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THE SMALL BUSINESS HEALTH MARKET: BAD REFORMS, HIGHER PRICES, AND FEWER CHOICES

HEARING

BEFORE THE

SUBCOMMITTEE ON REGULATORY REFORM AND OVERSIGHT

OF THE

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

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THE SMALL BUSINESS HEALTH MARKET: BAD REFORMS, HIGHER PRICES, AND FEWER CHOICES

THURSDAY, JULY 11, 2002

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON REGULATORY
REFORM AND OVERSIGHT,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:13 a.m., in room 2360, Rayburn House Office Building, Hon. Mike Pence (chairman of the subcommittee) presiding.

Chairman PENCE. This hearing of the Subcommittee on Regulatory Reform and Oversight for the Committee on Small Business is called to order. And this hearing is entitled, "The Small Business Health Market: Bad Reforms, Higher Prices, and Fewer Choices." We are very grateful for all the witnesses and the members who are in attendance.

The Chair will make a brief opening statement, then recognize any members that have an opening statement. Then we will proceed immediately to our witnesses. The procedure we will follow today will be to encourage our witnesses to make brief remarks within a five-minute time frame and then we will reserve all of our questions for them at the conclusion of all of the prepared remarks.

Witnesses should also know that it is not necessary for you to hurry through your written statement, that without objection, your written statements will be entered into the full record of this hearing. And you might use your time more to amplify the points that you would like to make to the members gathered here and to the record.

Our hearing today essentially addresses the rising cost of health care to Small Business America. Of the 43 million Americans without health insurance, 62 percent are either small business owners and their families or small business employees and their families. The problem of the uninsured is very clearly a problem of small business access to health care at reasonable prices. Well intentioned reformers in the States and in Congress over the last decade have managed to dramatically increase the cost of health care and practically destroy the small group market.

Two of three reforms that sound particularly harmless are guaranteed issue and community rating. Guaranteed issue has given healthy people a reason not to purchase insurance. If you can get coverage at any time, then why purchase it before you get sick, in

effect. Community rating, which was meant to keep prices reasonable for high risk customers, has actually led in many cases to prices spiraling upward and healthier people dropping their coverage.

Both combined have led many companies to drop out of the small group market in most of the states. A few examples, according to one of our witnesses who represents the nation's largest health care actuarial company, 40 states and the District of Columbia have no small group market left. Insurance companies have just stopped offering coverage in those states.

Additionally, a small employer in Florida trying to buy health insurance from e.healthinsurance.com, the nation's largest on-line insurance broker, cannot find any health insurance. Otherwise, they have a choice of two HMOs.

Also, according to "The State," which is a newspaper in South Carolina, small businesses in South Carolina have "given up providing health insurance." According to the South Carolina Department of Insurance, eight out of ten uninsured individuals are members of working families. Since 1992, 73 companies have withdrawn in whole or in part from Arkansas' health insurance market. Fifty-six of these withdrawals have taken place within the last four years.

Obviously, in states where there is no competition for the small business dollar, prices will continue to rise. The National Association for the Self-Employed reports in a recent survey that seven out of ten small businesses do not provide health insurance to their employees and costs are almost uniformly cited as the chief reason for this trend.

It is imperative that we act and act quickly in Congress to reverse the course of small business health insurance market, before we reach a point where no small business can afford health insurance for its employees.

I certainly look forward to the testimony of all of our witnesses and, in the absence of the ranking member, the gentleman from Pennsylvania would recognize the gentlelady from the Virgin Islands.

[Mr. Pence's statement may be found in the appendix.]

Ms. CHRISTIAN-CHRISTENSEN. It is going to be very brief, because I do have an opening statement that I will submit for the record. But I just wanted to say that the issue of coverage is a critical one that we face in this country, being the last industrialized nation not to cover all of its residents and citizens. And I am on several bills that either express the sense of Congress that we should have universal coverage by 2004 and related bills. But I realize that there are many, many different approaches to this very important issue and I welcome all of the participants in this hearing today. I thank the chairman for calling it. Because all of the different approaches ought to be on the table. We need to have a very open and an ongoing dialogue so that we can insure that everyone is covered. It is amazing that 60 percent of the people who make up over 40 million uninsured work for small businesses, small business employees or employers. We welcome you and we look forward to your testimony.

Chairman PENCE. With apologies to the gentlelady from the Virgin Islands, thank you for your opening statement and we will enter your formal remarks in the record without objection. With that, I would recognize for any opening remarks she might have the former chairman of this committee, the gentlelady from New York, Congresswoman Sue Kelly.

Ms. KELLY. Thank you, Mr. Chairman. I have no remarks. I am interested in hearing what the witnesses have to say to us today, but thank you for holding this important hearing.

Chairman PENCE. And now the much anticipated opening statement of the distinguished gentlelady from Ohio, Congresswoman Tubbs Jones.

Ms. TUBBS JONES. Mr. Chairman, thank you for such a kind introduction to my colleagues on both sides of the aisle. Access to health care—in addition, this is really not my subcommittee, but I appreciate the opportunity to be here, because this issue is so important to the small businesses in my district.

Access to health care is the most important concern facing small business. Approximately 43 million people are without health care insurance in this country. Many of these are employed by small business. It is shameful that these businesses are at such a competitive disadvantage compared to big business when it comes to providing health plans. Small businesses drive our economy through innovation by opening doors for women and minorities.

This Congress must work to remove the barriers that inhibit access to health care. We must do so not only for the health of small business workers, but also for the health of small business. Association health plans and tax credits represent important ideals that will ultimately figure into a plan to reduce the number of uninsured small business employees.

However, we must recognize that there is no blanket solution to this problem. Allowing small business access to health care will require a unique combination of ideas. Ultimately our solution must afford small business the economies of scale enjoyed by big business while reducing the punishing effects of community rating and guaranteed issue. However, this solution must not make irrelevant laws that mandate coverage of certain benefits and must not force workers to purchase coverage that includes riders. Insurance policies that include riders do not constitute adequate coverage because such policies do little to make adequate health care more affordable.

As we move forward with our work in this area, I encourage my colleagues to keep plans offered by entities like the Greater Cleveland Growth Association and COSE, which is the Council of Smaller Enterprises, in mind. These organizations are prominent advocates for greater access to health care for small business in my own congressional district, the 11th Congressional District of Ohio. The Growth Association has written many helpful articles in order to help small business evaluate options for providing care. With their front-line perspectives, both organizations will prove helpful to us as we attempt to expand small business access to health insurance.

I was talking with the president of the United Food and Commercial Workers in Cleveland the other day. They have their own health care plan and they are self-insured. He said to me for nine

years their health care coverage remained pretty equal, pretty steady. But in the last two years, their health care costs have doubled, I mean, have increased by 50 percent. That is like doubling, right?

I said to him, what are you going to do about that? And he said, you know, we are sitting at the table, we are in negotiation right now, trying to figure out how do I work with this small business to keep my union employees with some type of coverage and keep it processed. I think this becomes another issue, particularly, as well, as we move people from welfare to work. Many of the small businesses are being encouraged to bring former welfare workers into their business for employment. The dilemma then becomes you have people moving from welfare to work at minimum wage with no health care. And so it is like they are moving from welfare to poverty, based on the amount of income that they have.

So I am interested in this issue. I look forward to the witnesses' testimony on the issue and to working with them to try to resolve this issue. Mr. Chairman, I thank you for the opportunity to be heard.

[Ms. Tubbs Jones's statement may be found in the appendix.]

Chairman PENCE. And I thank the gentlelady for her passionate remarks. With that, before we move to our witnesses, I would certainly recognize the gentleman from Illinois for any opening statement or opening remarks that he would care to make. We thank him for his attendance and all the members gathered. With that, we would welcome all of our witnesses. We appreciate very much your commitment to public service and taking the time to be with us in this important panel today.

Most of you are veterans of Capitol Hill hearings and know the rules of the game. But for those few neophytes, the lights mean exactly what they do on the street coming here today. Green will mean go and yellow does not mean accelerate.

This chairman does not use the gavel too harshly, but once you are over the five minute time, we will ask you to wrap it up as quickly as you can. And again I would emphasize to all the members that we will entertain questions of all of the witnesses after we have heard the statements.

The Subcommittee will first hear from the Chief Economist at the Small Business Survival Committee, a prominent organization that has, particularly in recent years, risen to be a very trusted and oft quoted organization in the national media on issues related to small business. And their Chief Economist Ray Keating is with us today and is recognized for five minutes.

STATEMENT OF RAYMOND J. KEATING, CHIEF ECONOMIST, SMALL BUSINESS SURVIVAL COMMITTEE

Mr. KEATING. Thank you, Mr. Chairman, and thank you for the kind words about SBSC. We are very pleased to be here to speak on behalf of small businesses regarding health care costs and the impact that government reforms and regulations have had on those costs.

Again, my name is Ray Keating. I serve as Chief Economist for SBSC. We're a non-partisan, non-profit small business advocacy group and we have more than 70,000 members across the nation.

We work on a wide range of public policy issues that impact small businesses, their employees and the economy in general, and obviously health care policy is of critical interest to us. We hear regularly from our members about the problems they have in the health care marketplace. And obviously, number one on their list is rising health care costs.

Small business have been confronted with enormous increases in health care costs in recent years. I will offer you just a few examples from my written testimony.

There was a national survey of small businesses released in April of this year by the Kaiser Family Foundation. And of the small firms not offering coverage, 72 percent cited cost as a very important reason for not doing so. Of all the small businesses executives surveyed, 67 percent said they were very or somewhat dissatisfied with the costs of health care.

In Massachusetts, health insurance premiums went up by 12 to 15 percent this year, with many small businesses reporting increases of more than 20 percent. A Michigan survey taken, again, in April of 2002, found small business health insurance premiums had doubled in the previous four years and were expected to rise by 20 to 25 percent this year. The survey also found, which obviously is quite worrisome, that 24 percent of business owners said rising health care premiums threaten the existence of their business.

Another report noted that health insurance premiums in 2001 rose 55 percent faster for small businesses than for large firms in 2001.

So you get the basic idea of what the problem is right now and this has been a multi-year problem for small businesses. It has just not been the last year or two. Obviously, these rising costs take a heavy toll on small firms. Many did not survey. Some cannot afford to offer health insurance coverage in the first place and that places these firms at a competitive disadvantage in attracting good employees. Other businesses reduce coverage, including having employees pick up a bigger share of health care costs or they simply eliminate coverage altogether.

The obvious question is why? Why are health care costs on the rise, and not only for small businesses, but for individuals and other firms as well? The increase in health care cost is due, to a significant degree, to government's increasing role in the health care marketplace. One major problem is the third party payer issue. Government's ever increasing role in health care funding vastly accentuates the problem of third party payments which push health care costs higher.

Just to back track, insurance, of course, makes perfect economic sense. Health insurance, properly understood, protects individuals against large, unpredictable costs. However, many employer-provided health care plans and government programs have ventured far beyond the basic concept of insurance to offer first dollar coverage for small and predictable expenses.

When a third party, whether an employer-provided plan or the government, picks up the tab for reasonable and predictable health care spending, demand is driven up and consumers and health care

providers possess few, if any, incentives to be concerned about costs. The result is higher costs.

Another major impetus to increased health care costs and rising premiums is government regulation. More regulations and mandates on the part of government, no matter how well intentioned they might be, inevitably result in higher costs. Higher costs, of course, mean reduced access to quality health care.

As the chairman mentioned, we note the dire impact of two forms of regulation imposed to a significant extent in the States over the past decade or so, and that is guaranteed issue and community rating.

Guaranteed issue, in effect, means that individuals may not be turned down for health insurance coverage no matter the condition of their health. And community rating mandates that an insurer charge the same price for everyone in a defined region, regardless of their varying health care risks.

These regulations violate the basic tenets of the insurance business, namely, risk spreading. Guaranteed issue removes incentive for people to buy health insurance until they are ill. And community rating does not allow for critical risk factors to be considered when pricing insurance. And the results are completely predictable—much higher insurance costs and fewer insured individuals.

In my written testimony, I offer examples in New Jersey on how costs have skyrocketed, how in Kentucky, insurers have fled the case and, of course, those are just two prominent examples.

Unfortunately, looking ahead, it often seems that the only debate in policy circles today is how far new mandates and regulations should go. In our view, Congress and the White House need to dramatically shift the health care debate away from more government involvement and, instead, focus on removing governmental barriers to additional choices in the health care marketplace.

I see that my time is up, but I would like to highlight that one dramatic change that Congress could do would be on the reform and deregulation front, is to lift the current restrictions on, for example, tax-free medical savings accounts. MSAs, just for people who are not aware, they combine a traditional high deductible, catastrophic insurance plan with a tax-exempt savings account. MSAs reconnect that buyer-seller relationship in the marketplace. Individuals and their doctors make health care decisions, not some distant bureaucrat.

Again, in my written testimony, we offer various examples of the restrictions that are on MSAs right now, but this is a clear opportunity where deregulation can expand health care choices, expand competition, reduce the number of uninsured, and lower the cost for businesses of all sizes. That is the exact opposite of what happens with more regulations like guaranteed issue and community rating.

So in the end, market and competition work. Deregulation and expansion of choices in the health care marketplace will have positive effects on both costs and quality of care. Minimal government intervention and regulation allow businesses and consumers to seek out the type of health care coverage that meets their needs and pocketbooks. And I look forward to any questions that you might have after we are done.

[Mr. Keating's statement may be found in the appendix.]

Chairman PENCE. Thank you, Mr. Keating. Next, the Subcommittee will hear from Mark Litow, who is a consulting actuary for Milliman USA, the nation's largest health care actuarial firm. Mr. Litow is a fellow in the Society of Actuaries and a member of the American Academy of Actuaries and one of the most recognized experts in the country on the issues before this Subcommittee today and is warmly welcomed and recognized for five minutes. Mr. Litow?

STATEMENT OF MARK E. LITOW, CONSULTING ACTUARY, MILLIMAN USA

Mr. LITOW. Thank you and thank you very much for putting this together and giving me a chance to testify. I have been in this business for 27 years. I have been working in exclusively health care for that whole time and a lot of my time is spent in the small group as well as individual markets.

On Saturday, I am actually traveling to South Africa to deal with much the same problem. They implemented guarantee issue and community rating in South Africa January 1, 2000 and the market is totally falling apart. So this has been practiced in a number of countries throughout the world. This is not just the United States' problem. Australia did it in the 70s and has had dramatic problems, as well.

Just as a caveat, since consultants always need caveats, the opinions I express are my personal ones. They are not of the firm. I did have several of my colleagues, however, in the firm review this and they do agree with the opinions found in my testimony.

