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FULL COMMITTEE HEARING ON HEALTH CARE REFORM IN A STRUGGLING ECONOMY: WHAT'S ON THE HORIZON FOR SMALL BUSINESS?

COMMITTEE ON SMALL BUSINESS
UNITED STATES
HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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FULL COMMITTEE HEARING ON HEALTH CARE REFORM IN A STRUGGLING ECONOMY: WHAT'S ON THE HORIZON FOR SMALL BUSINESS?

Wednesday, February 4, 2009

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

The Committee met, pursuant to call, at 10:05 a.m., in Room 2360, Rayburn House Office Building, Hon. Nydia M. Velázquez [Chair of the Committee] Presiding.

Present: Representatives Velázquez, Moore, Dahlkemper, Schrader, Altmire, Sestak, Bright, Griffith, Graves, Gohmert, Buchanan, Luetkemeyer, Schock, and Thompson.

Chairwoman VELÁZQUEZ. Good morning. I call this hearing of the House Small Business Committee to order.

My colleagues, the ″American Recovery and Reinvestment Act″ will go a long way in helping entrepreneurs weather the storm of recession. But even after it is enacted, the new stimulus won't clear every cloud. The rising cost of health care continues to be a major stumbling block for small firms, an obstacle that threatens to restrict their ability to create new jobs for American workers. Until that roadblock is cleared, these businesses will be unable to grow and unable to help lead the path to economic recovery.

Most of the country's attention is now fixed on the faltering economy, but that does not make health care reform any less urgent. In fact, reining in health care costs is as critical to financial recovery as restoring accountability on Wall Street. As soaring premiums cut deeper and deeper into profit margins, many entrepreneurs are slashing coverage for their employees and families. Still others are dropping it altogether. But perhaps worst yet, countless businesses have been forced to scale back their workforce. With unemployment at a 16-year high, we simply cannot afford to lose more small businesses' jobs, especially considering that entrepreneurs are the country's greatest job creators.

Clearly, health care reform for small firms is more than a moral obligation; it is an economic imperative. In today's hearing, we will discuss the rising cost of small business health care and the barriers it creates for financial recovery. We will also explore ways to break down those barriers and to bring the economy back on track.

In the last 2 years, health care costs have climbed at twice the rate of inflation. For small firms, premiums have jumped 80 per-

cent since the year 2000. As a result, coverage for small-business workers has dropped off significantly. In less than a decade, it has declined by 16 percent for some of the smaller firms. Today, in the face of growing economic challenges, small businesses can no longer absorb these outlays. With lending down and credit tightening, few entrepreneurs have the resources to meet basic obligations like payroll, let alone provide health insurance.

Clearly, the current health care system is unsustainable for employers, as well as their employees. As Congress discusses health care reform, one of the issues before us is that of employer mandates. I understand there is significant concern about whether health care reform will include mandates that small firms offer coverage. This issue must be addressed in a way that will not unduly burden small businesses. The reality is that reform cannot work if it does not meet the needs of our Nation's entrepreneurs.

Beyond mandates, this Committee has been working to find consensus on the broader health care reform issues. Last Congress, working in a bipartisan manner, members of this Committee introduced the CHOICE Act, legislation that would have gone a long way in addressing small employers' health care needs. Today, along with Mr. Graves, I am reintroducing the bill. It is our hope that it will make health care more accessible for small businesses.

As the country continues to consider recovery legislation, it is critical that health care reform play a role in the process. Yes, the ″American Recovery and Reinvestment Act″ promises billions of dollars in tax relief to entrepreneurs, and, yes, it will help unfreeze credit markets. But unless we can find a way to make small business coverage more affordable, the benefits of the stimulus may be blunted by health care costs.

How can we expect entrepreneurs to lead the way out of recession when they cannot afford to insure their employees? The more money that small firms are forced to pour into health care, the less capital they have for bringing on new workers. And, at the end of the day, that is what a stimulus should be about: creating jobs. Small businesses can do it, but they are going to need all the means necessary, beginning with increased capital through health care reform.

I am pleased our witnesses could join us today, and thank them in advance for their testimony.

With that, I now yield to Ranking Member Graves for his opening statement.

Mr. GRAVES. Thank you, Madam Chair.

And I, too, would like to echo the chairwoman's thoughts on thanking you all for coming today. I appreciate it. I appreciate her having this hearing to give us some more insight on health care and how it is affecting our businesses.

Forty-seven million Americans are uninsured. By itself, that is a staggering number. Unfortunately, given the Nation's economic crisis, we can expect that that number is going to rise and rise significantly unless we work together to find some reforms that are practical, efficient, and realistic.

The United States has the best health care system around, but a wasteful and inefficient system for delivering that care. According to the Institute of Medicine, the United States spends nearly $100

billion per year to provide the uninsured with health care, often for preventable diseases that physicians could treat more efficiently with earlier diagnosis.

Clearly our system of health insurance and health care is financially unstable and threatens the health and financial security of small-business owners, their employees, and their families. Several consecutive years of double-digit premium increases have hit the business community pretty hard, especially small firms. An employee in a firm with fewer than 10 employees pays 18 percent more for health insurance than a worker in a firm with 200 or more employees. And disturbingly, health care costs are continuing to rise for small businesses. As a result, a significant number of the uninsured, 60 percent, are workers or dependents of workers in small companies.

Health care reform should make the market for health insurance more competitive, resulting in greater access to affordable health care. Many Members in Congress, including me, supported associated health plans, or AHPs, which would permit small-business owners to pool together to purchase their health insurance at lower rates. These arrangements could increase negotiating leverage and administrative efficiencies and help to ensure more consistent benefits among the States.

Another area to explore as we attempt to fix this problem is the way health benefits and spending are taxed. Federal tax treatment of health insurance is widely understood as a fundamental element in achieving affordable health care. It is arguably the most important factor shaping the health insurance markets and, thus, a key driver of the incentives that dominate health care financing and delivery.

Beneficial initiatives like health savings accounts need to be expanded and made more affordable through the Tax Code. Additionally, we must eliminate the inherit inequity within the Tax Code when it comes to the treatment of self-employed individuals, by allowing them to deduct their health insurance expenses when calculating their payroll tax returns. I also believe that changing the Tax Code to allow everyone to deduct non compensated health expenses on their taxes would provide a significant benefit in making health care delivery more affordable.

To this end, as Chairwoman Velázquez pointed out, I have decided to be an original cosponsor on the ″Small Business CHOICE Act,″ which she will be introducing shortly. The bill tackles two of the most significant challenges facing small employers: the high cost of providing comprehensive health insurance and the volatility of insurance premiums.

The bill would allow small businesses to form health insurance cooperatives, which would function similar to risk pools and provide insurance against high-cost or catastrophic claims. Additionally, the bill offers a key incentive in the form of a refundable tax credit to small businesses that choose to join a cooperative.

This is a good start, Madam Chair, and I look forward to working with you on it.

There are many ways to tackle this problem, however I firmly believe that mandating employers to offer coverage to their employees is not a workable option. Just last week, the National Federation

of Independent Business released a study measuring the economic impact of a national employer health care mandate and what it would do on small businesses. The study conducted business simulations to measure the effects of a hypothetical national mandate requiring employers to offer private health insurance to all employees starting in 2009 and to finance a minimum of 50 percent of the cost. Among other findings, the research found that a mandate could lead to more than 1.6 million jobs lost between 2009 and 2013, and small businesses would account for more than 1 million, or 66 percent, of those lost jobs. Additionally, small businesses would lose roughly $113 billion in real output and account for 56 percent of all real output that is lost. Labor-intensive industries with 20 to 99 employees would experience the most job-loss.

There is no way to fix a problem as big as this. We must continue working towards a solution because America's small businesses can't wait any longer.

And I look forward to working with you, again, Madam Chair. And I appreciate, again, the witnesses for being here and for everybody that has worked on this bill that you are getting ready to introduce.

Chairwoman VELÁZQUEZ. Thank you, Mr. Graves.

And it is my pleasure to welcome our first witness this morning, Mr. Dave Ratner. He is the owner of Dave's Soda & Pet City, a small chain of four pet stores in Springfield, Amherst, and Northampton, Massachusetts.

He is here to testify on behalf of the National Retail Federation. The NRF protects the interests of the retail industry and represents an industry that has more than 1.6 million U.S. retail companies and more than 25 million employees.

Welcome, Mr. Ratner. You have 5 minutes to make your presentation.

STATEMENT OF DAVE RATNER

Mr. RATNER. Thank you very much. Madam Chairwoman and members of the Small Business Committee, my name is Dave Ratner. I am pleased and actually pretty honored to appear today on behalf of the National Retail Federation.

And I have got to say this right away. They didn't know I was going to say this. I love the National Retail Federation. They really look after little guys like me. It is a great organization.

I am the owner of Dave's Soda & Pet City—yes, I sell soda and I sell pet food—a four-store business in greater Springfield, Massachusetts. My business has been named the Greater Springfield Chamber of Commerce Small Business of the Year. We are the habitual winners of the People's Choice Award. We sponsor every little league team. We sponsor every church, every cheerleader. Every everything that has anything to do civically in western Massachusetts, we are involved with. I am sure that all of you in your communities have a business like Dave's Soda & Pet City, and I am in the 20-to-99-employee group that is really nervous about what is going on.

The retail industry, as you know, is one of the biggest supporters of the employer-based health insurance system, despite not having an easy workforce to cover. We are strong supporters of health cov-

erage in spite of these challenges. It is not that we don't want health care for everybody, we just want to do it right and equitably.

As an industry that frequently endures wafer-thin profit margins, we are also well-acquainted with the need to manage the collective cost of labor in as an effective manner as possible. And maintaining the balance between these two imperatives is not always easy. It is borderline impossible, as you said, even in the best of times. And Lord knows, these ain't the best of times.

We hope to work with you and other Members of the U.S. House and Senate to bring about a meaningful relief from rising health care costs. And, to be honest, I am almost elated to just hear you two talk about what you think. It is fabulous.

The key, in our view, to reaching universal health care is getting rid of the high costs. The NRF has proposed a comprehensive solution to increase access to more affordable health coverage in our vision of health care reform. And I ask that it be included at the end of my written testimony. I would like to touch on just a couple of points.

Retailers who don't offer consistent value to their customers simply don't survive. Amazingly, the same is not true in our health care system. We need to develop consumer-friendly comparative cost and quality information. My customers know more about the pet products on my shelves than they do about the doctors or the health plans that they do. People should be able to select the best quality care just as they choose between me and my competitors on a daily basis.

And you do need competitors in order to have real competition. This was the first year in 20 years when my renewal came up that my health care costs didn't go up at least 15 percent. Why? Because there was a new legitimate player that came into western Mass, and they came in with a better plan at the same rate. It is amazing. Auto insurance in Massachusetts, when they finally let that get competitive, auto rates went way down. It is really about good competition.

Reducing the health care costs should be a central goal in all health care reform. Employer mandates, as you said, they add costs. The NRF particularly looks forward to working with the Committee on the Chairwoman's proposal to create a market for high-risk claims. I think it is a fabulous idea. When it comes to increasing access to coverage, we believe we can reach universal coverage without mandating that employers provide coverage.

The problem with employer mandates either to provide coverage or to provide specific coverages is that they directly increase the cost of coverage and, hence, the cost of labor. Here is the real-world deal: It will kill jobs. Employers simply will not bring on new employees if they get mandated. It is just basic common sense. Employer-mandated health insurance will leave everybody unhappy and ton of people unemployed. Who is going to pay the doctor bills if these people don't have jobs?

Yes, we urge policymakers to be wary about doing what Massachusetts did. I will tell you, it has not worked. Rates have skyrocketed, and many people are still unemployed. It didn't work.

And I understand one of the biggest challenges you will face will be building a consensus around the reform. And I would venture to guess that there isn't an industry or any American who doesn't have an idea about how it should be done. We hope that the NRF vision will help add to the growing consensus around reform. And it is time to get it done now with only the right reforms enacted into law.

I thank the Committee. I look forward to your questions. And let me just say, I am so elated to hear what you guys are saying. It is great.

[The statement of Mr. Ratner is included in the appendix in page 32.]

Chairwoman VELÁZQUEZ. Thank you, Mr. Ratner.

Our next witness is Ms. Janette Davis. She is the president and CEO of Southeast American Financial Group, Inc. Her firm is a residential and commercial real estate lending firm based in Pembroke Pines, Florida.

Ms. Davis is testifying on behalf of the U.S. Women's Chamber of Commerce. The Women's Chamber of Commerce was founded in 2001 to increase economic growth opportunities for women.

Welcome.

STATEMENT OF JANETTE DAVIS

Ms. DAVIS. Chairwoman Velázquez, Ranking Member Graves, members of the Committee, thank you for giving me the opportunity to share with you my challenges.

I am a small-business owner who is a president and CEO of Southeast American Financial Group, which is owned and operated by my husband and I. Through the years, I have employed as many as a dozen employees and subcontractors. However, during this economic downturn, we had to reduce our staff to one and a half.

The expensive cost of health care makes it extremely difficult for us to continue to afford, especially during this current economic crisis. Currently, I pay 50 percent of the monthly health insurance payment for my employee. To keep costs down, I chose an HSA, but this becomes a challenge for an employee who has a pre-existing health condition earlier in the year before they are able to see their deductible. And for small businesses like mine, it is very important that our employees get the health care they need so that they can proactively manage their care and be available for our business needs.

Like many husbands and wives who work together, my husband and I have to purchase individual policies instead of a family policy. In 2007, the insurance coverage increased for us to $1,400 per month. To continue to carry insurance, I switched my company to a high-deductible HSA policy. Now we pay $881 monthly for just both of us. However, we have to cover the first $3,000 of our expenses, and prescriptions are covered only after we exceeded these deductibles.

While our policies include preventative care, the insurance company almost always excludes something and sticks us with a copay. My doctor recommended a preventative procedure. I verified with my insurance company that the procedure would be covered 100 percent. During the procedure, the doctor discovered a minute

issue and recommended two additions to my diet. Consequently, my health insurance company changed the preventative classification and charged me $562.50.

The families of small-business owners bear the brunt of the inequalities in our health care system that is heavily skewed in favor of big business. When I worked for a larger business, I had a more affordable family policy, which also covered my husband. Because I am younger and healthier, our coverage was cheaper because it was issued to me as the primary. My husband had an eye emergency that resulted in a bill in excess of $80,000. The insurance company paid 25 percent of the street price based on its discounted arrangements with the hospital.

Why is it that the hospital services have to be priced at such exorbitant sums for the cash-paying customer who, in most cases, cannot afford to pay these astronomical bills? If we could reduce those costs to reasonable amounts, individuals could then afford to pay their bills.

We need affordable solutions now. I ask that you put health care back in the hands of the doctors and prevent insurance companies from dictating the care we receive. Remove the fine print and provide clarity so that we know what we are getting.

Health insurance companies shouldn't be able to wiggle out of paying for health care services. The restrictions should be lifted as to what doctor or hospital that you may be able to use.

Allow small businesses to pool together to purchase insurance under a national group umbrella policy. Provide tax credits to small business that purchase coverage. Remove the 7 1/2-percent-of-AGI threshold on income tax for medical expenses. Do not mandate that small business provide coverage. Remove the 75-percent threshold for business to cover employees before they can get coverage.

Divide insurance into medical and catastrophic care. Allow tax credits to individuals for direct pay to their doctor; then they can purchase insurance coverage for surgery and other catastrophic illnesses.

In conclusion, it is time to end the stranglehold health insurance companies have on American citizens. Small-business owners and their employees have been forced into paying exorbitantly high premiums, risking high deductibles, and then being nickel-and-dimed by the insurance companies. We need to wrestle the control of our health out of their hands and put it back into the hands of individuals and doctors.

Get rid of the endless administrative overhead, which is often aimed at finding ways to reject payment care. Help America's small businesses to pool together to leverage our scale and bring the cost of care down.

Thank you. I am open to any questions after.

[The statement of Ms. Davis is included in the appendix in page 44.]

Chairwoman VELÁZQUEZ. Thank you, Ms. Davis.

Our next witness is Mr. Thomas Haynes. He is the executive director of the Coca-Cola Bottlers' Association. Mr. Haynes previously served as president of the Association Health Care Coalition, which

helped improve the health care options available to their small-business members.

Established in 1914, the Coca-Cola Bottlers' Association assists its members in reducing costs and improving efficiency by meeting their needs in numerous areas.

Welcome back.

STATEMENT OF THOMAS HAYNES

Mr. HAYNES. Well, thank you, Chairwoman Velázquez, and thank you, Ranking Member Graves, for the invitation to address this Committee again. As Chairwoman Velázquez referred to, this is my third appearance before this Committee.

I won't go into quite as much detail about what the Coca-Cola Bottlers' Association does and some of our own history as a result of a lot of it is laid out in my statement. What I will say is that we are in the business of serving our members in every way we can, and a particular focus of that service is on our smaller members.

Our members range in size from the largest, which has 50,000 employees, down to a number of bottlers that are much like Mr. Ratner's companies, have 50 or fewer employees. So approximately half of our remaining 73 members have less than 150 employees, so they qualify as small businesses.

We serve them in every way that we can, and we are successful in almost every arena, in providing the same level of service to them and getting their cost to the same level as the largest members, ranging from liability insurance to employee benefits to purchasing to any number of other areas. The one place we cannot provide that service in the way we need to is in the health care arena. And I think that speaks volumes about the problems facing small business. Because it alone, among all of our challenges, is the one that we need help from Washington in solving.

Our small members were once part of a pool that the Bottlers' Association managed. Yet, in 2000, shortly before I joined the Bottlers' Association, we were forced to abandon that pool because of the administrative cost associated with compliance with State mandates, State regulations, and a number of other administrative issues. And, as a result of that, our members' costs went up astronomically very quickly.

What happened to them is reflective, I think, of what is happened in the small-business community in general. And why we have such a challenge with the uninsured is that a number of the members cut back on their policies. Many of them discontinued family coverage and offer only individual coverage. And, frankly, a lot of their employees have lost their health insurance, either because they can't afford the co-pays, they can't afford the share that our members have to charge in order to be economically viable, or the benefits have been cut in a way that they choose not to participate because of the remaining costs.

Now, why is that? Well, as I said, part of the issue is State regulation, but it is not the entire issue. I have attached to my testimony a study that Mercer did for us that looks at the sources of the 18 percent disparity that Congressman Graves referred to. And what it shows is there are three primary drivers of that. One is

higher administrative costs. The second is the significant difference in the premiums paid for shifting the risk. And the third is what I believe is some differences in terms of the effectiveness of chronic disease management by the employer.

The issue is, quite simply, that large employers operate in a self-insured environment, have efficient plans with scale in their administration, and don't pay a profit-driving premium to carriers to take on risk because they are largely self-insured. If we were in a position to create the same kind of pooling, the same kind of scale for our smaller members, we could achieve the same savings and reduce that disparity to a significant degree, even leaving State regulation in place.

So where does that leave us? Well, what that leaves us with, in my view, are three basic needs that small businesses have in order to solve the challenge they are facing relative to providing health care. One is an uneven playing field, so we need Congress's help in making the playing field even. Second is an opportunity do risk pooling and, in the process of doing risk pooling, do risk retention. And the third is to create a system where incentives between the employer, the employee, the people who are likely to be driving decisions as to health care utilization, are aligned in terms of the economic interest.

I believe that the bill that the Congresswoman Velázquez and Congressman Graves are introducing today, the CHOICE Act, will achieve all of those objectives, from our perspective, by creating a tax credit to facilitate the formation of the cooperative pools and by providing a sufficient tax credit to make the playing field more even.

In our case, our members will be able to offer affordable health care once again. It is the only solution, frankly, that our members need. If it were enacted by Congress, we would have no reason to oppose mandates, because our members would be able to provide coverage.

Now, I am not about to speak for every other small business and say that this is all they need. But, in our situation, based upon the way we do business, it is all we need to restore coverage and restore affordable health care for our smaller members.

[The statement of Mr. Haynes is included in the appendix in page 48.]

Chairwoman VELÁZQUEZ. Thank you, Mr. Haynes.

Our next witness is Ms. Alissa Fox. She is the senior vice president of the Office of Policy and Representation for the BlueCross BlueShield Association. BCBSA is a national federation of 39 independent and locally operated BlueCross BlueShield companies that provide health care coverage for more than 102 million Americans.

Welcome.

STATEMENT OF ALISSA FOX

Ms. FOX. Thank you very much, Madam Chairwoman, Ranking Member Graves, and other distinguished members of the Committee. Thanks for being here. I am Alissa Fox, senior vice president of the BlueCross BlueShield Association.

As you mentioned, the BlueCross BlueShield Association represents 39 BlueCross BlueShield plans across the country, and, col-

lectively, we provide coverage to 102 million people. We are unique in that we provide coverage in every ZIP code, in every part of the country. And all Blue plans offer coverage to small employers, a sign of our strong commitment to the small-employer market. We believe that expanding coverage and improving affordability for small employers must be a centerpiece of health care reform.

Today I would like to focus on three areas. First, I would like to talk a little bit about how States regulate health insurance sold to small employers today; second, highlight what Blue plans are doing to increase coverage for small employers; and third, outline our recommendations for Federal legislation.

Today, State and Federal law require insurers to offer coverage to every small business regardless of their employees' health. It is called guaranteed issue. Every insurer has to offer coverage to small employers, and the small businesses can't have their coverage turned town or cancelled if one of their employees becomes sick. That is both Federal and State law.

In addition, State law requires health plans today to pool all their small employers together when establishing premiums. And they limit the extent to which insurers can vary the premiums today based upon the health status of individual employees. These reforms spread the medical costs of all small employers more evenly to generate more affordable premiums for employers with less healthy members. However, this does result in higher premiums for the healthiest employers.

As you have heard this morning, affordability is a central challenge facing small employers. To help address these challenges, our plans across the country have been pursuing two strategies.

First, we are working on a variety of initiatives to rein in costs for everyone. Everyone is facing health care costs that are growing at much too high a rate. The initiatives we are pursuing range from changing the way we pay providers, to promote better care, not just more services; and to focusing on prevention, wellness, and managing chronic illnesses. We have a Web site we just put online that highlights many of the BlueCross BlueShield initiatives under way in each of these areas.

Second, our plans are developing special programs designed to make coverage more affordable for smaller employers. My formal statement includes several examples. I would just like to highlight one.

BlueCross BlueShield of Oklahoma worked closely with their State legislature to develop Insure Oklahoma, a program that provides subsidies to low-income workers in small businesses to help cover the cost of health insurance. This program has been very successful. To date, nearly 4,000 small employers are participating in the program and more than 11,000 employees and their families receive subsidized coverage from the program. According to a recent survey, 56 percent of new enrollees were previously uninsured and 37 percent of employers offered coverage for the first time.

While these types of programs are making a difference, Federal action is needed to address the problems facing the small-employer health insurance market as part of comprehensive health reform. We have three recommendations for your consideration.

First, we are recommending legislation to encourage States to establish what we are calling State insurance marts, to simplify shopping for small employers, increase competition among insurers, and help educate small employers on potential subsidy options. These marts would make it easier to shop for coverage by, for the first time, creating a central point in every State where a small employer knows they could go to identify what insurance options are in their marketplace and apply for coverage and for subsidies.

Our vision is that you go to the one site; if you want to get—you fill out an application, one application, regardless if you are applying for Aetna or BlueCross—you can check boxes that you want Aetna, BlueCross, etcetera, price quotes, push a button and get quotes pretty instantaneously. And then you could actually find out what subsidies might be available, and also enroll online.

Second, we are recommending four types of targeted subsidies. I am including one patterned after the Oklahoma plan that I mentioned earlier that would provide tax credits to small employers for their low-wage workers.

And third, we believe the underlying cost drivers in our current health care delivery must be addressed. And we have very specific recommendations in our ″Pathways to Covering America.″

I would like to close by saying reforming how we pay for and deliver care won't be easy, but it is the only way that affordability challenges facing small employers can be solved over the long term. We look forward to working with you, this Committee, other Members of Congress, the new administration, and other stakeholders to enact health care reform that works for everyone.

Thank you.

[The statement of Ms. Fox is included in the appendix in page 58.]

Chairwoman VELÁZQUEZ. Thank you, Ms. Fox.

And now I yield to the ranking member and recognize him for the purpose of introducing our next witness.

Mr. GRAVES. Thank you, Madam Chair.

Madam Chair, our next witness is Michael Beene. He serves as the senior health advisor and general counsel for the National Association for the Self-Employed.

The National Association for the Self-Employed is a national membership association, and they represent 250,000 micro-businesses. Those are businesses with 10 or less employees. As a senior health advisor, Mr. Beene works with the NASE's legislative staff. They educate policymakers on the health coverage issues faced by the self-employed and health policy options that would assist the micro-business community in gaining access to affordable health care coverage.

