurance coverage as easy as possible; insuring that each individual has a guaranteed source for purchasing coverage; keeping the administrative costs associated with delivering subsidies as low as possible; and, critically, identifying sufficient sources of financing.

With regard to financing, policymakers have begun to consider the possibility of eliminating the current tax exemption for employer sponsored insurance and redirecting that subsidy to finance reforms. The level of this tax expenditure is sufficient, in my opinion, to finance comprehensive health care reform and is already dedicated to subsidizing health insurance.

The current exemption is not particularly effective in expanding coverage, however, since it subsidizes most those who are most likely to purchase coverage even in the absence of any subsidy. However, great caution should be taken before eliminating this subsidy outright, because any changes to the current tax treatment can be highly disruptive to the existing system of employer based health insurance. Eliminating this subsidy must be preceded with significant reforms to the private individual insurance market to insure that access to insurance coverage for those already insured not be adversely affected.

Thank you for your time, and I am happy to answer any questions you might have.

Chairwoman VELÁZQUEZ. Thank you, Dr. Blumberg.

[The statement of Ms. Blumberg is included in the appendix on page 29.]

Chairwoman VELÁZQUEZ. Our next witness is Dr. Len Nichols, Dr. Nichols is the director of the health policy program at the New American Foundation. This program aims to expand health insurance coverage to all Americans while reigning in costs and improving the efficiency of the health care system. Prior to joining New America, Dr. Nichols was the vice president of the Center For Studying Health System Change. Welcome.

STATEMENT OF LEN NICHOLS, DIRECTOR, HEALTH POLICY PROGRAM, THE NEW AMERICAN FOUNDATION

Mr. NICHOLS. Madam Chairwoman Velázquez, Ranking Member Chabot, distinguished members of the panel, I want to thank you for inviting me to testify here today. My name is Len Nichols and I direct the health policy program at the New American Foundation.

I would like to begin by congratulating, Madam Chairwoman, for your work on the CHOICE Act along with your cosponsors first and foremost because it is bipartisan. In my opinion, it is impossible for us to move our health care system forward unless we do it on a bipartisan basis. And I think probably you know better than most just how hard that is in this environment.

So I applaud you from the outset, keep up the good work. And I would say I will take this moment to also congratulate those who worked on the SHOP Act, another thing in the same direction, because that along with CHOICE adds to a growing course that we can indeed do better as a Nation in our health reform conversations than we managed to in 1993, 1994, when I got all this gray in my beard. Linda got tired of working the halls of OMB, we can do better and I thank you for that.

In a letter to testify you asked me to think about the question how can we structure a system to work better for small businesses. And I would say my primary answer is we can help small employers in the same way we can help all Americans, and there really are two big steps, some of which you have taken in your bill. The first is to create an insurance marketplace that is fair, efficient and fundamentally accessible. And the second is to reform the delivery system so that we can get more value for all our premium health

care dollars. If we don't do that, it doesn't matter what we do about financing.

Now the first step is to create a new market place that is accessible. This requires, as your bill does, that insurers be required to sell to all customers regardless of health status. There is no question that this is a problem in the individual market at the moment. And in the individual market, at the moment, of course, we have a lot OF entrepreneurs, we have self-employed people, sole proprietors and workers who work for firms who can't afford to offer right now. So I think it is important to think about extending that guarantee beyond the small group market to the individual market.

But just accessibility is not enough, in my view. We must also make it fair and affordable. So you have to have rules about what you are going to charge people where you don't distinguish people's rates by their health status.

Now I would quibble just a bit with the particulars of the CHOICE Act in the following way, it is designed, of course, to subsidize employers. I am not opposed to that, but a lot of analytic work has been done, some of which with myself and smarter colleagues to say that we can often get more efficient subsidy schemes if we direct them at individuals. And the main reason for that is that it is impossible for a firm to know the income of a worker, they know the wages. But if you know the income, you can actually tailor subsidies more precisely to low income families and you get more bang for your buck that way. So I would ask you to consider those kind of modifications which we can talk about off-line.

But even more than target efficiency, one of the reasons I am a little nervous about moving toward subsidizing employers is because when I look at the 21st century economy and I see the needs of competing around the world, I see a health care system here that is more inefficient than others in the world, and we rely more on employer financing.

So to move in a direction of trying to expand employer financing, even as we are trying to maintain middle class high value added jobs, competing against companies who come from far more efficient health systems and don't reply on employer financing as much, it puts a burden on us that we want to seriously reconsider going forward.

Now as you know quite well, and what impresses me about your Act is you clearly recognize this, that in order to make insurance markets work better, we have to re-orient incentives, and re-orienting incentives really means changing what we reward insurers for doing. At the moment, our insurance markets reward risk selection, that is to say, selling to the healthy, including the sick any way you can.

One important component that can reduce or change those incentives is an individual purchase requirement so that every person is required to buy whatever insurance they have access to. You have to subsidize them for sure, but if you do that, then you take away the incentive to aggressively underwrite and exclude the sick. Then you make an insurance market where you can only make money by delivering value for dollar and having better health services an better insurance bargains. So I think you want to think about adding that as well.

As I said the CHOICE Act succeeds in creating a marketplace that would work better than the market does now. And I applaud you for that. I do think we can improve going forward.

Let me just say a minute about delivery system reform if I could. No health reform proposal of any form is going to sustain an improvement in our health care system unless we bend the cost curve, unless get serious about delivery system reform. Just because you are a Small Business Committee doesn't mean you can't take this on. Indeed, you do by this Act by requiring employers to offer wellness programs in order to be eligible for the small business tax credit.

As you clearly know, wellness and disease management programs have had great success and have given value to workers and their firms, that is, one type of innovation that can help transform the system. Others you might consider include insensitive for having enrollees sign up for help homes or medical homes where they have a primary care provider completely oriented toward helping them navigate the system. And you also may consider incentives for providers who adopt electronic records and decision support tools.

Small employers will always hold a major role in our conversations about health care reform because no single group is more important to our economy and to our society. Small group insurance markets have been the focus of repeated policy interventions since even before Stuart and I started this a long time ago. And employers have suffered from high administrative loads, lack of competition, and I would say increasingly intense competition from firms from overseas.

Thus it is clear that health reform's focus on increasing access to quality affordable health care for small employers could serve as an important and catalytic step toward the changes we need nationwide. As you contemplate this, I encourage you to think about building a marketplace that can eventually welcome all Americans, not just small employers, so that we can improve value for dollar. Thank you very much.

[The statement of Mr. Nichols is included in the appendix on page 44.]

Chairwoman VELÁZQUEZ. Thank you. Our next witness is Mr. Stuart Butler. Dr. Butler is vice president of domestic and economic policy studies at the Heritage Foundation. Dr. Butler has been with the Foundation since 1979 and worked on an array of policy issues ranging from health care to welfare reform. The Heritage Foundation promotes public policies based on the principle of free enterprise, limited government and individual freedom. Welcome.

STATEMENT OF STUART BUTLER, VICE PRESIDENT, DOMESTIC AND ECONOMIC POLICY STUDIES, HERITAGE FOUNDATION

Mr. BUTLER. Thank you very much, indeed, Madam Chairwoman. I also want to join with Len and Linda in applauding you and the committee for approaching this in a bipartisan way. And I think that is reflected outside of the Congress. Len and I don't

always agree on things, and so I think there really is a good and spirited discussion which is very, very positive in this.

I also agree with you and with Mr. Chabot that we do see in the small business sector structural weaknesses in the ability of small firms to do the kinds of things that large firms can do in the insurance area. The nature of the workforce and the change in the workforce exacerbates that issue and the difficulty of grouping is of course, also an inherent problem. So there are many inherent problems with small business trying to do this which we all recognize.

So you have asked us how in this context should we move forward in trying to provide coverage. I would say that I am skeptical, and would caution you, about the idea of trying to model steps forward for small firms on what happens in the large business sector. That does go to ideas like creating larger groupings of smaller firms to try to operate as though they were large firms in the purchase of insurance.

I think that trying to group small firms in a co-op or some other type of device does risk various kinds of perverse incentives in terms of how individual companies will view those co-ops, view their joining or not joining, how risk is spread, and so on. Trying to group firms together also will not fully deal with the portability problem that we see generally in our society, and which is particularly noticeable in the small business sector.

I want to emphasize what Len said about the feature of your legislation that says let's try to provide a subsidy from the tax system through a tax credit directly to firms. We both agree that the evidence is that that is an extremely expensive way and a very imprecise way of providing subsidies when they are needed. You could end up with a situation where the costs for a newly insured employee under that arrangement could be more than double what we see for individual tax credits or even expanding public programs into those areas. So I certainly caution you about that.

A better approach in my view is to start down the road of thinking a little differently about the role of the small employer in the future with regard to insurance. And the key to this is to separate the notion of the employers's role as what I would call a facilitator of insurance during the financial transactions from the role of sponsoring insurance, or actually trying to organize insurance.

I would point out that if you look at the recent history of retirement programs and IRAs and so on, we have gone in that direction in the retirement area, saying employers have a certain role, but they are not there to manage your money in some way. There is a strong lesson there with regard to how we think about health insurance.

I would suggest that approach would indicate maybe a road that has three elements, and I think this does echo what you have heard already. The first element is to say well, let us set up an infrastructure, often called a health insurance exchange, modeled on the FEHBP or the connector in Massachusetts, which actually carries out the function of organizing and sponsoring the coverage itself and offering different plans. It would provide a menu of options, enabling people to have full portability if they change employers within that exchange. Plans within such an exchange could be offered by discrete organizations or groups such as labor unions,

consortia of churches, farm bureaus and so on. So there are lots of elements to bear in mind.

In this situation, the States would function as the primary place in which issues of pooling and risk would take place. It would be within the exchange, not within groups of employers under that model. Again, similar to how we look at it in the FEHBP.

The second element would be to explicitly make employers the facilitators rather than the sponsors of coverage. That means, in effect, that what small firms would do in this case is basically, specify that the exchange itself and the plans within it would be their plan, and they would not themselves be trying to organize insurance. This is much as you, as a Member of Congress, and other Members of Congress, don't get together as a co-op and try to offer insurance to your employees. You say the plan is the FEHBP and all those issues are carried out in that area.

So the employers role would be primarily making deductions from payroll deductions, sending premiums, perhaps adding contributions and so on.

The third element, which, again, reflects what you heard is that to make this more effective, and indeed to make the whole system more effective for employers, you must address the tax treatment of health care. I share Linda's cautions about the ways of doing that, but I think we see a health tax system today which is inherently inequitable, inefficient, and really gets in the way of creative solutions for the small business sector or for other sectors.

So just in conclusion, I applaud very much what you are attempting to do and that you recognize and are focused on the special concerns of small businesses. I think those concerns do force us to think creatively about better ways to organize and to reexamine the role of employer. And I just want to end by absolutely agreeing with Len that this gives us an opportunity to look at creating a structure and infrastructure, and a way forward, which will not only fix the problem for small employers, but in my view would be the model that over time would extend to the working population in general. Once you see the small business sector as potentially the model and the leader in dealing with this problem rather than thinking of it as sort of a step sister, you can deal with their particular problems.

[The statement of Mr. Butler is included in the appendix on page 53.]

Chairwoman VELÁZQUEZ. Thank you, Dr. Butler. Our next witness is Mr. Thomas Haynes, he is executive director to the Coca-Cola Bottlers Association. Mr. Haynes has served as president of the Association Health Care Coalition which aimed to improve health care options available to small businesses established in 1914, the Coca-Cola Bottlers' Association assists a 73-member company reducing costs by meeting their needs in a number of areas, including health insurance. Welcome.

STATEMENT OF THOMAS HAYNES, EXECUTIVE DIRECTOR, THE COCA-COLA BOTTLERS' ASSOCIATION

Mr. HAYNES. Thank you, Chairwoman Velázquez, and Ranking Member Chabot for this opportunity. I would also particularly like to thank Chairwoman Velázquez for the leadership that you have

shown over the years in trying to find creative solutions to the challenges facing the Small Business Committee. And most of all, frankly, for your authorship and sponsorship of the CHOICE Act, which I believe is a very well thought out and very powerful first step and a step that will probably have much more implications than people may see currently if Congress chooses to support it which I certainly hope they will. And really make a major dent in the problem that small businesses face.

The reason I believe the CHOICE Act is so powerful, and I think I find myself in disagreement with Dr. Butler on a number of issues, is our own practical experience at serving our members, both in the health care and outside the health care environment. As I have indicated in my testimony, the Association has been sponsoring and providing health care benefits for the members of our association for about 30 years. We had a very effective, very comprehensive program that included both our large members and our small members. Our members range from bottlers with as fewer as 12 employees to as many as 50,000, so we have that entire spectrum on both sides. And we were providing solutions to almost ends of that spectrum, not the highest, but certainly the next layer down through 2000 when the program we had built four or smaller members was disbanded because we could not find a carrier willing to support it.

Our program has always been based upon a fully insured model, although it includes significant elements of risk shifting both to the association and to the individual members. And we simply couldn't find any insurance carriers who were willing to support the small member part of that pool, even though it was working very effectively at the time and we had to disbanded that.

I have been with the Association since 2001. The single most important task that I pursued is how to reestablish that program. To give you an understanding of how important it would be for those members, health care costs represent in the range of 10 percent of the cost of a case of Coca-Cola, a 12 pack of Coca-Cola. We believe that our smaller members have as much as a 20 percent disadvantage vis-a-vis their competitors, vis-a-vis larger members.

That represents essentially a 10 cent per case competitive disadvantage between small and large members. And I have members with less than 100 employees who compete with businesses with as many as 35,000, 40,000 employees. So this is a real world business issue for those members. And frankly, it is an issue for the consumers of our products, who are buying those products in those territories, it either affects the profitability or it affects the cost of the product or both.

So this is a very important problem. The reason why I believe the CHOICE Act is the right solution is it basically models the solution that the Association has adopted outside the group health area. We have had a liability insurance program for 100 years. The single most powerful element of that liability insurance program is our captive. And we have had a captive that has operated very effectively for nearly 30 years.

That captive has moved from taking a small part of the risk to taking almost the entirety of the liability at risk in our liability insurance program. And we are able to deliver a 25 percent premium

credit to the participants in that captive while still being competitive with commercial insurers in the real world. So I, contrary to Dr. Butler, have real world experience that says this solution will work, it will work, I will guarantee for our members. We could cover, I believe, the 60 members who are not currently in our group health program very rapidly under this program and delivery lower costs than they face today.

Now, I think the issue that personally as an if physical conservative and would be very sympathetic to Dr. Butler and his organization on virtually every issue would look at it and ask is of course the Federal tax expenditure to subsidize this coverage. I have no trouble with that feature of it and I think it is entirely supportable as expendable Federal dollars.

In my mind what the subsidy will do is correct the uneven playing field that small business and large business currently operate on because of the disparate effect of all the state regulations on small businesses that are trained to pool. By equalizing that playing field and allowing us to create a cooperative, and, in fact, facilitating the cooperative, but including it as a requirement of the bill, it will put us in a position where we can put these smaller members back on an even playing field.

It is, in my mind, the impact it will have on competition, on allowing the members themselves to manage their risk as opposed to paying a carrier, the profit premium that they have to pay to take on those risks, the reality that a carrier is going to be worried about adverse selection when a small business comes to them is going to be worried about the reality that the people who are seeking insurance are going to be the people with the greatest health risk.

The reason why our members pay so much more for insurance in part, who are not in our program, is because of the premiums they are paying to the carriers for taking on those risks. And by simply pulling and retaining those risks, that profit part of the cost will come out of their cost and will be a real market-based savings. I am also very confident that with the subsidy for the members that have under 100 employees we could add double or triple the number of participants in our program among members with more than 100 employees, but with a lower cost for them. So the reality is, I think we would save more money internally than the Federal Government would provide us by a significant multiple. I think it is a dollar that would deliver tens or hundreds of dollars of benefits to the employees and our members. So I think it is an excellent solution. I welcome the opportunity to discuss the pros and cons of some of these ideas.

[The statement of Mr. Haynes is included in the appendix at page 63.]

Chairwoman VELÁZQUEZ. Thank you. The Chair recognizes the ranking member for the purposes of introducing our next witness.

Mr. CHABOT. Thank you, Madam Chair. And I am pleased to introduce James Eckstein, who is the president of C.A. Eckstein Roofing, Inc. which is located in Cincinnati, Ohio, Mr. Eckstein has been working for the company since 1975 and has served as president since 2002. His business has been providing the greater Cincinnati area with residential and commercial roofing services since

1945, C.A. Eckstein Roofing is a second generation, family-owned company with a third generation actively involved in the day-to-day operations. The company currently employs 35 people. So the epitome of a small business that we are trying to encourage in this country.

Mr. Eckstein also currently serves as Vice President of the National Roofing Contractors Association, one of the Nation's oldest trade associations which is based in Rosemont, Illinois. And I would note that he's come at considerable sacrifice because as some may know Hurricane Ike, at least the remnants of it, came roaring through our area, Cincinnati, Ohio and knocked down innumerable trees. And many, many people, in fact, over 90 percent of the people in the greater Cincinnati area were without power, some are still without power. Our home was out for about a day and a half.

My wife called me and told me that she had it back on, but reading by candlelight and that sort of thing which was unusual, but what we went through clearly wasn't as severe as what many others went through that were seriously impacted. But he came back from being out of the country and came to Cincinnati, I understand, to see this and had some challenges coming up here. And I also might note there were thousands and thousands of homes that had shingles ripped off the roof so I know there is considerable work here so we appreciate his coming here to share testimony that might be valuable to health care for small businesses. And so I will quit talking and start listening.