As Mr. Keating indicated, this market is in very, very bad shape. I think the Chairman indicated and I think that was from my testimony, that only ten states we see as being viable, as I recommended to insurance companies that I work with for entering those markets. There are some other states that are sort of on the borderline, another five. Another 15 states or so where the Blues or one other dominant carrier can get large, large discounts that other carriers cannot get and so they dominate the market, and 20 other states where there really is very little market left.

So the question is, how did we get there and that is a long history. But very quickly, we implemented the premium tax exclusion that was referenced by the earlier witness in 1954, which emphasized using third parties to cover everything. That led to Medicare and Medicaid in 1965, which led to cost shifting and many other problems. And we ended up with a situation where virtually somebody else is always paying for our health care. There is very little personal responsibility. And that afflicts all of the health markets and the small group market, with its inability to get the same leverage as large group, is even worse.

So we are in a real predicament. It has taken us a long time to get there and in the 90s we put in the rating bans and guarantee issue that made it significantly worse and has exacerbated the problem.

So the real question is, what do we do about it, given that we are in this serious position? And I have a couple of recommendations to put forward. First would be, I would look at seriously re-

pealing the premium tax exclusion, which created such heavy reliance on third party. That has created a serious problem and there are various things to do. You obviously need to replace it with something to help people who need the protection and cannot afford it. And I would suggest some form of tax credits as a possible solution to that.

Secondly, I would either look at either modifying HIPAA, which put in guarantee issue, or simply repealing it. To modify it, you could offer basic and standard plans as an alternative to people and then you would not have to repeal it.

The other thing are the rating bands that many of the states have put in. If those are too tight, generally less than plus or minus 25 percent, what you will see is just rate spirals develop very rapidly in the states. Some of the states have what they call pure community rating, where there is no allowance for rate differentiation. And so what happens in these situations is that the healthier people start to reduce their coverage or drop their coverage. The higher cost groups en masse by rich coverage, and it puts more and more weight—and, of course, then the insurers have to continue to increase the premiums and you develop rate spirals.

And that is what is happening in these markets. The key thing in health care reform is focus on keeping the healthy people in the system. Those are the people that subsidize the less healthy. If they start exiting the system, you will have problems.

So those are my three recommendations. We are going to need to show some patience in implementing this, because it has taken us a long time to get into this mess. It is going to take us awhile to get out. But we seriously need the rigorous debate that has just been talked about on this market and we need to start acting now, because if we do nothing, the situation will just continue to get worse. Thank you very much.

[Mr. Litow's statement may be found in the appendix.]

Chairman PENCE. Thank you, Mr. Litow and look forward to questions from the members gathered about your remarks. The Subcommittee will now hear from Dr. Merrill Matthews, who is the Director of the Council for Affordable Health Insurance. He is a public policy analyst specializing in health care issues and is the author of numerous studies in health policies, past President of the Health Economics Roundtable for the National Association of Business Economics, former health policy advisor for ALEC and his relationship with this Chair dates back over a decade of misadventures and per adventures in the area of health care reform and is very warmly welcomed by the Chair. And, Dr. Matthews, you are recognized for five minutes.

STATEMENT OF MERRILL MATTHEWS, JR., PH.D., DIRECTOR, COUNCIL FOR AFFORDABLE HEALTH INSURANCE

Mr. MATTHEWS. Thank you, Mr. Chairman, and I would like to thank you and the members for putting on this hearing. I believe, as was stated earlier, that for small businesses, this is one of the most important issues they are facing—how to provide affordable coverage to their workers.

As you mentioned, I am with the Council for Affordable Health Insurance. It has been in Alexandria for ten years. We are a re-

search and advocacy association representing small insurers in the small and individual group market.

I would like to start out by discussing a little bit, by going to an analogy and maybe making it clear what happens with guaranteed issue by doing that. My father-in-law is a homebuilder. Suppose that in his state, the state legislators looked out and said we have a problem with homelessness in this state. How are we going to get these people into homes? We would like to be able to fund some new homes, but we really cannot afford it. What are our options available?

Well, we have some homebuilders in the state. Why do we not just require them that for every, say, five homes they build, they have to build one free and provide it for a homeless person? If the state legislature was to do that, my father-in-law, of course, would have to struggle with that. He did fairly well being a homebuilder of middle class homes, but he did not make enough money off of four or five homes to build a whole new home.

As a result, as he started into this process, he would find he would have to raise the prices of those homes for paying customers in order to be able to afford to build the other home free of charge. As those prices began to rise for the paying customers, they would look at that and they would say, why are we paying more? We have friends living in other states that spend a lot less for the same size house.

And those customers would begin to look for options. They might not buy a new home. They might move across the state line. They may choose another alternative like moving into an apartment. They would begin to find other alternatives and as a result, my father-in-law would be building fewer homes. They would cost more, the ones that he built, and the people that this was set up to help, the homeless, would end up getting fewer homes out there, as well.

What happens with guaranteed issue is something very similar to what they would be trying to do with my father-in-law. Guaranteed issue is an attempt to try to make insurance companies the safety net. It is an attempt to try to make insurers become the provider for people who have medical conditions and other things and cannot get health insurance in a normal market.

Now what we do in other areas of the economy, if we have people who are in need, we let the market work for everybody else and we provide assistance for those that have needs. In food, we have people out there who cannot afford the food they need, we provide food stamps or a food stamp program. For those who need housing, we do not tell builders you have to build an additional house free of charge. We provide assistance for those who need the housing.

That is what we ought to look at in terms of health insurance. Instead of going to insurers and, in essence, saying you have got to take people who you would not normally take because they have a medical condition, which ends up, when those people move into the market, they have very high expenses. They end up bringing those expenses into the pool. The premiums rise for everyone, it has been discussed earlier. Young, healthy people begin to drop out of the pool because they say, my goodness, this is very high. And if I can go into the health insurance market any time I want to, why do I want to stay in here while I am healthy?

So you get the pool smaller and sicker. And as a result, you get fewer people insured and the people that you were really trying to help initially end up paying a whole lot more if the product is even available at all.

Now as mentioned by Ray, a number of states have tried to do this. It has never worked—never worked. At the federal level, we tried to do this in the small group market with the HIPAA legislation. If you looked at the American Academy of Actuaries report when this first came out, the press release said insurance premiums might rise between 2 and 5 percent. If you looked inside the report, it said, well, for some groups, the premiums could go up between 125 and 167 percent. That is exactly what we are seeing from the people you were discussing. The premiums are rising because people can move into the market and, in essence sick people can move in and the premiums will begin to rise.

We think there are two or three things that can be done with this. Number one, you need to have a program that creates government as a safety net and not tries to make business the safety net. You can do that by repealing HIPAA. That is one option that Mark Litow mentioned. You can provide some options out there and the NAIC has got model legislation that will, if you are going to have guaranteed issue in some areas, you can let insurers offer those that are underwritten in other areas, so that there are some choices out there. And you can move to a situation in which if a state has a risk pool, the risk pool becomes, in essence, the safety net for those people who are uninsurable.

If we are going to do this, ideally you move to a provision in which your high risk pool captures the uninsurable people. That lets the market work for everyone else. There is legislation in the Senate by Senators Baucus and Smith that would provide funds to do just that, and we think that is the way you need to go. And I will be available for questions later. Thank you, sir.

[Mr. Matthews's statement may be found in the appendix.]

Chairman PENCE. Thank you, Dr. Matthews. Our next witness is Robert de Posada. Did I pronounce that correctly?

Mr. DE POSADA. Yes, you did.

Chairman PENCE. Robert de Posada is President of the Latino Coalition. He is former president of the Hispanic Business Roundtable and brings a critical perspective about minority business enterprise and the challenges that they face in wrestling with the extraordinary costs of health insurance to this panel.

We are grateful for your national leadership. We are grateful to recognize you for five minutes.

STATEMENT OF ROBERT GARCIA DE POSADA, PRESIDENT, LATINO COALITION

Mr. DE POSADA. Thank you, Mr. Chairman. As you mentioned, Hispanics are disproportionately affected by the uninsurance crisis that we have, currently. We are three times as likely as the rest of the population——

Ms. KELLY. Excuse me, Mr. de Posada. Could you pull that microphone closer to you? Thank you.

Mr. DE POSADA. Is this better?

Ms. KELLY. Yes.

Mr. DE POSADA. Hispanics are disproportionately affected by this crisis. The census shows that Hispanics are three times as likely as any other group in the country to be uninsured and the reason is simple. I mean, it is source of employment and the economics, income levels. Americans get their insurance from their job and the overwhelming majority of Hispanics work for small business and in the service industry, which as we all know are more likely to not offer health insurance simply because they cannot afford it.

Also, according to the census, we are finding that less than 1 percent of all Hispanic owned businesses have 100 employees or more. Therefore, 99 percent of Hispanic businesses in this country, 1.4 million, are considered small businesses. Fifty-five percent of the Hispanic owned businesses are also in the service and in the retail sector. And if we add construction to this, we are talking about 68 percent of them.

After talking to many of these employers, we are convinced that they would love to move into a system that they could offer insurance to their employees. The problem is that with all the good intentions and all the good legislation and regulations at the state and federal levels that public officials are making, it is almost impossible for them to afford it. Guaranteed issues and community rating and, you know, modified community ratings are driving costs through the roof. And believe it or not, rates for small business, for small group market, is significantly higher than in the individual market, which is already very high.

What we are seeing is that too many working families are being left behind. We call them the too poor, but not poor enough. Too poor to afford health insurance, but not poor enough to qualify for Medicaid.

So what would we recommend? From a small business perspective, first, we strongly urge you to pass legislation to repeal guaranteed issue at the federal level and to continue to support high risk pools. Second, we would push for the association plan legislation again. These two proposals will help reduce the cost of health insurance overall.

Also, as a more creative approach and we have been looking at how to implement this, we would like to allow small businesses to actually purchase health insurance on the Internet. But the key here would be the regulations that would apply to these businesses would be the ones in the home state where the insurance companies are providing. This would help address the whole issue of the state regulatory level.

However, from an individual perspective, we are strongly recommending immediate passage of the bipartisan legislation to provide refundable tax credits or vouchers to workers who do not get health insurance from their jobs. This would help focus the assistance on those who need it most and would help cover the gap of uninsured, where it is needed most.

And do not let opponents fool you. I mean, this has become too much of a partisan attack. You can get health insurance for working families in the market for the $3,000 being proposed. Currently, on a quick search on the Internet, we found that in Anderson, Indiana, you can get for $172 a month coverage for a family

of four. In Chester, Pennsylvania, for $187 a month, you can find for a family of four. So it is affordable and it is doable.

Also, once this legislation is implemented and signed into law, what you are going to find is all the health insurance companies that currently are seeing this market as something that is not approachable, it is not worthwhile for them, all of a sudden, millions of families with $3,000 vouchers, this becomes a significant market for them and they will design plans to meet this need.

We have a serious uninsured crisis in the Hispanic community in our business sector and we urge you to stop the good intentions, new mandates and regulations that are driving prices through the roof. While politically popular, you are destroying the market and will end up leaving thousands of workers without coverage. We urge you to do what is right and to help small businesses and their employees. And we thank you for holding this hearing, because at least you are taking a first step in that direction. Thank you, Mr. Chairman.

[Mr. de Posada's statement may be found in the appendix.]

Chairman PENCE. Thank you, Mr. de Posada, for those very insightful and provocative remarks.

Our final witness this morning is Wayne Nelson, President of Communicating for Agriculture and the Self-Employed. And Mr. Nelson is a grain farmer from Winner, South Dakota, and was elected to his current post in 1993 and is one of the most recognized experts in the agricultural arena on challenges facing the self-employed in small business in agriculture in the country. And it is delightful to have you here and I am anxious to hear your remarks. You are recognized for five minutes.

STATEMENT OF WAYNE NELSON, PRESIDENT, COMMUNICATING FOR AGRICULTURE & THE SELF-EMPLOYED

Mr. NELSON. Thank you very much, Mr. Chairman and members of the Committee. CA, Communicating for Agriculture & the Self-Employed, is a national organization made up of farmers and small business members who are individual operators of very small businesses that only have one or two employees.

As you all know, it has been stated earlier, health costs are rising at very alarming rates. After a few years of lesser increases, the last two years have seen dramatic increases. This really hits small businesses very, very hard. And unfortunately, they are forcing more of them to drop coverage that they have previously offered to their employees or keep them from offering new plans.

Compounding the problem is that more insurance companies are dropping out of the small group markets in some states, leaving fewer choices for small businesses and a less competitive market. Many of the employees of these small businesses end up in the individual market.

While it is important to take steps to keep a viable small group market working in every state, it is equally important, we feel, that steps be taken to maintain a viable, competitive, affordable individual market, not only to serve the self-employed, but also to serve the individuals who work for small businesses that are not able to offer insurance under employer coverage.

Many of the federal and state reforms that were enacted in the 1990s with the intent of helping the small group market have backfired and actually done harm. Also, several states have tried reforms in the individual market, tried to make them more like the employer market with disastrous results.

Some state legislatures believe that simply legislating that every insurance company had to offer insurance to anyone at any time, regardless of their medical conditions, could really solve the problem. And this has led to sky high premiums and no competition, with many companies leaving states that have guaranteed issue in the individual market.

C.A. believes that everyone deserves access to quality insurance and we feel that high risk pools, sometimes called health insurance safety nets, are the best, most workable way to address the problem of access for people in an individual market.

Thirty states now have high risk pools that offer high risk pool programs that offer health insurance to individuals who are medically uninsurable. All risk pools by their inherent design need to be subsidized. Funding is an issue that is holding back more states from adopting them and funding poses a challenge for existing state programs, because they try to keep premiums as affordable as possible.

C.A. believes that some partial federal funding to help start pools in the remaining 20 states would be helpful. Additionally, federal funds to help pay the premiums in the existing states would also be very helpful.

The second issue that is very important is we are trying to do something to temper the high cost of health insurance that keeps many individuals and the small businesses from purchasing insurance. CA strongly supports refundable, advanceable tax credits or health credits as one way to make insurance more affordable.

There are several plans introduced in both the House and the Senate and the President has offered his health credit plan and they would offer up to $1,000 per individual and up to $3,000 per family. These health credits are refundable, which means that they would be available to an individual or family even if they have no income tax liability.

Department of Treasury has done review and estimates that the President's plan would lower the number of uninsured by six million people, which is very significant.

We also feel that MSAs or medical savings accounts would offer another alternative to help get more people insured. Recent legislation extended the period of time for the current MSA program by one more year, but much more needs to be done. MSAs need to be available to all sizes of companies, not just very small companies. We feel that a wider range of deductibles would allow consumers more choice and would allow companies to offer products better suited to customers. It would also be helpful to allow contributions by both the employee and the employer in the same year.

