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SMALL BUSINESS HEALTH INSURANCE: BUILDING A GATEWAY TO COVERAGE

HEARING

BEFORE THE

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CONTENTS

OPENING STATEMENT

WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL

COMMUNICATIONS

SMALL BUSINESS HEALTH INSURANCE: BUILDING A GATEWAY TO COVERAGE

THURSDAY, OCTOBER 25, 2007

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:06 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Bingaman, Kerry, Lincoln, Wyden, Hatch, Snowe, and Smith.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order.

In 1790, Edmund Burke wrote, "What is the use of discussing a man's abstract right to food or medicine? The question is the method of procuring and administering them."

Two centuries later, we in this committee continue to debate the right to health care. But two centuries later, the real question continues to be how to make sure that health care is actually available.

I have been saying all year that I view the expansion of the Children's Health Insurance Program as the first step toward providing access to health care for every American. I wish I could say we have taken that first step. Now it is time to plan the second step. We have not completed that first step, but we will soon. This morning we are here to explore our next steps. We are here to consider how we can help employees in small businesses to get the kind of health coverage they need, at a price they can afford.

Why small business employees? That is where half of the uninsured are. Half of the uninsured workers either work for employers with fewer than 25 employees or are self-employed. We will help a big chunk of the uninsured if we can figure out how to provide affordable insurance options to small business employees.

It is our job to create a gateway to health coverage for the millions of small business employees who have none, or who are struggling to keep the coverage that they have. What we learn today will help us to shape a bill that we can mark up in the committee later this Congress. We have some difficult decisions to make.

Many proposals to assist small business employees share common elements: they include a tax credit to help defray costs; they include a mechanism to provide more insurance options that are

meaningful and affordable; and they include opportunities to pool risk across State lines. As usual, the devil is in the details.

There has been strong disagreement about how best to approach broadening insurance options for small business employees. There have been differences about what rules should apply to pooling across State lines, and another difficult issue has been how to make sure that the self-employed will benefit from small business reforms.

The special concerns of the self-employed will be an important part of small business health reform. A tax credit or other financial assistance for a self-employed person is useful only if coverage is available. Many self-employed people have to look for coverage on the individual market, and in that market protections are limited and coverage can be denied.

A bill that comes out of this committee should provide more insurance options to the self-employed, and it should also make sure that this insurance offers real coverage that is worth the money. I hope that we will begin to tackle this and other difficult problems today.

Now, some may be thinking that we should not look at small business reforms. Some may be thinking that we should be bolder. Some may be thinking that we should revamp the whole system, and believe me, I understand the need for broad reform. But for now, I ask my colleagues to keep an open mind. Helping small business employees is, itself, a worthy goal. In helping small business employees, we can also take another step toward broader reform.

This committee has a proud tradition of coming together to resolve difficult issues, and I believe that we can continue that tradition here today. I believe that we can produce a proposal that will help small business employees get, and keep, meaningful health coverage.

Let me assure you, children's health insurance remains my priority at this moment. We will see it through. Then when we have taken care of America's children, we can take the next step to help employees. We can help small business employees to get, and to keep, health insurance coverage.

So we will continue to work to advance the right to health care. We will continue to fight to expand coverage for America's children and small business employees, and we will continue the struggle to ensure that affordable health care is available to all Americans.

I would like to introduce our witnesses. It is my pleasure to introduce Joel Ario, an insurance commissioner for the Pennsylvania Department of Insurance. Thank you for coming today, Mr. Ario. He will testify on behalf of the National Association of Insurance Commissioners. Then Alden Bianchi, a member of the law firm of Mintz and Levin. Next, we have Linda Blumberg, principal research associate at the Urban Institute.

I understand that Senator Bingaman would like to introduce our other witness today. Senator, please do so.

Senator BINGAMAN. Mr. Chairman, Monty Newman is here, representing the National Association of Realtors. He is a very prominent citizen of our State. He's the mayor of the town of Hobbs, NM and has been for several years, and before that was on the city

council and had a number of other civic positions of responsibility. He has been very successful as a realtor in southeastern New Mexico and is now the vice president and liaison of government affairs for the National Association. So, I am very glad to welcome him here, and thank you for including him as a witness.

The CHAIRMAN. Thank you, Senator. Welcome, Mr. Newman. Thank you.

All right. Let us begin. Mr. Ario, why don't you begin? As you know—or you may not know, but I will tell you—all of your statements will be included in the record, and we encourage you to stick within the 5-minute rule.

Senator SMITH. Mr. Chairman?

The CHAIRMAN. Senator Smith?

Senator SMITH. If I might give a special welcome to Mr. Ario. Before he was in Pennsylvania, he was the insurance commissioner in Oregon. It is great to see him again. I am counting on him giving us a dual-State perspective. We are dealing with dual eligibles all the time. Maybe you can talk about dual States, Joel. Good to see you. Thank you for being here.

The CHAIRMAN. Now, why did he leave Oregon?

[Laughter.]

Senator SMITH. I assume it was money, because there is no other reason.

[Laughter.]

The CHAIRMAN. Very good. All right.

Mr. Ario, with that, you can say whatever you want to say.

STATEMENT OF JOEL ARIO, INSURANCE COMMISSIONER, PENNSYLVANIA DEPARTMENT OF INSURANCE, HARRISBURG, PA

Mr. ARIO. Thank you, Mr. Chairman. I have not yet come up with a good answer for that, and I will not try today. It is good to be with you today. This is an issue—small business insurance and the affordability of insurance for small business—that has been at the top of my agenda for my 14 years as a regulator, and has been at the top of the NAIC's agenda as well.

States have taken a number of important steps to help the small business community, such as the small group reform laws that we passed through the States that eventually led to the HIPAA law in 1996. We look forward to working with this committee to take further steps to improve the climate for small businesses.

Today I am going to address three of the specific comments that are in front of the committee, as I understand it, in proposed legislation: the first one is multi-State pooling; second, pooling of individuals and sole proprietors into the small group market; and third, creating a uniform benefit package.

Let me start with the multi-State pooling issue. The States have some experience with pools beyond the small group pooling. I think it is important to always start with the fact that the small group laws in each State are a form of pooling risk, so, in every State except my current State of Pennsylvania, Hawaii, and the District of Columbia, there are small group pooling laws already that allow the small groups to pool risk.

But States have gone beyond that to create purchasing pools—the two most prominent examples are California and Florida—and they had some success in offering small businesses more opportunities through those pools. But they did not work as well as people had hoped they would on the efficiency and administrative savings side, and both of those efforts have floundered and basically are not operative today. So I think it is an area we want to proceed with caution on—with purchasing pools—but it is certainly an area to be looked at.

A couple of key issues that I would highlight from the insurance perspective when you are dealing with small group pools, and I am going to get right into the tough stuff here. One of them is the question of benefit mandates. I think in order to have an effective and efficient multi-State pooling, you have to have uniform benefits across States. Then you get into the question of, how do you balance the benefits?

I know, Senator Smith, you have been active on the mental health parity issue. You have seen some of the difficulty there where folks at the State level have passed these mandates, and they are very entrenched interests in the States and it is very difficult to figure out how to move across State lines and deal with that benefit mandate question. So that is one issue I think you have to wrestle with: how to define a uniform benefit package that deals with that question.

The second question is of great concern to us at the NAIC. Each State that has developed small group rating restrictions has done so in a way that is responsive to local conditions in that State. Sometimes people say, in order to have a multi-State pool, you need to preempt those State rating laws to be effective. That is not true.

In fact, insurance will be priced under a multi-State pool the same way Medicare is priced today—differently, State by State. So you can have a multi-State pool in which the rating laws stay in effect State to State, and we think that is very important.

If you do not do that, if you have a multi-State purchasing pool here and a State small group pool here, whichever one gives more favorable conditions will get the good risk and the other one will get the bad risk, and so you are going to create a lot of selection opportunities. So we think the rating laws need to stay in place in any multi-State pooling effort.

On the second issue, pooling of individuals and sole proprietors, the individual markets, as the chairman's remarks referenced, are generally more open and flexible than the small group markets. A lot of young and healthy people get pretty good rates in most States in the individual market. So, pooling the individual and small group markets is a very challenging thing to do because you are mixing two different types of rating systems.

The option that may be a better practical first step is to look at the sole proprietor issue and move them into the small group market. Twelve States already do that. When we get to questions, we can look into some of the details of that, but I would commend that as a first step rather than trying to merge the two pools directly, although Massachusetts is experimenting with that as well today.

Finally, on defining a benefit package, the States do not, in general, in their laws, define a benefit package. What they do is say health benefit plans have to have all these mandates and all these other rules, except the plans that are not health benefit plans are the following, and they do by exception what is not the benefit plan. So it is a real challenge, I think, to define specifically a major benefit package. But we as State regulators do look at that issue every day, and understand the fine print of how benefit configurations are put together, and we would be happy to work with the committee on those issues as you get into the details of doing that.

A final comment. I wanted to reference Senator Bingaman's bill, S. 325, which would give the States some funding and some potential to get some relief from ERISA and other restrictions that impede State reform efforts today, because I think the States and the Federal Government need to be full partners in this. Neither of us can go it alone. So, I would commend Senator Bingaman's and Senator Voinovich's bill as a good first step to allowing the States to be full partners here.

With that, I will conclude. Thank you.

[The prepared statement of Mr. Ario appears in the appendix.]

Senator ROCKEFELLER. Mr. Bianchi? I apologize to the witnesses and to my colleagues for my lateness. It rarely, rarely happens.

[Laughter.]

STATEMENT OF ALDEN J. BIANCHI, MEMBER, MINTZ, LEVIN, COHN, FERRIS, GLOVSKY, AND POPEO, P.C., BOSTON, MA

Mr. BIANCHI. Chairman Baucus, Ranking Member Grassley, and members of the committee, thanks for inviting me here to speak to you today. Thanks, also, to your staffs, who facilitated my appearance.

My purpose today is to outline for you key features of health care reform efforts at the State level, including my home State, the Commonwealth of Massachusetts.

During 2005 and 2006, I had the privilege of serving as outside counsel to the Romney administration in connection with our Massachusetts health care reform law, and I currently represent the Massachusetts Health Insurance Connector Authority. The connector, as it is called, is a quasi-governmental agency. Its principal purpose is to provide access to affordable health insurance by individuals and small businesses.

By way of background, and as the chairman alluded to in his introductory remarks, there are really basically two fundamental ways to do health care reform: one is a government-run, single payor approach, the other is market-based, where we facilitate coverage through private insurance companies. There is, of course, sharp disagreement over the merits of each, but, whatever your view of the merits, the market-based approach is the one that is currently being given the most serious consideration. It is also the approach that we adopted in Massachusetts.

I understand the committee is considering market-based reform proposals, and in this presentation I have identified five features that seem to recur quite a bit: (1) connectors and gateways; (2) small group insurance reform; (3) a section 125 plan cafeteria man-

date; (4) tax funding mechanisms; and (5) individual insurance mandates.

Connectors or gateways—remarkably flexible creatures, these things. They give the opportunity to provide information to folks, and access, particularly by small groups, to health coverage. They can also establish regulatory and underwriting standards.

A connector may or may not itself be a risk-bearing entity. It can be governmental. It can be a quasi-governmental agency. It can even be a private sector entity. Connectors could be State-wide, they could be regional, they could be super-regional, and I suppose you could even do a nationwide connector, if you like.

In Massachusetts, what the connector does is it establishes a marketplace. It is not an insurer, but it establishes a marketplace for insurance and it defines what constitutes minimum accreditable coverage for purposes of our State individual mandate.

Our connector has been very successful for a reason, and it starts with first-rate board appointments, both by Governor Romney and Governor Patrick, and also skilled leadership under John Kingsdale and his senior management team and a dedicated staff. I assure the members of the committee that this is not just an opportunity to suck up to an important client, this is the consensus view in the Commonwealth.

On the items of small group insurance reform, we did merge our individual and small group markets. This was a big, big step. But if you think about it for a second, the individual market tends to be relatively smaller, but much more highly adversely selected. When we merged the two, we ended up with a 15-percent decrease in individual rates for only a 2-percent increase in small group rates, and it is a trade-off that appears to be working pretty well.

Risk pools, as Mr. Ario pointed out, can be State by State, they can be multi-State, and you also get the opportunity to address such things as guaranteed issue, guaranteed renewability, and portability, which Mr. Ario understands far better than I, I will confess.

Cafeteria plan mandates. Obviously, a cafeteria plan, all it does is convert post-tax dollars to pre-tax dollars, but that is a pretty nice thing. In Massachusetts, we require it of employers, even of those employers that do not themselves offer health care plans. Their employees, rather than get coverage through employer-subsidized coverage, can go to the connector and get coverage. Now, to the extent that any of your proposals dispenses with pre-tax treatment, you could still require employers to funnel contributions from the paychecks to insurance coverage.

On the subject of tax funding mechanisms, one of the other alternatives is a tax credit. I think one of the early proposals there that lays it out in good detail was by The Heritage Foundation, where they proposed a refundable, assignable, and advanceable tax credit. These could either replace the current system or be used in conjunction with it, either way.

There is also the issue of individual mandates. I am not certain that that is something that is on you folks' agenda, but in Massachusetts—I guess we do not know yet. We have not put the real penalties in—but it does do a few things. First of all, it solves a lot of the problem of underwriting, where insurers are not worried

about adverse selection because everybody has to get covered, with the exception of folks who cannot afford it. We have affordability standards in our State. It also reduces, or at least in theory should reduce, substantially the ranks of the under-insured, thereby taking a lot of the pressure off of emergency rooms.

Thank you for this opportunity to address this committee. I appreciate your attention, and I would be happy to answer any questions at the end.

Senator ROCKEFELLER. Thank you, sir.

Mr. BIANCHI. You are welcome.

[The prepared statement of Mr. Bianchi appears in the appendix.]

Senator ROCKEFELLER. Ms. Blumberg? Were you properly introduced by the Senator from New Mexico? I mean, did he point out the Urban Institute, and all that? Did he just give you a name and pass on?

Senator BINGAMAN. The Senator from Montana had that responsibility.

Senator ROCKEFELLER. Oh. I thought he was somewhere else. All right.

STATEMENT OF LINDA BLUMBERG, PRINCIPAL RESEARCH ASSOCIATE, URBAN INSTITUTE, WASHINGTON, DC

Ms. BLUMBERG. Distinguished members of the committee, thank you for inviting me here today 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 funders, or its board of trustees.

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.

First, 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 employee benefit plans, or other such groups is an approach that could provide small employers, sole proprietors, and other individuals with an avenue for more efficient purchasing.

With regard to the second general 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 do large employers. Even one or two workers having a year with high health care costs can have a significant effect on the average medical costs in a small firm.

This is not the case in a large firm, since there are so many individuals over which to spread the excess costs of a small percentage

of high-cost workers. Their greater variability in health care costs means that small employers are, in general, better off when the health care costs of their workers are spread very broadly.

The third general problem, and the one that I think is by far the primary barrier to coverage for small firm workers, is that small employers tend to have lower-wage workforces than large employers. This means that expansions of insurance coverage will require significant income-related subsidies in order to make coverage affordable for a substantial number of uninsured workers.

For example, in 2007 a family of four with an income of 200 percent of the Federal poverty level earns $41,300. The average cost of a family insurance policy in the employer insurance market in the same year is about $11,730, or over 28 percent of that family's income. Because employers largely finance insurance by lowering the wages of their workers, it is not practical to expect low-income workers to voluntarily seek out that type of trade-off.

As a benchmark, it is worth noting that the median middle-income family with employer-sponsored health insurance today pays only about 6 percent of their income in the combination of premiums and out-of-pocket costs.

Once one accepts that significant subsidies will be required to expand coverage significantly, a host of design issues come into play. These include defining what is affordable for families at different income levels to contribute to the cost of their own medical care—including protecting the unhealthy from excessive out-of-pocket costs, mechanisms for making voluntary participation in insurance coverage as easy as possible, and keeping the administrative costs associated with delivering subsidies as low as possible.

I am quite confident, however, that we can design a policy approach that would significantly expand health insurance coverage, would spread health care risks more broadly, and would do so at reasonable administrative costs. 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, but I believe that serious consideration should be given to a redistribution of the current tax exemption for employer-sponsored insurance.

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 at all.

Reallocating the subsidy to provide greater value to the low-income would be tax dollars better spent. But any changes to the current tax treatment can be highly disruptive to the existing system of employer-based health insurance, so 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.

Thank you very much for the opportunity to share my thoughts on these important issues, and I will be happy to answer any questions that you might have.

Senator ROCKEFELLER. Thank you very much.

[The prepared statement of Ms. Blumberg appears in the appendix.]

Senator ROCKEFELLER. Mr. Newman?

STATEMENT OF MONTY D. NEWMAN, 2007 VICE PRESIDENT AND LIAISON TO GOVERNMENT AFFAIRS, NATIONAL ASSOCIATION OF REALTORS, HOBBS, NM

Mr. NEWMAN. Thank you, Mr. Chairman. My name is Monty Newman. I am a realtor from Hobbs, NM, where I own two real estate businesses. I also serve as the mayor of the city of Hobbs.

I appear here today in my capacity as the 2007 volunteer vice president of the National Association of Realtors, representing the Association's 1.3 million members. We thank you for holding this hearing, for the opportunity to testify, and particularly for your willingness to explore the unique obstacles the self-employed face.

Our members have been heartened by the attention that you and your colleagues on the committee have given this matter, as well as that which Senators Durbin, Lincoln, Enzi, and Ben Nelson have also demonstrated. Nearly all of NAR's members are either real estate sales agents who are treated as self-employed independent contractors, or self-employed broker/owners. The individual market is their primary source of health insurance.

Currently 28 percent of realtors have no health coverage. Ten years ago, only 13 percent did not have health coverage. That high number might surprise you. After all, under current law the self-employed seem to have the best of all possible worlds, an above-the-line deduction for 100 percent of their health insurance premiums.

This deduction has value, however, if, and only if, self-employed individuals can find an affordable insurance product. The realtor health insurance stories in our written statements show that affordable insurance products, even with high deductibles and/or minimal coverage, are often out of reach or unavailable.

NAR would submit, Mr. Chairman, that the self-employed will continue to struggle until there are corrections and improvements to both the individual and small group health insurance markets. We believe the tax incentives need to be coupled with the mechanisms that would create insurance coverage, gateways, and/or additional pooling mechanisms to create a more rational and effective system than currently exists.

Imagine yourself without health insurance or without an employer who covers a significant portion of your premiums. Would you be able to commit 10 percent of your income to insurance premiums? How about 20 percent, or even 25 percent? This is the dilemma of the self-employed person. Equally troubling, even if they are willing and able to pay such prices for coverage, many realtors have found that no insurers will offer them coverage. NAR has not the expertise that would enable us to provide you with a full-blown market reform model. That said, we do not have much good to say

about the current individual health insurance market. It simply does not serve the needs of our self-employed members.

Based on our experience and the things we do know, we can make several observations. First, the self-employed must be enabled to enjoy the benefits of larger pool risks, much as large group plans provide their participants. This would facilitate greater market efficiency so that the individuals can benefit from the economies of scale that large plans currently enjoy.

We have no preference on whether pooling should be on a State, regional, or other basis, but we do not seek Federal operation of these pools. We believe pooling structures used should permit individuals to continue their health insurance coverage, even when they move between States, and facilitate greater market efficiency to keep down premium costs.

Second, some sort of mechanism is needed to bring insurers and self-employed workers together, call that mechanism a matchmaker, gateway, coordinator, whatever you will. We believe that some combination of private, public, or private/public venture must be developed to allow self-employed persons to compare apples to apples in their analysis of insurers and insurance products. We do not seek a single-payor or a Federal insurance system. We do seek an official, reliable, regulated, information source or sources that will improve insurance market access for self-employed individuals.

Third, stakeholders, including insurers, regulators, legislators, health policy advocates, and consumers, must grapple with the question of what constitutes essential coverage. Today, a crazy quilt of mandates has contributed to a regulatory landscape that is fragmented, administratively complex, and obscures the fundamental reality that more or rigid coverage mandates may lessen access to health insurance for many consumers.

No single policy or list of mandates can satisfy the competing tensions between providing all desired, or desirable, coverage and creating affordable choices. It may be difficult to come up with guidelines to distinguish what constitutes "essential," "preventive," "desirable" or "Rolls-Royce" levels of coverage, but we do believe that it is possible.

Mr. Chairman, to close, I would simply reiterate my earlier statements. NAR believes that tax incentives are useful, important, and often necessary. Tax incentives will be most effective when they are accompanied by significant reforms to the individual and small group health insurance markets.

I thank you for the opportunity this morning to testify.

[The prepared statement of Mr. Newman appears in the appendix.]

Senator ROCKEFELLER. You have all broken a record, because you all have ended exactly on time.

[Laughter.]

Senator ROCKEFELLER. Now comes our part, which is sort of the lesser part of all of this. However, on a high note, we are going to start the questions with Senator Bingaman.

Senator BINGAMAN. Well, thank you very much, Mr. Chairman, for that very generous introduction. I appreciate it.

Let me ask about this issue of spreading risk and getting larger pools. Everybody seems to agree that that is a good thing. One of

the reasons that it costs so much for small employers to provide coverage or for the self-employed to get coverage is that the pools are not large enough.

Senator Lincoln and Senator Durbin had proposed a bill in the last Congress—I think again in this Congress—which would provide that we have a pool set up nationally for small businesses, essentially that would, as I understood it, be operated similar to the Federal Employees Health Benefit Plan pool, but it would be a pool strictly for folks who are involved in small business, employees of small businesses, and the self-employed.

We never were able to get the votes to move ahead with that, but I would be interested in any comment. Ms. Blumberg, you make reference here that some of the multi-group purchasing entities, such as proposed Federal licensing association health plans, would tend to further segment the risks of small business workers as opposed to spreading them more broadly. So you are opposed to the association health plan bill that I gather has been considered. Have you looked at this other option? Does it make any sense, or not?

Ms. BLUMBERG. I have not looked at this bill specifically. But my general comments are that when you are thinking about pooling risk more broadly, you have to think very carefully about the fact that we are still in an insurance system that is voluntary, so people can opt in and out of different types of coverage. Depending on how one of these pools is structured, you are either going to have more success or less success with achieving your goal.

Let us say you continue to allow small businesses that can get better prices to purchase their coverage outside such pools. If you are having the only guaranteed source of coverage with a broader risk pooling base in the purchasing pool, then you may still have very significant selection problems that do not really address your broader goals.

So, very much depends on how rating works within the purchasing pools and what other options are allowed for small employers. If they are opting in and out of these different options based on health care risk, the goal of achieving broader-based pooling is not going to be achieved.

Senator BINGAMAN. Mr. Ario?

Mr. ARIO. Yes. I agree very much with what Linda said there. I would just add this. The starting point is that 48 of the 50 States already have small business purchasing pools. They are called the small group rating laws. In my former State of Oregon, that was 200,000 lives; in some of the big States, it is more than a million lives. So there are those pools. They all have slightly different rating rules. Some of them are close to community rating, some of them have much broader rate bands. But they share the commonality of bringing all the small group risks together and forcing the carriers, the insurers, to pool the risk and then spread it a little bit underneath the rate band. So that is a starting point.

If you create another kind of pool, I think you can get some real advantages from it in terms of employee choice and that sort of thing, but you do not want to do it in a way that allows for the selection issues that Linda talked about there. So we think it is vital that those purchasing pools have the same rating rules as the State pools, otherwise one of them is going to lose. One of them is

going to attract all the good risks, one of them is going to attract all the bad risks; whether that is the national pool or the State pool, it is not going to be good overall.

So I think that the key issue in thinking about pooling is, do not upset the State pools, but you can do other pools on top of it as long as they have the same rules. The sole proprietor issue is, I think, a separate issue, because only 12 States allow the sole proprietors into those small group pools today.

A first step could be to say that all of the States should allow those sole proprietors in, but, if you did that, you are going to create the problem that Linda talked about, which is the ones that are the most healthy are going to go into those individual markets where there are very few restrictions, and where if you are a good risk you get a really good rate, and so the ones that will tend to go into the small group pool from the sole proprietor side are the ones that cannot get a good rate in the individual market. So, you have some selection issues. But 12 States have figured out how to do that, and that seems like a practical place to look.

Senator BINGAMAN. Let me ask one other question before my time is totally gone.

Could you talk a little more about ERISA? Mr. Ario, you referred to the fact that ERISA provisions interfere with the ability of States to do some of the things that we would like to see States doing here. What is that problem, and is it something we ought to try to fix?

Mr. ARIO. Thank you very much for that question, Senator Bingaman. It is a very important problem at the State level. We cannot, today, even collect data on the large employer market in order to figure out, what are their dynamics across the marketplace, because ERISA prohibits that kind of data collection. So we think at a minimum we ought to be able to collect that kind of data.

A lot of States, including my current State, Governor Rendell would like to do some form of pay-or-play system so that employers have a real stake in providing coverage. That is a big question mark under ERISA today. So what we would like to see is some relief from ERISA. We would prefer to have it across the board on certain issues like pay or play. I think there are a lot of folks that think States ought to be able to experiment with employer pay-or-play systems, and ERISA relief would allow that to happen.

If we cannot get that, then I think your bill is a very good bill which says we will at least give some funding to the State to do experimental things, and along with that funding we will give specific waivers of specific ERISA provisions as part of a specific reform effort. It is similar to what we have on the Medicaid side, and Oregon has been a leader in using the Medicaid waiver. So at a minimum, we think we need some kind of ERISA waiver to allow the States to experiment, but even better would be some more clarity from the Congress that would allow States to do pay-or-play type systems at the State level.

Senator BINGAMAN. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Bingaman.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

I really see this very differently than the discussion we have had today. If you open a small business today in the United States, your premiums go up something like 12 or 15 percent a year and you are up against foreign competition that gets health care for free. So what happens is, an American small business today spots their foreign competition something like 18 percentage points the day they open their doors. I think tinkering with this is not going to do very much.

I think that this fundamentally stems from a time warp that we have had since the 1940s. What we did is, we put it on the employers' shoulders and said, somehow you figure out how to make this work. Now we are the only country on earth that so directly puts health care into the price of goods and services.

So what I would like to ask you about is your thoughts about something that essentially takes us out of the vacuum tube era where we are and moves us to the microchip world for health care. What we do is, over a period of time, cut the link that says primarily health care ought to be on the employers' shoulders. Then we fix the private marketplace along the lines that you have said, Ms. Blumberg, because you are absolutely correct on that.

Then say we are going to have the individual purchase health care in a fixed, private marketplace and have the employer be a contributor to that, help to finance it. I would just be interested in your thoughts on that. Why do we not just go right down the row? There are nine U.S. Senators on a bipartisan basis who think that is the way to go.

Mr. NEWMAN. Senator, first of all, our members truly do appreciate the attention that you have given to significant health care reform. We also recognize that, as the American workforce continues to change, that there will be a continued erosion of the employer-based insurance program.

What I would mention is, while we are not experts in the insurance field, we would be willing, and are willing, to work with you in a very significant way regarding the health care needs of the Nation. But we do, in fact, recognize a changing in the structure of the American workforce, and health care coverage is a key component to our ability as a Nation to continue to meet the demands of products and services worldwide.

Senator WYDEN. Before we go on, let me thank NAR, because you all consistently are willing to work with us, and do it in a bipartisan way. People like Jerry Giovanella and others deserve great credit for their bipartisan approach, and we thank you for your comments.

Why don't we go, next, to you, Ms. Blumberg? And thank you also for pointing out that you can do this within the amount of money that is being spent today on American health care.

Ms. BLUMBERG. Thank you, Senator. In general, I have feelings that are quite consistent with yours on the current prominence of the employer-based system and the difficulties with it. I may have a couple of issues with some of the ways that you are thinking about this with regard to the burden of maintaining a financing responsibility for employers. While it is difficult to think politically about raising sufficient revenue to remove the employer payments from the equation, we just——

Senator WYDEN. We do not do that. The employers continue to have a shared responsibility.

Ms. BLUMBERG. No, I understand that. But my concern is that we think about that shared responsibility very carefully, because part of the problem with employer mandates, requirements of financing health care reform via employers, is that economists believe that the vast majority of the dollars that are contributed by employers for the benefits of their employees really are paid, in essence, by the workers through reduced wages over time.

When you think about putting new requirements on employers, the requirements are really going to fall most heavily, of course, on those employers and individuals who do not have health insurance today. Those are, in large part, the lower-wage, lower-income workers. So if you are thinking about putting more requirements on employers of low-income workers, then you have to think about that as putting a new burden of financing on the low-income worker. So that, I want to be really careful about.

The other issue that I would raise is that, when you are moving from a largely employer-based system to one that is more individually based, the transition is going to be very critical. You do not want to create new incentives to peel certain types of people out of the existing employer-based insurance market when there is really nothing to catch these people when they lose their coverage through their employer. Particularly this is the case for the low-income population and those with high medical needs.

So while I do not think any of us would pick the health care system we have today if we were starting from the beginning, we do have what we have, and we have to be very cautious about how we transition out into something new so that we do not, in the process, disadvantage people who currently do have good coverage.

Senator WYDEN. I share your view. One of the reasons that I feel so strongly about the change is that, if you make what we are calling for in terms of the tax changes, you get the money to subsidize those people and you also get administrative savings because you do it through the Internal Revenue Code. I know I am right on the brink, and I will stop talking and let the other witnesses comment.

Senator ROCKEFELLER. Wait. This is an interesting technique. In other words, you are a minute over your time.

Senator WYDEN. I learned this on the Intelligence Committee.

[Laughter.]

Senator ROCKEFELLER. Oh, you did? So you just ask all of them to comment, and 12 minutes later Senator Kerry gets to speak.

Senator WYDEN. I am done, if that is the chairman's pleasure.

Senator ROCKEFELLER. No. The chairman's pleasure is to keep you relatively happy.

[Laughter.]

Senator KERRY. In which case you make one relatively unhappy.

[Laughter.]

Senator KERRY. No, I am joking.

Senator ROCKEFELLER. Go ahead.

Mr. BIANCHI. A health care economist by the name of Len Nichols observed that if you assigned an economics graduate student to design a health care system, the worst health care system possible, that student would come back with what we have now.

I think there are five things, five criteria, that I think are required to make your proposal work, if I may be so bold: (1) guaranteed issue; (2) guaranteed renewability; (3) portability; (4) and this is, I will admit, a little out there, I think the individual mandate, because it does address the question of adverse selection. You get everybody into the pool and then you are not fighting the battles over that.

Then lastly, none of the proposals that I have seen to date address underlying cost. They are all aimed at access to coverage, which is very laudable, but at the end of the day, if we do not want to see the trend rate continue to climb, we have to do something about the underlying costs.

Mr. ARIO. I have heard you speak about your proposal, Senator Wyden, and we have had it presented at the NAIC. I think it is a very good proposal. I think if we were starting from scratch today, your proposal wins hands down over the employer-based system. So to me, the set of questions are, we have the employer-based system. Do we move immediately to your system or do we try to build on the employer-based system?

Governor Rendell wants to build on the employer-based system that we have and have elements of your plan come into it. I think one of the things that is very attractive about the individual approach is that it becomes an easier way to get at the cost control sorts of issues.

It is easier to get the consumer involved in a meaningful way in their own decisions, I think, under an individual approach as opposed to an employer-based approach. But I do think you need all of the things that Mr. Bianchi testified to. I would add to that list community rating, which I think is part of your proposal, too.

Senator WYDEN. Yes.

Mr. ARIO. If you have a level playing field for everybody, then conceptually I think you have a very strong proposal. It tests out well with the actuaries and so forth. It is just a question, really, of getting from our current system to that system and whether we want to preserve some of the things we have in the current system in terms of employer role in the system.

Senator WYDEN. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Senator Kerry?

Senator KERRY. Thank you, Mr. Chairman.

Senator Snowe and I have had the pleasure of working together as chair and ranking member of the Small Business Committee, and earlier this year we held hearings on this topic. We have sent a letter to Chairman Baucus and to Ranking Member Grassley in which we have set out four principles that I think ought to guide our approach to this.

One is, obviously, we have to increase health insurance coverage of small business, and we have been trying to do that by stabilizing the ability of small employers to provide that care through targeted employer-based tax credits for those who cannot afford it now. I think tax credits is one critical way of encouraging it.

But, two, you have to have some kind of pooling mechanism that empowers them to spread the risk and reduce the costs, but, third, at the same time protects—and this is critical, and this is where we find the greatest difficulty—vulnerable firms and workers from

being priced out of the market from cherry picking and through the issue of the mandates, et cetera. We want to increase the options available to them. Fourth, we want to provide self-employed and sole proprietors with additional opportunities to be able to buy it.