Thank you, Mr. Beene, for being here and for testifying.

STATEMENT OF R. MICHAEL BEENE

Mr. BEENE. Well, thank you.

Thank you to the Committee for visiting this important issue early in the session. And we do support the CHOICE bill, and I am pleased to hear that it is going to be introduced again.

The plight of micro-business owners, those with 10 or less employees, is becoming more challenging as our employee continues to

decline. The pool of money these entrepreneurs have to draw upon for both business and family expenses has been dwindling, forcing many self-employed to make tough choices. Most distressing, many of the self-employed are scaling back their health coverage, and some are dropping coverage completely in order to keep the doors of their business open.

As discussions on health reform progress, the National Association for the Self-Employed would like to emphasize that proposals must address two key issues, affordability and choice—those two issues being key in order to approve the ability of micro-business owners to obtain quality health coverage.

The common denominator for all small businesses is that they must pay taxes. Thus, the Tax Code is an excellent vehicle to provide financial relief to micro-business. A key step forward in addressing the affordability issue faced by the 21 million self-employed would be to tackle the current inequalities in the Tax Code that this segment of the business population faces as they purchase health coverage. And several of those things have been mentioned; I believe Mr. Graves mentioned in his remarks.

All business entities, except sole proprietors, receive a business deduction for health insurance premiums. Employees and owners pay for their health insurance premiums pretax, and, therefore, they are not subject to FICA taxes. However, a sole proprietor's premiums are not paid with pretax dollars, and they are exposed to the 15.3 percent self-employment tax.

The most recent Kaiser Family Foundation study indicated that the self-employed pay, on average, $12,000 a year annually for family health coverage. Because they cannot deduct these premiums as an ordinary business expense, that would require them to pay an additional $1,800 in taxes that no other business pays. Removing this inequity would be a significant economic stimulus for the self-employed and just a fair leveling of the playing field.

Discrimination against the self-employed also persists in health reimbursement arrangements, HRAs. HRAs, distinguishing from HSAs, HRAs are a flexible benefit option that allow small-business owners to reimburse employees for out-of-pocket medical expenses, including health insurance premiums. An HRA gives an owner of a business predictability when it comes to benefit costs, since the owner determines the maximum amount of annual reimbursement each employee will receive. It has to be the same across the board for the owners and employees. The reimbursements are tax-deductible for the business and tax-free for the employees.

An important component of HRAs is the nondiscriminatory rules that apply to them. If an HRA is set up, the benefits must apply equally to all employees. At present, self-employed persons are not eligible to participate in an HRA. Expansion of HRAs to allow the self-employed business owner to participate in the plan would likely significantly increase the number of businesses that use HRAs. And HRA reimbursements would likely be more generous if the owner also got to put his or her health coverage in that. So we would like to see that inequity removed.

As we look at our health insurance markets, it is important to consider the potential impacts of market reform on micro-business. The self-employed micro-business can purchase health insurance in

two markets: the small-group market, which was referenced, and the individual market. We have seen a definitive shift of micro-businesses from the small-group market to the individual market in the past 3 years. Thus, for health reform to be beneficial to the micro-business sector, proposals must tackle cost issues in the individual market.

The creation of pooling mechanisms can be utilized to begin addressing the high costs and lack of negotiating power faced by the self-employed. In current reform proposals, discussion has centered on creating a national pool managed by the Federal Government to allow small businesses and individuals to purchase coverage. Micro-business owners are evenly split in their opinion on whether a government-run health option is the right approach. Chief concerns expressed are the quality of their health care, would it be as good or not, would they have as many choices. And there also is a worry among micro-businesses that taxes would significantly increase.

The establishment of mandates, either for individuals or employers, has been a hot topic. The NASE does not support the mandating of health coverage at this time. In particular, an employer mandate to purchase and provide health coverage that does not exempt micro-business, 10 employees or less, would put millions of owners out of business and would leave millions of workers unemployed. The NASE believes that an individual mandate would be harmful in this current climate. This is not the time to do more harm to business.

As you look to reform the system, don't forget that the needs of the 10-or-less-employee micro-business may be very different than the 200-employee small business.

Thank you.

[The statement of Mr. Beene is included in the appendix in page 74.]

Chairwoman VELÁZQUEZ. Thank you, Mr. Beene.

And now, again, I recognize the ranking member for the purpose of introducing our next witness.

Mr. GRAVES. Thank you, Madam Chair.

Our next witness is Dirck Clark, and Dirck serves as the chief business development officer for Heartland Health Systems in Saint Joe, Missouri. His responsibilities include strategic planning, advocacy, regional development, and medical student education.

Prior to coming to Heartland, Mr. Clark spent 7 years working in the United States Senate with Senator Kit Bond. Most of his tenure with Senator Bond was spent working on health care and rural development issues.

Originally from Savannah, Missouri, he received his bachelor's degree in business administration and master's degree in health care administration from the University of Missouri. In addition, Mr. Clark serves on the Board of Governors of Missouri Western State University, the Board of the Missouri Chamber of Commerce, and the Executive Council of the Boy Scouts of America there in St. Joe.

So thanks for being here, Dirck.

STATEMENT OF DIRCK CLARK

Mr. CLARK. Thank you.

Madam Chair, members of the Committee, I appreciate the Committee's interest in the effect of health insurance of small business and this opportunity to testify.

As background, St. Joseph is a town of about 75,000 people, located an hour north of Kansas City. Heartland is comprised of the only hospital in St. Joseph. We also have a small rural insurance company and a physician group practice of about 110 physicians.

Heartland is the only tertiary hospital between Kansas City, Omaha, and Des Moines. Like many hospitals in rural areas, we are the largest employer in town. It is in that role, as an employer, that I am here today. Fifty-one percent of our costs, of our expenses, are related to labor, and 10 percent of that goes to health care costs.

As a health care provider, we have an understanding of the effect of health status on health care cost and insurance rates. We have a team that works with local employers to help them keep their health care costs down.

My main focus today is on the subject of individual responsibility and the role an employer can have in improving employee health, ultimately impacting health care expenses. With our employees at Heartland, we have implemented some ambitious programs to help employees with their health status, at the same time giving them an incentive as a reward for helping keep their health care costs down.

Some examples would be the following. If you are an employee of Heartland and on our insurance program and are injured in an automobile accident, we will only pay 60 percent of the health care costs associated with that accident. I would note that Missouri is a mandatory seat-belt State, and so all employees would have to do is comply with the law.

Like many other businesses, we offer a 10 percent health insurance differential incentive for employees who choose not to use tobacco products, along with reimbursement for smoking cessation programs and free nonsmoking classes.

This year, based on research showing an increased medical cost for those whose body mass index, or BMI, is above certain benchmarks, we started a program to offer a premium discount for lower BMIs. If you are a Heartland employee and on our insurance plan and have a BMI below 35, you receive a premium discount of 10 percent. In this first year, if an employee has a BMI above 35 and wants to improve, we will offer the incentive to the employee if they agree to participate in wellness programs.

In order to help the employees earn this benefit, we have built an on-site fitness center that is free to employees and spouses. Along with the fitness center, we offer free classes on weight loss, nutrition, and exercise, to name a few. Our hope is to break ground this spring on a daycare that will allow employees to exercise before work and after work and have their children nearby.

This first year, the BMI threshold is 35. However, each year the BMI threshold will be decreased until it reaches 29. Our goal is to work with employees to help them stay below the threshold as it decreases.

The result has been that 92 percent of eligible employees have signed up for the benefit; 84 percent of those who signed up have earned the discount outright; and an additional 12 percent are earning the discount through participation in wellness programs.

As this is the first year of the BMI incentive, we don't yet have trend data showing its impact. However, the effect of these programs has been a dramatic increase on participation in the self-help programs and a fitness center that is nearing capacity 4 months after it opened. This was the second fitness center; we had to expand the first one.

When the fitness center initially opened, as you would guess, it was populated primarily with employees who were already in good physical condition and enjoyed exercise. What we are finding now is that more employees are showing up to exercise and participate who have higher BMIs. Our hope is that we can continue to work together with the employees to improve their overall health risks and keep their BMI under the insurance threshold as it decreases.

My hope, as you look at health insurance challenges for small business, that you also look at programs that provide workers incentives to improve their health and help keep health care costs down.

I thank you for the opportunity to testify and look forward to your questions.

[The statement of Mr. Clark is included in the appendix in page 82.]

Chairwoman VELÁZQUEZ. Thank you.

I would like to address my first question, if I may, to Ms. Davis.

You mentioned that you offer high-deductible coverage for your employees. For many here in Congress, these plans were supposed to be the answers to all the problems in the small-group market. And while these plans may be lower-priced, can you talk to us about some of the shortcomings of these plans in controlling health care costs?

Ms. DAVIS. The major shortcoming with the high-deductible policy—Congresswoman Velázquez, the major shortcoming with the high-deductible policy is that for the employee who, say, for example, has a pre-existing condition and they have not yet saved that deductible, that becomes an issue for them in terms of they may have to scale back on their care because they cannot afford to pay all the funds up front to pay for themselves.

That is a major issue that employees face. Face it, not everyone can find $3,000 up front right away if they become sick early in the year. Maybe, say, after 12 months of saving, that money is there. But that is a major issue that they have.

Chairwoman VELÁZQUEZ. Ms. Fox, this Committee held a series of hearings last Congress focusing on consolidation of the health care industry. What we have learned is consolidation has left small businesses with fewer insurance carriers to choose from and higher prices.

According to your testimony, State-based connectors or exchanges are better for small businesses than national ones. Given that consolidation threatens to eliminate competition in the State insurance markets, why would the State-based connector be better?

Ms. FOX. Thank you.

Well, first of all, we don't think that consolidation has really reduced the number of insurers in the marketplace in a significant way. GAO looked at this back in 2005, and what they estimated was that, on average, there are 28 insurers in most States, which is a lot of competition. I think when we—

Chairwoman VELÁZQUEZ. Down from how many?

Ms. FOX. I am not sure, but I think still 28—

Chairwoman VELÁZQUEZ. Well, that is the real question.

Ms. FOX. I don't know that. I would be happy to look for that. But I think 28 insurers in a State is a significant number of competitors.

I would say that, when you look at the States where there have been a lot of competitors leaving the market, the reason has not been consolidation; it has been the regulation has been very, very tight. You look at places like Maine, Massachusetts, New Jersey. That is where you have seen a lot of insurers leave the marketplace. And our perception—and I think it is best to ask them—is that they have left because the rules have been very tight.

Chairwoman VELÁZQUEZ. Well, perception is not fact.

Ms. FOX. Right. I understand. That is only our perception.

Mr. HAYNES. If I could interject, in another life I was an antitrust lawyer, and the one thing I would say is you never measure competition by counting competitors. You have to measure it by share.

And I think, you know, you have looked at that issue, and there are definitely some issues in terms of shares that would suggest from an antitrust perspective that there might be market power in at least some markets.

Ms. FOX. Well, I would add to that that the Federal Government has looked at this. And they have—where there has been consolidation, and, you know, when insurers get to a certain size, they use it to get leverage with hospitals and doctors, and it directly benefits the consumers. So this is something that has been examined very closely. And, you know, I will just be candid. On our market share, we have about a third across the country in market share.

And State connectors, we think State connectors would be better because it would be piggybacked on the existing State infrastructure. There are State regulators who have excellent, long-term expertise in protecting consumers, and we don't think that it makes sense to reinvent that at the Federal level when we have State experts there.

So what we designed is a program to get the benefits of what we have heard of from a national exchange, which is to simplify shopping for small employers. I think when you go and you try to shop as a small employer—I used to be a small employer, and it is very difficult to shop for insurance. So we designed this to really simplify the process, make it easier. And I think it would also reduce the administrative costs for us, as well as small employers.

Chairwoman VELÁZQUEZ. But don't you agree that a national exchange will provide more transparency, and that consumers care more about what is out there for them to see and to choose from?

Ms. FOX. We agree 100 percent that we need transparency, but we think you can get all that transparency at the State level and having State connectors; and require every insurer to be listed on

that site, so it is not just some, but everybody, so you know everybody in the market. I think it will really increase competition.

Chairwoman VELÁZQUEZ. So why do you think that—you know, the real issue here in terms of cost, bringing down cost, that the rising health care costs is a systemic one. So how could you explain that the premium cost has not come down, even after you talk about putting together a strategy that will have the effect or the goal of bringing costs down?

Ms. FOX. I agree. You know, bringing costs under control is a huge problem facing this country, and we all need to work together. We have strategies in place, but we can't do it alone. We need to partner with the Federal Government. And we have very specific recommendations on how, working with the Federal Government, that we need to be looking at changing the incentives, for example, for providers. Right now, the way we and the government pay is that the more you do, the more money you make. We need to change those incentives.

And I will give you just one example of a program that we have under way where we think it is really making a difference. Our plan in Pennsylvania is now paying hospitals to reduce their infection rates. And what they have shown is that, through giving them coaches to help them in the hospital and giving financial incentives, they were able to bring the infection rates, where people were getting sick unnecessarily, way down. We think these are the kinds of initiatives that need to be pursued.

Chairwoman VELÁZQUEZ. Anybody else who would like to comment?

Let me ask you, Ms. Fox, why do you think that the Massachusetts experience has not been able to bring costs down?

Ms. FOX. Well, I forgot who—I think it was Mr. Ratner who was talking about that. I think that they focused on expanding access first, and controlling costs is something that they are now working on. And we think you need to do both together. We think everybody needs to be covered, but you need to attack the rising costs at the same time. And I think they did the expansion first. And I think that is—you know, we would do them together.

Chairwoman VELÁZQUEZ. Thank you.

Mr. Haynes, one of the reasons small businesses find it hard to maintain coverage is affordability. If pooling risk is part of the solution, what other kinds of reforms should we be discussing that will help move us in that direction?

Mr. HAYNES. Well, going back to, sort of, the core issue and what caused the abandonment of our small-group program, it was variability in State regulation. Particularly, mandates created so much complexity. That group had probably about 2,500 employees in 40-some-odd different States. So we had a lot of States where we might have 15, 20, 25 employees, and having to write unique coverages with unique rules in that kind of a program just drove the administrative costs up.

So if we could figure out a way to make State regulation more consistent—I mean, one example that I think probably added no value was, at one point, we had eight different rules to administer as to the age at which and the circumstance at which dependents had to come off the coverage. Because there are eight, nine, 10 dif-

ferent State rules on something as simple as that: 18, 19, 20, full-time student, part-time student. And just the complexity of managing that with a relatively small group across multiple States is a real problem.

Chairwoman VELÁZQUEZ. Thank you.

Mr. Ratner, we are working here, both in the House and in the Senate, on this stimulus package that will have the goal of getting the economy back on track. And, to get this economy growing again, we need to create jobs. And, of course, we all know that the backbone of our economy are small businesses that creates all the new jobs, between 70 and 80 percent.

In yesterday's New York Times, there was a story about how small firms were choosing between laying off workers and providing health insurance. So, with the current economy, how have the additional costs of health coverage affected your ability to hire or provide additional wages to your workers?

Mr. RATNER. I think I am probably the luckiest guy in the business world right now that I am in a business, the pet business, that has not gotten whacked with the recession. So I have not had to lay off people or to deal with that.

What I will tell you is that every person that we look to hire is a a part-time person so that we don't have to pay the benefits, especially in light with what our State wants to add on on top of what they already added on.

So I will speak for a few friends of mine who have small businesses. They literally have laid off people solely for the reason of the health insurance. And they have laid off some people my age so the rates are even higher and they just couldn't do it, or they cut their hours to part-time. And it is happening.

Chairwoman VELÁZQUEZ. Yeah.

Mr. Clark, to a lot of people in this country, you know, when presidential candidates were running, they were discussing health care reform as an important issue, especially for small businesses. But now we are dealing with the economic crisis that we are facing in this country.

Your firm not only provides medical services, but you also provide insurance to many small firms. Can you talk to us about how health insurance coverage can be critical to the economic wellbeing of this country?

Mr. CLARK. I think the answer we just heard a minute ago is the most important one: because of layoffs. We are seeing that in our communities, layoffs with small business.

One of the things that we do is we sit down with the small employers and look at their health care costs. We do a health risk assessment on their employees to help them determine what their issues are, and then we try to provide programs for them to help them keep their employees healthier and then help them keep their costs down.

Chairwoman VELÁZQUEZ. Thank you.

Now I recognize Mr. Graves.

Mr. GRAVES. My question is to Mr. Clark now, and I might open it up to some of you who represent associations or your own business.

But out of curiosity, health care savings accounts—which we created, I don't know, what was it, 5 years ago or 6 years ago, something like that—I am hearing mixed feelings. You know, they were created as a possible alternative for small businesses to be able to create a health care savings account for their employees, rather than the expense of full-blown health insurance. But I have heard some small business saying it is too expensive or it is too tough to get them going.

Are you seeing any of that as a provider, more health care saving accounts, or are you seeing any at all?

Mr. CLARK. Virtually none in our rural area at all right now.

Mr. GRAVES. How about anybody—yes?

Mr. HAYNES. We have had some firsthand experience with that. We have encouraged some of our members who are in our health care plan to look at health care savings accounts. And the take rate is tiny.

Mr. GRAVES. Really.

Mr. HAYNES. Virtually zero.

And I think the reason is, frankly, making financial decisions about health care without knowing what is going to happen is very difficult for people. I think folks are simply reluctant to set aside money or to completely understand the tradeoffs between coverage and a health care savings account because of the uncertainty aspect of it.

And I just think, as it has been discussed with both our modelers and their employees, I think there is an uncertainty and fear factor that is a significant impediment, particularly for folks who may not be highly educated.

Mr. GRAVES. Ms. Fox?

Ms. FOX. I would just add that, according to Kaiser Family Foundation, 13 percent of workers in small firms are now in high-deductible health plans. And many of our plans do sell HSAs with high-deductible health plans. And they have found, one plan has reported that 20 percent of its enrollment in their products are from people that were previously uninsured.

And what our plans do is we give our customers a range of products, so that they could pick what best meets their needs. So it is not that we are favoring one versus another. But we do find that some previously uninsured workers, small employers have found that very attractive.

Ms. DAVIS. I would like to add for the HSAs, I have an HSA with my company. But as the economic times get tougher and tougher, the employee tends to pull back the coverage, the money that they will be contributing, to use for something else.

Mr. GRAVES. Kind of a—

Ms. DAVIS. It is a Catch-22 situation.

Mr. GRAVES. We all think we are going to be healthy forever, and so we don't worry about it.

Mr. RATNER. And with my company, we have a lot of young employees. You couldn't get them to sign up for that. They want every nickel to come home. They are young. ″Nothing is going to happen to me. I don't need to contribute to it.″

Mr. BEENE. You know, the good side of the HSAs is that they do allow more comprehensive coverage for catastrophic events for less

money. And so, all of this is such a tradeoff between what does it cost to get coverage.

And, you know, we want to avoid this underinsured situation, as well. And I understand the people that say, well, the HSA may keep you from going to the doctor when they need to. But there are ways with the PPO that I think it can be structured well. But, obviously, it needs more education and more examination.

Chairwoman VELÁZQUEZ. Mr. Schrader?

He is not here.

Mr. Moore?

Mr. MOORE. Thank you, Madam Chair.

I would like to direct my first question to Ms. Fox and Mr. Beene.

Last summer, President Obama proposed a new tax credit for small businesses that offer quality health care to their employees. Specifically, under his proposal, small businesses would be offered a refundable credit of up to 50 percent on premiums paid on behalf of their employees.

Some have recently expressed questions about whether or not such a tax credit would be sufficient, given the dire circumstances that most small businesses currently find themselves in and the difficulties associated with restraining costs and maintaining cash flow.

Given your policy expertise in this area and your understanding of the circumstances that many small businesses currently find themselves in, do you think that a tax credit would do enough to encourage small businesses to provide health care coverage for their employees, or would additional incentives need to be offered?

Ms. FOX. We are very supportive of the tax credit proposal that is in President Obama's plan. We think that it would go a long way. EBRI did a survey on that and surveyed small employers that didn't offer coverage. Seventy-one percent said they would be interested in offering benefits. That was a little while ago before the economic downturn. But 71 percent said it would make a big difference.

We are finding in Insure Oklahoma that that really is being very successful, having some assistance to provide benefits. So we do think it would be helpful, but we think it needs to be more. We need to rein in costs across the board. So it needs to be a multiplicity of approaches.

Mr. MOORE. Good.

Mr. Beene?

Mr. BEENE. Yes, well, we believe tax credits are really probably the key help that we can give small business. And we would like the tax credits to be refundable, and I think that they need to come monthly. They need to come at a time when a business can use them. Be refundable, I support and we agree with the concept.

And, specifically, I think we—most small businesses in our surveys want to provide health coverage for their employees, and they think they need to from a competitive standpoint, because often they are competing with a big company. You put these things together. If you can just give some financial help so that it is not a question of paying the mortgage at home or getting some health coverage for the employee, and I think the one way you can really

get an effect and help small businesses with the refundable tax credit issue.

Mr. MOORE. Anybody else care to comment?

Mr. HAYNES. Yeah, if I could comment briefly, I think tax credits are a good idea. I think it is necessary. But they only achieve one of the objectives that I think ought to be the focus, and that is to get more people covered.

I think a targeted tax credit—and I think it needs to be larger than 50 percent because, after all, that is not a whole lot more than simply making it deductible—I think a targeted tax credit that works against market forces is very important. I think we need a tax credit that has enough effect on the market to reduce overall cost.

And that is one of the reasons I would, frankly, prefer the CHOICE Act solution over a simple 50 percent tax credit.

Mr. MOORE. Anybody else?

Okay. More broadly, do any of you have thoughts on various options that are out there that are designed to ensure that a higher percentage of small businesses are able to provide their employees with health insurance? Should the Federal Government be encouraging the development of purchasing groups, which would increase plan choice and lower administrative costs? Subsidize insurance coverage for high-cost individuals? Subsidize insurance coverage for low-income individuals?

Any thoughts about any of those proposals?

Mr. BEENE. I would say yes to all three of those.

Mr. MOORE. Consensus, huh?

Mr. BEENE. We think that supported groups for certain individuals is one way to deal with the small business problem of the unhealthy individual. We don't want to see—I know the law is everybody hires equitably and doesn't base things on health, but you wonder out there—we have to give options to businesses, because we can't bankrupt businesses, especially now when things are tight. And I think all of those proposals have appeal to the small-business community.

Mr. MOORE. Any other comments?

Mr. RATNER. I think that is a huge deal. I think it would help immensely, between the tax credits and the pooling.

You know, no one here has had the problem of if you have four or five employees in their 30s and you have one who is in his 50s, the rate just goes right through the roof. Or you have someone who has a pre-existing condition, forget it, they won't write the policy.

So I think that would be a huge deal to get more people signed up. And, again, you know, we still have to address the issue of controlling costs. That has to go along with it.

Mr. CLARK. I would just add from the providers standpoint, anything we can do to see more coverage. We are seeing a dramatic increase in our bad debt, as you would imagine. We are at a point now where 50 percent of the babies born in our OB unit are born into the Medicaid program. So anything you can do would be helpful.

Mr. MOORE. Thank you all. Thank you, Madam Chairman.

Chairwoman VELÁZQUEZ. Mr. Thompson.

Mr. THOMPSON. Thank you, Madam Chairwoman and ranking member Graves. I very much appreciate your leadership on these issues. I am new here by about 5 weeks. I come from the hospital floor to the House floor, where for 26 years, these have been very important issues to me. I represent one of the more rural districts in the country. So small businesses are our backbone and having employers growing those jobs and health concerns are obviously very important for our economy and to me in my former profession, and now as a Member of Congress.

Mr. Clark: In terms of rural America, rural residents rely more heavily on the individual and small group market and because these economies are dominated by small business and self-employed, they are less likely to be offered health insurance through an employer. Could you explain how much more difficult this makes things for people from rural areas, from rural America?

Mr. CLARK. We are seeing two things: We are seeing, one, fewer people insured obviously; but number two, more and more people that are underinsured. So they show up at the emergency room with a card that says they have got insurance only to find out it doesn't cover much. So it is causing, as I mentioned earlier, a tremendous increase in our bad debt and we are seeing it more and more every month.

Mr. THOMPSON. Mr. Haynes, you stated that some form of financial support for the small business community is needed to create fundamental fairness. How would the Federal Government fairly distribute financial assistance to small businesses when given the situation with State by State, the small business community faces significantly different mandates and regulations?