C.A. believes that our power is in our association to help our members have better health insurance. CA has offered an endorsed health plan to our individual members for the last 26 years. Even though CA members participating in the plan are in the individual

market, they have similar power to those in groups in regard to health products offered and the cost of premiums.

The association can negotiate with an insurance company with a much louder voice in terms of tempering rate increases and offering quality products than the individual can alone. That combined voice is a power of the association.

We will continue to work toward keeping a viable individual insurance market to also help the small group market. We will strive to have high risk pools for individual market access in every state, to have refundable tax credits, to help make insurance more affordable, to expand MSAs, to offer more choice and to enforce the power of the association to try to help individuals get better health benefits at a lower price.

Together, we think these things can make a significant change in helping small business and the self-employed have better insurance products. Thank you very much, Mr. Chairman.

[Mr. Nelson's statement may be found in the appendix.]

Chairman PENCE. Thank you, Mr. Nelson, for those thoughtful remarks. The Chair is going to pose just a couple of quick questions and then yield to other members before I ask the balance of the questions I have.

Beginning with Mr. Keating, from your perspective as an economist, what are small businesses going to do if Congress does not—we are talking about repealing HIPAA, we are talking about the fair care—no one has used that term, but that is the legislation, the Army-Lipinski legislation. If we do not do something, medical savings accounts expanded beyond the pilot program. Give me a scenario and I am just going to run down the line, anybody who wants to take a whack at it, where agriculture, the Hispanic community, where are we going to be in five years if we just let this continue to go in the direction it is headed?

Beginning with Mr. Keating, let us go down the line.

Mr. KEATING. Well, if you look at the rate increases that small businesses are facing, five years from now, you know, you could easily talk about doubling the cost of your health care. How are they going to react? They are going to react in a lot of ways.

Number one, maybe some of them are going to have the ability to eat that, as they say. But you know what happens when small business owners eat those costs? That means there is less money for investment, there is less money for expansion. That means less job creation and small businesses are the engine of job creation and innovation in the economy.

But most of them, our 70,000 members, most are not going to be able to eat costs like that, so they are going to then turn around to their employees, they are going to offer, perhaps, eliminate coverage as many of the surveys are indicating that small businesses will do that. They will ask for a bigger chunk to be picked up by employees. They will drop coverage, they will not offer it in the first place.

Those costs are real. One of the things that is very frustrating from an economist's perspective when you look at the policy arena is that the things that might sound nice politically often are really ugly when you look at the economics. I mean, it sounds nice to say, okay, all you people have to charge the same rate for health insur-

ance, you have to guarantee that no matter where a person is in terms of their life and their health, they have to be able to be issued health insurance. That all sounds very nice, but there are very real costs that go along with that.

And just as sure as taxes are costs to small business owners and the rest of us, and we can see the cost of taxes. It is real easy. You know, you get your tax bill, you see how much money comes out of your paycheck. Regulations are very dangerous, because they are hidden largely from the consumer. But nonetheless, the costs are quite real. So you are going to see small businesses react in all of those ways that I mentioned before and that is going to have a real impact on the U.S. economy without a doubt.

Chairman PENCE. Mark Litow, same question.

Mr. LITOW. I agree with that. I think two of the other speakers mentioned at least high risk pools. You are already seeing in a number of states where the small group market has deteriorated rapidly, that the healthiest people in those groups are going into individual markets and the sickest will go into the high risk pool. And without any changes, you will see that happen.

The individual market is also deteriorating, but at a slower rate. Ultimately, those pressures and the pressures from Medicare and Medicaid will create a situation where health care really becomes a crisis from the whole system standpoint. And I think the CBO projections or 75 year projections show that anywhere between 2027 and 2042, that it will bring down, effectively, say, bring down the economy. But what is going to happen is, you are going to get serious ramifications from that.

So I think without any change, that is clearly the direction. And there will have to be a change made, a very drastic change at some point. But it is always very difficult to predict how fast that will occur, whether it is in the next ten years or 25 years. But I think the small group market in the next five years without any change, you will just continue to see a reduction and you will see a lot of those people flow into the individual market and/or some into large groups and more into uninsured.

Chairman PENCE. Is there any question in your mind, Dr. Matthews, that doing nothing simply exacerbates the problem, will swell the ranks of the uninsured and create even a larger problem than we have today?

Mr. MATTHEWS. Doing nothing will do nothing but get more uninsured. It will exacerbate the problem. There is one caveat here which I think we are seeing coming into the market now. A number of the insurance companies are looking, seeing the prices increase, are looking for alternatives. Through most of the 90s, most employers moved to some type of managed care plan in order to be able to hold down costs. But by and large, the patients, the consumers, they do not want these. The doctors are not pleased with managed care. So there is a sense in which we are trying to figure out some way to get away from the more restrictive types of managed care like HMOs.

But I think you may see an evolution in policies in which companies begin to move to something more like a high deductible, which is less expensive. Get you away from some of those costs that guar-

anteed issue will impose upon people who have a number of costs, but they are still in the low range.

So policies at even larger companies like Humana and Aetna have moved to a medical savings account type of policy now that they are offering, for the opportunities to get a higher deductible, making it less expensive, and then moving more money into the employee's medical savings account. And I bring this up because it has been interesting. In '96, with the debate over medical savings accounts, a number of people opposed them because they did not want people to have to have high deductible policies. They did not feel like they were that good, they did not feel like they provided the coverage and so forth, especially for sick people. What we are seeing in the market is employers and insurers beginning to move to that as a result of the legislation that was trying to escape that.

Chairman PENCE. Thank you.

Mr. DE POSADA. Well, you know, what you are going to see is a huge rise in the number of uninsured. That is a certainty. In addition to that, you are going to see a huge crisis in the hospital emergency room operations. I mean, most of these people currently that are uninsured are relying on emergency rooms to take care of their most basic needs and you are seeing a very serious and financial crisis in a lot of these hospitals.

I think ultimately you are going to see what we are seeing already in the Hispanic community, which is a huge black market for prescription drugs that are, in many cases, counterfeits and ineffective.

Finally, I think what you are going to end up seeing is a very strong push for us to expand the Medicaid program, which, I mean, we have been battling this at the state levels, where you are seeing that the budgets are going out of control and states are significantly restricting services. And it is becoming extremely poor services that these Medicaid individuals are receiving.

On a personal level, I mean, I live and my business is in Washington state. We have, you know, we are hit by community ratings and by guaranteed issue. And probably, I mean, you are going to end up seeing people like me not hiring people, but just hiring people on a part-time basis, in order to avoid any potential crisis of me being forced to offer health insurance.

I mean, there are proposals in the Senate to force people like me to offer health insurance to my employees. I mean, ultimately, that would be disastrous for my business. So I think what you are going to see is a lot of people going, also moving from a defined benefit to a defined contribution, which is already happening and groups like Aetna are already offering, you know, using other terms. But I think it would be a serious problem, particularly in our community, it would be disastrous.

Chairman PENCE. Mr. Nelson.

Mr. NELSON. I think that the same consequences would be evident in rural America, with real small businesses and farmers, as well. There certainly would be an increase in the number of uninsured.

One thing I wanted to point out was that a lot of these things together, MSAs and tax credits and some partial federal funding and risk pools can do a lot. But they are not going to solve 43 mil-

lion uninsured in one fell swoop. And I feel that some people think there is a fix out there somewhere that we can enact one piece of legislation that will fix this whole problem in just a matter of a year or even less.

And I think it is important to note that these are just cogs in the wheel. And why not get started and try to do some of these what we call re-reforms, to try to fix some of the reforms that have not worked in order to help lower that number of uninsured. Thanks.

Chairman PENCE. I have a number of other questions to follow up on the witnesses' remarks, but I want to yield to my colleagues, beginning with Mr. Phelps from Illinois for any questions he might have of any members of the panel.

Mr. PHELPS. I appreciate the opportunity and the testimony has been very enlightening. I chaired the Health Care Committee in the Illinois House when I was there and I have a large rural district, so my interest mostly has been trying to focus on challenges in the rural setting, although we have a combination of some urban areas, too.

It may not be a question, most of mine is going to be just comments and maybe if anybody has a reaction, instead of all of you reacting, just feel free to pitch in, one or all.

I guess one of the things in this discussion that maybe I have missed and I know it is just part of the overall problem that we take for granted and accept, but I guess I did not hear enough or would be interested in hearing about how we contain the cost of health care? Because most, if not all, the comments are on target, which I mostly agree with, I think we are looking at the effects of the system that has gone bad. What is the source of the problem? We know people that are uninsured cannot afford it, maybe because they do not have a high enough wage or maybe do not have a job at all, so we have different layers of government that has responded to these situations.

But the cost of care, how can we involve ourselves with insurance reforms that might get to the source of the problem? Because we can have prescription drug coverage plans, you know, that has been offered and one that has passed at least the House last week or so, two weeks ago. You know, what about the cost? How do we get to the cost? Does there need to be regulation? Has regulation caused the high cost? And I think if you study it closely—I have my own opinions, because I have seen both sides from a public service, elected official, as well as a small businessman and someone who raised a family of four. My youngest is still at home and a senior at a university.

But the cost keeps escalating. Does that mean there is not enough profit being made by the doctors and nurses, the hospitals, the deliverer of care? If profit does not happen, we all are in trouble. You know, that makes the world go round.

The cost of equipment, do we need those sophisticated equipments and miracle drugs that are on the scene if everybody cannot afford it or if it is exacerbating the problem? Why are we making them to begin with? Well, because we want to save lives and extend the care and the age of people. But what is the problem with the costs going up?

I heard back in the early 90s that it was administrative costs, too much paperwork. That has been reduced quite a bit, maybe not enough. So I guess instead of deliberating, going on a self-filibuster, I will just let you react to some of my frustrations, any of you.

Mr. LITOW. Well, first of all, you are right. The cost of health care from 1975 to 2000 went up at 8.3 percent per year. It is right out of the government statistics books. And the inflation rate for non-medical service was 4.3 percent and wage growth and assets have not kept up.

So as long as we continue to double the rate and, of course, the last two years, the gap is even much wider than that, we are in a problem. People just cannot afford it. And the reason that has occurred is a lot of things we talked about. It goes back to we have created a system where somebody else is paying for it. I think everybody talked about that and the demand—we have set up a system where the demand for health care is up on the ceiling and somebody else is paying for that. And whether we did that for health care or for the three basic needs of food, shelter and clothing, we would have the same dilemma.

And so we need to sit down and modify the system, not that people—we should have high quality care and access to that, but we have to find a way to bring cost into the equation with equal weight. And that will change the way providers are operating. It will change the way insurers are operating and it will change the way consumers are operating, for sure.

And our models show, we ran a model a number of years ago called Simucare with the Council and we have updated that. And right now, our model is showing that health care should cost about 53 percent of what it costs today. So that will give you some idea of what we think could be done, but it is going to take a long time to unravel that.

Mr. PHELPS. I know I just made general statements and it is tough to respond without a specific question. I guess I just like to see the industry focus on the source of the problem, instead of setting up all kinds of mechanisms to respond, to react, and I think that is the situation we are in. Because I have watched it carefully over the last two decades, at least.

When you say, and I am not necessarily taking issue, but just as the devil's advocate, let us say, it is shifting responsibility if someone else pays, even though we know over 40 million people uninsured are too many, there are a whole lot more people that are paying for health care. So I do not think what is coming out of my check, although we have a nice situation, being government officials and I wish and hope that happens for everyone in the country, but we are paying and not shifting responsibility to someone else. We are paying so much out of our earnings for health care. But evidently, that is not enough to keep up with the cost that is rising each year.

So I do not know what the justification really is for all the costs rising at the percentage that you just quoted, other than if you are saying that there are too many that are not contributing anything and taking too much out.

Mr. LITOW. Well, let me try to explain. Utilization of health care services, especially for outpatient type services, anything that is discretionary, changes dramatically when the consumer is involved in paying for that cost. So that, and we have seen that in all kinds of markets and all kinds of countries.

And so what has happened in the country is utilization is very high, partly because consumers ask for all these services because somebody else is paying for it. Providers create all these things and can charge a lot of money for them, more than they would, because somebody else is paying for it.

So you have created a system—and then we put in laws that have created certain things and we have had to, the providers, you know, once you have price controls on services they have had to operate to make a profit. So what has happened is you go through this whole pattern of trying to provide, providers having to deal with somebody else, the government, the insurers, everybody but the person using the services.

And so the number of services are way up, services are unbundled, we have all kinds of rules which create administrative costs. So it is a very complicated thing. But the point is, we have got a lot of extra utilization, we have got a lot of extra charges. We have got unnecessary visits, we have defensive medicine, it is a long list.

And you can get ten people to testify and people will give different balances, but I think people will generally—they may agree on, have different weights on it, but you will find most people agree that you have all these issues going on and it is not just one fix. There are a lot of problems.

Mr. PHELPS. One final comment for your consideration and you can take it as you like. Thank you, Mr. Chairman, for the time. I believe very much in being innovative and trying to work the system to improve it and that is why I am cosponsor of the Armey-Lipinski bill, as well as MSAs since I have been here and in Illinois legislature.

But the bottom line is, we keep talking about competition and less government regulation, which I think is part of the answer. But I do not know of any other situation where, if the price of some product gets so expensive that the consumer cannot afford it and there truly is competition, some way or another the person providing that product brings down the price. But I think we see a very unusual dynamic here. The price and the cost of health care keeps going up no matter what we do and so we are adjusting everything to meet the cost, no matter how high it keeps spiraling.

And we have all kinds of people justifying why it keeps going up, but everything we do does not seem to affect the price of care and that is frustrating.

Mr. KEATING. If I could just throw in one comment? The key and your support of MSAs is right on the mark. That's a big issue that we push and tax credits and so on. The key is—there was an article in "The Washington Post" earlier this week and somebody said, whatever we do, health care costs keep rising.

Well, you have to do the right thing. And the problem is when you look at things like increased regulation, whether it is mandated benefits, community rating, etc., etc., guaranteed issue, those

are the wrong things. So we have to make sure our policies are geared in the right direction that so that we wind up with more choice and more competition in the end, and not just more regulation that we can all feel very nice and warm and fuzzy about, but it does not really accomplish anything and makes things worse in the marketplace.

Mr. MATTHEWS. Let me respond with a couple of points. Number one is, health care costs are probably going to continue to rise, even if we had a perfectly efficient system in there, maybe perhaps at a lower rate, because there is so much more we can do. The doctors, the medical schools, the hospitals, the pharmaceutical companies, there is just a range of new procedures and so forth that is coming out available that we are going to be able to do. So you would anticipate some kind of increases just in the ability to be able to do things we could not do ten years, 20 years ago.