STATEMENT OF JAMES ECKSTEIN, PRESIDENT, C.A. ECKSTEIN ROOFING, ON BEHALF OF NATIONAL ROOFING CONTRACTORS ASSOCIATION

Mr. ECKSTEIN. Thank you, Madam Chairwoman, Ranking Member Chabot and members of the committee for the opportunity to discuss health care reform for small businesses. My name is Jim Eckstein, I am President of C.A. Eckstein Roofing Incorporated in Cincinnati. I also serve as a vice president of National Roofing Contractors Association, and I am testifying on behalf of NRCA.

First, I want to commend Chairwoman Velázquez and Congressman Chabot for your outstanding leadership on health care and other issues of importance to small business. Your tireless efforts on behalf of working Americans are greatly appreciated by NRCA. NRCA welcomes the opportunity to testify on the problem of excessive increases and the cost of health insurance for small businesses which, has been a major concern for roofing contractors for many years.

NRCA strongly supports the small business CHOICE Act of 2008, because we believe it will address this critical issue. We commend you, Madam Chairwoman, as well as Congressman Joseph Pitts for recently introducing this legislation. NRCA also commends Congressman Chabot for introducing the Health Insurance Affordability Act of 2007, which would allow individual taxpayers to take a tax deduction for their health insurance costs.

At C.A. Eckstein Roofing, we believe it is very important to provide our employees with high quality health care benefits and we have done so for many years. Moreover, it is necessary that we do

so in order to remain competitive in attracting high quality employees. However, providing health coverage for our employees is becoming more difficult each year as we continue to be hit with double digit premium increases.

Our most severe problem now is that insurance companies are unwilling to provide us with competitive pricing because of cancer and other health conditions among a few of our spouses and the families. As a result, we have no choice but to accept the double digit premium increases from our current insurer. The excessive premium increases charged by our insurance company year after year forced us to increase the amount that our employees pay for health care benefits which I greatly regret.

In addition to jeopardizing the health of many workers, lack of affordable health insurance also greatly hinders economic growth across the Nation. Small entrepreneurs are the primary source of job growth in our economy and difficulties in providing affording health benefits to employees slow their ability to grow their business and create new jobs. Moreover the current manner in which health insurance is regulated puts small business at a disadvantage to large corporations in providing health benefits to our employees.

It is clear from the situation at our company that some form of expanded pooling is necessary in order to spread risk across greater numbers of insured lives. Expanded risk pooling is essential if we are ever going to restrain the excessive cost of health insurance for small businesses. NRCA strongly supports the Small Business CHOICE Act.

This is one method of expanding pooling opportunities for small businesses. The CHOICE Act is a private sector solution that creates new purchasing cooperatives designed it allow small businesses to stabilize health insurance costs by pooling risks. The bill also provides a tax credit to small employers who purchase health insurance for their employees through a cooperative.

Finally the bill provides a role for trade associations like NRCA to be involved in the development of purchasing cooperatives. We believe that the establishment of new pooling options for small businesses, such as the cooperatives envisioned by the CHOICE Act will inject greater levels of competition into the health insurance market. The need for increased competition in health insurance markets is widely agreed upon as a key ingredient to help restrain the excessive cost of insurance.

NRCA is committed to working with Congress to obtain enactment of the CHOICE Act, and possibly other bipartisan proposals that address the problem small businesses face obtaining access to affordable health insurance. NRCA strongly urges Congress to take up small business health reform early next year to address this urgent issue.

Again, thank you for the opportunity to share NRCA's views and I would be pleased to answer any questions you may have.

[The statement of Mr. Eckstein is included in the appendix at page 72.]

Chairwoman VELÁZQUEZ. Thank you, Mr. Eckstein. Dr. Nichols, can you please elaborate on how changing our health care delivery

system will have a positive impact on the small business health insurance market?

Mr. NICHOLS. Madam Chairwoman, I welcome the opportunity to answer that question, because it may seem disconnected, but basically we tend to focus a lot as the distinguished members who actually run businesses or talk to people who do on a daily basis like my brothers, I would say, but they tell us they focus on insurance costs because that is the price they pay. But as the gentleman from Cincinnati mentioned, it's the health care cost of the people we are covering that actually drive everything. And what we know, Madam Chairwoman, is that health care costs have been growing so much faster in economy-wide productivity more and more, Americans are finding it unaffordable. More and more small businesses are having a hard time. We just learned about that record.

So the core issue is how do we reduce the rate of cost growth. And I would even say it is really about how do we get more value for dollar as opposed to cost per se. So I want to both encourage you to work with everybody to make the insurance market better, but the insurance market just reflects what the health care cost structure is underneath, so we have to dig underneath and do that. Your emphasis on wellness is a great place to start, but we basically have to buy smarter.

We have tolerated far too much imprecision, not knowing, assuming all hospitals and doctors are the same, assuming they all know everything they need to know. You know, I had a dean of a medical school tell me a couple of years ago when he started practice 30 years ago he had to understand 8 drugs, because that is really all you needed to do to practice medicine in the United States then. There were 200 new ones last year. No one can manage that much information. We need to provide information tools, better incentives an get way smarter about buying.

Chairwoman VELÁZQUEZ. Mr. Haynes, a growing number of small firms are using consumer driven, high deductible health plans as a mean of containing premium costs, are high deductible plans addressing the problems being faced by your members or is more needed?

Mr. HAYNES. I think it is a difficult and possibly not that effective solution. I say that believing in theory that if you create the right kinds of incentives for consumers markets will work better. The practical real world experience that we have is that it is very difficult for consumers of health care services to understand all the choices that are available to them, to process all the information they need to process in order to make the right decisions on how much money should go into a pool and how to manage their own health care. I think they need help. That is my opinion.

And I can't debate the academic merits issue of the employer provided versus individual insurance, but I do believe that individuals need help from a trusted source in managing their health care in a way that they are comfortable with and that will deliver the best results.

Chairwoman VELÁZQUEZ. Dr. Nichols, let me ask you, do you find that these plans tend to shift the responsibility of who is paying for health care coverage?

Mr. NICHOLS. They have, but I would also say the record is mixed. I would say it this way, they are sort of what you might call consumer driven 101, which was, in some ways, more an attempt to just shift the responsibility and the risk, but increasingly there is some consumer driven 201. And let me hasten to agree with my colleague, Mr. Haynes, people need agents; they need help. It turns out if insurers and employers do provide that information, people can make better choices. What Stuart and I are thinking about instead of having a marketplace that brings those kind of advantages to all would still hinge on individual choice, but informed choice, the choice that actually uses the information tools we have.

We are going to always trust our docs, but our docs need help. We need to trust our employers, we do in small employer cases, large employers I am not so sure, but in small employers we do, but they need help too because purchasing health care efficiently is a complicated thing. Web M.D. Is wonderful, it can't always help you decide, you need an agent you trust.

Chairwoman VELÁZQUEZ. Thank you.

Dr. Butler, critics of individual tax credits to increase coverage argue that it has the potential of eroding employer base coverage. Is it possible to avoid this outcome while still offering tax credits or incentives to individuals?

Mr. BUTLER. Yes, I think it is. I would agree with Len and Linda on the importance of structuring the insurance market in parallel to providing individual tax credits. I would certainly agree that if you merely gave somebody a tax credit and let them sort of go off on their own, then indeed you would get massive adverse selection. You would get only certain people leaving an employer's plan and so on, and that would be destabilizing. So I do think it is important to combine them.

In my view, in terms of a health insurance exchange system, I do believe that the employer should actually make the basic decision about whether their employees have access to plans and to credits through the health insurance exchange. So I recognize that. But I think there are steps - prudent steps - that can be taken to make sure you are minimizing your risk of unraveling of existing coverage.

And I would point out, of course, that we are all basically saying that there has to be some means to make sure that people have both adequate resources to obtain coverage and an adequate array of reasonable and affordable plans. I think it was Len who emphasized this. Trying to focus that subsidy on the individual is better than trying to focus it on the individual's employer.

Chairwoman VELÁZQUEZ. Dr. Blumberg, what are the advantages of a system where Americans secure health insurance through their employer?

Ms. BLUMBERG. Well, the advantage of this system as it is now, while it is highly imperfect, and I think there is a lot of room for improvement, is that when individuals are going to look for a job, they are not necessarily coming together as a group for the purpose of buying health insurance. They are coming for other reasons.

Once individuals are in and employment group, particularly in large employers, the employer acts as a natural risk pooling mechanism for buying health insurance. So that in a very large firm, the

average healthcare cost in that pool is going to usually be about the average that you see in the population at large. And so it makes sense from a risk pooling standpoint for those individuals to come together and purchase health insurance.

The advantage, also particularly for larger groups, is that there are some administrative economies of scale of buying in a big pool like that. And so the cost of buying health insurance for them is going to be lower per unit of benefit than an individual or a smaller group.

Chairwoman VELÁZQUEZ. Thank you. Mr. Eckstein, you testified that the tax credit element of the CHOICE Act is justified because large employers have significant benefits under ERISA. Can you talk about some of the advantages that larger firms currently have over small businesses when it comes to purchasing health insurance.

Mr. ECKSTEIN. Well, they have a larger pool of people that makes it a little more of an advantage for the insurance company to deal with that large group. For a small group, all we need is one or two catastrophic illnesses and we become very unattractive to the insurance companies. As I stated, we have been stuck with the same insurance carrier for 4 or 5 years now because no one else wants to quote us because we have had one spouse with cancer, one of our employees had cancer and they just, we are stuck with them, nobody else will quote us.

Chairwoman VELÁZQUEZ. Let me go to Mr. Chabot.

Mr. CHABOT. Thank you. Dr. Blumberg, I will begin with you if I can. Can you discuss again a little bit how small businesses can, since they have a disadvantage to larger corporations, larger companies with respect to scale, et cetera, how can the little guy compete against these larger companies if they are trying to provide health care for their employees?

Ms. BLUMBERG. Truthfully, I don't believe that they can. And that is why I think that placing emphasis on trying to get more small employers to be direct providers, their own purchasers of health insurance coverage, is probably not going to be an effective way for significantly expanding health insurance coverage, because they will always suffer from being smaller scale and having the risk pooling issues and the administrative cost problem. They also have higher turnover than larger firms, which increases the administrative costs of the firm providing health insurance. They have got the problem of having lower wage workers than larger firms and medium size firms, on average. So the affordability issue is also a very prominent one.

So from my perspective, the way to get more workers in small firms into health insurance coverage is through a broader based reform mechanism that will address the needs of really all uninsured individuals and particularly with these modest income and high health care needs.

Mr. CHABOT. Thank you. Dr. Nichols, I notice you are a big proponent of the CHOICE plan. Could you tell us again what are a couple of the major things that you think are so beneficial of the plan and why those of us who may not be co sponsors yet should consider co sponsoring the legislation?

Mr. NICHOLS. Well, first of all, it is bipartisan. And in my opinion we need to show the country that we can work together. And I think that just the fact of cosponsorship and leadership that has already been shown reassures the country frankly those of us who live in Washington are trying to solve problems and not just posture about them.

Secondly, it sets up a mechanism whereby people could buy health insurance that would be cheaper than it is for them today, and it targets that incentive directly at the group that is probably in most need of relief, and that is the small business sector. There is no question.

I think Mr. Eckstein's story is the most ringing in my ears. Here is a family-owned company, two generations, I believe you told us, that is having a hard time maintaining, offering what they want to do because of one or two people in their health care family getting sick. It is that kind of, I will just say outrage, that we ought to fix. I don't blame the insurer. The insurers are in the world where they are following the rules they have that we have set up. The point of the CHOICE Act is to change the rules and to change incentives and to change the ways to make it available to more people. So all of that is good.

My quibbles are that I think we could actually have our subsidy dollars go farther to cover more people if we are able to target them to low income workers as opposed to higher income workers who just happen to be in smaller firms. The classic example, not at the table today, would be a law firm or a consulting firm of a bunch of egghead economists, doing very well, thank you very much, why should you subsidize them? They don't need it.

The second thing is I would agree with Linda in the long run you want to think about how are we going to help more workers in general. And more firms concentrate on what they do best, what they do best, as you all know, is create jobs. I want to remove the worry of health insurance from the plate of the CEO so he can focus on fixing roofs and making Coca-Cola even cheaper. I am in favor of that, I am a big Coke fan. So what I want to do is remove the health insurance, if you will, nightmare, from their plate by creating a marketplace where all workers can go. They can contribute to those workers purchases if they want to. It is America, it is part of the labor contract, but let's not build that as the only way to do it. And that is where I would quibble.

Mr. CHABOT. Thank you. Dr. Butler, the Heritage Foundation, and of course, Brookings are a couple of top think tanks that we often read your reports and listen when you all talk about important issues like we have here today. And obviously, we are way down the road on health care for the most part being provided through one's employer. It really didn't have to be this way from the beginning. I am just curious as to what your thinking is, because I have heard you speak at a number of different forums in the past. Is there a way that would have made better sense so that we wouldn't be here at this point in time? And how realistic is that at some point, maybe get back to what would make more sense?

Mr. BUTLER. Well, I am a historian so don't get me started on that. I think we are facing a number of problems these days, if we had done things a little differently in the past, we may not be

where we are today. But anyway, when I look at this, and actually when I look at it as somebody who is an immigrant to the United States, albeit having been here for 30 years, you are right.

When you start looking at the American system, and as Len said, you have employers here that are trying to make something, yet having to worry about how sick might their employees be. That doesn't typically happen in other countries. You have employees shopping around for employers, wondering whether their benefits package is going to cover their problem. That is a problem too. And part of the root here, I think, is the tax treatment, which many people have pointed to that skews us to go down a certain road. We have all said that that needs to be addressed, and we need to make some steady changes in that to move the subsidy more to the person and away from another institution.

However, I would say that given where we are and how we need to think about the future, I do want to just reemphasize the distinction I tried to make in the role of the employer between the role of the place of employment as a very useful convenient place to do a number of transactions to enroll people. Most Americans pay their tax via their employer. They are very good reasons for this, very sound reasons for doing this. To distinguish between that and who actually organizes coverage and who is at risk.

I think the discussion we have been having to some extent is do we envision a future in America where the employer, particularly the small employer, continues to be a key part of organizing that coverage, and is in fact, holding the risk in some way, or should we try to move away from that system? That is what I would argue for.

I think the analog with the way with you as Members of Congress provide insurance to your employees is a good analogy to look at. And you don't come together. You don't have to worry about the medical condition of any employee of yours because; it doesn't affect your ability to function as a Member of Congress; it doesn't affect the bottom line of your office in that sense. But you are a very important individual in terms of giving people who come to work for you access to a system based on an exchange where the risk is handled separately, and I think that is the way forward.

So given the choice you can make, I would advise you, when you look at the CHOICE Act, to examine the opportunity for seeing a somewhat different role for the employer in the future than you are currently looking at, and to move in a slightly different direction than is implied by what you are doing. As you go down your current route, you still have the inherent problem of the medical risk of the employees of any individual company, and should they be in the co-op or should they not. The decision they make is going to still be one of who is going to carry the risk and what is the cost. I think that is inherent.

I would just say finally and maybe this is a point of clarification for Mr. Haynes, my understanding from your testimony from the Bottlers' Association is that you still really don't provide the same kind of system of benefits to your smaller members and to your larger members, maybe I misheard that. But I thought that was the case, so you are still facing that situation of having a particular problem for the smaller members.

Mr. HAYNES. Well, if I can clarify, that is because of regulation, there is not a choice on our part, the system has State regulation. So we are going to come up with a solution for our small members. I am committed to doing that. And it is going to be based upon a captive.

Mr. HAYNES. One way or the other we are going to do it. We are going to struggle to be effective if we don't have some help financially in overcoming the competitive handicap that we already face because of the cost gap. But we are going to do it.

And if I could just comment briefly, I think that the workplace is a very natural place for employees to get their health care insurance now. You can argue whether we might be better off if they didn't, but if you consider the fact that retirement is primarily coming through workplace-based 401K plans, that we provide a whole range of benefits, programs that we administer. I think it is both current reality and, frankly, fairly natural for employees to look to the workplace for help on their health care. After all, I think small business is concerned about the health and welfare of their employees separate and apart from the cost component.

Mr. CHABOT. Let me just ask one last quick question , and I will address this to both Mr. Haynes and Mr. Eckstein.

In the scheme of challenges that those of you on the small business community have to deal with, where does health care in coming up with additional costs—I know it has been going up double digit in recent years. Where does that fall in the challenges that you face? And just a pretty quick answer, not a long one, Mr. Haynes and Mr. Eckstein.

Mr. HAYNES. It is very high and it is probably number one and I could even extend that beyond my organization because I have been working closely with the National Beer Wholesalers vis-a-vis health care and they did a member survey of the largest challenge that their members face and health care was number one in that survey; so our experience is typical.

Mr. CHABOT. Thank you.

Mr. Eckstein.

Mr. ECKSTEIN. Health care has become just absolutely huge for us. Running a business myself, I didn't have the time to spend on health care every year, to shop it and try to find someone. I actually brought my wife to work, and now basically her job is she monitors our health insurance on a yearly basis. And we actually last year went to a health reimbursement account to absorb some of the increase and not pass it along to our employees and it actually worked out fairly well last year.

Mr. CHABOT. Thank you. And that's consistent with what I have been hearing. I go to small business folks in my districts a lot and I will tour their plant and meet with their folks, and I hear that if it is not the number one issue, it is very close to the top with just about every small business and I would venture to say that is probably true nationally as well.

Thank you very much, Madam Chair. I yield back my time.

Chairwoman VELÁZQUEZ. Mr. Ellsworth.

Mr. ELLSWORTH. Thank you, Madam Chair.

Maybe not so much a question, but I would like to thank you and the ranking member so much for keeping the spotlight on this

issue. I know we have had several hearings about this. We have had governors in talking about State health insurance individuals and small business. So thank you very much.

Obviously this is something that we look forward to getting something done about and I know you are committed to that, and I look forward to next year too. Like Dr. Nichols said, regardless of who is in the White House, this is going to be a pressing issue for the new administration as well as us.