Mr. HAYNES. Well, the issue with the mandates is not simply the cost of the individual mandates; it is the collective cost of the difference between the mandates. So it is simply a part of our Federal regulatory system when you have got a bunch of different regulations, it makes it much more expensive to comply with all of them. I was a supporter of the HP legislation but understand that there was concern about the federalism principles of it, and I respect and support that.

A tax credit that recognizes the uneven playing field is really what I am talking about, and the uneven playing field is basically good because big businesses don't have to comply with these mandates. They simply create a self-funded program that is not treated as insurance for purposes of State rules and they don't comply with them.

So all small businesses face pretty much the same issue. There may be differences in magnitude, but because they are not large enough to have an individually self-funded plan, they can't therefore take advantage of the ERISA preemption. They are in a position where economically the only way they can put together a viable plan is by pooling themselves with other businesses. I think the reality of a tax credit targeted to small businesses is it simply compensates for the extra costs that they pay because of an uneven regulatory system.

Mr. THOMPSON. Thank you. Would anybody else like to comment on that?

Mr. BEENE. Well, just briefly, the mandates in certain States often—I mean there is a lot of good that comes from it. Often it is political. Obviously people in different interest groups want to have—it's easy, let's put it in, it's paid for. But then you look up and you are in a small business situation and you are completing with someone who has got ERISA plans. So you are faced with just that situation where on the one hand, regulation makes it impossible. On the other hand, some of it is just too expensive because there are things you don't need that you are having to pay for.

Mr. THOMPSON. Thank you, Madam Chairwoman. I yield back the balance of my time.

Chairwoman VELÁZQUEZ. Mr. Griffith.

Mr. GRIFFITH. Thank you, Madam Chairman. I appreciate so much being here and hearing the comments. I do believe that we are trying to figure this out from within the box, and I appreciate all the calisthenics that we are going through to exist within a structure that, over the last four or five decades, have proven intractable to lowering costs, and although we are figuring out various ways to increase the deductible or a tax credit, it has nothing to do with lowering the cost of health care. I think we are not addressing the problem. I think maybe some stakeholders that need to be at the table are not at the table.

Less than 2 percent of all of our medical school classes are going into primary care. A third of all of our primary care physicians are 55 years of age and older. We have a huge, huge deficit of primary care providers and that is what we need to preventative care. A child born today in America that does not smoke and is reasonably well informed about nutrition is going to live to be 100 years old. We now have the ability to cure many, many major diseases that are or at least allow the patient to live with them.

My concern from business, and I am hearing the insurance industry, the small business hospital industry, etcetera. We are all advocates for our industry, but there are no patient advocates here. And I think that America is faced with a huge crisis that unless we come to grips with the fact that there are no primary care providers and they are distributed when we do have them so unevenly that we are going to have to look for other solutions, and one of those solutions is that we need traditional medicine, the American Medical Association and State medical associations, to allow our nurse practitioners who are certified in multiple specialties to be in touch and help us care for America.

It is an artificial restraint, and I think that would go a long way to preventative care when we realize that half of all lives lost in the next century will be life-style-related disease, whether it be obesity, hypertension, and what have you. We have the solutions to affordable health care, but they are not going to be within the traditional boxes that we are looking in right now.

Thank you, Madam Chair for allowing me to make that comment.

Chairwoman VELÁZQUEZ. Sure. Thank you. Mr. Gohmert.

Mr. GOHMERT. Thank you, Madam Chair. And I appreciate having the hearing. I appreciate the work in this area because this is something affects everybody and during the time I left the bench to run for Congress and the time I got elected, I learned some valu-

able lessons about health care. I also had learned them as when I was in a small business myself as an attorney. But they became more pronounced. For one thing, I had a relative who was in a car accident, the fault of the another driver; so I agreed to help this person with their 2 days of medical expense, make a claim from the other guy's insurance company. And we did so. And the way the practice goes, you gather all available medical receipts. We did that. Supply those to the car insurance company. And we had a settlement.

And then under Texas law, once that is done, you can't distribute any proceeds until you pay back all of the medical, which I contacted the hospital, ambulance, doctors, MRI, all that procedures, and we had about $10,000 in medical bills. They all said we have been taken care of pursuant to our contract with the health insurance company.

So once I had all those agreements in, that they had all not been taken care of pursuant to their agreement with the health insurance company, all I had to do was pay the health insurance company, and for the $10,000 in bills their total out of pocket was about $800. So it brings me to wondering if there wasn't some way to get total truth about what procedures cost in cash.

I am told, and I have not allowed to see actual contracts, but I am told in some perhaps Blue Cross contracts there are provisions that do not allow hospitals or health care providers to charge a cash price that is as low as what the insurance company could get. I had a daughter that needed a procedure. We got a $200 discount for $2,300 or $2,400 procedure, but I am told that the health insurance companies pay a fraction of that but they couldn't charge us that little because of their agreement.

So it just seems that what we have in this country, everybody talks about health insurance, but we most of what we have other than the catastrophic care is not health insurance. We have the insurance companies and we have the government running health care. And I also think for those who want to be entrepreneurs, since health care insurance has taken off so well, you could do the same thing with gasoline. The price is up; it is down. Tell America you pay us, you know, a big wad of money every month and we will give you a copay and a deductible and we will pay your gasoline bill every month.

It is the same type thing. It is not insurance as much as it is management. So I would love to see us get back to the place where we were when I was younger when you could have catastrophic care. Insurance did a phenomenal job of taking their monthly payments, depositing them, making them grow, and then covering catastrophic events instead of managing health care. I would love to see us get back to a doctor/patient relationship that we don't have anymore. It is either patient/government/doctor or patient/insurance company/doctor. I want to see the health insurance companies do well and take care of us on catastrophes.

The HSAs seem like an avenue to address that, especially if it is pretax money, goes into an account, can't be spent on anything else, can be rolled over and not one of these if you don't use it you lose it. It could even be inherited. We could provide for future generations. I have had seniors say I am to too old and I am too sick

to ever have an HSA. So we looked at numbers. We looked at 2006 and were told that the Federal Government spent the average for households in America of around $6,100 per household of America of tax dollars, that State governments spend around $2,200 or $2,300, about $8,400 per household. Heck, for that much money, we could tell everybody here is your HSA. If you are too sick and too old or out of work, here is your HSA, here is your catastrophic care, you are covered. And we would save $3,000 or $4,000 worth of tax dollars for everybody in the country and it would be back to a doctor/patient relationship.

So I am open to any proposals but I am not sure that we are back to where we should be where we can have a doctor/patient relationship. I saw socialized medicine in the Soviet Union when I was an exchange student there. I don't want to go there. Socialized medicine needs people to die before they get their care so it doesn't cost too much. I don't want to go there.

So thank you, Madam Chair.

Chairwoman VELÁZQUEZ. Thank you. I don't know who is proposing that because even the President is talking about tax credits for small businesses. That is not socialism. But Mr. Ratner I would like to—Mr. Nye. I am sorry.

Mr. NYE. Thank you. Just a quick question.

Mr. Ratner, I am interested to hear from you if you wouldn't mind commenting from a small business owner. Clearly right now we are very focused on trying to create jobs. Small businesses we are counting on to create most of those jobs. And I just wanted to hear your input on how our treatment of health benefits from a tax perspective impacts your ability to hire people and to grow your business.

Mr. RATNER. It is part of the package. Every time—if there is a mandate, every time there is an added cost to bringing on a new employer, it is one more thing in the liability column when you look at should I hire someone or should I not? So it is not 100 percent that I am not going to hire someone but you really have to have a real strong desire or need to hire that person. If not, you are just not going to hire them. There is no need to. There are too many costs. Frankly, what we are going through, and I should have said this before, is now instead of hiring new people we will just give our regular crew more hours and give them more overtime. It is cheaper to pay them overtime than it is to hire new people. So it kills job creation.

Mr. NYE. I want to allow anybody else that had another comment if they want to join in.

Mr. HAYNES. If I could just add a little bit to that too because I hear a lot of this from my members, the smaller guys. Most of my small members compete with big public companies. It is just the way the system is configured. There are large bottlers and small bottlers throughout the country. They often can compete with each other. What they tell me basically, the smaller members, because they can't offer the same level of insurance is they keep losing people to big business. They keep losing people who are good employees and having to go through this cycle of hiring new employees and training them. So it drives up their costs from multiple perspectives. I don't think it should be lost on this committee that

the Fortune 500 companies are engaged in a fairly large-scale job reduction. It is going to happen.

When a big public company misses an earnings report, they have a—they both have reduced needs for people but they also have unfortunately incentives to take one-time write-offs and have large-scale job reductions. And last week, I think the number between eight companies was over 100,000 job cuts, eight, nine public companies. And small business does have to scale down its employees when the needs change, but I don't think they have quite the same pattern of behavior in terms of eliminating people because there is an expectation they do so. And that is something that concerns me and I think would concern the members of this committee and Congress.

Mr. NYE. I yield back the remainder of my time.

Chairwoman VELÁZQUEZ. Thank you.

Mr. Ratner, I will recognize Mr. Sestak; then I will come back to you.

Mr. SESTAK. Madam Chair, maybe most of these questions have been asked.

Mr. Ratner, if I could follow up with a mandate question. I think it was your testimony or, sir, it might have been yours of Coca-Cola, talking about the direct cost of a mandate. I understand the direct cost of a mandate. But the indirect cost of a mandate bodes in many studies a real benefit to—not directly to your cost, but to the Nation's cost for health care. So how do we take that on board when one-fifth of all uninsured in America earn more than $50,000 or above? Generally the youth of America that have a great job don't bother to spend the couple of thousand bucks out there for health insurance. They are in a car accident, and now we have to take care of the TBI with the Nation's money, which basically taxes you anyway.

How do you measure the days off of your sick person, sir, down there that, yeah, you have got 10 employees, you don't want to raise another one, but you've got to give them some sick leave, but generally—but you lose that and there are a lot of studies that show that mandating—let us just say it is the Massachusetts health care plan way. You are from Massachusetts; correct?

Mr. RATNER. Right.

Mr. SESTAK. That in the social cost, and I don't mean goodness, I just mean as a business, that mandating that everyone is involved drives the risk down for those pools when the healthy are in it as well as unhealthy, and by mandating that everybody is in it, people actually go in for your preventative care. For example, the unemployed—the young woman who testified here on the unemployed and self-employed. I read her testimony. Is she here? Was that you? I mean you didn't go in for some preventative care or I guess you went in and they switched it on you—

Ms. DAVIS. I do have insurance.

Mr. SESTAK. There was one woman here—I can't remember who it was—that had testimony—

Ms. DAVIS. But I had preventative care that I went in before and I got a bill after the fact.

Mr. SESTAK. Let me read get back. I probably just misread. My question is then why not mandate if we all benefit from it?

Mr. RATNER. Well, that is the problem. We don't all benefit from it. If I was sitting here and I am from Massachusetts and it is mandated and I said to you, you know what, guys? My premium has dropped 20 percent. Everyone has got coverage. Everyone is healthy. Let us go for it. But that didn't happen.

Mr. SESTAK. But the Urban Institute study last June said that the Massachusetts health care plan seems to be working. Yes, it is costing a bit more, but so is doing nothing. Probably the premiums would have gone up even more than what Massachusetts tried to do.

So my question is, overall, when you take direct and indirect costs, mandates—when we look at mandating it—and I am not saying single payer at all. I am not a single payer type—appear to say that we all benefit as a Nation with greater savings than if we don't mandate.

Mr. RATNER. You know, I guess the devil is in the details, which is what everyone is struggling with here . If it came out in Massachusetts and you know, again, if the rates had dropped and if her business with two employees was paying—the playing field was level and she was paying the same as the guy with 200 people and everything was level and all premiums were level, I don't know how much of an argument you would get from me, but the problem is getting all that stuff to work with you.

And here is the other problem: We keep hearing that the small business, the entrepreneurs, are the backbone of the country. It is so out of whack that every time you add one of these costs to these micro businesses, you just literally cripple them. So if you came to me and said, listen, we are going to have this mandate but there is going to be a tax credit for the micro businesses and we are going to level that out so the cost doesn't cripple them, that is what I am afraid of.

Mr. SESTAK. I have to agree with you, how we do this. It just seems that so many people's testimony—and I am sorry, I had another hearing on Pakistan. It just seemed to me, as you said, how the mandate is done because there seems much good in getting those people who are healthy and uninsured into the risk premium pools.

My second question, if I could ask one more, is I am very attracted to the idea of pooling and Massachusetts kind of goes head off, and the chairwoman has the CHOICE Act, but that is kind more of risk retention, as I believe her Act does. And one of you testified on that, or has it in written testimony, how do you compare risk retention to an assoc cooperative versus—what I found also attractive, at least as it was supposed to have been done, was this quasi government connector that actually, with a mandate, then puts them in these same 20 insurance plans theoretically that Congress has access to, the Federal Government. Is one better than the other of that pooling?

Mr. HAYNES. I can speak—I am not sure I can speak to superiority. I have an opinion on superiority. I can speak to what you can do with pooling because, as I indicated in my testimony—that may be my testimony you are referring to. We have a pooled captive-based program with our liability insurance. It works beautifully. We have got large members, we have got small members, and we

take 100 percent of the risk or nearly 100 percent of the risk even though there is an admitted insurer that writes the paper, but we do the reinsurance. We take the money that goes into the lost fund and invest it. We have active claims management people. We have active loss control programs to reduce the cost. We are totally motivated to reduce the total cost.

And we work very hard on that, sharing best practices. And that program delivers—we have been at it for 5 years. We deliver about a 25 percent reduction to our members that participate in that. So it works beautifully in the liability area, and I don't know why it wouldn't work just as well in the health insurance.

Mr. SESTAK. Can I make one last statement, Madam Chair?

My prejudice, so you know, is I was in the military up to about 3 years ago, and only about 23 percent of high school graduates every year can qualify to go in the U.S. Military because physically and healthwise they don't qualify. So to some degree we get healthy kids. But once you are in it, there is this mandate that everybody and their families are covered. Now, it is a different health care plan. All that said, we don't deploy overseas; so everybody has 99 percent dental readiness. It sounds funny, but in a real sense, we are a real healthy force out there with this. Then I was quite struck when my daughter had a brain tumor and I needed to get out to take care of that by the failure to have transparency first off and who is the right doctor to go to, which is why fee for service has to change in Medicare and all. I mean, I love Medicare.

Number two, that I could go to an 11-month war and my mind was strictly on the mission because I knew my family was there and I wasn't away from work, for this Nation's work at the time. So to my mind that model, and I understand TRICARE is different and all, bodes to me that if cost for the economy overall is to be something having healthy preventative care with everybody involved, the healthy as well as the unhealthy, and how you do that it seems to me is one of the most critical pieces that we can have, to have the most proficient economy we have because you do have people who wouldn't get sick if they had the preventive care.

I am sorry to go on, but I think this is one of the most important hearings we can have. Thank you, and I am sorry I was late.

Chairwoman VELÁZQUEZ. Thank you, Mr. Sestak. Mr. Graves, do you have any questions? Mr. Moore?

So let me thank all of you for your insight on this issue.

Mr. GRAVES. I have one. Mr. Ratner, what came first? The soda pop or the pet food?

Mr. RATNER. I was wondering if I should put that in the testimony and decided not to. I started selling all different brands of soda in an empty gas station in 1975 and about a year later I bought a dog. And I walked into a grocery store to buy dog food for Bentley, and I looked down the aisle and I said, holy smokes, there is more pet food in here than there is soda. So I bought dog food for Bentley and went back to my store and called 9Lives and Purina and went into the pet food business.

Mr. HAYNES. If I could just comment, as the owner of seven dogs and a representative of the soft drink industry, I think it is a marriage made in heaven.

Mr. RATNER. Except soda is now 2 percent of my business. We can't compete with Costco, Wal-Mart, and these guys.

Chairwoman VELÁZQUEZ. I have just one.

Mr. Beene, the issue of national mandates requiring employers to offer private health insurance, everybody has an opinion about that. But let me ask you to what extent do you think that the small employer will support such mandates?

Mr. BEENE. I think at this point, there is a lot of hesitancy from the small employer because of the fear of the unknown, especially in this economic time. We are talking at a time that people are—I think generally across the board things are pretty tight, and while I think as time goes, people will—perhaps the ideas will come around because I do think there are some benefits to it. It is certainly one way to look at things. But I think that right now the reaction is from what will this do to me? How much is this going to cost? Will it ruin my business? So I think right now we have got issues with support of that from small business.

Chairwoman VELÁZQUEZ. Do any of you have an opinion as to being able to structure a mandate that could address concerns over costs?

Mr. BEENE. I think bringing the tax credit into it at the same time would be probably the place to start.

Chairwoman VELÁZQUEZ. Mr. Ratner.

Mr. RATNER. I think the mandate, unless there are very good tax credits in it, would cripple the micro business. The guys with two and three folks like her, it would be a disaster.

Chairwoman VELÁZQUEZ. Ms. Fox?

Ms. FOX. I would just add that we are supportive and I think there is becoming more broad support for an individual mandate. I know there is a lot of concern in the business community about—especially small employers and large employers have lots of concerns about the mandate but I am hearing a growing consensus that an individual mandate might make sense especially if we can address the affordability and provide reining in costs and provide appropriate subsidies because I think the issue we have heard about young people not purchasing coverage is a real serious issue. I know I have a 23-year-old son, and he would rather buy fancy phones than his insurance. So they tend to feel invincible and we need to get them in the system to make sure that everything works best for everyone.

Ms. DAVIS. I think the mandate has to be on the individual as opposed to the small business owners because putting the burden just on the small business owners and not on the individuals to take care of themselves is not going to work.

Chairwoman VELÁZQUEZ. Mr. Haynes.

Mr. HAYNES. I have got a concern about individual mandates, and the question is how do you price it? The reality is that young person—the pricing on that insurance to be fair to that person is going to have to be very, very small, and so you can't have any kind of, you know, what typically happens in insurance markets, which is ratings and community ratings and all that kind of stuff. Otherwise, we are going to impose costs on our young people who are already paying a lot of costs associated with the aging of the population, that just isn't fair. So if there was a pricing mechanism

that was fair to me and made that cost containable I could see it. But I think a lot of young people are making individually rational decisions not to be insured.

Chairwoman VELÁZQUEZ. Thank you.

Mr. SESTAK. Madam Chair, would you yield?

Chairwoman VELÁZQUEZ. Yes.

Mr. SESTAK. If I could, though, don't we end up paying anyway, you businesses, for that youth who decides not to be insured, and even on the tax credits; don't you pay anyway because you are going to pay it out of your income tax the Federal Government to give it? So anything great that is done is hopefully done in a bipartisan, shared responsibility between individual business and society. Can we really, in something like this that is so dramatic to our future, exclude one of those three?

Mr. HAYNES. The way I would put it is it should be an objective to have as many people insured as possible because it is correct that we all pay the cost for the uninsured. It is the reason why there is such a difference between the quoted price and what might be negotiated as part of a network.

On the other hand, what I see as what should be your objective is to find a way to adopt policies that both provide coverage and affect the marketplace. And if your focusing is entirely on getting coverage you're not going to decrease the total costs that our society pays for health care, and that has to be at least as important an objective as obtaining universal coverage. So focus on things that will change the marketplace.

Chairwoman VELÁZQUEZ. Mr. Ratner, in terms of the Massachusetts experience, how much of an economic burden is imposing upon the State government?

Mr. RATNER. At this level—imposing on the government?

Chairwoman VELÁZQUEZ. Yes.

Mr. RATNER. That I don't know. I can tell you that at this level, it is tolerable by the employers, but there is a new wrinkle that they are trying to put in, which is insane. Now they want to take all your part-time employers and use them as full-time equivalents. So if you are not paying 33 percent of your full- time equivalents' insurance premiums, they are going to whack you another mandate, another fine of $275—this is the nuts part—even if that employee is covered somewhere else. And these are the costs that you don't think about. It is the other costs to the businesses and they want you to pay it four times a year. So now we have to hire—because we can't figure it out-- we have to hire someone else to figure that out. So the cost goes up and that will have a real detrimental effect to everyone who has a seasonal business because this is not just for guys like me who are year round. Now you are talking seasonal businesses who just hire kids who may have coverage elsewhere. So I don't know what it is doing with the government but...

Chairwoman VELÁZQUEZ. Well, we will continue to have a discussion on this issue. It is a very important issue that has such a direct impact on our economy and particularly small businesses. So I want to thank all of you for coming here this morning.

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

Without objection, so ordered.

This hearing is now adjourned.
[Whereupon, at 11:45 a.m., the committee was adjourned.]

National Retail Federation Testimony

Hearing on

**"Health Care Reform in a Struggling Economy:
What is on the Horizon for Small Business?"**

Committee on Small Business

United States House of Representatives

February 4, 2009

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Madam Chairwoman and honored members of the Small Business Committee, my name is Dave Ratner and I am the owner of Dave's Pet & Soda City, a four store business in the greater Springfield region of Massachusetts. I am pleased to appear today on behalf of the National Retail Federation (NRF). I serve on the Boards of the Retail Advertising and Marketing Association of the NRF and the Retail Association of Massachusetts.

On behalf of my fellow retailers, I commend you for holding this hearing to focus attention on the difficulty the small business community has in providing health insurance coverage generally and particularly in this down economy. Like you, I am hopeful that health care reform will provide real relief from rising health care costs. We need all the help we can get as soon as we can get it. Yesterday might have been better.

The National Retail Federation is the world's largest retail trade association, with membership that comprises all retail formats and channels of distribution including department, specialty, discount, catalog, Internet, independent stores, chain restaurants, drug stores and grocery stores as well as the industry's key trading partners of retail goods and services. NRF represents an industry with more than 1.6 million U.S. retail establishments, more than 24 million employees - about one in five American workers - and 2008 sales of $4.6 trillion. As the industry umbrella group, NRF also represents more than 100 state, national and international retail associations.

The retail industry is one of the biggest supporters of the employer-based health insurance system – despite not having an easy workforce population to cover. We have a fairly young workforce (though with a significant senior cohort) with a high turnover rate. We employ half of all teenagers in the workforce and a third of all workers under 24 years old. More than a third (35 percent) of this workforce is part-time. Two-thirds of our part-time employees are women. Often retail industry employees are second wage earners, mainstays of family economies. Some qualified retail workers opt-out of the coverage we offer because they already have alternative coverage through a family member or another job.

As a labor-intensive industry, retailers are strong advocates of quality and affordable health coverage in order to help keep our employees healthy and productive. As an industry that frequently endures wafer-thin profit margins, we are also well acquainted with the need to manage the collective cost of labor in as cost-effective a manner as is possible. Maintaining balance between these two imperatives is not always easy – it's borderline impossible, even in the best of times. These are far away from being the best of times.

We hope to work with you and other members of the U.S. House and Senate to bring about meaningful relief from rising health care costs – the key, in our view, to reaching universal access to health coverage. NRF has proposed a comprehensive solution to increasing access to more affordable health coverage in our "Vision for Health Care Reform." A copy of the complete NRF proposal is attached at the end of this testimony.

NRF Vision for Health Care Reform

The National Retail Federation's Vision for Health Care Reform was approved in final form by the NRF Board of Directors in January 2008. We are proud of this document, but are also flexible enough to look beyond its corners for other good ideas. We are aggressive proponents for enacting the right kinds of health care reform as soon as is possible.

Elements of our Vision document were recommended by a special CEO Health Care Taskforce and associated Health Care Taskforce Workgroup formed by the NRF Board in 2006. Both groups contained both small and large retailers, chain restaurants and representatives of member state associations. Individual sub-workgroups (Retail Industry and Health Care; Innovation in Health Care; Innovations in Plan Design; and Ongoing Policy Debates) were formed to study the health care crisis in depth before developing these recommendations for the NRF Board. Our Vision document is the product of that intensive review process. Again, we are eager to assist in your efforts to improve the quality, cost and access to health coverage.

Four Pillars for Reform

The four key elements of the NRF Vision are to: improve health care quality; lower health care costs; increase access to coverage; and reform state health insurance markets. Stated differently, our proposal seeks to increase access to a value-oriented health care and coverage system. We seek to improve quality, lower costs, increase access and address the divergent needs of federally and state-regulated markets.

We believe that until we can create better value in health care and coverage, we will never be able to spend enough collectively to expand quality and affordable health coverage to all Americans – a goal we retailers share. The challenge, clearly, will be getting there. Retailers who don't offer consistent value to their customers don't survive; amazingly the same is not true in the main for our health care system.

Improving Health Care Quality

We spend more than any other nation on health care but get only middling to poor returns on life expectancy, disease states and other health care quality indices. Connecting the myriad disorganized elements of our health care system through health information technology (HIT) will help, as will development of consumer friendly electronic personal health records.