But in addition, going back to your point about the cost of health insurance, the interesting thing here is, in certain sectors of the market, prices remain fairly affordable. If you go to certain states that have minimal regulations, have not done certain things to sort of destroy the market, in many of those states you can find affordable policies.

In addition, in many of these states, the companies themselves are looking for ways to create new products that are innovative in the way they are trying to address the cost. So if you go—increasingly, some of the Blue Crosses around the country and other insurers are moving to what would be a high deductible, say a $2,000, $2,500, $3,000 deductible for major medical care. But as long as you are staying within the network, you can get primary care, preventive care, prescription drugs and so forth, for $20 or $25 co-pay out of pocket. So they have a high deductible policy if you are going to have, if there is major medical accident procedure, sickness or something of that nature. But for standard care, it still remains very affordable. In other words, they try to get the benefits of the high deductible policy along with the provision in there to encourage people to get preventive and primary care.

Those policies are still, in many states, quite affordable for a family of three or four and you referred to some of those. My point being is, the insurers are looking for ways to sort of make the market work, but there are fewer and fewer options out there available for them, as state legislatures and Congress have passed more and more regulations giving them fewer options.

I think if you were to remove some of those regulations, give them a little more freedom out there, you would find them creating policies that are very affordable in a lot of areas, but they need to have that freedom to be able to do it.

Mr. NELSON. I think one thing, a very simple thing that could be very helpful, is to have the health consumers recognize what it is really costing them. I would guess that there are a significant number of employees that do not know how much their health insurance is costing, because it just automatically comes out of their check. And they do not know when they go in for a procedure or go in for a check up how much that is really costing.

So simply educating and empowering the consumer to learn more about what health care really costs and how much their care is costing them would be very helpful.

Chairman PENCE. I thank the gentleman from Illinois and would recognize the gentlelady from the Virgin Islands for any questions or comments she might have to the panel.

Ms. CHRISTIAN-CHRISTENSEN. Thank you. Just a few brief questions and mine have to do more with quality, because as a physician and chair of the Health Trust of the Congressional Black Caucus, a lot of my time is spent on the elimination of disparities and providing for some equity in health care and health status for people in this country.

So I probably will just ask two questions and I direct the first one at Dr. Matthews and anyone else can also answer it. The Associated Health Care Plans would be exempt from state-mandated coverage of benefits. Do you see this possibly reducing the quality of health care available to small business employees and, if not, can you explain how it does not do it?

Mr. MATTHEWS. In my opinion, it would not reduce the quality. And the reason is that under ERISA, large employers that self-insure under ERISA are not subject to the state mandates. And yet, if you go by and look at the types of benefits that those large employers offer, in many cases they cover the same types of things that the states would require by the mandate.

So the policies from large employers that are not required to do that, because they have the money and other things, typically have very comprehensive policies that are very good. So the Association Health Plans are an attempt to try to do something very similar. And I would expect some of the benefit plans to have comprehensive benefits in there. But I think it would also give them the opportunity to offer basic coverage for those employees, individuals, associations, that do not have the money to be able to get the comprehensive plan.

Like you, I like to have a comprehensive plan covering me and managing to cover just about all the health care costs. But sometimes, some people cannot afford the Cadillac with all the options. They need to be able to get the lower cost plan that provides the basic care because that is all they have the money for, and the Association Health Plans would give them that option.

Ms. CHRISTIAN-CHRISTENSEN. I mean, we need to try to get away from two-tiered levels of services. The same question about the risk pools. It sounds as though they foster a two-tiered system of services. And I guess I would start by directing this to Mr. Litow first. Can you talk a little bit about the high risk pools and whether or not they also would provide a good, comprehensive quality level of services, equal to the other insurances?

Mr. LITOW. Well, high risk pool plans, very often you don't have the same level of choice of coverage. But as far as the level of services go, I am not aware—I was on the Board of the Wisconsin High Risk Pool for a number of years. I would not say that the quality of service, those people—it is private coverage. The coverage is subsidized. In Wisconsin, we pay about 60 percent of the costs and I think that is consistent with a number of the states. The person

gets in and pays 150 percent of the normal rate in this high average of five top companies in the state.

So the intent of a high risk pool is two-fold. One is to encourage healthy people to buy insurance at that time, so when they get sick, they have the protection. If they wait until they get sick, then there is a penalty. But as far as the access to treatment——

Ms. CHRISTIAN-CHRISTENSEN. And as far as the basic level of services?

Mr. LITOW. They would have that. They are just paying the penalty for having waited and getting into the system late. But they are not, I do not believe they are penalized in any way. Like I said, sometimes the coverage choices are not as substantial.

I do not know, is anybody else aware of any?

Mr. MATTHEWS. I can say that in the Texas High Risk Pool, basically, in several of the states and I do not know about all of them, but in the high risk pools, you are basically getting a Blue Cross policy that is subsidized by the state, because you are getting people who have expensive medical conditions.

And so I know in Nebraska, it is a Blue Cross policy. The insurers make very little policy if they sell that policy. I think the last I heard, it was like a $25 commission or something like that. But you get a comprehensive plan.

In the Texas High Risk Pool, you get three or four options. You can have an HMO, a PPO. They give you options of deductibles. It looks very much like a standard insurance policy.

And I think what Mark was saying is that the providers themselves, the doctors and hospitals, are largely blind to that aspect of it. I mean, they do not—it is not an issue of you are in the high risk pool so I cannot give you the coverage or I cannot provide this or give you this prescription.

Mr. NELSON. In a couple of states, in Wisconsin, in fact, where Mark was on the board, they have another plan that offers some help to low income people to be able to better afford entrance into the high risk pool. And there is a pilot study now in Montana, who has a high risk pool, a federal study of a couple million dollars this year to help low income people be better able to afford getting into the high risk pool.

In one of the proposed bills in the House right now with some partial federal funding for high risk pools, there are some dollars set aside for low income people going into the pool, as well. So I think that people are looking at that.

Mr. MATTHEWS. And—go ahead.

Mr. DE POSADA. On the two-tier system that you were talking about, particularly in the minority communities, you are seeing it already.

Ms. CHRISTIAN-CHRISTENSEN. Absolutely.

Mr. DE POSADA. I mean, you are seeing all of our communities, all of our businesses not being able to offer, so therefore you do have a two-tier system. We are very strong supporters of Association Health Plans because at least that will reduce the cost significantly so that businesses can, these businesses will be able to afford it.

However, there is no one silver bullet. And unless you start targeting the same kind of support that you are giving businesses to

employees who do not get health insurance from their job, you are basically ignoring a huge part of the market. So that is why you need to focus a lot more also on the individual market.

Mr. MATTHEWS. Just if I can add this. I share your concern. We do not want a two-tiered system out there. In my opinion, the high risk pool, in fact, prohibits or prevents that two-tiered system because it makes insurance accessible to somebody who can then move into the system and pay for it with their insurance plan just like everyone else.

Ms. CHRISTIAN-CHRISTENSEN. I—go ahead.

Mr. NELSON. Another quick point is that the high risk pool population of these 30 state—well, 28 operating now, and two states, New Hampshire and Maryland are coming on this year—it is a fluid population. It is not a static population. And some people move from the risk pool into an employer, get employed by someone or maybe are able to get other insurance. So people do not stay in there forever, so it is helpful to have them in there for a short period of time at some point.

Ms. CHRISTIAN-CHRISTENSEN. Well, with the tens of millions of people who are the folks who are employed by small business that make up the uninsured right now, this is a critical issue and one that we have to address.

I look at some of the things that we are discussing today as really sort of stop-gap measures. Because what we really need to be doing as we provide the relief to small businesses and help them to be able to insure their employees is do something about those high risk persons that are creating the problems we are trying to solve coming into the insurance system. And reaching them, providing the prevention, providing the improvements in the health care structures and the poor communities, rural as well as minority communities, and making sure that everyone has equal access to quality health services, quality prevention services, have good health care infrastructure in their community, so they are not coming into the insurance pool at high risk. That is what is really driving up the cost at that front end.

But we will be working with our chairman to resolve the issues that are before us today. That is a longer term problem, but we realize that we do have to provide some relief to our small businesses in terms of providing insurance coverage. We know that those tens of millions of people do need to be covered, that is something that we must address. And we look forward to working with you on it.

Chairman PENCE. I thank the gentlelady from the Virgin Islands for her attendance, participation and am very much looking forward to working with you on addressing these issues.

I would also recognize the gentleman from Puerto Rico for any comments or questions to our panel and am grateful for your participation in the hearing today.

Mr. ACEVEDO-VILÁ. Thank you, Mr. Chairman. I just have one quick question to Mr. de Posada. I am not surprised at the numbers about the uninsured Hispanics. I am just a little bit curious. What were the numbers, let us say, five years ago? Has there been any improvement or are we in a worse position? I just want to know if there is a trend in the amount of uninsured Hispanics.

Mr. DE POSADA. I mean, like the rest of the population, what you are seeing is whenever there are good economic times, obviously the numbers drop a little bit. But what you are finding is that——

Mr. ACEVEDO-VILÁ. My point is, are we closing the gap or has it been like that for the last whatever years?

Mr. DE POSADA. No, it has been like that for a very long time and it will continue to be like that simply because these are people that are working for small businesses that do not offer health insurance. So unless we figure out ways to encourage those employers to offer or go into the individual market, allowing, you know, giving them the support through tax credits or vouchers to be able to afford it, you are going to see the number continue to increase.

Mr. ACEVEDO-VILÁ. Thank you.

Chairman PENCE. I thank the gentleman for his participation and know the gentleman from Puerto Rico to be probably the most outspoken and outstanding advocate of issues related to the Hispanic community in this country.

Mr. ACEVEDO-VILÁ. I have the biggest Hispanic congressional district. [Laughter.]

Chairman PENCE. No argument. I have a few more questions for the panel, although this has been an enormously valuable and illuminating discussion.

Earlier, the Chair asked about scenarios if we do not act. I would like to have you elaborate for the record on some of the proposals, some of which have been challenged here today by my colleagues. But it seems like in the area of reform, there was a consistent call for refundable or advancable tax credits.

I know Mr. de Posada called for that and Mr. Nelson did, as well. Mr. Litow and Mr. Matthews, just from my notes alone. I am an original cosponsor of the Fair Care Armey-Lipinski bill. What advantages are there between one reform and another? If history teaches us that in legislation as well as military affairs that you move the line when you put mass on point, where would this panel, beginning with Mr. Nelson and we will go in the opposite direction, where would the experts on this panel suggest that this committee and this Congress put mass on point? If there are a host of good ideas from repealing HIPAA to medical savings accounts, the Fair Care initiative, refundable tax credits, what is the most promising, if there is one? And why would that be the most promising, both from the standpoint of public policy and from the standpoint of the internal politics within the Congress itself? Mr. Nelson, your opinion?

Mr. NELSON. Well, if this was, the world was free of budgets, my answer would be different than it is, because we are under constraints of budgets. And then when we start looking at the availability of money to try to do these reforms, I think that if we look at reforming MSAs, which is relatively low cost at some partial federal funding of high risk pools, which is relatively low cost, we are looking at several bills that may be $100 million a year and at these tax credits, some of the tax credit bills being proposed are fairly low cost. Then that is what I guess, in the reality of the next two years in terms of the cost, the budget that is available to us, that would be my three choices, I think, of trying to do something to really help.

Whether one of those is more important than the others, I do not really have an answer for that. I just think that all three are very, very important. What I wish is that we could pass Fair Care, which has all three in them, and be done with it, but I am afraid that that might not be possible. I wish it was.

Chairman PENCE. Mr. de Posada, in your testimony you eventually got to the conclusion that we would see a significant increase in Medicaid, pressure for increase in Medicaid spending, which is terribly frustrating to me as a conservative. But it is also frustrating to me because this entire hearing, this entire discussion, is about working Americans.

The people that are working, that are employed, and despite the hateful stereotypes that can attach to minority communities, you have been an eloquent voice in this hearing today for the Hispanic community and its desire, people's desire to build wealth and be productive parts of the economy and small business sector, in particular.

Where do we focus right now that is going to make the biggest difference?

Mr. DE POSADA. I think there are two pieces of legislation that you can move very quickly, and actually the House already passed one of them, which would be, I think, Association Health Plans, because that would take care of reducing costs. And in some essences, will allow people to by-pass some of the state regulatory policies that are really increasing the prices.

The second issue would be immediate passage of Fair Care. I mean, when you focus the support on those individuals that are currently being affected by this, those that are working but do not get health insurance from their job, I think automatically you are going to be opening a huge new market of people that actually will not have to depend either on Medicaid, potentially, or having to rely on the hospitals. I mean, it is very sad.

We did, last year, yes, last year we issued a report on the re-importation of drugs into the United States. And we were followed, when we were doing a press conference in California, we were followed by a TV crew from Chicago. When we went there, they did this report about the sale of illegal prescription drugs in Chicago, in the little 7–11 type stores, where people were coming in and they would sell them drugs.

Most of these people did not know that there was a community health center two blocks away. So, I mean, what we are seeing is, these people are taking drugs or getting sick or getting immune to major drugs and ultimately going to emergency room hospitals and increasing the prices for everybody. And I think if we start focusing on giving that support to the individuals to be able to enter the private market, I think we are going to see a significant reduction in the dependency of and in the complications, which always end up to be more costly.

Chairman PENCE. Dr. Matthews, your remarks today were most helpful to the Chair, because being from south of Highway 40, it is hard for me to get my brain around some of these things and I was particularly grateful for the home building analogy. You made the comment, though, that we need to get insurance companies out of the safety net business and get the government in. I

want to get your opinion about where we put mass on point, and if you could pick one, I would be grateful. But when you say that government should be the safety net and not insurance companies, are you suggesting that through reform, or are you suggesting that through direct subsidy?

Mr. MATTHEWS. I think in both. We have a model out there that works pretty well. I mentioned it earlier. On, for instance, where you are talking about housing or food, we have people out there that cannot afford the food they need, but we do not go in and regulate the grocery stores and the farmers. We simply provide assistance to those people who need the help and then we let the market work. And we let them enter the market with the assistance.

Now what we are talking about is not necessarily welfare. But it is an attempt to say if you have people out there who cannot function in the market as it exists, then do not go in and regulate the insurance companies. Let the market work and provide the assistance through the Armey-Lipinski bill is one way to provide assistance. For those who cannot enter the market because they have a medical condition, you do not go tell the insurers you have to take them, you provide some additional assistance to them is one way to do it, and Mark Litow has done an analysis of how you might do that. But you have the high risk pools as the safety net. The high risk pools are public, private entities that provide health insurance for those people who cannot enter the standard market.