Sitting over here listening to the panel, I had a flashback to when I was interviewing—in my former life interviewing potential employees. And being a former law enforcement officer, you always ask the question why do you want to become a deputy sheriff? And you would think it would be to protect and serve and things like that. And as time went on, I had people saying, well, I hear the county has really good health benefits as their reason for wanting to become a deputy sheriff.

Now, I didn't hire those people, but they were pretty honest. But I thought that was a telling thing that they were willing to come in and want that job just to get the health insurance benefits. I hope they are listening today and if they are reapplying they will think of a better answer than that.

But as Mr. Chabot said, I spent yesterday on the phone anticipating this hearing talking to small business owners in my district with my roundtable, and just the stories that came from them. One gentleman who owns a trucking company and fuel prices are his number one, but health insurance and health care for him and his employees were all of their number one issue. And just listening to some of the stories that they had, gaming that deductible system. I know one of the gentlemen talked about that he selected a plan with a $2,500 and had asked the employees to pay the first $750. He would take the gamble on paying above the $750 anything that they didn't spend. He was just gambling.

Other issues that they talked about were the insurance companies that are demanding that 50 or 60 percent of the employees get on the program, and that is not always possible. In a five-person job, if the spouse of somebody works and it's a better insurance plan, they are not there. So they are hampered. But again, I don't have a lot of questions because I think we all know where this has to go. It is letting the rubber meet the road and getting these things done, and I look forward to you and the rest of us keep pushing until this actually happens.

With that, I yield back, but thank you all very much for your input.

Chairwoman VELÁZQUEZ. Thank you.

Mr. Fortenberry.

Mr. FORTENBERRY. Thank you, Madam Chair.

Thank you all for joining us today.

Dr. Blumberg, if I could summarize your testimony because unfortunately, it was the only one I was able to read through since being here fully, I think your suggestions can be summarized as follows: better pooling for small firms; high-risk pools, which is a government subsidy for persons who have chronic health conditions; and some form of premium assistance for individuals of lower income; is that correct?

Ms. BLUMBERG. Not necessarily. The issue of the high cost is a really critical one from my perspective. But whether you are going to address that problem by taking the people and separating them out into high-risk pools versus changing the way insurance is priced and risk is pooled in private insurance in general is a very big decision.

So I think we need to be very cautious about how we go about that in order to make sure that coverage remains adequate and affordable for people regardless of their health status. For example, if you take the route of going with high risk pools for those who are high cost, they are separated out from the people that are lower cost. So if you are going to subsidize their coverage explicitly in order to make it affordable, the cost to the Government is going to be considerably higher than if their costs are averaged throughout the population. The total healthcare costs are the same. You have to pay for the costs eventually one way or the other. But it is a matter of how much is going to come directly from Government revenue versus how much is going to be spread through premiums. So those are big policy decisions and I wouldn't say that high-risk pools are necessarily the right way to go.

Mr. FORTENBERRY. Then that would beg the question as to whether a form of premium assistance is the most efficient way and perhaps the most societally beneficial way, to continue to have proper access to health insurance coverage in the event that a person who falls out of normal risk categories and can not then be absorbed into smaller pools like you have.

Ms. BLUMBERG. I think that buying coverage through employers, particularly large employers, is more efficient at this point than buying person by person because of administrative costs, but I think a lot of us have been talking about the notion of creating structures or building on existing structures that would allow coverage to be purchased outside of the employment context as efficiently as many employers do.

Mr. FORTENBERRY. What would that look like?

Ms. BLUMBERG. What that would look like is a purchasing entity, maybe something structured similarly to the Federal Employees Health Benefits Plan, which is what Stuart was speaking about, based on State purchasing pools, or State employee plans. You could do it through public programs, you could open up Medicaid and SCHIP for purchasing coverage for individuals of varying income levels. Most people in those plans are already enrolled in private health insurance plans, they are just being contracted by the State. You could set up a connector-like entity as they have done in Massachusetts. Where the State creates an entity through which they decide what the array of health benefits are going to look like and they contract with the insurers in order to provide that for individuals and/or small businesses that want to buy into it.

But the key is that we have to be really careful about how we slice up the covered individuals in insurance coverage. The more choices that they have, the more options that they have available to them, the more we segment risk. So we have to be very careful about how many choices people face and how they are priced in order to make sure that we spread the cost as broadly as possibly.

Mr. FORTENBERRY. Let us talk about two aspects of that, and others of you can chime in.

One is the Health Savings Account initiative that tries to drive the consumer back into the equation when rationing limited dollars in ordinary costs while there is an extraordinary or catastrophic condition. Mr. Ellsworth is right, and it is an amusing story, but I think it is very true. And this also is a question of portability, that the dampening effect on economic productivity created by having a person seek employment merely for the benefit of health insurance, versus using their skill sets to find the right place to exercise their gifts, is a very real drain on productivity.

So we talk about an employer-based system and you all are generous people, those of you who have a business. I think most small business people are trying to help their employees. But because you get a tax benefit, in effect, for doing this (plus the fact that it is about retaining employees) we used to call it in the corporate world ″golden handcuffs.″ If these benefits get big enough, you are going to think twice before leaving or you are going to seek a position for the benefit alone versus the opportunity to again find the right fit for your own skill set. This happens a lot in rural communities where a spouse will leave a farm or another entity simply to go to some level of governmental—a level of governmental entity for the health insurance benefits.

So while I agree with many of the points you are making in regards to the efficiency of delivering health care through the business platform, I think we have to think also about this issue of portability and this drain on productivity when a person ends up being basically chained to the desk that they are at because of their need for health insurance.

Ms. BLUMBERG. That is actually one of the advantages of these purchasing entities, that an individual regardless of where they are working, can maintain their health insurance coverage when they move from job to job and whatever employer they are working with at the time, if they have decided to make contributions, can pay those contributions into the purchasing pool or the individual could hopefully go there and get income-related support in order to be able to afford coverage there. So I think most of us are realizing that, particularly for small businesses and some medium-sized businesses as well, it is inefficient for them to be the location of purchasing coverage. But these purchasing entities are basically the solution to the issues that I think you are raising.

Mr. BUTLER. I might add that in addition to issue of so-called job lock, with people making decisions as to who they work for, there is of course the other issue which I am sure you are very familiar, which is how people's decision to go into business for themselves is affected by the insurance issue. There has not been so much research done on that but we certainly know anecdotally very much how that is affected. We have done a summary of the research that is out there and I would be more than happy to—

Mr. FORTENBERRY. Madam Chair, I think that Dr. Butler is making an extraordinary point, one that should be impacted further by this committee because this drain on entrepreneurial productivity is very real because of this issue.

Mr. BUTLER. We would like to be helpful. We see it all the time - people who just cannot go into business for themselves unless they have coverage through a spouse, for example. You see these patterns very, very clearly. People maybe get divorced and then suddenly, because they are in business, they cannot afford to continue because of the immediate effects of running out of—

Mr. NICHOLS. If I could, Stuart mentioned, and I welcome to see it, it has been hard developing empirical models to do this, but I think he probably knows and I certainly know there are surveys of people thinking of business formation. And I know Todd Stottlemyer, the president of NFIB, has made very clear, and I think he has got a hard survey to back this up, it is the number one problem, the number one impediment to business formation is worrying about how you're going to cover your family and your would-be employees; so I certainly agree it is very important.

Chairwoman VELÁZQUEZ. We are having some votes the floor, but I have two more questions and then, Mr. Chabot, if you have any other questions.

Dr. Nichols, despite some of the successes of the Massachusetts Commonwealth connector plan, it hasn't delivered on the promise of low-cost small business plans. Small businesses appear to be disproportionately funding the State's health care system in comparison to big business and government payers. Do you believe that there was a way that this could have been avoided?

Mr. NICHOLS. Well, Madam Chairman, I think the fundamental cost structure in Massachusetts is driven by the unfortunate fact that health care costs a lot in Massachusetts, and unfortunately there is no magic wand you can wave when the providers up there get paid what they get paid, and that is the fundamental thing. Now, Linda actually probably knows more about Massachusetts specifically than I do so I will defer to her, but I will say when you structure a new marketplace, I think all of us would agree you have to have transitions that are smooth. You don't want to have a big jump.

Massachusetts had a fair number of benefit mandates that were already in place that in some sense the market had adjusted to. You could get money back although not nearly as much as the advocates would tell you. You can get money back by taking mandates away, but if you do that precipitously, you end up uncovering cancer and so forth. So you have to be careful about that. What they did do, which I was very much in favor of, was they allowed there to be products sold to young workers, to young people, between, I think, 21 and 29 that had fewer mandates so that they could offer those people a little bit lower premium.

But Linda, you may want to speak to—

Ms. BLUMBERG. I think the underlying cost structure of the State is the major issue and they are focusing their attention now on strategies to contain costs. It was a very difficult political calculus to try to expand coverage substantially while at the same time containing costs, lower provider payment rates, et cetera. It would have been a very difficult piece of legislation to pass without support of the providers; so now I think the focus is on cost containment.

But I would mention a survey that was done by the Urban Institute prior to the reform implementation and the survey was done again more recently. It was demonstrated that employer-sponsored insurance coverage in Massachusetts has increased since the implementation of the reforms. So more employers seem to be offering and more workers taking up.

Chairwoman VELÁZQUEZ. Dr. Butler, you suggest giving tax credits to individuals as opposed to employers because it is a more effective means of expanding traditional coverage. Can you envision any circumstances in which tax credits for small businesses could be effectively used to expand coverage?

Mr. BUTLER. Well, I do think that there is a case to be made for credits in the transition especially, if you are asking employers to set up systems. And we see this, incidentally, in the area of pensions as well, that legislation has been put forward to address the fact that there is a direct cost to a small business person, that might discourage them from setting up an alternative system. I think covering that with a credit can make sense, to cover those transition costs. What I was referring to is the idea of trying to subsidize with a tax subsidy directly to the employer in order to bring down the cost of coverage per se. So I would draw that distinction between the role of any kind of subsidy to the small employer.

Chairwoman VELÁZQUEZ. Yes. I am sure Mr. Haynes would want to comment—

Mr. HAYNES. Yes. I would say looking specifically at the Choice Act, there is probably dramatic evidence to the contrary because I think in our situation the tax subsidies would allow us to bring a lot more people into our existing pool. Frankly, I think more money would be saved by the people who wouldn't get—by the employers who wouldn't get the subsidies than the people who would get the subsidies and there would be more benefit to the participants in the pool that we could create outside of the group being subsidized than inside the group.

Mr. BUTLER. Well, with respect, I mean, the actual econometric data that has been done—there has been a number of econometric studies looking at this in terms of the cost, the revenue loss associated with providing a subsidy to an employer who is already providing coverage to their employee and to try to level the playing field. There is a huge revenue loss associated with that. And I mean Econometricians do look at these things, and the data I think is pretty clear that it really is almost pushing on a string in terms of cost. It costs an enormous amount for those who are already covered if you go through the employer, and it is a much higher cost method of trying to cover those people. I just think the data shows that very clearly.

Mr. HAYNES. I think the difference is between a targeted subsidy and a general subsidy. This is a targeted subsidy that works specific on the marketplace.

Chairwoman VELÁZQUEZ. Mr. Chabot.

Thank you.

Mr. CHABOT. Thank you, Madam Chair. I know we have votes; so I won't ask any more questions. But I just want to thank you for holding the hearing and I want to commend the panel. I think

they have done an excellent job and have really shed a lot of light on this. I think this is an excellent panel, especially the panel member from Cincinnati.

Chairwoman VELÁZQUEZ. Thank you all.

I ask unanimous consent that members will have 5 days to submit a statement and supporting materials for the record.

Without objection, so ordered.

This hearing is now adjourned.

[Whereupon, at 12:00 p.m., the committee was adjourned.]

NYDIA M. VELAZQUEZ, New York
Chairwoman

STEVE CHABOT, Ohio
Ranking Member

Congress of the United States

U.S. House of Representatives

Committee on Small Business

2361 Rayburn House Office Building
Washington, DC 20515–6315

STATEMENT
of the
The Honorable Nydia Velazquez, Chairwoman
House Committee on Small Business
"Universal Coverage: Making Health Insurance Reform Work for Small Businesses"
Thursday, September 18, 2008

Last month, the Census Bureau came out with what appeared to be good news for our nation's uninsured. In the year between 2006 and 2007, the number of people without healthcare decreased from 47 million to 45.7 million. But while that would seem to be an encouraging drop, the reality is that it simply masks a growing crisis. In fact, the decline was the result of expanded government programs like Medicare and Medicaid, not increased access to affordable private insurance.

Despite a modest uptick in coverage, our country's healthcare concerns are deepening. Within the entrepreneurial community alone, 20 million men and women are uninsured. Since the year 2000, small business premiums have jumped more than 80 percent. As a result, millions of entrepreneurs and their employees have been forced out of the market.

Clearly, healthcare remains a serious problem for the small business community. Already, this committee has held more than a dozen hearings on the issue. In July, I helped to introduce bi-partisan legislation called the CHOICE Act, which included a number of provisions designed to make healthcare affordable for small firms. In this morning's hearing, we will continue to explore the various coverage challenges facing entrepreneurs, and discuss options for reforming the current system.

By definition, small firms have fewer employees and less capital than their corporate counterparts. Accordingly, they have less clout and bargaining power with big insurance companies. As a result, providers are not as compelled to offer competitive small business rates, leaving entrepreneurs with fewer options.

In addition to a lack of choices, small businesses are forced to foot the bill for insurance companies' high administrative costs. Because of their unique nature, small business coverage tends to be more specialized. Providers pour a great deal of money and man-hours into micro-targeting entrepreneurs. These expenses are ultimately reflected in increased premiums.

These steep administrative costs and limited provider options have made healthcare a small business nightmare. A movement towards universal coverage would be the best way to ensure that every entrepreneur and small business employee is covered. That said, any overhaul of the current system will have to be carefully orchestrated. At present, there are a number of potential means for doing so. They include allowances for personal tax incentives, mixed private-public insurance groups and public coverage.

But in order for any of these approaches to be viable, they must take a number of key provisions into account. They must be capable of not only easing administrative burdens and creating more choices, but also of eliminating the current system's complexity.

Any move to repair our broken healthcare system will have to strike a delicate balance. It must be cautious without being wavering. It must be resolute without being reckless. And-- most importantly-- it must be universal without being one-size-fits-all.
This is particularly true for our entrepreneurs, whose businesses represent 50 percent of the workforce and a myriad of diverse industries. But while small firms may be diverse in their unique interests, they are united in their need for healthcare. A need which must be met not just for the sake of our 26 million small businesses, but for the sake of America's 45.7 million uninsured, and the country as a whole.

U.S. House of Representatives
SMALL BUSINESS COMMITTEE
Thursday, September 18, 2008
Representative Steve Chabot, Republican Leader

Opening Statement of Ranking Member Steve Chabot

"Making Health Insurance Reform Work for Small Businesses"

"I'd like to thank each of our witnesses who have taken the time to provide this Committee with their testimony. I'd like to extend a special welcome to fellow Cincinnatian, James Eckstein, who I will introduce later.

"The cost of health insurance in general is rising faster than inflation, while the percentage of individuals without health insurance is rising. Today, more than 47 million Americans are without health insurance.

"For small businesses and their employees, soaring health costs are a critical issue. The cost of health insurance continued its 20-year reign as the number one issue worrying small business owners, according to NFIB. Roughly 63% of all uninsured workers are either self-employed or work for firms with fewer than 100 employees, estimates the Employee Benefit Research Institute. According to National Small Business Association, in 2007, only 47% of businesses with fewer than 500 employees offer health insurance, down from 58% in 1997.

"Our current system of health insurance and health care is financially unsustainable, and threatens the health and financial security of small businesses and their employees.

"Large employers, unlike small employers, are able to spread risk more broadly among their workers and enjoy economies of scale that keep administrative costs low. When a large employer self-insures, its health benefits are not subject to state insurance laws and regulations because it is not defined as "insurance." This, along with the broad risk spreading and low per person administrative costs, confers a considerable cost advantage over similar benefit plans in the small group or individual markets for insurance.

"Health care insurance reform should make the market for health insurance more competitive, resulting in greater access to quality care. Health care policy reforms should balance the competing goals of access to quality care, affordability, and predictability and consumer choice.

"Madam Chair, I look forward to working with you on this important issue. Again, I thank each of you for being here today and I yield back."

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MAKING HEALTH CARE REFORM WORK FOR SMALL BUSINESSES

Statement of

Linda J. Blumberg, Ph.D.

Principal Research Associate
The Urban Institute

Committee on Small Business
United States House of Representatives

September 18, 2008

Ms. Chairwoman, Mr. Chabot, and distinguished Members of the Committee:

Thank you for inviting me to share my views on health insurance and strategies for health care reform that affect small businesses and their workers. While I am an employee of the Urban Institute, this testimony reflects my views alone, and does not necessarily reflect those of the Urban Institute, its trustees, or its funders.

In brief, my main points are as follows:

- Small employers face substantial disadvantages relative to large employers when providing health insurance to their workers. These problems can largely be summarized as higher administrative costs of insurance, limited ability to spread health care risk, and a workforce with lower wages. All of these problems must be addressed if insurance coverage is to increase significantly among workers in small firms.

- Fixed administrative costs make it inefficient for insurers to sell coverage to small employers. The per-person price of buying insurance for a small group of individuals will always be higher than buying those same benefits for a large group. Allowing small employers and individuals to purchase coverage through organized purchasing pools, such as the Massachusetts Connector, state or federal employees benefit plans, public programs, or other such group purchasing entities is an approach that could provide small employers and individuals with an avenue for more efficient purchasing.

