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ALTERNATIVES FOR EASING THE SMALL BUSINESS HEALTH CARE BURDEN

HEARING

BEFORE THE

COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP

UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

FEBRUARY 13, 2007

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ONE HUNDRED TENTH CONGRESS

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ALTERNATIVES FOR EASING THE SMALL BUSINESS HEALTH CARE BURDEN

TUESDAY, FEBRUARY 13, 2007

UNITED STATES SENATE,
COMMITTEE ON SMALL BUSINESS AND
ENTREPRENEURSHIP,
Washington, D.C.

The Committee met, pursuant to notice, at 10:11 a.m., in room 428A, Russell Senate Office Building, the Honorable John F. Kerry, Chairman of the Committee, presiding.

Present: Senators Kerry, Cardin, Snowe, and Thune.

OPENING STATEMENT OF THE HONORABLE JOHN F. KERRY, CHAIRMAN, SENATE COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP, AND A UNITED STATES SENATOR FROM MASSACHUSETTS

Chairman KERRY. Well, officially, this hearing will open, since we already have order. Welcome, everybody. Thank you very much for coming in today. We welcome all of our witnesses.

Senator Snowe and I share the opportunity of both serving in a responsible position on this Committee and also being on the Finance Committee, so we thought we would take advantage of that and lay a foundation here with respect to the health care issue and then dovetail and try to advance it within the framework of the Finance Committee, which has major jurisdiction, together with the HELP Committee, and see if we can't move that.

This is, without doubt, the single most important issue that any of us hear about as we criss-cross the country and talk to small business owners. The inability and struggle of small businesses to be able to provide health care to their families and their employees is a growing crisis. All of us understand that we have to reform the system, and I think a lot of us are getting a little bit exhausted with the expenditure of Congressional rhetorical energy on this instead of legislative energy. It is really almost incomprehensible how people can be watching the trend lines—I don't know if we have a chart here somewhere—without a growing appetite for something to be done, hopefully.

There are unlikely alliances between traditional rivals. Just the other day, we saw SEIU and Wal-Mart, who had been at loggerheads, stand up and join forces in a push to try to get everybody covered by health care.

Done the right way, health care reform ought to be able to solve the three major challenges that we and particularly small businesses face. No. 1, give them access to a functioning insurance

market. That is the first thing you have to do. The second thing is you have to make sure that whatever is offered in those markets are sensible quality care opportunities. And finally, the affordability issue. You have to be able to help people be able to afford it and buy it once they have the access.

My own State of Massachusetts has made a step towards trying to do this. We are still going to try to figure out whether there is enough money in the system to handle it. But the basic structure is to create a central purchasing exchange for individuals and small businesses and to offer financial help on a sliding scale to small businesses and low-income residents, but requiring as a mandate that everybody has got to purchase some type of insurance.

The fact is, and none of us, I think, take pleasure in this, but the fact is that in 6 years, we have had a failure of executive leadership here. They just haven't wanted to tackle this, period. There is no other way to explain it. There hasn't been one proposal of major broad coverage, no significant effort. We have had small little chinks here and there, including one we will talk about today, Health Savings Plans, but any legitimate analysis of that has to acknowledge the narrowness of the market being served and the folks that are helped by it.

So we still have the larger issue. The President is now proposing a standard deduction for those who have health insurance, but the difficulty with that is it is not even based on actual health care expenses. Many observers think that approach actually hurts small businesses in a couple of ways because while small employers would get a tax deduction for covering themselves and their families, they wouldn't be required to provide a similar benefit to their employees, so there is not necessarily a downstream impact here.

And secondly, small businesses that currently offer health insurance to their workers would be less able to do so under the President's plan. If just one of their employees gets sick, the insurance premium could easily exceed the amount of the deduction, thereby imposing tax penalties on all the workers or causing the small business itself to drop coverage as a consequence.

So we have got to look carefully at the tax incentives and see what push-pull occurs as a consequence of whatever the proposal is.

As we know, the Health Savings Accounts are still on the table. I think it is a fine option for somebody who has the ability to save to be able to deduct, though in many cases those most able to save are those who least need the deduction. But it must be acknowledged as a niche market. And for those who lack insurance or who lack the ability to have a tax impact, it just does nothing. That is the bottom line.

So whether the President is with us or not, I think this Congress has to try to move forward, and Senator Snowe, as I mentioned before you got here, the fact that you and I serve on the Finance Committee, I think gives us particular ability to try to leverage what we glean here and the record that we build here to be quickly transferred over there to help support whatever efforts we try to make.

The reauthorization of the children's health insurance program this year is key to whatever we might be able to do. We have 11

million uninsured children under 21 in this country. I proposed legislation 3 years ago called Kids First which would help us move down the road of at least insuring all children in America. If you can't do that, where can you begin? It seems to me that it would be enormously helpful, also, to a lot of the small businesses.