One of the biggest changes will be the development of consumer-friendly comparative cost and quality information. My customers know more about the pet products on my

shelf than they do about the doctor down the street, and that is not right. People should be able to select the best quality care just as they choose between me and my competitors on a daily basis. Competition encourages lower prices and better quality. More and better appropriate competition could do wonders for health care.

Partners HealthCare Inc.

You can see an example of where inappropriate competition and market concentration has increased costs and lowered the quality of care close to my Massachusetts home. The Boston Globe studied the effect of Partners HealthCare Inc. (parent of Massachusetts General Hospital and the Brigham and Women's Hospital) on the Boston healthcare market in November 2008. Those reports concluded that the disproportionate market share enjoyed by Partners had distorted costs and delivered lesser quality care than would have been expected due to the reputation of these institutions. Better information in the hands of Boston area patients might have helped to reduce this problem and helped to create better and more affordable care.

Lower Health Care Costs

We believe that the key to making health coverage more accessible lies in reducing its cost. This should be the central goal in all health care reform efforts.

We have a number of proposals in this area including: better engaging consumers in self-management and value-conscious shopping for care; promoting wellness and better managing chronic conditions; and preserving the federal ERISA law to help more employers sponsor uniform benefits across state boundaries. I note that Chairwoman Velázquez has previously introduced an interesting proposal to help the private market better manage the cost of high dollar claims. NRF looks forward to continuing to work with this Committee on the Chairwoman's proposal.

Increase Access to Coverage

As I have noted previously, reducing the cost of health coverage will help many more businesses and individuals gain access to that coverage. Increasing access will help better spread insurance risk and help reduce overall costs.

We believe that we can reach universal coverage (a goal we retailers share) without mandating that employers provide coverage. We would urge the Congress to consider requiring all individuals to obtain a basic level of health coverage and encourage (but not require) businesses to offer employees access to coverage.

The problem with employer mandates – either to provide coverage or provide specific coverages – is that they directly increase the cost of coverage and hence the cost of

labor. Higher labor costs mean fewer employees to enjoy less coverage: the opposite effect that pro-mandate policymakers seek.

As a rational businessman, I want to employ as many people as I can afford to employ and that my business can support. Employer mandated health insurance will distort that balance and leave everyone – including me – unhappy. I would guess that someone – perhaps the medical community – would gain from an employer mandate, but who will pay the doctor bills if people don't have jobs?

We also continue to support various pooling mechanisms including insurance exchanges, such as the one in place in my home state of Massachusetts. We would urge policymakers to be wary about trying to transplant the bulky and bureaucratic Massachusetts exchange to other states: we had a particular set of circumstances that helped make the Massachusetts Connector possible. We might have done just as well (or better) by implementing an electronic portal-type exchange (like the commercial "Travelocity" website, but for health insurance) at lower cost and better choice.

My own health coverage costs recently decreased purely by reason of the entry of a single new competitor in my local market. Beneficial competition can do much to help.

State Insurance Market Reform

In order to help encourage more affordable access to state-regulated insurance coverage for single-state companies like mine, we urge steps to help reduce the complexity and expense of state markets. Weeding out or applying sunset dates to coverage mandates, encouraging more flexible plan designs (especially for part-time workers) and shoring up access to high risk pools or carriers of last resort for the medically uninsurable will all help. We would also encourage the states to enact less restrictive rating reforms to help encourage lower employees to obtain coverage and thus lower costs for older workers in the process.

Building Consensus for Reform

As proud as we are of our Vision for Health Care Reform, we are under no illusion that Congress or the Obama Administration will turn to us and say "oh, there's the final answer." I would venture that there is no industry in America – and practically no American – without big ideas for health care reform. There are quite a few ideas that have appeared in Congress and during the recent Presidential campaign as well. But, we do hope that our Vision will help add to the growing consensus around reform. I'd be glad to discuss any of the elements of our proposal that interest you in greater depth as would NRF staff[1].

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[1] Contact Neil Trautwein, NRF Vice President and Employee Benefits Policy Counsel at trautweinn@nrf.com or 202.626.8170.

Our members want, need and expect to see real relief from rising health care costs enacted and are determined to play a positive role in the reform cause. Success will also depend in part on whether a strong pro-reform coalition can be built among the myriad, diverse and frequently contrary interests outside the political process.

It's relatively easy to build a coalition of the disaffected to oppose reform. We hope to work with you to help build a stronger coalition of the eager and willing supporters of reform. The talking phase has gone on for long enough, at least in our view.

Conclusion

Again, NRF greatly appreciates the opportunity to appear before you today. In sum, we urge you to work to create a value-oriented health care system that promotes lower cost and higher quality care and coverage for employers of all sizes and individuals from all walks of life. We would urge you to carefully consider the downstream implications of specific proposals on the cost and quality of care and coverage and particularly how different proposals interact.

Again, we look forward to working with you to help promote the enactment of positive health care reform.

NRF Vision for Health Care Reform

The retail industry employs one out every five workers in today's economy and is an important source of health coverage for our associates and their dependents. The industry is eager to assist in efforts to improve the quality, cost and access to health coverage. Americans deserve better value for our collective health care dollar. The National Retail Federation supports the following principles to help reform our nation's health care system:

Improve Health Care Quality – we need better value (defined as the quality and cost of care) from our health care system. We spend more than any other country but lag behind other countries in leading health care indicators.

- Promote the implementation of health information technology as quickly as possible to transform health care administration from paper to interoperable electronic records. This will allow health care professionals to better coordinate care and also make timely clinical information available to health care professionals to help reduce medical errors and avoid duplicative or unnecessary procedures.
- Promote the development of an interoperable, electronic Personal Health Record that can be used by licensed health care professionals in any setting and can be used by patients to transfer their medical history as they move from plan to plan.
- Encourage the use of evidence-based medical standards wherever possible.
- Encourage the availability of comparative health cost and quality information (e.g. transparency). Encourage the availability of this information in easy-to-understand consumer guides.
- Encourage a team-based approach to medicine with the patient as an active participant in managing his or her health. (Electronic medical records can help).
- Encourage quality-based payment programs (a.k.a. value-based purchasing) and other payment reforms to encourage the highest quality integrated care.
- Facilitate the reporting of information through financial incentives for providers.

Lower Health Care Costs – the key to making health coverage more accessible is in reducing its cost. The NRF believes effective measures to improve health care service delivery and reduce costs must be a first and central focus of health care reform at any level.

January 2008

- Support initiatives that serve to engage consumers in managing their health and shopping for high quality and lower cost health care services when needed.
- Promote initiatives to promote wellness within the workforce and better manage and prevent chronic illness conditions.
- Preserve the federal ERISA law to help employers sponsor uniform benefits across state boundaries.
- Permit the medical management of covered benefits (including mental health benefits) to help provide necessary and equitable coverage.
- Enact medical liability reforms to reduce the downstream costs of medical litigation. Reforms should clearly differentiate process failure, human error, negligence and malpractice, including errors caused by obsolete processes and practices.
- Continually work to eliminate waste and inefficiencies in the health care system.
- Establish a "no tolerance" position on fraud and abuse by health care service providers and consumers alike.
- Encourage participation in local and regional reform coalitions that align themselves with broader national initiatives that are consistent with this vision.

Increase Access to Coverage – reducing the cost of health coverage will help many more businesses and individuals gain access. Increasing access will spread insurance risk and help reduce overall costs. In addition, the NRF recommends the following steps:

- Consider requiring individuals to obtain health insurance coverage. Encourage but do not require businesses to offer employees access to coverage.
- Consider voluntary coverage options for part-time workers that emphasize wellness and prevention coverage and help protect against catastrophic health expenses.
- Consider group purchasing or other risk-pooling programs to increase access to coverage for small businesses and individuals. Encourage access to state, regional or national high risk pools or carriers of last resort for the medically uninsurable.
- Consider tax credits for individuals or small businesses to help make coverage more affordable.
- Consider creating personal health savings accounts to accumulate personal savings and voluntary contributions from one or more employers, along with public subsidies or credits and individual funds to help pay for health insurance premiums.
- Add additional flexibility to Health Savings Accounts (HSAs) to make them more attractive to businesses and individuals. Allow Health Reimbursement Arrangements (HRAs) and Flexible Spending Accounts (FSAs) to more effectively coordinate with HSAs. Allow FSA funds to roll over from year to year.

State Insurance Market Reform – in order to encourage more affordable access to state-regulated insurance coverage, the NRF recommends the following principles:

- Help reduce the complexity and cost of coverage by encouraging lawmakers to refrain from passing benefit coverage mandates, employer mandates or mandatory employer contributions.
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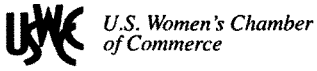

Testimony
of
Janette L. Davis, MBA, CPA
on behalf of the
U.S. Women's Chamber of Commerce

Before the House Small Business Committee

Health Care Reform in a Struggling Economy:
What is on the Horizon for Small Business?
February 4, 2009

Chairwoman Velázquez, Ranking Member Graves, Members of the Committee. I am here today as a member of the U.S. Women's Chamber of Commerce representing our 500,000 members and the millions of American small businesses who are struggling to provide health insurance for themselves, their families and their employees.

Thank you for providing me the opportunity to share with you the challenges I have had as a small business owner in securing and using health insurance for myself, my family, and my employees.

I am a small business owner, a lender and a certified public accountant from Southern Florida. My company, Southeast American Financial Group, Inc. is owned and operated by my husband and myself. Together, our combined banking and financial services experience totals over fifty years. We have guided and assisted our clients in expanding their business operations, purchasing their company's locations, investing in multifamily, office buildings, shopping centers and strip shopping centers.

Through the years, I have employed as many as a dozen employees and subcontractors. However, during this economic downturn, my husband and I have reduced our staff to one full time. and one part time who is covered by medicare. The cost of health care is extremely expensive for small business owners making it very difficult to afford, especially during the current economic crisis. The costs have risen so much, that it is simply becoming cost prohibitive to maintain. But, it is also difficult for me to get and keep quality employees if I am unable to provide a good health insurance benefit.

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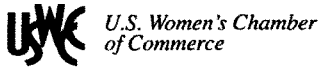


Currently, I pay fifty-percent of the monthly health insurance payment for my employee. Since the employee is currently healthy, it might seem like an HSA would make sense to help keep the costs down, but what happens if they run into a major health issue early in the year before they are able to save any part of their deductible? These high deductible solutions are fine for those who do not incur a health problem, but can pose big problems for those who do incur a sudden health problem. And, for small businesses like mine, it is very important that our employees get the health care they need so that they can proactively manage their health, and be available for our business needs.

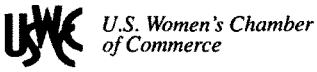
Like many husband and wives who work together in their businesses, my husband and I have to purchase individual policies instead of a family policy because we both work in the same company. In 2007, the insurance coverage for my husband and I increased to approximately $1,400 per month. In order for us to continue to carry insurance, I had to switch my company to a high deductible HSA policy.

My husband and I now pay $881 monthly for health insurance coverage. However, I have to cover the first $3,000 of my expenses and my husband has to cover the first $3,000 of his expenses. While our policy is supposed to cover preventative for primary care physicians and specialty care physicians, we have found that the insurance company almost always finds a way to exclude something and stick us with a co-pay. Additionally, we are responsible for our prescriptions until we each exceed the $3,000 of our deductibles.

The health insurance costs are more expensive for a woman of child bearing age as compared to her male counterpart of a similar age even though she may be healthier than her male counterpart. This should not be the case. But, due to the high costs involved, many women who purchase insurance policies are opting to exclude the pregnancy option so they can obtain an affordable policy. In addition, after the age of 40 insurance costs increase significantly even though you may not have any medical issues.

The families of small business owners really bear the brunt of the inequalities in our health care system that is heavily skewed in the favor of big business. Before owning my business, I worked for larger businesses. During this time, I had a more affordable family policy – which also covered my husband. Because I am younger and healthier, our coverage was cheaper because it was issued to me as the primary.

My husband had a retina detachment followed by a macular hole that developed in his eyes in 2004. The bill was in excess of $80,000. However, the insurance company only had to pay about 25% of the street price (based on its discounted arrangements with the hospital). I believe that if the hospitals can afford to discount that much for the insurance companies, why is it that their services have to be priced at such exorbitant sums for the cash paying customer who in most cases cannot afford to pay the astronomical bills?



If we could reduce those costs to a more reasonable amount, it is likely that more bills would be paid to hospitals. It is situations like these that make it necessary to have insurance to avoid the astronomic bills that can ensue from an unexpected issue.

While the insurance companies collect these large sums, only a fraction of what we pay goes to the doctors and hospitals. The bulk of the money appears to be spent on operations and compensation to the insurers.

My doctor recommended that I do a colonoscopy for preventative purposes. Prior to setting up the procedure, I verified with my insurance company that the procedure would be covered one hundred percent as a preventative procedure. During the procedure, the doctor discovered that my colon was working too hard and stated that I needed to add more fiber to my diet and drink more water. Consequently, my health insurance company determined that the procedure could not be classified as preventative and charged me $562.50.

While we currently have health insurance, with a declining business climate, and a declining stock market, it is extremely difficult to continue to afford the high premiums. We are forced to secure expensive individual policies. Individual policies and small groups pay disproportionate premiums as compared to their big business counterparts as we do not have the bargaining power of the company with a large number of employees.

What Are the Solutions?

We need to put health care back in the hands of the doctors instead of the insurance companies who dictate what you can and cannot receive even though it may be medically necessary to save your life. There are too many health insurance plans with too much fine print and exceptions. It is hard to even understand what one is purchasing. There needs to be more clarity and an easier way to know what you are getting. Health insurance companies shouldn't be able to wiggle out of paying for health care services. The restrictions should be lifted as to what doctor or hospital that you may be able to use.

Small businesses should be allowed to pool together and be allowed to purchase insurance under a national group umbrella policy. This should lessen the costs and at the same time afford quality coverage to smaller companies who now are forced to buy coverage as individuals.
Provide tax credits to allow small business who would like to purchase coverage but cannot afford to do so. Remove the 7.5% of AGI threshold on claiming medical expenses on schedule A of the income tax return. Do not mandate that they have to provide coverage because if they are struggling to survive that would further destroy them.

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In regional areas where hospitals receive funds to provide care to lower income individuals, outpatient clinics should be created where patients could go to receive preventative care as opposed to only going to the emergency room when they are really ill. Employees who are unable to afford the higher insurance costs could pay a monthly co-pay of $100.00 into a fund from which the hospitals could be paid. This would reduce health care costs as the employee would get regular screenings and be taken care of before becoming ill.

Insurance could be divided into medical and catastrophic care. Individuals could be allotted tax credits that would allow them to pay their medical costs directly to their doctor and then they could purchase insurance coverage for surgery and other catastrophic illnesses.

It's time to end the stranglehold health insurance companies have on American citizens. Small business owners and their employees have been forced into paying exorbitantly high premiums, risking high deductibles, and then nickel and dimed by insurance companies. We need to wrestle the control of our health out of their hands and put it back in the hands of individuals and doctors. Get rid of endless administrative overhead which is often aimed at finding ways to not pay for care. Help American small businesses to pool together to leverage our scale and bring the costs of care down.

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Statement of W. Thomas Haynes

Executive Director, The Coca-Cola Bottlers' Association

House Committee on Small Business

"Health Care Reform in a Struggling Economy:

What is on the Horizon for Small Business"

The Intersection of Health Care Solutions, Small Business

and Economic Stimulus

February 4, 2009

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

I thank both of you not only for the invitation, but more importantly for your leadership and support of innovative solutions to the small business health care crisis, including your sponsorship of The Small Business Health Care "CHOICE" Act. For reasons which I will outline, I believe that the CHOICE Act will dramatically expand the affordable options available to small businesses and will make a sizable contribution toward solving America's health care challenges, probably beyond the expectations of those who may only see it as a first step toward health care reform.

Inasmuch as this is my third appearance before this Committee, I will dispense with a full recitation of CCBA's experience in providing health insurance solutions for its members. For the benefit of the new members of the Committee, I will simply summarize by saying

that, like many trade associations, CCBA has struggled recently in its efforts to provide affordable health care programs for its smaller members.

Unlike many associations, however, CCBA has achieved significant success in maintaining health insurance programs for its larger members and even greater success in providing virtually every other imaginable form of insurance and employee benefits to members of virtually all sizes. This contrast between the opportunities available to groups of small business and large businesses in the health care arena, and between the success of pooling efforts for small businesses in health care and other forms of insurance and employee benefits, speaks volumes about the problems facing the small business community in finding solutions to the health insurance dilemma that they face. It also sheds light on the key questions now facing Congress, namely how to control the raging growth of the ranks of the working uninsured and underinsured in the small business work place without crippling a struggling economy, driving further unemployment or adding further stress to a federal budget deficit that should frighten all of us. To put it simply, there are too many roadblocks to finding health care pooling solutions for small businesses and too much of a gap between the opportunities available to large and small businesses. The small business community needs the help of Congress and this Committee in this critical arena.

For decades, CCBA administered two separate health care plans: a fully-pooled program for small bottlers under 100 employees; and another individually experience rated program for those bottlers with over 100 employees. Both programs were fully insured, but involved various levels of risk retention by CCBA and its members. In 2000, CCBA's small member health care plan was disbanded due to the overwhelming complexity of state small group reform laws and regulations.

As a result, quotes for our smaller member bottlers for comparable coverage increased by double digits for several years in the early part of the decade. Their only option has been to cut back on their plans, utilizing higher copays, higher deductibles, elimination of employer-supported family coverage and higher annual out-of-pocket maximums. These changes have greatly reduced employee participation rates, effectively pricing 50% of the employees out of the market for the coverage they once had. Many of our members are left with offering nothing but employee-only coverage, increasing the number of uninsured employees and/or their family members, including children.

We have been able to continue operating a CCBA-administered health plan for the benefit of our larger employer members (Coca-Cola bottlers with more than 100 employees). Our larger employer members have been able to continue benefiting from the cost-saving efficiencies of participation in the CCBA plan, with average annual premium increases approximately equal to, or in some cases less than, the market average. Our large employer program also provides stability of plan design offerings and long term carrier contracting that enables access to a consistent provider panel enabling fewer provider–patient disruptions. Moreover, our largest members, as well as the largest competitive bottlers, are able to provide high quality health care benefits at acceptable costs through the mechanism utilized by almost all large employers—self-funded single employer programs—without any assistance from CCBA.

The Economics of Small Group Insurance

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

Attached to my testimony is an analysis prepared for CCBA by Mercer concerning the relative costs of the components of health insurance costs for small, medium and large employers and groups. As it shows, non-actionable claim costs (the actual amounts necessarily received by providers of medical services) are roughly equal for small, medium and large groups. Other costs, such as administrative and risk underwriting expenses, are dramatically different depending on the size of the employer or group.

Importantly, as the Mercer analysis shows, the amounts paid to providers for medical services are only slightly more than two-thirds of total costs in the small group market. In my view, any solution to the health care challenge facing small business and its employees (which is a large part of the overall health care challenge) must significantly shrink those non-provider costs, since they are not likely to be affordable to any of the players (the small business community, its employees, or the federal government and the federal taxpayer). By my estimate, those non-provider costs for small business health insurance exceed $100 billion!!! Those costs cannot be eliminated, because any form of small business health insurance will involve significant administrative costs, but surely they can be reduced.

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

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

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

small businesses with the major insurers to achieve the best possible rates for all eligible small businesses.

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

One very reasonable solution is simply to provide federal financial support to small business programs, given that a major source of their disadvantage is that federal law puts them at a disadvantage relative to large employees by exempting large single employer programs from state regulation while leaving small business subject to the same regulations even if they pool their coverage with other small businesses to create the same scale. Some form of financial support for the small business community is almost certainly necessary to create fundamental fairness in an environment in which many believe (and some states have required) that businesses should provide mandated levels of coverage to their employees. The fair choice is to support small business financially if we believe that they should provide health care benefits to their employees, but face incremental costs in doing so because of an imbalanced regulatory environment.

Insurance Markets and Risk Shifting Costs

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

CCBA has extensive experience in dealing with pricing and pooling of insurance risks, since we have been operating in the liability insurance arena throughout our nearly 100-year history. In our experience, the key to achieving savings on risk underwriting costs is to pool and retain those risks to the maximum extent possible, rather than relying on insurance markets and pricing mechanisms to mitigate those costs.

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

For the business that seeks to obtain health coverage for its employees, the profit generated by the carrier in assuming part of the risk associated with writing health insurance policies is simply an additional cost. The objective of a small business employer offering health

insurance is to help its employees by relieving them of a part of the burden of unanticipated health care costs that they cannot afford, while reducing in a cost effective way the risk that they are taking as employers and businessmen or women to a level that their business can potentially afford. Carrier profit, while necessary to the risk shifting bargain, is simply an additional cost.

The solution for large businesses is through self-insurance and risk retention, and virtually every large business has elected to self-insure most of its health care benefits. By doing so, the large business not only avoids paying the profit that the carrier understandably must make if it is to take on health insurance risk, but also minimizes its administrative costs by taking advantage of ERISA preemption and employing consistent plan designs that do not necessarily comply with each state's unique coverage mandates.

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

Outside the health insurance arena, CCBA has implemented that strategy by forming its own liability insurance captive and retaining as much risk as possible within that captive. Over time, CCBA has built up the reserves contained in that captive through premiums received by its members and has taken on more and more of the insurance risk traditionally assumed by commercial insurers. As those reserves have grown, CCBA has been able to return much of the premium to its members in the form of renewal credits, while still pricing the coverage at highly competitive levels. In 2007, CCBA was able to provide renewal credits amounting to over 25% of the normal premiums charged for its liability insurance programs.

The same solution can and will work within the health insurance arena, not only for CCBA and its members, but for other groups of small businesses. If, as the Mercer analysis indicates, that risk shifting cost is nearly 10% of the total cost of health insurance, CCBA or other organizations pooling groups of small businesses can reduce that cost to a very small number (or zero) over time, by simply pooling and retaining the risk. In order to do so, however, significant pools must be created (since short term fluctuations associated with risk retention for small groups would present too much risk) and other forms of cost disadvantages must be neutralized.

Employer-Provided Health Care Benefits and Cost Containment Incentives

While administrative costs and risk shifting premiums are two of the most important drivers of health insurance costs for the entire system, there are other important drivers, including provider costs. As noted in the Mercer data, "actionable" claim costs are another significant component of health insurance costs and another source of substantial disparity between small and large groups.

Based upon my discussions with major providers and other market participants, a major driver of unnecessary or avoidable claims costs (which may not all be captured in Mercer's

estimate of "actionable" claims) is ineffective management of chronic disease. Those industry participants emphasize the importance and effectiveness of disease management programs, particularly for major chronic conditions like diabetes, heart disease and other similar conditions and believe that a large part of the treatment provided by the medical community would be unnecessary or less costly if patients with those chronic conditions would simply participate in the effective disease management programs. There is some debate about the quality of some of those programs, but there appears to be a consensus that effective programs are underutilized.

As is turns out, the data again shows a large gap between the experience of small and large businesses in this arena. Not only does the Mercer data reflect a significant actionable claim cap between large and small business, but a separate recent Mercer survey shows that utilization and availability of health and disease management programs as a part of large employer (over 500) programs is more that double the utilization in small employer programs.

This huge gap may have significant implications for both the cost of small business health care programs and the long term health of the small business workforce. On one level, the gap is somewhat surprising since employees at large and small businesses with chronic health conditions would seem to have roughly equal financial and non-financial incentives on their own to participate in and adhere to health management plans. As is widely recognized, at least one reason why formal health disease management programs are necessary is because employees (and in fact all of us) may need additional incentives to take the steps to remain healthy and avoid expensive treatment regimens resulting from poor management of chronic diseases, particularly when a third party payor system reduces the financial incentives for both the patient and the provider proactively to invest time and money in disease management.

It would appear that the driver of the gap must be the differences in the external (third party) disease management incentives provided to employees of large and small businesses. It is my speculation, based in part on discussions with industry experts, that the driver of that difference is the incentives provided to large employers by the self-funded, self-insured model, where the cost of ineffective chronic disease management is ultimately borne by the employer. The self-insured employer tends to adopt disease management strategies and provide employee incentives as part of the loss control programs that are central to any well-run self-insurance program. In contrast, for a small employer that is purchasing a fully-insured policy, the financial incentive to encourage or incent employees to manage chronic diseases is far more attenuated. Indeed, because insurer-provided health management programs may impose additional upfront premium charges, small employers may have disincentives to encourage aggressive chronic disease management, given their need to minimize upfront costs by eliminating "optional" features in insurance programs.