- With regard to the second problem facing small employers—the limited ability to spread risk—small employers tend to have workforces with greater variance in year-to-year health care costs than large employers, a sheer consequence of small numbers. Strategies are available to more broadly spread the risk associated with small-group and individual purchasing. Doing so could make coverage more affordable and accessible for workers in small firms. Strategies that would tend to further segment

the risks of small-firm workers, such as proposals to federally license association health plans or to increase coverage in the existing non-group insurance market, might lead to some savings for the healthy, but would do so at increased cost to the unhealthy, leading to no expected increase in insurance coverage.

- The third general problem—that small employers tend to have lower wage workforces than large employers—means that expansions of insurance coverage will require significant income-related subsidies to make coverage affordable for many uninsured workers. Because employers largely finance insurance by paying lower wages to their workers, expecting low-income workers to voluntarily seek out that type of trade-off is not practical.

- Once one accepts that substantial subsidies will be required to expand coverage significantly, a host of design issues come into play. These include defining what families at different income levels can afford to contribute to the cost of their medical care—including protecting the unhealthy from excessive out-of-pocket costs; mechanisms for making voluntary participation in insurance coverage as easy as possible; ensuring that each individual has a guaranteed source for purchasing coverage; keeping the administrative costs associated with delivering subsidies as low as possible; and, critically, identifying sufficient sources of financing.

- With regard to financing, policymakers have begun to consider the possibility of eliminating the current tax exemption for employer-sponsored insurance and redirecting that subsidy to finance reforms. The level of this tax expenditure is sufficient to finance comprehensive health care reform and is already dedicated to subsidizing health insurance. The current exemption is not particularly effective in expanding coverage, however, since it subsidizes most those who are most likely to purchase coverage even in the absence of any subsidy. However, great caution should be taken before eliminating this subsidy outright, because any changes to the current tax treatment can be highly disruptive to the existing system of employer-based health insurance. Eliminating this subsidy must be preceded with significant

reforms to the private individual insurance market to ensure that access to insurance coverage for those already insured not be adversely affected.

I. The Scope of Health Insurance Problems Facing Small Employers and Their Workers

As of 2006, only 35 percent of establishments in firms of fewer than 10 workers offer health insurance to any of their workers, compared with 98 percent of establishments in firms of 1,000 or more workers.[1]

Approximately 46 percent of workers employed by firms with fewer than 10 workers are offered and are eligible for enrollment in their own employer's health insurance plan, compared with 88 percent of workers employed in firms of 100 or more workers.[2] Workers in the smallest firms are also less likely than their large-firm counterparts to take up employer offers when they have one, although some of these workers receive coverage through a spouse employed by a larger firm.[3]

The lower rates of offer and take-up among small firms and their workers results in roughly 36 percent of workers in the smallest firms being uninsured, while only 10 percent of workers in the largest firms lack coverage.[4]

These lower rates of coverage among small employers are due, at least in part, to the fact that small employers must pay significantly more for the same health benefits than large employers. Smaller firms face much larger administrative costs per unit of benefit.[5] Administrative economies of scale occur because the costs of enrollment and other

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[1] Published tables, 2006 Medical Expenditure Panel Survey – Insurance Component, http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2006/tia2.pdf
[2] L. Clemans-Cope and B. Garrett. 2006. "Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005," Report to the Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/uninsured/upload/7599.pdf
[3] L. Clemans-Cope and B. Garrett. 2006. op cit.
[4] L. Clemans-Cope and B. Garrett. 2006. op cit.
[5] Congressional Research Service. 1988. *Costs and Effects of Extending Health Insurance Coverage.* Washington, DC: U.S. Government Printing Office.

activities by plans and providers are largely fixed costs.[6] Insurers simply have fewer workers over which to spread these fixed costs in small firms. In addition, insurers charge higher premiums to small employers, because small employers experience greater year-to-year variability in medical expenses than do large firms[7] simply because there are fewer workers over which to spread risk.

Another barrier to small employers providing health insurance is that the average worker in a small firm is paid significantly less than workers in large firms.[8] Economists believe that there is an implicit tradeoff between cash wages and health insurance benefits.[9] In other words, workers actually pay for the cost of their employers' contributions to their health insurance by receiving wages below what they would have received had no employer health insurance been offered. The lower wages of small-firm workers imply that they are far less able to pay for health insurance through wage reductions; consequently, their employers are less likely to offer them such benefits.

Workers in small firms that do not offer health insurance are often left with few options for health insurance coverage, and 70 percent of uninsured workers have no access to an employer-based insurance plan (either their own or through a family member). Those that do not have a spouse with an employer offer and who are not eligible for public insurance programs have the option of pursuing coverage in the private individual insurance market. In the vast majority of states, there is no guarantee that an individual can purchase health insurance in this market at any price. If a policy is made available, premiums in most states can be set very high as a consequence of current or prior health status, and benefit exclusions may permanently or temporarily exclude coverage for particular conditions, body parts, or body systems. Policies in this market also tend to have considerably higher cost-sharing requirements than is the case in the employer

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[6] L. J. Blumberg and L. M. Nichols. 2004. "Why Are So Many Americans Uninsured?" *Health Policy and the Uninsured*, Catherine G. McLaughlin, ed. Washington, DC: Urban Institute Press.
[7] D. Cutler. 1994. "Market Failure in Small Group Health Insurance." Working Paper No. 4879. Cambridge, MA: National Bureau of Economic Research, Inc.
[8] L. M. Nichols, L. J. Blumberg, G. P. Acs, C. E. Uccello, and J. A. Marsteller. 1997. *Small Employers: Their Diversity and Health Insurance.* Washington, DC: The Urban Institute.
[9] L. J. Blumberg. 1999. "Who Pays for Employer Sponsored Health Insurance? Evidence and Policy Implications," *Health Affairs*, vol. 18.

group market, as insurers perceive demand for more comprehensive policies as a signal for high expected medical care use. As a consequence, affordable policies in this market may still pose significant medical service access limitations for modest-income workers.

While increasing the offer rate among small employers might appear to be an obvious strategy for increasing employer-based insurance, doing so means pressing for an expansion of coverage by purchasers relatively inefficient at buying health insurance. Because small-employer purchasers face higher prices for the same set of benefits and tend to face barriers related to having a lower-wage workforce, changing their offer decisions absent a mandate is unlikely. In addition, it is much more difficult to target government subsidy dollars to the population most in need of financial assistance via employer as opposed to individual subsidies. This is because employer subsidies must be allocated according to employer characteristics, whereas need is much more closely related to individual characteristics. For these reasons, I would not encourage a strategy of subsidizing small employers to provide additional coverage directly. However, reforms should be structured in such a way as to not undermine the efforts of small employers who do provide coverage to their workers.

II. Possible Approaches for Addressing the Insurance Problems of Small Employers

A number of mechanisms can be used to address the problems facing small employers in the provision of health insurance to their workers. Some are strategies that apply to reducing the problem of the uninsured in general, and some are of particular interest to small employers and their workers. I focus my comments here on incremental types of reforms that deal explicitly with the small-business problems of high administrative loads, limited ability to spread health care risk, and low relative wages.

Purchasing Groups. Allowing small firms to band together for purchasing health insurance has some potential for lowering administrative cost loads. This has been the motivation of a number of purchasing pools that have been set up in various states. These purchasing pools often provide the additional benefit of making it more feasible for small employers to offer their workers a choice of health insurance plans. Instead of shopping

for plans independently, small employers (and sometimes individual purchasers) pay premiums to the purchasing pool on behalf of their workers, and the pool performs the administrative functions of plan choice, premium negotiation, enrollment, etc. Ideally, the insurance plans interact with the pool's administrator instead of each member firm, with marketing and screening activities performed more centrally.

While small-employer purchasing pools have met with success in some cases, realizing the efficiencies of large-scale purchasing has been difficult for several reasons. Chief among them has been the limited ability to reduce the role and inherent expense of insurance agents in the process.[10] So while purchasing pools can lower the administrative loads for small-group purchasers, these savings are more difficult to capture in practice than many policymakers and analysts have presumed. The most well-documented positive impact of purchasing pools to date has been an increase in the availability of plan choice for enrollees. Some pools have been plagued by adverse selection, due in large part to low enrollment, which has led to their eventual dissolution.[11] This highlights the need for additional risk-spreading approaches (discussed below) or of other strategies that would increase the size of purchasing pools.[12]

These types of purchasing pools also have significant potential for acting as the organizing entity for more comprehensive health care reforms.[13] In such a capacity, the pools would offer families and individuals both easier access to and a broader choice of health plans, provide consistency in coverage as people move from one job to another, and would lower administrative costs relative to those in the private nongroup market. This type of pool could also focus on the administration of subsidies, eliminating the

[10] D. W. Garnick, K. Swartz, and K. Skwara. 1998. "Insurance Agents: Ignored Players in Health Insurance Reforms," *Health Affairs*, 17(2): 137-143.
[11] E. K. Wicks and M. A. Hall. "Purchasing Cooperatives for Small Employers: Performance and Prospects," *Milbank Quarterly*, 2000, 78(4): 511–546.
[12] For example, one could increase the size of a purchasing pool by requiring that all employers of a particular size insure through the pool if they were to provide insurance at all; government employees can be provided coverage through the pool; subsidies for the purchase of insurance by low-income individuals could be provided only through the pool, etc.
[13] L. J. Blumberg et al. 2005. "Building the Roadmap to Coverage: Policy Choices and the Cost and Coverage Implications," Report to the Blue Cross Blue Shield of Massachusetts Foundation, http://www.roadmaptocoverage.org.

complexities of providing subsidies in a dispersed and varied market. If large enough, an organized purchasing pool could also provide an administrative structure that would manage competition among private plans to control the growth in premiums. Competition within the pools could be amplified by adding a public insurance option in the pools that could compete with private plans.

It is important to note that the purchasing pools described here do not include the legislatively proposed entities known as federally licensed association health plans (AHPs). The implications of AHPs are altogether different in that they are designed to allow particular multiemployer and multistate purchasing entities to avoid compliance with state health insurance regulations. As a consequence of the AHPs' ability to limit membership to select groups and to have their premiums determined separately from the traditional commercial insurance market, they are largely a tool for segmenting health care risk rather than for generating economies of scale.[14] In addition, analysts have concluded that AHPs are unlikely to increase health insurance coverage.[15]

Subsidization of Insurance Coverage for High-Cost Individuals. Insurers and others recognize that small employers are not large enough to have stable annual average health expenditures. Large firms have average health expenditures that are generally comparable to averages for the whole insured population; this is not the case for small firms. Even a single seriously ill worker or dependent enrolled in a small-group insurance policy can have tremendous effects on the average expenses of the group in a particular year, whereas a small number of high-cost cases in a large group would not substantially affect the group average. Unfortunately, regulatory reforms implemented thus far have

[14] M. Kofman and K. Polzer. 2004. "What Would Association Health Plans Mean for California?: Full Report." Prepared for the California Health Care Foundation, http://www.chcf.org/documents/insurance/AHPFullReport.pdf; L. J. Blumberg and Y. Shen. 2004. "The Effects of Introducing Federally Licensed Association Health Plans in California: A Quantitative Analysis." Prepared for the California HealthCare Foundation. Http://www.chcf.org/documents/insurance/AHPBlumberg.pdf.; and M. Kofman, K. Lucia, E. Bangit, and K. Pollitz. "Association Health Plans: What's All the Fuss About?" *Health Affairs*, November/December 2006, 25(6): 1591–1602.

[15] J. R. Baumgardner and S. A. Hagen. "Predicting Response to Regulatory Change in the Small Group Health Insurance Market: The Case of Association Health Plans and HealthMarts," *Inquiry*, Winter 2001/2002, 38(4): 351–364; L. J. Blumberg and Y. Shen. 2004. op. cit.

been unable to sufficiently spread these risks, perhaps, in large degree, due to the voluntary nature of insurance. State insurance regulations serve to spread the risks within the small-group insured population itself. But because firms can opt to provide coverage or not, when insurance regulations increase premiums for the healthy and decrease prices for the sick, some healthy groups opt out of insurance coverage in this market. The result has generally been found to be no net change in the number insured.[16]

Other risk-spreading mechanisms could work much more effectively, however. One proposal would combine the concepts of purchasing pools for administrative efficiency with explicit subsidization of the high-cost and low-income populations.[17] This proposal allows groups wishing to purchase insurance coverage in current markets under current insurance rules to continue to do so. However, it would provide structured insurance purchasing pools in each state in which employers and individuals could enroll in private health insurance plans or a public plan option at premiums that reflect the average cost of all insured persons in the state. Broad-based government funding sources would compensate insurers for the difference between the cost of actual enrollees and the statewide average cost.

The reforms implemented in Massachusetts include another risk-spreading approach. The state has merged the small-group and individual markets for premium-rating purposes, and requires that premiums charged for plans within the Connector not be higher than those charged for the plans outside the Connector. Effectively, these rules spread risk across the small-group and individual markets and across both the Connector and non-Connector plans. Whether this spreads risk sufficiently remains to be seen; the mandate that all adults have insurance coverage is likely to make the approach more sustainable than it would be in strictly voluntary markets.

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[16] L. M. Nichols. 2000. "State Regulation: What Have We Learned So Far?" *Journal of Health Politics, Policy, and Law.* 25(1): 175–96.

[17] J. Holahan, L. M. Nichols, and L. J. Blumberg. 2001. "Expanding Health Insurance Coverage: A New Federal/State Approach," *Covering America: Real Remedies for the Uninsured,* Jack Meyer and Elliott Wicks, eds., Economic and Social Research Institute.

Some have advocated using states' high-risk pools as the basis for addressing the needs of high-cost cases. These pools are generally available to individuals who have been refused insurance coverage in the private market, and who do not have offers of employer-sponsored insurance. This approach raises a number of concerns. First, by sending high health care need individuals to high-risk pools for coverage, risk within the insurance market is segmented further. Because the distribution of health care risk is highly skewed, with 10 percent of individuals accounting for about 50 percent of total national health expenditures,[18] cordoning this population off into their own insurance pools instead of averaging their expenses with the healthier population will lead to extremely high premiums. Providing them with adequate and affordable coverage through those separate pools would require enormous levels of government funding, far more than recent policy proposals would suggest.

Additionally, not all states currently have high-risk pools, and among those that do, limited public funding through state sources (frequently premium taxes on private insurance policies) have led to many of these pools having enrollment caps and charging premiums well in excess of standard policies in the private market. Some offer very limited benefit packages and most maintain preexisting condition exclusion periods and/or waiting periods. All of these limitations hamper the effectiveness of today's high-risk pools in absorbing risk from the private market. Broadening the base for financing these pools, loosening eligibility criteria for enrollment, making the insurance policies more comprehensive, and offering income-related premiums have the potential to make these high-risk pools powerful escape valves for the high cost in the small-group insurance market. However, doing so, as already noted, would require a tremendous dedication of government finances.

Subsidization of Insurance Coverage for Low-Income Individuals. Extensive research has demonstrated that low-income individuals are less likely to have health insurance than their higher-income counterparts. This holds true for workers in small and large

[18] S.H. Zuvekas and J.W. Cohen. 2007. "Prescription Drugs and the Changing Concentration of Health Expenditures," *Health Affairs*, 26(1): 249-257.

firms. Analysis has also shown that higher-income individuals are significantly more likely to take up an employer offer of health insurance than are lower-income workers.[19] In addition, there is evidence that low-income workers' decisions to take up health insurance offers are more responsive to price than are the decisions of higher-income workers.

The average wage of workers in the smallest firms (fewer than 10 workers) is 63 percent of that of workers in the largest firms (500 workers or more).[20] Workers in these small firms are more than twice as likely to have family income below 200 percent of the federal poverty level (FPL) than are workers in firms of 500 or more. This information, taken together with the analyses described above, suggests that affordability of health insurance is a significant barrier to coverage for many small-firm workers, as it is for the uninsured population at large. Consequently, significant inroads into reducing the number of uninsured in this population will require income-related subsidization of insurance coverage.

Subsidies to low-income families can take a number of forms: tax credits, vouchers, or other direct subsidies. What they are called is not important, but how they are designed, administered, and establish a guaranteed source of insurance for those using the credit are clearly critical to their potential for expanding coverage and for the governmental costs associated with delivering them. The more generous the subsidies relative to the price of insurance, the greater voluntary participation in health insurance coverage will be. However, it is highly subjective as to how much should be considered "affordable" to a family of a given income.

In work done to inform the reforms being implemented in Massachusetts, my colleagues and I developed benchmarks that policymakers could use to determine the maximum amounts individuals and families should be expected to pay for insurance premiums and

[19] L. J. Blumberg, L. M. Nichols, and J. Banthin. 2001. "Worker Decisions to Purchase Health Insurance," *International Journal of Health Care Finance and Economics.* vol. 1, pp. 305–325.; M. E. Chernew, K. D. Frick, and C. McLaughlin, "The Demand for Health Insurance Coverage by Low-Income Workers," *Health Services Research* 32, no. 4 (1997): 453–70.

[20] Urban Institute tabulations of a merged file of the 2005 February and March Current Population Surveys.

overall health spending.[21] In order to ensure affordable access to necessary medical care, we feel strongly that one must consider standards for both premiums and out-of-pocket expenses. If an insurance premium is low because the benefits provided are limited and/or require high cost-sharing, then the policy may not improve affordability of care, which depends on a combination of premiums and out-of-pocket expenses. This is especially a problem for those with chronic illness and others with above-average health needs. We have studied affordability by analyzing the family financial burdens of medical care relative to income of those between 300 and 500 percent of the FPL. This group is largely insured and does not have its financial burdens relative to income skewed downward as a consequence of extraordinarily high incomes. For families in this income group with full-year employer-sponsored insurance, median spending on premiums and out-of-pocket expenses constitutes just over 6 percent of family income, excluding contributions to coverage made by employers.[22] Families in this income group purchasing full-year nongroup health insurance spend about 12 percent of their income on premiums and out-of-pocket expenses. We suggested that those with lower incomes have affordability standards set below typical levels of spending for those with incomes of 300 to 500 percent of the FPL, with individuals at very low incomes (say below 150 percent of the FPL) not required to make any significant contributions to their medical care. Setting affordability standards and related subsidy schedules using designated shares of medical spending relative to income allows the policy to protect families from the likelihood that medical expenses continue to grow faster than wages.