The statistics, if you look over at the graphs over here, since the year 2000, premium prices have gone up by a total of 87 percent compared with almost stagnant growth, as you can see in the lower two lines, in worker wages and inflation. As a result of these increases, a mere 48 percent of firms with 10 or fewer employees are offering health benefits. This percentage, sadly, is down from 58 percent just 5 years ago, so we are clearly going in the wrong direction.

According to a study done by the Kaiser Family Foundation, the number of uninsured employees increased by 3.4 million between 2001 and 2005, and two-thirds of that increase, ladies and gentlemen, came from low-income families. So that brings the number of uninsured employees and self-employed people to a staggering 23 million Americans. So 23 million Americans play by the rules, pay their taxes, get up, and go to work, but they are either self-employed or employees of a company and they have no health insurance whatsoever.

It is simply an unacceptable statistic in a civilized, wealthy nation such as ours which has the ability to provide care in a more effective and thoughtful way. I am not saying that some of those folks, if they get sick, don't get care. We all know what happens. You go to the hospital and somebody takes care of you. But it is a remarkably inefficient way to care for people. It is a remarkably inefficient way to distribute the costs.

And all our businesses wind up picking up those costs, which is why it is so staggering that we can't persuade people to get smart up front and do it in a smart way. I mean, we could save $100 billion from early screening of diabetes alone so you don't wind up with amputations and dialysis, the most expensive form of treatment, instead of preventing it early.

It is the same thing for many cancers. I was very lucky. I had early cancer screening. I caught it, managed to have an operation, got rid of the cancer, knock on wood, but a lot of people don't get early screenings. That is particularly the case among African-Americans in this country, where they have a much higher rate of death, as well as incidence of cancer. Screening and prevention are key components and we need to get there.

So I am glad Massachusetts has taken some steps. California is now wrestling with the idea. Others are looking at it. As with many other issues, like global climate change and other kinds of issues, the American people and the local communities are way ahead of the United States Congress.

So my hope is we can take a good look at that this morning. I have introduced the Small Business Health Care Tax Credit Act, which is an effort to try to cut the cost of health insurance by up to 50 percent for small business owners with fewer than 50 employees, and that would provide health insurance for their low- and moderate-income employees. But until we can enact proposals that will reduce the cost for small and large business alike and help

with health information technology, which the RAND group estimates could save an astounding $81 billion per year, this tax credit legislation is the best way we have to go until we do some sort of comprehensive effort.

So I am hopeful that we can work with the States. Senator Snowe, I hope you and I can help this Committee to make a contribution to this dialogue. But we are going to have to really find a new equation around here to figure out how we do this in tough budget times with the other issues we have created for ourselves.

There are some other issues here. Senator Lincoln and Senator Durbin have taken an idea that I talked about a lot in 2004, which was access to the FEHP program. If we allowed people to have access to a system like that, they could buy in and you would have greater affordability for everyone. There are a number of different ways to skin this cat.

I was talking the other day with my colleague, Senator Kennedy, who spent 40 years trying to get health care legislation through here, and there are 12, 11, 10, whatever number of ways that you could do it. It is really the lack of willpower, not the lack of different modalities for how you do it.

The astounding thing is that Americans always say, well, I don't want a Government program, but the fact is, over 50 percent of our health care system is devoted to much beloved health care programs called Medicare, the Veterans Administration, and Medicaid.

So we are kind of spinning wheels and going around in circles and talking past each other, and my hope is that we can get a conversation going on here that helps us to be smart and do something better about it.

Thank you all for being here. I will introduce you in a moment after Senator Snowe says a word.

OPENING STATEMENT OF THE HONORABLE OLYMPIA J. SNOWE, A UNITED STATES SENATOR FROM MAINE

Senator SNOWE. Thank you, Mr. Chairman. First of all, I thank you for focusing on such a pivotal issue as one of your first hearings as Chair of this Committee. It is obviously of crucial concern to the small business community throughout the country and I welcome our panel here today and most especially Tarren Bragdon from Augusta, Maine, who is the director of Health Reform Initiatives at the Maine Heritage Policy Center and is an authority on the Maine health insurance landscape and also small business health plans, Health Savings Accounts, and also the impact of potential reforms on small business. I welcome you, Tarren, here today, and I welcome all of you.

It is critical that we build a record that hopefully will be the impetus for change in this Congress. It is long overdue, we recognize that. Chairman Kerry and I have worked together on this initiative in the past and hope to break the deadlock and stalemate on this issue.