Key features of Effective Health Care Reform and the CHOICE Act

Based on the foregoing, our experience suggests that effective health insurance reform must have four significant characteristics: (1) it must eliminate or significantly reduce the disparity between opportunities for small and large employers, (2) it must create real opportunities for improved risk and administrative pooling across groups of small employers, (3) it must create opportunities for small employer risk retention, to reduce the cost of carrier

risk shifting or create additional competition in the pricing of risks and (4) it must create the right type of incentives for effective chronic disease management programs and, more broadly, healthier behavior by all Americans.

In my opinion, of all of the legislation introduced or discussed thus far, a single bill, the CHOICE Act, seems to best combine all of those key features.

It recognizes that the largest driver of the uneven playing field, disparate state regulations that do not apply to large employer self-funded programs, is simply a product of core federalism principles that should not lightly be compromised. It thus requires that covered programs be fully insured and also comply with all applicable state laws concerning mandated coverage and other state insurance regulations. While that recognition of the prerogatives of the states will leave in place the administrative cost disadvantages that make pooling of coverage for multiemployer groups small businesses so difficult, the CHOICE Act proceeds to solve that disadvantage by providing an offsetting federal tax credit for the small business employer, provided that certain reasonable requirements are met (employer subsidies of a reasonable portion of the cost). Moreover, the second major required feature of programs complying with the CHOICE Act, inclusion of a wellness program, goes directly to the fourth objective outlined above—improvement in small business employee participation in chronic disease management.

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

Properly employed, the incentives provided by the CHOICE Act will also work to reduce many of the other costs disadvantages facing small businesses, by allowing formation of relatively large pools of lives relatively quickly. In CCBA's case, we believe that it would allow us to re-form our small bottler program within a very short period of time and to restore the competitive benefits that we were once able to provide to those bottlers, perhaps on even more favorable terms. We also anticipate that we can successfully extend the program into similar businesses with minimal additional work. Indeed, we believe that, over time, we will be able to make that program extremely attractive for even bottlers and other businesses that are not eligible for the full tax credit because they have between 100 and 500 employees (our captive-insured liability programs work very successfully for somewhat larger business). In those cases, we believe that we be able to provide more affordable insurance coverage and reduce the ranks of the uninsured without any major expenditure of federal tax dollars to support the particular medium sized businesses that might participate.

The Small Business Health Care Crisis and the Economic Crisis

Finally, I would note that the CHOICE Act approach has a number of other advantages and provides a number of collateral benefits that are not delivered as effectively by other proposed reform measures. The first two, and most important, of these benefits is that the CHOICE Act is (a) simple and (b) immediate in the way that it can be implemented. Unlike many other reform proposals, the CHOICE Act leaves in place both the workplace and the private insurance model for delivery of health care benefits. While there is room for debate as to whether those models are perfect, or even ideal, there seems to be little question that any reform that is dependent on a radically different model (e.g., individual insurance, single provider, etc.) will take years, or even decades, to fully implement. Likewise, the CHOICE Act is not dependent on a lengthy process of ground-up reform at the state and local regulatory level. In essence, it facilitates the adoption of the model that works reasonably well for big business (self-funded risk retention) and makes it more available to small business pools. In these troubled times, legislation that carries the promise of delivering more affordable benefits to small businesses in 2009-10, rather than 2013 or beyond, should be a central objective.

The other important collateral benefit delivered by the CHOICE Act is restoration of parity between small and large businesses. CCBA's mission is to create parity of opportunity and parity of cost for all of its members, so that small town fourth and fifth generation bottling companies can continue to exist and thrive, even when they compete with global multinational public companies. The single remaining gap that we have not been able to close is the health care gap and my small members continue to tell me that they are not able to offer the types of benefits that allow them to compete for employees with large public companies, including some of their Pepsi competitors.

I believe that elimination of that gap should be important not only to this Committee, but to the Congress and the nation as a whole. Last weeks' news, when a handful of public companies tried to dampen the impact of disappointing earnings reports with announcements of over 100,000 job cuts, should not be lost on any member of Congress. As is widely recognized, this economic slowdown will have a huge impact on employment, the size of which cannot currently be predicted. Small business is not only the engine of job creation in the U. S., but must also play a particularly large role in mitigating the Main Street impact of a Wall Street collapse, given the scope of the Fortune 500 job cuts that are well underway. Now, more than ever, Congress should act quickly to address the Hobson's choice facing small businesses—eliminate health care benefits to their employees or eliminate some of the employees themselves--by providing targeted help to the small business community. Relative to any other form of federal spending on health care, it is my view that such assistance is more likely to stimulate the economy by improving the competitiveness of the small business community.

Conclusion

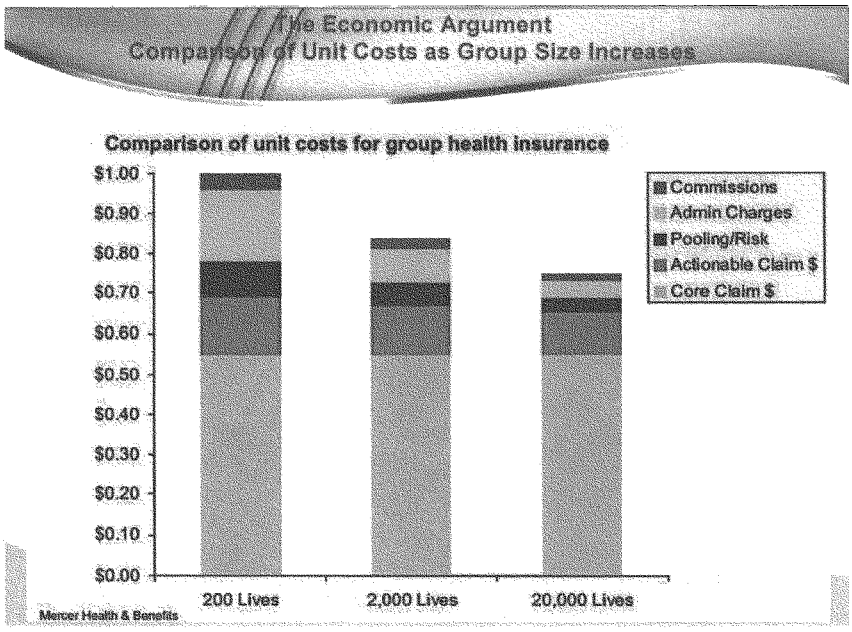
As a strong believer in the superiority of market-oriented, rather than public sector driven, solutions to policy challenges (all other things being equal), I would like to add a footnote to my comments that is directed at others that share that belief. The CHOICE Act does involve the investment of federal tax dollars (whether viewed as a tax credit or a

subsidy) to the problem of declining access to affordable health benefits for our nation's small employers and their associates. That should not deter any fiscal conservative from providing their enthusiastic support to the Act, because it represents the type of investment that will deliver huge returns to the public because of the way in which it will affect the markets for the delivery of health care and health insurance.

As noted above, the cooperatives that it will "seed" will take billions of dollars in costs out of the system that are not reaching the hands of providers of health care services. By addressing the current imbalances between small and large employers it will place those employers on more equal footing in recruiting new employees and in competing in the marketplace for the goods and services that they produce and sell.

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

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


The Economic Argument
Comparison of Unit Costs as Group Size Increases
Comparison of unit costs for group health insurance
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Testimony

Before the

Committee on Small Business
U.S. House of Representatives

on

Health Care Challenges for Small Business

Presented by:

Alissa Fox
Senior Vice President

February 4, 2009

Introduction

Madame Chairwoman and other distinguished members of the Committee, my name is Alissa Fox and I am Senior Vice President of the Office of Policy and Representation of the Blue Cross Blue Shield Association (BCBSA). I would like to thank you for the opportunity to testify before you today on the challenges small businesses face in providing health coverage for their employees.

BCBSA is a national federation of 39 independent, community-based Blue Cross and Blue Shield companies that collectively provide health care coverage for more than 102 million individuals – one in three Americans. Blue Cross and Blue Shield Plans are the only health plans that provide coverage across every zip code in the United States. All Blue Cross and Blue Shield Plans offer coverage to small employers – a sign of our strong historical commitment to the small employer market.

BCBSA strongly believes that all Americans should have health care coverage. BCBSA has put forth a comprehensive, five-part proposal – *The Pathway to Covering America* – designed to build on today's employer-based system to improve the quality and value of our health care system while simultaneously extending coverage to all. We believe that finding effective solutions that expand coverage and improve affordability for small employers must be a centerpiece of our nation's efforts to reform the health care system – a need only made more urgent by recent economic turmoil. We are pleased to be with you today to share our recommendations on how to achieve these goals.

Today, I would like to focus on several key areas:

1. Review challenges facing the small employer health insurance market;

2. Discuss what Blue Cross and Blue Shield Plans are doing to address these challenges; and

3. Provide BCBSA's recommendations on federal efforts to improve coverage for small employers.

Challenges Facing the Small Employer Health Insurance Market

As our nation works to extend coverage to all Americans, we must pay particular attention to the challenges small employers face in offering health insurance coverage to their workers. According to a recent analysis by the Employee Benefit Research Institute (EBRI), nearly 63% of all uninsured workers are either self-employed or working for private-sector firms with fewer than 100 employees (EBRI, 2008).

Ninety-nine percent of large employers (with 200 or more employees) offer health insurance coverage to their employees (Kaiser/HRET, 2007). Among firms with 50 or fewer workers, offer rates are relatively high for larger small firms – 83% of firms with 25-49 employees and 76% of firms with 10-24 workers offered coverage in 2007. However, offer rates decline significantly among the smallest firms. Only 45% of small

employers with 3-9 workers offer coverage. More than 34 percent of workers in private-sector firms with fewer than 10 employees were uninsured (EBRI, 2008).

The reasons for these low offer rates and high uninsured rates among very small employers are complex. They include the ability of firms to afford to offer coverage as well as the ability of workers to afford their share of the premium when coverage is offered. This situation is compounded by certain characteristics among small employers, who may be less established, have less certain cash flow, and employ more low-wage workers than larger employers. The affordability challenges faced by small employers will only be exacerbated by the current economic downturn.

To understand the challenges that small employers face when purchasing health insurance, it is important to understand how this market functions and how it is regulated. Traditionally, small employers faced two major challenges in purchasing health insurance: access and affordability. The issue of access has largely been addressed as a result of the enactment of state small employer health insurance reform laws in the 1990s. However, the challenge of affordability remains, as I will discuss in detail later in my testimony.

In the 1980s, states were faced with a small employer health insurance market that was in crisis. Small employers in many states were having difficulty purchasing insurance at any price if they had sick workers. In response, states enacted reforms to assure that small firms with sicker workers could obtain coverage at reasonable premiums.

Today, state and federal law requires insurers to offer coverage to all small businesses (2-50 workers) regardless of their employees' health status. In all 50 states, small businesses cannot have their coverage turned down or cancelled if their employees become sick. Thus, small employers that can afford coverage are guaranteed access to coverage today.

The premiums that insurers charge small employers are now highly regulated. State law requires health plans to pool all of their small employers together when establishing premiums. State laws also limit the extent to which premiums can vary for individual small employers based on a variety of factors, including health status or claims experience. These reforms spread the medical costs of all small employers more evenly to generate more affordable premiums for employers with less-healthy members. However, this results in higher premiums for the healthiest employers.

Affordability is the central remaining challenge in the small employer market today. Since 1999, average health insurance premiums for family coverage for small employers have more than doubled from $5,683 to $12,091 in 2008, according to the 2008 Kaiser Family Foundation/HRET employer health benefits survey. As health care cost increases continue to outpace inflation, small firms have found it more and more difficult to provide or maintain coverage.

A survey of small employers BCBSA sponsored with the Employee Benefit Research Institute indicated that being able to afford health insurance was the top challenge facing small businesses that offer health coverage (EBRI, 2002). For many small employers, however, offering coverage is not a financially viable proposition, especially when they have large numbers of low-wage workers. In this same EBRI survey, 61% of uninsured small employers reported that they did not offer benefits because they did not think that their employees could afford it.

It is important to note that escalating premiums are not limited to small employers. In fact, average family premiums for covered workers in small and large firms have grown at similar rates since 2004 (24% in small firms vs. 29% in large firms) and since 1999 (113% in small firms vs. 122% in large firms), according to the Kaiser Family Foundation/HRET survey. These premium increases are due to substantial growth in the underlying cost of medical care that impact premiums for all employers – large and small.

The causes for premium increases are due to many factors. According to the Congressional Budget Office (CBO), the bulk of rising health care costs over the past four decades can be attributed to our nation's use of medical services made possible by technological advances (CBO, 2008). In fact, CBO found that approximately half of all growth in health care spending during this time is associated with the emergence of new medical technologies and services and their adoption and widespread diffusion by the U.S. healthcare system. Additional factors contributing to rising healthcare costs

include the aging of the population, increased utilization due to the greater prevalence of chronic disease, and cost-shifting resulting from underpayments in government programs. According to a recent report by Millman, Inc., and co-sponsored by BCBSA, annual health care spending for an average family of four is nearly $1,800 higher than it would be if Medicare and Medicaid paid hospitals and physicians rates that were comparable to those paid by private plans.

The significant premium increases over the past decade point to an urgent need for the private sector and government to work together to help make coverage more affordable for small business and address the underlying cost-drivers in the health care system.

What the Blues are Doing to Address These Problems

The Blues have been working aggressively to improve quality and control costs – while meeting consumer demands for choice in plan and benefit design – through a variety of innovative strategies and initiatives. Our 39 Blue Cross and Blue Shield Plans across the United States are taking action to improve the healthcare systems in their states and expand access to coverage. Profiles of the many programs underway within the Blue Cross and Blue Shield system can be found at: http://www.blueadvocacy.org/plans.

Working to ensure products meet the needs of small employers is a major priority for the Blues. Throughout our history, Blue Cross and Blue Shield Plans have had a strong commitment to our small employer customers. We are pleased that Blue Cross and

Blue Shield Plans are the number one choice of small employers in most states in the U.S., despite strong competition in this marketplace.

I would like to highlight a few of the initiatives where Blue Cross and Blue Shield Plans are taking action to help small businesses by offering innovative and affordable products and programs to small businesses and their employees.

- **Blue Cross and Blue Shield of Oklahoma** (BCBSOK) worked closely with the state legislature to develop *Insure Oklahoma*, a premium assistance program funded by tobacco taxes that provides financial aid to low-income, uninsured workers in eligible small businesses to help cover the cost of health insurance. Through *Insure Oklahoma*, employers contribute 25 percent of the monthly premium and employees are responsible for paying only up to 15 percent of the total monthly balance. BCBSOK supports the program with plan offerings that provide comprehensive, low-cost coverage to ensure uninsured residents have access to affordable health insurance. To date, *Insure Oklahoma* has enrolled 3,777 small employers and provides subsidized coverage to 11,078 employees and their dependents. According to a recent survey of 400 employers in *Insure Oklahoma*, 56% of enrollees were previously uninsured and 37% of participating employers offered coverage for first time. Oklahoma recently received a waiver from CMS to expand this program to larger employers and college students.

- **Blue Cross and Blue Shield of Arizona's *BlueSolutions*** plan enables small businesses with fewer than 50 employees to offer low-premium, high-deductible health coverage to their workers. The plan covers a broad range of healthcare services such as urgent and maternity care, with affordable co-pays for in-network physician visits and generic prescriptions. *BlueSolutions* provides an affordable coverage solution to small businesses that were previously unable to offer health insurance to their employees.

- **Anthem Blue Cross and Blue Shield** has developed a portfolio of affordable small group products aimed at decreasing the number of uninsured in Colorado. *BeneFits* provide health coverage for small businesses with fewer than 50 employees that do not currently offer health insurance. The six *BeneFits* plan options feature low employer contribution and employee participation rating requirements, making them more affordable for small businesses and offering flexibility in choosing coverage.

- **Blue Cross and Blue Shield of Montana** is the insurance carrier for *Insure Montana*, a state-sponsored program that uses tobacco taxes to provide tax credits and premium subsidies to small businesses that were previously unable to afford health coverage for their workers. The *Insure Montana* pool, available to companies with 2-9 employees, provides health insurance to 731 businesses covering 2,000 employees and an additional 1,902 family members.

While these initiatives highlight some of the ways that Blue Cross and Blue Shield Plans are working to assure affordability for small employers, there are limitations to what the private sector and states can do without additional federal support. That is why it is essential for Congress to take action to address the problems facing the small employer health insurance market as part of comprehensive health insurance reform.

Recommendations for Federal Efforts to Improve Coverage for Small Employers

BCBSA strongly believes reform is needed to address the challenges individuals and small businesses face when purchasing health coverage. To this end, BCBSA supports federal action to make it easier for small employers to shop for coverage in a manner that will enhance competition, provide targeted subsidies for small employers and individuals, and change incentives to attack costs and improve the quality of healthcare.

Making it Easier to Shop for Coverage: The State Health Insurance Mart (SIM) Model

In today's health insurance market, small employers and individuals often face challenges in shopping for health insurance and comparing choices based on important criteria such as cost and quality. As part of a comprehensive health reform plan, BCBSA urges Congress to enact legislation to encourage states to establish "State Insurance Marts" (SIMs) to simplify shopping, increase competition among insurers and help educate purchasers on subsidy options. SIMs would make it easier to shop for

coverage by creating a central point in each state where individuals and small businesses could easily compare coverage options and apply for both coverage and subsidies.

Under the SIM model, each state – building on their expertise as the regulators of the health insurance market today – would develop a central internet portal listing for all products for sale to individuals and small groups. These sites could be linked via a national framework and would enable:

- **Comparison of all insurance options** in a respective state based on key factors, including benefits, price, quality metrics, and provider networks. Each state would develop easy-to-understand comparison templates to promote transparency and informed decision-making.

- **Real-time price quotes** from multiple insurers. Each state would develop standard applications that individuals and small businesses could use to apply to several insurers simultaneously and to obtain estimated premium quotes instead of completing multiple applications and waiting for each insurer to follow-up.

- **Calculation of any tax benefits and subsidies** available or determination of eligibility for public programs. Enrollees could enter basic financial information, learn about the estimated final cost of coverage (considering any applicable subsidies), and learn if they are eligible for public programs such as Medicaid.

- **Simplified enrollment** in the plan of choice. Individuals and small businesses could easily enroll in coverage online or apply for subsidies directly through interface with the agency verifying eligibility.

BCBSA's SIM proposal would increase competition in the small employer and individual health insurance markets. SIMs would list all products for sale to individuals and small groups by all insurers in the state and for the first time allow consumers and small businesses to compare all plans in a state on price and other important factors. This will increase competition and place downward price pressure on premiums.

A number of federal health care reform proposals would create a new federal agency called a "connector" or an "exchange," intended to make it easier for individuals and small businesses to purchase health insurance. However, creating a federal "connector" would be complex, costly and time-consuming. Creation of a federal connector could also undermine state regulation and authority, creating conflicting federal-state rules that would result in regulatory confusion and adverse selection.

A state-based approach would accomplish the goals of a federal connector while ensuring current consumer protections afforded by state oversight and assuring faster implementation at lower costs by avoiding the creation of a new federal bureaucracy. To encourage states to establish State Insurance Marts, federal funding should be provided to offset the cost of development.

In addition, many purchasers today are unaware of the tax advantages for purchasing health insurance, the availability of public programs, and other options for obtaining coverage. State Insurance Marts would address this need by providing a central online site in each state (with a national landing pad for nationwide outreach) where consumers and small employers could learn about coverage and subsidies, and obtain information on public programs, including Medicaid and SCHIP.

Provide Targeted Subsidies for Small Employers and Individuals

To assure health care coverage is affordable, BCBSA also urges Congress to provide targeted subsidies to help those likely to have difficulty affording insurance. These include:

1. **Tax credits for low-wage workers in small businesses.** Low-wage workers in small firms are less likely than those in large firms to have employer-sponsored coverage. According to research conducted by the Employee Benefits Research Institute, many small firms cite that they do not offer coverage because their workers could not afford. This tax credit is likely to encourage small businesses to offer health coverage. EBRI reports that among small employers who do not offer coverage, 71 percent would be more likely to seriously consider offering health benefits if the government provided assistance with premiums.

2. **Tax-deductible insurance premiums for those without access to employer-sponsored coverage.** Today, the vast majority of individuals without access to

employer-sponsored coverage must pay for coverage without an income tax advantage or deduction, unlike those receiving coverage through an employer, who do not pay taxes on the value of their employer-sponsored plan. Adopting this proposal would address this fundamental inequity and improve affordability for individuals without employer coverage.

3. **A refundable, advanceable tax credit for those whose premiums represent a disproportionate share (e.g., six percent) of their income.** This tax credit would help millions of people who would otherwise have difficulty affording coverage while targeting resources to those who are most in need of assistance.

4. **A refundable tax credit to help those between jobs.** People who are unemployed often have difficulty affording coverage, and this tax credit would provide stop-gap assistance, helping to ensure there is no lapse in health care coverage.

Change Incentives to Attack Costs and Improve Quality

To assure affordable, high-quality coverage for all Americans, the underlying cost-drivers in our current health care delivery system must be addressed. We can get to tomorrow's coverage – but we must change incentives in today's system to improve quality and attack rising costs.

Misaligned incentives are drivers of health care costs. Today, providers are generally paid based on the number of services they provide regardless of the quality of outcomes. In fact, approximately 30 percent of all health care spending goes toward ineffective, redundant, or inappropriate health care.

BCBSA believes we must change incentives in our current health care system to advance the best care possible, not just to increase services. Despite the ongoing efforts by many private payers and public programs, our delivery system too often rewards care that is fragmented, duplicative, and wasteful.

Our proposal, The Pathway to Covering America, seeks to expand coverage, rein in costs and improve quality through:

- Encouraging research on what works by establishing a comparative effectiveness research institute;
- Changing incentives to promote better care instead of more services;
- Empowering consumers and providers with information and tools to make more informed decisions; and
- Promoting health and wellness by encouraging healthy lifestyles to prevent disease and managing and coordinating the care of those with chronic illnesses

Providers should be rewarded for delivering high quality health care with incentives to coordinate care, especially for the increasing number of individuals with chronic

conditions. Properly aligned incentives can reinforce the adoption of evidence-based practice standards and transparency in outcomes and quality information. Raising the bar on quality – while working to eliminate wasteful spending – will result in better outcomes and more prudent use of valuable resources.

Reforming how we pay for and deliver care will not be easy, but it is the only way that the affordability problems facing small employers can be solved over the long-term.

Conclusion

We all know there is no simple solution to the nation's health care crisis – to improving the quality of care, reining-in rapidly rising costs to keep health care affordable and extending coverage to all. However, improving health insurance coverage for small businesses is a critical step toward expanding coverage to all Americans. The recommendations I outlined today build on BCBSA's *Pathway to Covering America* proposal to help achieve this important goal.

As leaders in the health care community for over 80 years, BCBSA looks forward to working with Congress, the new Administration and other stakeholders to make quality health care affordable and accessible for all Americans this year. Thank you for the opportunity to present our views on this important subject.

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Testimony of

Michael Beene, Senior Health Advisor
The National Association for the Self-Employed

House Committee on Small Business
"Health Care Reform in a Struggling Economy: What is on the Horizon for Small Business?"

February 4, 2009

Introduction

The plight of micro-business owners, those with ten or less employees, is becoming increasingly more challenging as our economy continues to decline. The pool of money these entrepreneurs have to draw upon for both business and family expenses has been dwindling, forcing many of the self-employed to make tough choices. The majority of micro-businesses are curtailing the purchase of inventory and equipment as well as downsizing staff or refraining from hiring additional help. In addition, a large percentage of micro-business owners are dipping into their savings to stay afloat, leaving their future retirement at risk. Most distressing is that many of the self-employed are scaling back their health coverage, and some are dropping coverage completely, in order to keep the doors of their business open and to pay for basic needs such as their home and utilities.

The cost of health coverage for micro-businesses plays a significant role as to why so many self-employed business owners go without or purchase a minimum coverage policy. In a 2008 survey, the National Association for the Self-Employed (NASE) found that micro-businesses are spending a median of 5.5% of their total sales on health insurance benefits, an increase of 48.6% since 2005. Additionally, this increase is most strongly felt by solo practitioners – they are spending 28.1% more of their total sales on health insurance compared to three years ago. With such a large percentage of revenues going to health coverage, we can see why this expenditure is one of the first to be decreased or cut when business owners are faced with hard economic times.

As discussions on health reform progress in the 111th Congress and within the Obama Administration, the National Association for the Self-Employed (NASE) would like to make clear that in order to improve the ability of micro-business owners to obtain quality health coverage, health reform proposals must address two key components: affordability and choice.