My point being is that you create a system that works off a model like we already have that provides assistance and creates a safety net, but you cannot make business, whether you are talking about insurance or other things, you cannot make business a safety net. You need to create a safety net and government is really the only functional way of doing that.

Chairman PENCE. Thank you, Dr. Matthews. Mr. Litow, in the category of reforms, you said that repealing the premium tax exclusion would do much to stem the tide of almost the lemmings over the cliff drive to third-party payer that we have.

Mr. LITOW. Right.

Chairman PENCE. And I was very provoked by your comments about that. Is that tax credit, is tax credits where we put mass on point to move this issue quickly?

Mr. LITOW. Yes. I believe so. In fact, I think that is what Merrill was talking about. We have actually constructed a proposal where tax credits replace the premium tax exclusion step by step and actually over a long period of time, we believe it will be revenue neutral. So we are not even certain, we do not think there is a cost.

Now I am sure people would have various assumptions about that. But that is where I would start, yes.

Chairman PENCE. Would you start there or do you think that is, in fact, the most promising to close this wound and begin to reverse what I think I will characterize in this hearing as horrendous trends for small business America?

Mr. LITOW. That is fair. I do not think there is any disagreement here. It is always tough to estimate the progression, but what I believe will happen is, as people start to become aware of the costs that they are paying for health care and what other people are paying for health care, so, for instance, under Medicaid, part of the

issues with Medicaid are very few providers will take people under Medicaid. Why? Because the reimbursement rates are so low. And if people start to realize that they are paying a lot more because Medicaid reimbursements are so low or Medicare or they are paying for uncompensated care, it will open up a whole area of debate. And I believe that actually that will allow us to do some more substantial reforms in those areas, but at least to open up a debate.

And that is why I believe bringing the consumer back in on the cost side and changing from a premium tax exclusion system, which relies on third party to tax credits, particularly to give help to people who need it, as Merrill talked about, is a critical first step in that.

Chairman PENCE. And lastly, is it Dr. Keating?

Mr. KEATING. No, just a Masters, sorry.

Chairman PENCE. Well, I admire your thinking, regardless of your title. I just simply did not want to improperly recognize you. I would like to get your sense. You said in your testimony, according to my notes, that we needed to dramatically shift to additional choices, drive competition into the equation. And it seems like your focus was less on the issue of subsidies and what we have heard some others place emphasis on with regard to Fair Care and Armey-Lipinski, but was to lift restrictions on tax-free medical savings accounts. Is that the most promising area of reform? Is that where Congress should go to expand the pilot programs we have?

Mr. KEATING. We certainly agree with, if not all, most of the proposals that have been talked about here. But we think the key here, Congressman Phelps had asked, you know, what is the core problem here? And it is the third-party payer issue. That is why we emphasize making medical savings accounts permanent, lifting the many rules and restrictions on them so they can flourish as a viable choice for everybody in the marketplace. When you think about how MSAs work, they directly deal with that third-party payer issuer. The consumer has money in that savings account. It is his or hers, he or she, they are concerned about the costs, how that money is spent, they are concerned about their health care, and they have the back up of what insurance is supposed to be, that catastrophic plan that helps you weather those large, unforeseen costs.

So our emphasis is on dealing with that third-party payer issue and the true emphasis of my testimony was that and that is easy, or it should be easy. I know there are a lot of opponents in Congress that are not crazy about medical savings accounts for a variety of reasons, but that should be easy.

The hard part is the other side that we talked about. It is deregulation. You know, the trend here, unfortunately, in Congress and the states has been towards more and more regulation, more and more government funding, expanding government programs. We need the emphasis to move in the opposite direction. That is hard, I mean, I know that is hard. I understand politics as well as economics, so it is very difficult to move to deregulate. But we need to deregulate when it comes to things like guaranteed issue and community rating and mandated benefits. Again, a lot of these things sound nice but the economics are ugly.

Chairman PENCE. With that, the Chair would like to thank all of the witnesses for outstanding and very provocative remarks today. Mr. Keating made the comment that he understood politics as well as economics, which is also true for the Chair. I have very little understanding of economics and my understanding of politics, after a year and a half in Congress, matches that.

Let me thank you for your willingness to help us in this subcommittee draw attention to not only the reforms but to the deleterious and harmful effect that issues like guaranteed issue and essentially price fixing have affected in our system.

You may all be assured that this subcommittee and the full Committee on Small Business will continue to call on you as we try and take your counsel to stem what I believe is a dangerous rising tide in small business America. That if we do not stem this tide, it seems evident to me and other limited government conservatives, that we will be faced with no choice but to grow public assistance through Medicaid to address this gaping hole in America, and take us even farther down the road of socialized health insurance in the United States of America.

It is this Chair's ambition that we would reverse this trend, that we would build on the strength of a competitive free market model and we will enlist your assistance and your proposals and your energy as we try and drive that agenda before the advent of that legislative and public crisis arrives.

So with that, this hearing of the Subcommittee on Regulatory Reform and Oversight of the Committee on Small Business is adjourned.

[Whereupon, at 11:43 a.m. the Subcommittee was adjourned.]

MIKE PENCE, INDIANA
CHAIRMAN

ROBERT BRADY, PENNSYLVANIA
RANKING MINORITY MEMBER

Congress of the United States
House of Representatives
107th Congress
Committee on Small Business
Subcommittee on Regulation Reform and Oversight
2361 Rayburn House Office Building
Washington, DC 20515-6315

Statement of Mike Pence
Chairman
Subcommittee on Regulatory Reform and Oversight
Committee on Small Business
United States House of Representatives
Washington, DC
July 11, 2002

Our hearing today addresses the rising cost of health care to small businesses. Of the 43 million Americans without health insurance, 62% are either small business owners and their families or small business employees and their families. The problem of the uninsured is very clearly a problem of small business access to health care at reasonable prices.

Well intentioned reformers in the states and in Congress, over the last decade, have managed to dramatically increase the cost of health care and have practically destroyed the small group market. Two of these reforms that sound particularly harmless are guaranteed issue and community rating. Guaranteed issue has given healthy people a reason not to purchase insurance. If you can get coverage at any time, then why purchase it before you get sick. Community rating, which was meant to keep prices reasonable for high-risk customers, has actually led to prices spiraling upward and healthier people dropping their coverage. Both combined have led many companies to drop out of the small group market in most of the states.

A few examples:

- According to one of our witnesses, who represents the nation's largest health care actuarial company, 40 states and the District of Columbia have no small group market left. Insurance companies have just stopped offering coverage in those states.
- A small employer in Florida trying to buy health insurance from ehealthinsurance.com, the nation's largest online insurance broker, can't find any health insurance. Otherwise they have a choice of two HMOs.
- According to The State (a newspaper in South Carolina), small businesses in South Carolina "have given up providing health insurance." According to the South Carolina Department of Insurance, 8 out of 10 uninsured individuals are members of working families.
- Since 1992, 73 companies have withdrawn in whole or in part from Arkansas's health insurance market. Fifty-six of these withdrawals have taken place within the last four years.

Obviously, in states where there is no competition for the small business dollar, prices will continue to rise. The National Association for the Self-Employed reports in a recent survey that 7 out of 10 small businesses do not provide health coverage to their employees and "costs" are cited as the chief reason for this trend. It is imperative that we act and act quickly to reverse the course of the small business health insurance market before we reach a point where no small business can afford health insurance for its employees.

I look forward to the testimony of all our witnesses. Now we'll hear from the Ranking Member, Congressman Brady of Pennsylvania.

Congresswoman Stephanie Tubbs Jones
Statement
"The Small Business Health Care Market"
Committee on Small Business
Subcommittee on Regulatory Reform
and Oversight
July 11, 2002

Mr. Chairman, Ranking Member Brady, Colleagues and Guests:
Rentz

Access to health care is the most important concern facing small business today. Approximately 43 million people are without health insurance in this country. Many of these individuals are employed by small businesses. It is shameful that these businesses are at such a competitive disadvantage compared to big business when it comes to providing health plans. Small business drives our economy through innovation while opening doors for women and minorities. This Congress must work to remove the barriers that inhibit access to health care. We must do so not only for the health of small business workers but also for the health of small business.

Association health plans and tax credits represent important ideas that will ultimately figure into a plan to reduce the number of uninsured small business employees. However, we must recognize that there is no blanket solution to this problem. Allowing small business access to health care will require a unique combination of ideas. Ultimately our solution must afford small business the economies of scale enjoyed by big business while reducing the punishing effects of community rating and guaranteed issue. However, this solution must not make irrelevant laws that mandate coverage of certain benefits and must not force workers to purchase coverage that includes "riders." Insurance policies that include "riders" do not constitute adequate coverage because such policies do little to make adequate health care more affordable.

As we move forward with our work in this area I encourage my colleagues to keep plans offered by entities like the Greater Cleveland Growth Association and COSE in mind. These organizations are prominent advocates for greater access to health care for small business in my own congressional district, the 11th of Ohio. The Greater Cleveland Growth Association has written many helpful articles in order to help small businesses evaluate options for providing health care. With their front-line perspectives, both organizations will prove helpful to us as we attempt to expand small business access to health insurance.

Mr. Chairman, I thank you for my time.

Testimony before the

Subcommittee on Regulatory Reform and Oversight

Committee on Small Business

U.S. House of Representatives

July 11, 2002

Hearing on

"The Small Business Health Market: Bad Reforms, Higher Prices, and Fewer Choices"

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Thank you for inviting me to speak on behalf of small business regarding the issue of health care costs, and the impact that government reforms and regulations has had on those costs.

My name is Raymond J. Keating, and I serve as chief economist for the Small Business Survival Committee (SBSC). SBSC is a nonpartisan, nonprofit small business advocacy group with more than 70,000 members across the nation. SBSC works on a wide range of public policy issues impacting small businesses, their owners and employees.

Obviously, health care policy is of critical interest to us. Indeed, since SBSC opposed the attempted imposition of nationalized health care in the early 1990s, we have been intimately involved in the health care policy debate.

Small businesses have been confronted by enormous increases in health care costs, and past and future increases clearly have very real impacts on businesses. For example:

• An April 2002 national survey of small businesses with 3-24 workers by the Kaiser Family Foundation found that 56% of businesses with 3 to 9 workers offered health insurance coverage, while 72% of firms with 10-24 employees did so. Of those small firms not offering coverage, 72% cited costs as a very important reason for not doing so. Of all small business executives surveyed 67% said they were "very or somewhat dissatisfied" with the cost of health care and health insurance. Looking at future cost increases, "if costs increased by 25%, employers say they are equally likely to absorb the cost and increase what employees pay (60% say each are likely), and almost half (48%) say they would be likely to increase what employees pay," and

36% said they would be likely to reduce benefits, and 17% would drop coverage altogether.[1] (In 2001, 65% of businesses with fewer than 200 employees offered health care coverage, compared to 99% of firms with 200 or more employees.[2])

• The Council for Affordable Health Insurance recently noted that "health insurance premiums are rising about 15 percent on average, but many individuals and businesses are seeing increases of 30 percent to 40 percent."[3]

• In Massachusetts, health insurance premiums went up by 12% to 15% this year, with many small businesses reporting increases of more than 20%. One independent insurance broker reported increases of between 17% and 19% for his small business clients, which came on top of double-digit jumps in the prior year.[4]

• A Michigan survey taken in April 2002 found that small business health insurance premiums had doubled in the previous four years, and were expected to rise by 20% to 25% this year. The survey found that 24% of small business owners said rising health care premiums threatened the existence of their business.[5]

• Another report noted that health insurance premiums in 2001 rose 55% faster for small businesses versus larger firms in 2001 – 17% for businesses with fewer than 10 employees as opposed to 11% for bigger businesses.[6]

• A fall 2001 study by the Kaiser Family Foundation reported that between the spring of 2000 and 2001, small business health insurance premiums increased by 12.5%, while larger firms saw increases of 10.2% on average.[7]

• In the summer of 2001, eHealthInsurance reported that the "average premium per-member-per-month for policies sold through eHealthInsurance is 25 percent higher for small business members than for individual members."[8]

• And small businesses have been confronted by large cost increases for many years now. According to a Dun & Bradstreet small business survey in February and March of 2000 found that 74% of small businesses offering health care coverage saw an increase in premiums over the previous year, with 29% experiencing an increase of more than 20%.[9] At the start of 1999, while larger businesses saw increases of about 6% on average, small firms experienced hikes in the range of 10% to 13%, or about double the increases of bigger businesses.[10] Indeed, over at least the past decade, one can find a wide array of reports each year pointing to large increases in health care costs for small businesses.

Obviously, these rising costs take a heavy toll on small businesses. Many do not survive. Some cannot afford to offer health insurance coverage in the first place, which places these firms at a competitive disadvantage in attracting good employees. Others reduce coverage, including having employees pick up a bigger share of health care costs, or eliminate coverage.

The obvious question is: Why are health care costs on the rise – and not only for small businesses, but for individuals and other businesses as well?

The increase in health care costs is due to a significant extent to government's increasing role in the health care marketplace. First, there is the third party payer issue. Government's ever-increasing role in health care funding vastly accentuates the problem of third-party payments, which push the costs of health care ever higher.

Insurance, of course, makes perfect economic sense. Health insurance, properly understood, protects individuals against large, unpredictable costs. That is, it protects against catastrophic events. However, employer-provided health care plans and government programs have ventured far beyond the basic concept of insurance to offer first-dollar coverage for small and predictable expenses. When a third party—whether an employer-provided health plan or the government—picks up the tab for reasonable and predictable health care spending, demand is driven up, and consumers and health care providers possess few, if any, incentives to be concerned about costs. The result is higher costs. In this sense, Americans are not under-insured, as is the conventional wisdom, but instead are over-insured. The government's role as third-party payer has been on an unmistakable upward trend, as noted in the following table.

National Health Care Expenditures

Year	Percent Private	Percent Public
1929	86.4%	13.6%
1940	79.7	20.3
1950	72.8	27.2
1960	75.4	24.6
1970	62.2	37.8
1980	57.3	42.7
1990	59.4	40.6
2000	54.8	45.2

Data Sources: Health Care Financing Administration and U.S. Census Bureau

The increasing role of third-party payments is made most clear by noting the dramatic decline in out-of-pocket payments by consumers.