This is a crisis for small businesses. I certainly heard that repeatedly in the State during the fall. Without question, it is a crisis across this country. It is a foremost concern among small businesses in each and every one of the 50 States based on all the sur-

veys. It is a crisis. Hopefully, the Congress can ultimately respond by addressing this issue.

It is going to require a variety of components to make it happen, and I do believe that it is possible to get there. I think it is a question of political will in the final analysis and trying to determine how we can overcome the criticisms of creating small business health insurance plans, and there are going to be differences. Senator Enzi chaired the HELP Committee in the last Congress, which managed for the first time to at least report out of Committee a bill concerning small business health insurance plans.

On the other hand, it would have harmonized health insurance regulations across State lines. That engendered considerable concern and opposition. We tried to deal with the preemption of mandates. I had an amendment that would have created a uniform 26-State "floor" or threshold. If 26 States had enacted a benefit, that benefit that would have to be included in the minimum package within any standard benefits package of a small business health plan.

Nevertheless, we weren't able to get there from here, as the saying goes in the State of Maine. But the question is, what can we do now to overcome the obstacles and criticisms of the previous plans that have been offered and how can we coalesce around these issues?

One potential solution is using the tax code, as Senator Kerry said. We are both Members of the Senate Finance Committee. I think that it is certainly possible to create incentives to help solve this crisis.

Second, how do we price or "rate" these products? How do we make small group markets more competitive, because that is a crucial challenge. As you see all the statistics and the dominance of health insurers, few health insurers in our State and across this country dominate the markets. I requested a GAO report that indicated that fact precisely. Large insurers control 43 percent of State small group markets. The five largest carriers now have more than 75 percent of the market share in 26 States, and more than 90 percent market share in 12 States. In Maine, one insurance carrier currently controls 63 percent of the market share. Five have 98 percent.

I think it illustrates the point. There is very little competition. When you have low competition, you have higher prices. Higher prices mean no health insurance. It is as simple as that, and that is exactly what has happened. Health insurance has moved out of reach for most small business owners.

Last October, I remember doing my very first walking tour during the campaign recess, and I walk into the first shop and this store owner puts down his Blue Cross-Blue Shield increase, which was more than 20 percent in addition to 16 percent last year, and also his bill for a family plan. It was exorbitant, making it out of reach for the average small business owner and their families and their employees.

If the uninsured is growing at a great number as it is, now to almost 47 million Americans, we could have a substantial impact on that if we address this crisis because 60 percent or more of those uninsured work for small businesses or depend on somebody

who does. So clearly, the evidence, I think, speaks to the fact that we have to address and to tackle this problem.

I also have another chart here, and I think that we are seeing what higher prices are also doing in terms of employer-sponsored health insurance. It has declined by 10 percentage points over the last 5 years. That is a dramatic drop, frankly, because again, it puts health insurance out of reach. Small businesses cannot compete with large companies who offer this vital benefit. People seek jobs that provide attractive benefits, and one of which is health insurance. So it makes small businesses less competitive with other companies to attract the talent and the skills necessary to be competitive with other larger entities.

So that is the problem. I think that it is possible to get this done if we can build around some common ground, and I think there are some common elements to all of these plans. So many people have some great ideas and I think it is possible to accomplish it and provide some form of pooling. For example, Senator Kerry and I worked on developing regional small business health plans. That was one initiative. I am working with Senator Lincoln on other possible initiatives. Senator Enzi came up with his proposal. I think there are workable solutions if we can just build across the party line.

Second, HSAs are a component, an option, especially with high-deductible health plans. I think that is crucial. I have introduced legislation on cafeteria tax plans, to give more flexibility for small businesses to offer those plans because that is another dimension that is very attractive in making it easier and creating more flexible regulations for small businesses to offer cafeteria plans. Again, it is another option that should be available and we should make it easier for small businesses to offer it, as well.

So there are a number of issues, an array of components, and I think it is a question of if we can build that support. But hopefully, this is going to be the year to do it, Mr. Chairman, and I think that this is a great start and hopefully we can get there. Thank you.

Chairman KERRY. Thank you, Senator Snowe. Thank you very much. Thanks for your cooperative effort on this, which I really hope we can leverage with Senator Baucus and Senator Grassley.

Mary Beth Senkewicz is president of MBS Consulting, former senior counsel for National Policy at the National Association of Insurance Commissioners.

Tarren Bragdon has already been introduced by Senator Snowe. We welcome you here from the Maine Heritage Policy Center.

Jon Kingsdale, executive director, Commonwealth Health Insurance Connector Authority.

William Sweetnam, Jr., former benefits tax counsel, Office of Tax Policy, U.S. Department of Treasury, and also formerly worked up here.

And Ann Sullivan, head of Government Relations for Women Impacting Public Policy.

Thank you all for being here. Your full testimony will be put in the record as if read in full, so if we could ask you to summarize your prepared comments in 5 minutes, that will give us more chance to have a little exchange.