Premium costs are the single most important factor that determines whether a business owner will insure herself and provide coverage for her employees. Most importantly, if a micro-business owner cannot afford insurance for herself and her family, she will not likely provide health benefits to employees. The issue of choice or lack thereof in both carrier and plan options plays a role in terms of how they affect price.

How to Make Health Coverage More Affordable for Micro-Business

The common denominator for all small businesses regardless of size or business structure is that they all must pay taxes. The NASE strongly urges policymakers to utilize the tax code in efforts to reform our health system. The tax code is an excellent vehicle to provide financial relief to micro-business owners currently with health coverage as well as financial assistance to encourage those that are uninsured to purchase coverage.

A key step forward in addressing the affordability issue faced by the self-employed would be to tackle the current inequalities in the tax code that this segment of the business population faces as they attempt to purchase health coverage. According to the IRS, there are approximately 21 million sole-proprietors in the United States. At present, these self-employed business owners do not receive a full deduction for their health insurance costs and are also ineligible to participate in a Health Reimbursement Arrangement that they may set up for their employees.

Self-Employment Tax Deduction on Health Insurance

Sole proprietors are not able to deduct the cost of their health insurance premiums for the purposes of self-employment tax. Self-employment tax is FICA tax for the self-employed. The self-employed pay FICA at a rate equivalent to employees and employers for a total of 15.3 percent. While 100 percent deductibility of health insurance premiums has been phased in, it does not solve this tax inequity. Sole proprietors are required to pay two types of taxes on their annual tax returns: income tax and self-employment tax. One hundred percent deductibility relates only to income tax and not self-employment tax.

Sole proprietors are the only business entity that does not receive a full deduction for health care costs. All other business entities receive a deduction for health insurance premiums as an ordinary and necessary business expense for all employees, including owners. Employees and the owner pay for their health insurance premiums pre-tax, and therefore they are not subject to FICA taxes. However, sole-proprietors (Schedule C filers) do not receive this "business deduction" for health insurance premiums. The premiums are not paid with pre-tax dollars and are exposed to self-employment tax. Accordingly, the sole proprietor pays this tax (15.3 percent on self-employment income up to $106,000) on his insurance premiums.

The most recent Kaiser Family Foundation study indicated that the self-employed pay on average $12,106 annually for family health coverage. Because they cannot deduct these premiums as an ordinary business expense, they are required to pay $1,852.22 in additional taxes that no other business entity must pay. This is money that NASE members tell us they would use to reinvest into their business, or utilize to offset the rising premium costs they face each year so they may hold on to their coverage a little longer. In these difficult financial times, removing this inequity would be a significant economic stimulus for the self-employed.

Health Reimbursement Arrangements (HRAs)

Discrimination against the self-employed also persists in Health Reimbursement Arrangements (HRAs). Health Reimbursement Arrangements are a flexible benefit option that allows small business owners to reimburse employees tax free for out-of-pocket medical costs, including health insurance premiums.

There are many benefits for a micro-business owner to set up an HRA for her employees. HRAs are often set up by small businesses in coordination with a high deductible health insurance plan. However, since many micro-business owners are unable to afford employer-based health insurance, a key benefit of an HRA is that they do not require the business owner to purchase a group health plan. Thus, business owners unable to afford insurance can offer some financial assistance to their employees.

HRAs are extremely flexible and easy for a micro-business owner to set up and administer. This is an important feature for a business owner who is responsible for managing every aspect of their business. Plan designs are limitless as long as they are consistent with IRS guidelines. A small business owner can write their own plan or obtain assistance from numerous vendors that offer prototypes of written HRA plans.

Since cost is such a crucial factor for micro-business when it comes to health benefits, an HRA gives the owner consistency when it comes to benefit costs. An HRA allows the business owner to determine the maximum amount of annual reimbursement an employee will receive, whether the HRA funds may be rolled over to the next year and if so, how much of an employees' HRA funds can be rolled over to the next year. Furthermore, the reimbursements are tax-deductible for the business.

At present, self-employed persons are not eligible to participate in an HRA; an inequity that negatively impacts millions of business owners and employees. While there are a myriad of generous self-employed business owners out there, a key rule of thumb is that an owner is unlikely to set up a benefit for employees that he is unable to participate in as well.

An important component of HRAs is the non-discriminatory rules that apply to them. If an HRA is set up, the benefits must apply to all employees. A business owner is not allowed to offer the benefit to only certain employees or allow some to have a higher amount of annual reimbursement. What is set forth in the plan will apply to all those working in the small business. Therefore, expansion of Health Reimbursement Arrangements to allow the self-employed business owner to participate in the plan would likely significantly increase the number employees of micro-businesses receiving health benefits and financial assistance with medical costs. Additionally, HRA annual reimbursement amounts would likely be more generous if the self-employed owner receives the same benefit.

Health Tax Credits

With the number of working uninsured rising every year, the NASE supports health reform proposals which include health tax credits to assist the self-employed in purchasing health insurance. Again, the primary reason small businesses go without coverage is cost. Tax credits would assist owners and individuals employed in businesses that do not have employer-sponsored health plans to afford health insurance. Since over

60% of our nation's uninsured work for small businesses or are the dependents of workers in small business, health tax credits would facilitate a large portion of our uninsured gaining access to coverage.

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

Health tax credits do not impose a one-size-fits-all standard, but instead seek to enable and empower individuals to choose the policies and features that most appeal to them and that work best for their business. As mentioned, choice is another key component desired by micro-businesses in health reform options. Only health tax credits would allow the self-employed to purchase insurance policies they own and control. The individual maintains choice of insurance carriers from which to purchase coverage, of doctors, and of services she wants covered.

Health care tax credits are a more cost-effective method of insuring workers who are able to pay some (but not all) of the cost of their health insurance and encourage business owners to provide an employer-sponsored health plan. The amount of the tax credit is essential to ensure affordability. A targeted tax credit can provide quality coverage to low- and middle-income families and self-employed individuals at a more modest cost.

How Insurance Market Reforms May Affect Micro-Business

As policymakers take a look at our health insurance markets as part of reform efforts, it is important that they consider the potential impact of market reforms on micro-business. Key debates are ongoing in regards to the use of pooling mechanisms, mandates and as to whether we take an individual and/or employer-based approach to health reform.

Individual vs. Employer-Based Coverage

The self-employed and micro-businesses purchase health insurance in two markets: the small group market and the individual market. The definition of a small group is determined by each state, though most define it as one with 50 or fewer employees. Firms in this size range looking to offer employer-based health coverage to their employees will look to the small group market for insurance options.

However, of those currently insured, the majority of self-employed and micro-businesses have purchased individual health coverage. According to the NASE 2008 Health Care

Survey, of the more than 46 percent of responding micro-businesses offering health insurance, only 18.6 percent offer coverage for full-time employees. That is a significant decline from 2005, when 46.2 percent reported covering full-time employees. What we see from this data is a definitive shift of micro-businesses from the small group market into the individual market. The high cost to both the business and the employee in terms of cost sharing are the top reasons for this shift.

The NASE believes that in order for health reform to be beneficial to the micro-business sector of the small business population, proposals must tackle the individual market. Key issues in the individual market are cost and underwriting based on health status.

State Mandates

Many states have a suitable number of carriers in the individual insurance market to offer the self-employed and micro-business owners an array of options. However, cost increasingly becomes an issue for business owners and workers in small businesses purchasing insurance on their own. While there may be some competition in states to allow for a range of pricing options, state mandates in the individual market result in high premium costs.

The NASE believes that the state regulatory climate plays a critical role in keeping costs high. State mandates on coverage in all markets increase the cost of basic health coverage from a little less than 20 percent to more than 50 percent depending on the state. The Council for Affordable Health Insurance has identified that there are currently over 1,600 mandates in our health care system. While mandates can make health insurance more comprehensive, they also make it more expensive by requiring insurers to pay for certain health services that consumers previously funded out of their own pockets. It is likely that insurers will push that added mandate cost into premium rates.

The cost that excessive mandates add to health coverage can mean the difference between a micro-business going uninsured or purchasing coverage. Additionally, the regulatory and statutory conditions in states have created barriers that make it difficult for new carriers and new products to expand into markets. Without new carriers or competing insurance products, prices will remain high when one insurance carrier dominates a market.

Health reform proposals must take a good look at the role that states play in our health care system. A balance must be struck between adding costly mandates and ensuring that critical health services are covered by insurance.

Pooling Mechanisms

The creation of pooling mechanisms, if properly formed, is another method that can be utilized in health reform proposals to begin addressing high costs and the lack of

negotiating power faced by the self-employed. Pooling arrangements would allow small business owners to band together to negotiate for better rates and better plan options. In addition, dependent upon how the pool was structured, it may also alleviate some of the administrative burdens of managing a health plan.

There have been previous legislative attempts to create pools via associations or organizations, as well as regional or state pools. In current reform proposals, discussion has centered on creating a national pool managed by the federal government to allow small business and individuals to purchase health coverage.

Micro-business owners are evenly split in their opinion on whether a government-run health option is the right approach. Chief concerns expressed are that the quality of their health care would not be as good or they would not have as many choices (i.e. plan options, doctors, specialists) in the government pool option. Also, micro-businesses are worried that if the federal government begins to manage our health care system, their taxes will significantly increase.

The NASE recommends that policymakers proceed with caution as they discuss the possibility of our federal government managing all or some components of our health care system.

Underwriting Based on Health Status

At present, the individual market requires underwriting based on health status. If you are a business owner or worker with a medical issue, your health premiums will likely be significantly higher in the individual market or you may be turned down for coverage, leaving you with minimal options to obtain insurance.

Tackling the issue of underwriting based on health status is complex. Some reform proposals have recommended that health insurance should be guaranteed issue, meaning that individuals cannot be denied access to coverage based on health status. This approach does have some negative consequences at it relates to affordability. Carriers are likely to charge higher premiums on guaranteed issue policies to allay potential costs related to undisclosed health issues. Though a self-employed business owner may now be able to access health coverage, it does not mean he will be able to afford it.

Improving and increasing funding for programs such as state high risk pools are a beneficial way of dealing with the population unable to gain access to health insurance in the current market due to health issues.

Mandates

Another option present in recent health reform recommendations has been the establishment of mandates, either for individuals or employers. As discussed earlier,

micro-businesses have a limited pool of financial resources to draw from for both business and personal expenses. Policymakers considering the use of mandates in their reform proposals must be mindful of the detrimental effect they may have on these smallest businesses in this current economic state.

The NASE does not support the mandating of health coverage at this time. In particular, an employer mandate to purchase and provide health coverage that does not exempt micro-business, those with ten or less employees, would be destructive to this important sector of the economy. To reiterate, based on NASE's 2008 health study, only 18.6 percent of micro-businesses nationwide were currently providing employer-based coverage to full-time employees. Consequently, an employer mandate would put millions of owners out of business and leave millions of workers unemployed.

The NASE believes an individual mandate would also be harmful in this current economic climate. However, such a mandate requiring all citizens to have health coverage may be more workable in the future if paired with a meaningful subsidy such as a health tax credit to help with affordability. In addition, the self-employed and micro-business owners must be able to purchase the coverage of their choice. Any attempts to restrict plan options in order to obtain the subsidy would make the mandate unworkable.

Conclusion

The National Association for the Self-Employed (NASE) strongly supports continued efforts to find proactive solutions to address the root causes of skyrocketing health costs in order to increase the number of insured micro-businesses. The self-employed and micro-business community continues to be the backbone of our nation's economy and immediate action must be taken to alleviate the massive health cost burden laid at their feet in order to ensure their survival.

As legislators begin their efforts to reform our health care system, we must realize that there is not a one-size-fits-all solution to this issue. The needs of the smallest businesses are not the same as those of a small business with 50, 100 or 200 employees. We must ensure that the policies created have the desired effect on the populations in need of the most assistance. The NASE recommends we proceed down the path of reform with diligence and with caution.

Madam Chair, members of the committee, my name is Dirck Clark and I am the Chief Development Officer for Heartland Health in St. Joseph Missouri. I appreciate the Committee's interest in the effect of health insurance on small business and this opportunity to offer testimony.

St. Joseph is a town of 76,000 located in Northwest Missouri, an hour north of Kansas City and two hours South of Omaha. Heartland is comprised of the only hospital in St. Joseph, a small rural insurance company, and a medical group practice of 110 physicians. Heartland is the only tertiary hospital between Kansas City, Omaha, and Des Moines.

Like many hospitals in rural areas, Heartland is the largest employer in town. It is in that role, as an employer, that I am here today. 51% of our total expenses are related to labor costs, and of that 10% goes to health insurance.

Through our insurance company, we have a great understanding of the effect health status has on health care costs and insurance rates. We have a team that works with local employers to help them keep their health care costs down."

My main focus today is on this subject of individual responsibility and the role an employer can have in helping improve employee health, ultimately impacting healthcare expenses.

With our own employees at Heartland we have implemented some ambitious programs to help employees with their health status, and at the same time given incentives as a reward for helping keep healthcare costs down. Some examples would be the following:

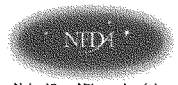
- If you are a Heartland employee and on our insurance program and are injured in a car accident without a seatbelt, we will only pay 60% of the costs. Missouri has a mandatory seat belt law.
- Like many other businesses, we offer a 10% health insurance differential incentive for employees who choose not to use tobacco products. We also offer smoking cessation classes for free to our employees, along with reimbursement for smoking cessation products.
- This year, based on research showing increased medical costs for those whose body mass index, or BMI, above certain benchmarks, we started a program to offer a premium discount for a lower BMI. If you are a Heartland employee, on our insurance, and have a BMI below 35 you receive a premium discount of 10%. In this first year, if an employee has a BMI above 35 and wants to improve, we will offer the premium discount if they agree to participate in wellness programs. In order to help employees earn this benefit we have built an on-site fitness center that is free to employees and spouses. Along with the fitness center we offer free classes in weight loss, nutrition, stress management, exercise to name a

few. Our hope is to break ground on a daycare that will allow employees to exercise after or before work, and have their children near by.

- This first year the BMI threshold is a 35. However, each year the BMI threshold will be decreased until it reaches 29. Our goal is to work with employees to help them stay below this threshold as it decreases.
- The result this has been that 92% of eligible employees signed-up for the benefit, 84% of those who signed-up earned the discount outright, and 12% are earning the discount through their participation.
- As this is the first year of the BMI incentive program, we don't yet have trend data showing it's impact. However, the effect of these programs has been a dramatic increase in participation in self-help programs and a fitness center that is nearing capacity within four of it being opened. When the fitness center opened, as you would guess, it was populated primarily with employees who were already in good physical condition and enjoyed exercise. What we are finding now it more employees showing up to exercise and participate who have higher BMIs. Our hope is that we can continue to working together with our employees to improve their overall health risks, and keep them under the BMI insurance threshold as it decreases.

My hope that as you look at the health insurance challenges for small business that you also look at programs that provide workers incentives to improve their health and help keep healthcare costs down.

I will submit my full testimony for the record. Thank you for the opportunity to testify.



Affordable Health Care Study

August 11, 2008
Deana Gillespie, Research Manager

Purpose
The purpose of this study was to measure how the rising costs of health care premiums are affecting funeral directors' ability to hire and retain employees as well as to measure the interest in a potential NFDA National Health Care Plan.

Methodology
This was a Web-based study. A survey invitation was posted in The Bulletin (NFDA electronic newsletter) containing a link to the online survey. A reminder was also posted in The Bulletin one week after the initial invitation was sent. This effort yielded a total of 55 completed interviews with a reliability estimate of ±12.0%.

Executive Summary

- Most (over 90%) of respondents stated they would be either very likely or somewhat likely to sign up for a NFDA National Health Insurance Plan if it was more affordable than their current health insurance options.
- Almost half (41.7%) of the respondents stated having Affordable Health Plans is the most important issue in Congress.
- Only two-thirds (67.7%) of respondents currently offer their employees a health insurance plan.
- Almost two-thirds (64.9%) of members stated they have had to reduce health insurance coverage due to increased premiums.
- Over half (51.4%) stated increased premiums have caused problems in hiring new employees.
- Over one-third (37.8%) have had problems holding onto current employees due to rising premiums.

Key Findings

- Approximately two-thirds (67.7%) of respondents currently offer their employees a health insurance plan. Of the respondents who do not, 30.9% stated that they had to discontinue it due to increased premiums.

	Do you currently offer health insurance?	If no, have increased premiums forced you to discontinue health insurance?
Yes	67.7%	30.9%
No	32.3%	69.1%

- For comparison purposes, the NFDA 2007 Member Insurance Survey asked members what is the most important factor when you buy a specific type of insurance. In 2007, 20.5% stated that they do not offer a group health insurance plan. Cost was cited as the most important factor (44.0%) when choosing a plan.

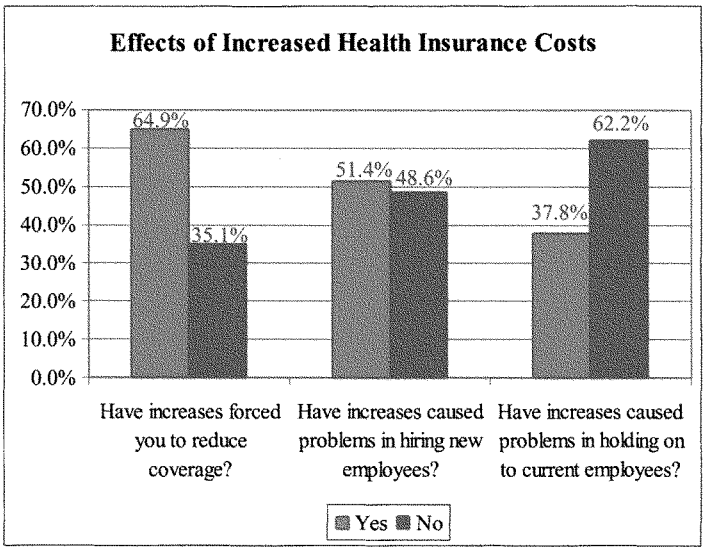
	Do not carry	Cost	Local agent or company	Satisfaction with current provider	Offered by state association
Group Health Insurance*	20.5%	44.0%	14.1%	16.7%	4.7%

**Source: NFDA 2007 Member Insurance Survey (December 2007)*

- Over half of the respondents said that premiums have increased more than 30% over the past three years.

How much have premiums increased over past three years?	Percent Responded
0%-10%	2.7%
11%-20%	10.8%
21%-30%	32.4%
31%-40%	21.6%
41%-50%	2.7%
51%-60%	16.2%
61%-70%	2.7%
71%-80%	5.4%
81%-90%	2.7%
91%-100%	0.0%
100%+	2.7%

- Almost two-thirds (64.9%) of members stated they have had to reduce health insurance coverage due to increased premiums. Over half (51.4%) stated increased premiums have caused problems in hiring new employees and over one-third (37.8%) have had problems holding onto current employees.



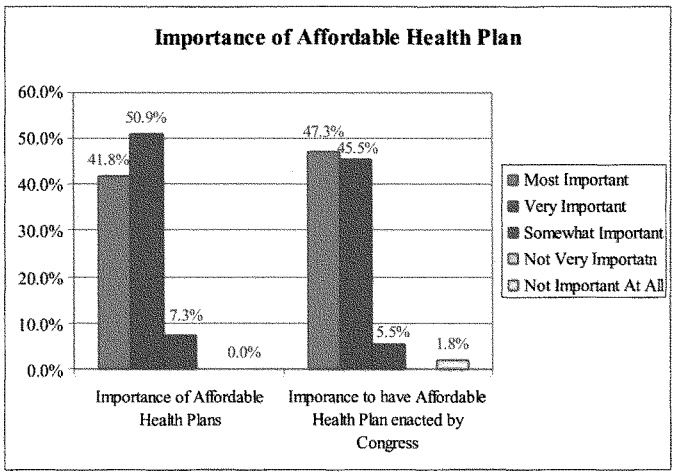
- More than half of the respondents stated that rising premiums have required employees to pay a larger share of their premiums (21.6%), lower their workforce (16.2%), or both (16.2%).

Have rising premiums forced you to require employees to pay a larger share or lower workforce?	Percent
Yes - Paying a larger share	21.6%
Yes - Lowering the workforce	16.2%
Yes - Both	16.2%
No	45.9%

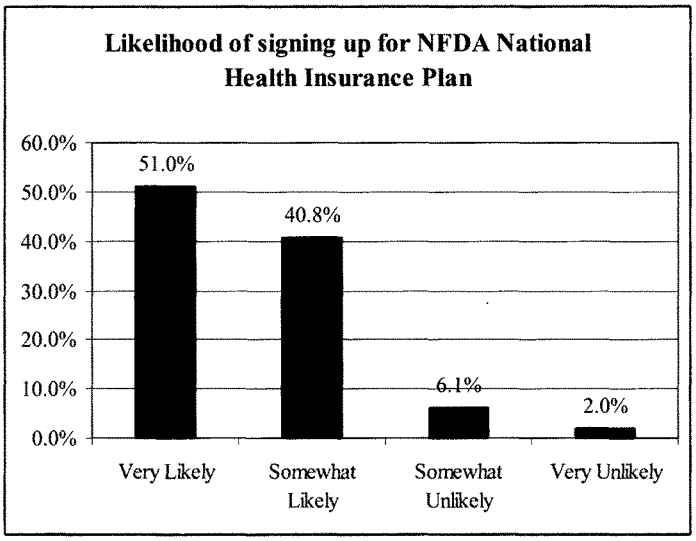
- Approximately one-third (32.7%) of state associations offer a health insurance plan. Of the state associations that do not, 24.5% of members have contacted them about adding one.

Does your state association have a health plan?	Percent
Yes, they have a health plan	32.7%
No, but I have contacted them about adding one	24.5%
No, I have not contacted them	42.9%

- Almost all respondents (over 90%) rated having Affordable Health Plans as either the most important issue or a very important issue facing the funeral service industry. Similarly, almost all (over 90%) rated the importance of having Affordable Health Plans enacted by Congress as being the most important issue or a very important issue.



- Over 90% of respondents stated they would be either very likely or somewhat likely to sign up for a NFDA National Health Insurance Plan. This finding is similar to the one found in the 2007 Member Insurance Survey where 67.0% of members stated they would be interested in NFDA health insurance coverage if it offered favorable pricing with strong customer service.



- **Most respondents stated they would sign up for a national health insurance plan if it was more affordable than their current health insurance options.** The tables below contain members' verbatim comments regarding their likelihood of signing up for an NFDA National Health Insurance Plan.

Very Likely to Consider NFDA National Plan
• This is an important issue in recruiting and retaining. • Would like insurance coverage for myself and my employees. • I have employees that really need affordable ins. I can't do it at today's costs. • One employee is currently insured but with minimal benefits and a very high cost premium. Very underinsured...never going to the Dr. because of this. I would most definitely look at a NFDA group coverage plan....our health care system is in total collapse. • Would like to decrease the costs to my business. • Only if premiums, drug co-pays, and overall coverage were competitive with what we already have through our Association. • I believe that if all NFDA members had good and affordable health insurance, why wouldn't you sign up. • At this point I would deal with the devil to get affordable health insurance. • I believe there is strength in numbers - large corporations and groups pay much lower rates for their employees. Small businesses really get hurt. • Any group plan (especially one with options) would greatly reduce the monthly premiums. It would also greatly increase a funeral home's ability to hire more licensed funeral directors. Problems with soaring health insurances costs' greatly reduces being able to hire more people. I, for example, need to hire at least two more full time funeral directors. But, I can't afford health insurance for them. So, this means at least two, probably well qualified funeral directors out there, may not be able to find work, just because no one can afford to offer them benefits that are offered to current staff. If NFDA can get something together on this issue, it is something that I would very seriously consider looking at. • Would need more information. • If it can meet or beat our group plan now, we are on board. • If the quality of the providers was on par with our current coverage, I would have no trouble utilizing NFDA. The relationship matters less with the agent. They have not been good to us. • If an affordable coverage was available, I would offer it to my employees. Currently, since I am a small operation, I can't.

Very Likely to Consider NFDA National Plan (continued)
• Wife a cancer survivor. Cannot purchase individual policy for her that is realistically affordable.
• I would like to be able to offer current and future employees health insurance to make me more competitive with corporate firms and it's the right thing to do as an employer. It would also give all of us an opportunity to get insurance through a group plan and hopefully at an affordable cost.
• If it was a good plan.
• If the plan is affordable and excepted by area doctors and the coverage I need, I would be very interested.
• If the premiums were affordable. All of the non-licensed personnel can not afford any health benefits because of the cost of living.
• Always looking at more affordable options.
• This is very important as we are thinking of what to do regarding insurance and will probably make some changes.
• Please.
• We can barely afford the premiums now and have raised our deductible to continue having coverage. WE NEED HELP!
• Rates for large groups tend to be more coverage for less.