Now, Mr. Bianchi, you have been through the experience of Massachusetts. We have this mandate there. But in Massachusetts, we have some of the highest mandates with respect to the care that we provide. The minute you start expanding this pool across State lines, you run into this huge issue of dumbing down the system, of not requiring people or not putting people in a position where they are going to lose coverage that they currently have, or employers are racing to an alternative that is less comprehensive than what they currently have.

They may have certain screening tests, they may have certain coverage that just is not going to be available in the other State. How do you deal with that? Do you take the highest level of care and say that is going to be the care in the pool, and if you want to be in a pool it is going to be the highest? How do you avoid this scaling down of the quality of care between States and pools? Mr. Bianchi, do you want to go ahead?

Mr. BIANCHI. Sure. I think one approach was suggested in the association health bill, either last year or the year before, and Senator Enzi's bill, where they looked to a combination of the mandates of various States that mixed them together into kind of a mash-up of mandate requirements and then used that regionally. I kind of like that idea.

Senator KERRY. But the minute you sort of do that mix-up, mash, whatever you want to call it, let us say you are covered for X number of visits or you have a particular cancer screening that is covered, or mental health, or some other component, and then the minute you switch out of there, those are not there? Are you not creating an incentive for people to rush to the lesser coverage because it is less expensive?

Mr. BIANCHI. Well, Senator, I am not sure. We do not do that now. Even in Massachusetts, you can buy low, medium, and high coverage, with higher deductibles and co-pays. So I am not sure there is ever a way out of that conundrum, except to say that we all know, or we suspect, that a policy ought to at least cover critical major medical items. I think there is, if not a consensus, some general agreement on the big——

Senator KERRY. But there are differences between the States in what they are mandating.

Mr. BIANCHI. No question. No question.

Senator KERRY. So there are different standards of care that are being provided.

Mr. BIANCHI. Right.

Senator KERRY. So if, all of a sudden, you cross those State lines, who is going to regulate? I mean, are you giving up the mandate? Is there no longer a standard of care in that State?

Mr. BIANCHI. I think ultimately, if you want to do this on a super-regional basis, the answer is yes. I think that is a huge political step that would move us away from the McCarran-Ferguson structures where the States were primarily responsible, to having some sort of super-regional responsibility. It is possible and it is

one way to, I think, start to address your dilemma. But it is a big step.

Senator KERRY. Yes. I wanted to ask Ms. Blumberg. But go ahead, Mr. Ario.

Mr. ARIO. I think you are right on point, Senator Kerry, with the issue of adverse selection there. Right now we have a system where each State has its own mandates that are different State to State, but people cannot pick and choose among the States. They are in one State or another. If you open up the multi-State issue and have a different mandate—just take mental health—you will have, then, people in Massachusetts or in Oregon where we passed a very strong mandate, or in Pennsylvania where we have a very strong mandate, looking at those mandates versus the regional mandate. People who really want mental health will stay in the State and people who see the other mandate will move.

Senator KERRY. It is a big issue. I appreciate your saying that. It seems to me that, if you are not going to see the system go backwards, then you may have to say, all right, if we are going to get the virtue of pooling and therefore expand the risk pool and bring well people into it to hopefully lower premiums, we are also going to provide the highest standard. That may be the only way to skin that cat.

But let me just ask you, because my time is up, Ms. Blumberg, if I could, just quickly. I have a bill that gives a refundable 50-percent tax credit for employers to provide the premium, and I also introduced in 2004 the concept of a reinsurance pool which would take all the catastrophic cases off the backs of small business, any case $50,000 or more, which would lower the premiums automatically by $1,500 per individual.

If you then add to that a 50-percent premium to a 50-percent tax credit to the employer for the purchase of the insurance, you will not only have the lower premium, you also have the advantage of the 50-percent tax credit, so you are really reducing those premiums, which makes it very attractive to purchase the insurance.

The President, on the other hand, wants to give tax incentives to individuals, not to the business, for that health insurance. Could you comment on the efficiency of providing a meaningful tax credit to the employer versus providing it to the individual?

Ms. BLUMBERG. Well, there are a couple of issues that are kind of tied in there together, because there is the administrative cost of putting the tax credit in place and just having the IRS interacting with the employers, and then there is the target efficiency of a subsidy.

When you look at small businesses, the reason that I referred to the low-income problem as being a primary problem with coverage in that population is that the probability of a worker being below 200 percent of poverty is much higher in a small firm than in a large firm. This, of course, moves a little bit depending upon how you define small, but the worker is twice as likely, or more than twice as likely to be low-income if they are working in a small firm than in a large firm.

But when you look at small firms, not all of those workers are low-income. You have heterogeneous workers even in the small firm pot. So when you provide subsidies that are directed to the

employer, you have a situation where you end up not targeting to the most high-need individuals very well because you end up subsidizing all the people in the small firms, many of whom are low-income, but many of whom are not. So that is the target efficiency difficulty with subsidizing the employer. They have a mix of workers.

When you are targeting your subsidy to the individual, you can much more easily peg the dollars that you are spending to the individual characteristics of the people that you want to help.

Senator KERRY. What about the efficiency of actually getting them covered, though?

Senator ROCKEFELLER. This will be the last.

Senator KERRY. Yes.

Senator ROCKEFELLER. I mean, we are way, way over time here.

Ms. BLUMBERG. You cannot just give an individual a tax credit, a modest tax credit, and send them out into the non-group market, for all the reasons that were discussed here today. They just do not have access to adequate, affordable coverage that way. So, if you are not going to do something through an employer, then you have to have another catch-all for them to buy affordable, adequate coverage.

I would suggest that, even if you want to target your subsidies to the small employers, that you have that kind of mechanism anyway just because small firms are not efficient purchasers of health insurance, and I would hate to throw dollars after purchasers who are really not efficient at getting the coverage.

Senator KERRY. I appreciate it.

Mr. Chairman, thank you for your indulgence.

Senator ROCKEFELLER. Thank you.

We have not had very good success on the Democratic side with respect to discipline. I expect that standard to increase now substantially with Senator Smith.

[Laughter.]

Senator SMITH. Thank you, Senator Rockefeller.

Joel, when Mr. Newman's good realtors from all over the country, particularly from Oregon, come in to see me, they invariably ask me to support what we debated last Congress, which is the association health plans. I did not do that in the end, not because I was not trying to find a solution, but because, frankly, we ran into the buzz saw that you referred to earlier, which was the mandates that Senator Kerry has mentioned, and others. There are tremendously entrenched bureaucracies in every State as it relates to their view of what insurance ought to be, at least at a minimum level.

It seems to me, and I think what you are saying is, the one area where Congress might be able to incentivize some cost savings is through the whole standardizing rate guidelines. Am I understanding that correctly, that there are the savings that we could pursue if we wanted to incrementally approach health care reform?

Mr. ARIO. Senator Smith, I think you could achieve some savings in that direction, although when you look at the issue State by State, you do see some significant differences. So, coming to some kind of common agreement on where that standardization fits, I think, is difficult. I think it is probably much more difficult today than it was even 10, 15 years ago. When Senator Kitzhaber started

the Oregon Health Plan, there was kind of agreement that we could define a common benefit package.

In the intervening time, we have seen this rise of consumer-driven health care and a lot more products that are a lot more differentiated and aimed at particular constituencies. So I think today, talking about kind of a one-size-fits-all benefit package across the country would be a heavier lift than it would have been even 10 or 15 years ago.

I do think that it is an important issue on the association health plan issue that you referenced, which is, if the association health plan is the way it was proposed last Congress, that it is a cherry-picking operation where the rating can be different than it is at the State level and it is based on health status and so forth, or other factors that are proxies, then I think it does have a detrimental effect on the States.

If it is more in line with what I hear the realtors saying, which is a community-rated kind of pool, multi-State pool or State pool, then I think it offers just another option. So, it really comes to how the rating is done in an association or broader pool as to whether it will weaken the current pools or whether it can be complementary.

Senator SMITH. And if association health plans were modified to include that feature, would the State bureaucracies not go crazy with such a proposal?

Mr. ARIO. Senator Smith, I do not think there is a good way around the issue, as you have seen with mental health parity.

Senator SMITH. Yes.

Mr. ARIO. People are going to look at their own specific mandate, and, if there is even an iota of difference between it and what is being proposed, they are going to see disadvantage in it. That is my experience.

Senator SMITH. Well, that might even happen with my colleague's plan then, which is a much more national approach to setting the standard. It would still undermine the State bureaucracies.

Mr. ARIO. Senator Smith, I think, again, you are going to see the same issue play out on the mandates.

Senator SMITH. Speaking of Senator/Governor Kitzhaber, I have met with him many times on his plan. As you know, when we did the Oregon Health Plan, it basically has a defined benefit for anyone on Medicaid. This would take it to everyone, essentially, as a defined benefit.

It is his view that the only way we ever get a control on cost is to produce such a defined benefit, whether you do it through government providing it or markets providing it, and that that be done at least on a State-wide basis or a national basis. Anything anyone wants above that, they simply pay fee-for-service. Is that your understanding?

Mr. ARIO. Senator Smith, I believe that is former Governor Kitzhaber's view. I think he got religion on cost control because he saw that the gains that were made through the Oregon Health Plan in the early 1990s washed out with the recession earlier in this decade, so he is now focused on cost control.

Most of what we are talking about today does not really directly affect cost control, but that is the elephant in the room, and it has to be addressed. I think if Congress were able to get to a minimum benefit plan for everybody, achieve a definition that worked and could be approved, it would have some very positive impacts.

Senator SMITH. So you would agree with him that that is the only way, ultimately, that we will get a handle on health care costs in our country?

Mr. ARIO. Senator Smith, I think there are more ways than one to skin a cat.

Senator SMITH. All right.

Mr. ARIO. So I do not think that is the only approach, but it is one approach.

Senator SMITH. I have 7 seconds left. I just want to ask one question to Massachusetts. That is, I am intrigued with the plan. I think it has many good features, but some I do not fully understand. I know there is low-income support, and I suppose it is somewhat like Medicare Part D for prescriptions for low-income people. I am wondering, is there low-income support for small business?

Mr. BIANCHI. Senator, there is no separate support for small business.

Senator SMITH. All right.

Mr. BIANCHI. The subsidies are for low-income individuals. There is a provision in the Massachusetts Health Care Reform Act that allows small businesses to designate the connector as the small business's own group health plan. Now, what that does, it is still an ERISA-covered plan, but what it does is it takes all of the administrative issues off the back of the small employer and places them with the connector. The connector is currently working on regulations implementing that. It is not out yet.

Senator SMITH. Thank you, Mr. Chairman. I am only a minute over.

Senator ROCKEFELLER. A minute and 5 seconds.

Senator SMITH. Oh. Sorry.

[Laughter.]

Senator ROCKEFELLER. But you were worth it.

[Laughter.]

Senator ROCKEFELLER. One of the things which has always angered me about health insurance, among the many things that do, is the way we treat people with preexisting conditions, or rather how we do not, how badly we treat them. I would like, Ms. Blumberg and Mr. Newman, to have you kind of comment on this problem. They do not basically have access to health care. I will just make that flat statement. All right. It is not in the American spirit. It is discrimination of a legal and lethal nature.

Under current law, employed individuals can move from one employer-based health plan to a new employer-based health plan and they do not have to worry about preexisting conditions. On the other hand, individuals with preexisting conditions who move from employer-based plans to the vaunted individual market, about which I have a great deal to say, to one of those plans or those who move from one individual market plan to another, are subject to denial of coverage due to preexisting conditions.

Now, I do not know how much people care about that, but I think it is one of the great disgraces of our maw of the health care system. Because of preexisting conditions, these individuals are, in fact, uninsurable. Now, I am going to introduce a bill this week which gets at this. The crazy thing is, in the end we all end up paying for it anyway, everybody else does, so it just ratchets up the cost of health care while taking people who, through virtually no fault of their own, are deprived of one of the things that America is meant to stand for.

So, Ms. Blumberg, I would like to have you comment on that. Then, Mr. Newman, I would like to have you comment on how preexisting conditions affect your members. If, for example, we took away the preexisting condition barrier for individuals seeking coverage in the individual market, would that increase access to coverage for those who work for the realtors?

Ms. Blumberg?

Ms. BLUMBERG. I agree with you that the lack of access to adequate coverage for people with high medical needs is one of the great disgraces of our health care system. My concerns in trying to deal with this problem within the existing non-group market are founded in the fact that the non-group market is very, very small. In fact, a recent analysis has suggested that our household surveys, which show that maybe 4 to 5 percent of the Nation is covered in the non-group market, may be overstating that enrollment by a factor of as much as 4. So we are talking about——

Senator ROCKEFELLER. A factor of four what?

Ms. BLUMBERG. That there is probably a fourth as much of enrollment——

Senator ROCKEFELLER. Oh, I see.

Ms. BLUMBERG [continuing]. In private, non-group insurance today as we see in the household surveys that we rely on, like the Current Population Survey. So we are talking about a private market that is tiny. In all of the issues that we have discussed today with regard to risk and risk selection, it is the law of large numbers that helps you. The more bodies over which you have to spread these costs, the better you are able to deal with them.

So when you think about the unregulated non-group market, which clearly does not serve this population well, anything that you do to maintain high-cost individuals in that small market is going to have some kind of impact on the premiums in that existing market. So it is not going to be costless for those in the existing non-group market to put more regulations in place to keep higher-cost people in that market.

It may be a reasonable short-term strategy, but I think in the longer term what we really need to be focusing on are ways to make sure that the costs of the high-cost population are spread very broadly across the entire insured population, or that we are doing some kind of explicit subsidization based on a broad-based revenue source, to make sure that these costs are shared among the population as a whole.

Senator ROCKEFELLER. Thank you, Ms. Blumberg.

Mr. Newman?

Mr. NEWMAN. Senator, based on some survey work that we have done, approximately 7 percent of our membership would not have

access to coverage because of preexisting conditions in the individual coverage market.

I think in the real estate industry it is important to understand, so let me give a brief synopsis of what my company is like, for example, in a small market. I have seven people whom I have employed, four people in the property management department and three people who work in my residential/commercial firm.

Of that, I have eight associates who are brokers under my license who work for me. They are truly independent contractors. They are self-employed. They have no other employees working for them, so their direct coverage has to go to the individual market.

Now, I range anywhere from single moms with children to older adult males and females, some single, some married. Some have preexisting conditions, others are very healthy, so it is all over the place. But one particular agent in my office is a close friend of mine who is in her 70s and has a preexisting heart condition. The only way that she was able to find coverage was through a State health insurance pool. Outside of that, she would have been denied coverage, given the preexisting conditions.

I do concur, and I think it is explained in our testimony, that the ability to pool and to manage that risk across broad-based numbers is absolutely imperative, and the ability, might I say, that in the event a self-employed individual moves from one State to another, that that coverage be able to move with them is critical to solving this issue.

Senator ROCKEFELLER. I thank you both. I am over my time.

I call upon Senator Snowe.

Senator SNOWE. Thank you, Mr. Chairman. I want to thank all of you for being here today on this critical issue. I have been traveling this journey on small business health insurance plans since I was chair of the Senate Committee on Small Business and Entrepreneurship back in 2003 and I introduced the original association health plan bill.

As Senator Kerry, who is now chairman of the Small Business Committee, indicated, we have not only established various guidelines that we think are essential, but it has also been premised on the numerous hearings that have been held, both in the Small Business Committee because of the impact on small businesses in Maine and throughout the country, but here in the Senate Finance Committee as well. It has been a long journey, and most especially for small businesses and their families who depend on some type of change and reform at the Federal level to make it happen.

The question is, how do we jump-start this process? We went from the original bill that I introduced, association health plans, then Senator Enzi, as former chair of the HELP Committee, developed a plan. There were some problems with the preemption of benefits because in my bill it included preemption of benefits in the plans themselves, but not in the individual and group insurance markets.

So that meant the preemption of benefits across the landscape, which, obviously, created serious problems. Last year, we developed an amendment that would have been offered to bridge the divide on what mandates should be included. I used the standard of 26 States. I introduced this with Senator Byrd. Those benefits that

had been adopted in 26 States, basically became the median of that standard. Those benefits would be benchmarked to the Federal Employees Health Benefit Plans and the three most heavily subscribed plans utilized in terms of the level of care in those benefits. But, unfortunately, we did not get to that point.

Now, of course, I have been working with Senator Lincoln, and we are trying now to bridge this political divide as well, along with the chairman of this committee and Ranking Member Grassley. I have worked with Senator Bingaman as well on cafeteria plans, because I think that should be part of a solution. We have been working mightily. I hear the concerns, and also the preferences that have been discussed here today.

But if we were to try to arrange a potential solution between refundable tax credits and offering a multi-State pool as one approach, how do we address the rating issue? I know in my State we have adjusted community rating and it allows for premium variations at a range of 4.2 to 1, on various issues such as age, geography and industry. How do we standardize a rating across the regions? Do the States have to be contiguous or not? What are the issues that could help us now to overcome and transcend some of the serious impediments to developing a program that will address this crisis for small business owners in America? It is a crisis. I mean, it is a decline of 10 percent of employer-sponsored health insurance over the last 6 years.

Maine's rates just came out on October 1 for individual and family plans. In the Maine small group insurance market, it is now $14,605 for family plans and $4,868 for an individual policy. That is in the small group market. I hesitate to think about others who cannot even get into that market. So that is the point here. We are facing escalating costs. So what could we do?

I will start with you, Mr. Ario, because you represent the insurance commissioners. We have heard from them repeatedly. Could you create a standard? If we would create a multi-State pool, for example, could you come up with an adjusted community rating standard, and how do we handle the benefits issue?

Mr. ARIO. Senator Snowe, yes, we could. I believe you are absolutely right about the nature of the problem. We want to work to solve it. I think on the rating issue there is a clear pathway to a solution, which is to say that the States, each of which has decided what kind of rating makes sense in their State, have the multi-State pool incorporate each of those State plans.

Again, when you go State to State in a multi-State pool, the rates are going to vary anyway. It is going to be just like Medicare. The rates are going to depend on what local conditions are in the marketplace, the nature of the delivery system, and so forth. So you are going to have differential pricing State to State so you can have each State's rating system left in place, and then the pool operates with a common benefit package, priced differently State to State.

So I believe that will work. It would protect the State pools. It would allow for the purchasing options. It would allow broader choice. It would allow more carriers to get involved, and so forth. So I think the rating issue can be solved in that way. The benefit issue that you reference, I do not have an easy answer on that. I

know as an insurance regulator, our role when the legislature is debating a new mandate is to provide information on both sides.

Once a legislature votes a mandate, my experience in both Oregon and Pennsylvania is that my Governors are dead set against Federal preemption of any of the details of those mandates, so that is a very difficult issue that way. But on the rating issues, I believe we can get there in the way that I outlined.

Senator SNOWE. Well, that is why we went with a 26-State approach, and it would change over time. If another State adopted a benefit, then that would obviously add to the expansion of benefits. But it is really a struggle. I think that there has to be a way to transcend these barriers, and we need your help in that respect because you do represent the insurance commissioners of various States. I think that is a critical issue here in trying to resolve this question. I would hope that you could come up with some ideas in that respect so that we could address this.

Mr. Bianchi, could you share with us anything on the Massachusetts level that would help in that regard?

Mr. BIANCHI. Senator, this is really beyond my area of expertise. I am going to pass on that one.

Senator SNOWE. All right.

Ms. Blumberg?

Ms. BLUMBERG. I would just echo Mr. Ario's comments. The key is that, as soon as you put a wedge between what is being done in a State outside a pool and what is being done inside the pool, you are going to set yourself up for trouble with selection. So I am not sure how to get around this problem either, but you do not want to make segmentation of risk worse, whatever you do. You want to be working towards greater pooling, not less.

Senator SNOWE. Could you use actuarial value? That is something I understand the Federal Employees Health Benefit Plan does. I do not know if you referenced it, Mr. Ario, on using an actuarial value of benefits. Is that possible?

Mr. ARIO. Senator Snowe, yes. There are many approaches to defining the standardized benefit package. We certainly are expert at looking at benefit packages and giving expert advice on what does or does not cover what kinds of situations, that sort of thing. We would be happy to work with the committee. It is when you get to the next level of it, whether that is going to please all the different constituencies, that is kind of beyond our control as insurance regulators.

Senator SNOWE. All right. Thank you. Thank you very much.

Senator HATCH. I think I am next in line.

Senator LINCOLN. You are. Absolutely.

Senator HATCH. All right. Thank you.

Well, I want to thank everyone here today for your testimony. There is broad agreement here on Capitol Hill in the policy making community that our health care system is in need of reform. But how do we go about it? Can we make targeted and progressive changes that will create a better health care marketplace for Americans? Is the system in need of radical reform and nationalization? In short, do we use a scalpel or do we use a sledgehammer?

The testimony today recommends a scalpel. I would like to thank the chairman for drawing attention to really an important, but

often overlooked, fact about access to health care. Certain groups are much more likely to have trouble accessing health care insurance than others. The self-employed are at the top of this list. According to the 2005 data from the IRS, the number of sole proprietors filing a schedule C was 21,287,828. In the States represented by members of this committee, there are 5,601,405 schedule C filers. My State alone had 167,994 in 2005.

We can help these folks right now. Today, Senator Bingaman and I will introduce legislation that would merely provide tax equity for the self-employed. Corporations are allowed to deduct health insurance premiums as business expenses, and of course forego payroll taxes.

Yet the tax code, perversely, punishes the self-employed for their entrepreneurship. The self-employed must pay an additional 15.3-percent self-employment tax, the equivalent of payroll taxes on those expenses. Now, in my opinion, this is ridiculous, and it is very unfair. It is something that we could fix today.

Mr. Newman, let me just ask you this question. Short of wholesale reform, how would the changes that Senator Bingaman and I are proposing impact you, your family, and other self-employed Americans who currently do not have these rights?

Mr. NEWMAN. Senator, I think I am on very safe ground saying that we would absolutely support that concept. It would be a tremendous relief to the small business person as relates to its operational business model, and we would wholeheartedly support and endorse that concept.

Senator HATCH. Well, thank you. I would ask consent that we put into the record a list of the sole proprietors by State.

[The list appears in the appendix on p. 100.]

Senator HATCH. You will find that there are a lot of people here who just are not being treated fairly, in my eyes. I think hopefully we can pass this bill, even though it is a small, little thrust compared to what probably most all of us would agree needs to be a major wholesale reform. But I appreciate your testimony.

If anybody else has any comments about it, I still have a few minutes. I am going to finish on time.

Mr. ARIO. Senator Hatch, I would just say that I, too, agree that focusing on the sole proprietor has more promise than trying to merge all of the individual market and all of the small group market, and would cause some issues in the small group market that would have to be managed. But 12 States have already done it and included the sole proprietors in that market, so I think that is the kind of scalpel approach that you are talking about.

Senator HATCH. Well, thank you very much. Thanks to all of you.

Senator LINCOLN. Last, but not least, I am here. I apologize for being late. It certainly is no reflection of my interest in this issue. We are marking up the farm bill over in the Agriculture Committee, and that is where the rest of this bunch has all gone, I think.

But we are appreciative of you being here. I am certainly pleased to be here today to continue to explore the challenges that we see with small businesses and self-employed individuals and what they face in providing health care coverage to their employees, to themselves, to their families.

We definitely want today to be not just the first step, but a continuing step in working to find a solution. I want to thank Senator Snowe before she leaves, because she has been an incredible part of this discussion, and I have certainly appreciated working with her. We are going to keep working at it, without a doubt.

We do have to find many solutions to so many of the questions that both you have heard from here that we have posed, but also some that you have posed yourselves in answer to those questions. Our hope is that we can build a gateway to coverage that will really encompass a large portion of America's working families in a way that is responsible and accessible.

We certainly have seen Medicare, Medicaid. Those were programs that were designed over 4 decades ago covering health care needs to some of our most vulnerable, our seniors and our low-income. Through the years, we have made changes, some of them good, some of them not so good.

The 10-year-old bipartisan CHIP program was created because even Medicare and Medicaid do not reach out and encompass all that needs to be encompassed in terms of facilitating and getting individuals, particularly working families, into the marketplace. Our hope is that we will be able to come to some resolution.

I do hope that the reauthorization of SCHIP will come first, and that it will come soon. It certainly should not take—and I do not believe has taken—the place of the discussion that we have had here, because many of us, although we may not have had public hearings like this, have been working behind the scenes tremendously on health care availability to the small business industry and to the small business market and the self-employed.

I constantly hear from my small businesses in my State, and I am sure I am on the list that Senator Hatch just put into the record. Based on their size, they disproportionately shoulder the burden of the ever-increasing cost of health care benefits, and particularly to their employees. It is a huge issue for us in States like Arkansas.

I have just come from where we have had a very long, 2-day debate on the farm bill. I come from a 7th-generation Arkansas farm family, and my dad was a little bit of a novelty, I guess, in the sense that most farmers hired their workers seasonally and my father had several workers on the farm that he kept year-round, and he did so with health insurance. They had children. They had families. They did not want seasonal jobs, they wanted a year-round job that provided them health care coverage. He knew what that meant to his family, and he knew what it meant to their families, and it made a big difference.

So I think it is absolutely essential that we consider health care legislation in the weeks and months ahead, particularly directed in this direction. But we have to be smart about how we focus because we know, with the longevity we have seen in both Medicare and Medicaid, we also see not only the positive aspects of SCHIP, but the fact that it is here and it is going to continue and we are going to make sure that it continues, that we do want to get as much of this right the first go-around as possible, because the popularity of it, as well as the success of it, is going to depend on that. I think that gives us incentive to really try to work hard to get it right.

Following up Senator Snowe's question, which was, as usual, quite on target, and your responses, I think, showed that, what we have learned from our work on the issue of the past few years is that you do run into trouble with the States when you start talking about Federal preemption of benefit mandates. We have tried to work through that issue, making sure that what we are providing is not only an accessible product, but one that is comprehensive enough and is certainly a good product. I do think that we are at a point where we are going to have to reach a collaborative approach, though, for addressing the mandate issue.

If any of you all want to expand on that, and some of what Senator Snowe brought up, but to comment on how we come to a strong State and Federal dialogue on this issue. Do we establish Federal principles and let the States work within those confines? How do we really start that dialogue in a productive way? You have had a lot of practice at it, Mr. Bianchi.

Mr. BIANCHI. Senator, the issue of ERISA preemption is certainly a daunting one, and I think there are just solid arguments on both sides, whether you maintain strong preemption or you loosen up the rules and allow the States to enter more into the health regulatory universe. If you look at the original ERISA bill before it was passed, before it went to committee, if you look at the bills from both sides, neither had this strong ERISA preemption provision.

That was inserted in the conference committee in the last 10 days before ERISA was signed back in 1974. Before that, there was language to the effect that States could regulate within—and I am drawing a blank now on exactly what the language was, but it did give the States——

Senator LINCOLN. Well, it was 1974.

Mr. BIANCHI. Yes. And I was not paying much attention to it back then, to be honest. There was a much greater role for the States, and I think your committee wants to get a sense of—you have some precedent to look to. You can go back and look at that history and see what is out there.

Senator LINCOLN. Well, that is interesting. Of course, also, I guess, our objective, too, is some of what Ms. Blumberg brought up when she said, if you build a wedge between there, then you create more room for, I guess, really, the problem of adverse selection, and we do not want to do that either. We do not want to create States that are winners or losers.

We want to maintain the quality of health care as well in terms of what is available. We want it to be meaningful. I guess that is what always draws us back to setting principles so that we can feel like there is a collaborative effort of what is meaningful in terms of coverage.

Did you want to comment?

Ms. BLUMBERG. Yes. I would like to make one suggestion, Senator. If we are talking about the problem of small businesses, or businesses really of any size, when they are purchasing coverage for their workers who reside in multiple States, they do not want to be shopping in every State for different kinds of packages and having to negotiate in different ways.

Senator LINCOLN. Right.

Ms. BLUMBERG. Maybe the way to address this, instead of thinking about a way in which to have a single plan that conforms across all States, is to think about it as a system across all States of having organized purchasing entities for small businesses and sole proprietors. You could even potentially do it for larger businesses who are in a similar situation with multi-State workers.

And in each of those States, those purchasing pools would have regulatory rules consistent with regulations in the markets outside of that pool. But if that pool was set up in such a way that it was an individual worker choice pool, as has been in the case of a number of the different small business purchasing pools that have been set up across the country, the employer says, this is where you are getting your health insurance benefits, I am making a contribution of X dollars, but you can take those X dollars into the pool and choose the plan that works best for you. And those plans are contracting with the State purchasing pool, not with the individual employer.

That way, any employer can say, there is one of these organized pools with acceptable plans meeting State requirements in each State, here is how much I am willing to contribute in each State for each of my employees, and then there is no wedge set up, there is no concern that they have to be buying the same thing for every worker in every State. The worker is getting choice from having the available pool, and the firm can just decide what their contribution is and not worry about the negotiations for contracting with individual plans.

Senator LINCOLN. That sounds similar to—I know I have heard there are some different products out there, particularly for wholesalers. I know that there is a contract basis for—I think it's Sam's Wholesale that does a very similar package to something like that, which is interesting because it goes across different States, obviously, and then they contract and then the employee goes to that contract and chooses what they want, and then chooses how much they are going to add to whatever the employer puts into it.

I think that one of the other questions that I really think is important to be asked, and I am not expecting you all to pull a rabbit out of a hat here, but it is something we have to talk about. That is, how do we pay for a small business tax incentive? That is obviously one of the things this committee does, and it is a component that is likely to be included in a Finance Committee product on this issue.

It is going to be those tax incentives of some sort that are going to assist the employees of small businesses with the purchase of health insurance coverage. So, whatever the incentive is, it is going to have a cost and that, in this day and age for us, with pay-go and everything else, requires us to come up with a way to pay for it.

I think one of the things that is a little bit different on this initiative is that the largest tax expenditure in the code today is the exclusion for employer-provided health benefits. It costs more than $2 trillion over 10 years in income tax, and almost half of that is FICA contributions. So there is an existing cost now already.

I guess my question for you all would be your thoughts on how we approach the revenue loss associated with new small business tax incentives. Do we just lay that on top of what we are already

doing or do we look innovatively in some ways to try to make sense of some modest modifications to the current exclusions?

Maybe some wholesale elimination of exclusions like the President is offering could cause, I think, some significant disruptions. I do not know. I would like to know your opinion in terms of what might happen if we just had this total exclusion of those benefits, what that does to the marketplace, and are there some simple modifications? I am not a tax attorney. I do not know if you all are or not. But maybe some modifications there where we can use those existing revenues that are already being spent.

Mr. BIANCHI. Senator, I will be glad to address that, but I am not sure I can add a lot. In Massachusetts, we faced a microcosm of that same question. But one of the ways we solved it was a creative reallocation of our Medicaid monies. I am not sure that anyone solved that problem yet, and it remains to be seen whether we truly did in Massachusetts, once we get past the first 3 years.

Senator LINCOLN. So you redirected your funding stream, or some of your funds.

Mr. BIANCHI. Yes. We did two things. We redirected the funding stream. We also took the money that we were spending on the uncompensated care pool and Medicaid, principally the uncompensated care pool, and redirected that into subsidies for low-income folks on the theory that we could expand coverage that way and drive down the cost of the uninsured.

Ms. BLUMBERG. I think there is potential for restructuring the current tax exemption for employer-sponsored insurance, but my concern is that you have to approach it very cautiously.

Senator LINCOLN. Oh, yes.

Ms. BLUMBERG. Because, as you mentioned with the President's proposal, any wholesale change which can disrupt the balance between incentives to be purchasing through employers versus through the non-group market could end up releasing a lot of people from their employer-sponsored insurance in the non-group market who will not be well-served by that market as it stands. So there has to be something set up there and organized for them to have a reasonable alternative for buying adequate insurance before any kind of wholesale change like that can take place.

So "approach with caution" is exactly the right way to be thinking about this. In terms of near-term revenue sources, you could do something like putting a cap on the tax exemption, particularly for higher-income people. That would be something that I think you could do with minimal disruption to existing insurance arrangements. Because you are talking about directing a new subsidy to small businesses, you want to be very careful about taking away the tax exemption which is providing some subsidy and assistance not only to high-income people, but also to middle-income people. The middle-income people in larger firms are not going to be the beneficiaries of the new subsidy that you are putting in place.