Ms. Senkewicz?

STATEMENT OF MARY BETH SENKEWICZ, INDEPENDENT CONSULTANT, MBS CONSULTING

Ms. SENKEWICZ. Chairman Kerry, Senator Snowe, I appreciate the opportunity to testify before you today on small businesses and health care insurance.

With the ever-increasing numbers of uninsured in our country, it is apparent that the system is not functioning efficiently or fairly. Small businesses have been hit particularly hard. Small businesses have more difficulty regarding health insurance for their employees primarily because they are small. Insurance is about spreading risk, and in order to spread risk more efficiently, larger pools of insureds are required. Insurance is about the law of large numbers. That is why one small employer can't be a pool by itself. If an employee becomes ill, their group is quickly priced out of the market.

As Congress contemplates the complex issues surrounding our troubled health care system and financing mechanisms, it is important to keep certain principles in mind to ensure that any proposals are likely to result in a fairer, more stable system.

At Georgetown's Health Policy Institute, my colleagues have developed a "triple A" of principles to consider in thinking through these issues. Any outcome of thoughtful public policy should have these principles fulfilled.

The first "A" is adequacy of coverage. This generally means coverage without holes. This principle is particularly important because if coverage has significant holes, it can lead to risk selection, which results in sicker persons in any pool thereby driving up premiums. Therefore, we need to address minimum benefit packages so insurers cannot risk select by benefit design.

The second "A" is affordability of coverage. This principle is self-evident. The primary reason small businesses don't buy health insurance for their workers or cut back on benefits is because it costs too much. Health care costs have spiraled, and that fact is simply reflected in health insurance premiums.

The third "A" is availability of coverage. Some proposals, such as the Durbin-Lincoln bill, try to address this issue by creating regional or national purchasing pools where small businesses can shop for insurance. Policy makers should be wary of sending small businesses and individuals to shop in markets where they can be denied coverage or rated up sharply for adverse health conditions. Health insurance needs to work for people when they are sick. After all, 80 percent of claims are generated by 20 percent of insureds. A system that works will cover people who are sick when they need the coverage the most rather than having them discover the plan has so many holes as to be almost worthless or price them out through punitive premium increases. But the only way to cover them when they are sick is to cover them when they are well, to spread the risk as broadly as possible.

More efficient pooling is necessary to help small businesses with health insurance. Larger pools can spread risk across larger populations with those attendant benefits. Larger pools will also have lower administrative costs, one factor in the price of health insurance. The pools can have rules that treat people fairly and don't kick them when they are down, such as a prohibition against rating up based on health status. The pools can have rules about min-

imum benefit packages to avoid risk selection. A fair and efficient pooling mechanism will go a long way to stabilizing a market in the long run. And rules do not necessarily mean less choice. Rules just mean there is a level playing field.

There are other mechanisms being considered as part of the solution. We will hear later about the Massachusetts law, and other States are considering employer and individual mandates. Reinsurance, purchasing groups, and tax credits to help small employers with the purchase of insurance are options on the table.

One common thread running through many of these proposals is subsidies to assist with the purchase of health insurance. The simple fact is, health insurance costs a lot of money and a lot of people simply can't afford it. It is going to cost tax dollars to provide subsidies so people can become insured and access the health care system most efficiently. Employer and individual contributions can contribute to the financing, but some subsidization is almost certainly going to be required.

Thank you. It is heartening to see your Committee tackle these issues so early in this Congressional session.

[The prepared statement of Ms. Senkewicz follows:]

Testimony of

Mary Beth Senkewicz
MBS Consulting
Independent Consultant Specializing in Health Policy and Insurance

on

"Alternatives for Easing the Small Business Health Care Burden"

before the

Committee on Small Business and Entrepreneurship
United States Senate

February 13, 2007

Chairman Kerry, Senator Snowe, members of the Committee, I appreciate the opportunity to testify before you today on small businesses and health care insurance. With the ever-increasing numbers of uninsured in our country, it is apparent that the system is not functioning efficiently or fairly. Small businesses have been hit particularly hard.

Small Businesses Have More Difficulty

In order to understand why small businesses are in such difficulty regarding health insurance for their employees, it is helpful to review some basic principles of insurance. Insurance, first and foremost, is about spreading risk. In order to spread risk most efficiently, pools of insureds need to be big rather than small. One saying has it that insurance is about the laws of large numbers. But small businesses are just that – small. One small employer can't be a pool by itself – we saw the terrible consequences of being priced out of the market very quickly when one employee of a small employer became ill back in the days before states enacted small group reform.