National Health Care Expenditures:
Private Out-of-Pocket Payments as a Percent of Total

Year	Percent Private Out of Pocket
1950	56.3%
1960	48.3
1970	35.3
1980	27.1
1990	22.5
2000	17.2

Data Sources: Health Care Financing Administration and U.S. Census Bureau

While some of the increase in health care costs in recent decades reflects the very positive developments of better care, more treatments, and longer life spans, a significant portion clearly can be attributed to this vast expansion in third-party payments. In particular, the aforementioned combination of falling out-of-pocket payments and rising government funding has been a major impetus to rising health care costs. Not only do consumers and providers have few incentives to be concerned about costs, but the incentives in government make matters far

worse as well. When spending other people's money, politicians and government bureaucrats also possess no real incentives to watch costs.

As a result, the tab for taxpayers predictably skyrockets. Just consider Medicare, for example. Since 1966, payroll taxes dedicated to funding Medicare Part A, Hospital Insurance, have been increased 36 times—26 increases in the applicable tax base and 10 hikes in the tax rate.

Eventually, cost control measures are attempted, namely, price controls and rationing of care. Of course, these measures carry their own costs. Price controls diminish incentives for production, innovation and invention, thereby threatening both the short-term and long-term health of consumers. Meanwhile, rationing of care creates immediate, obvious dangers. After all, waiting lists literally can be deadly. People suffer whichever path government chooses to deal with rising costs—higher taxes, price controls and/or rationing of care. In fact, extensive government involvement in health care--as illustrated in nations like Great Britain that have established socialist health care systems--usually brings about all three of these dire outcomes.

Another major drive behind increased health care costs and rising premiums is government regulation. More regulations and mandates on the part of government – no matter how well intentioned they might be – inevitably result in increased costs. Higher costs, of course, ultimately mean reduced access to quality health care.

Consider the dire impact of two forms of regulation imposed to a significant extent in the states over the past decade or so – guaranteed issue and community rating. Guaranteed issue in effect means that individuals may not be turned down for health insurance coverage no matter the condition of their health. Community rating mandates that an insurer charge the same price for everyone in a defined region regardless their varying health care risks.

These regulations violate the basic tenet of the insurance business, namely, risk spreading. As the Council for Affordable Health Insurance has pointed out:

> Risk-spreading rests on these principles: the uncertainty by both parties of who will get sick and have a claim; having enough healthy people insured, and enough reserves, so there are sufficient funds to cover the claims of those who get sick; and pricing which consumers find reasonable in relation to their own situation. The intent of purchasing health insurance is to be protected from financial ruin. People do not expect to become gravely ill, but they do recognize that possibility. Hence, they seek to avoid financial ruin by making affordable and budgetable payments for health insurance to protect themselves against large unexpected medical expenses. Healthy people do not need health insurance but sick people do.

Guaranteed issue, though, removes incentives for people to buy health insurance until they are ill. As many have pointed out, it is the equivalent of not buying car insurance until after you have an accident, and the government mandating that the insurer must cover the costs of that accident.

Meanwhile, community rating does not allow for critical risk factors to be considered when pricing insurance. No matter what the risks involved, everybody pays the same price for insurance.

The results are completely predictable – much higher insurance costs, and fewer insured individuals. And that has been the case in the states that have imposed guaranteed issue and community rating.

For example, New Jersey imposed guaranteed issue in the individual market in legislation passed in 1994. From December 1994 to January 2002, among four insurers offering family coverage during this period, monthly premiums increased by 556% (Aetna), 344% (Blue Cross Blue Shield NJ), 612% (Metropolitan Life), and 471% (National Health Insurance).[11]

In Kentucky, after the state adopted guaranteed issue and community rating in 1994, 45 insurers fled the state and premiums skyrocketed. Also in 1994, a similar scenario played out in New Hampshire in response to passing guaranteed issue and community rating.[12]

In a November 1995 column, SBSC chairman Karen Kerrigan explained what happened in New York after it imposed guaranteed issue and community rating in 1992: "Since then, several major insurers simply stopped serving the market altogether, and by some estimates more than 500,000 New Yorkers dropped their coverage due to skyrocketing costs. The New York Department of Insurance reported that in some cases, rates for a single, 30-year-old male increased by 170 percent."[13] The Council for Affordable Health Insurance recently noted about New York's small and individual insurance market: "The situation has continued to deteriorate."[14]

Unfortunately, it too often seems that the only debate in policy circles today is how far new mandates and regulations on health care should go. In our view, Congress and the White House need to dramatically shift the health care debate away from more government involvement. Instead, the focus should be on removing governmental barriers to additional choices in the health care marketplace.

First, that means moving away from more regulation – such as measures like guaranteed issue, community rating, as well as dictating exactly what insurance policies have to cover. Instead, the focus should be on deregulation, so insurance coverage of all kinds, costs and scope may be offered. Choice and competition in the marketplace remain the most productive route for expanding access to affordable, quality health care.

One reform/deregulation measure in particular would go a long way in dealing with the aforementioned third party payer issue as well. Congress should immediately lift the current restrictions on tax-free medical savings accounts (MSAs).

MSAs combine a traditional high-deductible, catastrophic insurance policy with a tax-exempt savings account, or MSA. Consumers use the funds deposited tax free in their MSA to pay for routine medical care. In a year with high medical expenses, where all the funds in the account are spent and the deductible on the insurance policy is reached, then the catastrophic insurance policy kicks in to pay remaining medical bills. In a year with minimal medical bills, then funds are accumulated in the account and the interest is earned.

With MSAs, the traditional buyer-seller relationship in the marketplace is re-established. Unlike when a third party picks up the tab for health care services, consumers and health care providers become concerned about costs. Also with an MSA, all medical expenses are covered, including prescription drugs, and no limits exist in terms of choices of doctors, hospitals, and specialists. Individuals and their doctors make health care decisions, not some distant bureaucrat.

Unfortunately, tax-free MSAs today are a temporary measure, and are shackled by a wide array of counter-productive rules and restrictions. For example, unfortunately, many restrictions were imposed on MSAs that limit their effectiveness in the marketplace. For example, the number of accounts was basically capped at 750,000. MSAs were only made available to the self-employed or to businesses with 50 or fewer employees. In addition, deductibles must be between $1,500 and $2,250 for individuals and $3,000 and $4,500 for families, and tax-free deposits into MSAs were limited to 65 percent of the deductible for individuals and 75 percent for families. For good measure, either the employee or employer can contribute to the MSA, not both.

Here is a clear opportunity where deregulation will expand health care choices, expand competition, reduce the number of uninsured, and lower costs for businesses of all sizes. The exact opposite of what happens when government imposes mandates like guaranteed issue and community rating.

In the end, the market and competition work, even when it comes to health care. Deregulation and expansion of choices in the health care marketplace will have positive effects on both cost and the quality of care. Minimal government intervention and regulation allow businesses and consumers to seek out the type of health care coverage that fits their needs and pocketbooks.

As for those who truly cannot afford health insurance, the government should look to vouchers or tax credits that will allow those individuals to purchase coverage in the marketplace, while limiting government interference. High risk pools in the states – when properly designed and funded – also can assist with getting health coverage for sick people who could not otherwise acquire insurance.

In particular, for those concerned with the occasional HMO bureaucratic snafu or abuse, the answer is not to get the government more involved in dictating procedures and policies. After all, government bureaucrats, lawyers and regulators do not have a long track record of being responsive to consumers. Instead, a more competitive marketplace driven by consumers seeking out affordable, quality care, and businesses being able to respond accordingly, will prove far more efficient and beneficial.

Testimony of Mark E. Litow for Congress on the Small Group Market July 11, 2002

My name is Mark Litow. I am an actuary with Milliman USA and have done pricing for many companies in the small group market over the last 27 years. I have also worked with governments, providers, consumer groups and think tanks on public policy issues. I am representing the Council for Affordable Health Insurance today, a group that represents a number of small insurance companies as well as other organizations and individuals involved in the health care system. I greatly appreciate this opportunity to testify.

The comments that I make today are my opinion based upon many years of experience working in the small employer group and other health markets as applicable. They should not be viewed as being the opinion of Milliman USA or its other consultants. Some of my colleagues at Milliman may have differing opinions regarding the issues I discuss in this testimony. Others may agree.

The small group market is in very bad shape. That is so because of a continuing series of incentives that began with the actual implementation of the premium tax exclusion in 1954, continued with passage of Medicare and Medicaid in 1965, and was seriously exasperated by the use of community rating or rating bands and guarantee issue as implemented during the 1990s. These incentives have caused skyrocketing premiums in the market combined with a gradually decreasing proportion of eligible groups being insured.

I have attached information on this paradigm, including both the significant and minor problems plaguing the market. Rather than elaborate on this history any further, I would like to note what I believe are the most important things that could be done to help this market; again this is only my personal opinion; not that of Milliman USA.

These are:

1. Eliminate the medical insurance premium tax deduction for employers and replace it with tax credits, preferably for individuals who truly need it. This step will help not only the small group market but the entire health care system, by restoring personal responsibility. Models I have worked on suggest this can be done to be revenue neutral.

2. Modify or repeal the guarantee issue provisions of HIPAA. If modification is more desirable, systems should be changed to allow that basic and standard plans can satisfy this requirement with underwriting being allowed on other plans. Otherwise, guarantee issue should be eliminated. Experience indicates that guarantee issue is guaranteed to destroy the individual market as a viable,

competitive marketplace, and since small groups (particularly <10) act like individuals, this part of the market is also harmed. As a result, the very small groups (<10) need in general to be subsidized by the larger groups in the market and as such the entire market is compromised.

3. Limit rating bands to a minimum of ±25%. This will allow states reasonable flexibility, and send the joint message: i) Limiting the ability to implement excessive rate increases is warranted, but ii) Intrusive rate limitations will prevent a market from operating properly.

These changes will greatly help the small group market over the near term, and will also help the entire health care system. The reason is that these changes will begin to more directly involve consumers with the cost of their own health care in counter balance to the demand for care. Today, consumers have an insatiable demand for health care, because someone else is paying for most of that care. In other words, we need to greatly reduce reliance on third party payors, not encourage others to pay for our care.

If people need subsidies to buy coverage, the subsidies should go directly to them for the purchase of needed protection, with the potential that savings can come back to the consumer. Indirect subsidies to organizations may have the unintended consequence of encouraging consumers to again concern themselves only with demand for care rather than both the level of care or service and cost simultaneously.

These changes by themselves will not remove all of the problems as there are many and they have built up over a long period of time. Even with immediate attention, these problems will take a long while to unravel, and substantial patience will be needed along with close monitoring of progress and issues that emerge.

Without any changes, the small group market will continue to deteriorate, and become more and more unaffordable for an even greater number of businesses. Ultimately, the crisis will be so great that radical reforms will be necessary to either restore the market or replace it with a different mechanism for coverage of these businesses.

Today, I tell my insurance company clients that perhaps only 10 states offer reasonable opportunities to make a profit, assuming you are not a Blue Cross plan, and that number continues to decline. Another 5 states appear to offer a less certain opportunity but one that is perhaps viable, and an additional 15 states represent an opportunity for those who can procure a large enough discount from providers to make a profit (this often is the Blue Cross plan which leverages its large presence to obtain significant discounts. Otherwise, most carriers cannot compete in these 15 states, and in the remaining 20 states plus Washington, D.C. the market by itself is generally a losing proposition, which means that carriers cannot be expected to subsidize this market indefinitely.

For all of these reasons, I urge a strenuous debate on the small group market and attention to the various influences that drive it. This debate should reflect on all of the participants that make up this market in aggregate, and not focus only on selected issues or participants.

Respectfully Submitted,

Mark E. Litow

Attachment

Issues Plaguing the Small Group Market and a Current Assessment of Viability for Carriers

Issues Plaguing the Small Group Market:

A. Most Serious

1. Rating Band Limitations of ±20% or Less: This factor by itself appears to produce losses for the entire market in aggregate. It is possible that some carriers might recognize a profit for a short while, but the long term results for these carriers will be unacceptable as other carriers leave the market due to losses.

2. Guarantee Issue: This generally leads to rating bands as it otherwise requires insurers to charge substantial loads for those groups entering the system in poor health.

3. Cost shifting from providers due to large discounts afforded others such as large groups and Medicare and Medicaid patients. These scenarios may differ significantly from state to state or even within a state depending on the particular demographics of various populations, the strength of particular carriers or providers, and government reimbursement levels under Medicare and Medicaid.

B. Less Serious But Significant

1. The size of the uninsured population or otherwise uninsurable population and how access and costs are covered. Various mechanisms are in place that vary by state, and their success or lack there of may or may not place a burden on the small group market.

2. Issues in the individual market: Individuals in small groups may move back and forth between the individual and small group market depending on the environment and rules applicable to each. As such, problems in the individual market can cause healthier individuals to move to the small group market by adding a relative or friend to their own business, or the opposite may occur. In some states today, the perils of the small group business in some states may result in healthier groups exiting that market, with all of the healthier risks being covered by the individual market, and the remaining risks covered by a state's high risk pool or insurer of last resort. In some states, the collapse of the individual market may result in the opposite type of action occurring.

3. Litigation Costs: Increased litigation of providers and insurers has resulted in costs for each increasing to cover the corresponding expenses and/or awards. It has also resulted in a greater number of defensive procedures being performed, further escalating insurance premiums.

4. Mandated Benefits: Each time a new mandate is passed, it enables some groups or individuals to anti-select against the system and forces others to buy coverage or provisions they must pay for, but do not want. Many of these mandates again cause the less healthy groups or individuals to buy even greater protection while the healthier groups and individuals reduce or eliminate their protection. The result is not only the extra cost for the mandate, but any extra cost that comes with the selection/anti-selection created by the mandate.

Small Group Market Viability by State

Shown below is a list of states based on my perception of their ability to be profitable for insurance carriers in general. All states are divided into four categories as defined preceding the chart.

- ***Viable***: Profit potential exists with prudent company management due to a combination of a reasonable if not favorable regulatory environment in the state and external influences that do not appear to be causing rapidly rising trends due to cost shifting.

- ***Between Viable and Questionable at Best***: This category indicates a state where some carriers are still able to be profitable, but often that may be the case only in local markets. Further attention will be needed in the future so that this state can become viable in all cases, as opposed to moving into the Questionable at Best category.

- ***Questionable at Best***: These are states where the market has recently been deteriorating and indications are that future profitability is questionable for most companies. Thus, the most common scenario is that losses will exist for most companies even with prudent management. In some states, one company may dominate the market, and they can get much greater discounts than others, meaning they can be profitable where others are often not.

- ***Poor***: These are states where most, if not all, carriers lose money due to the regulatory environment and/or substantial cost shifting, and the environment is unlikely to improve without substantial modifications. The reasons for problems in states typically include very tight rating bands, often ranging from no allowed variation to $\pm 20\%$, in conjunction with guarantee issue requirements of

HIPAA, and /or heavy cost shifting due to larger than average Medicare and Medicaid populations and/or an uninsured population creating significant amounts of uncompensated care.