So let us say you are thinking about small businesses as being under 25 workers or under 50 workers. Those individuals could be getting a new subsidy under whatever policy you develop. But if you are paying for that by taking away a tax subsidy from a middle-income person who works in a firm of 100, then that indi-

vidual may have their affordability of insurance affected adversely, even though you are helping people in the under 50 group.

So you want to be sure that the people who are going to be most responsive to changes in subsidies in terms of their decision to buy coverage, and those are people who are middle-income and of more modest income, you do not want to decrease their subsidy in order to pay for a new subsidy.

Senator LINCOLN. Right. You do not want to shift the burden.

Ms. BLUMBERG. Exactly. You do not want to finance help for modest-income people in small businesses by taking money away from modest-income people in middle-sized businesses or large businesses. But I think there is some potential, without disruption, for capping the existing tax exemption for higher-income people.

Senator LINCOLN. Any comments from anybody else on that?

Mr. ARIO. Just the observation, going back to what Ms. Blumberg said much earlier, most of the problem with uninsurance in the employer community is with the small businesses which have generally lower wages, so some form of capping of the sort that she is talking about would have a general subsidization from people who currently are doing quite well to people who are most in need.

Senator LINCOLN. All right.

Mr. Chairman, I will gladly hand this all back to you.

The CHAIRMAN. Thank you, Senator, very much for your questions. I also thank the panel.

I have a question for Mr. Ario. I think in your testimony you may have said that 12 States help self-employed persons by redefining the size of a group from 1 to 50, as opposed to 2 to 50. I take it you think that is a better way, a good way—a potentially good way—to help provide insurance for the self-employed. The question is, how has that worked in those 12 States?

What about preexisting conditions, maybe for the one, and other problems that otherwise would occur, the problems that the self-employed may have faced? How are those problems remedied with those 12 States that redefine a group from 1 to 50 instead of 2 to 50? If you could just comment on that, please.

Mr. ARIO. Mr. Chairman, good question. Some of the little bit broader frameworks—at this point, Massachusetts is the only State that has experimented with combining the individual and small group markets, and I think in general those two markets are quite different in most States.

The CHAIRMAN. Right. Your view is, that is not a good way?

Mr. ARIO. I think that would cause a lot of disruption along the lines we have been talking about today with selection issues and so forth. A more modest step is exactly the one that you are talking about, which is to take and build on the experience of the 12 States that have said if you are self-employed and can show that through tax records and so forth, you can come into the small group market essentially as a business of one.

That, too, does create some of the selection issues in the States that have done it, and it is somewhat interactive with how broad or narrow the rules are in the individual market because, of course, when you do that, the individuals who have a choice—unless you change the rules for that. In today's market, they will have a choice between the individual market—will tend to stay there if the indi-

vidual market is more wide open and they are healthy. They will tend to go into the small group market if that market is better for them, so you are bringing some new risk probably into the small group market, but you are spreading that risk among all the small businesses.

So it has been something that the 12 States have done, and none of those States, to my knowledge, has repealed that once they have done it because it has worked well enough that it has kept the small business market, small group market, effective. But you have to do it very carefully and you have to be sensitive to the adverse selection issues there.

The CHAIRMAN. Yes. So you are basically telling me those States so far have been able to basically handle the adverse selection issues or questions.

Mr. ARIO. Mr. Chairman, I know in some of those States that there have been vigorous debates back and forth about trying to undo that, because there is a claim by other small businesses that it is driving up costs too much for everybody else.

But so far, in the balancing of all those factors, to my knowledge, none of those States has seen fit to repeal it because it does serve the kind of interests of the sole proprietors that Mr. Newman represents here today. It is clearly good for them. The question is, how much new problem do you bring into the small group market when you do it?

The CHAIRMAN. Are other States looking at redefinition?

Mr. ARIO. Mr. Chairman, to my knowledge that is not a hot topic among the States. The realtors in the State that I am familiar with have tended to propose more association-type approaches to the problem, requiring the insurers to serve associations that would include their members rather than this strategy of adding sole proprietors to the small group market. But Mr. Newman could probably speak better to that than I.

The CHAIRMAN. Right. But have there been more self-employed covered in those 12 States?

Mr. ARIO. Mr. Chairman, yes. Yes, it clearly does. It takes individuals, who today in the individual market can either not get covered at all because of a preexisting condition or get rates that they considered too high, too unaffordable, it does give them guaranteed access to the small group market.

The CHAIRMAN. And that has been the experience? That has been the experience in those States?

Mr. ARIO. Yes. It would give that access, yes. It clearly would give the access to those people who may not get favorable treatment today in the individual market.

The CHAIRMAN. All right.

Mr. Newman, do you want to comment on that?

Mr. NEWMAN. Thank you, Mr. Chairman. I think the comment that I would basically like to make is, it is a concept of being able to pool in broader markets in order to create efficiencies in the cost for health care, and also to provide for those who might not be able to receive it in the individual market an opportunity to, in fact, receive it. Whether it be through an association health plan or whether it be through pooling, it is absolutely critical to bring people into the system.

The CHAIRMAN. Any other comments on that basic question, Ms. Blumberg or Mr. Bianchi?

[No response.]

The CHAIRMAN. All right. I want to thank you all very, very much. I apologize for my inability to be here for most of the hearing. I was in an Agriculture mark-up and had to be there. But we have great staff who heard everything. We will have lots of follow-up questions we are going to ask. I know Senators asked terrific questions. So, thank you, all four of you, very, very much for taking the time.

The hearing is adjourned.

[Whereupon, at 11:45 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

TESTIMONY OF

Joel Ario
Acting Commissioner of Insurance
Commonwealth of Pennsylvania

Testifying on Behalf of the
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

BEFORE THE

SENATE COMMITTEE ON FINANCE

on

Small Business Health Insurance:

Building a Gateway to Coverage

October 25, 2007

Introduction

Good morning Mr. Chairman. My name is Joel Ario, the Acting Insurance Commissioner of Pennsylvania and Chair of the National Association of Insurance Commissioners (NAIC) Health Insurance and Managed Care Committee. I am testifying today on behalf of the NAIC, which represents the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. The primary objective of insurance regulators is to protect consumers and it is with this goal in mind that I comment today generally on the small business healthcare crisis, and in particular on certain proposals currently being considered at both the state and federal levels.

To begin, I would like to emphasize the commissioners' recognition of how important it is to ensure that affordable health coverage is available to small business owners and their employees and I offer the full support of the NAIC in developing legislation that will reach this goal.

States led the way in requiring insurers to offer insurance to all small businesses in the early 1990s, and the federal government made guaranteed issue the law of the land in 1996[i] for all businesses with 2-50 employees. Federal law does not limit rating practices, but forty eight states have supplemented the guaranteed issue requirement with laws that limit rate variations between groups, cap rate increases, or impose other limitations on insurer rating practices. These rating laws vary significantly in response to local market conditions, but their common objective is to pool and spread small group risk across larger populations so that rates are more stable and no small group is vulnerable to a rate spike based on one or two expensive claims. In addition to requiring insurers to pool

their small group risk, many states have established various types of purchasing pools and licensed associations to provide state-approved insurance products to their members.

States continue to experiment with reinsurance, tax credits and subsidies, and programs to promote healthier lifestyles and manage diseases as they pursue the twin goals of controlling costs and expanding access. In Pennsylvania, for instance, new programs have been enacted to control costs by reducing hospital infections and enhancing chronic care management, and Governor Rendell has reforms pending on covering the uninsured and regulating insurance rates.

As always, states are the laboratories for innovative ideas. The federal government must work closely with their state partners, as well as with healthcare providers, insurers and consumers, to identify and implement reforms that will make insurance more affordable to small businesses.

It is in this spirit of cooperation and information-sharing that I was asked to testify before you today, and I appreciate this opportunity. Specifically, I was asked to comment on several reform concepts that are currently being considered at the federal level: multi-state purchasing pools; pooling for individuals and sole proprietors; and creating an affordable health coverage option. I will discuss each of these issues in turn and conclude with two brief observations on cost control and state innovation.

Multi-State Purchasing Pools

Small businesses in some states face limited choices when it comes to selecting a health insurance carrier. This can occur for a variety of reasons, including the fact that small businesses do not have the same market advantages that large businesses do. The

expectation of multi-state purchasing pools is that by pooling the purchasing power of many small businesses in multiple states they will be able to take advantage of the same economies of scale and negotiating power as large businesses.

While the multi-state pooling approach is untested, the experience of single-state purchasing pools created in the mid- and late-1990s suggests that adding more pooling options to the risk pooling that already exists in small group markets by virtue of state rate regulation may not add much value. While purchase pools did allow some employers to provide greater choice of plans to their employees, they unfortunately were not able to reduce costs and increase the number of small employers offering coverage to their employees.[ii] This was the result of several factors, which would also apply to multi-state pools.

First, grouping many small employers does not create the equivalent of a large employer any more than grouping three twelve-year-olds creates a thirty-six year old. The advantages that large employers have when purchasing coverage stem not only from their size, but also from their cohesiveness. The employees of a large employer are highly unlikely to reject the employer's choice of plan and purchase coverage on their own in the nongroup market due to the size of the employer's contribution to the cost of coverage. There is no similar incentive keeping small employers and their employees from purchasing outside the pool, however, and they will go wherever they can get the lowest premium for comparable coverage. So long as there is an outside market to compete against, a purchasing pool will not offer insurers the large, cohesive group that would give them the incentive to negotiate aggressively.

Second, the ability of pools to reduce administrative expenses through economies of scale has been less than expected. Early proponents of pooling initiatives expected that a purchasing pool would eliminate the need for participating plans to market as extensively and would help facilitate enrollment in the pool, reducing the substantial administrative costs in the small group market. Actual experience has shown, however, that small businesses continued to rely upon agents and brokers to assist them in selecting health insurance coverage for their employees, and without commissions comparable to those in the outside market, agents were not inclined to participate in marketing the pools.[iii] Furthermore, the reduction in administrative expenses that pools expected to realize by facilitating enrollment did not materialize to the extent that proponents had hoped.

In considering the creation of national, regional or multi-state pools, at least four key issues must be considered by policy makers:

- **Benefit Mandates** – For a plan to be effectively and efficiently marketed to the entire pool of small businesses, the package of benefits included in the policy cannot differ from state to state. This means state benefit and provider mandates would need to be preempted to a certain extent. However, as the current debate over mental health parity illustrates, the consumer, provider, and other interests that champion specific mandates at the state level tend to be very wary of federal efforts, however well-intentioned, that threaten to undermine their gains at the state level.
- **Rating Laws** – It is sometimes argued that multi-state pooling also requires the preemption of state rating laws. This is flat wrong, as evidenced by the current Medicare market, where benefit designs may be uniform across states but pricing varies based on local market conditions. As noted above, state rating laws vary significantly and it is absolutely critical that the rating laws in force for each

state's small group market continue to apply within the multi-state pool. If these rules differ, businesses will choose to purchase where the rules are most advantageous to them, resulting in adverse selection that will ultimately undermine either the multi-state pool or the state small group market. Applying state rating laws will not impede the creation of multi-state pools since geographic variations in the cost of health care services will necessitate different premiums state by state in any event.

- **Eligibility** – Eligibility rules can greatly impact the outcome of the pool. Including individuals and sole proprietors in the pool can provide additional options for these difficult-to-cover purchasers, but can also have implications for adverse selection, the stability of the pool, and the average cost of coverage. Requiring all small businesses coverage to be purchased through the pool can help reduce some adverse selection problems and create a more cohesive group to more effectively reduce rates, but also reduces the choice of plans available to employers.
- **Carrier Participation** – Like eligibility rules, the rules governing carrier participation can also have a profound impact on the success or failure of the pool. If all carriers are eligible to sell through the pool, participant choices will be maximized, but the pool's negotiating leverage will be reduced. Conversely, limiting the number of carriers that sell through the pool can provide greater leverage to reduce premiums, but also reduces participant choice.

There are many other issues to consider, such as how many states would constitute a pool, who would administer the pool, would there be risk adjustment among the participating carriers, and how would network adequacy be assured. However, the four key issues above must be hammered out first before these other matters are addressed.

Pooling for Individuals and Sole Proprietors

Massachusetts is experimenting with combining the individual and small group markets. The experiment merits close attention because the individual market is less regulated in most states than the small group market, leaving individuals vulnerable to exorbitant premiums if they are sick, limited coverage through a high risk pool, or even no access to coverage at all. Only a handful of states (including Massachusetts) have guaranteed issue in the individual market, and most states have more flexible rating laws in the individual market than in the small group market. This leads to better pricing for the best risks, but less protection for those most in need of health services. In this context, a federal mandate to combine the individual and small group markets – unless it were part of a comprehensive federal effort to achieve universal coverage—would cause major disruption.

A more practical first step could be the inclusion of self-employed individuals in small group markets. In most states, sole proprietors must purchase coverage in the nongroup market and thus cannot take advantage of the guaranteed issue and rating requirements in the small group market. However, twelve states have included these "groups-of-one" in their small group markets in an effort to reduce premiums and increase coverage for these sole proprietors.

While this is an effective tactic for helping these individuals purchase coverage, it can result in adverse selection problems if not done carefully. Groups-of-one generally tend to have higher health care costs than larger groups, as healthy individuals are more willing to go without health insurance than unhealthy individuals and can often get

cheaper coverage in the nongroup market where risks are not pooled as extensively as in the small group market.

For example, prior to the recent merger of the small-and non-group markets in Massachusetts, sole proprietors could purchase coverage in the small group market. In that state, groups of one had average claim costs of $296 per member per month, compared to average costs of $273 for groups of 2-5 employees and $250 for groups of 26-50 employees. To mitigate this risk of adverse selection, when the state merged the two markets, insurers were given more flexibility to take group size into account in their rating formulas.[iv]

Defining a Benefit Package

One of the most difficult issues in health insurance reform is how to define a basic benefit package that is both "adequate" to meet health needs and "affordable". The issue has become even more challenging in recent years with the advent of "consumer-driven health care" and the proliferation of new benefit designs to serve the preferences of targeted populations. The voices that decry any "one size fits all" solutions are getting louder, and they have their point about the diversity of health needs and preferences between, for example, a healthy 20-something and a 60 year old with a chronic condition. At the same time, other voices call for more standardization, and they have their point about how benefit design can be used as a discriminatory tool and how too many choices can lead to confusion rather than empowerment.

A successful approach will have to combine enough standardization to ensure adequate coverage and meaningful comparison of plans with enough flexibility to ensure

affordability and responsiveness to different needs and preferences. In practice, this means starting with a benchmark plan or a list of benefit categories and then making some hard decisions about how much flexibility to allow in modifying either the benefits or the cost-sharing to balance adequacy and affordability.

An example of the benchmark plan approach is to start with the basic FEHBP plan. The average total premium for coverage offered by the ten largest carriers under the FEHBP in 2007 is $415 for an individual and $942 for family coverage.v This would meet most adequacy tests, and flexibility could be added by allowing carriers to vary benefits as long as the variations achieved the same "actuarial value." Affordability could be achieved by allowing for higher cost-sharing versions, although it should be emphasized that any true measure of affordability must consider both premium costs and out-of-pocket costs.

An example of the benefit category approach is the NAIC's high risk pool model. That model defines what benefit categories must be covered by a state high risk pool plan, but allows flexibility in the specifics of the coverage based on state requirements and the needs of consumers. The model does not address cost-sharing requirements, which gives the states broad flexibility in that area, though I again emphasize that cost-sharing cannot be increased without considering all the ramifications, including the potential for some to go without needed services.

Finally, the most important point about benefit packages is that the devil is always in the details. As insurance regulators, we review the fine print of health insurance contracts on a daily basis and so we are quite knowledgeable about various benefit

configurations and how they impact the consumer. The NAIC would be happy to share that expertise at any point it would be helpful to your deliberations.

Conclusion

In conclusion, let me offer two brief observations on topics that should always be on the radar screen in discussions of health care reforms. The first observation concerns the growth in health care spending. Total spending on health care now makes up 16% of the gross domestic product, and spending continues to grow at 7% per year while our economy grows at less than 3% per year. This is not sustainable.

Health insurance reform will not solve this problem since insurance is primarily a method of financing health care costs. Nevertheless, insurers do have a vital role to play in reforms such as disease management, enhanced use of information technology, improved quality of care, wellness programs and prevention, and evidence-based medicine—all of which have shown promise in limiting the growth of health care spending. Whatever is done in insurance reform should be done in a manner that is consistent with sound cost control practices.

The second observation concerns the interplay between state and federal reform. States cannot solve the health care crisis alone; they need the help of the federal government. But neither can the federal government go it alone, at least until there is a much broader consensus for a specific plan to achieve universal coverage. In this context, the Congress should support efforts like S. 325, the Health Partnership Act, that provide funding for state initiatives and establish procedures for waiving federal requirements, such as certain ERISA provisions, that impede state innovation. Even

more important is to carefully consider the impact of any new federal reforms on the states' ability to be effective partners in solving our health care crisis.

The NAIC looks forward to working with the Members of this Committee and other policymakers to find real solutions for small businesses and individuals.

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[i] 42 U.S.C. 300gg-12.

[ii] Long, Stephen H. and Marquis, M. Susan, "Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?" *Health Affairs* 20:1 (January/February 2001), pp. 154-163;
Long, Stephen H. and Marquis, M. Susan, "Pooled Purchasing: Who Are the Players?" *Health Affairs* 18:4 (July/August 1999), pp. 105-111; and
Wicks, Elliot K., "Health Insurance Purchasing Cooperatives" Commonwealth Fund, November 2002.

[iii] Wicks, p. 4.

[iv] Lischko, Amy, "Merging the Massachusetts Non-Group and Small Group Health Insurance Markets." January 25, 2007. <http://www.statecoverage.net/0107/lischko.ppt>

[v] John E. Dicken, United States Government Accountability Office, "Federal Employees Health Benefits Program: Premiums Continue to Rise, but Rate of Growth Has Recently Slowed," testimony before the Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia, Committee on Homeland Security and Governmental Affairs, U.S. Senate, May 18, 2007, GA)-07-873T.

U.S. Senate Committee on Finance Hearing
"Small Business Health Insurance: Building a Gateway to Coverage"
October 25, 2007

Questions for Joel Ario
Chairman, NAIC Health Insurance and Managed Care Committee
Acting-Commissioner, Pennsylvania Department of Insurance

Senator Grassley

- Mr. Ario, you note in your testimony that some states have faced adverse selection when they have set up purchasing pools. In these states, people could buy coverage outside the pools that was priced differently than the coverage inside the pool. To date, most of the state experimentation around what you are calling purchasing pools has been without significant state subsidies of the coverage. Assume that employees of small employers are provided a significant tax subsidy to purchase coverage. The coverage would have to be purchased through a pool, or gateway, to be eligible for the subsidy.

  a) Would the subsidy alone be enough to help reduce adverse selection against the pool?

  The answer depends on three factors: 1) the disparity between the pool rating rules and the state market rating rules; 2) the amount of the subsidies; and 3) who is eligible for the subsidies.

  For example, let's assume the new pool's rating rules do not allow for factors such as health status, industry or class of business, and limits the age factor to 2 to 1 – which is in line with the current NAIC model. If the state market does allow for health status (even if limited by rating bands) and does not limit other rating factors, including age, then there will be significant adverse selection against the pool. The disparity in rate ranges could be from over 20 to 1 in the state market to less than 3 to 1 in the pool. In such an environment, a small business with predominantly younger and healthier employees would certainly find a better rate in the state-rated market and that difference could be significant – likely as much a $300 per month. Conversely, a small business with predominantly older and/or sicker employees would find a better rate in the pool.

  A subsidy could entice the younger, healthier groups into the pool, but the greater the disparity in rating rules the higher the subsidy would need to be to offset the difference in costs. Also, of course, a significant number of the employees must be eligible for the subsidy or it becomes moot.

  b) Or would there also need to be a requirement that all small-group coverage within a given state could be sold only through the pool, even with the subsidy?

  Such a requirement would eliminate the adverse selection, but it would require preemption of state rating rules, which the NAIC does not support. Instead, we recommend that the pool rating rules be the same as the state market rating rules, thus eliminating adverse selection. The subsidy could still exist to entice small businesses to purchase through the pool and to assist certain populations, but it would not be needed to offset adverse selection.

- Mr. Ario, we understand that the NAIC has been considering a way for states to agree on inter-state rules for the health insurance market that might allow states and insurers to set up multiple-state insurance pools with a common set of benefits. Please answer the following questions:

  a) What is the current status of that effort?

  There is no effort at the NAIC to create a single benefit package that could be sold across state lines. Several bills were introduced and debated in the Senate in 2006 that would have taken a variety of approaches to this issue, but the NAIC did not comment on those approaches. Reaching agreement on the benefits in a package sold across state lines will be politically difficult, as the legislatures of each state have set different minimum requirements for health insurance sold in their state. Harmonizing these requirements will require some states to reduce their minimum requirements, which could make certain benefits less available in those states.

  The NAIC has developed model rules for rate and form filing and internal review processes, and is developing standardized rules for external review processes and producer licensing. In addition, the NAIC, in accordance with federal law, created the standardized Medigap rules that are adopted by all states (except the three grandfathered states).

  These efforts demonstrate a strong interest at the NAIC in facilitating greater interstate cooperation.

  b) In your experience, do the states really have an interest in joining forces on a common health insurance market?

  Twenty-nine states and Puerto Rico, representing over half of the premium volume nationwide, have entered into an Interstate Compact for asset-based insurance products, including life, annuities, disability income and life insurance. Another 12 states are considering joining the Compact. The purpose of the Interstate Compact is to streamline the process of filing, reviewing and approving insurance products. In addition, the NAIC has developed one-stop-shop systems for electronic filing of rates and forms which are used by all states. States have also entered into compacts in other areas, such as Medicaid drug purchasing and regulation in multi-state metropolitan areas.

  States recognize that more standardization could be beneficial in the current interstate and global marketplace and the NAIC is seeking ways to encourage streamlining of regulations.

  c) And if states are interested, how would you recommend such a multi-state effort be set up?

  I do not know that this can be determined, yet. States are starting at starkly different places. Regulations vary, demographics and economies vary, incomes and uninsured populations vary, health care costs and delivery systems vary. Given this, I do not believe a one-size-fits-all solution is likely to work. I would recommend that the federal government provide resources and incentives to states to experiment with pooling options and let them find out what may work. There are a myriad of decision points that can make or break reform efforts – as many states have already discovered with past pooling and reform concepts – and flexibility will be needed to find the right mix for each state or region.

- Mr. Ario, you are knowledgeable about the approaches states are taking in reforming their health care systems.

  a) Are you finding similarities in the various approaches?

  States watch the results of reforms elsewhere in the country very closely and often adopt promising ideas from other states. In the early- and mid-1990's, for example, many states responded to premium growth and substantial premium spikes for small businesses by enacting reforms that required carriers in the small group market to offer coverage on a guaranteed-issue basis and restricted the degree to which carriers may vary premium based upon factors such as health status, age, occupation or geography. Guaranteed-issue requirements for small employers were later incorporated into the Health Insurance Portability and Accountability Act (HIPAA), and 47 states have enacted restrictions on rating in the small group market to pool risk.

  More recently, states have been looking closely at elements of reform legislation adopted in Massachusetts. This legislation included an "individual mandate" to purchase coverage accompanied by subsidies for those who cannot afford coverage without assistance, individual market reforms, and a health insurance "exchange" that acts as a clearinghouse to facilitate enrollment in participating health plans and to direct employer contributions and government subsidies to the plans that individuals have selected. Recent state reforms in Maine and Vermont, in addition to Massachusetts, have also placed a great deal of emphasis on controlling costs by effectively managing chronic conditions in order to ensure better outcomes for patients and reduce unnecessary hospitalizations.

  Going forward, it is becoming apparent that federal preemption of state health insurance regulation is creating obstacles for innovative reform initiatives. For instance, several states have considered requiring employers who fail to make minimum contributions to employee health benefits to pay an assessment to support safety net programs. Uncertainty surrounding federal ERISA preemptions and the threat of protracted legal battles has derailed efforts to enact these provisions in several states. Unless the federal government clarifies that such requirements are not preempted by federal law, it will be difficult for states to enact these "pay-or-play" requirements, which may be an effective way of shoring up the employer-based system of health coverage.

  b) Are the states investigating using a connector—or what we like to call a "gateway"—approach for making coverage available to residents?

  Many states are watching the results of the Massachusetts reform very carefully and are evaluating whether elements of that legislation could be applied to their health insurance markets. While no other states have adopted a connector or gateway, Minnesota Governor Tim Pawlenty and Washington Governor Christine Gregoire have proposed reform plans that include an exchange, as have several presidential candidates, members of Congress, and state legislators.

  There are several different ways of structuring these gateways. Some, like the one enacted in Massachusetts, are open to all licensed insurance companies that wish to participate. Others seek to reduce premiums by leveraging their ability to limit participation in the gateway to sharpen competition between carriers. Gateways can also differ in the types of policies

allowed, and in whether or not employees may choose whichever available plan they want, or whether the employer selects a plan for all employees.

Senator Salazar

- I am happy to see that your testimony recognizes the delicate balance between state and federal regulation in the area of small business reform and the complexity of trying to reconcile the efforts that both have made to increase access to affordable health insurance. Of the areas discussed in your testimony, which do you feel are most appropriately addressed at the federal level, and which are best addressed by the states?

  The best approach to health reform is to allow states to develop and test innovative new reform strategies. By allowing states to act as the "laboratories of democracy" reforms can be tested in the real world without applying them to all fifty states, with their many differences in health insurance markets, regulations, and delivery systems. As reforms are proven effective, they are often adopted in other states, while those that are ineffective are discarded. In the past, the federal government has looked at these state reforms, and has enacted legislation, such as HIPAA, portions of which are based upon state small-group reforms.

  There is clearly both a state and federal role in addressing the challenges of the small group market. Because each of the fifty states and D.C. faces different circumstances in their health insurance markets, each state must have the flexibility to adopt the strategies that best suit its needs. For example, a strategy that is very effective in addressing market problems in New Hampshire, New Jersey, and Connecticut - where over 70% of the nonelderly population receives coverage from an employer - may not be effective in New Mexico, Mississippi and Arizona - where just over 50% receive coverage from an employer.

  For this reason, the federal government will be most effective if it supports state-based efforts to expand coverage. Federal assistance in the form of subsidies and regulatory flexibility would be extremely helpful to the states, and would allow them to function as "laboratories of democracy." States could then develop new and innovative approaches to the specific challenges they face to increasing access to affordable health insurance. Another area in which the federal government could be helpful is in helping to reducing the cost-shifting that occurs due to low reimbursement rates in public medical assistance programs.

  States have a great deal of experience and expertise in areas such as licensure, solvency, consumer protection, and market regulation. As we have seen recently with the Medicare Advantage program, consumers are best served if the states retain oversight in these areas. Consumer protection and market regulation, in particular, require a regulatory staff that is well-acquainted with market conditions in the state to quickly and effectively respond to problems that are very time-sensitive.

Senator Snowe

- In my time as leading Republican on the Senate Committee on Small Business & Entrepreneurship, since 2003, much of the debate on solving the small business health insurance crisis has centered on proposals that would enable the creation of multi-state "pooling" proposals to greatly augment small business purchasing power. A complicated and

controversial issue related to small business health insurance reform is how to design a benefits package for small businesses that is both "adequate" and "affordable". Your testimony references an approach that would consider the "actuarial value" of a benchmark plan for benefits – such as the basic plan under the Federal Employee Health Benefits Plan (FEHBP).

a) Please explain how an "actuarial value" approach could help to design an affordable, quality benefit package for small business? Has this approach been tried on the Federal level or in any State insurance reform? Would such an approach potentially provide cost savings for small businesses and their employees? Why or why not?

The primary purpose of using the "actuarial value" approach is to provide consumers more coverage options, not to make coverage more affordable. Under this approach, a standard level of coverage is established to ensure that "bare bones" coverage may not be offered. Then, insurers are allowed to mix and match benefits and cost-sharing requirements, as long as the "actuarial value" is the same. Unless the standard level of coverage is very minimal, this approach will not significantly reduce the cost of coverage. In fact, it typically ensures a high level of coverage.

The "actuarial value" approach is used in the Medicare Part D program and has resulted in a wide range of coverage choices – many Commissioners and consumer groups believe it is too many choices – for Medicare beneficiaries.

b) Do you believe there is merit to an actuarial approach that references the general "categories" of benefits that would be required under a plan? For example, under the FEHBP, a general statutory section lists different service and indemnity benefit categories that must be included in a health plan offered to Federal employees. These include hospital, surgical, and obstetrical benefits, and prescription drug coverage. What are the pros and cons of such a proposal?

Using categories, rather than actual benefit amounts, would provide even greater flexibility in the development of coverage choices. However, cost-sharing amounts must be added and it would be very difficult to determine what is the standard actuarial value. Insurance companies would have a lot of discretion to set their packages and could create plans that promote adverse selection or provide very limited benefits. I believe it would be better to set the standard benefit level and then allow companies to create packages that are, say, 90% of the actuarial value to provide some lower-cost options. This would provide greater protection for consumers and more stability in the market.

- Moving forward, I remain very interested in a possible "regional" approach to small business health insurance legislation. Such a proposal could allow states to voluntarily "opt in" to participate in a regional small business pooling entity. This is a concept that would create large, multi-state risk pools in which small businesses in participating states could access a range of affordable coverage options. This would allow small businesses to receive greater bargaining power and economies of scale, while lowering health care costs through reduced administrative costs.

  a) What hurdles do you envision with a regional approach and how could we overcome these? Would the states need to be geographically contiguous? Why or why not?

There will be two main hurdles to implementing a regional pooling mechanism. The first hurdle will be developing a common minimum set of benefits that must be included in any coverage offered through the regional pool. This is politically difficult, as state legislatures have made decisions regarding what benefits should be included in all health insurance policies, and reducing these benefits can be difficult unless there is some incentive to do so. The most practical way to approach this hurdle would be for regulators from each state in the region to agree on a common set of benefits. The second hurdle will be ensuring that neither the pool nor the existing state markets suffer from adverse selection. If the pool's rating and access rules are more generous than the outside markets' it will attract a disproportionate share of high risk enrollees and will ultimately fail. If the regional pool's rules are less generous than the outside market's, the outside market will attract the higher risks and will fail. By incorporating rating and access rules from the outside markets into the regional pool, you will ensure that neither market is selected against.

There would be no absolute requirement that the states in a region be geographically contiguous. However, in order for a carrier to offer policies throughout the region, they must meet network adequacy requirements in each state, which would make geographically contiguous regions more practical.

b) How would regional SBHPs be regulated—by the state, the Federal government, or a combination of both? Do you envision that a regional plan would require the creation of a quasi-administrative entity? What are the pros and cons to this? What would the role be for state insurance commissioners under a regional pooling arrangement?

I would envision a regional pooling mechanism to be regulated by state governments. Some sort of multi-state entity would be necessary to develop common minimum benefit standards for the regional pooling mechanism. This entity should include the insurance commissioners from each state in the region.

Once these standards have been approved, individual states would be responsible for approving policy forms and rates and would provide assistance to consumers who need it. The enforcement of any regional standards and all applicable state laws and regulations would continue to be carried out by the individual states, as all enforcement actions are tied to an insurer's status as a license holder. For this reason, the regional entity would not have authority to impose penalties, but could serve as a coordinating body for any multi-state actions or investigations.

c) Do you think that states would voluntarily want to "opt in" to regional pooling entities? Why or why not? What specific incentives for the federal government would be most helpful to spur greater state participation in regional plans?

Some states, those with high costs and insufficient pooling capacity, may find it beneficial to voluntarily opt into the regional pooling mechanism, as the claims costs from their enrollees would be subsidized by premiums from those in low-cost states. These low-cost states would require a financial incentive of some sort to make the pooling arrangement beneficial to them. Without these incentives, low-cost states would not be inclined to participate. Furthermore, small businesses in low-cost states would not be inclined to participate in a pool where they are subsidizing the coverage of someone in a high cost state, as this would increase premiums above those found in the outside market. A financial incentive sufficient to bring premiums below those in the outside market of a low-cost state would be required to effectively pool risks across state lines.

Testimony for the Record
Submitted to the

UNITED STATES SENATE COMMITTEE ON FINANCE

for the October 25, 2007

Hearing on Small Business Health Insurance: Building a Gateway to Coverage

Dirksen Senate Office Building, Room 215

Remarks of:

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Introduction

This testimony is being submitted to the U.S. Senate Committee on Finance in connection with its deliberations with respect to the availability of health care insurance coverage. The rising costs of health care coverage and the increasing ranks of the uninsured are well documented, and lawmakers at both the Federal and state levels are under increasing pressure to provide or at least assist with a solution. The conventional wisdom is that existing regulatory structures need to be significantly adjusted or entirely replaced in order to make health insurance coverage more widely available.