Part of an individual's perception of what is affordable is whether the subsidy is made available when premium payments are due and whether there is any uncertainty as to what the subsidy will be. These issues relate, in particular, to practical concerns with the design of tax credits. Many low-income workers are likely to not have sufficient liquidity to front the full cost of health insurance premiums today on the promise of a refund after filing their tax return. Some mechanism for advancing the value of the credit

[21] L. J. Blumberg, J. Holahan, J. Hadley, and K. Nordahl. 2007. "Setting a Standard of Affordability for Health Insurance Coverage," *Health Affairs*, July/August 2007; 26(4): w463–w473.
[22] Including the tax preferred contributions made by employers, the median level of spending for this group is about 17 percent of income. The analysis also provides data on the mean and 75th percentile of spending.

to the insurer will be necessary for them to purchase coverage. While the Health Coverage Tax Credits (HCTC) for workers displaced by international trade advance tax credits to health insurers, there are delays in doing so, and that is with a very small program. Also, if, under a new program, tax credits were to vary with income and advanced tax credits were to be reconciled with end-of-year taxable income, a family might not know today what their final subsidy amount would be. Such uncertainty in the price they ultimately face for insurance could dissuade some from voluntarily purchasing coverage. Allowing subsidies to be determined based on prior-year income and/or limiting end-of-year reconciliation to very large changes in income could be helpful in this regard.

To get the largest possible bang for the government's subsidy dollar, the approach should also be sensitive to the administrative costs of delivering the subsidy. Some recent experience through the HCTC suggests that the administrative costs associated with delivering health-insurance tax credits are very high relative to administering subsidized insurance coverage through public programs. One recent estimate indicates that in FY 2007, only 66 percent of the cost of the HCTC went to pay for health care. The rest went to the Internal Revenue Service (IRS) (21 percent) and the cost of health plan administration (13 percent).[23] And the value of the HCTC does not vary with income; administering an income-related tax credit would surely cost significantly more to administer.

I believe that we could streamline the administrative costs of delivering subsidies if they were made available only for the purchase of coverage through organized guaranteed-issue purchasing pools, eligibility determination were done centrally following the most successful models used in public programs today, and mechanisms were developed for

[23] S. Dorn. 2007. "Administrative Costs for Advance Payment of Health Coverage Tax Credits: An Initial Analysis." The Commonwealth Fund Issue Brief; GAO. 2007. "Trade Adjustment Assistance: Changes to Funding Allocation and Eligibility Requirements Could Enhance States' Ability to Provide Benefits and Services," Washington, DC: U.S. Government Printing Office.

sharing data among public programs,[24] the IRS, and the new purchasing pools. Financing the subsidies is, however, where the rubber meets the road in health care reform. I am quite confident that we can design a policy approach that would significantly expand health insurance coverage, would spread health care risk more broadly, and would do so at a reasonable administrative cost. Designing such a reform, complex as it may sound at first, is actually the easy part. The most difficult truth is that financial resources are necessary for ensuring accessible, affordable, and adequate insurance for all Americans. There are many options for identifying the necessary funding. The current tax exemption for employer-sponsored insurance is one obvious source for consideration, and its redistribution has been proposed in a number of recent reform proposals. This subsidy could be redistributed to provide those with the greatest needs the greatest assistance, as opposed to the opposite, which is true today. The current level of this tax expenditure is sufficient to finance comprehensive health care reform and is already dedicated to subsidizing health insurance. The current spending is not particularly effective in expanding coverage, however, since it subsidizes most those who are most likely to purchase coverage even in the absence of any subsidy.

However, it is critical to remember that a reform of the tax code such as this would constitute a significant change in current incentives to purchase health insurance through employers. Eliminating the tax exemption would decrease the likelihood that individuals would purchase insurance through their employer. Because a majority of Americans still obtain insurance through their employers, such a change must be preceded by substantial reforms to individual insurance markets across the country, otherwise many individuals with current insurance coverage could find themselves without access to adequate coverage or to any coverage at all. Organized purchasing pools with guaranteed access to a defined minimum set of benefits would be a necessary component of such an approach. It is also advisable that such a change be phased in over time in order to minimize disruptions in coverage.

[24] S. Dorn and G. Kenney. 2006. "Automatically Enrolling Eligible Children and Families into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Federal Policymakers," Report to the Commonwealth Fund, http://www.cmwf.org/usr_doc/Dorn_auto-enrollingchildren_931.pdf, acc. 5/1/07.

III. Conclusions

While small businesses face formidable difficulties in providing affordable health insurance to their workers, tools are available for increasing coverage in this sector. The focus of such efforts should be on lowering administrative burdens, developing mechanisms for spreading the risk of high-cost cases more broadly, and subsidizing low-income workers. But while high administrative costs do raise premiums, the primary barriers to coverage for small-firm workers are their low incomes and their lack of insurance options that allow for broad-based pooling of health care risk. Both of these problems can be effectively addressed by developing a system of carefully designed purchasing pools and subsidies.

NEW AMERICA
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Statement of Len M. Nichols
Director, Health Policy Program
New America Foundation

House Committee on Small Business
Making Health Care Reform Work for Small Business

September 18, 2008

New America Foundation
1630 Connecticut Avenue, NW
Washington, DC 20009

Introduction

Chairwoman Velázquez, Ranking Member Chabot, members of the Committee, thank you for inviting me here to testify today. My name is Len M. Nichols and I direct the Health Policy Program at the New America Foundation, a non-profit, non-partisan public policy research institute based in Washington, D.C., with offices in Sacramento, California. Our program seeks to nurture, advance, and protect a fact- and logic-based conversation about comprehensive health care reform. We remain open minded about the means, but not the goals: all Americans should have ensured access to high-quality, affordable health care that is delivered within a politically and economically sustainable system. I am happy to share ideas for your consideration today and hereafter with you or your staff.

I would like to begin by applauding the work of the Chairwoman Velázquez (D-NY) and her cosponsors, Representatives Fattah (D-PA), Graves (R-MO), Pitts (R-PA), and Sires (D- NJ) for their work on the CHOICE Act. First and foremost, CHOICE is bipartisan. This is exceedingly important in this sometimes extremely partisan time. Bipartisanship is likely the only way we will be able to move our nation's health care system forward; members of both parties must agree on the general direction policy is headed. Specifically, this legislation would enable small employers to achieve some of the advantages—economies of scale, administrative efficiencies, and large risk pools—that large group insurance offers, and would subsidize small firms that offer coverage. Congresswoman Velázquez and her cosponsors should be commended for their efforts.

I would also like to take this occasion to congratulate the bipartisan, bicameral cosponsors of the SHOP Act[1] who have also created a bill that would enable more small businesses to gain access to quality, affordable health coverage. It is inspiring to see such efforts in both houses of Congress focused on small employers and on our health system in general, especially given our failure as a nation to reform our health system in the early 1990s.[2] Those of you who have read my prior work and testimony know I believe strongly that comprehensive health care reform is neither possible nor sustainable without bipartisan support.[3] The CHOICE and SHOP Acts add to a growing chorus that proves it is possible for us to move in this direction.

Overall Solution

In your invitation to testify you asked me to address a key question in the broader health reform conversation: how to make our health care system work for small businesses. This is clearly a critical question. More than 50 percent of uninsured workers are self-employed or work in a firm with fewer than 100 employees.[4] My primary answer is that we can help small employers and their workers the same ways that we can help all Americans:

1) Create a marketplace that is accessible, competitive, and fair; and
2) Reform our delivery system to elicit far more clinical value for our health care dollar.

New Marketplace

The current small group and individual insurance markets do not work very well for many Americans. Therefore, the first step to creating a health system that works for small businesses and the nation is to create a marketplace that is accessible. This requires guaranteed issue, a requirement that insurers sell to all customers, regardless of health status. The Health Insurance Portability and Accountability Act (HIPAA) made this a requirement for small business insurance products nationwide. However, this is not the case in the non-group insurance market in a vast majority of states where lack of guaranteed issue in the individual market leaves many Americans—sole proprietors, self-employed, and workers whose employers do not offer coverage—unable to access insurance.

However, just requiring access to the insurance marketplace is not enough. The marketplace must also be fair and affordable, which means insurers should not charge premiums based on health status (though modified community rating by age has a number of advantages over pure community rating[5]), and there must be subsidies for individuals who cannot afford health insurance on their own.

In the context of small employers, it is worth describing briefly the tradeoffs between subsidizing firms versus workers. While encouraging employers to offer coverage by subsidizing them would surely lead to more insurance coverage than we observe today, a fair amount of research has concluded that it is more efficient, especially in terms of dollars per newly insured, to subsidize workers directly.[6] Subsidizing employers without regard to income or wages will inevitably end up directing some portion of the limited subsidy resources to firms with higher wage workers. These types of firms (e.g. law or consulting firms), would likely offer generous coverage without new employer subsidies because many of them are already offering today. Subsidizing workers directly allows us to target those with lower incomes who are more likely to be uninsured because they cannot afford coverage, regardless of whether their firm offers health insurance or not. There are ways to target employer subsidies to be more efficient, and I would be glad to discuss some of those in the Q&A session and in follow-up meetings with your staffs if you would like.

More than target efficiency, the main reason to consider subsidizing workers instead of employers is the direction our health economy is headed. Compared to our global competitors, the U.S. health care system is both far more expensive and more reliant upon employer contributions. This does not help our country's ability to create and hold high value added, middle-class jobs.[7] Thus, policy changes that would increase, not decrease, reliance on employer financing should be weighed very carefully against feasible alternatives. If employers can remain American's primary source of health insurance only with greater and greater public subsidies over time, we might be wise to restructure insurance markets now in order to: 1) allow insurance markets to serve workers and families better and more efficiently, and 2) let most employers, especially smaller employers who face inherent diseconomies of scale in insurance provision, focus

on what they do best—creating jobs for Americans and generating products and services for the increasingly global marketplace.

Once insurance is accessible and affordable then there must also be a requirement that all individuals purchase health coverage. This protects against adverse selection (the tendency for high risk or sick people to buy insurance because they expect to need it, and for low risk or healthy people to remain uninsured) and enables insurers to compete based on price and value, not marketing and underwriting. Insurers competing in markets wherein individuals can remain uninsured will always seek to create value for the healthy by excluding the sick from their risk pools. The best way to transform insurers' business models into strategies that create value for everyone by improving enrollee health and convenience as much as possible is to re-organize their incentives. Purchase mandates, in addition to guaranteed issue and modified community rating, accomplish this goal by essentially making the risk pool the population and erasing the potential to earn high profits from excessive underwriting. If there is no financial incentive to underwrite aggressively, aggressive underwriting will disappear. The only way to make more money in an insurance environment where there is no incentive to underwrite is to demonstrate to more and more enrollees that you can improve their health efficiently in exchange for their premium dollar. These are exactly the market signals we need to send health insurers in the 21st century.

Both CHOICE and SHOP succeed in creating a marketplace that would work better than the status quo for American workers in small firms, regardless of whether they are sick or healthy. CHOICE would also create a new insurance company to spread the risks of those who enter the new marketplace. This could have advantages down the road. As we proceed toward more comprehensive reform, more people might be allowed to join in the new marketplace. This new "captive" insurer, for example, would never have had a culture of selecting risks and aggressive underwriting. Therefore, it could demonstrate the viability of a "new" kind of business model from its inception. Similar long run outcomes might be obtained just from melding the non-group, small group, and eventually the large group markets into one and using regulation to force existing private insurers to adopt the same kind of business model. However, the insurance model under the CHOICE Act might speed the transition along and therefore is worthy of serious consideration.

Delivery System Reform

No health reform proposal will be sustainable over time without serious efforts to improve the quality of patient care and get more value for our health care dollar. This will require a 21st century information infrastructure as well as more data about what works and does not work for whom in our health system. However and probably most importantly, we will never control health care costs unless we pay providers in a way that makes sense and introduce smart incentives to encourage patients to do the right thing. Comprehensive payment reform that uses health information technology and comparative quality information to align financial incentives with quality practice will save money and improve patient care.

Just because you are the Small Business Committee does not mean you must avoid considering key delivery system reform innovations. Indeed, the CHOICE Act requires employers to offer wellness programs in order to be eligible for the Small Business Choice Credit. As you clearly know, wellness and disease management programs have had very positive results for both large and small employers, and certainly for employees. This is one type of innovation that could help transform our health care delivery system and the health of our nation. Additional reforms you might consider include: incentives for enrollees to sign up with a qualified medical or health home and for providers to adopt electronic records and decision support tools.

Additional Issues to Consider

Anytime small business health care solutions are being discussed, a number of policy issues are brought to the forefront because they are either so important they should be considered or because they are particularly salient in health policy debates in general and should not be ignored. I will address three such policy questions during the remainder of my testimony:

1) If you create a new marketplace, should the old marketplace be allowed to continue?
2) Should you expand markets across state lines?
3) Who should be allowed to purchase insurance from the new marketplace?

Consequences of Multiple Marketplaces

As stated above, in order to address the small business health care crisis we must first create a marketplace that is accessible, fair, and affordable. The creation of a new marketplace, however, requires an answer to the question: What do you do with the old one? Ideally, the new marketplace would become the *only* small group (and possibly individual) market to protect against any risk of adverse selection over time and create the largest risk pool possible. Should you decide to leave both markets in place, however, the rules and requirements must be the same so that the healthy and sick have an equal likelihood of choosing to buy insurance through one market or the other. If the rules are not the same, then the healthy would always be attracted by lower premiums to the more heavily underwritten market. This will leave the other pool full of high risk, high cost customers, who will be hard for insurers to serve alone.

Now, making subsidies available only in the new market with the more stringent regulations will compensate for any inherent underwriting disadvantage, but a simpler strategy of making the new market work better is to make the new market the only market. If you believe the rules of the CHOICE Act's purchasing pool—guaranteed issue and strict community rating—are the right rules for small employers and their employees, why not make them the law of the land? Under this scenario your subsidies will actually go farther toward covering more Americans because they will not be diluted by higher premiums as a result of lower quality risk pools in the new marketplace.

Selling Insurance across State Lines

Several previous and current proposals purporting to help small businesses would allow groups to purchase insurance across state lines. While this sounds inherently appealing to anyone in favor of market competition, this approach has a number of risks that stem from the intrinsically problematic nature of insurer competition when insurers are governed by different regulations. In the small group market case (unlike the non-group market case), these risks are mitigated somewhat by HIPAA, which requires insurers in every state to offer all products on a guaranteed issue basis to all small employers. Still, across-state-line competition would make it very difficult for insurers in states which require certain benefits (i.e. maternity care) to be covered to compete on price with insurers from states without a maternity benefit mandate. The logical and practical extension of this would be very few if any benefit mandates could survive in the long run. In effect, selling across state lines would reduce every state's insurance market rules to those that are operable in the least restrictive state in the country. Thus, "across state lines" is in essence a federal law that would undermine the insurance laws of all but one state (the state with the fewest regulations).

The fundamental problem with "across state lines" is that buying health insurance is not like buying a car where you can add air conditioning or a high-end stereo system as a matter of on-the-spot consumer preference and differential willingness to pay. Health risks are *probabilities*. Very few people know the odds of getting cancer or conceiving a child. Therefore, if benefit packages were allowed to vary infinitely and carve out expensive conditions or treatments that "many will not need," many people would be effectively uncovered for what they may need the most. Policies that were more comprehensive in this environment would end up costing high health risks—or regular people who want what we consider to be standard insurance protection today—quite a bit because risk pools would become increasingly segmented over time.

Market Eligibility

If you take the first step by creating a new insurance marketplace for small firms, who should be allowed to buy health coverage in it? In the context of proposals aimed at small employers this question usually focuses on whether or not to permit the self-employed or "business groups of one" to buy coverage in the new pool. Prohibiting the self-employed from accessing the new market could inadvertently stifle entrepreneurship by encouraging "job lock" or staying in a job as an employee in order to maintain health benefits. On the other hand, there is a selection risk associated with allowing the self-employed to enter the pool initially, especially if the non-group market is allowed to remain as it is at present. In that case, since guaranteed issue is the law in the small group market but typically not in the non-group market, the self-employed who would fare well in a heavily underwritten market will purchase in the non-group market and only those with significant health risks will purchase in the guaranteed issue small group market. If pooled with *all* small groups, the impact on average premiums in the small group market might not be very great, but in most markets insurers are allowed (and therefore do) segment their pricing by business size classes. In this case, as in Colorado in the mid-

1990s, passage of a business group of one rule can lead to very rapid increases in premiums for the 1–5 employee size class.

This problem could be mitigated if the small group and individual markets were combined with one set of guaranteed issue plus modified community rating rules for all people. Under this scenario, employer groups would not be rated separately as employer groups and all people the same age would be charged the same premium by each insurer. Employers could contribute whatever they and workers negotiate in that regard. In the long run, large firms could also be allowed to enter the marketplace. This would lead to the kind of efficient and powerful insurance marketplace that a number of health proposals have envisioned recently: Insurance marketplaces that can be catalytic in bringing about the delivery system reforms we need to sustain comprehensive health reform.[8]

Conclusion

Small employers will always hold a large stake in conversations about health care reform because no single group is more important to the American economy and society. Small group insurance markets have been the focus of repeated policy interventions since the late 1980s. Small employers have long suffered from high administrative loads (and therefore high premiums), little effective competition (and therefore rapidly rising premiums), and increasingly intense competition from large domestic firms and foreign competitors. Thus, it is clear that health reforms focused on increasing access to quality, affordable health coverage for small businesses could serve as an important and catalytic step for changes nationwide. As you contemplate how best to design a marketplace for small employers, I encourage you to take care to build a marketplace with rules and institutions that would welcome more and more Americans into the new risk pool over time. This eventual marketplace could prove to be an essential part of a more value-oriented health system that would better serve small employers and all Americans.