State Rankings			
Viable - 10 States		**Between Viable and Questionable at Best - 5 States**	
Illinois	Nebraska	Arkansas	
Indiana	Ohio	Oklahoma	
Iowa	Tennessee	Pennsylvania	
Michigan	Virginia	Texas	
Mississippi	Wisconsin	West Virginia	
Questionable At Best - 15 States		**Poor- -21 States/ Jurisdictions**	
Alabama	Missouri	Alaska	Massachusetts
Connecticut	Montana	Arizona	Minnesota
Georgia	Nevada	California	New Hampshire
Hawaii	North Carolina	Colorado	New Jersey
Idaho	North Dakota	Washington, D.C.	New Mexico
Kansas	South Carolina	Delaware	New York
Louisiana	South Dakota	Florida	Oregon
	Wyoming	Kentucky	Rhode Island
		Maine	Utah
		Maryland	Vermont
			Washington

The above classifications reflect my opinion only based on my experience, knowledge of the regulatory environment and potential external influences, and discussions with others in Milliman who work in this market. Since the environment in a number of states is changing with new regulations or changes in the external environment, states should be expected to improve or deteriorate from time to time. However, since the small group market overall is currently deteriorating, my expectation is that over time states are more likely to move toward a poorer rating (viability-wise) than to a more positive rating. That is, of course, unless changes in regulation or the external environment can be implemented that reverse the current direction.

The opinions in this attachment and the letter to which it is attached do not necessarily reflect the opinion of all Milliman consultants. The attachment and letter are for the purpose of providing Congress with information about the market and to assist Congressmen in their deliberations about it. This material should not be used for any other purpose without our written consent.

Statement on the Impact of Certain Health Insurance Reforms on Small Business' Access to Affordable Health Coverage

Testimony before:
The Subcommittee on Regulatory Reform and Oversight
Committee on Small Business
U.S. House of Representatives.

July 11. 2002

Merrill Matthews Jr., Ph.D.
Director, Council for Affordable Health Insurance

I would like to begin by thanking the Chairman for putting together this hearing on the impact of such reforms as guaranteed issue and community rating on small employers' access to affordable health insurance. Ensuring access to affordable health coverage is one of the most important issues facing small employers. Government can facilitate employers' ability to provide health coverage, or it can impede it. In my testimony, I intend to discuss what government is doing wrong and outline some positive steps it can take.

Let me begin by telling you about myself. My name is Merrill Matthews Jr., and I am the director of the Council for Affordable Health Insurance (CAHI), based in Alexandria, Virginia. CAHI is a research and advocacy association of insurance carriers active in the individual, small group, MSA and senior markets. CAHI's membership includes more than 40 insurance companies, small businesses, physicians, actuaries and insurance brokers. Since 1992, CAHI has been an advocate of market-oriented solutions to the systemic problems in American health care.

As a former philosophy and ethics professor, I learned that an issue may be easier to understand when it is put in a slightly different context. That is what I would like to do in order to explain why certain health insurance regulations are counterproductive.

My father-in-law was a homebuilder for many years. Suppose his state legislature, seeing a number of homeless in the city, had decided to do something about it. However, providing homes or sheltersis expensive, and the state's budget was already strained to the point of breaking.

These elected officials might have wanted the political credit for "fixing the homeless problem," but they wouldn't have wanted to raise taxes or appropriate other moneys. So they might have come up with this solution: to tell

my father-in-law that for every five homes he build for paying customers, he would have to build one for a homeless person free of charge or at a greatly reduced rate.

Now, although my father-in-law made a middle-class income building middle-class houses, he could not have made enough from five houses to absorb the cost of building that additional house. So while he might have absorbed some of the cost, he would have had to charge his paying customers more in order to cover the difference.

But then the paying customers would have begun to see that their homes cost significantly more that those across the state line. While some would simply have paid the difference, others might have moved to another state. Some would have chosen apartments or mobile homes, and some would have complained to their elected officials, who might have considered imposing price controls to preclude or limit these "outrageous" price increases.

Finally, as paying customers sought alternative housing options, my father-in-law's business would have begun to decline, which means the number and quality of homes he built for the homeless would also have decreased while the ire of legislators would have increased. They would probably have accused him of being a greedy, self-centered businessman trying to shirk his responsibilities.

While legislators are not likely to pass a law requiring builders to absorb the cost of free or discounted housing for the homeless, that is precisely what many state legislators and congresspersons are doing to insurers when they impose guaranteed issue and community rating.

What Is Guaranteed Issue? Guaranteed issue is a requirement that everyone who applies for health insurance be issued coverage, regardless of the condition of his or her health. This is comparable to allowing a person to purchase auto insurance *after* being involved in a car wreck.

What Happens When Guaranteed Issue Is Implemented? Guaranteed issue legislation leads to some very predictable outcomes.

Premiums Begin to Rise – If people know they can get health insurance when they get sick, they don't buy it when they're healthy. Younger and healthier people cancel their polices – or decline to buy one in the first place. As the health insurance pool gets smaller and sicker, premiums go up, which forces even more people to drop out. This process is known as the "death spiral," as escalating premiums drive out all but the sickest people with the most expensive health care needs. Is there a way to avoid the death spiral? Two options are available.

Mandating Coverage – One option is to force everyone – young and old, healthy and sick – to have health insurance. The failed Clinton health care plan would have included such a provision, and several state legislatures have toyed with the idea.

The biggest problem with mandating coverage is that it is largely unenforceable at the state level. Employers who self-insure come under the federal law known as ERISA, so states can't regulate their coverage. In addition, employers can move across state lines to escape the mandate.

Requiring Everyone to Pay the Same Price. Perhaps the most common approach to ensure that premiums stay affordable, even in the death spiral, is to impose community rating.

What Is Community Rating? Community rating has two general forms. Under "pure" or "flat" community rating, insurers are required to charge every policyholder the same rate for coverage, without regard to individual risk factors such as health status or age. Modified community rating allows for small variations in rates due to health status, age or other factors. And while some states may prohibit the use of health status to set premium rates, they may allow the use of demographic factors such as age.

Who Is Responsible for the Safety Net? There appears to be a general consensus in the American public that markets ought to be allowed to provide most people with goods and services, but that there should be a safety net for those who cannot meet their own needs. For example, the market system provides the vast majority of Americans with numerous choices of high quality food and housing at relatively affordable prices. But some Americans can't afford the food and housing they need, so we help them to buy what they want, using food stamps and housing vouchers. We don't tell grocery stores they have to let low-income families walk in the store and take what they want. If we did, prices for paying customers would go up to offset the difference. We simply provide low-income families with food assistance that lets them enter the store and buy what they want – just like everyone else.

We let the market work for the vast majority of people and provide a safety net for those who need it.

The real issue behind attempts to impose guaranteed issue and community rating is who should be responsible for maintaining and funding the health insurance safety net? I believe that is properly the role of government and not of business. What guaranteed issue and community rating seek to do is make business the safety net. Such legislation tells insurers that they must accept those who are uninsurable and pay their claims. What community rating says is that insurers can't charge any more for that coverage, even though the

claims will be more than for the average policy. It tells insurers that politicians don't want to pay for those who can't buy health insurance, so companies have to. Such a system doesn't – and probably can't – work. How do we know? Experience.

The Results of Guaranteed Issue Legislation. During the early 1990s, the quest to make health insurance accessible and affordable for everyone led a number of state legislatures to pass guaranteed issue and community rating legislation in the group and individual or nongroup health insurance markets. Some of those states spent the latter part of the 1990s trying to reform the reforms – with little success. Here are a few examples.

New Jersey – New Jersey is the poster child for why a state SHOULD NOT implement guaranteed issue in the individual market. It passed the legislation in 1994, when the state's health insurance rates were already high. Here are some results:

- In 1994, a New Jersey family policy with a $500 deductible and a 20 percent copayment (i.e., the insurer pays 80 percent) cost as little as $504 a month and as much as $1,076, depending on which of the 14 participating insurers the family chose.

- By January 2002, that same policy purchased from one of the 10 remaining companies cost between $3,085 (Blue Cross Blue Shield) and $17,550 (Trustmark) per month – *that's $38,040 to $210,600 a year.*

Maine – Maine passed guaranteed issue and community rating in 1993, driving up rates and driving out insurers. A 2001 report notes, "Rates have risen sharply in the past three years, especially for HMO coverage, making coverage unaffordable for many." Maine Sen. Susan Collins recently noted, "Anthem Blue Cross Blue Shield – the single remaining carrier in Maine's nongroup market – has increased its rates by 40 percent over the past two years."

Kentucky — The state adopted guaranteed issue and modified community rating in 1994 and required carriers to offer a limited number of state-designed, standardized health plans. As a result, 45 insurers left the state, leaving only Anthem Blue Cross and KentuckyCare, the state-run plan. Legislation passed in 2000 to reform the reforms encouraged four insurers to return. But premium costs are still above average.

New Hampshire – New Hampshire passed guaranteed issue and modified community rating reforms in 1994. Within three years, three of the six insurers left the market and the number of individual policies declined by almost half, while premiums for the Blue Cross policy nearly doubled.

New York — Did New York's 1992 legislation imposing guaranteed issue and community rating create affordable health insurance for everyone? When the law was passed, a 55-year-old healthy male paid about twice what a 25-year-old healthy male paid for a policy. As a result of the reforms, the 25-year-old male paid about 60 percent more, while the 55-year-old paid about 30 percent less — a great deal for the older person, who on average will have a higher income, but a disaster for the younger. The death spiral started and within a few years, both young and old were paying more than the 55-year-old paid when the law was passed. The situation has continued to deteriorate.

The Health Insurance Portability and Accountability Act. I wish I could say that only states had undertaken these attempts. But in 1996 Congress imposed guaranteed issue on virtually all small businesses through the Health Insurance Portability and Accountability Act (HIPAA).

What has been the result? There is no indication that HIPAA led to an expansion of coverage, but it has clearly led to higher prices. Health insurance premium increases slowed dramatically in the middle of the 1990s. But within a year or two after HIPAA's passage in 1996, the increase began. Today we are seeing an overall average premium increase of about a 16 percent, but some small businesses are looking at 40 to 50 percent increases. Not all of this is due to HIPAA. New medical technology and new pharmaceuticals add to the cost. But guaranteed issue has, in my opinion, been the primary culprit, and it shouldn't take any well-informed observer by surprise. When the American Academy of Actuaries released their analysis of HIPAA (prior to its passage), the press release said implementation would drive up cost by between 2 and 5 percent. Supporters jumped on this figure pronouncing HIPAA "affordable."

But anyone who actually opened the actuaries' study and looked inside would have seen that some people could expect premium hikes between 125 and 167 percent — which is about where we are now. And the premiums are climbing. Many employers who could afford the annual premium increases during the boom years can no longer do so.

Can Guaranteed Issue Be Made to Work? Legislators, having seen what guaranteed issue has done in other states, often think they can make it work by creating a longer waiting period before an uninsured person is eligible to enroll or by limiting the number and scope of those eligible to participate.

But guaranteed issue is not about closing loopholes, it's about offering bad incentives. It rewards people for remaining uninsured until they need coverage. Even trying to encourage young, healthy people to stay in the pool by providing a tax credit will not solve the problem if they have to pay something out of pocket for the insurance. Paying nothing to be uninsured is cheaper than paying something for coverage they can easily get when they do need it.

Ensuring Access to Affordable Health Insurance. State legislators pass guaranteed issue legislation in order to keep health insurance accessible and affordable for their constituents – *but it has never worked in any state.* Fortunately, there are better ways:

Consumer Choice – Consumers should have access to the widest possible number of health insurance options – from very basic to comprehensive coverage, low and high deductibles, different levels of managed care, or no managed care at all. Minimal government regulation allows consumers to choose the plan that best meets their needs and budgets.

Premium Assistance – Even though there are people who can't afford food, we don't try to regulate grocers or the price of groceries; we help low-income people by providing food stamps. Similarly, legislators should provide refundable tax credits to help people afford a policy. For example, House Majority Leader Dick Armey (R-TX) and Rep. Bill Lipinski (D-IN) have introduced "Fair Care" legislation, which would provide a refundable tax credit for up to $3,000 annually for a family that did not get health through an employer. Such a tax credit would make health insurance affordable for many working families.

A Workable Safety Net – Guaranteed issue tries to force health insurers to cover sick people who could not otherwise buy a policy. However, only governments can and should provide social safety nets. They can do so by establishing high-risk pools – public-private partnerships that provide an insurance safety net to the uninsurable at affordable prices.

In February, the U.S. House of Representatives passed $100 million for states to establish high-risk pools. More recently, Senators Max Baucus (D-MT) and Gordon Smith (R-OR) introduced the "Health Insurance Access Act of 2002." This bill would provide $20 million in 2002 and $50 million annually (2003–2006) in funding to states for the creation and maintenance of high-risk pools. The 30 states that already have high-risk pools can use the funds to help cover the costs of their existing programs.

Conclusion. State legislatures thought that passing guaranteed issue and community rating would make health insurance more accessible and affordable. Just the opposite happened. Congress thought that by passing guaranteed issue in the small group market, more people would be covered and costs might even go down because more people were in the pool. Neither occurred. If Congress and the states refuse to learn from this experience, they will only decrease consumer choice and increase the number of uninsured.

*Portions of this testimony were extracted from "What Were These State's Thinking," Council for Affordable health Insurance," Issues & Answers No. 104, May 2002.

TESTIMONY OF WAYNE NELSON
PRESIDENT OF COMMUNICATING FOR AGRICULTURE
& THE SELF-EMPLOYED

TO THE
SMALL BUSINESS SUBCOMMITTEE ON REGULATORY
REFORM AND OVERSIGHT

HEARING ON

THE SMALL BUSINESS HEALTH MARKET: BAD REFORMS, HIGHER PRICES
AND FEWER CHOICES

JULY 11, 2002

WASHINGTON, D.C.

Mr. Chairman and members of the committee:

Thank you for the opportunity to share with the committee our concerns about the rising costs and availability of health insurance to small business people throughout the country.

Communicating for Agriculture and the Self-Employed (CA) is a national organization made up of farmers and small business members who are individual operators or who operate small businesses with only a few employees. My name is Wayne Nelson and I serve as President of CA. I am involved in CA's public policy advocacy work in Washington and the different state legislatures on tax issues, regulatory issues and especially health issues as they affect small business and the self-employed. CA is celebrating its thirtieth anniversary this year.

Healthcare costs are rising at alarming rates this year after a few years of lesser increases. These increases hit small businesses especially hard, and unfortunately are forcing more of them to drop coverage they have previously offered to employees, or keep them from offering a new program.