The United States is unique among industrialized nations in how it provides its citizens employment-based welfare and retirement security. More than 140 million workers are covered by employer-sponsored group health plans that are regulated by an overlapping web of sometimes conflicting Federal and state laws. Ours is a voluntary system: employers are not required to provide health care coverage to employees, nor are employees required to purchase employer-based coverage when offered. We rely instead on market forces and fiscal policy (i.e., tax breaks) to encourage employers to offer, and employees to accept, health insurance coverage.

My purpose with these remarks is to present to the Committee an overview of the nascent and emerging features of market-based health care reform mechanisms, drawing principally, though not exclusively, on the experience of the Commonwealth of Massachusetts. During 2005 and 2006, I had the privilege of serving as outside counsel to the Romney Administration in connection with the Massachusetts health care reform act, and I currently represent the Massachusetts Health Insurance Connector Authority, the health insurance clearing house established under the Massachusetts law that is central to our new law. That a single state, in this instance Massachusetts, adopted a

health care reform measure is, by itself, unremarkable. What is remarkable, however, is the extent to which key features of the Massachusetts health care reform act have been adopted by other states and included in so many other health care reform proposals at the Federal level.

The need for broad-based health care reform is generally well-accepted. Some cite the rising ranks of the uninsured and under-insured, while others focus on the rising cost of care. Whatever the reason, the conventional wisdom is that there are only two ways to accomplish health care reform. The first is a government-run, "single payer" approach, which might resemble a vastly expanded, traditional Medicare program. The second is a market-based approach, which relies on existing, private sector insurance companies to provide coverage. Whatever one's personal views of the relative merits of these two options are, it appears clear that support for the single-payer system has not reached anything approaching critical mass. Where market-based reform proposals are concerned, the opposite appears to be the case.

Dividing the universe into "single payer" and "market-based" reform proposals is something of an oversimplification. Rather than being unique and mutually exclusive regimes, these are perhaps better understood as the opposite end-points on a continuum. It is possible to combine these approaches to produce a broad range of hybrid schemes. But of the myriad of health care reform bills and proposals currently in circulation, the ones with the most practical and immediate promise appear to be market-based, and they generally adopt many of the key design features and structures of the Massachusetts law.

Review of Available Precedent

My understanding is that your Committee is working toward a market-based health care reform proposal, but that you have not yet settled upon all of the particulars. In an effort to assist in these efforts, I have identified a handful of market-based reform features and the experience to date (if any) with respect to each. I caution, however, that these are all "early returns." In undertaking major structural reforms aimed at expanding health care coverage nationally, the Committee is breaking much new ground. And while the experience at the state level may inform your efforts, these experiences are of relatively recent vintage. (The Massachusetts law, for example, is only a year and a half old, and many of its regulatory and oversight structures are still being developed.)

(1) *State-based, or Multi-State, Health Insurance Connector, Gateway, or Clearinghouse*

The concept of a health insurance "connector" (alternatively known as a "gateway" or "clearinghouse") is a flexible instrument that has worked well to date in Massachusetts. Generally, the concept of a connector is to provide a focus of health care administration efforts. They can provide access to insurance products and information and facilitate compliance.

Example: In the decades following the enactment of ERISA, many states were plagued with an onslaught of fraudulent health plans sponsored by

shady commercial operators, who would enter a market, collect premiums, then leave. Where health insurance products are offered through a connector, and are accompanied by a connector "seal of approval," however, individuals and employees have the confidence that a health plan has been independently vetted.

The purpose of the Massachusetts Connector is to "furnish access by eligible individuals and eligible small groups to affordable health insurance products." It has six main functions:

(i) Facilitating health insurance access;

(ii) Defining "minimum creditable coverage" for purposes of the state's individual health insurance mandate;

(iii) Administering the state's low income health plan;

(iv) Establishing "affordability" standards (also in connection with the individual mandate);

(v) Promulgating "section 125 cafeteria plan" regulations (see discussion below); and

(vi) Administering waivers and appeals.

More generically, connectors or gateways need not be confined to a single state (they can be multi-state), and they can be organized as governmental, quasi-governmental or private sector entities.

(2) *Small-Group Insurance Reform*

One of the Massachusetts act's more ambitious reforms is the merger of the non-group and small-group health insurance markets. Of the two markets, the non-group market is by far the more adversely selected. The act commissioned an actuarial study of the consequences of merging the two insurance markets before the merger went live. The study, which was issued in December 2006,[1] estimates that the effect of the merger on the small group and non-group markets will result in a decrease in non-group rates of approximately 15% and an increase in small group rates of approximately 1 to 1.5%.

But small group reform need not be limited in the manner chosen by the Massachusetts legislature. Rather, it can be used to establish multi-state pools with uniform coverage requirements, in the manner proposed in connection with association health plans. States could also be permitted to vary coverage within a prescribed corridor so that they can offer less expensive, custom health insurance products. Additionally,

[1] *See* "Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets," by Gorman Actuarial, LLC. Prepared for the Massachusetts Division of Insurance and Market Merger Special Commission, December 26, 2006..

your Committee has the option of revisiting issues such as guaranteed issue, guaranteed renewability, and portability that were first considered in a comprehensive fashion in the Health Insurance Portability and Accountability Act of 1996.

(3) *Section 125 Cafeteria Plan Mandates*

Internal Revenue Code § 125 permits employees to make pre-tax contributions under employer-sponsored group health plans. These plans are referred to as "cafeteria" plans. Cafeteria plans allow employees to make contributions toward the costs of employer-provided coverage with pre-tax dollars. The advantages accrue to both employers and the employees: Where an employee pays for health insurance on a pre-tax basis, the employer saves FICA taxes of 7.65%, and the employee saves FICA, state and federal income taxes (about 40% on average).

Under a "section 125 cafeteria plan" mandate, employers are required to offer coverage under a plan that meets the requirements of Internal Revenue Code § 125 so that employees can pay the employee portion of their health care insurance premiums with pre-tax dollars. Under the Massachusetts law, employers are required to offer access to a cafeteria plan even if they do not offer any health coverage. Connecticut and Rhode Island have also enacted cafeteria plan requirements.

A cafeteria plan requirement assumes that there is no change to the underlying income tax rules. Health care reform proposals that include structural reforms of the underlying tax rules may have no need for a cafeteria plan requirement, especially if funding is based on refundable tax credits (which I discuss below). However, a requirement that an employer reduce an employee's salary to pay health premiums may be a key feature if tax subsidies are run through the employer.

(4) *Tax Funding Mechanisms—Limits on Employer Exclusion, Refundable Tax Credits, etc.*

Under our current income tax regime, employer contributions for employee health care coverage is deductible without limit for both income and employment tax purposes. In his 2007 State of the Union address, President Bush proposed to eliminate this deduction in its entirety in favor of a personal income tax deduction for employees. There is a middle ground, however, in which the employer's deduction is capped instead of eliminated. Moreover, employer contributions to Health Savings Accounts (HSAs) could be counted or not counted toward the cap, as the Committee chooses.

Under current law, the cost of employer-provided health care coverage is excluded from an employee's income. Under an alternative, this exclusion could be repealed and replaced with either an above-the-line deduction for the cost of employer-provided health coverage, or a refundable income tax credit. While the tax-credit concept for health care is currently untested, existing tax laws contain a variety of tax-credit features, with respect to which there is no shortage of date or experience (for example, the Health Care Tax Credit or Earned Income Tax Credit).

In the health care context, one of the most well-developed tax-credit proposals was put forth by the Heritage Foundation in or about 2005.[2] The Heritage Foundation proposal called for a refundable, advancable and assignable tax credit. A "refundable" health care tax credit ensures that an individual is eligible for the credit even if he or she owes little or no taxes. It is, effectively, a direct subsidy for the purchase of health care coverage. To say that a credit is "advanceable" simply means that the credit can be claimed "up front" when insurance premiums are due rather than having to wait until the end of the year for reimbursement. Lastly, an "assignable" tax credit is one that could be forwarded directly and automatically to the insurer.

At bottom, in any market-based health care reform, dollars must flow from individuals, employers and the government to the health insurance issuer that provides the insurance. Under the Massachusetts approach, governmental dollars originate with government subsidies that flow through a government agency on their way to the insurance companies. Where market-based reforms are financed with tax mechanisms, dollars from the government flow through the tax system to the insurance companies. The end result is the same; what differs is the policy mechanism whereby the ends are achieved.

(5) *The Individual Mandate*

Perhaps the most novel feature of the Massachusetts health care reform act is its "individual mandate," under which all residents of the Commonwealth must obtain and maintain a minimum level of health insurance coverage—referred to as "minimum creditable coverage"—based on an annually published premium schedule. The individual mandate is controversial, and it has not been widely embraced by other reformers. It does, however, solve some intractable problems relating to underwriting, and it also ensures that the risks are spread over as large of cohort as possible.

Tax Considerations

The proposal floated by President Bush in his State of the Union address was both innovative and novel. The President's plan had two parts: Under the first part, the current system (based on a tax exclusion for employer-provided health insurance premiums, with a corresponding employer deduction) is replaced with a standard tax deduction for health insurance for families and individuals with private coverage. The rationale for this is that the current system penalizes individuals who obtain coverage other than through their employer. Under the second part of the Bush proposal, States are encouraged to pursue their own, independent efforts to expand access to affordable coverage. To encourage this, the Secretary of HHS would be given the power to redirect Federal payments in support of state efforts to help low-income individuals purchase private health insurance.

It is possible to envision tax-based reforms that are not as radical as the Bush proposal. Rather than eliminate the exclusions, they can be capped, with the resulting tax

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[2] *See* "Health Care Tax Credits: Designing an Alternative to Employer-Based Coverage," by Nina Owacherenko at http://www.heritage.org/Research/HealthCare/bg1895.cfm (Nov. 8, 2005).

savings applied to tax credits or other relief. Alternatively, the tax benefits of the current system can be replaced with tax credits in an effort to encourage employers to make coverage more widely available. The availability and use of tax credits can also be tied to state reform efforts.

Conclusion

I hope that this overview has been helpful to the Committee in understanding something of the course that health care reform is currently following. Some of these concepts are new and untested or little tested, while others are old concepts that are being put to new uses. Each has its defenders and detractors, though, in the end, the purpose is the same, namely, to expand the availability of health care coverage in these United States and to reign in the rapidly increasing costs of that coverage.

Appendix

U.S. SENATE COMMITTEE ON FINANCE
Hearing on Small Business Health Insurance: Building a Gateway to Coverage

October 25, 2007

Summary of Key Features of Existing and Proposed, Market-Based Health Care Reform Features

Item	Design Component or Feature	Comments
1.	State-based, or multi-state, health insurance connector, gateway, or clearinghouse	First adopted under the Massachusetts health care reform act, this approach appears both flexible and promising.
2.	State or multi-state insurance pooling arrangement	State high risk pools are already common. Multi state pooling arrangements (i.e., association health plans) were proposed, but never enacted into law. (*See, e.g.*, S. 1955, the *Health Insurance Marketplace Modernization and Affordability Act*).
3.	Small-group insurance reform—individual and small group merger	Adopted under the Massachusetts health care reform act in the form of a merger of the individual and small group health insurance markets. Early indications are that this approach has brought significant downward pressure on individual rates without any marked increase in group rates.
4.	Small-group insurance reform—combine small groups for underwriting purposes	Not yet tested, but the larger the pool, the more diverse the risk, and the more stable and predictable the rates.

5.	Small-group insurance reform—multi-state uniform coverage requirements based on NAIC-developed standards, with options to vary coverage within a prescribed corridor that permits states to craft less expensive, custom products	Not yet tested, but would appear to have a salutary effect. **NOTE:** This is similar to a codification of current practice, under which there is a good deal of uniformity among the mainstream group health insurance products, but it would furnish protection from what appears to be an explosive growth in non-standard products.
6.	Section 125 cafeteria plan mandate.	Massachusetts, Connecticut and Rhode Island have adopted some form of a "section 125 cafeteria plan" requirement for the purpose of ensuring that employees get the benefit of pre-tax treatment on their employee-paid health care premiums. **NOTE:** Proposals that rely on income tax-credits or other tax-based financing mechanisms generally have no need for a cafeteria plan requirement, unless the tax subsidies are run through the employer.
7.	Individual market reforms—guaranteed issue, guaranteed renewability, limitations on pre-existing condition exclusions, etc.	These have been successfully tested, for the most part, under the HIPAA.
8.	Cap on income tax exclusion for employer-provided health coverage—with HSA contributions counting toward the cap.	Not yet tested, but is not too different from current rules.

9.	Include cost of employer-provided health coverage in employee's income. Employee is provided with an above-the-line deduction for the cost of employer-provided health coverage (up to the amount of the cap described in item (8) above). **NOTE:** See item (10) below for an alternative.	This approach has not yet been tested, but think tanks on both the left and right contemplate similar changes in the tax treatment of health insurance.
10.	Refundable income tax credit to the employee for health insurance (reduced by payments made on the employee's behalf). **NOTE**: The credit would be revenue neutral and indexed for medical care cost inflation.	Not yet tested. An advanceable, refundable, assignable health insurance tax credit was previously proposed by the Heritage Foundation.
10.	Individual coverage mandate	Adopted in Massachusetts, but not generally gaining traction in most other states or proposals.

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November 20, 2007

VIA EMAIL AND FIRST CLASS MAIL

U.S. Senate Committee on Finance
Democratic Staff
Senator Max Baucus, Chairman
Dirksen Senate Office Building, Room 219
Washington, DC 20510

Re: United States Senate Committee on Finance Hearing—Small Business Health Insurance: Building a Gateway to Coverage
Hearing Date: October 25, 2007
Responses to Questions Submitted for the Record

This letter responds to the letter of Senator Max Baucus, Chairman, U.S. Senate Committee on Finance, asking me to respond to written questions for the record in connection with the above-reference hearing. I am happy to oblige.

Questions of Ranking Member Grassley

(1) *Mr. Bianchi, the idea of a health information exchange or "gateway" is being floated by a number of states. Massachusetts so far is the most advanced in its planning and its "connector" is pretty involved. The "gateway" -- which would be similar to the Massachusetts Connector -- could present all the insurance options in the state to individuals and give them an easy way to compare options. Of course, it would have to be set up so that you could not get cheaper coverage outside the gateway. Otherwise, it would be gamed. Could you explain how the Massachusetts Health Connector has been a useful tool to the citizens of Massachusetts, and how Massachusetts structured the Connector to ensure that individuals could not get cheaper coverage outside of the Connector?*

The Massachusetts Health Insurance Connector Authority (a/k/a the "Connector") does not sell health insurance coverage so much as it furnishes access to the product offerings of existing Massachusetts-licensed health insurance carriers. Health Insurance products offered through the Connector are also available in our state's individual insurance market. However, the Connector offers employers a turn-key, web-based set of enrollment and funding tools that make it simple for employers to provide access to coverage paid for with employee pre-tax premiums. Individuals also appreciate the ease of access to coverage using the Connector's website as a gateway, as well as the Connector's "seal of approval," which assures Massachusetts residents that they are purchasing quality products from reputable issuers.

The problem of cheaper product offerings outside the Connector is further mitigated by the Massachusetts individual health insurance mandate under which residents over the age of 18 are generally required to obtain and maintain coverage that satisfies the requirements for "creditable coverage," as promulgated by the Connector. The creditable coverage requirements set a floor for coverage that prevents issuers from undercutting the Connector with cheaper health insurance products with either inferior coverage or significantly higher co-payments and deductibles.

(2) *All of those involved in the Massachusetts reform plan worked together to come up with a more affordable health plan option for people buying their coverage through the connector. Mr. Bianchi, will you please tell us how the process worked to come up with the more affordable benefits and what the state decided upon*?

I wish that I could regal the Committee with fascinating tales of innovative leadership and adroit legislative maneuvering. But the truth is far more mundane. Although the Massachusetts Health Care Reform Act was the product of bipartisan compromise, it was enacted as a matter of necessity. The Centers for Medicare & Medicaid Services refused to extend our state's Medicaid waiver unless the legislature took drastic steps to reduce the number of uninsured individuals. As a result, the Romney Administration and the leadership of our Legislature had a proverbial gun to their heads. That said, credit for the success of our Health Care Reform Act goes in equal parts to Governor Mitt Romney, Massachusetts Senate President, Robert Travaglini, and the Speaker of the Massachusetts House of Representatives, Salvatore DiMasi. Credit also goes to our U.S. Senators Kennedy and Kerry for their assistance in dealing with the Federal regulators.

In formulating our health care reform law, Governor Romney began with a bedrock principle, i.e., that any reforms must expand coverage using existing private and public sector channels. These include existing employer-based arrangements, along with Federal programs (e.g., Medicare and SCIP). The Governor and the Legislature also insisted that the burdens be shared among employers, individuals, providers and the government, and they leveraged existing tax rules (i.e., section 125 cafeteria plans) to take advantage of existing tax savings opportunities. Lastly, they prevailed upon health insurance carriers to create affordable products and upon providers to adopt cost and quality standards. It is these efforts that, in the aggregate, have produced what has become the template for many of the state-based reform efforts currently under various stages of consideration.

(3) *Mr. Bianchi, you are knowledgeable about the approaches states are taking in reforming their health systems.*

(a) *Are you finding similarities in the various state approaches?*

Generally, yes. The Connector concept and cafeteria plan mandates are common, but the individual mandate is not being widely adopted. States are shying away from tax-based financing mechanisms, but this is because the real tax leverage is at the Federal level.

(b) *Are the states investigating using a connector - or what we like to call a "gateway" approach - for making coverage available to residents?*

Each state that I am aware of that is seriously considering health care reform is looking at the role that a connector might play. One particular advantage the connector confers is the ability to screen individual and small group health products, in order to weed out fraudulent and fly-by-night schemes. In Massachusetts, for example, the Connector issues its "seal of approval" attesting to the product's quality.

Questions of Committee Member Salazar

I was especially intrigued by your statement because similar to Massachusetts, Colorado is engaged in an intensive process to examine health care coverage needs and solutions in our state. For the first time ever, health care leaders from all over Colorado have come together to form a Blue Ribbon Commission to consider specific alternatives for ensuring all our citizens have access to affordable health coverage, and the experience of Massachusetts has been very valuable in their discussions. I have heard a great deal of praise for the Massachusetts Connector and its ability to enhance access to plans and information. Is it feasible for us to develop a similar resource at the federal level, and do you have specific recommendations on what a federal counterpart might look like?

In my view, it is entirely feasible for your Committee to develop a resource at the Federal level that is similar to the Connector. At bottom, the Connector's strength is serving as a market facilitator. It provides reliable, one-stop shopping. This model is relatively simple to replicate, whether at the state, regional, or even Federal level. As I endeavored to convey at your October 25 hearing, the Massachusetts Connector is widely viewed as highly successful for two reasons: its design is fundamentally sound, and its board, management and staff are all top-flight individuals who are keenly aware that they are breaking new ground, and that the rest of the country is watching carefully.

As for specific recommendations, I would suggest that the Committee study the experience in Massachusetts. In addition to its function as a health insurance market, the Connector also implements our state's section 125 cafeteria plan mandate, administers the state's health insurance program for low income individuals, prescribes standards for affordability and minimum creditable coverage, and handles administrative appeals. Certain of these functions relate to the individual mandate, and may not apply, but others are clearly portable and scalable to a Federal platform.

Questions of Committee Member Snowe

Under current law, many larger businesses and the Federal government enable their employees to purchase health insurance and other qualified benefits with tax-free dollars. Larger businesses are able to do this by establishing a cafeteria tax plan whereby employers offer their employees the opportunity to purchase certain qualified benefits of their choosing, including health insurance, dependent-care reimbursement, and life and disability insurance. Small businesses, on the other hand, face significant barriers in offering cafeteria plans because they must satisfy strict non-discrimination rules under the tax code. Although these non-discrimination rules serve a legitimate purpose, many small businesses simply cannot satisfy these mechanical rules because, through no fault of their own, they have relatively few employers and a high proportion of owners or highly compensated individuals. This seems to me an inequity in the treatment between large and small businesses.

(1) *Mr. Bianchi, in your testimony you mention the cafeteria plan requirement under Massachusetts, Connecticut and Rhode Island law. Have small businesses in these states experienced difficulties in qualifying for such plans?*

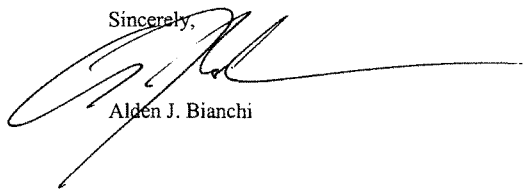
The Connecticut and Rhode Island section 125 cafeteria plan mandates are new, and they have not yet gone into effect. Therefore, we do not yet have any experience with them. But the recent issuance of comprehensive proposed cafeteria plan regulations by the Department of the Treasury and the Internal Revenue Service have done much to clarify the basic rules of cafeteria plan adoption and maintenance. I would expect these rules to have a salutary effect on state mandates, particularly since they lay important groundwork relating to the efficacy of the state rules.

(2) *I have introduced the SIMPLE Cafeteria Plan Act, with Senators Bond and Bingaman, which I believe would greatly facilitate the ability of small businesses to set up cafeteria plans. Under this bill, a small business employer that is willing to make a minimum contribution for all employees or who is willing to match contributions of employers will be permitted to waive the non-discrimination rules that currently prevent these owners from otherwise offering these benefits. Given the disadvantage that small employers face in offering cafeteria plans, do you believe that we should provide small businesses with more flexibility to offer this type of plan? Why or why not?*

The recently issued proposed cafeteria plan rules referred to above establish a safe harbor for broad based, premium-only cafeteria plans, under which the testing rules are dispensed with. Assuming that this rule is preserved in the final regulations, I think that the impediments to cafeteria plan maintenance (other than perhaps the need to adopt a written cafeteria plan document) are largely removed. Therefore, I am not sure that the legislation that you describe is necessary.

There is, however, a simplification measure that you might consider: why not dispense with the written plan requirement entirely for a basic, broad-based premium-only section 125 cafeteria plan? The net result is that employee-paid health insurance premiums would be treated as pre-tax automatically. As a consequence of lax enforcement of the cafeteria plan rules by the IRS, this is functionally the current state of the law.

Sincerely,



Alden J. Bianchi

AJB/dln

INCREASING HEALTH INSURANCE COVERAGE OF WORKERS IN SMALL FIRMS: CHALLENGES AND STRATEGIES

Statement of

Linda J. Blumberg, Ph.D.

Principal Research Associate
The Urban Institute

Finance Committee
United States Senate

October 25, 2007

Mr. Chairman, Mr. Grassley, 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 employees benefit plans, or other such group 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. While strategies are available to more broadly spread the risk associated with small-group and individual purchasing, some multigroup purchasing entities, such as proposed federally licensed association health plans, would tend to further segment the risks of small-firm workers, as opposed to spreading them more broadly. While that approach might lead to some savings for the

healthy, it 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 significant 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, serious consideration should be given to a redistribution of the current tax exemption for employer-sponsored insurance. 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. But any changes to the current tax treatment can be highly disruptive to the existing system of employer-based health insurance, and so 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

Only 36 percent of establishments in firms of fewer than 10 workers offer health insurance to any of their workers, compared with 99 percent of establishments in firms of 1,000 or more workers (figure 1).[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 (figure 2).[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 (figure 3).[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 (figure 4).[4]

These lower rates of coverage among small employers are due, at least in part, to that fact that small employers must pay significantly more for the same health benefits than do 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 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

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[1] Published tables, 2005 Medical Expenditure Panel Survey – Insurance Component, http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2005/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: US Government Printing Office.
[6] LJ Blumberg and LM Nichols. 2004. "Why Are So Many Americans Uninsured?" *Health Policy and the Uninsured,* Catherine G. McLaughlin, ed. Washington, DC: Urban Institute Press.

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. 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 most 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 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 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.

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[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.

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. It is important to keep this in mind when considering reform options and the incentives they implicitly create, and for this reason, I would not encourage a strategy of subsidizing small employers to provide additional coverage directly. At the same time, 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 complexities of providing subsidies in a dispersed and varied market. These roles are consistent with what policymakers envision for the Massachusetts Connector. 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.

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

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[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.

(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 been unable to sufficiently spread these risks, perhaps, in large degree, due to the voluntary nature of insurance. State insurance regulations served to spread the risks within the small-group insured population itself. But because firms can opt to provide coverage or not, when insurance regulations increased premiums for the healthy and

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[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.

[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; Blumberg and Shen,.2004. op. cit.

decreased prices for the sick, some healthy groups opted out of insurance coverage in this market. The result was generally no net change in the number insured.[16]

Other risk-spreading mechanisms could work much more effectively, however. For example, many states have established high-risk pools. 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. However, due to the limited public funding through state sources (frequently premium taxes on private insurance policies), these pools may have enrollment caps and usually charge 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 high-risk pools in absorbing risk from the private market. However, 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. Allowing small employers to buy their high-risk workers into well-funded high risk pools would decrease the level and variability in the expenditures of the remaining small-group workers and consequently would lower their premiums. The cost of subsidizing the medical care of the high risk could be spread across the entire population using a broad-based tax.[17]

Another proposal would combine the concepts of purchasing pools for administrative efficiency with explicit subsidization of the high-cost and low-income populations.[18] 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

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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] L. J. Blumberg, L. Cope, F. Blavin. 2005. "Lowering Financial Burdens and Increasing Health Insurance Coverage for Those with High Medical Costs," *Health Policy Briefs*, Urban Institute.
[18] J. Holahan, L. Nichols, and L. 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.

in private health insurance plans 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.

Under the reforms being implemented in Massachusetts, 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.

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 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

[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.

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 guaranteed a source of insurance for using the credit are clearly critical to their potential for expanding coverage and for the governmental costs associated with delivering them. but how they are designed and administered is 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 support 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 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

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

premiums and out-of-pocket expenses constitutes just over 6 percent of family income.[22] 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 to the insurer will be necessary for them to purchase coverage. While the Health Coverage Tax Credits (HCTC) for workers displaced by international trade will 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

[22] The analysis also provides data on the mean and 75th percentile of spending, as well as estimates for spending under non-group coverage and under employer based coverage including the employer's premium

with delivering health-insurance tax credits may be 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 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. If asked for one potential funding source, I would suggest we turn to a redistribution of the current tax exemption for employer-sponsored insurance, providing 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

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contributions in the calculations of spending.

[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.

[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, accessed May 1, 2007.

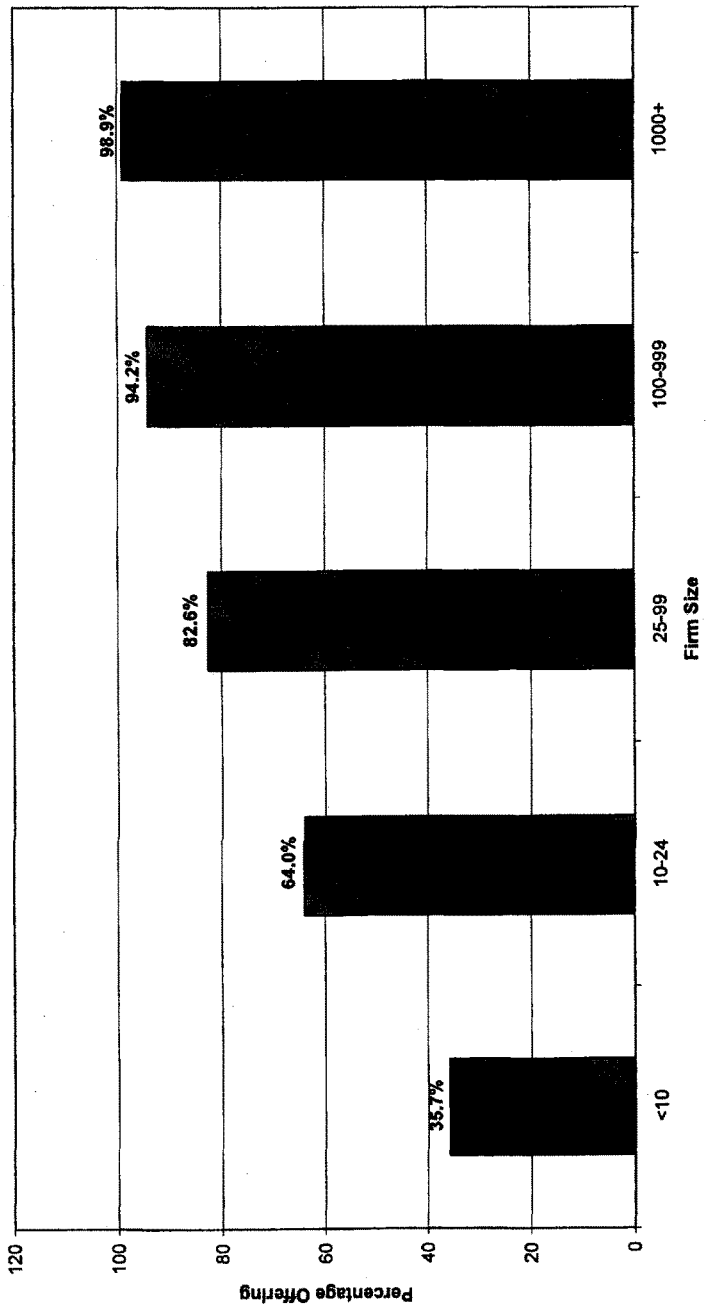
comprehensive health care reform and is already dedicated to subsidizing health insurance. The current spending is not particularly effective in expanding coverage, however, since it subsidizes most those who are most likely to purchase coverage even in the absence of any subsidy. And while the notion of restructuring the current tax subsidy has been somewhat politically taboo in the past, the president himself has recently opened the political conversation regarding how best to spend that that money.

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.

III. Conclusions

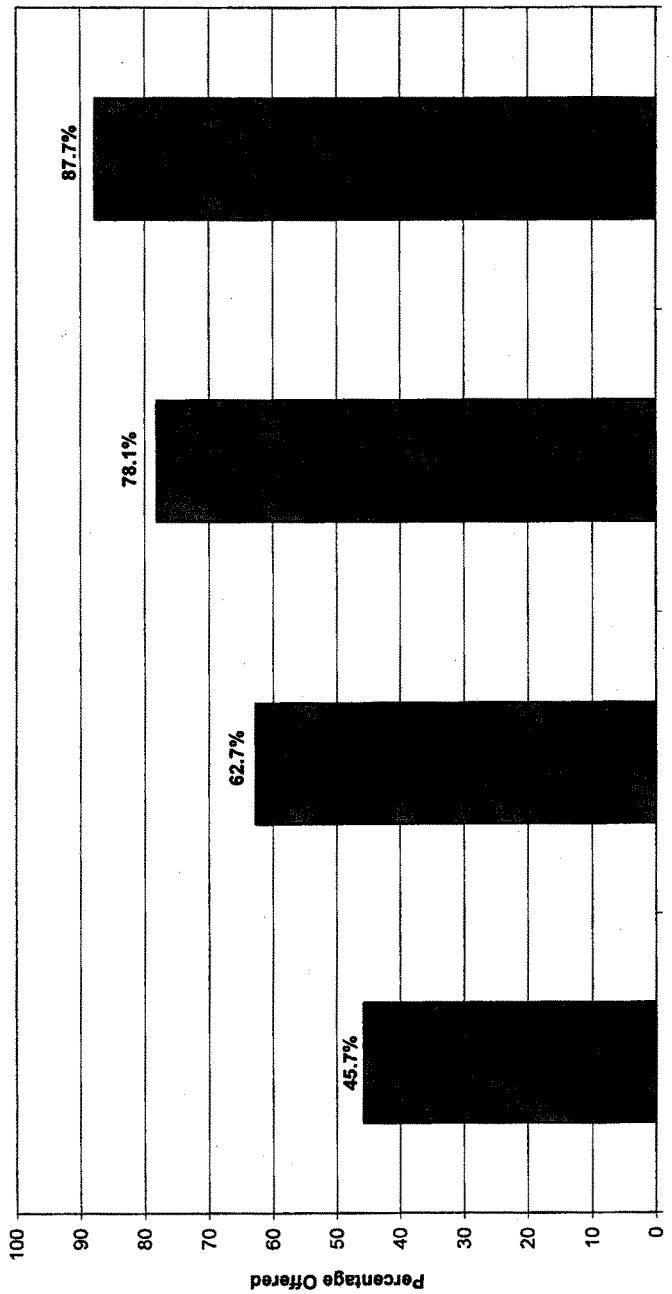
While small businesses face formidable difficulties in providing affordable health insurance to their workers, tools are available for increasing coverage in this sector. The focus of such efforts should be on lowering administrative burdens, developing mechanisms for spreading the risk of high cost 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.