Notes

[1] Sen. Richard Durbin (D-IL), Sen. Jeff Bingaman (D-NM), Sen. Christopher Bond (R-MO), Sen. Robert Casey (D-PA), Sen. Norm Coleman (R-MN), Sen. Susan Collins (R-ME), Sen. Amy Klobuchar (D-MN), Sen. Herbert Kohl (D-WI), Sen. Joseph Lieberman (I-CT), Sen. Blanche Lincoln (D-AR), Sen. Mark Pryor (D-AR), Sen. Ken Salazar (D-CO), Sen. Olympia Snowe (R-ME), and Sen. Arlen Specter (R-PA). Rep. Ronald Kind, (D-WI), Rep. Thomas Allen (D-ME), Rep. Jason Altmire (D-PA), Rep. John Barrow (D-GA), Rep. Roscoe Bartlett (R-MD), Rep. Shelley Berkley (D-NV), Rep. Bruce Braley (D-IA), Rep. Lois Capps (D-CA), Rep. Russ Carnahan (D-MO), Rep. André Carson (D-IN), Rep. Donald Cazayoux (D-LA), Rep. Travis Childers (D-MS), Rep. Steve Cohen (D-TN), Rep. Jerry Costello (D-IL), Rep. Joe Courtney (D-CT), Rep. Joseph Crowley (D-NY), Rep. Diana DeGette (D-CO), Rep. Charles Dent (R-PA), Rep. Joe Donnelly (D-IN), Rep. Brad Ellsworth (D-IN), Rep. Rahm Emanuel (D-IL), Rep. Jo Ann Emerson (R-MO), Rep. Philip English (R-PA), Rep. Bill Foster (D-IL), Rep. Jim Gerlach (R-PA), Rep. Gabrielle Giffords (D-AZ), Rep. Kay Granger (R-TX), Rep. Paul Hodes (D-NH), Rep. Jesse Jackson (D-IL), Rep. Steve Kagen (D-WI), Rep. Daniel Lipinski (D-IL), Rep. Tim Mahoney (D-FL), Rep. Donald Manzullo (R-IL), Rep. Patrick Murphy (D-PA), Rep. Tim Murphy (R-PA), Rep. Joseph Pitts (R-PA), Rep. James Ramstad (R-MN), Rep. Mike Ross (D-AR), Rep. Allyson Schwartz (D-PA), Rep. Christopher Shays (R-CT), Rep. Carol Shea-Porter (D-NH), Rep. Albio Sires (D-NJ), Rep. Zachary Space (D-OH), Rep. Peter Welch (D-VT), Rep. Charles Wilson (D-OH), Rep. Frank Wolf (R-VA), Rep. Bill Young (R-FL), Rep. Christopher Carney (D-PA), Rep. Michael Michaud (D-ME), Rep. Robert Wexler (D-FL), and Rep. Kirsten E. Gillibrand (D-NY).

[2] As in: "Healthy Americans Act," *S. 334*, 110th Cong., 2007–2008. These efforts are spearheaded by: Sen. Ron Wyden (D-OR), Sen. Robert Bennett (R-UT), Sen. Lamar Alexander (R-TN), Sen. Maria Cantwell (D-WA), Sen. Thomas Carper (D-DE), Sen. Norm Coleman (R-MN), Sen. Bob Corker (R-TN), Sen. Michael Crapo (R-ID), Sen. Charles Grassley (R-IA), Sen. Judd Gregg (R-NH), Sen. Daniel Inouye (D-HI), Sen. Mary Landrieu (D-LA), Sen. Joseph Lieberman (I-CT), Sen. Bill Nelson (D-FL), Sen. Gordon Smith (R-OR), Sen. Debbie Ann Stabenow (D-MI). As in: "Healthy Americans Act," *HR. 6444*, 110th Cong., 2007–2008, Rep. Debbie Wasserman Schultz (D-FL), Rep. Brian Baird (D-WA), Rep. Earl Blumenauer (D-OR), Rep. Jim Cooper (D-TN), Rep. Artur Davis (D-AL), Rep. Norman Dicks (D-WA), Rep. Jo Ann Emerson (R-MO), Rep. Philip English (R-PA), Rep. Anna Eshoo (D-CA), Rep. Jane Harman (D-CA), Rep. Alcee Hastings (D-FL), Rep. Rubén Hinojosa (D-TX), Rep. Darlene Hooley (D-OR), Rep. Daniel Lipinski (D-IL), Rep. Carolyn McCarthy (D-NY), Rep. Kendrick Meek (D-FL), Rep. James Moran (D-VA), Rep. Ileana Ros-Lehtinen (R-FL), Rep. Victor Snyder (D-AR), Rep. Niki Tsongas (D-MA), Rep. Peter Welch (D-VT), Rep. David Wu (D-OR). As in: "American Health Benefits Program Act of 2008," *HR. 5348*, 110th Cong., 2007–2008, Rep. Jim Langevin (D-RI) and Rep. Christopher Shays (R-CT).

[3] For Len M. Nichols testimony, see: http://www.newamerica.net/files/archive/Doc_File_2330_1.pdf; http://www.newamerica.net/files/archive/Doc_File_3018_1.pdf; http://www.newamerica.net/files/Nichols%20Testimony%20-%20Senate%20Budget%20June%2026%202007%20Final.pdf

[4] Sarah Axeen & Elizabeth Carpenter, "Who are the Uninsured?" *New America Foundation*, (December 2007).

[5] Age rating allows premiums to be as low as possible for young customers, which helps bring healthy enrollees into the risk pool. In addition, young people are more likely to be low-income. In a world with income-based subsidies, older, low wage workers are also protected.

[6] Ferry, Danielle, Sherry Glied, Bowen Garrett, and Len M. Nichols, "Health Insurance Expansions of Working Families: A Comparison of Targeting Strategies," Health Affairs 21, no. 4 (July/August 2002).

[7] Len M. Nichols & Sarah Axeen, "Employer Health Costs in a Global Economy: A Competitive Disadvantage for U.S. Firms," *New America Foundation*, (May 2008).

[8] For examples of proposals that would, see: Len M. Nichols, "A Sustainable Health System for All Americans," *New America Foundation*, July 2007; ERISA Industry Committee, "A New Benefit Platform for Life Security," May 2007; Committee for Economic Development, "Quality Affordable Health Care for

All," *Research and Policy Committee of the Committee for Economic Development*, 2007; Senator Ron Wyden, "Healthy Americans Act," *S. 334*, 110th Cong., 2007–2008; Representative Debbie Wasserman-Schultz, "Healthy Americans Act," *HR. 6444*, 110th Cong., 2007–2008; Representatives Jim Langevin & Christopher Shays, "American Health Benefits Program Act," *H.R. 5348*, 110th Cong., 2007–2008.

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CONGRESSIONAL TESTIMONY

Time to Evolve Beyond Traditional Employer-Sponsored Health Insurance for Small Firms

Testimony of

Stuart M. Butler, PhD
Vice President, Domestic and Economic Policy Studies
The Heritage Foundation

Before the
U.S. House of Representatives Committee on Small Business

Delivered on
September 18, 2008

My name is Stuart Butler. I am the Vice President of Domestic and Economic Policy Studies for The Heritage Foundation. Thank you for inviting me to testify today. The views I express in this testimony are my own, and should not be construed to represent any official position of The Heritage Foundation.

Summary Points

- *The nature of the workforce is changing*, as it is decreasingly characterized by traditional, long-standing employer-employee relationships.

- *Insurance is not sufficiently portable*, which endangers coverage when workers switch jobs or work arrangements and inhibits labor market efficiency.

- *Firms, and especially small firms, face difficulties and disincentives*, and they may not have either the capacity or the incentive to offer health insurance benefits.

- *Unequal tax treatment skews the system*, benefiting the employer-sponsored system to the exclusion of others and offering little relief to low-income families.

Crafting a better health insurance opportunities for working Americans in small firms includes three key elements.

1. *Create insurance exchanges.* State-chartered insurance exchanges would offer menus of portable health plans to working families and enable the development of large and diverse insurance pools with stable and predictable premiums.
    - A range of plans would be offered, much like the FEHBP.
    - With the state, exchanges would develop risk adjustment and pooling mechanisms.
    - Plans could be offered by organizations with a common affiliation, such as labor unions, farm bureaus or church consortia, with limited membership or open to all, much like the FEHBP.

2. *Transform employers into facilitators, not sponsors, of coverage.* Employers choosing not to sponsor coverage would take on the role of facilitating coverage by performing payroll deductions and consolidating and distributing premium payments.
    - Employers, either individually or as a group, would not be the risk holder or the direct purchaser of insurance. As in the FEHBP, employees would make the plan selection.

3. *Reform tax treatment.* Insurance exchanges would be explicitly given the same tax exemptions enjoyed by the employer-based system today. In addition, a cap on the tax exemption for health benefits and a refundable, advanceable credit for low-income families would be introduced to promote fairness.

The Problem We Face[1]

The current employer-sponsored health insurance system has created two very different worlds. In one, long-serving employees of large firms receive adequate and dependable health-care coverage. In the other—which generally includes workers who are more mobile, part-time, self-employed, or employed by smaller firms—health-care coverage is far less predictable and often more costly. This challenge is only getting more urgent as increased labor mobility and escalating health costs strain the fraying employer-linked health infrastructure, leaving more workers facing dire health-care burdens or joining the ranks of the uninsured.

Our unique employer-based health system emerged out of historical accident. Most notably, the wage controls imposed during World War II and regulations providing the tax exemption for employer-sponsored health insurance encouraged employers to use health insurance coverage as compensation.

In some cases, this system operates well. But increasingly and especially for those in the small business sector, the traditional vision of employer-based system is insufficient to meet the needs of today's fluid economy and workforce. For the small business sector four significant factors contribute to the shortcomings of the present system.

- **The changing nature of the workforce**. The traditional case for employer-sponsored insurance implicitly assumes that families have a strong and continuous link with their workplace. But this is becoming less true in the United States. While in 1983, almost two-thirds of men in their fifties had spent 10 or more years with the same employer, by 2004, that ratio had fallen to about one-half. Today, as much as a quarter of the workforce changes jobs every year. In addition, the number of workers with alternative working arrangements, such as independent contracting, has increased substantially and now represents about 11 percent of the workforce, with another 17 percent of the workforce classified as part-time. These workers lack the close and long-standing links to large firms assumed by the current health coverage system.

- **Lack of insurance portability.** Though workers are more mobile, their health insurance is not. Changing jobs may mean giving up preferred doctors, losing specific drug coverage, or even losing coverage altogether. Health benefits have also become an influential factor in employment decisions. Workers are reluctant to leave jobs with good health-care coverage or to take jobs with insufficient health benefits, jamming labor markets and inhibiting labor market efficiency.

- **Difficulties and disincentives faced by firms.** Some firms, particularly small ones, struggle to offer health-care benefits to their employees. In fact, most very small firms offer no coverage at all. A large proportion of workers in certain types of firms

[1] Parts of this testimony draw from Stuart M. Butler's discussion paper: *Evolving Beyond Traditional Employer-Sponsored Health Insurance.* (The Brookings Institution, Washington D.C., 2007). Available at http://www.brookings.edu/papers/2007/~/media/Files/rc/papers/2007/05healthcare_butler/200705butler.pdf

are not even offered insurance. According to EBRI, data from the Census Bureau's Survey of Income and Program Participation for 2002 indicate that 54.1 percent of uninsured employees were not offered insurance by their employer. Firm size is the dominant factor. The annual survey of employers conducted by the Kaiser Family Foundation and the Health Research and Education Trust found that, in 2005, only 48 percent of firms with 3 to 9 employees, and 73 percent of firms with 10 to 24 employees, offered coverage at all, compared with 98 percent of firms employing 200 or more. Another Kaiser study found that almost half the decline in adults with employer-sponsored insurance during 2001-05 was due to employers (typically small firms) dropping coverage.

A small employee base limits the extent to which risks can be dispersed, making it more perilous for smaller firms to sponsor health insurance. In addition, small firms may have trouble shouldering the administrative burdens of health insurance sponsorship. Accordingly, firm size is a dominant factor in explaining whether a firm offers coverage: under half of firms with three to nine employees offered coverage in 2005, compared with 98 percent of firms employing 200 or more. Additionally, firms with relatively high turnover have little incentive to invest in the long-term health of their employees. Finally, the primary concern of firms is their bottom line; putting health benefits on a precarious footing should the firm need to cut spending.

- **Unequal tax treatment.** Employers receive a tax deduction for contributing to insurance coverage for their employees, as they do for most forms of employee compensation. But health insurance premium contributions are also excludable from the employee's taxable income, a tax break that totaled an estimated $210 billion in 2006. This tax break can be both unfair and inefficient. First, it is only available if the employer offers insurance, excluding millions of working families. Second, because the subsidy is effectively a tax deduction, the benefit is highly skewed towards upper-income employees with higher tax brackets and typically more generous coverage. Thus, whereas families with incomes of $100,000 or more received an average subsidy of $2,780 in 2004, families in the $40,000 to $50,000 range received only $1,448, and families making less than $10,000 received a meager $102.

Avoiding the Mistake of Turning Small Firms into Large Insurers

As noted, owners of small firms face a lopsided playing field in trying to offer their employees health insurance. So it is understandable that an attractive approach to dealing with this might seem to be to find netter ways of enabling small firms to organize and finance insurance much like that offered by larger firms. That approach has led some analysts and lawmakers to proceed down the road of grouping small firms together in some way in order to increase their purchasing power and risk pool. The approach has also led to suggestions that tax breaks or other subsidies be designed to induce small employers to offer coverage.

While there might be elements of this approach which would somewhat improve the current situation, as a strategic step it is the wrong one.

For one thing it does not tackle the inherent weakness of using the place of employment as the determinant of coverage, a weakness that is especially problematic for small firms. Portability would still be a problem for employees in a sector marked by high employee turnover. It would be reduced somewhat if firms were grouped together, but there would still be a high probability of households encountering different plans or gaps in coverage when an employee changed jobs. And owners of firms would still lack the technical skills to provide good coverage – or they would have to contribute to the cost of such expertise in a cooperative or group of some form.

Moreover, trying to incetivize small firms to take on insurance responsibilities through such things as a special tax credit is likely to be complex and very expensive. In particular, a tax credit to subsidize small employer coverage could turn out to be among the most expensive ways of increasing coverage. If a credit were to be offered only for firms not now covering their employees there would be a perverse incentive for firms to drop their current coverage until they could quality for a credit as a non-offering firm. But if the credit were offered to all firms below a certain size, then money would be "wasted" on owners already covering their workforce. Meanwhile many small business owners would still not want to take on the responsibility of providing coverage even if they were offered a subsidy.

For these reasons the cost per newly insured individual associated with tax credits to employers is likely to be very high. Indeed, some reliable estimates put the cost at more than double the cost of other approaches, such as a credit directly to workers or an expansion of public programs.

A Better Approach: Health Exchanges with Small Employers as Insurance Facilitators not Sponsors

An alternative approach is to start by envisioning a separation of the two functions of the employer in traditional employer-sponsored insurance: organizing or sponsoring insurance; and facilitating the transactions and other paperwork associated with coverage. We have been steadily separating these functions with employer-based retirement plans – by transferring the sponsorship function increasingly to mutual funds available through 401(k)s, while employers focus more on payroll deduction systems, financial contributions, and providing information. The same approach should characterize how we think of the future of health insurance coverage in the small business sector, with health insurance exchanges taking over the organization and sponsorship of insurance. While this shares some of the features associated with a small business cooperative, it differs in that it does not see the employer as part of an insurance cooperative. On the other hand, cooperatives based on union membership or other non-employer specific affiliations, would be compatible with the health exchange approach.

This separation of employer sponsorship and facilitating functions would be good for employees, since it would increase their choice of tax-advantaged plans by providing access to plans available through trusted agents in the exchange, rather than only plans selected by the employer. Families with plans obtained through an insurance exchange would also gain the certainty and true portability of coverage that millions of working families lack today.

The separation would also be good for employers. While the typically larger firms that are comfortable with traditional plan sponsorship could continue to organize and manage employee coverage, other employers could avoid those headaches. Yet they would also have an important new way of providing health benefits via the workplace—benefits that would typically be more attractive than those available through the vast majority of firms today, with expanded choice and improved portability. By delegating the cumbersome sponsorship functions, these employers could then focus greater attention on their core business activities. In addition, with the exchange itself distributing the insurance risk associated with higher-risk families, employers opting for the exchanges would have few or no concerns about potential medical problems associated with new hires.

Separating the sponsorship and facilitation functions would actually make it more attractive for smaller firms to make coverage available to employees, and even to contribute to it. With the exchange available as a source of coverage, small firms could offer access to a range of coverage that is normally unthinkable for them to offer today. And free of the administrative complexity and selection risk, many such firms likely would decide to contribute to comprehensive benefits (for example, through a defined financial contribution), rather than struggle to offer less adequate benefits themselves as they often do today.

This general approach has three elements:

Element 1: A State-Based Health Exchange Approach

The structural weaknesses of the employer-sponsored insurance system are likely to get worse over time, given the increasing mobility of the workforce and rising pressures from growing health-care costs. A health exchange addresses these weaknesses by giving all workers access to portable health insurance coverage, effective insurance pools, and the tax benefits provided to today's employer-sponsored system.

Insurance exchanges would be single-market clearinghouses offering menus of portable health plans to families via their employers. They would not operate insurance plans but would serve as the central venue for parties offering and purchasing health insurance. Examples of exchanges already in existence include Massachusetts' "Connector" and the Federal Employee Health Benefits Program (FEHBP). The latter provides complete plan portability within federal jobs, serving approximately eight million federal employees and retirees nationwide.