Compounding the problem, more insurance companies are dropping out of the small group market in some states leaving fewer choices for small businesses and a less competitive market. Many of the employees of these small businesses end up in the individual market.

While it is important to take steps to keep a viable small group market working in every state, it is equally important that steps be taken to maintain a viable, competitive, affordable individual market -- not only to serve the self-employed, but also to serve individuals who work for small businesses that aren't able to offer employer coverage. We all need to understand the importance of keeping a viable individual market because of the role it serves, directly or indirectly, in seeing that our whole insurance system serves everyone.

Many of the federal and state reforms that were enacted in the 1990s with the intent of helping the small group market have backfired and actually done harm. Some of these reforms have caused unnecessary increases in premiums and have quickened the pace of small group companies leaving states. It appears that states where the problems are particularly acute include those that adopted regulations making their small group insurance markets provide insurance down to "groups of one". Business groups of one essentially have the same market characteristics as the individual market. In states where these so-called "groups of one" had the same access rules as the rest of the employer group market, insurance carriers have taken high losses and insurance rates for the whole small group market have skyrocketed.

Several states also tried reforms in the individual market to try to make them more like the employer group market with disastrous results. Some state legislators believed that simply legislating that every insurance company had to offer insurance to anyone at any

time regardless of their medical condition could solve the problem. This led to sky-high premiums and no competition with many companies leaving states that have guarantee issue in the individual market.

CA believes that everyone deserves guaranteed access and that high-risk pools, sometimes called health insurance safety nets, are the best, most workable way to address the problem of access for people in the individual market who have medical problems that would otherwise make them uninsurable.

Thirty states now have, or soon will have, high-risk pool programs that offer health insurance to individuals who are medically uninsurable. All risk pools by their inherent design need to be subsidized. Funding is the issue that is holding back more states from adopting them, and funding poses a challenge for existing state programs to keep premiums affordable. CA believes that some partial federal funding to help start pools in the remaining 20 states would be especially helpful. Additional federal funds could be used in existing state pools to help reduce the cost of premiums and losses.

It seems to us that the small group market needs some type of workable risk spreading mechanism to reduce the risk and costs for the smallest of groups in that market, which is the role that risk pools can and do serve in the individual market.

The second issue is making an effort to do something to temper the high cost of health insurance that is keeping many individuals and small businesses from purchasing coverage. CA is backing refundable, advancable tax credits or health credits as one way to make insurance more affordable. There are several plans introduced in both the House and Senate and the President has offered his health credit plan which would offer up to $1000 per individual and up to $2000 per family. Other plans have offered up to $3000 per family at varied income level thresholds. These health credits are refundable - which means they are also available to the individual or family has no income tax liability. They certainly will not pay the whole health premium for the year, but they will enable millions of individuals to purchase health insurance or to keep their existing insurance in effect. The department of Treasury has estimated that the President's plan would lower the number of uninsured by 6 million.

MSAs or Medical Savings Accounts would offer another alternative to help get more people insured. Recent legislation signed into law a one-year extension but more needs to be done. MSAs need to be available to all sizes of companies. The deductible ranges of current Archer MSA's are too restrictive. A wider range of deductibles would allow consumers more choice and allow companies to offer products better suited to customers. It would also be helpful to allow contributions by both the employee and employer in the same year.

The tax laws have not been fair to individuals who pay for their own health premiums. The self-employed will finally get tax parity with one hundred percent deductibility next year. Unfortunately, other individuals paying for their own health insurance have zero deduction. A single mom who has to work two part time jobs of which neither offers

health insurance benefits has to buy her own health insurance. But because she is not self-employed her deduction is zero. CA believes strongly in expanding the one hundred percent deduction to everyone who pays for his or her own health insurance.

CA believes in the power our association to help our members have better health insurance. CA has offered an endorsed health plan to its individual members for the last 26 years with the same health insurance company. Even though the CA members participating in the plan are in the individual market, they have similar power to those in groups in regard to health products offered and the cost of premiums. The association can negotiate with an insurance company with a much louder voice in terms of tempering rate increases and offering quality products than an individual alone. That combined voice is the power of the association.

CA will continue to work toward keeping a viable individual insurance market. We will strive to have high-risk pools for individual market access in every state; to have refundable tax credits to help make insurance more affordable; to expand MSAs to offer another choice; expand the one hundred percent deduction to all individuals to create tax fairness; and to enforce the power of associations to help individuals get better health benefits at a lower price.

Thank you Mr. Chairman and members of the committee and I will be happy to respond to any questions at your request.

Testimony by Robert Garcia de Posada,
President of The Latino Coalition before the
House Small Business Regulatory Reform & Oversight Subcommittee
on July 11, 2002

My name is Robert Garcia de Posada and I am the President of The Latino Coalition. The Latino Coalition was established in 1995 to address policy issues that directly affect the well-being of Hispanics in the U.S. The Coalition's agenda is to develop and promote policies that will enhance overall business, economic and social development of Hispanics.

When it comes to health insurance, according to the U.S. Census Bureau, the highest uninsured rate in the U.S. is among people of Hispanic origin. Over one third, or 34.2% of Hispanics were uninsured compared to only 12% for non-Hispanic whites. U.S. Hispanics also have the largest percentage of the working uninsured, at 37.9% compared to only 14.9% for non-Hispanic whites. Foreign-born immigrants were even worse off, with more than half without health insurance. According to the Commonwealth Fund, in small-to medium-sized companies with fewer than 100 workers, 63% of white workers have health benefits, compared to 38% of Hispanic workers.

There is a strong relationship between un-insurance and the kind of employment a person has. The reason is simple: Most Americans get their health insurance through their place of work. Moreover, in getting their health insurance through the workplace, they are also eligible to get large and, under current law, unlimited federal tax breaks for the purchase of health insurance. There is no such tax relief for workers who get health insurance outside the workplace or for workers and their families who cannot get employer-based health insurance.

Today, 65 percent of the uninsured are in working families where the breadwinner works full time. Because Hispanic workers are heavily concentrated in the service industry and in small businesses — working for firms that do not or cannot offer them health insurance coverage — they are disproportionately found outside of the normal channels of health insurance in the United States.

People who are working should not be discriminated against by the federal tax code in their purchase of health insurance simply because they buy a policy outside of their place of employment. There is a better policy. The best option to expand health insurance for Hispanic workers is to give them direct tax relief, either in the form of tax credits, if they are paying taxes, or vouchers — in effect, refundable tax credits —if they do not have taxable income. This will establish equity in the tax code and the health insurance market, reduce the need for these families to depend on government insurance programs like Medicaid or other forms of public assistance, expand health insurance coverage, and mainstream millions of uninsured Hispanic workers into America's private insurance market.

The health insurance market in the United States is uniquely job based. All Americans, both employers and employees, get tax relief, if and only if, they get their health insurance coverage through their place of employment. If the employer offers health insurance, the employer gets unlimited tax relief in the form of a tax deduction as part of the cost of doing business. Likewise, under this arrangement, employees also get unlimited tax relief for purchasing health insurance through their employer. But, instead of a tax deduction, an employee gets what is technically called a "tax exclusion" on the value of the job's health benefits. If an employee does not get his health insurance through the place of work, he gets little or no tax relief; indeed, the federal tax code punishes workers who buy health insurance outside the workplace by making that worker buy health benefits with after-tax dollars. For most workers, this cost is a huge disincentive for obtaining health insurance on their own.

The main reasons so many Hispanics do not have health insurance are they generally have lower incomes and they work for smaller firms. Employment and income level are the leading indicators of health insurance coverage in this country. The lower the income, the more likely a worker will not have coverage. If they are working independently or with a firm that does not provide health insurance, they simply do not have coverage because they cannot afford it. Small firms with fewer than 25 employees are the least likely to provide employment based health insurance. Based on the 1990 Census, odds are that Hispanic workers--with a per capita income of only $10,773 and a solid majority employed by small businesses, particularly the service industry--will not be offered health insurance at the workplace and will not be able to afford it on their own.

If a worker is employed by a large corporation, the chances are that both the benefits package and the tax benefits are very generous. However, if a worker is middle-or low-income and is employed by a smaller company, the tax benefits are less generous. Low-skilled workers often do not work for large companies or command a wage that enables them to buy health insurance, and they get little if any government assistance in purchasing it. If a worker decides to purchase individual policies, they will soon realize it is prohibitively expensive. This is the problem facing America's working poor.

At The Latino Coalition, we strongly support policies to promote equality and equity between employer-based health insurance coverage and consumer-based coverage. We are here to call on Congress to end the discrimination that exists against people who buy health insurance outside the place of business.

Most Americans are personally familiar with such cases. But, for purposes of illustration, consider Martha Sanchez, a single mother of two in Miami. Martha works as a receptionist for a small law firm, earning approximately $10 per hour. Her employer does not provide health insurance, and she cannot afford to buy an individual health insurance policy.

This is the case for many Hispanic workers. They are not poor enough to qualify for Medicaid, but are too poor to afford private health insurance. In addition, there is a high degree of mobility in the Hispanic workforce. And, as noted, the current system of employment-based health insurance is simply leaving too many working people who have families and are willing to work without affordable insurance.

So what can Congress do to help someone like Ms. Sanchez get health insurance?

First, enhance tax incentives for individuals without access to employer-sponsored coverage. You can enact refundable tax credits or vouchers to help low-income workers purchase health insurance. In order to make these tax credits truly accessible to low-income workers and small businesses, we believe that these tax breaks could be blended into the withholding system. In other words, allow the worker to withhold the cost of health insurance from the payroll tax, in order to afford insurance. We should also offer employers the authority to pay this premium if they wish. We salute President Bush and the bipartisan group of senators and representatives who have signed on to support refundable tax credits for the uninsured. This is without a doubt the most important initiative that
Congress can undertake if they seriously want to improve access to affordable health insurance.

Second, Congress should support the President's initiative to expand our Community Health Centers. These centers are in many cases the first line of defense for many uninsured Latinos across the country. However, while we expand the network of community health centers, we should also develop a stronger public education campaign to promote the existence of these centers, particularly in underserved communities.

Third, Congress can equalize the tax laws so that associations and community-based organizations have the same tax breaks as large businesses, when they provide health insurance. This would promote a more community-based insurance system that would have a better understanding of the community they serve. Don't forget that health patterns in our population are not the same. For instance, in the U.S. Hispanic community, there is an instance of diabetes, three times the level of the population at large. Having organizations and doctors who understand these differences are critical to provide cost-effective services to their customers.

Last year, we strongly supported the bipartisan efforts of Congressmen Lipinski and Shadegg to permit Individual Membership Associations to offer mandate-free health insurance (H.R. 4119). This effort would allow community-based groups, churches and advocacy organizations to offer individual health insurance to its members. This legislations required that these IMAs offer at least two health insurance choices to its members, including one that is mandate-free. According to the Council for Affordable Health Insurance, we can expect a reduction in price of approximately 20-25% with this initiative. But aside from the reduction in cost, what makes this plan so attractive is the ability of community-based groups and churches to reach out to underserved communities in a much more effective way than current government health programs.

Fourth, Congress should eliminate the obstacles to pooling. This will help promote more affordable, accessible and accountable coverage for consumers. The Latino Coalition strongly supports Association Health Plans, as a way to reduce the cost of health insurance and offer small business a mechanism to pool together to increase their bargaining power.

Fifth, Congress must work to simplify he application process and modernize programs like Medicaid and SCHiP. Simplifying these programs will be of critical importance to families who currently qualify for these programs but do not want to go through an incredibly complicated and burdensome process.

However, we oppose current legislative efforts to expand Medicaid as a main tool to address the uninsured crisis. For the past three years, The Latino Coalition has been battling severe cuts in Medicaid services at State legislatures across the country. At a time when most states are gutting the services available to Medicaid patients, it would not be financially responsible to add millions of new patients into this program. This would make the program less stable financially and would force more severe restrictions on much needed services for our most vulnerable citizens.

Sixth, Policymakers must make health insurance affordable for people who can't qualify for health insurance because they have a preexisting condition. The Latino Coalition believes sick people cannot be left out of the world's greatest health care system and must have access to affordable health insurance.

Yet, there are only two ways to provide coverage to uninsurable individuals: (1) guaranteed issue or (2) health insurance safety nets. One works, the other doesn't.

- **Guaranteed issue.** Guaranteed issue means that anyone can get health insurance at anytime regardless of their health condition. This means that people can actually wait until they are sick before they buy health insurance, giving people an incentive to opt out of the health insurance pool. When people opt out and are guaranteed coverage at any point, rates escalate in an actuarial death spiral. This is what happened in New Jersey after the state legislature enacted guaranteed issue. ***According to the New Jersey Department of Insurance, family rates for a $500 deductible plan now range from $3,170 a month to $17,550 a month!*** Guaranteed issue has not succeeded in making rates affordable for families, especially those who need access to our health care system.

- **High Risk Pools.** Health Insurance Safety Nets, or high risk pools as some refer to them, are the best and most affordable way to provide coverage for individuals who are otherwise uninsurable. A Health Insurance Safety Net is a special state-based, privately funded comprehensive health insurance plan. Currently, 29 states have safety net plans, and approximately 127,000 people were covered by these plans last year. The way they work is pretty simple: The enrollees pay a premium, and these premiums are usually capped so the enrollee has price protection. To help fund the safety net plan, the state usually assesses insurance companies based on the amount of business they conduct in that state.

On February 14, Republicans and Democrats voted to send $120 million to the states to help existing safety nets plans and to establish one in those states that currently do not have one. The Latino Coalition supports that initiative and applauds those members of Congress who voted to help sick people get affordable health insurance.

Seventh, Congress can promote changes in our tax laws to help low-income workers and small businesses have access to affordable heath insurance. For example, Small businesses could get a tax credit that could be phased-in beginning with the smallest firms of fewer than 10 employees;

- Individual purchasers of health insurance and the self-employed should be able to fully deduct the cost of premiums.
- Employee contributions for health insurance should not be considered taxable income: and,
- Tax credits should be made available for risk pools sponsored by the private industry.

Finally, we cannot ignore the fact that reducing regulatory burden and government mandates, reforming liability laws, and promoting personal responsibility are also key components of any solution to this problem. Access to affordable heath insurance is a problem that disproportionately affects the U.S. Hispanic community. The Latino Coalition strongly commends this committee for addressing this issue, and we look forward to working with you to break down the barriers and build the necessary bridges to improve the access to affordable health coverage for the uninsured.

Thank you.

For more information on The Latino Coalition, please visit our website at www.TheLatinoCoalition.com or call us at 202-546-0008. Our offices are located at 725 Massachusetts Avenue, N.E. in Washington, DC 20002.