Figure 1. Share of Establishments Offering Health Insurance, by Firm Size, 2005



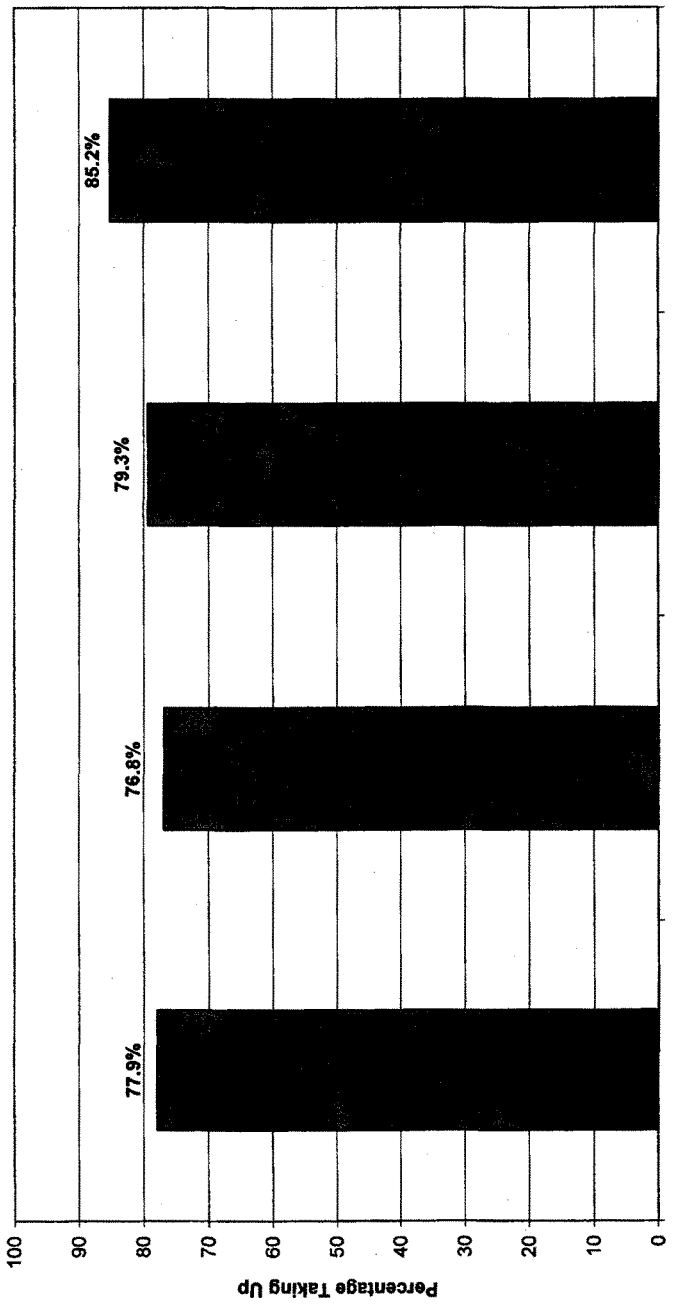
Source: 2005 Medical Expenditure Panel Survey-Insurance Component

Figure 2. Share of Workers Offered Employer-Sponsored Health Insurance, by Firm Size, 2005



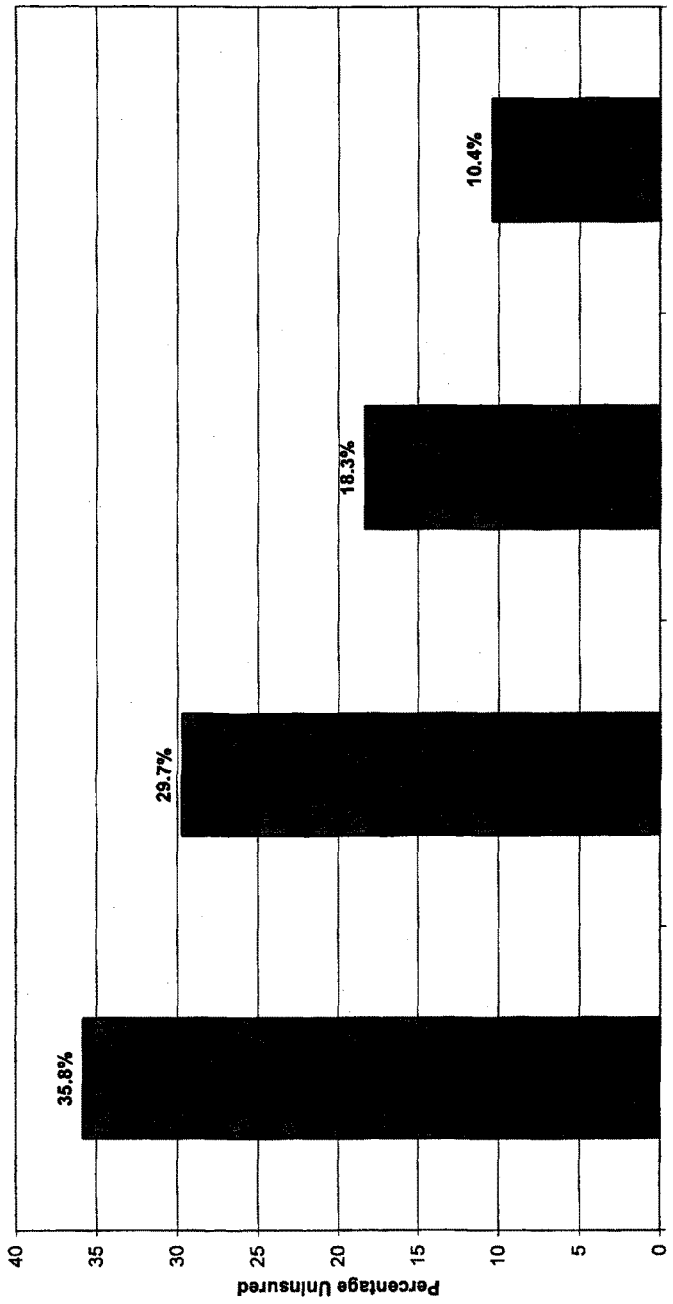
Source: L. Clemans-Cope and B. Garrett, 2006. "Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005."

Figure 3. Share of Workers Taking Up Own Employer Offer, by Firm Size, 2005



Source: L. Clemans-Cope and B. Garrett, 2006. "Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005."

Figure 4. Share of Workers Uninsured, by Firm Size, 2005



Source: L. Clemans-Cope and B. Garrett, 2006. "Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005."

Response to Questions from the Senate Finance Committee
Hearing Date: October 25, 2007

Linda J. Blumberg
Principal Research Associate
The Urban Institute

Questions from Senator Baucus:

You discuss in your testimony the challenges that lower-wage and small business workers face in deciding to purchase health insurance.

You specifically mention your work around how to define an "affordable" benefit and what level of subsidies would need to be offered to make a difference in workers' decisions to take-up coverage.

1) Can you elaborate on this research?
2) Have you reached any conclusions regarding a minimum level of coverage that constitutes a meaningful benefit?

Response:

I am attaching the article that summarizes the research on affordability that my colleagues and I have done; the paper was published as a *Health Affairs* web exclusive in June of 2007. In this work we assessed affordability by determining the level of health care spending relative to income that is typical for those with full-year health insurance. We used spending by individuals and families with incomes between 300 and 500 percent of the federal poverty level (FPL) to determine these benchmarks. Large numbers of individuals with incomes below 300 percent of the FPL do not have full year private health insurance, suggesting that observed current spending for such coverage among this lower income group may not reflect affordable coverage for many. Benchmarks for affordable health care spending relative to income would be skewed downward as a consequence of very high incomes if they were calculated taking into account the experience of those above 500 percent of the FPL.

We calculated benchmark spending levels at the mean, median, and 75th percentile of the spending distribution for singles and family units with full year private non-group and full year employer sponsored insurance coverage. For those with employer sponsored insurance, we computed spending levels based upon the worker share of the premium alone and on the total premium (worker plus employer shares), taking the current tax subsidy for employer-based insurance into account in the latter. The median is probably the best reflection of typical spending relative to income in each group, although it is probably not unusual for spending to reach the 75th percentile levels in occasional years.

We conclude that it is critical to not only take premium expenses but also exposure to out-of-pocket medical costs into account when determining affordability. For example, a narrow benefit package or insurance coverage with very high deductibles may very well have premiums that could be considered "affordable" for a broad swath of the population. However, these limited coverage policies may leave enrollees with such large out-of-pocket expense liabilities that the individuals still cannot afford to effectively access necessary medical care. These burdens can be particularly difficult to bear for those with serious medical conditions which require high levels of utilization of health services.

Taking total medical expenses (premium plus out-of-pocket) into account, we found that the median individual (family) with full-year non-group coverage spends 10.4 percent (11.6 percent) of their income on health care. Individuals with full-year employer sponsored insurance spend 12.6 percent of their income on health care (17.4 percent for families) if both worker and employer shares of the premium are included. Using both the worker and employer shares combined takes into account the extensive economic empirical analyses that demonstrate that employer contributions to health insurance are, to great extent, passed back to workers in the form of lower wages. If, however, only the worker's portion of premium is included, individuals with employer coverage spend 2.9 percent of their income and families spend 6.1 percent.

At this time we have not done work to specifically establish an appropriate minimum level of coverage. However, it is clear that limited benefit packages and high cost-sharing requirements will most adversely affect those with low-incomes and those with serious medical conditions. This suggests that subsidies for the low-income be sufficient to provide access to insurance policies that are more comprehensive than the insurance available to those with higher incomes (see, for example, the policies provided to the subsidized population through Massachusetts' Commonwealth Care program), and that separate subsidies for those with high medical costs be considered as well.

Questions from Senator Grassley:

Think tanks on both the right and left – the likes of the Heritage Foundation, Cato Institute, Brookings Institute, and the Progressive Policy Institute – have stated at one point or another that the employer-provided exclusion for health coverage could be capped. From a policy perspective, experts argue that the exclusion for employer-provided health coverage motivates taxpayers to "over-insure." These experts further argue that the overuse of health care services drives up insurance costs and makes insurance less affordable, especially for low-income workers. The primary benefit of a cap would be to reduce unnecessary health care costs. In addition, the goal of the cap would be to limit the growth of health spending and then health insurance premiums. I have three questions for you:

1) Do you agree with these experts and could you explain why you agree or disagree?

2) Could a portion of the exclusion be replaced with a choice between a tax credit and a deduction for health insurance?
3) Could the cap be set at a level where revenue could be generated to pay for a tax credit and a deduction for health insurance without disrupting the current employer-based system.

Response:

The summary of the tax exclusion issue that you provided is consistent with traditional economic theory on this topic. I do agree that over a number of years, the tax exclusion contributed to the purchase of more health insurance and more comprehensive health insurance than many individuals would have purchased in the absence of the tax subsidy. More comprehensive insurance is more expensive than less comprehensive insurance, and this surely had an impact on the level of premiums observed. However, the subsidy also very likely increased the number of people with insurance, providing them with financial access to necessary care, and that combined with simultaneously increasing the comprehensiveness of insurance, likely led to increased pooling of health care risk over a heterogeneous population, an outcome that many would consider to be favorable to the one that would have persisted in the absence of any subsidy.

However, it is also important to distinguish between the reasons why spending on medical care is high and why it has grown, by roughly 4 percent per year in real terms, for more than 5 decades. As Newhouse has shown,[1] increased insurance and the moral hazard associated with it accounts for very little of the growth in medical care costs in recent decades. He makes a very strong case that the vast majority of spending growth is attributable to technological advances in medical care. This means that removing the current tax subsidy is unlikely to address the problem of steadily increasing costs. And, as Cutler et al[2] explain, "..., much of the increased spending on medical care induced by insurance may represent efficient spending, precisely because consumers may value income extremely highly when sick. Therefore, spending of insured consumers will exceed (potentially by a great deal) the spending of noninsured consumers, but the increase need not represent a welfare loss."

In addition, it is my perspective that the growth in the premiums associated with private health insurance has now swamped the moral hazard effect of the tax subsidy. Individuals and employers are struggling to find ways to limit premium growth and contain costs, and the trend is toward increased cost-sharing requirements and financial burdens on high users of medical care, and clearly away from first dollar coverage and more comprehensive benefits. So while I agree with traditional economic theory that there has been an effect of the tax subsidy on insurance purchase decisions and use of medical care, I believe that its importance has been significantly overstated in terms of its implications for the *growth* in health care spending, and at this point in time the downward pressure on benefits resulting from high premiums clearly outweighs any upward pressure on benefits that might have resulted from the tax incentives.

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[1] JP Newhouse. 1992. "Medical Care Costs: How Much Welfare Loss?" *The Journal of Economic Perspectives*, vol. 6, no. 3, pp.3-21.
[2] DM Cutler, M McClellan, JP Newhouse. 1998. "What Has Increased Medical-Care Spending Bought?" *American Economic Review*, vol. 88, no. 2, pp. 132-136.

But while I think the importance of moral hazard resulting from the current tax exemption has been over-emphasized, this tax subsidy is regressive, giving greater financial assistance to the higher income, those who are the most likely to buy insurance even without a subsidy of any kind. This makes the subsidy inequitable, and worth reforming. Changing it without causing significant disruption to current insurance arrangements will be difficult, however. Simply eliminating the subsidy would remove a significant incentive for purchasing insurance through employers and would likely leave many workers to attempt to obtain adequate and affordable coverage in the private non-group market. This market is not conducive to doing so for a substantial segment of the population, meaning that many who currently have insurance through their employers would likely find themselves uninsured or underinsured in such a circumstance.

Capping, as opposed to eliminating, the current subsidy provides a better avenue for reform without wholesale disruption of coverage. Continuing to provide a tax subsidy to those purchasing insurance through employers, but limiting the value of the subsidy for high income individuals could be effective, particularly if the tax savings from doing so were redistributed to subsidize the purchase of health insurance for the lower income population. Lower income workers receive little to no benefit from the current tax subsidy, and the substantial recent decline in employer-based coverage within this population suggests that the coverage is neither sufficiently available nor affordable to them.

A refundable tax credit could be structured to provide greater financial assistance to lower income workers for the purchase of insurance. However, doing so in a way that effectively increases insurance coverage will be administratively challenging. First, the majority of uninsured workers do not have an offer of employer-sponsored health insurance. This means that these individuals would need a guaranteed source of purchasing adequate health insurance with their tax credit. Examples of sources of coverage that could be developed/used include state run purchasing pools (e.g., the Connector in Massachusetts), state or federal government employee health plans, or existing public programs which already contract with private insurance plans (such as SCHIP).

But the most important barrier to coverage for most of these workers is their low income, which means that subsidies would have to be large relative to premiums in order to induce them to obtain insurance coverage. Unless the subsidies are income-related, i.e., those with low income offered the largest subsidies, the level of financial assistance is unlikely to be sufficient to make the purchase of coverage attractive to this group. And the IRS has suggested that the administrative costs associated with implementing an income-related tax credit would be very high.

When considering tax subsidies for small employers it is also critical to remember that not all workers in small firms are low income, and not all low income workers are employed in small firms. Greater assistance to all workers in small firms may still leave the system with significant inequities if the low income workers in larger firms are disadvantaged relative to those in small firms, and particularly if higher income workers in small firms are made better off than are lower income workers in large firms. Particular care should be taken, at a minimum, not to disadvantage low or middle income workers in large firms, potentially compromising the affordability of their insurance coverage, in order to subsidize low or middle income workers in small firms.

Questions from Senator Salazar:

My understanding is that even where small businesses are able to afford some sort of health care coverage for their employees, many employees are still not enrolling in that coverage. In Colorado, only 38 percent of employees in small firms enroll in their employers' insurance plan, and over 11 percent of our uninsured populations has access to employer coverage but does not exercise that option. Is this dynamic due to rising premiums alone, or are there other obstacles to participating that explain this low enrollment rate?

Response:

According to an analysis by my colleagues at The Urban Institute, the decline in employer-sponsored insurance coverage between 2001 and 2005 is attributable in largest part to declines in the likelihood that workers receive offers of employer-sponsored insurance.[3] The decline in offers accounts for about 48 percent of the decline in coverage nationwide, while the decline in take-up conditional on having an offer accounts for about 27 percent of the coverage declines. The remainder is due to declines in employer-based coverage as dependents (11 percent) and declines in eligibility for coverage that is offered by employers (14 percent). For small employers, those with fewer than 25 workers, roughly 55 percent of the decline in coverage is attributable to the falling rate of employers offering insurance coverage. The likelihood of take-up stayed roughly constant among workers in firms of fewer than 10 workers and dropped by less than a percentage point over this period for workers in firms of 10 to 24.

To understand the source of observed declines in take-up of insurance coverage one must look at changes over time by worker income. While take-up stayed roughly constant over this period among workers with incomes of 400 percent of the federal poverty level (FPL) or higher, it fell by 7.2 percentage points for workers with family income below 100 percent of the FPL. Take-up rates fell by 3 percentage points for workers between 100 and 199 percent of the FPL, and by 1.4 percentage points for those between 200 and 399 percent of the FPL. These dramatic differences by income group in the take-up dynamic strongly suggest that affordability of the worker portion of the employer insurance premium is driving the declines in take-up. Yet even among the lowest income workers, a majority still take-up employer offers of insurance when they are eligible for one. Sixty-four percent of workers with income below the poverty level took up their employer offers in 2005 and 78 percent of workers between 100 and 199 percent of the FPL did so.

In addition to premium growth, low-income workers may be responding to the increasing trend toward greater out-of-pocket liabilities in employer-sponsored insurance plans. As out-of-pocket requirements increase, low-income workers may find the offered insurance less valuable to them, as they may not be able to afford the deductibles, co-payments, and co-insurance that they would have to pay on top of their premiums in order to access medical services.

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[3] L Clemans-Cope and B Garrett. 2006. "Changes in Employer-Sponsored Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005," issue paper prepared for the Kaiser Commission on Medicaid and the Uninsured, available at http://www.kff.org/uninsured/upload/7599.pdf.

Questions from Senator Snowe:

In my time as leading Republican on the Senate Committee on Small Business and Entrepreneurship, since 2003, much of the debate on solving the small business health insurance crisis has centered on proposals that would enable the creation of multi-state "pooling" proposals to greatly augment small business purchasing power. A complicated and controversial issue related to small business health insurance reform is how to design a benefits package for small businesses that is both "adequate" and "affordable". Mr. Ario's testimony references an approach that would consider the "actuarial value" of a benchmark plan for benefits – such as the basic plan under the Federal Employee Health Benefits Plan (FEHBP).

1) Please explain how an "actuarial" value approach could help to design an affordable, quality benefit package for small businesses? Has this approach been tried on the Federal level or in any State insurance reform? Would such an approach potentially provide cost savings for small businesses and their employees? Why or Why not?
2) Do you believe there is merit to an actuarial approach that references the general "categories" of benefits that would be required under a plan? For example, under the FEHBP, a general statutory section lists different service and indemnity benefit categories that must be included in a health plan offered to Federal employees. These include hospital, surgical, and obstetrical benefits, and prescription drug coverage. What are the pros and cons to such an approach?

Response:

The Connector in Massachusetts utilizes an actuarial value approach to defining the benefit packages offered there. Each insurer selling coverage through the Connector must offer four different insurance plans, with their actuarial values defined relative to each other in percentage terms. There are two plans at the premier level, a plan that has an actuarial value of 80 percent of the premier plans, and a plan that has an actuarial value of 60 percent of the premier plans. The lowest actuarial value plan constitutes minimum creditable coverage under the state mandate.

This approach provides greater flexibility to insurers in designing benefit packages than does a stricter standardization of benefits, and the variety of ensuing insurance packages may provide more consumers with options that are more consistent with their preferences for insurance. However, the more benefit design flexibility afforded to insurers, the greater the opportunity for insurers to design benefits in such a way as to attract lower risk enrollees, potentially disadvantaging those with greater health care needs.

The plans in the Massachusetts Connector are also required to comply with state benefit mandates, which would address the categories of benefits issue that you raised. I believe it is critical to include general categories of benefits that must be included in a plan under an actuarial value approach. If even such general categories are not defined,

the approach runs the risk of engendering policy options that would not even be considered insurance by many (e.g., a plan with no hospitalization benefits), and could lead to significant out-of-pocket burdens and uncompensated care in the event of serious illness or injury. Allowing insurers complete freedom to define benefits will very likely lead to insurance package options being designed to attract the lowest risk/lowest cost enrollees, instead of a system that would have private insurers competing on the efficient, quality provision of highly valued services.

MARKETWATCH

Setting A Standard Of Affordability For Health Insurance Coverage

Findings using national data could help Massachusetts determine what is "affordable" for its health insurance reforms.

by Linda J. Blumberg, John Holahan, Jack Hadley, and Katharine Nordahl

ABSTRACT: Recently, Massachusetts passed landmark legislation designed to expand health insurance coverage. This legislation includes a requirement that all adults enroll in a health insurance plan. This mandate takes effect only if an "affordable" plan is available. The definition of *affordability* for individuals and families of different incomes or circumstances is a critical decision in implementation and is relevant to any state or federal reform requiring individual premium or cost-sharing contributions, or both. This analysis was done to assist the policy design process in Massachusetts and delineates an empirically based approach to setting affordability standards. [*Health Affairs* 26, no. 4 (2007): w463–w473 (published online 4 June 2007; 10.1377/hlthaff.26.4.w463)]

IN APRIL 2006 the commonwealth of Massachusetts passed landmark legislation designed to expand health insurance coverage. This legislation includes expansions of the state's Medicaid program (MassHealth); a purchasing entity (the Commonwealth Health Care Connector) that will contract with private health insurance plans to provide both subsidized and unsubsidized insurance to individuals and small employers; a requirement that employers with more than ten employees make a fair and reasonable contribution toward employee health insurance or face an assessment; and, for the first time in the United States, a requirement that all adults purchase health insurance (with no premiums required of those with the lowest incomes). This individual mandate takes effect only if an "affordable" policy is available to an individual, however. The law does not define what is affordable for individuals or families of different incomes or circumstances, leaving that decision to the board of the Connector.

This analysis follows the framework of the Massachusetts reforms, because it was developed in an effort to provide the Connector board with information to assist in setting affordability standards. More broadly, setting affordability standards is relevant to any insurance reform that mandates participation and requires contributions toward premiums or cost sharing (copayments, coinsurance, and deductibles), or both. Even in the absence of mandates, this information can assist policymakers in the design of equitable individual and family contributions to coverage.

After briefly discussing the role of afford-

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ability standards and different conceptual approaches to determining affordability, we focus on one specific approach: developing benchmarks based on the range of the financial burdens actually borne by Americans covered by either employer-sponsored or nongroup health insurance.

The Role Of Affordability Standards

A standard for health insurance affordability plays two major roles in the implementation of the Massachusetts reforms. First, the law establishes a new program of subsidized health insurance, the Commonwealth Care Health Insurance Program (CommCare), for low- and moderate-income people, and it requires a new state authority, the Connector, to develop a sliding-scale subsidy schedule based on family income. Second, the law includes a mandate for adults to obtain coverage if "affordable" insurance is available, or face tax penalties. The Connector must set a percentage of income that will serve as the maximum amount individuals and families will be expected to pay toward the purchase of health insurance coverage, with amounts above that deemed unaffordable. The law explicitly states that the board of the Connector shall consider deductibles when determining affordability. Although the CommCare subsidy schedule is not explicitly linked to the affordability standard for the individual mandate, the two standards are interrelated and must work together to create an equitable and effective structure for expanding coverage across income groups.

The affordability standards for these programs will have major policy and practical consequences for the law's success and its ability to expand coverage. If a low standard for affordability is established—that is, expecting consumers to pay a low percentage of income toward insurance—the government's subsidy costs will be higher, or many people will have to be exempted from the mandate. On the other hand, a high standard could create sizable financial burdens for uninsured residents, raising equity issues. Many may opt to face the tax penalty—equal to half the cost of the lowest premium available—rather than to pay what they regard as too high a percentage of income. This would undermine the goal of expanded coverage.

Massachusetts is the first state to adopt an individual mandate for health coverage, and many are watching its implementation closely. The mandate makes the purchase of health coverage an individual responsibility for those who can afford it, within a framework that also expands Medicaid and provides government subsidies to help low- and moderate-income people comply. The individual mandate is a key component of the state's plan to achieve near-universal coverage. However, it is not yet clear whether or not the mandate will be accepted by the public at large. If the public regards the standards for affordability set by the Connector as overly stringent, public and legislative support for the mandate could erode, jeopardizing the goal of achieving near-universal coverage.

This analysis seeks to develop benchmarks that policymakers could use to determine the maximum amounts individuals and families should pay for insurance premiums and overall health expenses. They could be used under the new Massachusetts law or under other states' reforms as well. To ensure affordable access to necessary medical care, one must consider standards for both premiums and out-of-pocket expenses. If an insurance premium is low because the benefits are limited or require high cost sharing, or both, then the policy might not improve the affordability of care, which depends on an appropriate combination of premiums and out-of-pocket spending. This is especially a problem for those with chronic illness and other above-average health needs.

Approaches To Defining "Affordability"

"Affordable" health insurance is a subjective concept based on judgments about the appropriate share of income a person or family should be expected to pay for health insurance. Several approaches could be used to define *affordability*: benchmarks from other public programs; household budgeting as a determi-

nation of income available; and current spending by the privately insured. Standards from existing public programs are readily accessible, but their underlying rationales are generally unknown and are the result of political compromise more than objective analysis. Thus, we do not discuss them here.

■ **Household budget approach.** Household budgeting is another approach to defining affordability. Consumers at each income level spend their resources on housing, clothing, food, transportation, and other essentials. One could compare these expenses to income and assume that the remainder is available for health care. One example is the Family Economic Self-Sufficiency Standard.[1]

This approach is appealing because it can adjust for unique circumstances—for example, with respect to geographic variation in housing costs. It also acknowledges that the share of income available for health insurance is inversely related to income because there are minimum costs associated with housing, food, and other basic necessities. Conversely, this approach is highly prescriptive, particularly in categorizing spending as "essential." Another problem is that it leaves health care as a residual, even though health care needs often supersede other priorities: Individuals and families can and do make trade-offs within their household budgets. Finally, this approach provides no guidance about how much of any residual income should be spent on health.

■ **Actual household spending on health.** The approach to defining *affordability* explored in this paper focuses on people's actual spending on health care (health insurance premiums and out-of-pocket expenses), at various income levels. This approach has the strength of reflecting people's actual purchasing decisions, thereby revealing what they are both willing and able to spend, albeit in the context of a voluntary health insurance system. Others have also suggested using such a behavioral definition of *affordability*, one that takes into account the share of people in a given health care risk and income category that purchase insurance coverage of a minimum acceptable level.[2]

Study Data And Methods

Here we provide a brief overview of our methodology. An online appendix provides a more detailed description.[3]

■ **Data.** We used national data from three components of the Medical Expenditure Panel Survey (MEPS) for our analysis. The MEPS Household Component (MEPS HC) is a large, nationally representative sample of households that collects detailed information on insurance coverage, out-of-pocket spending for medical care, family structure, income, and employment status. It enables the identification of homogeneous health insurance units (HIUs) in which all people have the same type of private health insurance coverage for the full year. Limiting the analysis to these HIUs increases the precision of estimates of the premiums and out-of-pocket medical care spending associated with each type of coverage.[4]

The MEPS Insurance Component (MEPS-IC) surveys employers to obtain data on total premiums and employees' contributions to employer-sponsored insurance. We imputed premiums for nongroup coverage by calculating 70 percent of the premium for firms with fewer than ten workers in the person's region of residence. This approach was based on our analysis of a third MEPS database, the Person-Round-Plan (PRPL) file, which contains information on actual non- group out-of-pocket premiums. Unfortunately, the PRPL data are not available for all years. We computed the relative adjustment necessary to the MEPS-IC average premiums for the smallest employers that would make them consistent with the available PRPL data on premiums for nongroup coverage. This adjustment is consistent with the fact that nongroup insurance enrollees tend to purchase less comprehensive policies than are usually found in the employer-based market. In addition, the smallest employers face administrative loads that are not appreciably lower than those found in the nongroup market. The combination of these MEPS surveys provides the most reliable and detailed data available for estimating the range of household spending for medical care and insurance premiums.

We pooled data from the three most recent MEPS surveys (2001–2003). We inflated income, out-of-pocket medical spending, and premiums to 2005 values. We used data for the entire United States, to obtain sufficient samples to examine the distribution of spending within income groups.

We excluded families with incomes below the federal poverty level, since the Massachusetts law, like many other proposals, calls for fully subsidizing this group. We grouped other families into four categories of income relative to the federal poverty level (100–199 percent, 200–299 percent, 300–499 percent, and 500 percent or more), by type of health coverage (nongroup or employer), and by family type (single adults or families).

Because we were interested in the maximum amount that should be paid, our analysis focused on the median (fiftieth percentile), mean, and seventy-fifth percentile of the spending distribution. The median and mean are good measures of "typical" spending by the population, although the mean is affected by outliers while the median is not. The seventy-fifth percentile illustrates the spread of spending relative to income and probably reflects a level of spending that is not unusual for a large share of the population to incur at some point, as a result of an acute illness or injury. Setting a cap at the median or mean level of spending would ensure consistency in expected year-to-year spending that is likely to be affordable but probably would understate actual current spending by much of the population in occasional years. Setting a cap at the seventy-fifth percentile could be overly financially burdensome, particularly for those who bear this level of out-of-pocket spending consistently year after year.

One limitation of our analysis is that the data did not include details of the benefits and cost-sharing requirements associated with insurance coverage. So while the MEPS-IC and PRPL provide data on premiums and the MEPS HC provides data on type of coverage and out-of-pocket spending, we do not know how broad or narrow that coverage is for each purchaser. As noted earlier, ideal affordability standards will take both premium and out-of-pocket liability into account. Although we identified current levels of spending in both categories separately for analytic purposes, the combined standard should be the key focus for policy purposes. Otherwise, independent premium standards would have to be associated with minimum accepted standards for covered benefits and cost-sharing limitations.

■ **Analytical approach.** *Type of coverage: nongroup.* We analyzed spending for people with nongroup coverage and with employer coverage. Many of the uninsured people subject to an individual mandate would probably purchase nongroup coverage, either directly from insurers or through a new organized purchasing entity (like the Massachusetts Connector) because most uninsured people lack access to employer coverage.[5] In the Massachusetts structure, the subsidized CommCare plan will also be sold directly to individuals through the Connector. Thus, one possible approach would be to link the affordability standards to current spending on nongroup coverage as a percentage of income.

Nongroup policies tend to be more expensive in Massachusetts than in many other states because its insurance regulation includes guaranteed issue, modified community rating, and a standardized and comprehensive benefit package. In most other states, however, nongroup insurance premiums are lower as a percentage of income because only relatively healthy people are able to purchase coverage. This is borne out by the data presented in this analysis, which found that nongroup premiums were roughly 70 percent of the cost of employer coverage premiums in firms with fewer than ten workers. Thus, using national data indicates what relatively healthy people who purchase nongroup coverage spend as a percentage of income. Using this standard implies that the less healthy should not spend any more than the relatively healthy.

Type of coverage: employer-sponsored. For those with employer coverage, we analyzed the share of income spent on coverage in two ways: (1) Based on the employee share of premiums: This approach ties the affordability

standard to what most insured people (nearly 70 percent have employer coverage) are currently paying for coverage. (2) Based on the combined employee and employer premium: The rationale for this approach is that there is considerable evidence in the economics literature that individuals actually bear most or all of the cost of their employer's contribution by accepting lower wages in return for their employer's paying the bulk of their premiums.[6] This approach corrects the likely understatement of spending that arises if the affordability standard is based solely on the employee's share of employer coverage costs.

To develop our estimates for this approach, we calculated the worker incidence of employer contributions to health insurance (WIH) as $WIH = H(1-\tau-\tau_p)/(1+\tau_p)$, where H is the employer contribution, τ is the marginal personal income tax rate, and τ_p is the marginal payroll tax rate. This formula takes into account the fact that employer contributions to health insurance are not subject to taxation, unlike wages. When computing the share of income spent on health care, we added the employer premium payments to both the numerator and the denominator, increasing income as well as health care expenses.