Georgetown's Triple A Elements

As Congress contemplates the complex issues surrounding our troubled health care system and financing mechanisms, it is important to keep certain principles in mind to ensure that any proposals are likely to result in a fairer, more stable system. Karen Pollitz and her colleagues at Georgetown have developed a triple A of principles system to consider in thinking through these issues. Her written testimony has been submitted for the record. Any outcome of thoughtful public policy should have these principles fulfilled.

Georgetown's first A is adequacy of coverage. This generally means coverage without holes and Ms. Pollitz' testimony encompasses that concept on several levels. This principle is particularly important because if coverage has holes, it can lead to risk selection. Risk selection results in sicker persons in any pool, thereby driving up premiums. Therefore, any requirement needs to address minimum benefit packages so insurers cannot risk-select by benefit design.

Georgetown's second A is affordability of coverage. This principle is pretty self-evident. The primary reason small businesses don't buy health insurance for their workers, or cut back on benefits, is because it costs too much. Health care costs have spiraled, some would say out of control. That fact is reflected in health insurance premiums. (As an aside, our system will continue to have problems until we can figure out how to contain health care costs.)

Georgetown's third A is availability of coverage. Some proposals, such as the Durbin-Lincoln bill, try to address this issue by creating regional or national purchasing pools where small businesses can shop for insurance. Georgetown notes that policymakers should be wary of sending small businesses and individuals to shop for insurance in markets where they can be denied coverage or rated up sharply for adverse health conditions, and further notes that health insurance needs to work for people when they are sick. That is absolutely correct. After all, 80% of claims are generated by 20% of insureds. A system that works will cover people who are sick, when they need the coverage the most, rather than having them discover the plan has so many holes as to be almost worthless, or price them out through punitive premium increases. But the only way to cover them when they are sick is to cover them when they are well – to spread the risk as broadly as possible.

Pooling

The principle of pooling needs to be considered. More efficient pooling is necessary to help small businesses with health insurance. Larger pools can spread risk across larger populations with those attendant benefits. Larger pools will also have lower administrative costs, one factor in the price of health insurance. The pools can have rules that treat people fairly and don't kick them when they are down, such as a prohibition against rating up based on health status. The pool can have rules about minimum benefit packages to avoid risk selection. A fair and efficient pooling mechanism will go a long way to stabilizing a market in the long run.

And rules do not necessarily mean less choice. Rules just mean there is a level playing field. Although I would add a word of caution about choice: too much choice can be confusing and anti-efficient. I think we can learn a lesson from Medicare Part D in this regard. Some would argue that choosing from among 45 plans is not particularly efficient for the consumer.

Mandates for Coverage, Reinsurance, Tax Credits

Other mechanisms are being considered as part of the solution. We will hear later about the Massachusetts law, and other states are considering employer and individual mandates. New York has had a positive experience using reinsurance as the primary vehicle in the Healthy New York initiative, and has seen significant increases in insured rates among low-wage workers in small businesses. Reinsurance structures, however, can be quite varied and would need careful study to ensure appropriate insurer participation occurs. I have talked about more efficient pooling, and some are promoting purchasing groups as a vehicle to do that. And tax credits to help small employers with the purchase of insurers are an option on the table.

One common thread running through many of these proposals is subsidies to assist with the purchase of health insurance. The simple fact is health insurance costs a lot of money and a lot of people simply can't afford it. It's going to cost tax dollars to provide subsidies so people can become insured and access the health care system most

efficiently. Employer and individual contributions can contribute to the financing, but some subsidization is almost certainly going to be required.

Thank you for the opportunity to testify. The challenge of promulgating good public policy to address our broken system is enormous, but absolutely necessary. I commend you for starting to address this important challenge early in this 110th Congress.

Chairman KERRY. Thank you very much, Ms. Senkewicz.

Mr. Bragdon?

STATEMENT OF TARREN BRAGDON, DIRECTOR OF HEALTH REFORM INITIATIVES, THE MAINE HERITAGE POLICY CENTER

Mr. BRAGDON. Good morning, Chairman Kerry and Ranking Member Snowe. Thank you for inviting me to testify.

I believe there are five specific steps that Congress should take to assist small businesses. One, encourage small employers to offer coverage regardless of the share of the premium paid by the employer. While a lot has been said about the cost of health insurance, employees are very likely to get coverage through their employer if it is simply offered, even when the employer pays only a small share of the premium. Employees in the highest cost-sharing category have a take-up rate of 68 percent, compared to those who have 100 percent employer-paid coverage have a take-up rate of 89 percent. So even with high cost-sharing, employees are very likely to buy health insurance if they can buy it through the workplace.

A lot has been said about choice, as well. Blue Cross-Blue Shield of California has introduced a small business option that allows small businesses to offer up to 17 different plans to their employees with a minimum employer share of the premium of just $100 per employee per month. Again, I think insurers are beginning to recognize that if they can buy through the workplace, more people will purchase coverage.