State Role. States would charter insurance exchanges under state law. States would take the lead in establishing the rules and regulations governing insurance and the functioning of the exchanges, as well as requirements, if any, regarding employer participation (though employers offering health insurance coverage under ERISA could continue their sponsoring role). This state-based approach has three important benefits: First, states would be better able to design exchanges to meet local conditions and needs. Second, variations from state to state would provide useful data about which models work. Third, it sidesteps logistically and politically difficult issues regarding federal versus state control, especially as insurance regulation is primarily a state function.

Alternative Pooling Groups. Under the exchange system, many organizations would be able to offer insurance under the same tax exemptions that employer-sponsored insurance receives today. Unions and religious organizations, for example, could take on this role. These groups could also offer coverage to workers outside of their regular membership, expanding the choices available to workers. Typically, they would negotiate with carriers to provide insurance rather than undertake the insurance risk themselves. These alternative insurance pools would free insurance from current ties to the workplace. Self-employed workers would be able to join insurance pools simply by virtue of being state residents, and all working families would have the opportunity to participate in insurance pools that were large, stable, and spread risk more effectively than many employers can.

Element 2: The Employer as Facilitator, Not Sponsor

Insurance exchanges would coordinate coverage options and facilitate the development of insurance pools, both things that the current employer landscape fails to do consistently. In addition, it would mean a change in the role of employers choosing not to sponsor health insurance, turning them into access points for the exchange. Though in theory people could join the insurance exchanges directly, employers would serve as useful intermediaries. Employers already have payroll deduction and tax withholding infrastructures, and employers have generally become efficient facilitators of payments over their long history of experience. Employers' proximity to workers could also boost enrollment, as workers could easily signup for benefits at their workplace. In addition, retaining an employer-centric system would enhance this approach's compatibility with the current system; this could reduce potential opposition and prevent disruptions to well-functioning employer-sponsored structures already in place.

Employers using the exchange would have two key functions: handling tax subsidies and organizing the collection and payment of premiums. This facilitation role would be nothing new for most firms. Employers of all sizes today are required to distribute IRS withholding forms, deduct amounts from paychecks for taxes, and remit money to the government. Employers also commonly facilitate employee payments into retirement and college savings plans, many of which are portable. The new roles under the insurance exchange would thus represent a minimal burden on employers, a point supported by survey data: the Commonwealth Fund has found that some 73 percent of large firms and 88 percent of small firms expressed willingness to organize payroll deductions and to coordinate premium payments for government-administered health programs.

Under this system, employers would benefit from more choice and flexibility. Employers could offer health benefits to their workers through the insurance exchanges without taking on the full burden of sponsorship, and in doing so could offer a much wider variety of plans than would be conceivable for most small businesses today. Employers could also continue to contribute to insurance, as many currently do, and could do so with more flexibility, including offering prorated plans to part-time workers (who could fund the rest of the plan from other family earnings). An additional benefit would be the freeing up of labor markets, as employees would no longer need to consider health benefits in making career decisions, and employers would no longer have an incentive to avoid potential hires based on their health risks.

Element 3: The Tax Treatment of Health Insurance

While states do not need federal legislation to create insurance exchanges, a clarification of federal rules would be important in order to ensure that exchanges can function as valid and equal alternatives to employer-sponsored health care. Specifically, federal language should explicitly allow qualified state health insurance exchanges to receive the same tax exemption that applies to employer and employee contributions today. Though this is generally possible today, ambiguity remains in various areas, such as what legal role the employer must play.

Wider tax reform, however, would make tax subsidies for health coverage more fair and efficient. For instance, Congress could enact a gradually tightening cap on the value of the tax exclusion for employer-sponsored health insurance while simultaneously introducing a tax credit for low-income families. Sponsored benefits above the amount of the cap would be taxed as cash compensation for families above a certain income. To minimize economic disruptions and political opposition, the cap could be structured to affect only a relatively small proportion of Americans initially, but be indexed at a rate lower than the expected rise of health benefit costs, so that over time, the number of people affected would increase. This cap would limit the inefficient incentive for employers to provide compensation in the form of health benefits (rather than other benefits or wage increases) and could encourage employees and employers alike to press for more economical health services.

The tax credit would be available to families below 200 percent of the poverty level and would be designed to offset most of the cost of a base plan. As many scholars have noted, a credit is more efficient and vertically equitable than a deduction or exclusion. The federal government would bear primary responsibility for funding the tax credit (which could be funded, in part, by potential revenue from the cap).

Insurance Exchanges in Practice

In sum, the exchanges would help to aggregate consumers into insurance groups, whether by employer, union, or other organizing scheme. The groups would pool large numbers

of participants with diverse risk profiles and choose among the plans offered by insurers through the exchange to provide coverage options to their members. The insurance exchange would provide the venue and regulation for these transactions. The access point for most consumers would be their employer, who would also facilitate payroll deductions, tax withholding, and premium payments.

The benefits would be multifold. Insurance premiums would be more stable and predictable, as workers would be pooled into large and stable groups, dispersing the risks of unpredictable and extreme costs. Consumers would have the choice of a variety of plans that they could keep from job to job while still being able to arrange insurance conveniently through their workplace. Employers could continue to offer their own coverage but would have the option of instead facilitating their employees' health benefits through the exchange system, with the ability to still contribute to their employees' plans. Furthermore, the development of more permanent relationships between workers and insurers would give insurance providers the incentive to craft policies designed and priced for long-term coverage, including more attention to lifelong wellness and preventive care.

That concludes my testimony today. Thank you for this opportunity. I look forward to your questions.

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The Coca-Cola Bottlers' Association

Statement of W. Thomas Haynes

Executive Director, The Coca-Cola Bottlers' Association

House Committee on Small Business

"Making Health Care Reform Work for Small Business"

September 18, 2008

Thank you, Chairwoman Velazquez, for the opportunity to testify before the House Committee on Small Business to discuss policy solutions aimed at providing small businesses and their employees with access to affordable health care. I am appearing today as Executive Director of The Coca-Cola Bottlers' Association (CCBA), which represents 73 bottlers and 87,000 employees in all 50 states. I have also previously served as President of the Association Health Care Coalition (TAHC), a coalition of trade and professional associations that is committed to improving the health care options available to their small business members and testified in 2004 and 2005 on behalf of both CCBA and TAHC before both this Committee and the Senate Committee on Small Business & Entrepeneurship on various options for solving the health care challenges facing small businesses and their employees.

I thank you not only for the invitation, but more importantly for your leadership and support of innovative solutions to the small business health care crisis, including your sponsorship of HR 6582, The Small Business Health Care "CHOICE" Act of 2008. I also commend Congressman Pitts for his leadership in joining you as the lead cosponsor. For reasons which I will outline, I believe that the CHOICE Act will dramatically expand the affordable options available to small businesses and will make a sizable contribution toward solving America's health care challenges, probably to a degree that is far beyond the expectations of most, who may only see it as a first step toward health care reform. To a significant degree, and for the reasons that I will articulate below, I think it will eventually be viewed as the centerpiece of a marketplace-oriented, bipartisan solution to a problem that has plagued us for at least two decades—the challenges associated with providing affordable health care primarily through the workplace in an economy in which small businesses are the job creation and growth engine.

Before I specifically address this groundbreaking bill, I would like to provide you some background on CCBA's experience with health care insurance programs, its learning from participation in other insurance markets, and its efforts to develop new solutions for its

members, many of which are prototypical small and mid-sized businesses, but some of which are very large businesses. That experience has taught us a lot about the very different challenges facing small businesses and larger businesses in providing health care to their employees and the forces that have driven increases in the ranks of the working uninsured, almost all of whom are employed by small businesses that would like to provide competitive health benefits. It also demonstrates the genius of a creative solution in the form of the CHOICE Act.

Coca-Cola Bottlers' Association Health Care Plans

For nearly 100 years, the CCBA has sponsored programs for our member bottlers. For most of that period, medical and other benefit programs have been one of our core offerings. We historically administered two separate health care plans: a fully-pooled program for small bottlers under 100 employees; and another individually experience rated program for those bottlers with over 100 employees. Both programs were fully insured, but involved various levels of risk retention by CCBA and its members.

Until 2000, CCBA's small member health care plan was able to significantly reduce the cost of insurance by combining over 60 small employers who participated in our fully pooled program with administrative costs of approximately 7%. This fully-pooled program for small employers (under 100 employees) was disbanded at the end of 2000 due to the overwhelming complexity of state small group reform laws and regulations. These well-meaning but complex and expensive laws caused virtually all insurance companies to cease participating in multi-state arrangements due to their reluctance to navigate the myriad individual state premium and coverage requirements for small employers.

Since then, health insurance premiums for our smaller member bottlers have increased from 20% to 25% annually. Further, their plan offerings have increasingly utilized higher copays, higher deductibles and higher annual out-of-pocket maximums. These changes have greatly reduced the employees' participation rates, effectively pricing 50% of the employees out of insurance and increasing the number of uninsured employees.

While CCBA was forced to disband our benefit plan for small employers, we have been able to continue operating the health plan for the benefit of our larger employer members (Coca-Cola bottlers with more than 100 employees). While our small employer members have incurred **20% to 25% annual** premium increases, our large employer members have been able to continue benefiting from the cost-saving efficiencies of participation in the CCBA plan, with average annual premium increases approximately equal to, or in some cases less than, the market average. Our large employer program also provides stability of plan design offerings and long term carrier contracting that enables access to a consistent provider panel enabling fewer provider – patient disruptions. We face vigorous competition in retaining those larger members, however, because they always have the option of switching to a self-insured/self-funded program and avoiding the additional costs associated with state regulations because of the applicable ERISA preemption for large employer self-funded programs. In other words, we often compete successfully for this business (particularly for members with 100 to 500 employees, which are not pursued as aggressively as larger members), but on an uneven playing field.

The Realities of the Small Group Health Insurance Market

This imbalance between the options available to our large and small members is reflective of the market imbalances facing large and small businesses. The implications of that imbalance become apparent upon examination of the basic economics of health insurance.

Attached to my testimony is an analysis prepared for CCBA by Mercer concerning the relative costs of the components of health insurance costs for small, medium and large employer groups. As it shows, non-actionable claim costs (the actual amounts necessarily received by providers of medical services) are roughly equal for small, medium and large groups. Other costs, such as administrative and risk underwriting expenses, are dramatically different depending on the size of the employer or group. "Actionable" claims (claims that can be managed in a way to achieve lower costs) and broker commissions are only modestly different.

Importantly, as the Mercer analysis shows, the amounts paid to providers for medical services are only slightly more than two-thirds of total costs in the small group market. In my view, any solution to the health care challenge facing small business and its employees (which is a large part of the overall health care challenge) must significantly shrink those hundreds of billions of dollars in non-provider costs, since they are not likely to be affordable to any of the players (the small business community, its employees, or the federal government and the federal taxpayer).

The two components that drive the greatest disparities and the greatest incremental costs for small business (administrative and underwriting risk expenses) must be the focus of any reform-based solution if that solution is to be effective. For a small group or small business, administrative costs are generally greater because the costs of setting up an insurance program, deciding on benefits, communicating benefit selections, enrolling employees, establishing a claims management process and processing rules that fit with the program benefits, etc., all tend to be fixed costs that drop on a per employee basis as those costs are spread across larger groups.

One solution to that administrative challenge, of course, is to pool smaller groups of individual employees into larger multiemployer groups under a common program to further spread those costs, such as through a pooled health care plan like CCBA's. Many such plans were built in the 80s and 90s, but virtually all multi-state plans, like CCBA's pooled small bottler plan, eventually forfeited the pooling administrative cost benefit because generally well-intentioned state regulations and coverage mandates forced the plan administrators to design distinct plans and distinct claims processing rules for every state (and in CCBA's case, nearly every different small bottler participant).

If state prerogatives are to be preserved, driving somewhat higher administrative costs for small businesses that band together to create scale in their own programs, how can Congress (or the marketplace) provide the solution that will deliver competitive total costs to small groups and small employees? One frequently discussed solution is to allow a government agency or other federally sponsored organization to negotiate on a national basis on behalf of small businesses with the major insurers to achieve the best possible rates for all eligible small businesses.

That approach (which essentially involves creation of pooled market power among buyers to counteract the perceived market power among sellers and thereby eliminate any excess profits collected by the sellers) has some promise to the degree that the source of the disparity in costs for large groups and small groups is the lack of bargaining power in the hands of the small group. To the extent that the disparity is driven by true cost differences in servicing large businesses and small businesses, and not differences in insurer profitability, however, even a massive coalition of small businesses is not going to achieve major savings.

My suspicion is that while some savings in administrative charges might be accomplished, national pooling will not close the majority of the approximately 13% gap in program administrative expenses for large and small groups, as reflected in the Mercer analysis. Some of those differences are reflective of real costs, largely driven by the costs of complying with state laws in dealing with multi-state groups of small businesses.

One very reasonable solution is to simply provide federal financial support to small business programs, given that a major source of their disadvantage is that federal law puts them at a disadvantage relative to large employees by exempting large single employer programs from state regulation while leaving small business subject to the same regulations even if they pool their coverage with other small businesses to create the same scale. While many in Congress are appropriately reluctant to use federal tax receipts to provide subsidies to particular categories of employers, I believe that the philosophical argument against those subsidies is not particularly strong when the subsidies are intended to counteract economic disadvantages resulting from state and federal regulations that have differential (and detrimental) economic impacts on the recipients of the subsidies.

I would also note that some form of financial support for the small business community is almost certainly necessary to create fundamental fairness in an environment in which many believe (and some states have required) that businesses provide mandated levels of coverage to their employees. The fair choice is to support small business financially if we believe that they should provide health care benefits to their employees, but face incremental costs in doing so because of an imbalanced regulatory environment.

Insurance Markets and Risk Shifting Costs

Moreover, an effective solution to the challenges facing small business and small groups also needs to address the second other major source of cost disadvantage, namely the much larger price that small businesses pay for risk retention services provided by insurance carriers. The reasons for that disparity are fairly obvious, since insurance carriers are in the business of understanding and pricing the risks that they take and fully realize that risks get smaller and smaller as they are spread across larger and larger pools of policyholders.

CCBA has extensive experience in dealing with pricing and pooling of insurance risks, both in its dealings with health insurance carriers, but more importantly in its even more extensive experience in dealing with property and casualty insurance, since CCBA has been operating in that liability insurance arena throughout its nearly 100-year history. In our experience, the key to achieving savings on risk underwriting costs is to pool and retain those risks to the maximum extent possible, rather than relying on market and pricing mechanisms to mitigate those costs.

Although carriers create pools for small plans, these pools have typically been ineffective in keeping costs down and do not necessarily reflect the size of the pool; they also tend to have a disproportionate amount of bad risk in the pools and that also varies by carrier and by state. These pools tend to have much higher annual increases than experience rates plans that are not placed in pools. Typically, the actual experience of a business is going to be better than the carrier's pooled or manual rate (which is what the small business rates typically are).

The simple truth is that insurance carriers are in the business of pricing risks to generate profits for their shareholders. That is entirely natural and is simply reflective of the appropriate behavior of any participant in capitalistic markets. To some extent, carriers are able to price those risks efficiently and still generate profits because of their ability to spread the uncertainty associated with underwriting projections over such large groups of policy holders that the uncertainty risk becomes minimal.

For the business that seeks to obtain health coverage for its employees, the profit generated by the carrier in assuming part of the risk associated with writing health insurance policies is simply an additional cost. Its objective is to help its employees by relieving them of a part of the burden of unanticipated health care costs that they cannot afford, while reducing the risk that they are taking as employers and businessmen or women to a level that their business can potentially afford.

The solution for large businesses, in both the health care arena and in many other forms of risk management traditionally managed by individual and small businesses through insurance markets is through self-insurance and risk retention. Captives are often an effective vehicle for isolating and managing those retained risks and often provide some financial reporting and tax benefits by allowing those costs to be spread over the long time periods when they are likely to be recognized, rather than allowing financial results to swing significantly based on the timing when those unpredictable risks are actually realized. In either event, the large business avoids paying the profit that the carrier understandably must make if it is to take on that risk.

Our experience is that the same solution works equally well for small businesses. By combining with other businesses that face similar risks (or in some case totally unrelated businesses), to form cooperatives or multi-parent captives, and then retaining as much of the risk as is reasonably possible, small businesses can reduce insurance costs by minimizing the amount of actual risk that they attempt to shift to carriers, thus reducing the profit premium that they must pay to shift that risk.

Outside the health insurance arena, CCBA has implemented that strategy by forming its own liability insurance captive and retaining as much risk as possible within that captive. Nearly 30 years ago, CCBA began retaining some of the liability insurance risk that it had purchased from commercial insurers on behalf of its members within that captive, sharing the insurance premiums with the carriers and investing the premiums to generate further capital within its captive.

Over time, CCBA has built up the reserves contained in that captive through premiums received by its members and has taken on more and more of the insurance risk traditionally assumed by commercial insurers. As those reserves have grown, CCBA has been able to return much of the premium to its members in the form of renewal credits, while still pricing

the coverage at highly competitive levels. In effect, CCBA has collected enough in premiums to cover both claims and the profits that a commercial carrier would expect to retain and distribute to its shareholders. Instead of retaining those profits, CCBA has instead returned them to the participants in its programs, reducing program costs. In 2007, CCBA was able to provide renewal credits amounting to over 25% of the normal premiums charged for its liability insurance programs.