Somewhat Likely to Consider NFDA National Plan
• The benefits would have to be comparable and the rates comparable also.
• I have a daughter with extreme health issues so I may not be eligible. If I was, I may hurt the cause.
• If the coverage was equal and cost less, I would consider changing.
• Considering my age (over 60) I am not sure that you could offer anything for my age group, and that we could pass health questions!!
• It would depend on the cost.
• Depends on cost, types of coverage and benefits. If we can get better rates for similar coverage without loss of coverage.
• It would depend on the coverage and cost.
• It depends on the network coverage.
• My employee base is very diversified. Some are already on Medicare and are not interested in opting in to a company plan while others are single and feel they are invincible and have no need for coverage. A plan that required a minimum number of company employees to participate based on the census has presented problems.
• I'll use our state association's plan before looking elsewhere.
• My decision would be based on coverage vs. premium. Most plans I have seen by different organizations cost more than what I have been able to do with my personal insurance. For example: 55 year old male, non smoker, no health issues or existing conditions with a health savings account the premium is $280 per month. A 47 year female, no existing conditions, non-smoker in good health through Aetna with a $500 deductable is $260 per month. The deductable for the male is $2500.00 annually. Obviously this insurance is used for major medical. This is not to be used as a maintenance insurance running to the doctor every 2 weeks. One must be disciplined and use common sense with these products. These products are not for everyone. For that reason, for me to use an organizations health plan all things must be considered prior to committing to the plan.
• Has to be of like quality, no permission slips, easier than what's out there, at comparable rates or back to catastrophic.
• Costs and coverage would be the issue.

Somewhat Likely to Consider NFDA National Plan (continued)
• Rather an all encompassing questions, factors of my choosing NFDA would (1) cost (2) type of coverage and (3) sign up time limits. Also on previous question of Congress having an affordable health insurance, I think Congress ahs enough control over funeral directors without them forcing a health plan on us. Whatever happened to private enterprise?
• Depends upon the insurance carrier; half my employees want a PPO and half an HMO.
• I live in a state with 4 major health care centers, so coverage that is accepted by all health care facilities is of utmost importance to me.
• Reduced Rates.
• Depends on cost.
• Would need to know rates and coverage.
• Depends on rates and requirements for acceptance!
***Somewhat Unlikely* to Consider NFDA National Plan**
• It depends where it stands with the state health program.
• Prior medical conditions.
• If the rates were very competitive, I might switch.
***Very Unlikely* to Consider NFDA National Plan**
• Not at all.

Demographics

➢ Almost one-third of respondents had three or less employees at their funeral home.

# of employees (all locations)	Percent
1-3	30.6%
4-6	28.6%
7-10	14.3%
11-15	18.4%
16-20	2.0%
21-30	4.1%
More than 30	2.0%

- Almost two-thirds of funeral homes represented in this study have been in business for more than 50 years.

Years in business	Percent
Less than 5	4.1%
6-10	4.1%
11-20	12.2%
21-30	6.1%
31-40	4.1%
41-50	8.2%
More than 50	61.2%

TESTIMONY BEFORE THE UNITED STATES CONGRESS
ON BEHALF OF THE

NATIONAL FEDERATION OF INDEPENDENT BUSINESS

NFIB
The Voice of Small Business.

Statement of
National Federation of Independent Business

Submitted to the
U.S. House Committee on Small Business

On the date of
Wednesday, February 4, 2009

On the subject of
Health Care Reform in a Struggling Economy: What is on the Horizon for Small Business?

Thank you for holding this hearing to examine the challenges and opportunities for healthcare reform in a struggling economy. As the Committee continues to explore issues surrounding health insurance access and affordability, it is critical to consider the implications that reform proposals will have on small business. We applaud the committee for undertaking this necessary examination.

With the cost of insurance for small business owners rising every year and 28 million uninsured Americans working for small businesses, access to affordable healthcare ranks as the top problem and priority for small business owners. Healthcare premiums continue to skyrocket, increasing by nearly 113% since 1999, and are, on average, 18 percent higher than those of large businesses. These unsustainable costs significantly hinder small businesses' ability to invest in and grow their business.

The necessity for solutions tailored to the needs of the small business community cannot be overstated. Small businesses have struggled with this problem for years. We believe that in order to do something about coverage, you must do something about cost – the two are not mutually exclusive. If small business is to help with coverage, then Congress must do something about the cost of health insurance. For NFIB, that means transforming today's healthcare system through an approach that utilizes pooling, market reform and tax treatment to reform the broken healthcare system of today into a cohesive system where private insurance is available and built on quality, value, competition and, most of all, affordability.

As the healthcare reform debate begins to take shape, employer mandates have re-emerged as a frequently mentioned tool to help finance and increase insurance coverage. Two new pieces of research released by the National Federation of Independent Business Research Foundation examine and analyze the potential impact of a national employer mandate on small businesses to provide healthcare. The "costs" of an employer mandate are significant to employers, employees and the overall economy.

Brief descriptions of the research follows and are included as a supplement to this statement.

Business Simulation (B-Sim Modeling) Study

In the B-Sim study, authors Michael J. Chow and Bruce D. Phillips of the NFIB Research Foundation, conducted business simulations to measure the effects of a hypothetical national mandate requiring employers to offer private health insurance to all employees. The simulation required employers to finance a minimum of 50 percent of the cost. The simulation ran six classes of business to determine the impact on employers of different sizes. The results show that an employer mandate would have significant negative impacts on local jobs and on state revenues, particularly considering the rising costs of health insurance. Simulation results suggest:

- Of the more than 1.6 million jobs lost between 2009 and 2013, small businesses would account for more than 1 million or 66 percent of all jobs lost.
- U.S. real GDP would contract by approximately $200 billion between 2009 and 2013.
- Small businesses would lose roughly $113 billion in real output and account for 56 percent of all real output lost.
- Labor intensive industries (e.g. construction or restaurant) and businesses with 20 – 99 employees would experience the most job loss.

Discussing Effect of an Employer Mandate: A Primer

In "The Case Against Mandated Employer-Provided Health Insurance: A Practical Business Perspective," William "Denny" Dennis Jr., Sr. Research Fellow at the NFIB Research Foundation examines and discusses the economic and human effects of mandated employer-provided health insurance.

Dennis reviews mandated employer-provided health insurance and its impact through three lenses:

- A pure mandate, requiring an employer to provide and pay a fixed percentage of an employee's health insurance premium;
- A mandate requiring an employer to provide and pay a fixed percentage of payroll for employee health insurance (with some mechanism to transform unequal per capita premium payments into equal per capita policy benefits); and
- A mandate requiring an employer to provide employee health insurance or pay a tax, the so-called "pay-or-play" option.

The three are essentially the same in their effects on employers and employees as are the arguments against them. Dennis' piece concludes that mandated employer-provided health insurance is poor policy. The research suggests three reasons for reaching such a conclusion:

1. The policy is highly regressive as the uninsured, typically though not always low- wage earners, eventually pay for their own health insurance through job loss, depressed wages and erosion of other benefits;
2. The policy is inefficient because it is too blunt to distinguish between those needing and those not needing assistance to purchase health insurance; and,
3. It is unfair to small employers and employees because the policy fails to address the real problems of the insurance market for small businesses, while retaining rigidities that injure both, and substituting a hefty, direct penalty on them, i.e., a tax, in large part because they are small and lack market power.

The newly released NFIB research shines a bright light on the consequences of costly mandates to small businesses. In our current economic environment, it is critical that we stimulate and support our country's job creators – small businesses. Enacting healthcare reforms that fail to address rising costs, and place unmanageable burdens on business, is not a viable pathway for meaningful reform. Instead, reforms must foster much-needed growth without placing undue burdens or new financial pressures on our nation's small employers.

Again, we appreciate the Committee's interest in this important topic. Examining all aspects of the healthcare landscape is an important step in crafting a workable solution to decrease the number of uninsured Americans and to reduce the cost of health insurance. Healthcare reform is NFIB's number one priority, and we look forward to working with the Committee to find solutions that will help solve the biggest problem impacting small business owners and their employees.

STATEMENT
of the
American Optometric Association
to the
Committee on Small Business
United States House of Representatives

RE: Health Care Reform in a Struggling Economy: What is on the Horizon for Small Business?

February 4, 2009

The American Optometric Association (AOA) appreciates the opportunity to provide our views on "Health Care Reform in a Struggling Economy: What is on the Horizon for Small Business?" We commend you, Chairwoman Velazquez, Ranking Member Graves, and Members of the Committee, for the leadership and vision you have shown in recognizing the fundamental need to address the devastating impact that an ailing health care system is having on American small business as well as the central role that small businesses and, in particular, small business health care providers will play in bringing needed change and lasting reform to the American health care system.

Thank you for the strong efforts of this Committee and Congress to fight for thousands of small businesses and millions of Medicare beneficiaries across the nation by working to address the increasing strain on the current health care system that threatens the ability of health care providers to deliver needed care. In particular, we applaud the enactment of H.R. 6331, the *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA), which made many important but temporary changes in Medicare policy. For example, an essential MIPPA provision exempts doctors of optometry, who supply eyeglasses to beneficiaries following cataract surgery, from burdensome durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) requirements designed for companies in the business of supplying durable medical equipment but leaves the door open for the Centers for Medicare & Medicaid Services (CMS) to enact other prohibitive requirements on physicians.

We urge this Committee and Congress to work with America's doctors of optometry and other stakeholders to help usher-in needed health care system reforms while ensuring that the existing system becomes more equitable for small health care providers and more accurately reflects their true value in the delivery of health care in America. As an initial step, we urge Congress to address and repair harmful flaws now plaguing the current public payer system. In particular, dwindling payments from federal health programs and increasingly daunting Medicare enrollment and re-enrollment issues continue to have a devastating effect on America's small business health care providers and for America's seniors.

We are confident that, working together, Congress, the U.S. Department of Health and Human Services and other federal agencies, and the AOA can help America achieve long-lasting and equitable health care reform while delivering on the long-held promise of ensuring access to needed health care services, including comprehensive eye and vision care, that are high quality, furnished by the beneficiary's provider of choice, yet affordable and cost-effective.

The Approaching Medicare Meltdown

The Medicare physician payment formula is badly damaged and desperately needs repair. Swift and decisive action by Congress is needed to overhaul the existing Medicare payment system to ensure that doctors of

optometry and other health care providers are able to continue providing needed services to current and future Medicare beneficiaries.

"Access to quality care, particularly that provided by small health care providers, is increasingly at risk because of the strains on the current system that threaten the ability of providers to deliver needed care," said Dr. John Whitlow, a small business owner of an independent private optometric practice in LaGrange, GA, when he testified before the House Small Business Subcommittee on Regulations, Healthcare and Trade in October 2007 regarding the chilling affect that minimal Medicare reimbursement is having on efficient and high quality health care, including the delivery of eye and vision care.

As the frontline providers of eye and vision care and often the only eye care providers available in rural communities and underserved areas, doctors of optometry are struggling to serve America's children, seniors, and the underserved while keeping pace with health care demands and rising costs. "Low payments from federal health care programs and administrative burdens put on providers by the ongoing transformation of the current health care system are creating an undue burden on America's health care provider network," added Dr. Whitlow in his testimony before the Committee.

Currently, Medicare's Sustainable Growth Rate (SGR) payment formula is linked to economic factors that fail to accurately account for rising practice costs, the increased utilization of services, and needed investment in technology as well as a host of other factors that are beyond the provider's control. Without repeated congressional action, the flawed SGR formula would have kept payment rates about the same as they were in 2001 and further prevented many physicians from making needed investments in technological infrastructure and staff. In fact, when utilization of physicians' services exceeds the SGR target, physicians are unfairly targeted with steep cuts in their payments. In effect, when reimbursement rates are pegged at artificially low levels that do not reflect genuine practice costs, patient access and care suffer because clinicians are unable to serve as many patients or invest in appropriate technology.

As a result of the defective SGR formula, Congress has repeatedly had to intervene to prevent massive cuts in the Medicare physician payment rate in order to avert a full-blown Medicare meltdown. Despite the sound and decisive actions of Congress, doctors of optometry and other physicians continue to face a scheduled 21 percent reimbursement cut to take effect in 2010 and the prospect of more than 40 percent payment decrease over the coming decade. Doctors cannot continue to absorb these growing shortfalls, particularly as an aging baby-boomer generation makes plans for retirement and most pathways to national health reform are likely to lead to increased utilization of the Medicare system.

The AOA applauds these temporary "fixes", but reinforces that a permanent solution must be found to ensure continued access to needed health care services. Going forward, the AOA believes that successful efforts to encourage judicious use of care are best fostered through positive incentives that inspire doctors of optometry and other health care providers to work toward this end, not by top-down spending targets that cannot distinguish between appropriate and inappropriate care. The AOA urges the Committee and Congress to work with CMS to avert future cuts by repealing or rebasing the SGR and developing a system that produces rational health care provider payments that accurately reflect increases in practice costs.

RECOMMENDATIONS:

- Replace the looming 21 percent Medicare physician payment cut to take effect Jan 1, 2010 with a positive physician payment update that accurately reflects the ongoing inflation of practice costs.

- Develop a path for permanent replacement or equitable rebasing of the flawed SGR payment formula to ensure beneficiaries' access to needed care.

The Pitfalls of Medicare Enrollment

Medicare enrollment is the pathway for hundreds of thousands of small business physicians to bill Medicare for the medically necessary covered services and supplies provided to beneficiaries. However, the current enrollment process discourages and often prevents licensed, willing, and able doctors from treating patients who need their care. Rather than an enrollment process that opens the door to physicians to provide services to the growing Medicare population, the existing process places undue financial and administrative burdens on small businesses health care providers and threatens access to care.

According to CMS, there are approximately 980,000 physicians, other practitioners and Medicare suppliers that receive Medicare payments. The agency estimates that 95 percent of physicians are considered to be small entities. CMS is the largest health insurance payer in the nation, processing more than a billion claims and spending nearly $700 billion annually. With more than 44 million Americans as Medicare beneficiaries, Medicare is an important source of patients and revenue for physicians and Medicare policy has financial and regulatory burdens on hundreds of thousands of small businesses.

CMS has made incremental changes to the enrollment process over many years, but recently these changes have been too frequently to the detriment of small business. CMS revisions, many of which are not necessarily subject to public notice and comment, have touched on at least 200 sections of the enrollment requirements within Chapter 10 of the Program Integrity Manual (PIM), and nearly all of them have increased the burden on physicians. In the 30 months since June 30, 2006, CMS issued at least 25 revisions of Chapter 10 of the PIM and nearly all of these changes were implemented over the objections of the physician community and had a negative impact on small business. While CMS rarely acknowledges enrollment delays and problems, in reality, this is normally a three to six-month process which severely disrupts the provision of needed services and these small businesses.

For example, CMS sets the date of enrollment as the date the contractor approves the enrollment application and has reduced the time frame when physicians can retroactively bill for services provided prior to the date of enrollment. However, because CMS forces many longstanding participating physicians to submit completely new enrollment applications for a variety of reasons, including simply a change in mailing address, this traps many physicians who have served Medicare beneficiaries for years and decades. Now, if the enrollment takes many months, the doctor might not be able to bill Medicare for seeing regular patients in the interim. This is a burden on small businesses and not only affects patient care when a doctor will not be paid for treating the patient, but it also severely disrupts the business' cash flow and future viability.

The Medicare enrollment crisis became most acute in 2008 in California due to concurrent transition to the National Provider Identifier (NPI) and a new Medicare Administrative Contractor (MAC) in the region. A longtime Medicare physician from California, Dr. Thomas Lim, who incorporated his office last year, has spent 12 months trying to get re-enrolled in the Medicare program. Dr. Lim and his partners have tried repeatedly to remedy the situation with the MAC, but have largely been unable to work with or even receive a return telephone call or email response. After a full year of frustrating and unsuccessful attempts, Dr. Lim and his partners have been forced to suspend care to Medicare beneficiaries because their re-credentialing process is hopelessly stalled and payments for services rendered are consistently denied. Thus, the simple act of incorporating his business has led him to not get paid by Medicare and to not be able to see Medicare patients.

In December, the AOA received a note from an affiliated state optometric association summing-up much of the frustration that is typical across the nation: "We have had members who through no fault of their own have found themselves removed from the provider rolls. Then when they try to get back-on, they reapply, the application is lost, and then when they are reinstated the start date and termination date are the same so they are back to reapplying...Just this morning, I had a call from an optometrist who is owed over $60,000. For a solo practitioner in a rural area, that kind of cash flow issue is devastating to their practices."

The AOA does not intend for these comments to be critical of CMS personnel as we acknowledge that the agency is understaffed for its massive responsibility of overseeing the Medicare program while remaining accountable to the American taxpayer. However, we are concerned that CMS overestimates the need to use the physician enrollment process to prevent fraud and abuse, and underestimates the unnecessary burden the current methods place on small business health care providers.

The Medicare payment error rate was 3.6 percent in Fiscal Year 2008 with most improper payments stemming from services considered not medically necessary or improperly coded. We do not believe that the Medicare enrollment process is the place to address these problems. Instead, the AOA believes that it should be easier for physicians, most of whom are small businesses, to navigate and secure the required enrollment in order to continue providing care to beneficiaries and successfully bill Medicare for medically necessary services. Contractor verification of physician licenses should suffice to discover and block enrollment by physicians who are not licensed to practice in their states. Not only does the difficulty of enrolling and being paid hurt small business, it is not good for access to care for the Medicare program and patients.

The AOA believes changes are necessary to ease the financial and administrative burden of Medicare physician enrollment on small businesses. Fixing the enrollment process would also allow Medicare contractors to return their focus to proper claims payment and oversight. The Medicare physician enrollment process is not an effective or appropriate tool to prevent Medicare billing mistakes. The increased red-tape deters legitimate physicians, not the scofflaws that CMS wishes to bar from the program. The AOA believes that reforming the Medicare enrollment process will enable physicians to continue to see Medicare patients for their health care needs while still able to successfully run their small practices/businesses.

The AOA has recently petitioned the Small Business Administration Office of Advocacy, and is now also urging Congress to step-in on behalf of hundreds of thousands of small businesses across the nation.

RECOMMENDATIONS:

- Direct the Small Business Administration to work with the AOA and other physician groups to review the entire Medicare enrollment process for its financial and administrative burden on small businesses.

- Direct CMS to stop using the Medicare enrollment process to deter willing and able doctors of optometry from treating Medicare beneficiaries and focus its enrollment requirements to reduce financial and administrative burden on small businesses.

The AOA looks forward to working with the Small Business Committee and Congress to pass immediate legislation to prevent the looming 21 percent cut to Medicare physicians and develop a pathway to needed reform of the flawed SGR formula to preserve patient access and provide positive updates that reflect optometric practice cost increases. We also look forward to addressing the growing frustration of Medicare physicians with the broken Medicare enrollment process which discourages and often prevents licensed and compliant doctors from treating patients who need their care.

The AOA firmly believes that if America is to fulfill her promise to current Medicare beneficiaries, we must act swiftly to avert payment cuts and abolish unnecessary and burdensome Medicare enrollment issues. The ailing American health care system is having a devastating impact on American small businesses. If authentic and lasting national health care reform is to become a reality, small businesses and, in particular, small business health care providers must – and will – play a central role in bringing needed change and lasting reform to the American health care system.

The Small Business Coalition for Affordable Healthcare

www.SmallBusinessHealthcareCoalition.com

February 4, 2009

Dear Chairwoman Velazquez and Ranking Member Graves:

On behalf of the **Small Business Coalition For Affordable Healthcare**, the nation's leading small business coalition dedicated to increasing access and affordability of health insurance for the small-business owners, their employees, the self-employed and their dependents, we are writing to express our strong desire to work together with lawmakers to construct meaningful healthcare solutions for our nation's job creators – small business.

America's small businesses play an essential role in our nation's economy. Small businesses employ half of all private sector employees and have generated 60 to 70 percent of net new jobs over the last decade.

Our country, this Congress and the Administration face many challenges – most significantly a slowing economy and growing financial insecurities. As Congress explores ways to rebuild and strengthen our economy, the Coalition urges lawmakers to be mindful that the cost of health insurance is one of the most critical economic issues facing small businesses – and for them it is both a healthcare issue and a pocketbook issue.

Health insurance remains one of the fastest growing and most unpredictable costs small employers face from year to year. For example, since 1999 health insurance costs for small firms have increased by 113 percent. Although small businesses cover nearly 68 million people through the employer-based system, still only about half can afford to even offer insurance. Those not offering health insurance cite cost as the primary explanation. Furthermore, the nation's smallest firms pay an average of 18 percent more in health insurance premiums for the same benefits than those in the largest firms.

The necessity for healthcare solutions tailored to the needs of the small business community cannot be overstated. Small businesses have struggled with this problem for years. We believe that in order to do something about coverage, something must be done about cost – the two are not mutually exclusive. Simply put, Congress *must* do something about costs – for the individual, the employee, the employer and the overall delivery system. That begins with transforming the broken marketplace of today into a system where private insurance is available and is built on quality, value, competition and, most of all, affordability.

Thank you for holding the first hearing of the year focusing on the unique needs and challenges facing the small business community. America's small businesses are the risk takers and job creators in our economy. But in the current economic environment, small businesses like the rest of the economy are struggling. The **Small Business Coalition for Affordable Healthcare** looks forward to working with all those in Congress and the new Administration who are dedicated to crafting meaningful solutions for small business during the healthcare reform debate.

Sincerely,

(see reverse for signing organizations)

The Small Business Coalition for Affordable Healthcare

www.SmallBusinessHealthcareCoalition.com

American Association of Advertising Agencies
American Bakers Association
American Farm Bureau Federation
American Foundry Society
American Hotel & Lodging Association
American Institute of Architects
American Rental Association
American Society of Association Executives
American Society of Home Inspectors
American Veterinary Medical Association
Associated General Contractors of America
Association for Manufacturing Technology
Association of Ship Brokers & Agents
Automotive Aftermarket Industry Association
Automotive Recyclers Association
Commercial Photographers International
Computing Technology Industry Association
Evidence Photographers International Council
Independent Office Products & Furniture Dealers Association
Interlocking Concrete Pavement Institute
International Franchise Association
International Housewares Association
Motor & Equipment Manufacturers Association
National Association of Computer Consultant Businesses
National Association of Convenience Stores
National Association of Home Builders
National Association of Manufacturers
National Association of Mortgage Brokers
National Association of Realtors
National Association of Theatre Owners
National Association of Wholesaler-Distributors
National Burglar and Fire Alarm Association
National Club Association
National Federation of Independent Business
National Funeral Directors Association
National Lumber and Building Material Dealers Association
National Retail Federation
National Newspaper Association
National Restaurant Association
National Roofing Contractors Association
National Tooling and Machining Association
Ohio Valley Automotive Aftermarket Association
Outdoor Industry Association
Printing Industries of America
Precision Metalforming Association
Professional Golfers' Association of America
Professional Photographers of America
Service Station Dealers of America and Allied Trades
Small Business & Entrepreneurship Council (SBE Council)
Society of American Florists
Society of Association Executives

The Small Business Coalition for Affordable Healthcare

www.SmallBusinessHealthcareCoalition.com

Specialty Equipment Market Association
Student Photographic Society
Textile Rental Services Association of America
The Adhesive and Sealant Council, Inc.
The Society of Sport and Event Photographers
The Society of the Plastics Industry
Tire Industry Association
U.S. Chamber of Commerce
Wedding & Event Videographers Association International

THE MAIN STREET ALLIANCE

Statement submitted to the House Committee on Small Business – Friday, February 6, 2009
For the official record of committee hearing held February 4 on the topic:
"Health Care Reform in a Struggling Economy: What is on the Horizon for Small Business?"

Madam Chair and Members of the Committee:

The national Main Street Alliance is a network of state-based small business coalitions from across the country that have joined together to build a new voice for small businesses on health care. Alliance partners represent small business owners in ten states across the country, including New York, New Jersey, Maine, Illinois, Iowa, Colorado, Montana, Idaho, Oregon and Washington. Together, we share a vision of health care that works for small businesses, our employees, and the communities we are proud to serve.

Because small businesses are among the hardest hit in our current broken health care system, we believe small business owners deserve the chance to speak for themselves about health care and how to fix it. In 2008, the Main Street Alliance launched a national survey project to facilitate this, going door to door and getting face to face with local small business owners to invite their input. We surveyed 1,200 small business owners in 12 states and also conducted in-depth interviews to find out how theyÑre managing currently and what they want done on health care.