All this would suggest that a fairly modest Federal tax incentive encouraging very small businesses, those with less than 25 employees, to offer coverage would greatly increase offer rates and likely also increase the take-up rates for the 25 million employees who work in these very small businesses. Employer premium subsidies as provided in the Chairman's legislation would likely increase offer and take-up rates even further.

Second, I would encourage you to consider a regional approach to small business health plans. We appreciate Senator Snowe's long-standing support of association health plans and small business health plans. These would provide critical and immediate Federal relief to small businesses. This is most acute, the need for this relief, in Maine. We only have four active insurers in the small group market, yet we have the eighth highest premiums small businesses pay in the country.

Medicare provides a model of a regional approach, giving more options to individuals in particularly small or rural States than would be likely available if each State were its own region. Maine and New Hampshire, as well as the four New England States, are combined into two Medicare regions. This provides many more options for Maine people, Maine seniors, than if they were in their own single-State Medicare region.

New England States have a total of 55 unique benefit mandates that are required in one but not all of the six States. Sixteen of these mandates are required in a majority of the New England States, but only 10 of those same 16 mandates are required in a majority of all 50 States. Therefore, if you had a regional approach to small business health plans, you would include mandates in a majority of States in that region and reflect regional values.

Three, allow employees to easily pay their share of the premium pre-tax. Senator Snowe's proposal that would allow very small businesses to more easily set up Section 125 plans is a critical step. It is not enough to just offer health coverage. You also have to allow employees to pay for it pre-tax. A Maine family earning $50,000 a year would save about 30 percent if they could pay their share of the premium pre-tax through a Section 125 plan.

Fourth, I would encourage you to consider auto-enrollment in a default health plan. The Pension Protection Act of 2006 allows companies to auto-enroll people in a 401(k) plan. That increases employee participation by 25 percent. Why not allow employers to do the same with a default health plan? The average employer-sponsored HSA-qualified plan requires an employee contribution of just $9 a week. Often, young and single employees are the least likely to participate in employer-sponsored coverage. Auto-enrollment could encourage increased take-up and spread the risk across a larger and healthier population.

Five, create a national or regional market for individual insurance, as well. Often, this gets lost in the conversation about the small group market, but Congress needs to consider allowing more competition and options in the individual market. For very small businesses, entrepreneurs, freelancers, and independent contractors, the individual insurance market is the only place to purchase coverage.

Again, Maine has led the way in how not to regulate. In Augusta, Maine, a $10,000 deductible policy for my family, my wife and our one son, costs $511 a month, a $10,000 deductible policy. That same plan in Alexandria, Virginia costs $145 a month. Regulations matter.

High individual insurance costs discourage entrepreneurs from setting out a shingle and starting a new business. Drawing from the Small Business Health Plan legislation or Senator DeMint's Health Care Choice Act, Congress should consider national or regional individual insurance carriers and plans.

Thank you for holding this hearing and allowing me to testify.

[The prepared statement of Mr. Bragdon follows:]

United States Senate Committee on Small Business & Entrepreneurship
Hearing:
"Alternatives to Easing the Small Business Health Care Burden"
February 13, 2007
Testimony

TESTIMONY OF TARREN BRAGDON
DIRECTOR OF HEALTH REFORM INITIATIVES
THE MAINE HERITAGE POLICY CENTER

Introductory Remarks

Good morning, Chairman Kerry, Ranking Member Snowe, and members of the Committee. Thank you for inviting me to discuss ideas for expanding access and increasing affordability of health coverage for small businesses and their employees. The Maine Heritage Policy Center is non-profit, non-partisan research and educational organization located in Portland, Maine.

There are three main challenges for small business owners:

1. Offering coverage to employees
2. Affording a share of the premium necessary to attract the desired workforce
3. Finding competitive offerings in the small group market

There are many steps Congress can take to ease the health care burden and support health benefits for small businesses.

Encourage Small Employers to Offer Coverage, Regardless of the Share of the Premium Paid by the Employer

While much has been said about the cost of health insurance, federal studies show that employees are very likely to get coverage through their employer if it is offered, even when the employer pays only a small share of the premium.

Although only 61 percent of small firms (fewer than 50 employees) offer health insurance to their employees compared to almost all (97 percent) larger firms, a similar 78 to 81 percent of those eligible enroll (take-up) health insurance provided through their employer. Those very small businesses with less than 10 or 25 employees have much lower offer rates - 34 and 64 percent, respectively. Interestingly, states with a higher share of small business employees who are offered health insurance also tend to have higher take-up rates.[1] This suggests that having more small businesses offer health insurance, almost regardless of the employer's contribution, could significantly increase the portion and total number of those insured.