The same solution can and will work within the health insurance arena, not only for CCBA and its members, but for other groups of small businesses. If, as the Mercer analysis indicates, that risk shifting cost is nearly 10% of the total cost of health insurance, CCBA or other organizations pooling groups of small businesses can reduce that cost to a very small number (or zero) over time, by simply pooling and retaining the risk. In order to do so, however, significant pools must be created (since short term fluctuations associated with risk retention for small groups would present too much risk) and other forms of cost disadvantages must be neutralized. Elimination of other cost disadvantages is critical because the only responsible way to manage pooled risks within a captive is to charge a market price for the risk at the inception and return the profits over time, because the captive must be capitalized at a level that can absorb unexpectedly adverse results in the early years; it is very unlikely that potential participants will be willing to be patient about receiving those risk retention benefits if they are paying higher costs for other components of the insurance "package" while they are waiting for risk retention benefits.

The HR 6582 Solution

Against this background, the CHOICE Act works almost perfectly against the major drivers of costs and cost disparities. It is faithful to core federalism principles and requires that covered programs be fully insured and also comply with all applicable state laws concerning mandated coverage and other state insurance regulations. While that recognition of the prerogatives of the states will leave in place the administrative cost disadvantages that make pooling of coverage for multiemployer groups small businesses so difficult, the CHOICE Act proceeds to solve that disadvantage by providing an offsetting federal tax credit for the small business employer, provided that certain reasonable requirement are met (employer subsidies of a reasonable portion of the cost and inclusion of a wellness program).

After putting the small business cooperative program on a reasonable competitive footing from a cost perspective, the CHOICE Act proceeds to call for a quid pro quo which actually works as a second benefit, by both requiring and enabling formation of a cooperative and captive to reinsure substantial individual claims. One obvious rationale of that feature is to assure that catastrophic claims by individuals insured within the program remain covered and are not excluded because the carrier is unwilling to cover or provide affordable pricing for employers and their employees that present obvious and known risks (the "lazering" process that CCBA and its members have sometimes faced). At least as importantly, however, the cooperative requirements provide incentives and opportunities for small businesses and their trade associations or other partners to not only cover catastrophic claims, but to retain most of the risk associated with health insurance programs, by retaining all individual risks exceeding $10,000 annually.

The incentives provided by the CHOICE Act will also work to reduce many of the other costs disadvantages facing small businesses, by allowing formation of relatively large pools of

lives relatively quickly. In CCBA's case, we believe that it would allow us to re-form our small bottler program within a very short period of time and to restore the competitive benefits that we were once able to provide to those bottlers, perhaps on even more favorable terms. We also anticipate that we can successfully extend the program into similar businesses within minimal additional work. Indeed, we believe that, over time, we will be able to make that program extremely attractive for even bottlers and other businesses that are not eligible for the tax credit because they have more than 100 employees (our captive-insured liability programs work very successfully for somewhat larger business). In those cases, we believe that we be able to provide more affordable insurance coverage and reduce the ranks of the uninsured without any expenditure of federal tax dollars to support the particular medium sized businesses that might participate.

Collateral Benefits Derived from Promoting a Role for Associations in Health Care Benefits

Bona fide trade and professional associations are established and run by their employer members and exist for the sole purpose of serving the needs of their members and members' employees. Bona fide associations, including national, regional and state-based associations, have been a vital source of health coverage for millions of American workers employed in small businesses for decades. They must be part of any health care solution for it to be effective, because they provide the expertise, support and infrastructure needed by the small business community to effectively tap the opportunities that will flow from any form of meaningful health care reform.

Associations are uniquely structured to be part of our healthcare delivery system. Because they are established to represent their members in other areas, they possess the infrastructure, administrative mechanisms, and experience needed to unify employers and employees into effective consumers of health services. By serving this need for small employers, associations add value to our health care system as a whole, as well as to their members.

In our own case, we go considerably beyond simply building a program that our members can use. With the help of our consultants and insurance partners, we work closely with our members to develop and implement wellness programs for their employees. We also provide a critical role in providing support from a trusted and familiar source to our members and their employees in making the right choices that will help them manage costs and avoid behaviors that tend to drive up those costs, through smoking cessation, weight management and other similar programs.

Conclusion

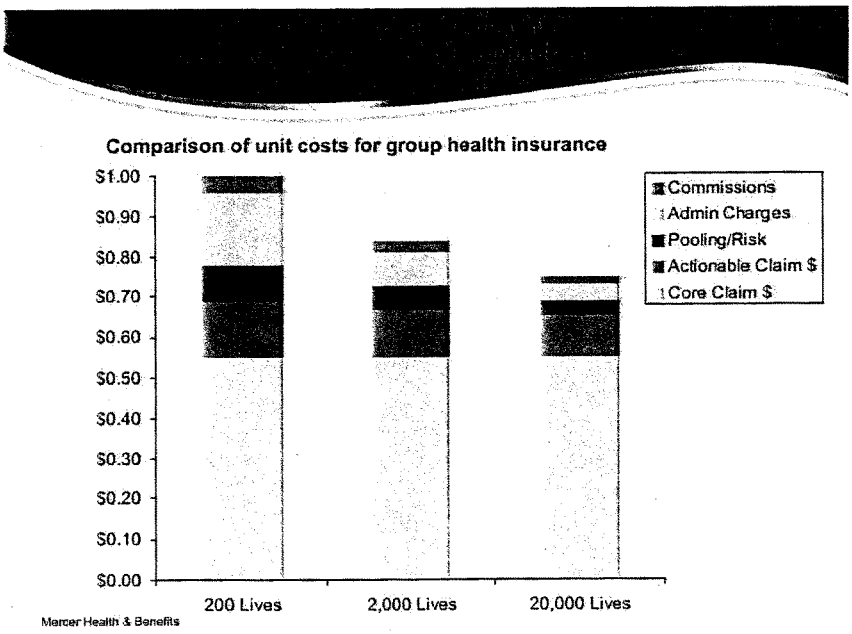
As a strong believer in the superiority of market-oriented, rather than public sector driven, solutions to policy challenges (all other things being equal), I would like to add a footnote to my comments that is directed at others that share that belief. The CHOICE Act does involve the investment of federal tax dollars (whether viewed as a tax credit or a subsidy) to the problem of declining access to affordable health benefits for our nation's small employers and their associates. That should not deter any fiscal conservative from providing their enthusiastic support to the Act, because it represents the type of investment that will deliver huge returns to the public because of the way in which it will

affect the markets for the delivery of health care and health insurance. Beyond the direct role that it will play in promoting the formation of small business cooperatives, it will also open up the carrier market in that more carriers will be willing to quote on the business (because their own potential exposure will be mitigated by cooperative reinsurance), thus creating market competition that can further drive costs downward.

As noted above, the cooperatives that it will "seed" will take billions of dollars in costs out of the system that are not reaching the hands of providers of health care services. By restoring the current imbalance between small and large employers it will place those employers on more equal footing in recruiting new employees and in competing in the marketplace for the goods and services that they produce and sell. Small business has always been the engine of innovation and entrepeneurship in America (as well as job creation) and restoring competitive balance will generate long term returns in nearly every arena imaginable.

Moreover, the tax credits provided under the CHOICE Act are not, at their essence, incremental public expenditures. By significantly reducing the ranks of the uninsured, market-based reform (and federal spending) that empowers small business to provide quality health care benefits (including preventative care) will reduce the cost of uncompensated care by providers and will shrink total health care spending. Moreover, unlike many other type of public programs, which are unable to deliver a dollar in benefits to the intended targets because of the administrative costs associated with program administration, the CHOICE Act will require minimal administration and will drive market forces that will deliver tens or even hundreds of dollars in benefits to its targets for every dollar of tax revenues expended. In my view, it is a paradigm for the kind of federal spending that should be embraced, and not questioned, by fiscal conservatives.

Thank you again Madam Chairwoman for the opportunity to share my views and the experience of CCBA and other similar trade associations in supporting the small business community in providing quality health care benefits.


Comparison of unit costs for group health insurance
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Pooling/Risk
Actionable Claim $
Core Claim $
Mercer Health & Benefits

NATIONAL ROOFING
CONTRACTORS ASSOCIATION

Statement of James Eckstein

On Behalf of the

National Roofing Contractors Association

ON: **"Making Health Reform Work for Small Business"**

TO: **Committee on Small Business**
U.S. House of Representatives

DATE: **September 18, 2008**

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Introduction

Thank you, Madame Chairwoman, ranking member Chabot and distinguished members of the committee, for the opportunity to appear before you today to discuss health care reform for small businesses. My name is James Eckstein, and I am president of C.A. Eckstein Roofing, Inc., a small business which employs 35 workers in Cincinnati, Ohio. I also currently serve as a vice president of the National Roofing Contractors Association (NRCA) and am testifying before the committee today on behalf of NRCA.

First, I want to commend Chairwoman Velazquez and ranking member Chabot for your outstanding leadership on health care and other issues of importance to small businesses. Your tireless efforts on behalf of working Americans are greatly appreciated by NRCA and the roofing industry. We also commend you for holding this hearing today on health care reform, an issue that is critical to both small employers and workers across our great nation.

Established in 1886, NRCA is one of the nation's oldest trade associations and the voice of professional roofing contractors worldwide. We are an association of roofing, roof deck and waterproofing contractors; industry-related associate members, including manufacturers, distributors, architects, consultants, engineers, government agencies and international members. NRCA has approximately 4,500 members located in all 50 states and 54 countries, and is affiliated with 105 local, state, regional and international roofing contractor associations. NRCA contractors typically are small, privately held companies, with the average member employing 35 people in peak season and attaining sales of just over $3 million per year.

NRCA welcomes the opportunity to testify on the long-standing problem of excessive increases in the cost of health insurance for small businesses. The enactment of legislation to expand access to affordable health insurance for small businesses has been a major priority for NRCA for many years, and we believe that Congress must address this urgent problem.

NRCA strongly supports the Small Business Cooperative for Healthcare Options to Improve Coverage for Employees (CHOICE) Act of 2008 (H.R. 6582), legislation designed to provide small businesses with access to affordable health insurance. NRCA commends Chairwoman Nydia Velazquez and Energy & Commerce Committee member Joseph R. Pitts (R-Penn.) for their strong leadership in introducing this legislation, and urges Congress to consider the bill as expeditiously as possible. NRCA also commends Rep. Chabot for introducing the Health Insurance Affordability Act of 2007 (H.R. 3975), legislation to allow individual taxpayers to take a tax deduction for health insurance costs.

Impacts of Increases in Health Insurance Costs

The enactment of health insurance reform for small businesses is long overdue. Since 2001, premiums for family health coverage have increased on average by 78 percent, according to a recent report by the Kaiser Family Foundation. For many small businesses, the increases in health insurance premiums have been even greater than this average. The severe lack of access to affordable health insurance for small firms is disturbing and does great harm to both small

employers and working families. This situation compromises the health of many small business persons and their employees who may be uninsured or under insured due to the excessive cost of insurance coverage.

At C.A. Eckstein Roofing, we believe it is very important to provide our employees and their families with high quality health benefits, and it is necessary that we do so to remain competitive in attracting and retaining quality employees. However, providing coverage for our employees is becoming increasingly difficult each year, as we continue to be hit with double digit premium increases from our insurance company. Our most severe problem now is that insurance companies are unwilling to provide us with competitive pricing because of cancer and other health conditions among a few of our spouses and families. Thus, we have no choice but to accept double digit premium increases from our current insurer. These excessive premium increases year after year have forced us to increase the amount that our employees pay for health care benefits, which I greatly regret.

In addition to jeopardizing the health of many small business workers, the lack of affordable health insurance for small businesses also greatly hinders economic growth across the nation. Small entrepreneurs are the primary source of job growth in our dynamic economy, and difficulties in providing affordable health benefits to employees slows their ability to grow their businesses and create new jobs. Moreover, the current manner in which health insurance is regulated puts small businesses at a distinct disadvantage to large corporations in providing health benefits to employees. This situation makes it difficult for small businesses to attract and retain high quality employees in today's competitive labor markets.

It is clear from our situation at C.A. Eckstein Roofing, and based on the experience of many other small businesses, that some form of expanded pooling is absolutely necessary in order to spread risks across greater numbers of insured lives. Expanded risk pooling is essential if we are ever going to restrain the excessive cost of health insurance for small businesses.

NRCA looks forward to working with Congress to develop innovative solutions which address risk pooling and other needs of small employers in our efforts to offer high quality, yet affordable, health benefits to working families. It is absolutely critical that we do so for the health of working families as well as the vitality of our economy.

The Small Business CHOICE Act

As mentioned, NRCA strongly supports the Small Business CHOICE Act as one method of expanding health insurance pooling opportunities for small businesses. The CHOICE Act is a private sector solution that addresses the high cost of heath insurance by enabling the establishment of new purchasing cooperatives designed to allow small businesses to stabilize health insurance costs by pooling risks and increasing their economies of scale. The legislation also provides a refundable tax credit to small employers who purchase health insurance for their employees through a cooperative, a promising idea that will further promote the expansion of coverage to small businesses. Finally, the bill provides a role for bona fide trade and professional associations like NRCA in the development and expansion of purchasing cooperatives.

The market-oriented CHOICE Act recognizes the need to expand pooling options for our nation's job-creating small businesses in order to stabilize insurance premiums and expand access to coverage for working families. Given the huge disparity between the health insurance costs of small businesses and those of our larger competitors, it is critical that Congress, the Administration and state governments work together with the private sector to create new pooling options for small businesses, such as the cooperatives envisioned in the CHOICE Act.

Under the CHOICE Act, private, voluntary purchasing cooperatives would be established under state captive insurance laws to provide excess claims insurance coverage to participating small businesses. In doing so, the CHOICE Act tackles two of the most significant challenges facing small employers – the high cost of providing comprehensive health insurance to employees and the volatility of premiums. Thus, it addresses those underlying factors which have led directly to the double digit premium increases that we at C.A. Eckstein Roofing have experienced in recent years.

NRCA believes that the establishment of viable pooling options for small business, such as is envisioned by the CHOICE Act, will inject significantly greater levels of competition into health insurance markets, which too often are dominated by one or only a few large insurance companies. The excessive market power enjoyed by large insurance companies in many markets has certainly contributed to the trend of rising premiums for small group health insurance, and the failure of either the federal or state governments to address this problem is disturbing. A Government Accountability Office study issued in 2002 documented this problem, which continues to persist to this day. There has been a great deal of consolidation among health insurance companies in recent years, which I presume have created significant efficiencies. However, any cost savings from such efficiencies are not being passed on to small businesses, at least not small businesses that actually utilize coverage to pay for health conditions. As an entrepreneur, I can tell you that there are few things that will control price increases better than greater competition in the marketplace.

The CHOICE Act also offers a refundable tax credit to small employers who choose to join a health care purchasing cooperative. The credit would be available to small businesses with 100 employees or less, and the employer would be required to offer a wellness program to its employees in order to receive the credit. The tax credit would be 65 percent of the cost of insurance, and the employer would be required to subsidize at least 65 percent of "self-only" coverage and 35 percent of "family" coverage for its employees.

NRCA believes the refundable tax credit provided by the CHOICE Act is a prudent investment of federal resources given the immense social and economic damage that now results from dysfunctional small group health insurance markets. By expanding access to health benefits for small businesses, the tax credit will help improve economic growth and productively by promoting a healthier workforce. The tax credit is further justified because the federal ERISA law provides large employers with an option for providing health care benefits to employees that is not available to small businesses. The current disparity in health benefit costs between small and large businesses puts the former at a huge disadvantage in labor markets, as previously noted.

NRCA is also pleased that the CHOICE Act contains a meaningful way for trade and professional associations to participate in the establishment of purchasing cooperatives under the bill. Bona fide associations exist for one purpose and one purpose only – to serve their members. Associations are uniquely structured to add value to their small business members on a wide array of issues, and NRCA has extensive experience in working with the insurance industry to achieve savings on various insurance products for our members. NRCA has attempted to develop some form of risk pooling arrangement that will lower health insurance costs for our members for many years. However, we have had limited success in this area because existing state small group laws and regulations make it very difficult for associations to operate across state lines. We believe that enactment of the CHOICE Act would allow our association to play an important role in helping our roofing contractor members obtain affordable health care benefits.

Conclusion

NRCA believes that health reform legislation should focus primarily on market-oriented, private sector solutions to address health care costs because we believe market forces that lead to greater competition are the most effective method for reducing costs. In addition, we recognize that sensible government regulation is necessary in order to provide fairness and transparency in health insurance markets, the lack of which often puts small businesses at a disadvantage. NRCA strongly urges Congress to take up small business health reform early next year and work with the new President to address this urgent issue as expeditiously as possible.

Again, NRCA supports the Small Business CHOICE Act and urges all members of the committee to consider cosponsoring H.R. 6582. We are committed to working with members of Congress to obtain enactment of the CHOICE Act and any other bipartisan proposal that effectively addresses the problems small businesses face in obtaining access to affordable health insurance. Enactment of such legislation will improve the health and well-being of millions of working families across the nation and will also greatly enhance our economy.

Again, thank you for the opportunity to share NRCA's views on this important issue with you today.

Statement of Rep. Jason Altmire
Committee on Small Business Hearing
"Universal Coverage: Making Health Insurance
Reform Work for Small Business"
September 18, 2008

Thank you, Madam Chairwoman, for holding this hearing about health insurance reform and the effect it has on small businesses. Currently, more than 27 million small business employees do not have health insurance due to high cost and limited availability. The National Federation of Independent Business (NFIB) has cited health insurance as the number one concern of small business owners.

To help resolve this important issue, I joined a group of bipartisan lawmakers and introduced the SHOP Act (H.R. 6210) in July. The SHOP Act will make health insurance less costly, more predictable, and more accessible for the nation's 47.1 million small business employees and 14.1 million self-employed individuals.

Affordable health insurance remains a major problem for small business owners and their employees. It is important, during these hard economic times, that hard-working Americans know their health care needs are covered, no matter the size of the company they own or work for. I am committed to working with my colleagues to help develop a better plan to cover small business owners and their employees that continue struggle to find affordable health insurance.

Thank you again, Madam Chairwoman, for holding this hearing. I look forward to hearing from our panel today and getting their input on the best way to solve this problem facing so many small businesses.

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