■ **Premiums and total health care spending.** An affordability standard could be based on either premiums alone or total health care spending. Because the variation in premium and medical care expenditures as a percentage of income can be very large within each income level, our analysis considered spending on both premiums and out-of-pocket cost sharing. This extreme variation reflects a variety of factors: choosing to buy a policy with very limited or very comprehensive benefits; being in good health or in poor health; having a job where the employer pays all of the cost of insurance or none of the cost; experiencing transitory changes in income relative to existing insurance coverage; or having access to savings or financial resources outside the family to help pay insurance premiums and medical expenses.

The variation in out-of-pocket spending is much greater than that for premiums. At the high end of the spending distribution, affordability can become a serious issue. As discussed below, our analysis of out-of-pocket costs for medical care highlighted the importance of including caps on out-of-pocket costs within the discussion of affordability.

Study Results

Exhibits 1–3 present detailed results of the distribution of spending relative to income at different levels of income, by type of coverage. The data present the median, seventy-fifth percentile, and mean along the distribution. We also show the ninety-fifth percentile for out-of-pocket costs to illustrate the great variation in this measure resulting from the highly skewed distribution of medical expenses.

In creating CommCare, Massachusetts recognized that large numbers of people with incomes below 300 percent of poverty do not have coverage, which suggests that available premiums combined with out-of-pocket medical care expenses are too high for many in these income ranges. The data we present bear this out as well. Relatively small proportions of people at low income levels relative to poverty had full-year private insurance coverage, and many of those who did have such coverage appeared to spend very high shares of their incomes on premiums and out-of-pocket expenses. We suspect that the high spending shares at low income levels reflect exceptional circumstances, such as a very costly illness or unexpected income drop. If this is the case, then the spending experience of higher-income people is a more reasonable benchmark for setting affordability standards. Since health care spending relative to income will be skewed downward as a consequence of very high incomes, we highlight affordability measures based on spending shares for people with incomes of 300–500 percent of poverty. Equity considerations suggest that affordability standards should be lower for people below 300 percent, since spending for other necessities will constitute a bigger share of their spending than it does for a higher-income family. Therefore, we assumed that the benchmarks for health insurance affordability high-

EXHIBIT 1
Premium Payments As A Percentage Of Income, By Income, Coverage Type, And Medical-Cost-To-Income Ratio Percentile, 2001–03

	Percent of family income					
Cost-to-income percentile	Single nongroup coverage	Family[a] nongroup coverage	Single ESI	Family[a] ESI	Full cost of single ESI[b]	Full cost of family[a] ESI[b]
Median						
All (percent of poverty)	11.5	9.6	2.0	3.6	10.9	13.1
100–199%	20.9	21.8	5.2	10.4	25.5	34.4
200–299%	12.1	13.8	3.2	6.5	17.1	23.0
300–499%	7.9	8.3	2.1	4.2	11.3	15.2
500% or more	4.6	4.6	1.1	2.2	6.5	8.7
75th percentile						
All (percent of poverty)	19.0	15.4	3.1	5.4	15.9	18.7
100–199%	25.3	26.3	6.2	12.6	29.4	39.2
200–299%	13.6	15.1	3.7	7.6	18.9	25.6
300–499%	9.0	9.9	2.4	5.0	12.8	17.4
500% or more	5.3	5.8	1.4	2.9	7.7	10.5
Mean						
All (percent of poverty)	13.3	11.4	2.4	4.3	12.4	15.0
100–199%	21.7	22.9	5.5	10.9	26.6	35.2
200–299%	12.3	13.7	3.2	6.7	17.4	23.2
300–499%	8.0	8.5	2.1	4.4	11.5	15.5
500% or more	4.2	4.5	1.1	2.3	6.3	8.5

SOURCE: Analysis of 2001–2003 Medical Expenditure Panel Survey, Household Component (MEPS HC) data and MEPS Insurance Component (MEPS-IC) premium data.

NOTES: All costs are inflated to 2005 dollars. Health insurance coverage is defined as twelve months of the same coverage for all family unit members. Income is calculated separately for each family unit and set to 100 percent if costs are greater than or equal to health insurance unit income. ESI is employer-sponsored insurance.

[a] Includes families, couples, and adult-plus-one family units.

[b] Assuming employees pay full cost of the premium by accepting lower income. Calculated as (employee premium payment + worker incidence of employer premium payment)/(family income + worker incidence of employer premium payment). Set to 100 percent if costs (numerator) are greater than or equal to income (denominator).

lighted here would be most appropriately applied to those with incomes of 300 percent of poverty or higher. Moreover, those benchmarks would decrease on a sliding scale for people with lower incomes, presumably reaching zero at some income level (such as 100 percent or 150 percent of poverty). Inevitably, the precise shape of the affordability-income trade-off has an inherently arbitrary component. Political and social values will clearly play a major role in determining the particular design chosen.

■ **Premium payments as a percentage of income.** Exhibit 1 shows the value of current premium spending as a share of income at the median and seventy-fifth percentile and the mean of the spending distribution.

Nongroup coverage. There was much variation in median premium payments across income groups in 2001–03, ranging from under 5 percent for the group above 500 percent of poverty to 21 percent for people in the lowest income group. For those in the 300–499 percent group, the median and mean premiums were about 8 percent of income for single coverage and 8.5 percent for family coverage; the seventy-fifth percentile of premiums was 9–10 percent. Regardless of income, nongroup premium payments were at least three to four times higher as a percentage of income than for the employee-paid portion of employer coverage premiums.

Employee spending for employer coverage. Median and mean payments in 2001–03 by employees for employer coverage were roughly 2–4 percent of income across all income groups and

EXHIBIT 2
Out-Of-Pocket Medical Care Costs As A Percentage Of Income, By Income Group And Coverage, 2001–03

	Percent of family income			
Income group/cost-to-income percentile	Single nongroup coverage	Family[a] nongroup coverage	Single ESI	Family[a] ESI
All				
50th percentile	2.9	4.3	0.8	1.4
75th percentile	8.7	9.6	2.4	3.1
95th percentile	27.8	29.4	9.4	9.8
Mean	7.0	7.5	2.3	2.8
100–199% of poverty				
50th percentile	7.1	10.9	2.2	3.2
75th percentile	17.7	23.9	6.7	9.0
95th percentile	38.3	41.2	20.4	26.6
Mean	12.3	16.3	5.6	7.2
200–299% of poverty				
50th percentile	3.8	6.7	1.1	2.2
75th percentile	7.4	12.6	3.6	4.9
95th percentile	18.4	25.3	11.9	12.3
Mean	5.5	9.3	2.9	3.9
300–499% of poverty				
50th percentile	2.0	4.0	0.8	1.7
75th percentile	5.0	6.8	2.1	3.5
95th percentile	13.4	11.9	7.1	9.6
Mean	4.2	4.8	1.8	2.8
500% of poverty or more				
50th percentile	0.6	1.5	0.5	1.0
75th percentile	2.0	3.5	1.4	2.1
95th percentile	7.3	8.2	4.3	5.1
Mean	1.7	2.5	1.2	1.6

SOURCE: Analysis of 2001–2003 Medical Expenditure Panel Survey, Household Component (MEPS HC) data.
NOTES: All costs are inflated to 2005 dollars. Health insurance coverage is defined as twelve months of the same coverage for all family unit members. Income is calculated separately for each family unit and set to 100 percent if costs are greater than or equal to health insurance unit income. ESI is employer-sponsored insurance.
[a] Includes families, couples, and adult-plus-one family units.

for those with incomes of 300–499 percent of poverty. Considerable variation in premium payments as a percentage of income existed for people with employer coverage but at much lower percentages of income compared to those with nongroup coverage.

Total spending for employer coverage. The last two columns of Exhibit 1 show spending percentages assuming that employer premium payments are added to workers' spending as well as to their income. The median percentage of income spent on employer coverage across all income groups in 2001–03 was 10.9 percent for single coverage and 13.1 percent for family coverage (mean: 12.4 percent and 15.0 percent of income, respectively). The medians for those with incomes of 300–499 percent of poverty were 11.3 percent (single) and 15.2 percent (family); mean values in this income range were roughly the same.[7]

■ **Out-of-pocket medical care costs.** In addition to paying for insurance premiums, in-

EXHIBIT 3
Total Medical Costs As A Percentage Of Income, 2001–03

	Percent of family income					
Cost-to-income percentile	**Single nongroup coverage**	**Family[a] nongroup coverage**	**Single ESI**	**Family[a] ESI**	**Full cost of single ESI[b]**	**Full cost of family[a] ESI[b]**
50th percentile						
All (percent of poverty)	16.9	14.7	3.1	5.5	12.3	15.1
100–199%	29.4	35.0	7.9	14.7	28.6	38.5
200–299%	16.2	21.0	4.5	9.2	19.1	25.8
300–499%	10.4	11.6	2.9	6.1	12.6	17.4
500% or more	5.4	6.1	1.7	3.5	7.4	10.0
75th percentile						
All (percent of poverty)	27.0	25.0	5.3	8.5	18.2	21.8
100–199%	41.1	47.3	12.5	20.5	34.2	46.2
200–299%	20.0	26.5	6.8	12.2	21.4	29.4
300–499%	12.6	15.1	4.2	7.9	14.4	20.2
500% or more	6.5	8.6	2.6	4.7	8.7	12.3
Mean						
All (percent of poverty)	18.1	16.7	4.4	6.7	14.5	17.6
100–199%	29.3	32.6	9.9	16.2	31.1	41.1
200–299%	16.6	20.6	5.8	10.0	20.1	26.7
300–499%	11.5	12.5	3.7	6.9	13.2	18.2
500% or more	5.7	6.7	2.3	3.8	7.5	10.1

SOURCE: Analysis of 2001–2003 Medical Expenditure Panel Survey, Household Component (MEPS HC) data and MEPS Insurance Component (MEPS-IC) premium data.

NOTES: All costs are inflated to 2005 dollars. Health insurance coverage is defined as twelve months of the same coverage for all family unit members. Income is calculated separately for each family unit and set to 100 percent if costs are greater than or equal to health insurance unit income.

[a] Includes families, couples, and adult-plus-one family units.

[b] Assuming employees pay full cost of the premium by accepting lower income. Calculated as (out-of-pocket medical costs + employee premium payment + worker incidence of employer premium payment)/(family income + worker incidence of employer premium payment). Set to 100 percent if costs (numerator) are greater than or equal to income (denominator).

dividuals and families spent a considerable amount of money out of pocket for deductibles, copayments, coinsurance, and uncovered services in 2001–03 (Exhibit 2).

Nongroup coverage. Out-of-pocket medical costs as a share of income were particularly high for those with nongroup coverage and varied inversely with income. Median out-of-pocket spending was 2.9 percent and 4.3 percent of income for single and family coverage, respectively (mean: 7.0 percent and 7.5 percent). At the seventy-fifth percentile, spending shares increased to 8.7 percent (single) and 9.6 percent (family). Spending exceeded one-fourth of family income at the ninety-fifth percentile—the top of the spending distribution. At incomes of 300–499 percent of poverty, median out-of-pocket spending was 2 percent of income for singles and 4 percent for families; spending was still above 10 percent of income at the ninety-fifth percentile.

Employer coverage. For those with employer coverage, out-of-pocket costs were considerably lower, presumably because benefit packages were richer. The average across all income levels was 2.3 percent for individuals and 2.8 percent for families (median: 0.8 percent and 1.4 percent, respectively). At the ninety-fifth percentile, expenditures were 9.4 percent (single) and 9.8 percent (family). Median out-of-pocket spending was about 1–2 percent of income for those at 300–499 percent of poverty, with spending at the high end of the distribution rising to 7 percent for singles and approaching 10 percent for families.

■ **Total medical costs.** Exhibit 3 presents results for total medical costs (that is, premiums plus out-of-pocket costs) as a percentage

of income. The results reported in Exhibit 2 showed that out-of-pocket costs relative to income were fairly low on average, particularly for those with employer coverage or those with incomes above 300 percent of poverty. But when added to the premium cost, they can result in fairly high spending relative to income. Moreover, the large variation in out-of-pocket costs highlights the importance of providing additional financial protection for those with high medical needs or skimpy insurance benefits, or both.

Nongroup coverage. The median individuals and families with nongroup coverage across all incomes spent 16.9 percent and 14.7 percent of income, respectively, on health insurance and out-of-pocket costs. The median values for those with incomes of 300–499 percent of poverty were 10.4 percent (single) and 11.6 percent (family).

Employee spending for employer coverage. The median direct employee spending for individuals and families across all income groups was 3.1 percent and 5.5 percent of income, respectively (mean: 4.4 percent and 6.7 percent). For those with incomes of 300–499 percent of poverty, the median figures are 2.9 percent and 6.1 percent, respectively (mean: 3.7 percent and 6.9 percent).

Total spending for employer coverage. If it is assumed that workers ultimately bear the cost of the employer contribution, then spending levels increase considerably, exceeding those of people covered by nongroup policies. At the median, spending was 12.3 percent and 15.1 percent for individual and family coverage, respectively. For those with incomes of 300–499 percent of poverty, these figures were 12.6 percent and 17.4 percent, respectively (mean: 13.2 percent and 18.2 percent).

Summary And Policy Implications

We believe that basing the benchmark standard for affordability on the share of income now devoted to health spending by privately insured people is a sound approach because it reflects actual experience. We draw several conclusions from our analysis of current medical spending.

■ **Differences by income level.** Low-income people with private insurance spend much higher percentages of their incomes on health care than middle- or high-income populations do. The financial burden of full-year private insurance is more than most families below 300 percent of poverty are able or willing to bear. This evidence suggests that typical spending levels among this income group are unlikely to be considered affordable by most of that population. As a consequence, using the typical spending of a higher income group, such as those at 300–499 percent of poverty, might be preferable as a basis for setting a standard for lower-income people.

The exact approach for applying middle-income affordability standards to a lower-income population will inevitably reflect social and political judgments. However, many are likely to feel that most lower-income families will not be able to spend as high a percentage of income on health care as will those in the middle income group, because of minimum necessary subsistence levels of spending on other goods and services. As such, socially acceptable affordability standards are likely to require that standards based on middle-income health care spending be adjusted downward for those with incomes below 300 percent of poverty.

■ **Setting the affordability standard.** There are advantages and disadvantages to using different points in the spending distribution when setting an affordability standard. The mean and median measures are most reflective of typical current levels of spending on health care. The two differ because of the skewness inherent in the distribution of health care spending. That is, extreme spending levels affect the mean but not the median. The seventy-fifth percentile of spending relative to income probably reflects unusual circumstances. Although such a spending level might be financially feasible in a given year, it is probably not sustainable on a continuing basis, particularly when both premiums and out-of-pocket spending are taken into account.

■ **Difference by insurance type.** Spending patterns in the alternative reference popu-

lations (nongroup spending, employee-only coverage spending, and total employer coverage spending) lead to considerably different affordability standards. If a public program bases the standard of affordability on what all people who now have nongroup coverage throughout the United States spend on premium payments as a share of income, the program would establish a maximum payment in the neighborhood of 10 percent of income. If it were based on mean or median spending on nongroup premiums for those at 300–499 percent of poverty, the maximum payments would be in the 8 percent range. Some will argue, however, that the nongroup basis cannot be considered typical since only a small percentage of individuals in any income group currently purchase it.

Policymakers could instead base the affordability standard on the employee share of employer-sponsored insurance, and the amounts that people would be expected to pay would be much lower. At the median, employee contributions are 2.0 percent for single coverage and 3.6 percent for family coverage; at the mean, they are slightly higher. For those at 300–499 percent of poverty, the medians and means are slightly above 2.0 percent and 4.0 percent, respectively.

Although setting the maximum at the employee share has intuitive appeal since it reflects what most of the currently insured spend directly, doing so ignores the empirical economic research findings that employees eventually pay much or all of the premium cost by accepting reduced wages. Incorporating this adjustment produces much higher amounts: the medians are 10.9 percent for single coverage and 13.1 percent for family coverage for those at all income levels, with the means slightly higher. The median percentages of income for single and family premiums for those at 300–499 percent of poverty are 11.3 percent and 15.2 percent, respectively, with means slightly higher. However, these levels will seem high to those unaccustomed to considering employer payments as being ultimately charged back to workers themselves in the form of lower wages.

■ **Role of out-of-pocket liability.** Because of the highly skewed distribution of health care spending and the large potential variation in plans' actuarial values, affordability must take out-of-pocket liability into account in addition to premiums. Our analysis shows that total medical spending, including premiums and out-of-pocket expenses, can be very high as a percentage of income, particularly for those with incomes below 300 percent of poverty and for those with high medical needs. Thus, any effective standard for affordability must consider both out-of-pocket costs and premiums. This is critical for the CommCare products, which will be available only to those with incomes below 300 percent of poverty. But it is also an important consideration for the enforcement of an individual mandate, because cost-sharing requirements can be overly burdensome for middle-income people as well, depending upon the out-of-pocket exposure associated with insurance and the intensity of required medical care.

Postscript

On 12 April 2007, the board of the Commonwealth Health Insurance Connector Authority in Massachusetts voted unanimously to approve draft regulations with a schedule of affordable premiums for the minimum coverage adults would be expected to have. The proposed schedule is generally consistent with the data on premiums presented in this paper. For example, single consumers below 150 percent of poverty were exempt from premium payments. At 200 percent of poverty, individuals would have to pay up to 2.1 percent of income; at 300 percent of poverty, 4.1 percent; and at 500 percent of poverty, 7.1 percent. These choices fall in between standards based on the employee share of employer coverage premiums and nongroup premiums for those at 300–499 percent of poverty. In our analysis, both the median and mean premium spending relative to income for single coverage in this income group was 2.1 percent for the employee share of employer coverage and 8 percent for nongroup insurance.

Those below 300 percent of poverty who do

not have employer coverage available will have access to quite comprehensive coverage in the state's subsidized Commonwealth Care program. Those above 300 percent of poverty will be required to purchase private insurance without subsidies if an option is available to them either at or below the premium affordability threshold applicable to their income level. The minimum required coverage for an individual policy includes a maximum deductible of $2,000 and a $5,000 limit on out-of-pocket spending, excluding all drug cost sharing and all copayments below $100. For a family policy, a $4,000 maximum deductible and a $10,000 out-of-pocket limit apply, with the same exclusions. The affordability standard set by the Connector does not explicitly take potential out-of-pocket exposure into account. As a result, people with persistently high out-of-pocket costs will face much higher financial burdens as a percentage of income than what our data indicate are typically borne nationally by those at 300–499 percent of poverty.

The Massachusetts approach is to exempt from the mandate all those who cannot obtain the minimum level of coverage at an affordable level. The number exempted could be substantial, and because of the age rating of premiums, many are likely to be older adults. An alternative would have been for the government to have financed the difference between a benchmark plan in the Connector and the affordability standard, thereby making it possible to include all adults in the mandate.

Results were discussed at a roundtable on reforms in Massachusetts during the 2007 AcademyHealth meeting, 3 June 2007, in Orlando, Florida. Funding for this work was provided by the Blue Cross Blue Shield of Massachusetts Foundation. The views expressed are those of the authors and should not be attributed to the Urban Institute; the foundation; or its directors, officers, or staff. The authors thank Nancy Turnbull and two anonymous reviewers for their comments and suggestions, and Joel Ruhter and Matt Craven for their research assistance. An earlier version of this paper was distributed to members of the board of the Massachusetts Connector, to assist them with their deliberations.

NOTES

1. See Crittenton Women's Union, "The Quest for Economic Independence in the Commonwealth: 2006 Self-Sufficiency Standard for Boston," http://www.liveworkthrive.org/docs/fess2006/2006%20FESS%20Boston.pdf (accessed 8 May 2007).
2. M.K. Bundorf and M.V. Pauly, "Is Health Insurance Affordable for the Uninsured?" *Journal of Health Economics* 25, no. 4 (2006): 650–673.
3. This appendix is available online at http://content.healthaffairs.org/cgi/content/full/26/4/w463/DC2.
4. Setting an affordability standard for annual coverage requires reliance on data for those purchasing coverage over the same time frame. In addition, part-year purchasers include those making many types of transitions, and their situations do not necessarily reflect equilibrium choices. If one presumes that those actually purchasing full-year coverage are somehow better off than those who do not, this would argue for an adjustment downward in the affordable spending levels calculated here.
5. L. Clemans-Cope, B. Garrett, and K. Hoffman, "Changes in Employees Health Insurance Coverage, 2001–2005," Issue Paper (Washington: Kaiser Commission on Medicaid and the Uninsured, October 2006).
6. See, for example, J. Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review* 84, no. 3 (1994): 622–641; L.J. Blumberg, "Who Pays for Employer-Sponsored Health Insurance?" *Health Affairs* 18, no. 6 (1999): 58–61; K. Baicker and A. Chandra, "The Labor Market Effects of Rising Health Insurance Premiums," NBER Working Paper no. 11160 (Cambridge, Mass.: National Bureau for Economic Research, 2005); and C. Olson, "Do Workers Accept Lower Wages in Exchange for Health Benefits?" *Journal of Labor Economics* 20, no. 2, Part 2 (2002): S91–S114.
7. Below 300 percent of poverty, the percentage of income spent on premiums is much higher than for those with higher incomes. There is some question as to whether employers are able to fully shift the cost of premiums to employees at the lowest income levels, so these numbers might considerably overstate the amount that is shifted to lower-income workers.

[SUBMITTED BY SENATOR HATCH]

Coalition Supporting Equity for Our Nation's Self-Employed

Sole Proprietors by State

According to 2005 data from the Internal Revenue Service, we can see the number of sole-proprietors (Schedule C filers) by state that would benefit from the passage of the self-employment tax deduction on health insurance premiums.

State	Number of Schedule C Filers	State	Number of Schedule C Filers
Alabama	308,764	Montana	82,869
Alaska	56,462	Nebraska	125,555
Arizona	365,984	Nevada	154,807
Arkansas	191,898	New Hampshire	108,314
California	2,829,278	New Jersey	577,358
Colorado	390,779	New Mexico	129,414
Connecticut	258,023	New York	1,444,960
Delaware	48,853	North Carolina	681,682
District of Columbia	42,695	North Dakota	46,892
Florida	1,392,959	Ohio	718,466
Georgia	708,741	Oklahoma	266,276
Hawaii	94,076	Oregon	263,753
Idaho	112,171	Pennsylvania	754,296
Illinois	851,330	Rhode Island	68,315
Indiana	376,843	South Carolina	274,290
Iowa	208,716	South Dakota	59,912
Kansas	192,578	Tennessee	453,170
Kentucky	269,589	Texas	1,829,796
Louisiana	284,506	Utah	167,994
Maine	115,581	Vermont	59,359
Maryland	423,902	Virginia	498,715
Massachusetts	481,960	Washington	420,838
Michigan	648,426	West Virginia	96,517
Minnesota	384,375	Wisconsin	340,015
Mississippi	180,314	Wyoming	41,894
Missouri	397,331		

TOTAL United States **21,287,828**

5,601,405

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WRITTEN STATEMENT OF

MONTY NEWMAN

ON BEHALF OF

THE NATIONAL ASSOCIATION OF REALTORS®

BEFORE THE

UNITED STATES SENATE
COMMITTEE ON FINANCE

"HEALTH INSURANCE CHALLENGES FACING SMALL BUSINESS"

OCTOBER 25, 2007

Mr. Chairman: My name is Monty Newman. I am a Realtor® from Hobbs, New Mexico and also serve as the Mayor of Hobbs. I own a real estate brokerage business there and also a real estate property management company. I have been a member of the Board of Directors of the NATIONAL ASSOCIATION OF REALTORS® (NAR) since 1995, and appear here today in my capacity as the 2007 volunteer Vice President of the Association. The NATIONAL ASSOCIATION OF REALTORS® represents about 1.3 million individuals who are engaged in all facets of both residential and commercial real estate sales, brokerage, leasing, property management and investment.

Research Findings

NAR periodically surveys its individual Realtor® members to compile demographic data and to learn more about member's business activities. According to the 2005 NAR Member Profile, the median age for real estate sales agents was 49 years. Seventy-one percent were married. More than half (54%) are female.

Consistently over the years, our profiles have shown that the overwhelming majority of our members are self-employed individuals. About one-third are organized as sole proprietors, one-third as C Corporations and another one-third as S Corporations. The "typical" firm has four employees (often including an owner-employee) and a group of independent contractor sales agents.

In 2006, more than one quarter of Realtors® (28%)[1] have no health insurance coverage from any source. Another 7% faced expiring COBRA coverage. In human terms, this means that about 450,000 Realtor® members have no insurance. If we extend that finding to households, more than one million people may have no health care benefits. By contrast, in 1996, only 13% of our membership had no coverage.

Of those who today have no coverage, only 7% report that they were denied coverage because of a pre-existing condition. More than 84% report that the main reason they have no coverage is its cost. More than half of those with no coverage (51%) are single. While 54% of our membership is female, our research shows that 62 % of those with no insurance are female. This may suggest that the problems of securing health insurance may fall most heavily on unmarried women.

A 2006 Firm Profile survey showed that only 13% of real estate firms offer health insurance coverage to their employees. By contrast, in 1996, 34% of real estate firms offered health insurance to their employees. Again, cost is the barrier.

Among those Realtors® who *do* have insurance, nearly half of them obtain coverage either through a spouse's employer (26%) or through group plans associated with other employment, military benefits or a retirement plan (20%). Thus, more than half of our self-employed members are left to find coverage in the individual market.

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[1] NAR conducted a survey to collect health insurance coverage data in March 2006.

Real Estate Brokerage Business Model

Most residential real estate brokerages use a similar business model, whether the operation is large or small. Let's say you are a real estate broker and own the Blackacre Real Estate Company. Your work force includes salaried employees as well as self-employed individuals who are under contract with you as independent contractors.[2] Your employees might include your own personal assistant and, depending on your size, additional front and back office administrative staff ranging from receptionists and clerks through skilled financial and managerial professionals.

You have complied with the tax law[3] and have the requisite written agreements with each of your real estate sales agents showing, among other requirements, that the sales agent will be an independent contractor for federal taxation purposes. Thus, as the broker-owner of Blackacre Real Estate, you face the challenges of finding health insurance to cover yourself and your employees, most likely in the small group market. In addition, you are keenly aware of the exceptional and even more expensive obstacles your independent contractor, self-employed agents face in the individual insurance market.

Tax Incentives

Under current tax law, Blackacre's self-employed sales agents (and all other self-employed individuals) would appear to have the best of all possible worlds, at least from a tax perspective: They receive a full "above the line" deduction for the health insurance premiums they pay. This deduction is unquestionably of great value. However, we must emphasize that the deduction has value if, *and only if,* these self-employed individuals can find an affordable insurance product.

NAR worked with Congress and a large coalition to secure the deduction for the self-employed and continues to fully support that benefit. Nonetheless, we would submit, Mr. Chairman, that the plague of uninsured workers will persist *unless and until* there are corrections and improvements to both the individual and small-group health insurance markets. We believe that tax incentives for the self-employed and for small employers, coupled with mechanisms that would create insurance coverage gateways and/or additional pooling mechanisms would create a far more rational and effective system than current law.

Attached to these remarks is a brief compilation of horror stories from our self-employed, independent contractor Realtors®. No working person should be subjected to the kinds of perversity described. The scariest: An individual who was able to find coverage for a premium of $1,000 *per month,* with a deductible of $15,000 per person. That Realtor® would have to expend $42,000 before ever receiving a dime's worth of benefit. Why bother?

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[2] A "typical" real estate brokerage company has fewer than 5 employees. The number of agents per firm varies significantly.

[3] Internal Revenue Code Section 3508 provides that real estate sales agents and direct sellers may be treated as independent contractors so long as specified requirements are satisfied. In the case of a real estate sales agent, the agent must (1) be licensed, (2) receive compensation based solely on sales or other output (and not on hours worked) and (3) have a written agreement with the broker-owner specifying that the agent is not an employee.

We should note, however, that this Realtor® and many of those who shared their stories (below) are among the "lucky ones" who actually found an insurer who would write a policy. A great number of the self-employed have found that even if they were willing to pay such a price that no insurer would accept them. Insurers reject applications for many more reasons – never disclosed – than the existence of pre-existing conditions. Guaranteed issue health insurance policies are all but unknown in the individual market.

Finding Insurance

Most independent contractor real estate agents and many employees of small brokerages must find coverage in the individual insurance market. That market presents itself as one in which there is no negotiating, no leverage, no economies of scale and absolutely no efficiency. For the most part, you basically take or leave whatever coverage is offered – at whatever price it is offered.

Imagine yourself without health insurance and without an employer who shares in some portion of the cost. Would you know where to find coverage? Would you know how to determine whether the policies offered would actually provide much benefit? Would you be willing to commit 10% of your income to be insured? 20%? 25%? This is the dilemma and challenge of the self-employed person.

Obviously, Realtors® are not alone in their struggle to obtain affordable health insurance today. Employment trends today suggest that there will be even more uninsured individuals in the future – and that more of them will be self-employed individuals. Today, as the result of corporate restructurings and job outsourcing, the share of the U.S. workforce that is self-employed – independent contractors, freelance workers, consultants, and other "non-traditional" workers -- has reached a remarkable level.

The General Accounting Office estimated that these workers comprised 30 percent of the American workforce in 2000. Some experts estimate that by 2010, 41 percent of the U.S. workforce will be so-called "free agent" workers. Without changes to the current health insurance system, we fear this shift in the composition of the workforce will be accompanied by increases in the number of the uninsured. Finding a solution to the insurance problem must become a top priority.

What Can We Do?

NAR has no particular expertise that would enable us to provide you with a full-blown market reform model. We don't have much good to say about the individual health insurance market. It does not serve the needs of our self-employed members. Based on our experience and the things we do know, however, we can make several observations.

First, the self-employed must be enabled to enjoy the benefits of pooled risks, much as large group plans provide. Downsizing, changes in the economy and cost of coverage will likely

deprive more and more workers any benefit of employer-provided insurance, thus forcing them into the individual market. Today, employer-provided group coverage is extended to groups of people whose sole common denominator is their employer. Enhanced risk-pooling opportunities in the individual market would facilitate greater market efficiency by combining groups of people whose sole common denominator is that they work for themselves. Pooled risk for individuals will also enhance economies of scale as insurance providers are able to consolidate and manage the expenses of administration, marketing and advertising.

We have no preference on whether pooling should be on a state, regional or other basis. We would simply urge that Congress find ways to enable pooling in a way that will (a) permit self-employed individuals to continue their health insurance coverage even when they move between states, (b) facilitate greater market efficiency and (c) keep down premium costs.

Second, we believe that some sort of mechanism is needed to bring insurers and self-employed workers together. Call that mechanism a matchmaker, gateway, coordinator, connector – whatever you will. We believe that some combination of private, public or private/public venture must be developed, preferably at the state or regional level, to put self-employed persons in a position where they can compare apples to apples in their analysis of insurers and insurance products. We do not believe this venture should be owned, managed or operated at the federal level.

We do not seek a single-payer, or a federal insurance system, nor do we seek a new entitlement. We do seek an official, reliable, regulated, information source (or sources) that will facilitate insurance market access for self-employed individuals. They need to have some sort of menu that could include information such as comparisons of available coverage options (e.g., basic, catastrophic, "Rolls Royce" or some combination), identification of vendors that can provide various options and where to find those vendors, as well as some sort of approximate cost comparison data (current and/or historic).

Third, we believe that stakeholders including (but not limited to) insurers, regulators, legislators, health policy advocates and consumers must grapple with the question of essential coverage. Today, a crazy quilt of mandates has obscured the fundamental reality that more guarantees generate more costs for consumers. No single policy or list of mandates can satisfy the competing tensions between (a) assuring all desired (or desirable) coverage and (b) creating affordable products.

We believe that it is difficult, *but not impossible*, for the stakeholders to come up with categories or guidelines that might distinguish among such categories as essential, preventive, desirable and "Rolls Royce" options. Such a drive toward consensus may provide a rational basis for strategies that would provide self-employed individuals some leverage for pushing insurers and regulators toward some sort of "core" coverages.

Mr. Chairman, we believe that health insurance reform makes tax reform look pretty easy. To conclude, we would reiterate that tax incentives are useful and important, and that they must be accompanied by significant reforms to the individual and small group health insurance markets.

Realtor® Stories -- Health Insurance Coverage

CONNECTICUT

As a self employed Realtor® I pay $703.00 / month for health insurance!! Just for myself!! And I'm perfectly healthy! That's with [Company X], one of just a couple of insurers that I could find that will write policies for self employed people. That's $8436.00/year! And I still have copays, no dental and no optical coverage. (They required that I join a Chamber of Commerce which was an additional cost.)