According to research published this month by the Kaiser Family Foundation, employees with the highest cost sharing (37 percent or more of the employee-only

premium, or $1,570+ per year) still have a very high take-up rate of 68 percent. Those with 100 percent employer-paid coverage only have an 89 percent take-up rate. For expensive family coverage, take-up rates for those with the highest cost sharing (56 percent or more, or $6,460+ per year) are 77 percent compared to 90 percent for those with no family premium cost sharing. Even lower wage firms (those with more than 35 percent of employees earning less than $20,000 a year) had similar take-up rates for high levels of premium cost sharing.[2]

These data seem to suggest that most employees will buy health insurance coverage at high take-up rates as long as it is facilitated through their employer.

Insurers seem to be recognizing the benefit of offering coverage through the workplace even with modest employer contributions. Blue Cross and Blue Shield of California BeneFits Portfolio and Employee Elect Plans offer participating small businesses (2 to 50 employees) a cafeteria plan with 6 to 17 different health plans. The minimum employer contribution is as low as $50 to $100 per employee per month with only 60 to 70 percent of eligible employees required to enroll. Plan range from first-dollar coverage HMO plans to HSA-compatible plans.[3] This concept is a private-market variation of the Connector that is part of the Massachusetts health reform of 2006.

All this would suggest that fairly modest federal tax incentives encouraging very small businesses (less than 25 employees) to simply offer health coverage would likely greatly increase offer rates for employers and take-up rates for employees. This more modest proposal would not have the significant federal fiscal impact of sizable small employer premium subsidies. This targeted approach would be broad in reach as there are an estimated 4.5 million such private establishments with a total 24.7 million employees. Employer premium subsidies, as provided in Chairman Kerry's Small Business Health Care Tax Credit Act (S.99), albeit more broadly, would likely increase the offer and take-up rates even more.

Consider a Regional Approach to Small Business Health Plans

We appreciate Senator Snowe's long-standing support of Association Health Plan (S.406) and Small Business Health Plans (S.1955). These would provide critical and immediate federal relief to small businesses struggling to provide coverage in the costly small group insurance market. These proposals should be part of any legislation designed to ease the small business health care burden.

This is most acute in Maine. Maine has only four active insurers in the small group market.[4] However, Connecticut, with just over twice as many small business employees, has 25 licensed carriers.[5] New Hampshire has fourteen, although it has fewer small business employees than Maine.[6]

Although much of the Small Business Health Plan legislation focused on benefit mandates, Maine's costly small group insurance – 8th highest in country[7] - is driven more by premium regulations – mostly Maine's restrictive modified community rating. This is particularly a problem in Maine as 40 percent of all private-sector

employees in Maine work for a small employer (less than 50 employees) – far above the national average of 29 percent. Only seven states have a larger share of the private workforce working for small businesses.

Medicare provides a model of a regional approach to coverage that provides more options to individuals in particularly small or rural states than would likely be available if each state were its own region. Maine and New Hampshire are combined for the Medicare Advantage (MA) and Medicare Part D Prescription Drug Plan (PDP) regions. The four remaining New England states are their own MA and PDP regions. This approach has given Maine seniors more affordable options.

According the Council on Affordable Health Insurance, New England states have a total of 55 unique benefit mandates that are required in some but not all six states. However, only 28 benefit or provider mandates are required in at least half and only 16 in a majority of the New England states. Of these 16, only 10 are mandated in a majority of all 50 states.[8] Thus, having a regional approach to Small Business Health Plans would include mandates reflective of the values of that region, while providing increased competition, more affordable premiums, increased plan offerings and reduced administrative costs for regional insurers. Regional Small Business Health Plans could be in addition to state-based licensed health insurers, providing insurers, like banks, the option of state or regional/federal licensure.

The key is to not be restrictive and allow numerous plan options with competitive premiums. A plan and premium attractive to a 30-year-old single mom working at a small business might not be an attractive value proposition for a 55-year-old married coworker. And any coverage – even a catastrophic plan - is better than being uninsured.

Allow Employees to Easily Pay Their Share of the Premium Pre-Tax with a Section 125 Plan

Currently the process for small businesses to offer a Section 125 plan is cumbersome and difficult, particularly for those very small employers that tend not to offer health coverage in the first place. It is not enough to offer health coverage through the workplace. Employees must be able to pay their share of the premiums pre-tax. In states like Maine with a high 8.5 percent state income tax, the benefits of Section 125 plan is even greater.

Senator Snowe's proposal to simplify the Section 125 process for small employers is a critical step toward making health premiums more affordable. A Maine family in the 15 percent bracket (up to almost $64,000 in taxable income for a married couple) would save over 31 percent by paying for their health premiums pretax – 7.65 percent in FICA, 15 percent in federal income tax and 8.5 percent in Maine income tax. The employer also saves with their reduced FICA obligation on the employee's contribution.