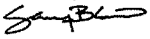
On January 15, we released the results of this survey project in a report titled ***Taking the Pulse of Main Street: Small Businesses, Health Insurance, and Priorities for Reform*** (excerpts attached to this statement; full report available at: www.mainstreetalliance.org). The report includes three key findings that will guide the Main Street AllianceÑ work to advance health reform that works for small businesses in 2009. These findings are:

- **Small business owners are willing to contribute for good health care, but can't go it alone:** When asked if they were willing to contribute for health coverage for their employees, more than two thirds (73 percent) of small employers surveyed said yes. Furthermore, 63 percent of small employers indicated they would be willing to pay 4 to 7 percent of payroll, or more, to guarantee quality, affordable coverage for themselves and their employees.
- **Small business owners want the choice of a public health insurance plan as an alternative to private coverage:** When asked to choose between a proposal with a public insurance alternative and a proposal with more private market choices, small business owners chose the proposal with a public alternative by a margin of more than two to one (59 percent to 26 percent, with 14 percent undecided/other).
- **Small business owners want government to play a stronger role to fix health care:** When asked about public oversight and the role of government, small business owners chose more public oversight of the insurance industry by a margin of almost six to one (75 percent to 13 percent), and support for a stronger government role in guaranteeing access to quality, affordable health care by a margin of over four to one (70 percent to 16 percent).

Small businesses want real health reform. Our members are willing to pitch in our fair share for a real fix. But policies like tax credits that donÑ provide real leverage and still leave small businesses a captive audience to the insurance industry arenÑ a real solution. ThatÑ why we support a stronger role for government, including giving small businesses the choice of a public health insurance plan that would force the private insurers to compete.

The issue of health care for small businesses is even more important now, in the face of the economic recession. Small business holds the promise to create jobs, help revitalize the economy and bring us out of the recession. But to clear the way for fulfilling that promise, weÑve got to fix health care, and do it right. Small businesses are ready to contribute, ready to do our part. We hope to work with you to advance comprehensive reform that fixes health care for small business owners, our employees, and the communities we serve.

Sincerely,



Sam Blair
Main Street Alliance National Director

ENCLOSURES: excerpts from Taking the Pulse of Main Street *report, including cover and pages 8-12.*

Taking the Pulse of Main Street

Small Businesses, Health Insurance, and Priorities for Reform

January 2009

Taking Action
Making Change

NORTHWEST FEDERATION OF COMMUNITY ORGANIZATIONS

THE MAIN STREET ALLIANCE

Maribel Peralez
Lynnwood, Washington

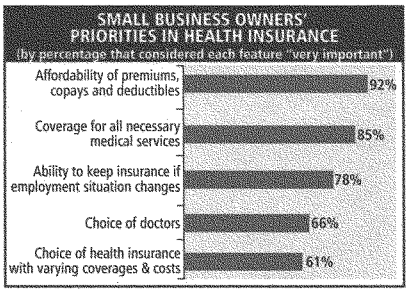
For four years, I had a successful business as a loan originator and insurance agent. I loved my work and, as an entrepreneur, I served my community and followed my dreams. Unfortunately, my dreams were forced to an end because of the skyrocketing cost of health care.

As a small business owner, I fell between the cracks: I made too much to qualify for public programs but I didn't make enough to pay the high cost of premiums with private health insurers. That's why I left my business and started a job with a large company that, at least for now, still provides health care. Small businesses and the self-employed have a hard enough time to begin with accessing loans. With the health care crisis, the self-employed dream is becoming a thing of the past.

Small Business Perspectives on Health Reform

Features of Health Insurance Important to Small Businesses

When it comes to the various features of health insurance, affordability and quality rank highest among the concerns of small businesses. Asked to state which of a standard set of features are "very important," participating small businesses responded as follows: affordability of premiums, co-pays, and deductibles (92 percent); quality, comprehensive coverage (85 percent); ability to keep insurance if employment status changes (78 percent); choice of doctors (66 percent); and, choice of health insurance plans with varying coverage and costs (61 percent).



Small Business Support for Competing Policy Proposals

To gauge the perspective of small business owners on possible reform proposals, the survey included questions testing support among small business owners for specific health reform proposals. The first of these questions asked small business owners their preference between two competing reform proposals, one focusing on a public insurance option and the other on creating more coverage choices through the private market:

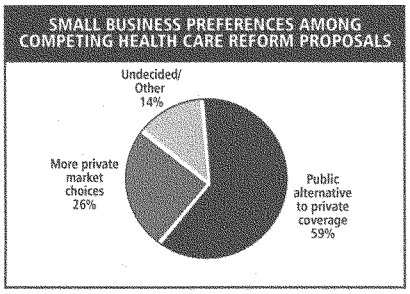
> **Proposal A:** Guarantee affordable health insurance to everyone with a public alternative to private coverage that covers all necessary medical services and is paid for by both employers and individuals according to their ability to pay.
>
> **Proposal B:** Create more affordable coverage choices by allowing insurance companies to sell more bare-bones plans and providing tax credits for buying insurance. Individuals could choose to buy a less expensive catastrophic plan, more expensive comprehensive coverage, or no insurance at all.

When asked to choose between these two proposals, 59 percent of respondents selected Proposal A, compared to 26 percent choosing Proposal B (the remaining 14 percent responded with "Undecided/Other").

Marinder Joshi
Marysville Tobacco Bar
Marysville, Washington

I have had this business for over five years and am in a really bad situation. Everywhere that we have looked insurance plans require either a really big deductible or a huge co-pay and none cover a pre-existing condition. My wife has knee problems and without insurance the surgery will cost over $20,000— for one knee! So, we will go overseas for the surgery. In this economy, I cannot afford to hire additional help and will need to close the shop... this situation has cost me my shop.

FINDINGS (continued)



Jim Houser
Hawthorne Auto Clinic, Inc.
Portland, Oregon

My wife and I have been running our auto repair business for 25 years. I love the customer contact, making people happy and solving problems. The costs of health care are quite a challenge, though. We offer health care for all our regular employees and their families, and the costs way outstrip the coverage we actually receive. The rates keep going up and up, and as a result we don't have as much money available to give good raises to our staff.

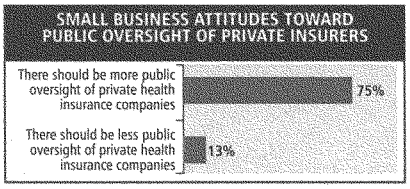
Most health insurance companies have so much power. They decide who is covered and who isn't, they determine what qualifies as a preexisting condition and what doesn't, and they can deny coverage for a procedure and you often have to go through a long appeals process. Health insurance companies are making huge profits off of people's ill health: that means money that could be taking care of people is going into the pockets of CEOs and investors.

Health care isn't like auto repair. Things like fixing or buying a car fit fine in the private sector. But essential community services like firefighting, police services, utilities and health care shouldn't be left up to the "free" market. These things should be our government's job to provide for.

The survey further questioned small businesses about their attitudes toward public oversight of private insurers. The survey asked respondents if they believed:

> A. There should be less public oversight of health insurance companies. In order to increase competition, companies should be allowed to set premiums without oversight, offer more bare-bones coverage options, deny coverage if someone is deemed too "high risk," and vary prices based on whether a person is healthy or sick, young or old, etc.,
>
> or,
>
> B. There should be more public oversight of private health insurance companies. Government should be a stronger watchdog over insurance companies by increasing oversight of premium-setting and profit margins, maintaining minimum standards for the quality of coverage in all plans, and ensuring that people can't be denied coverage or charged more based on age or preexisting condition.

In response to this question, 75 percent of respondents chose increased public oversight, compared to 13 percent who selected less public oversight.



Daniel Sherry
Kennedy's Creative Awards
Waukegan, Illinois

I am the owner of a family-run engraving business. About three years ago, we received a large order from one of our clients for plastic dog tags. This was a big boon for us. However, in the hysteria of increased production, my wife forgot to pay a health insurance bill and we were dropped from coverage.

After receiving that notification letter, we made the payment and asked the company to reinstate us. They said we had to reapply and be evaluated. That was infuriating. Then, they informed us that my wife and children could get back on the policy, but I couldn't due to a preexisting condition.

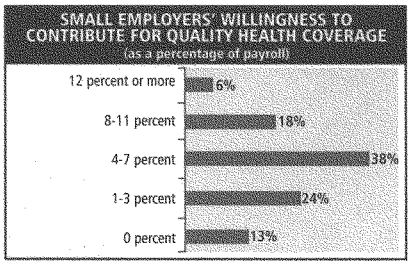
I had gone in for a checkup several months prior to all this, and the doctor had found high cholesterol. We decided to treat it naturally as my health had always been very good – I had even run a marathon five years ago. Despite these proactive steps, the insurance company would not allow me back on the plan.

It has been three years now and I feel like a walking time bomb. The way things stand if something happens to me, my wife and children will have to pay the consequences. Our house, business, and cars will all be gone if I am in need of medical care. I am seriously considering divorcing my wife of 21 years and giving her the house and the business so they will not be so at risk. It should not be this way but I don't know how else to protect my family.

Willingness of Small Businesses to Contribute Toward Health Coverage

Overwhelmingly, small business owners expressed a willingness to contribute to quality health coverage for their employees and their families. Sixty-one percent of self-employed respondents expressed interest in being able to buy into a statewide or national health care pool, and 52 percent said they would be willing to contribute four percent or more of their gross income, in place of current health care costs, to guarantee quality health coverage for themselves and their families.

Among small employers, 73 percent of respondents expressed a willingness to contribute financially to achieve quality, affordable health coverage for their employees, with 12 percent unwilling to contribute and 15 percent undecided. Sixty-three percent of surveyed small employers indicated a willingness to contribute four to seven percent or more of total payroll costs, in place of current health care costs, to guarantee quality health coverage for their workers and themselves: 38 percent were willing to contribute four to seven percent of payroll, 18 percent were willing to contribute eight to eleven percent of payroll, and six percent were willing to contribute twelve percent or more.



Rosalyn Redwine
Winning Coiffures
Denver, Colorado

Health care is a big concern of mine as a small business owner. I'm the working owner of Winning Coiffures, a full service hair salon in Denver with six employees. We have no health insurance – not for my employees, and not for me either.

We used to have a health care plan through the business, maybe 10 years ago, but then Aetna pulled out. Since then, the rates have just been going up and up and it's now too expensive to get an affordable plan that meets our needs. Where does that leave us? Going without. There are times when I have delayed and even avoided going to the doctor – when I should have gone but knew I couldn't afford it. My employees have had to do the same.

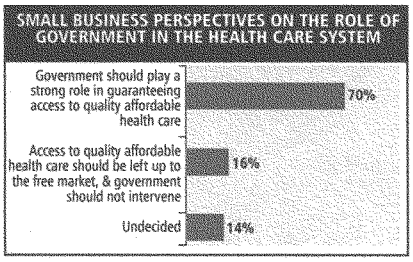
I'm willing to contribute financially to get decent health coverage for my employees, but I'm not keen on putting more money in the pockets of the private insurance companies. They're out of control; they charge as much as they want, and they can cut and run at anytime, leaving us behind. I think we should have a public plan we can choose instead. I'd pay up to 10 percent of my payroll for something decent for my employees. I want to help my employees get covered and it's the only way I see to get good health care for myself, too.

As small businesses, we can't solve this problem alone. We need government to step up and offer an effective alternative to the same old games the insurance companies play. This is the only way we're going to get control. The health care issue has gone unaddressed for too long and it's time to do something about it.

Small Business Perspectives on the Role of Government in the Health Care System

The survey concluded by asking small business owners to share their perspectives about the roles government and the market should play in the country's health care system. Seventy percent of respondents said they believe government should play a strong role in guaranteeing access to quality, affordable health care, compared to 16 percent who said they believe access to quality, affordable health care should be left up to the free market, and government should not intervene.

When analyzed separately, people of color business owners showed higher levels of support for a strong government role, more public oversight, and a public alternative by margins of 10 percent or more: 82 percent supported a strong role for government, 85 percent supported more public oversight of insurers, and 75 percent preferred a proposal with a public insurance alternative.



"Based on my experience as a small employer, I don't think we can trust private insurance companies to solve the problems they themselves have created and deliver quality, affordable coverage. We need a strong public alternative, so we're not held hostage to the industry."
- Matt Hisel, Home Resource, Missoula, Montana

"It's time we made a commitment as a nation. If we choose to solve this crisis together, we can allow small businesses to thrive as well as contribute positively to our communities and our nation's economy."
- Maribel Peralez, Lynnwood, Washington

CONCLUSION

Small businesses have found themselves at the center of the country's health insurance troubles. Lacking the bargaining power of large employers, they have watched their premiums increase at a higher rate while receiving less coverage. The difficulties are even greater for self-employed business owners, for whom the individual market is often the only source of private coverage. Without significant reform, small business owners and their employees will continue to be caught in a bind of paying unaffordable premiums and out-of-pocket costs, foregoing needed health care, and falling victim to mounting medical debt.

When thinking about how to improve the health care system, small businesses care about more than just purchasing any health insurance. They want their health insurance to cover necessary services and the associated costs. While they indicate a willingness to contribute, small businesses expect health insurance to deliver real value. Small businesses also believe government should play a stronger role in the health care system, rather than leaving access to affordable, quality health care up to the free market. When compared to market-based approaches, this stronger government role includes both providing a public alternative to private coverage and stepping up meaningful oversight of private insurers. Small business owners are willing to pay their fair share for quality coverage in a system of shared responsibility where government, business and workers all contribute.

RECOMMENDATIONS

The results of this survey indicate strong support from small business owners for concerted action to address the health insurance crisis. The federal government should enact comprehensive health reform that incorporates the concerns of small businesses. This reform ought to include the following features:

Commitment to Shared Responsibility

Small businesses are willing to contribute to a health care system that delivers quality coverage and in which all participants pay a fair share. Under reform, government, business, and workers should all contribute to make the health care system work.

Adequacy of Coverage

Small business owners and employees should not be at a disadvantage when it comes to covered services and out-of-pocket costs due simply to the size of their business. Health care reform should include a guarantee of adequate insurance: coverage that includes necessary services and financial protection.

Affordable, Predictable Costs

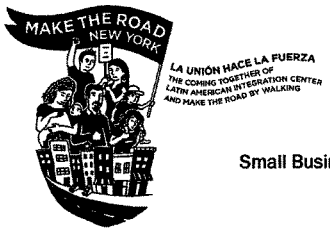
Small businesses need affordable avenues to contribute to health care for employees, and for owners themselves. Stable, predictable costs for which business owners can budget from month to month and year to year would be a welcome replacement for the anxiety and unpredictability of sky-rocketing premiums in the current system.

A Quality Public Health Insurance Option

Numerous health care reform proposals include the creation of a public plan option. According to this survey, small business owners prefer having a quality public option over expanded private options such as bare-bones plans. Health care reform should provide small business owners with this choice.

Strong Oversight of Private Health Insurers

Current state regulatory standards are inadequate for protecting small businesses from the harmful practices, such as preexisting condition rejections and discriminatory rating practices, they frequently encounter in the private health insurance market. Small businesses need stronger oversight of insurers to restore the balance of power and create a more level playing field.



Small Business United for Health Care Coalition

Statement submitted to the House Committee on Small Business – Friday, February 6, 2009 For the official record of committee hearing held February 4 on the topic: "Health Care Reform in a Struggling Economy: What is on the Horizon for Small Business?"

Madam Chair and Members of the Committee:

Small Business United for Health Care is a coalition of over 250 small business owners from the New York City area that have come together to push for health care reform that is quality, comprehensive and affordable. We are a project of Make the Road New York, a community-based organization in New York City and a member of the national Main Street Alliance, a network of small businesses committed to representing our voices in the national health care debate.

In a recent survey project aiming to capture the perspective of small business owners on health care reform that we participated in with the Main Street Alliance, we found the following results that challenge the conventional wisdom on health care and small business"

- **Small business owners are willing to contribute for good health care, but can't go it alone:** When asked if they were willing to contribute for health coverage for their employees, more than two thirds of New York small employers surveyed said yes. Furthermore, 69 percent of New York small employers indicated they would be willing to pay 4 to 7 percent of payroll, or more, to guarantee quality, affordable coverage for themselves and their employees.
- **Small business owners want the choice of a public health insurance plan as an alternative to private coverage:** When asked to choose between a proposal with a public insurance alternative and a proposal with more private market choices, New York small business owners chose the proposal with a public alternative by a margin of nearly five to one (80 percent to 17 percent, with 3 percent undecided/other).
- **Small business owners want government to play a stronger role to fix health care:** When asked about public oversight and the role of government, small business owners chose more public oversight of the insurance industry by a margin of almost 10 to one (89 percent to 9 percent), and support for a stronger government role in guaranteeing access to quality, affordable health care by a margin of over seven to one (82 percent to 11 percent).

Additional results of this survey can be found in the report, *Taking the Pulse of Main Street: Small Business, Health Care and Priorities for Reform* at the Main Street Alliance website:

www.maketheroadny.org

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www.mainstreetalliance.org. Please find the testimony of several of small business owner members of Small Business United for Health Care attached.

Sincerely,

Sara Cullinane
Coordinator, Small Business United for Health Care Coalition

EASTERN STATES: NEW YORK

Participating Businesses:

In New York, 117 small businesses participated in the survey, representing New York City (principally from the boroughs of Brooklyn, Queens and Staten Island). Thirty-three percent were small employers; 67 percent were self-employed business owners.

NEW YORK SMALL BUSINESS EXPERIENCES WITH PRIVATE HEALTH INSURANCE

Insured Rates:

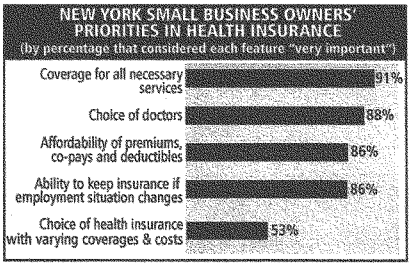
- Among small employers, 42 percent offered coverage to employees, and 56 percent had coverage for themselves through their business.
- Sixty-one percent of the self-employed had health insurance; 64 percent of those with insurance relied on public coverage.
- Sixty-three percent of respondents with current or recent coverage thought it would be a major challenge to obtain health insurance for themselves and their employees in the future.

Response to Premium Hikes:

- In response to premium increases, four percent of businesses with current or recent coverage reported switching to insurance with higher out-of-pocket costs and 15 percent reported switching to insurance that covers fewer services.

Business Impacts:

- Thirty percent of respondents said they or their employees had delayed or avoided treatment because of health care or health insurance costs.
- Forty-six percent of respondents said their business would be more productive if they and employees were covered.



NEW YORK SMALL BUSINESS PERSPECTIVES ON HEALTH REFORM

Public Alternative vs. Private Market Expansion:

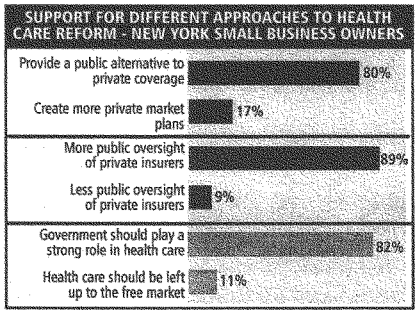
Between a plan with a public insurance option or expanded private market options, 80 percent of New York businesses selected the public option plan, compared to 17 percent for the private market expansion.

Public Oversight:

Eighty-nine percent of New York respondents said there should be more public oversight of insurers; nine percent said there should be less.

Role of Government:

Of New York respondents, 82 percent said government should play a strong role in guaranteeing access to quality, affordable health care; 11 percent said access to quality, affordable health care should be left up to the free market, and government should not intervene.



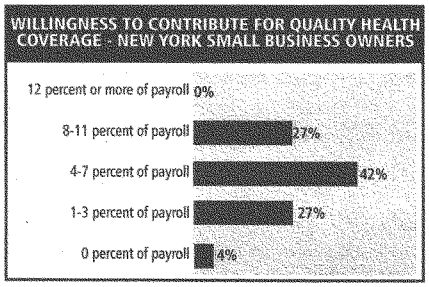
Carmen Ledesma
La Parisien Salon & Medi-Spa
Woodside, Queens

I have owned my business here in Queens for fifteen years. With nine employees, the salon is a growing business and an important gathering place in the community.

Without insurance, my health has suffered. I have not been to the doctor for a routine check-up in many years and have had to go without adequate medical care during two health emergencies. I've been trying to expand my business and open a beauty school – my dream as a small business owner. However, we lack the competitive edge to attract good teachers and professionals as staff since I can't provide health insurance, so I've had to put my dream on hold.

Willingness to Contribute to a System of Shared Responsibility:

- Among New York small employers, 67 percent indicated they were willing to contribute financially to achieve quality, affordable health care for their employees; 69 percent indicated they would be willing to pay four to seven percent or more of payroll to guarantee quality coverage for themselves and their employees.
- Among self-employed entrepreneurs in New York, 81 percent expressed interest in buying into a statewide or national health care pool; 10 percent said they would be willing to contribute four to seven percent or more of their gross income for health care.



Modesto Reyes
Recuerdos Mexicanos Restaurant
Port Richmond, Staten Island

I have no health insurance nor can I offer it to my family or employees. This has caused me great trouble to date. Once, one of my children got got sick and I had to take him to the doctor. Luckily, nothing was seriously wrong but a few weeks later I received a bill for $800 in the mail – this nearly made me sick myself. After this incident, I tried to buy health insurance but the monthly premium was almost as much as that hospital bill and it barely covered any of the services we needed.

Now that my business has grown, I would like to be able to offer my employees health insurance at a reasonable cost but I still can't afford to buy a plan. I support comprehensive health care reform and believe the government should regulate the insurance companies. Affordable, quality health care should be available to everyone.

Wendy Whiteside
Dandy Auto
Port Richmond, Staten Island

I am the owner of Dandy Auto, a business that has been in my family for 50 years. I am proud to provide health insurance coverage to my employees but every year the premiums increase and it's hard to stay on top of it. As a small business owner, it's now difficult to both give employees what they need in terms of health insurance coverage and make a profit.

We need health care reform to help small businesses provide affordable, quality coverage. As it stands, we are all alone in trying to provide health coverage for our employees. Even having a larger group pool would not guarantee us affordable coverage in the long term because health insurance companies can still increase our premiums at high rates. I support extra government regulation of health care companies and believe that everyone, including immigrants, should be included in health care reform because we all need quality health care coverage.

February 4, 2009

House Committee on Small Business
2361 Rayburn House Office Building
Washington, DC 20515

Dear Chairwoman Velazquez:

On behalf of the 24,000 association executives representing 11,000 associations, I want to thank you for your introduction of the Small Business CHOICE Act and your committee's hearing, "Health Care Reform in a Struggling Economy." The **American Society of Association Executives (ASAE)** is the largest association representing America's trade, professional, and philanthropic organizations. The size and scope of the association sector continues to grow, along with its role in American life, as almost 280 million Americans belong to or participant in the activities of our members' associations.

Health care reform has consistently been a top concern for employers and employees, including associations. A survey ASAE conducted in February 2007 of all CEO members revealed that *half of respondents characterize health care as "one of the most significant problems facing practitioners in our industry or profession"*. This data reinforces other surveys that show how many businesses are struggling with increasing health care costs. Associations alone have experienced an 11% increase in health care costs for employees, according to ASAE's 2008 Employee Compensation and Benefits Study.

In the past, ASAE has supported association health plan (AHP) legislation that allows small business owners to pool together across state lines through their membership in a trade or professional association to purchase health coverage for their families and employees. Associations have been sponsoring health plans for more than 50 years. In 1990, there were reportedly more than 1,000 AHPs. Today, that number has dropped to fewer than 200 due to the tightening of state regulations over the past decade that have made operating an AHP across state lines an administrative nightmare. However, in our February 2007 survey, 61% of respondents said that if the barriers to creating health care pools were removed, their association would consider providing this benefit to their own employees.

I want to thank the Chairwoman for her introduction of the Small Business CHOICE Act with Representatives Joseph Pitts and Sam Graves. The Small Business CHOICE Act would reduce the health care costs of small businesses by eliminating premium volatility and reducing premium costs incurred by businesses by transferring the risk of high medical costs to a captive excess claims insurer formed by a small business cooperative. The legislation would allow bona fide associations, unions, credit unions, and other specific organizations to form a captive insurance company chartered in one state that meets standards developed by the National Association of Insurance Commissioners as well as additional requirements. This legislation would help alleviate the problem small businesses and associations face in providing an important employee benefit in the face of rising and unexpected costs.

ASAE is willing to help the committee with solutions to the rising cost of health care for small businesses and associations. Please contact myself or Jim Clarke, Senior Vice President of Public Policy, at 202.626.2865 or jclarke@asaenet.org.

Sincerely,

John H. Graham IV, CAE
President & CEO

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