Most of the agents in my office don't even have health insurance coverage. It's just too expensive for a lot of people. It's too expensive for me, too, but I think it's too important not to have.

COLORADO

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

#2: We tried for the longest time to do the right thing but after the first quarter of 2004 we finally could no longer afford to maintain health insurance. The rate for my husband and myself had climbed to over $1,000 per month for the two of us and that great rate was achieved only by submitting to a $15,000 annual per person deductible...

#3: For a small office with a group of two, our premiums just went to $1200 monthly and it is a critical factor in evaluating the profitability and viability of the business.

#4: My husband and I are both CO Realtors□ . We have not had health insurance since the year 2000. My husband had a heart attack in 2000, and our insurance was cancelled. We can not afford health insurance at the rates that are needed for a person who has suffered a heart attack. Even with insurance in the year 2000, we have been paying to the hospitals, ambulance service and physicians a monthly rate of $250.00 and will continue to pay that amount every month until the year 2010. Talk about a horror story. We have no insurance - my husband should be own several drugs for his heart condition but we can not afford the additional $350 a month for these drugs. He has resigned himself - that if he suffers another heart attack (which is a definite per his doctors) that we can not afford to take him to the hospital.

IDAHO

#1: Our family has been with [Company X] for years. Healthy family, no big claims, no one leaping over one of the age barriers that cause rates to change - our monthly premium was adjusted from $363 to $525 in August 2004, then increased to roughly $750 per month in August

2005. Huge increase and again, no one in the hospital, no emergency room claims - just a healthy family. This is for major medical coverage with a $7500 per family member deductible. By the way, there is me, age 49, my wife is 47, 21 year old daughter (college) and 18 year old son (also in college).

#2: There are very few Health Insurance options in this state and at these prices there are many Idahoans who can't afford it and go without.

NEW MEXICO

#1: (Describing a spread sheet dated 7/1/2005.) The story is in the 3rd and 4th lines up from the bottom of the page. The first column is our plan from 7/1/2004 to 7/1/2005. The second column is the cost to renew effective 71/2005 showing an increase in premium of 59.55% in I year. The other 3 columns are alternate plans at least one of which is not as comprehensive of coverage. These alternative plans premiums reflect an increase of 91.39%, 43.27%, and 69.37% over existing premium.

We stayed where we were with the 59.55% increase. Clearly this is out of control and was the largest increase in premium I have seen in the last 10 years or so that we have been with this plan. It typically has been less than 10% annually.

#2: My way out is to stop providing group coverage. Should I do that I would go to New Mexico Health Care Alliance where the premium for me alone approaches $600.00/month I am told compared to the $355.36/month I am now paying.

#3: To control costs I have taken my one remaining minor child out of the group because I can buy her coverage for $100.11/month for an individual policy compared to $248.74/month in the group.

NORTH CAROLINA

#1: Had health insurance, but the premium was almost $8,000 a year, with a $5,000 deductible. Obviously couldn't keep it. Had to cancel. Tried to get reasonable coverage at many other places and could not. I finally decided if I had to pay $13,000 before insurance kicked in, I could get on one heck of payment plan with the hospital...

#2: I am a single Realtor□ earning an average of $30,000/year with no other resources for support. It is and has been a huge strain to try and keep my health insurance. Premiums through [Company X] have risen from $89/month to $421/month in the last 10 years. My coverage has declined from a $500 deductible with 80% co-insurance (no other deductibles or copays), to a $5000 deductible with 70% co-insurance. The deductible does not apply to doctor visits and prescriptions; I have a co-pay for these with a separate $200 deductible for prescriptions. Further, there is a $1200 annual maximum on brand name prescriptions drugs which causes me to incur an additional $200-$400 annually. There is no generic for the 3 medications I require.

Each year I struggle with the decision of whether to try and keep the insurance or let it go. There are many other single agents who have no insurance due to the high cost. Some married agents can get coverage under their spouse's group policy. With an industry of our size, it makes no sense why we cannot obtain some type of group coverage at more affordable rates with better coverage.

PENNSYLVANIA

My broker and I pay a total of $1208.88 for health insurance through [Company X]. The coverage is for my broker (single) and myself (single) and my 18 yr old son. That's $14,506 per year for 3 people. We joined the local Chamber of Commerce to be able to get decent coverage...individual programs do not offer the best coverage and my son is bi-polar so quality insurance is very important. In 2003 the cost was $683.70...2004 it went to $881.46/month...and now in 2005 it is $1,208.88. In other words - the premiums have almost doubled. And it seems the insurance companies realize we have no choice as consumers. Their response was - "increase your deductible" or "change to a plan with less coverage". Net result is the same - it would cost us more.

TEXAS

I am a 33 year old, real estate agent in Dallas TX. I am also, self-employed and uninsured. Two years ago my stomach ruptured. As a result of this near fatal event, I was in the hospital for 8 day starting to recover from this very invasive emergency surgery. I was unable to work for nearly 4 months afterwards. This left me with over $30,000.00 in medical debt, not to mention the loss of income from not being able to work. This was absolutely devastating.

Currently my doctor wants to do more testing to confirm the diagnosis of MS, but alas I still don't have health insurance. If I do in fact have MS, the medication I would require would run around $2,500 per month. As it stands now, I can not afford health insurance as an individual because of pre-existing conditions, however if I was able to get insurance through an organization I might be able to get a policy that would cover me.

United States Senate Committee on Finance Hearing
Small Business Health Insurance:
Building a Gateway to Coverage
October 25, 2007
Questions Submitted for the Record From Monty Newman

Questions From Senator Grassley

(1) Mr. Newman, the idea of a health information exchange or "gateway" is being floated by a number of states. Massachusetts so far is the most advanced in its planning and its "connector" is pretty involved. The "gateway" – which would be similar to the Massachusetts Connector – could present all the insurance options in the state to individuals and give them an easy way to compare options. Of course, it would have to be set up so that you could not get cheaper coverage outside the gateway. Otherwise it would be gamed. Do you think your members and their agents would find such a tool useful?

NAR's members and other self-employed individuals would benefit from having access to a centralized repository of information on all insurance options available in a given insurance market. Today, individuals can spend a significant amount of time and effort searching for a policy and still not find one that suits their needs, even if one is available.

If such a gateway were to be successful, however, it would be important that the number of insurance products or participating insurers not be limited. The individual market has been hampered in most states by a lack of sufficient competition among producers that has helped to keep premium prices higher than might otherwise be the case.

We also believe that, while a state-based system might be successful in some limited situations, it is clear that the problems faced by our members in the individual market will likely require the creation of a national risk pool. Small business pooling arrangements have been tried in many states. Even in one of the nation's largest states – California – these efforts have been unsuccessful. Given the relatively small number of individuals insured nationwide in the individual market, it is unlikely that a state-based, small business insurance gateway program would be successful.

We also believe that it would be important that any information that is made available be presented in a manner that makes sorting through information on the database convenient, easy and quick. The information management technology available today – searchable databases, decision-making software, and Internet-based systems – should be put to good use. In an ideal world, a small business owner should be able to submit information describing their firm, its location, its workforce, its health service needs and the resources available to purchase health

coverage and receive a list of the policies that are available, provide the type of coverage desired as well as those available at a range of different price points.

(2) Mr. Newman, your members have varied experience in finding health insurance coverage. In some states, they are considered a one-person group and so qualify for small-group coverage, while in others they are considered individuals and must buy health insurance subject to underwriting with no rate restrictions. Not counting making coverage more affordable, what are the three wishes you would have for your members in terms of making changes to the health insurance market?

In a perfect world, in addition to affordable coverage, the self-employed would have access to health insurance policies that are guaranteed issue, adjusted community rated and guaranteed renewal.

Questions From Senator Salazar

(1) As I hear the stories of my Colorado constituents, including the accounts in your testimony, I am astounded at the predicament faced by small business owners and employees. No American should feel so trapped by health care costs that they would consider refusing treatment for fear of paying for it. There is no question that we must find an affordable health care solution for small businesses, and integral to that task is making sure that whatever solution we devise is accessible and easy to maneuver. What should we be doing do to make sure that small business owners and employees are able to understand and navigate the results of our reform efforts?

First and foremost, any efforts to educate the self-employed, small business owners and their employees must begin well in advance of the implementation of any new program. Unlike larger firms, small businesses lack the human resources staff whose primary purpose is to stay on top of developments in the health or wider benefit areas. As a result, it will take more time for information to be widely disseminated or any necessary decisions and implementation steps to be taken than would be the case in a large firm.

In addition, a wide array of distribution methods should be used to disseminate program information. I believe that the most effective method for reaching the small business community is the professional and trade organizations that serve these small businesses. Associations like the National Association of REALTORS® make it their business to communicate on a very regular basis with their memberships; they know best how to get their members' attention. Members, in turn, regularly turn to their associations' conventions, meetings, publication, member benefit programs and staffs for information. Given the active role that most small business owners and the self-employed play in their communities, it would also seem wise to make use of service organizations, community groups,

churches, etc. as a means to communicate with their active small business participants.

Finally, it is important that the information be made available in a manner that makes sorting through information on any new coverage options convenient, easy and quick. We would hope that technology available today – searchable databases, decision-making software, and the Internet – would be put to good use. In an ideal world, small business owners would be able to submit information on their firm, its location, its workforce, their health service needs and the resources available to purchase health coverage and receive a set of policy options that are available, provide an array of coverage levels and/or are available at a range of different prices.

(2) Both your testimony and the testimony of Mr. Ario talk about engaging in a process that would provide guidelines for essential health care coverage and distinguish among different categories of services. As you mentioned, we must be very careful to do this in a manner that does not restrict access to necessary services. If we begin the process to develop these benefit basics, how do we ensure that small business owners will view this type of essential coverage plan as an adequate option?

As I stated in my testimony, we believe that it possible to develop a set of guidelines that would define what elements are essential for a quality insurance product. We envision these guidelines to define a benefit "baseline" necessary to promote health and prevent illness. Insurers would be able, and we would expect that most policies would, exceed this baseline. In order for there to be confidence in any core set defined by such an effort, it is essential that the "stakeholders" involved in that process include those that have (1) the expert knowledge necessary to evaluate current coverage mandates in terms of their proven efficacy, cost effectiveness and preventative value as opposed to their emotional or political value, i.e. medical professionals, health economists, etc. (2) those who understand the challenges involved in designing and implementing and managing a viable insurance program, i.e. insurance experts, actuaries, etc. and (3) a working knowledge of the challenges that small employers and self-employed individuals face.

Small business owners and the self-employed aren't typically medical experts. They do know what range of benefits are commonly available to large group participants and what services they, their employees, relatives and acquaintances have needed. They also know how to evaluate situations and products. If presented with a baseline set of benefits that can be justified in terms of the research which documents their efficacy, are backed by an impartial set of medical experts and are the result of a transparent process that involved credible representatives of the small business community, I believe that adequacy will not be an issue.

Statement of Senator Ken Salazar
Finance Committee Hearing
"Small Business Health Insurance: Building a Gateway to Coverage"
October 25, 2007

Thank you, Chairman Baucus and Senator Grassley, for holding this morning's hearing. Thank you also to our witnesses for being here to offer their perspectives on how we can effectively address the barriers that small business owners, employees of small businesses, and self-employed individuals face when it comes to providing and obtaining health care coverage.

This is an extremely important issue for me and for my state of Colorado, and I am glad to have the opportunity to explore the legislative options available to us as we work to make health care coverage more affordable and available to more Americans.

Small businesses and their employees play a vital role both in our economy and in our communities. On top of the fact that small businesses make up the vast majority of our nation's businesses and were responsible for creating almost 80% of new U.S. jobs over the past decade, employees of small businesses work hard, support families, and provide valuable services to their communities.

In Colorado, there are more than 482,000 small businesses. Of the nearly 150,000 businesses in the state that employ workers, over 97% are small businesses, and over 75% have fewer than 50 employees.

Yet, all too often, it is these individuals who go without health insurance. The high cost of providing coverage prohibits many small business owners from being able to provide health benefits to their employees, and individuals seeking to secure coverage on their own do not receive the same tax breaks available to workers covered under employer-provided plans.

In Colorado, nearly two-thirds of uninsured adults work for businesses with 100 employees or less, and employees in small and mid-sized firms are nearly twice as likely to be uninsured as those who worked for large employers.

This Committee and this Congress has a number of options to consider in an effort to address this problem: establishing meaningful tax credits for small businesses and individuals wishing to acquire health insurance; creating low-cost, high-coverage, and more portable health care policies; and considering the benefits of multi-state pooling arrangements are all on the table.

But whatever we choose to do, we need to act now.

In addition to providing more Americans with the health insurance they need today, I believe making health care coverage more accessible to small business employees will have far-reaching positive effects. Insured individuals are more likely to seek out preventative care, which in turn creates a healthier and more productive workforce. Additionally, reducing the number of individuals who rely on local emergency rooms as their main source of care reduces the cost of health care for the entire nation.

With those goals in mind, I look forward to hearing the viewpoints of my colleagues and our witnesses as we discuss how to best address this important matter.

Thank you.

Statement of Senator Olympia J. Snowe
Small Business Health Insurance:
Building a Gateway to Coverage
Senate Finance Committee
October 25, 2007

Thank you, Chairman Baucus, for holding this hearing on the small business health insurance crisis and for your steadfast leadership and stalwart commitment on this issue. I also couldn't be more grateful to Ranking Member Grassley for his stewardship in navigating us through the complex machinations that are part and parcel of this matter which is so central to countless American small business-owners. And for their crucial bipartisan contributions, Senators Lincoln, Kerry, Enzi, and Durbin and a host of others, are deeply appreciated as they remain dedicated to forging a viable solution to this on-going challenge.

Obviously, our first priority continues to be reauthorizing the S-CHIP program, which has proven to be both a successful program and a saving grace for millions of American families who otherwise simply could not afford to pay for their children's health care. The stakes could not be higher on such a monumental issue – the quality of health care one receives as a child can have dramatic implications on the rest of their life. S-CHIP has been the most significant achievement of the Congress over the past decade in legislative efforts to assure access to affordable health coverage to every American and its reauthorization should be our top domestic priority.

Just as this Committee came together on the S-CHIP issue and developed a bipartisan proposal that received 67 votes in this body, we should come together, reach across the partisan divide, to fashion a solution to the small business health insurance crisis. As Ranking Member of the Small Business and Entrepreneurship Committee, I can attest to the fact that access to affordable health insurance is the single greatest point of concern for small businesses in Maine and across the country.

In our leadership roles on the Small Business Committee, Senator Kerry and I have held numerous hearings on this issue over the past few years – including one in February of this year. Just yesterday, Senator Kerry and I delivered to you, Chairman Baucus and Ranking Member Grassley, a letter outlining key principles for moving forward on a proposal in this Committee. So let me just underscore that we're at a pivotal juncture when it comes to tackling this health care morass.

I want to stress that we should leave no stoned unturned in comprehensively confronting this issue. To that end, I am encouraged by the constructive and bipartisan dialogue that has transpired in recent months that reflects an emerging consensus. In order

to jumpstart this process, it's absolutely imperative that we resolve the lingering, persistent criticisms that have for too long mired small business health insurance legislation in Congress.

We should also probe the mechanics of how a tax credit for small businesses, their employees, and self-employed sole proprietors, could best assist with expanding coverage and reducing the ranks of the uninsured.

This morning, I look forward to hearing the expert testimony from this witness panel on how we can specifically enact the reforms that are required going forward.

Small businesses are the vital catalysts – the robust engines that drive America's economy and create nearly 75 percent of all new jobs each year. But at a time when health insurance premiums nationally have increased at double-digit percentage levels in four of the past six years – far outpacing inflation and wage gains – when sharply rising costs are leading fewer and fewer small businesses to offer health insurance to their employees and when studies such as one from the Kaiser Family Foundation conclude that just 45 percent of our smallest businesses are now able to offer health insurance as a workplace benefit – over a ten percentage point reduction over the past five years, can there really be any doubt whatsoever that we are undeniably heading in the wrong direction – and must reverse course now!

Further compounding the situation is the reality that small group insurance markets like the one in my state of Maine have no real competition. No competition means higher costs. And higher costs mean no health insurance. In Maine, only four insurers, controlling 98 percent of the market, are writing new policies in the small group market. On October 1st, new rates for health insurance plans in Maine went into effect with annual premiums for the most heavily subscribed plans now standing at a staggering $4,868 for an individual policy and $14,605 for a family plan. If nothing else, these sky-rocketing costs ought to sound a clarion call that the system is broken and it must be fixed!

This message, Mr. Chairman, is one I've stated time and again The status quo is unacceptable as we face a daunting challenge that is nothing short of a crisis – and yet, it's one that can be fixed, now. In the U.S. Senate, I have been a longstanding champion of Small Business Health Plans, which can be a integral part of that solution. I have introduced legislation in the past two Congresses that would allow small businesses to "pool" together, across state lines, and would offer uniform health insurance plans to their employees, at significantly lower costs. I firmly believe that Small Business Health Plans is a key solution to this crisis.

1. Additionally, I have introduced, with Senators Bond and Bingaman, legislation to enable more small business owners to offer a choice of a "cafeteria plan" that allow

employees to purchase health benefits with tax-free dollars. Our bill would simplify complex rules and provide more small businesses greater flexibility to meet the health care necessities of their employees.

In conclusion, the U.S. Congress must forge the political will to take action to provide relief from skyrocketing health insurance premiums, cover America's nearly 47 million uninsured, and increase access for small businesses to affordable health insurance.

Thank you, Mr. Chairman.

COMMUNICATIONS

FOR THE RECORD

Statement
on
"Small Business Health Insurance: Building a Gateway to Coverage"

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, DC 20004

Submitted to the
U.S. Senate Committee on Finance

October 25, 2007

I. Introduction

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

AHIP's members share the committee's strong interest in improving health care choices for small businesses and bringing costs under control for all Americans. We look forward to working with you to identify workable strategies to achieve these goals.

Our statement will focus on four areas:

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

II. Overview of Small Group Market and Health Care Spending

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

The Current State of the Small Group Health Insurance Market

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

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

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

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

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

Among small group enrollees, 57 percent had PPO coverage last year and 39 percent had HMO coverage, often with a point-of service (POS) option. Approximately 4 percent of enrollees were covered under HDHP/HSA plans, which are proving to be a valuable option for many individuals who previously were uninsured.

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

Factors Contributing to Rising Health Care Costs

A second report analyzed in greater detail the improving outlook for growth in health care costs, as noted in recent years by the Centers for Medicare & Medicaid Services (CMS) and private researchers. Specifically, the causes of rising health care costs and how health insurance premium dollars are being spent are examined by a report[2] AHIP released in January 2006. This report, prepared by PricewaterhouseCoopers, indicates that health insurance premiums are growing at a reduced rate, despite increased utilization and higher costs, while health insurance plans' tools and techniques are easing increases in drug costs.

Focusing on the 8.8 percent premium increase that was measured between 2004 and 2005, the report found that 43 percent of this increase could be attributed to higher utilization of services. The trend toward increased utilization was fueled by factors such as increased consumer demand, new and more intensive medical treatments, defensive medicine, the aging of the U.S. population, and unhealthy lifestyles. The report also concluded that price increases exceeding the rate of general inflation accounted for 30 percent of the premium increase and were impacted by consolidation among hospitals and other providers, increased costs of labor, and higher priced technologies.

Other findings show that 86 cents out of every premium dollar goes directly toward paying for medical services. Embedded within the 86 cents are the costs of medical liability and defensive medicine, which are estimated to be 10 cents of the premium dollar. Of the remaining premium dollar, five cents goes to consumer services such as prevention, disease management, care coordination, investments in health information technologies and health support, provider support, and marketing. Six cents goes to costs associated with government payments, regulation and claims processing, and other administration. Health insurance plan profits comprise three cents of the premium dollar.

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

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[2] PricewaterhouseCoopers, *The Factors Fueling Rising Healthcare Costs 2006*, January 2006

III. Private Sector Cost Containment and Quality Improvement Initiatives

Health insurance plans have been working aggressively to improve quality and control costs, while also meeting consumer demands for choice, through a variety of innovative strategies and initiatives. These efforts are making a difference, as evidenced by CMS data that was discussed in a February 2007[3] article published by *Health Affairs*. This article, authored by a team of CMS economists and actuaries, reports that national spending on private health insurance premiums increased by a projected 4.8 percent in 2006 – marking the fourth consecutive year in which premium growth decelerated – and that overall national health care spending slowed to a projected increase of 6.8 percent in 2006 (also the fourth consecutive year of declining growth).

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

Pharmacy Benefit Management

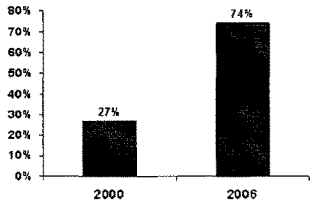
Health insurance plans use a wide range of pharmacy benefit management tools and techniques to reduce out-of-pocket costs for members and improve quality by reducing medication errors. These tools and techniques include:

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

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

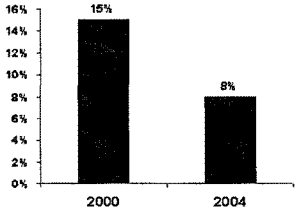
Prescription Drug Tiers Are An Effective Strategy in Controlling Health Care Costs

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



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

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



Prescription Drug Trends, June 2006. The Kaiser Family Foundation

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

The application of these tools and techniques in the Medicare Part D prescription drug program also has highlighted their effectiveness. According to CMS[4], beneficiaries who previously did not have drug coverage are saving an average of $1,200 annually by enrolling in Part D plans. The value offered by Part D plans also can be seen in the lower-than-expected premiums that beneficiaries are paying. CMS has reported[5] that the average Part D premium paid by beneficiaries in 2008 will be approximately $25 per month. This is roughly 40 percent less than the original estimate of $41 per month for 2008.

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

[4] CMS, *Part D Medicare Prescription Drug Benefit Fact Sheet,* January 2007
[5] CMS, *Medicare Part D Plan Premiums for 2008 Show Continued Impact of Strong Competition*, August 13, 2007
[6] *Health Affairs*, National Health Spending in 2005: The Slowdown Continues, January/February 2007

authors suggest that "the proliferation of tiered-copayment benefit plans" has been a key factor in the slowdown in prescription drug spending in recent years.

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

AHIP's members also are taking steps to improve patient safety and reduce the risk of medication errors. Health insurance plans have created pharmacy information systems which, as a matter of standard practice, alert pharmacists when the combination of two or more of a patient's medications could lead to an adverse drug reaction. Software that plans use in their pharmacy networks is programmed to identify hundreds of potentially harmful drug interactions, including those that could occur due to the patient's age or gender. When the system recognizes a dangerous combination of drugs or contraindications, an on-screen alert is sent to the pharmacist who can then call the patient's doctor to find a safer alternative.

Evidence-Based Medicine

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

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

[7] "To Err is Human," Institute of Medicine, 1999
[8] "The Quality of Health Care Delivered to Adults in the United States.," Elizabeth A. McGlynn, RAND, June 25, 2003

conducted by RAND, found that patients received only 55 percent of recommended care for their medical conditions.

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

The Dartmouth Atlas of Health Care[9] documents wide variation in the use of diagnostic and surgical procedures for patients with coronary artery disease, prostate cancer, breast cancer, diabetes, and back pain. For example, the rates of coronary artery bypass graft surgery were found to vary from a low of 2.1 per 1,000 persons in the Grand Junction, Colorado hospital referral area, to a high of 8.5 per 1,000 persons in the Joliet, Illinois region. The *Atlas*' findings[10] reveal wide variation in hospital care and outcomes for chronically ill Medicare patients. For example, the length of hospital stays varied – depending on a patient's geographic location – by a ratio of 2.7 to 1 for cancer patients and by a ratio of 3.6 to 1 for congestive heart failure patients.

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

To further advance the adoption of evidence-based medicine, we strongly support federal funding for comparative clinical effective research. Research that compares the relative effectiveness of existing versus new medical therapies that are designed to treat the same condition will yield valuable information for ensuring that patients consistently receive

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[9] Center for the Evaluative Clinical Sciences, Dartmouth Medical School, *The Dartmouth Atlas of Health Care*, "The Quality of Medical Care in the United States: A Report on the Medicare Program," 1999

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

treatments based on more definitive evidence and for learning how certain drugs and devices work for various populations.

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

Disease/Care Management

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

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

Transparency

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

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

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

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

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

Value-Based Purchasing

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

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

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

Health Information Technology

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

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

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

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

Generic Biopharmaceuticals

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

We applaud Senators Schumer and Hatch for sponsoring bipartisan legislation (S. 1695) that would accelerate approval by the Food and Drug Administration (FDA) of generic versions of life-saving biological products. For millions of health care consumers, this legislation offers the hope of significant cost savings and greater access to advances in biotechnology.

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

We appreciate the need for decisive action to help small employers. In fact, failing to take any action at all would be the most expensive outcome for the entire health care system – including small businesses – due to the cost shifting that is associated with uncompensated care for the uninsured. Therefore, as the committee considers legislative options to address the concerns of small employers, we would like to offer a number of promising solutions to address this priority while also addressing the broader issue of the uninsured and related challenges.

AHIP's members have approached this debate with a belief that the issues of access, quality, and affordability are interconnected and should be dealt with simultaneously. Accordingly, we have released comprehensive proposals outlining strategies for expanding access to coverage and improving health care quality and safety, and we are preparing to release a third set of proposals for making health care more affordable.

AHIP's Access Proposal

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

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

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

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

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

AHIP envisions that these initiatives – along with our proposals to improve SCHIP and Medicaid – would expand access to health insurance coverage to all children within three years and 95

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

percent of adults within 10 years. AHIP's members are working aggressively to build support for these proposals. At the same time, AHIP is an active member of the Health Coverage Coalition for the Uninsured (HCCU), which also is calling for broad reforms to expand health coverage to the uninsured. Through the HCCU, we have been working closely with a diverse coalition that includes Families USA, the Chamber of Commerce, AARP, the American Medical Association, the American Hospital Association, and other national organizations.

AHIP's Quality-Safety Proposal

In April 2007, AHIP announced a comprehensive proposal[13] to improve quality and safety throughout the U.S. health care system.

Our comprehensive quality-safety proposal includes a series of initiatives aimed at achieving three broad, interlocking goals: (1) supporting innovation by determining which procedures and technologies are most effective and safe; (2) enhancing clinical quality by improving the dissemination and transparency of information on safety, effectiveness, and performance; and (3) better protecting patients by creating new mechanisms to resolve disputes promptly, fairly, and effectively.

Specifically, these initiatives call for action in the following areas:

- establishing a new national entity – a Comparative Effectiveness Board – to evaluate and compare the safety, efficacy and cost effectiveness of new and existing health care treatments and technologies;

- reforming the FDA to improve its ability to assess the long-term safety and effectiveness of newly-approved drugs and devices;

- setting a national research agenda that addresses known gaps in evidence and makes communication regarding ongoing research studies a national priority;

- accelerating efforts to give patients and their physicians the information they need to make value-based health care decisions;

- emphasizing the adoption of best practices;

[13] "Setting a Higher Bar," AHIP, April 2007

- developing innovative tools to help physicians and patients manage chronic conditions; and

- creating a new, nationwide medical dispute resolution system that focuses on protecting patients and eliminating the runaway costs and risks of defensive medicine, suppression of information about medical errors, and litigation.

These proposals reflect our belief that a comprehensive strategy is needed to achieve significant improvements in the quality and safety of health care. By addressing this entire range of issues with a coordinated approach, we can advance a health care system that delivers consistently higher quality care, suffers from far fewer medical errors, promotes clinical practices based on sound evidence, and makes optimal use of health care resources.

Regulatory Reforms

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

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

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

- **Establish an independent advisory commission to evaluate the impact of mandates on health care costs and quality.** Such a commission could advise policymakers on the safety

and effectiveness of proposed and existing mandated health benefits, and assess whether proposed mandates result in improved care and value. The commission's findings also could inform public program coverage and decision-making to ensure that evidence-based standards are applied consistently in Medicare, Medicaid, and other public programs.

Funding for State High-Risk Pools

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

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

V. Our Perspectives on Legislative Proposals in Congress

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

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

Recognizing that the SEHBP bill is innovative in its use of tax credits, rating flexibility, and financial incentives, we believe this legislation is a worthwhile contribution to the congressional

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

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

Association Health Plans

Recognizing that AHPs have been an important part of this debate over the past ten years, we want to take this opportunity to discuss our concerns about legislative proposals that would establish special rules and exemptions for national and regional AHPs. We believe such proposals would lead to higher health care costs and more uninsured Americans.

In order to fully understand the implications of the AHP legislation, it is important to focus on the fact that most states have adopted some variation of the model the National Association of Insurance Commissioners (NAIC) adopted in 1991 for regulating rates in the small group market. This model limits rate variations – to no more than 25 percent above or below the average rate – for similar employer groups based on claims experience or health status. Moreover, this model limits annual rate increases for any one group to 15 percent on top of the rate increase applied to all groups.

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

While low rates initially may seem attractive to small businesses with a healthy workforce, if one of their workers developed a significant illness, they would face a rate hike from the AHP the

following year. Ultimately, the result would be a market in which a shrinking portion of healthy businesses would be covered by the AHP while businesses whose workers have significant health needs would be driven out of the AHP.

These concerns are reinforced by the Congressional Budget Office (CBO), which has reported [14] that AHPs would make health insurance less affordable for the vast majority of small businesses. According to CBO's analysis, 82 percent of small business employees would pay higher premiums under AHPs. This should be a major concern for all committee members.

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

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

Small Business Health Plans

In recent years, there has been an effort in the Senate to develop legislation authorizing Small Business Health Plans (SBHPs). This legislation, introduced as S. 1955 in the 109th Congress, focused on three key areas: (1) rating requirements for the small group market; (2) low cost plans/mandate relief for the group and individual markets; and (3) harmonization of process standards in the group and individual markets.

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

- **Mandate Relief:** The bill's proposal for a "Benefit Choice Standard" would allow SBHPs to offer a lower cost plan option that is not required to comply with state benefit, service, or provider mandates as long as a comprehensive plan option is also made available. We are

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

concerned that this approach would create an environment that would promote adverse selection among groups. Groups that do not envision requiring costly health care services would be likely to opt for the lower cost plan, while groups expecting high health care utilization would be inclined to select the comprehensive option. This outcome would almost certainly drive up premiums for the more comprehensive plan, ultimately pricing many small employers out of the market. Additionally, the bill would provide preferential rules for SBHPs, allowing them to offer lower cost plans three months earlier than other entities providing coverage to small employers within a state. We believe the timeframe for offering such plans should be consistent across the board for all entities, to ensure that there will be vigorous competition in creating high quality, affordable options for small employers.

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

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

Language in SCHIP Reauthorization Bill

Finally, we appreciate a provision that was included in the SCHIP reauthorization bill, H.R. 976, expressing the "sense of the Senate" regarding the need for legislative action this year to improve access to affordable health insurance coverage for employees of small businesses. It is very significant that this provision recognizes "the value of building upon the existing private health insurance market" and suggests that such legislation should include financial assistance and tax incentives for the purchase of private insurance coverage. While we recognize that this provision is nonbinding, we believe it sends a clear signal about the Senate's commitment to addressing this priority with thoughtful, balanced solutions.

VI. Conclusion

Looking forward, AHIP and our member companies stand ready to work with committee members to develop legislative solutions for meeting the health care needs of small employers and their workers. We appreciate the committee's leadership on this critically important issue.

Statement of
Mary R. Grealy
President, Healthcare Leadership Council

Small Business Health Insurance: Building a Gateway to Coverage
Hearing of the
U.S. Senate Finance Committee

October 25, 2007

The Healthcare Leadership Council, a coalition of the nation's leading health care institutions and organizations, applaud your efforts aimed at increasing coverage options for small business owners and their employees.

The information age and the rapid introduction of innovative health therapies are markedly changing America's health care. Increasingly, the prevention and control of disease are greatly enhancing the lives of those who have access to comprehensive health services and technologies. But, for those who are without health care coverage, this new age of medicine is not an everyday reality. As innovators with first-hand knowledge of our health system's tremendous potential, members of the Healthcare Leadership Council are keenly aware of what the nation's uninsured are missing, and the consequences they are experiencing as a result.

The Healthcare Leadership Council has had as its top priority issue, since 2001, increasing access to and affordability of health coverage. As we all know, a majority of the working uninsured are employed by small businesses, and, therefore, we have focused much of our work in addressing the challenges small businesses face in obtaining health coverage.

More than five years ago the Healthcare Leadership Council commissioned research and studies to determine the composition of the uninsured. We also conducted a poll of small business owners that found that a significant number of small business owners who weren't currently offering health coverage to their employees, had a desire to do so.

The Robert Wood Johnson Foundation awarded a grant to HLC to conduct a pilot program aimed at helping increase health insurance participation among America's small businesses. This grant helped fund a 12-month pilot program, HLC's *Main Street Initiative*, that studied the linkages between the availability of information on health insurance plans and the likelihood of small business owners to make coverage available to their employees.

While the primary barrier to health insurance for small businesses is cost, numerous studies from our literature search showed that many small employers aren't aware of the true cost and availability of health insurance plans in their area. Many overestimate the cost of health insurance and may be unaware that employer paid premiums are a tax deductible business

expense. Also, we found that programs that only offer subsidies without outreach to small businesses frequently are less effective than programs that provide education and outreach.

The pilot program helped determine effective methods of providing targeted, locally tailored information to small businesses about locally available health insurance options, the business case for providing health insurance, and other information including tax treatment and consumer protection mechanisms. At the end of the pilot period we found that small business owners who participated in an educational program (as short as ten minutes) and received information increased by about one-third both their knowledge about health insurance and "the business case" for it, and their interest in offering health insurance to their employees.

The pilot results were used to develop a model curriculum for other communities through the Robert Wood Johnson Foundation's Cover the Uninsured Week, as well as a website, materials and outreach for the Virginia Department of Health Office of Health Policy and Planning.

Building upon this experience, the Healthcare Leadership Council developed a website and materials aimed at college students nearing graduation to emphasize the importance of having health coverage. With student input, the website and materials attempted to address common misconceptions about health insurance from the young and healthy, another growing segment of the uninsured population.

These efforts were combined last year into HLC's *Health Access America* campaign to investigate ways to reduce the uninsured population using existing resources, and to emphasize the importance of linking people with information about health coverage. Working in nine communities around the country - Cleveland, OH; Corpus Christi, TX; Las Vegas, NV; Saginaw, MI; Columbia, SC; Nashville, TN; Baton Rouge, LA; Raleigh, NC; and Las Cruces, NM – *Health Access America* strives to enroll people in health coverage, whether public or private. The results have been striking:

- Recruited more than 500 national and local partner organizations
- Conducted more than 1,000 education and enrollment events
- Educated over 33,000 individuals
- Enrolled 16,000 individuals in public and private coverage
- Distributed more than 18,000 pieces of educational materials

Health Access America focused on four key cohorts of the uninsured, one of which was the small business community. More than 358 events were held focused on small business owners and their employees.

As part of the *Health Access America* effort HLC commissioned a study by The Schapiro Group to determine the types of outreach tactics that would be most effective in driving people to get health coverage. One of the most striking outcomes of this research was the discovery concerning how many people, including small business owners, have no idea where to go for information about health coverage. This public opinion survey work underscored the importance of accessible, reliable information about health insurance.

HLC plans to develop a template and policy recommendations based upon our on-the-ground experiences with the *Health Access America* enrollment campaign that can be shared with policy

makers and thought leaders as legislation is developed. For example, HLC found that in areas where a small subsidy to purchase coverage was offered, like in New Mexico, increased the interest and ability of small business owners to offer coverage.

Finally, the Healthcare Leadership Council launched its *Honor Roll for Coverage* campaign in 2001 to recognize local and state initiatives that aim to increase coverage, particularly for small businesses. To date, ten awards have been given. All of the lessons learned from these initiatives have been compiled and applied to HLC's policy recommendations and continued efforts to help small business owners and their employees obtain health coverage.

From launching its uninsured initiative in July 2001 to receiving the Robert Wood Johnson Foundation award grant, and various activities in between, HLC has stood steadfastly by its goal of reducing the number of uninsured Americans. HLC looks forward to working with the Senate Finance Committee and sharing our experiences as you work to expand health insurance coverage for small business owners and their employees.

Senate Committee on Finance
"Small Business Health Insurance: Building a Gateway to Coverage"
October 25, 2007

Statement for the Record by Joseph M. Stanton,
Senior Staff Vice President for Government Affairs
National Association of Home Builders
1201 15th Street NW
Washington, DC 20005

On behalf of the over 235,000 members of the National Association of Home Builders (NAHB), I thank you for the opportunity to submit this statement for the record in support of Association Health Plans (AHPs).

NAHB's 235,000 members employ more than 8 million workers nationwide. The vast majority of NAHB members are small businesses that employ 10 or fewer employees. NAHB members are involved in home building, remodeling, multifamily construction, property management, subcontracting, design, housing finance, building product manufacturing and other aspects of residential and light commercial construction. Known as "the voice of the housing industry," NAHB is affiliated with more than 800 state and local home builder associations around the country.

Day in and day out, the one issue we hear constantly from our members is the rapidly rising cost of health insurance and the increasing frequency of members losing access to coverage because their local small group market provider will no longer cover their small business. Although many building firms offer some sort of health insurance to their employees, these employers are finding it increasingly difficult to provide coverage at an affordable price, and ultimately, this additional cost is passed on to the housing consumer.

Health insurance coverage for employees is very important to NAHB's members. In our extremely competitive industry, which has suffered labor shortages for some time, the ability of a builder to recruit, train, and retain high-quality, hard-working employees is essential to the builder's ability to meet contractual commitments and have a solid team of reliable employees. As it becomes more and more difficult for builders to offer benefit packages that include stable, affordable health care plans, employees are more likely to leave smaller builders for positions with other companies that are able to provide a consistent benefit package. For many of our members, providing health insurance is a necessity benefit to retain their best employees.

NAHB strongly feels that the health insurance market in the United States is severely broken when small businesses can no longer obtain coverage, or are forced out of coverage by yearly double-digit premium increases. The most recent U.S. Census Bureau estimate indicates that approximately 46 million Americans lack health insurance. As has been the case for over a decade, the Census Bureau continues to believe that approximately 60 percent of the uninsured are employees of small businesses and their dependents. Small-business owners struggle with annual double-digit insurance premium increases that make providing and maintaining coverage

progressively difficult. Some estimates indicate that insurance premiums for small groups or single coverage have increased by more than 82 percent since 2000. As the ranks of the uninsured continue to increase dramatically, small businesses and their employees continue to bear the brunt of the costs, yet Congress has not addressed the problem.

NAHB's members strongly support association health plans, not because we believe AHPs will resolve the crisis of the uninsured in its entirety, but because we believe allowing AHPs to enter the small group marketplace at a level playing field will inject much-needed competition into the health insurance system. Today, small businesses, such as our members, have very few choices for health insurance coverage—and many have none at all. Strong health insurance monopolies in most states dictate coverage to our members, who do not have the necessary size or economy of scale to shop around for insurance.

NAHB believes that bona fide associations are well-positioned to negotiate on behalf of their members for stable, affordable, and high quality health insurance. Allowing association members to band together across state lines will provide them with the economies of scale necessary to obtain reasonably priced coverage.

NAHB believes that association health plans will offer millions of American small businesses the opportunity to obtain stable, affordable coverage. We believe that these types of plans—which level the playing field for small businesses—merit serious consideration and enactment by the U.S. Congress. Each year, a handful of insurers maintain their own segmented marketplace monopolies, while millions of Americans lose coverage or face premium increases so high that they must reduce the scope of their coverage in order to hold on to even basic protections. Congress has an obligation to enact legislation to allow small businesses the same opportunity and access to health care that large corporations and labor unions now enjoy.

Thank you for allowing the National Association of Home Builders this opportunity to share our opinion on association health plans. We look forward to continuing to work with the committee to bring common sense reform to health insurance, and give small businesses equal footing to obtain stable, affordable and quality health insurance coverage.

Written Testimony from

THE NATIONAL SMALL BUSINESS ASSOCIATION

For the hearing

"Small Business Health Insurance: Building a Gateway to Coverage"

Before the Senate Finance Committee

October 25, 2007

Small businesses are being pummeled by the increasing cost of health care. The small-business owners who make up the National Small Business Association repeatedly rank health care among their top concerns. NSBA is the nation's oldest nonpartisan small business advocacy group reaching more than 150,000 small businesses nation-wide. The Senate Finance Committee surely must hear on a daily basis that something must be done.

In April of 2007, NSBA conducted a nation-wide survey of small businesses and found some startling facts regarding health care. Only 41 percent of respondents—nearly 90 percent of whom employ less than 19 workers—offer their employees health insurance, down 10 percent from 2000. Despite the low-rate of offering health insurance, 77 percent of respondents rated health insurance as the top benefit they WANT to offer. Furthermore, the Kaiser Family Foundation estimates that 60 percent of small businesses shop for a new health insurance plan every year, but of those, less than half actually make any changes. These statistics tell us one very important, and far too bleak fact: small businesses have very few viable options.

While the need for reform is clearly urgent, and while there are a number of more short-term reforms that can improve on the system, what small businesses deserve is broad, comprehensive reform that will not only address the symptoms of a failing health care system, but cure the underlying illness plaguing the entire system.

The Realities of the Insurance Market

Implicit in the concept of insurance is that those who use it are subsidized by those who do not. In most arenas, voluntary insurance is most efficient since the actions of those outside the insurance pool do not directly affect those within it. If the home of someone without fire insurance burns down, those who are insured are not expected to finance a new house. But such is not the case in the health arena, where the costs of treating uninsured are split and shifted onto those with insurance in the form of increased costs. Moreover, individuals' ability to assess their own risk is somewhat unique regarding health insurance. People have a good sense of their own health, and healthier individuals are less likely to purchase insurance until they perceive they need it. As insurance becomes more expensive, this proclivity is further increased (which, of course, further decreases the likelihood of the healthy purchasing insurance).

Small businesses must function within the insurance markets created by their states. States have developed rules on rating and underwriting that attempt to establish the subsidies between the healthy and the sick. Most states require insurers operating in the small group market to take all comers and limit their ability to set rates based on health status and other factors. However, there is extensive variability among the states on these rules. Some states allow great latitude on rates, thereby limiting the cross-subsidies, but this makes insurance much more affordable for the relatively young and healthy. Other states severely limit rate variation, which often helps keep costs in check for many older, sicker workers, but drives up average premiums and puts insurance out of financial reach for many. These tight rating rules (known as "community rating" or "modified community rating") also can cause some insurers to leave certain markets they deem to be unprofitable. Problems in those states are then compounded by a lack of competitive pressures.

It is important to note the interplay between the small group and individual insurance markets, particularly in some states. In general, insurers in the individual market are not required to take all comers (at least not those not "continually insured") for all services and are allowed much greater discretion to underwrite and rate policies based on health history and a series of other factors. Individuals also can see their rates skyrocket if they get sick, usually to a much greater degree than in the small group market. In other words, there is far less of a cross subsidy in the individual market than the small group market. That means that relatively young and healthy individuals can get much cheaper insurance in the individual market (at least initially) than they can get through an employer—particularly in states that have

community rating in the small group market. In many of our smallest companies (under 10 employees but especially under five), it makes financial sense to increase wages to allow for the purchase of individual coverage. If the workforce becomes sicker, it may make sense to convert to the now-more-reasonably-priced small group market. This dynamic (and others) means that the "moribidity" of the under-ten market is much higher than the group market as a whole. Naturally, insurers often will seek ways to avoid serving an undue share of this market.

So long as we have in place a voluntary system of insurance, where individuals and businesses—at any given point in time—can choose whether or not to purchase insurance, this quest for the insurance rating "golden mean" will continue. While there has been endless debate about what the right set of rating rules should be, it is imperative that there be only one set of rules. Insurance markets where different players operate under different sets of rules are doomed to failure. Even in the interplay between the group and individual markets—which are different markets—we see the consequences of different rules. When two sets of rules operate within the same market, the self-interested gamesmanship that occurs among both insurers and consumers ultimately leads to dysfunction and paralysis.

Solution Principles

Any solution to the problem should abide by the following, most important principle - primum non nocere: first, do no harm. Often, legislation passed has hidden, unintended consequences that can create a larger problem than the bill initially sought to fix. Lawmakers must use a keen eye when considering any solution, no matter how incremental or sweeping, to ensure that the fix doesn't unearth an even bigger problem.

The second principle when discussing a health care fix for small business is to understand the real problems small businesses face. The biggest problem small businesses face is cost and competitiveness. Health insurance in the United States has transformed from a "fringe benefit" to a central component of compensation. The realities of the small group market make it much more difficult for a small firm to secure quality, affordable insurance than it is for a large business. The ebb and flow of workforce in a large company can be compensated for in their insurance pool simply due to the large number of workers. Whereas in a small business, that natural shift in workers can lead to extraordinary fluctuations in health premiums. Given these costs and general level of instability in the insurance market, the ability for a small business to effectively compete for good workers against large companies is exponentially more difficult.

There exists another competitiveness issue, and that is a global one. The U.S. boasts a unique entrepreneurial spirit and has been a leader in technological advances. A great deal of that innovation and creation comes from small businesses. According to the U.S. Small Business Administration's Office of Advocacy, small firms represented 40 percent of the highly-innovative firms in 2002, a 21 percent increase in just two years. Unfortunately, health insurance costs can serve as the deciding factor whether or not an individual will opt to continue with his or her business. A report released earlier this week by that same Office of Advocacy states that the presence of the health insurance deduction decreases the rate of exit from entrepreneurship for self-employed individuals by 10.8 percent for single filers, and 64.9 percent for married filers. What this tells us is that we are losing potential new advances and innovations due to the cost of health insurance, which holds serious implications to our overall global competitiveness.

The third principle is equity and common sense. While competitiveness does touch on fairness between large and small companies, equity in our mind is a different animal altogether. Any health care solution ought to provide the same benefits to a business owner as they do an employee. Tax benefits should be extended fairly to whichever party is paying for the health insurance, be it employers or individuals.

Continually providing tax benefits to companies and employment and not individuals perpetuates the current system where employers are practically forced into providing insurance to their employees.

NSBA's Comprehensive Solution

In attempting to create positive health care reform for small businesses, one quickly bumps up against the reality that small business problems cannot be solved in isolation from the rest of the system. Since small businesses purchase insurance as part of a larger pool with shared costs, the decisions of others directly affect what a small business must pay and the terms on which insurance is available to them. It has become clear to NSBA that—to bring meaningful affordability, access, and equity in health care to small businesses and their employees—a broad reform of the health care system is necessary. This reform must reduce health care costs while improving quality, bring about a fair sharing of health care costs, and focus on the empowerment and responsibility of individual health care consumers.

There is no hope of correcting these inequities until the U.S. has something close to universal participation of all individuals in some form of health care coverage. NSBA's plan for ensuring that all Americans have health coverage can be simply summarized: 1) require everyone to have coverage; 2) reform the insurance system so no one can be denied coverage and so costs are fairly spread; and 3) institute a system of subsidies, based upon family income, so that everyone can afford coverage.

Individual Responsibility
Small employers who purchase insurance face significantly higher premiums from at least two sources that have nothing to do with the underlying cost of health care. The first is the cost of "uncompensated care." These are the expenses health care providers incur for providing care to individuals without coverage; these costs get divided-up and passed on as increased costs to those who have insurance.

Second is the fact that millions of relatively healthy Americans choose not to purchase insurance (at least until they get older or sicker). Almost four million individuals aged 18-34 making more than $50,000 per year are uninsured. The absence of these relatively-healthy individuals from the insurance pool means that premiums are higher for the rest of the pool than they would be otherwise. Moving these two groups of individuals onto the insurance rolls would bring consequential premium reductions to current small business premiums.

Of course, the decision to require individuals to carry insurance coverage would mean that there must be some definition of the insurance package that would satisfy this requirement. Such a package must be truly basic. The required basic package should include only necessary benefits and should recognize the need for higher deductibles for those able to afford them. The shape of the package would help return a greater share of health insurance to its role as a financial backstop, rather than a reimbursement mechanism for all expenses. More robust consumer behavior will surely follow.

Incumbent on any requirement to obtain coverage is the need to ensure that appropriate coverage is available to all. A coverage requirement would make insurers less risk averse, making broader insurance reform possible. Insurance standards should limit the ability of insurance companies to charge radically different prices to different populations and should eliminate the ability of insurers to deny or price coverage based upon health conditions, in both the group and individual markets. Further, individuals and families would receive federal financial assistance for health premiums, based upon income. The subsidies would be borne by society-at-large, rather than in the arbitrary way that cost-shifting currently allocates these expenses for those without insurance.

Finally, it should be clear that coverage could come from any source. Employer-based insurance, individual insurance, or an existing public program all would be acceptable means of demonstrating

coverage. More and more health care policy leaders are realizing the need for universal coverage through individual responsibility and a requirement on each person to have health insurance. In testimony given to this very committee in March 2006, Former Treasury Secretary Paul O'Neill suggested such a requirement with financing mechanisms for low-income individuals.

Reshaping Incentives
There currently is an open-ended tax exclusion for employer-provided health coverage for both the employer and employee. This tax status has made health insurance preferable to other forms of compensation, leading many Americans to be "over-insured." This over-insurance leads to a lack of consumer behavior, increased utilization of the system, and significant increases in the aggregate cost of health care. Insurance now frequently covers (on a tax-free basis) non-medically necessary services, which would otherwise be highly responsive to market forces.

The health insurance tax exclusion also creates competitiveness concerns for small employers and their employees. Since larger firms have greater access to health insurance plans than their smaller counterparts, a greater share of their total employee compensation package is exempt from taxation. Further, more small-business employees are currently in the individual insurance market, where only those premiums that exceed 7.5 percent of income are deductible.

For these reasons, the individual tax exclusion for health insurance coverage should be limited to the value of the basic benefits package. But this exclusion (deduction) also should be extended to individuals purchasing insurance on their own. Moreover, the tax status of health insurance premiums and actual health care expenses should be comparable. These changes would bring equity to small employers and their employees, induce much greater consumer behavior, and reduce overall health care expenses.

Reducing Costs by Increasing Quality and Accountability
While the above steps alone would create a much more rational health insurance system, a more fair financing structure, and clear incentives for consumer-based accountability, more must be done to rein-in the greatest drivers of unnecessary health care costs: waste and inefficiency. Increased consumer behavior can help reduce utilization at the front end, but most health care costs are eaten up in hospitals and by chronic conditions whose individual costs far exceed any normal deductible level.

There is an enormous array of financial pressures and incentives that act upon the health-care provider community. Too often, the incentive for keeping patients healthy is not one of them. Our medical malpractice system is at least partly to blame. While some believe these laws improve health care quality by severely punishing those who make mistakes that harm patients, the reality is that they too often lead to those mistakes—and much more—being hidden.

Is it any wonder that it is practically impossible to obtain useful data on which to make a provider decision? Which physician has the best success-rates for angioplasty procedures? Which hospital has the lowest rate of staph infections? We just don't know, and that lack of knowledge makes consumer-directed improvements in health care quality almost impossible to achieve.

Health care quality is enormously important, not only for its own sake, but because lack of quality adds billions to our annual health care costs. Medical errors, hospital-acquired infections, and other forms of waste and inefficiency cause additional hospital re-admissions, longer recovery times, missed work and compensation, and even death.

In O'Neill's testimony in March 2006, he cites this as a major cost-driver in the health care market, estimating a 30 to 50 percent decrease in costs if health care providers performed at the top, theoretical limits. Pointing to a pilot project based at Allegheny General Hospital in Pittsburgh, O'Neill highlighted a

95-percent reduction in a targeted area of infection prevention in less than 90 days, and cited $2 million in savings in the two-and-one-half year period since the project began.

What financial pressures are we bringing to bear on the provider community to improve quality and reduce waste? Almost none. In fact, we may be doing the opposite, since providers make yet more money from re-admissions and longer-term treatments. It is imperative to reduce costs through improved health care quality. Rather than continuing to pay billions for care that actually hurts people and leads to more costs, we should pay more for quality care and less (or nothing) when egregious mistakes occur.

Improved Consumerism:
Pay-for-Performance must be a policy goal for all providers. Insurers should reimburse providers based upon actual health outcomes and standards, rather than procedures. In some pilots, the Centers for Medicare and Medicaid Systems (CMS) already have begun this process. Evidence-based indicators and protocols should be developed to help insurers, employers, and individuals hold providers accountable. These protocols—if followed—also could provide a level of provider defense against malpractice claims.

Enhancing the use of electronic medical records and procedures should be a priority. From digital prescription writing to individual electronic medical records to universal physician identifications, technology can reduce unnecessary procedures, reduce medical errors, increase efficiency, and improve the quality of care. This data also can form the basis for publicly available health information about each health care provider so patients can make informed choices.

NSBA's policy is broad, but clearly not undoable. Five years ago the concept of requiring individuals to carry insurance was a non-starter, but that is no longer the case. With the Massachusetts legislature passing broad reform legislation that incorporates some of NSBA's key proposals, and California Governor Arnold Schwarzenegger proposing a similar kind of reform, it is becoming clear that broad reform is really the only way to fix the problem. On the federal level, Sens. Ron Wyden (D-Ore.) and Robert Bennett (R-Utah) have introduced legislation that would be somewhat similar to the Massachusetts and California proposals. Though NSBA may disagree with certain aspects of each of these proposals, they are to be applauded for moving the ball down the field and in doing so, changing the dialogue on this very important issue.

Targeted Solutions

While we argue that a comprehensive policy is truly the way to fix the health care market, we also realize that our plan is aggressive. In the mean-time, NSBA would support a series of more targeted solutions to provide some relief to small businesses and their employees.

Expansion of Health Savings Accounts
Health Savings Accounts (HSAs) are tax-free savings accounts that people can set up when they purchase a high-deductible policy to cover major medical expenses. Money from the HSA can be used to pay for routine medical expenses or saved for future health needs, while the major medical policy helps cover big expenses, like hospital stays. Unlike their predecessors, Medical Savings Accounts (MSAs), however, HSAs allow for both employer and employee annual contributions and unused funds to rollover. Individuals with an HSA can contribute up to 100 percent of the annual deductible of their health insurance program. HSAs also have lower minimum required deductible and out-of-pocket limits. Perhaps one of the most important changes from MSAs to HSAs is the fact that anyone can participate, and there are no longer restrictive limits on the program.

While HSAs have been available for nearly three years, there are still further actions Congress should take to expand the program. Individuals participating in an HSA should be allowed to deduct the premiums for the high-deductible health insurance policies from their taxable income in conjunction with an HSA. Increasing the tax benefit to these plans will increase affordability.

Pool Small Businesses Locally
There have been calls from various national small business groups to create Association Health Plans (AHPs). The push for AHPs are a reaction to the very dire circumstances small businesses currently face in the health insurance arena: huge premium increases, a lack of control and clout, the costly tangle of state and federal regulations, and fewer funding, carrier, and plan selection options than their larger counterparts.

Despite those good intentions, we are concerned that AHPs are not only a non-answer to the real issues driving cost, but will exacerbate the problems small businesses face. The primary focus and cost savings of AHPs is through circumventing state laws and rating rules. AHPs threaten to greatly worsen the market segmentation and risk-aversion that currently characterize the small group health insurance market, which are at the root of the health care crisis uniquely faced by smaller firms. AHPs might be good for small business associations (like NSBA) who want to run them, but NSBA believes that they will not be good for the small business community at-large, whose interests we are bound to represent.

One of the fundamental precepts that underpins the arguments of those advocating for AHPs is the idea that big pools will equal bargaining clout. In almost every market in the world, the larger the quantity you buy of something, the lower its per-unit price. In the health insurance market, however, the make-up and location of that pool are both far more important factors in establishing a price than size alone.

A pool of 1,000 people with an average age of 40 could demand (and receive) a much better rate than a pool of 50,000 people with an average age of 55. Moreover, when a plan is negotiating reimbursement with providers, a local hospital or physician will be driven by how many patients the plan will bring them. A local plan with a total of 100,000 lives will be able to drive a much better deal than a big national plan with 5 million lives, only 15,000 of which are local.

NSBA encourages the development of local employer health care coalitions that would assist small employers in obtaining lower rates for coverage through group purchasing. Such coalitions also would assist small employers in learning about existing local health insurance plan options, how to be a wise health insurance purchaser, the issues of health care costs, health care quality and the availability of health care providers within their communities. Local employer health care coalitions would continue to be subject to their respective state laws. Therefore, there would continue to be a level playing field for all employers providing insurance in the small employer market. These coalitions already exist in many states, providing choice and savings for their members every day

Reform HRAs and FSAs
In 2002, President Bush and the Treasury Department highlighted Health Reimbursement Accounts (HRAs), which are similar to MSAs, but only can accept employer contributions, and employees cannot keep their excess funds. Though HSAs and HRAs are somewhat similar, HRA reform also would help those individuals seeking a low-deductible plan but also would like a savings account to help pay for medical costs. Reforming the HRA structure includes: allowing employees to contribute, allowing employees to roll excess funds into retirement plans, and, most importantly, allowing small-business owners to participate. Like so-called "cafeteria plans", HRAs specifically exclude owners of non-C Corporations from participating. This is a major obstacle that must be overcome if small companies are ever to take advantage of the potential of these plans.

On the subject of "cafeteria plans" (Section 125 plans), it should be noted that reforms of these plans also could be an important factor in increasing the ability of small-business employees to fund various kinds of non-reimbursed care. Two major roadblocks are in the way. First, small-business owners generally cannot participate in "cafeteria plans". Second, these plans have annual "use-it-or-lose-it" provisions, which cause some to spend money that did not need to be spent, but cause many more to never contribute to the plan in the first place. Fixing these two mistakes would be a real benefit to small-business employees struggling to meet their out-of-pocket medical bills.

Create Health Insurance Tax Equity
After 16 years of struggle and unfairness, small-business owners finally were able to deduct all of their health insurance expenses against their income taxes in 2003. Unfortunately, we are still only part-way to real health insurance tax equity for small business. Currently, workers are allowed to treat their contributions to health insurance premiums as "pre-tax," whereas business-owners are not. This distinction means that those premium payments for workers are subject neither to income taxes, nor to FICA taxes. While the self-employed owner of a non-C Corporation now can deduct the full premium against income taxes, that entire premium is paid after FICA taxes. Compounding matters, these business owners pay both halves of the FICA taxes as employer and employee on their own income for a total self-employment tax burden of 15.3 percent.

Right here in Washington, D.C., the cost of a Blue Cross/Blue Shield family policy in a small group plan has topped $12,000 per year. A business owner who makes $60,000 and purchases this plan for his or her family pays $2,000 in taxes on that policy. An employee who makes $60,000 and has the same plan pays nothing in taxes on that policy. By treating this business owner the same way that everyone else is treated in this country, we can give entrepreneurs an immediate 15-percent discount on health insurance premiums. Legislation was recently introduced in the House by Reps. Ron Kind (D-Wisc.) and Wally Herger (R-Calif.) (H.R. 3660) that would bring this much-needed equity and tax relief to the nation's self-employed. We are hopeful that Sen. Bingaman will continue his leadership on this issue in the Senate and reintroduce companion legislation.

Reform the Medical Liability System
The enormous costs of medical liability and the attending malpractice insurance premiums are significant factors pushing health care costs higher and restricting choice and competition for consumers of health care. Triple-digit increases in malpractice premiums over the last five years have been common in many states and specialties.

These costs have a distorting effect on the health care system by causing physicians to retire early, change their practices to serve lower-risk patients, move to states with reformed malpractice laws, and concentrate their practice in high-profit centers-making quality health care in rural areas and smaller towns increasingly difficult to access. All of these changes restrict competition and the ability of employers to negotiate lower reimbursement rates. But the most profound affect of the liability system is the "defensive medicine" that is practiced by many risk-averse providers. Unnecessary, purely defensive procedures, cost the health care system untold billions each year and drive up premiums for all of us.

Pay-for-Performance
NSBA is a strong advocate for pay-for-performance initiatives. One of the biggest usurpers of health care dollars is poor quality leading to further complications and cost. Quality health care is a major factor in reducing the cost of care, and providers must be compensated accordingly. The implementation of a third-party payer system has removed levels of accountability from all sectors of the current health care market where individuals, health providers and insurance companies have very different interests at heart. Individuals want ease and affordability, take very little responsibility in their care and do not generally make educated choices in terms of providers, procedures and costs.

NSBA strongly supports the CMS's new pay-for-performance policy change. CMS has taken the lead in implementing policy changes that will increase the importance of quality care. Through their reimbursements, CMS now will require hospitals to comply with certain quality standards. Those that do comply not will see a small percentage of their reimbursements withheld. This kind of thorough evaluating and monitoring is necessary in providing patients with the highest quality care possible.

Improvements in Technology
Improved and standardized technology is necessary to gauge provider quality and ensure simple mistakes are not made as frequently. Individuals all should have a privately-owned, portable electronic health record. This would enable individuals and their doctors to access the record without having to wrangle a massive paper trail.

The system currently used for prescriptions also is outdated. NSBA urges the use of technological devices when issuing prescriptions in order to avoid costly and dangerous mistakes. The medical industry needs to establish a set of protocols by which doctors, hospitals and other care-givers can be evaluated. Improved technology will help providers report their compliance with these protocols. Such information should be made widely available to health care consumers.

Protect the Small Employer Health Market from Gamesmanship
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 ensured that small groups could not be denied coverage by any insurer offering small group coverage in their state. The federal law, however, does not ensure that this coverage would be affordable, though states generally have implemented "rate bands" that provide some upper limit on rate increases for particular groups.

The individual market, however, is generally free of the guaranteed issue requirements enacted by HIPAA. Only those who had other insurance within the previous six months would be free of exclusion. This difference in rules between the individual market and the small group market means that premiums for younger and healthier individuals almost are always lower in the individual market than in the small group market. The opposite is generally true for older and less-healthy individuals: their premiums are less in the small group market than in the individual market. This dynamic understandably leads some employers to purchase less expensive individual coverage on behalf of their employees, when they can qualify for low rates. When significant illness occurs, the individual premium escalates sharply, and the business will often switch to a small group plan, where they must be accepted and where the premiums will be much lower.

While this entire process is perfectly rational from the employer's perspective, it forces small group premiums to be higher than they otherwise would be under a different set of circumstances. Premiums would be lower and overall access to health insurance higher if this practice were discouraged, perhaps through a surcharge when the business re-enters the small group market (much like the penalty for early withdrawal of Individual Retirement Accounts (IRAs)). Another way would be to clarify that employer-paid premiums in the individual market are taxable to the employee.

Help the Uninsured through Tax Credits and Current Programs
Much of the question of adequate health insurance coverage boils down to affordability. There is probably no more efficient way to provide public subsidies for health insurance than through a system of tax credits-scaled to income, and targeted at individuals, such as those proposals that the president has put on the table. Further expansions of Medicaid and SCHIP programs to serve uninsured populations should also be considered.

It is NSBA's philosophy that, while these piecemeal changes will have a very positive effect on small businesses, there ought to be a long-term health market reform movement. A health care system that embraces individual choice, consumerism, recognition for quality services and affordability is paramount.

Substantial cost containment is embodied in the NSBA Health Policy. Limits on the tax exclusion will drive individuals to become less-dependent upon third-party payers in their medical transactions. More of a consumer-based market will develop for routine medical care, thereby putting downward pressure on both prices and utilization. Through both increased consumer awareness and specific quality-control methods, costs can be reined-in and small businesses can get back to doing what they do best rather than searching for affordable health care: creating jobs.

Small Business Health Insurance -- Building a Gateway to Coverage
Hearing of the
Senate Finance Committee
October 25, 2007
Written Testimony
Submitted By
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We offer our thanks to Chairman Baucus, Ranking Member Grassley and all of the committee members for the opportunity to offer written testimony regarding the availability and affordability of health insurance for small business owners. Professional Photographers of America is joined in submitting these comments by the other organizations comprising the Alliance of Visual Artists: Society of Sport and Event Photographers, Commercial Photographers International, Evidence Photographers International Council and the Student Photographic Society. Together with our affiliates, we represent some 40,000 photographers and their families. PPA is the oldest and largest trade association for professional photographers; our members are engaged in all facets of photography and imaging.

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

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

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

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

Professional Photographers of America and its allied organization in the Alliance of Visual Artists have recently supported H.R. 3660 – The Equity for our Nation's Self-Employed Act. This bill introduced in the House by Congressmen Ron Kind (D-3rd-WI) and Wally Herger (R-2nd-CA) is a piece of bi-partisan legislation that will provide immediate relief to self-employed business owners allowing them to purchase health insurance using pre-tax dollars. It is anticipated that this bill will save the self-employed at least $1,700 annually. We ask that the Senate consider similar legislation when discussing small business health insurance remedies.

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