Support Auto-Enrollment in a Default Health Plan

The Pension Protection Act of 2006 allows companies to more easily auto-enroll employees in 401k retirement plans, provided the employer provides a 100 percent match for the first 1 percent of salary and a fifty percent match for the next 2 percent. According to the Employee Benefit Research Institute, employee participation jumps from 65 percent to 90 percent when employees are automatically enrolled.

Why not allow employers to do the same with a default health plan? According to the Kaiser Family Foundation 2006 Annual Benefit Survey, the average HSA-qualified plan with a $2,000 deductible costs $3,176 a year with an employee paying just $467 or $18 per two-week pay period - about $12-14 after tax. Often young and single employees are the least likely to participate in employer-sponsored coverage. Auto enrollment could encourage increased take-up, spread the health risk across a larger pool of employees and draw in a large number of younger and healthier employees, who are more likely to opt out of employer-sponsored health coverage.

For Very Small Businesses and Sole Proprietors, the Individual Market is Critical to Affordable Coverage

Even with changes to the small group market through Small Group Health Plans, Congress needs to consider allow more competition and options in the individual insurance market. For very small business, entrepreneurs and many freelancers and independent contractors, the individual insurance market is the only place to purchase insurance.

Again, Maine has led the way in how not to regulate. The 2006 President of the National Association of Insurance Commissioners and former Maine Insurance Superintendent Alessandro Iuppa candidly stated in a recent interview that "a cluster of regulations that Maine policymakers put in place in the early 1990s [are driving Maine's high health insurance costs]. These include 'guaranteed issue' which requires insurers to offer coverage to anyone who can afford it, regardless of pre-existing conditions; 'guaranteed renewal' which requires them to renew an individual policy even if the policyholder has been a very high user of services; and 'community rating' which regulates how much an insurer can adjust the cost of a coverage from one group to another. While many states have implemented one or two of these consumer protections, the combination of the three creates an especially burdensome environment in Maine that discourages competition and innovation."[9]

Consider a plan for me and my family as an example. In Augusta, Maine, a $10,000 deductible HSA-compatible plan for my family costs $511 a month through Anthem Blue Cross Blue Shield of Maine, a subsidiary of WellPoint. The same $10,000 deductible plan in Alexandria, Virginia would cost my family $145 a month - $4,400 less a year - through UniCare, also a WellPoint subsidiary. Such high individual insurance costs discourage entrepreneurs from setting out a shingle and starting a new business as it is unaffordable to provide even the most catastrophic coverage for their family. Over 20 percent of all Maine private sector employees work for a small

business with less than 10 employees. Again, only seven states have a larger share of employees working for very small business. These seven states have an average individual insurance market that covers 8 percent of all individuals under age 65, 60 percent bigger than Maine's individual insurance market. Regulations matter. Costly individual insurance regulations force people to drop coverage or struggle to afford even the highest deductible plans. They hurt very small business and entrepreneurs both of which are a state's economic drivers creating the vast majority of new jobs.

Drawing from the Small Business Health Plan legislation or Senator DeMint's Health Care Choice Act (S.1015 in the 109th Congress), Congress should consider allowing national or regional individual insurance carriers and plans.

State legislation is pending in Maine that would allow a small group or individual insurance carrier licensed in any New England state to offer those same plans in Maine. This is a state-based attempt to increase competition and provide more affordable options regionally.

Thank you for holding this hearing and allowing me to testify.

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[1] "2004 Medical Expenditure Panel Survey-Insurance Component." Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Table II.B.2 and II.B.2.a.(1). 2004. Available at: http://www.meps.ahrq.gov/mepsweb/

[2] Figures 1, 2 and 4. "Insurance Premium Cost Sharing and Coverage Take-Up." Kaiser Family Foundation. February 2007. Available at: http://www.kff.org/insurance/snapshot/chcm020707oth.cfm. Premiums based on Kaiser Family Foundation/Health Research and Educational Trust, Employer Health Benefits 2006 Annual Survey. Available at: http://www.kff.org/insurance/7527/, page 18.

[3] Information taken from Business Utility Zone Gateway-BUZGate available at: http://www.buzgate.org/ca/ch_anthem.html#what

[4] "Small Group Health Insurers: Employer Information." Maine Bureau of Insurance. February 7, 2007. Available at: http://www.maine.gov/pfr/insurance/employer/snapshot_small_group.htm

[5] Dicken, John. "Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market in 2004." Government Accountability Office. October 13, 2005. Available at: http://www.gao.gov/new.items/d06155r.pdf

[6] "Companies Licensed to Offer Small Group Health Plans (1-50) in the State of New Hampshire." New Hampshire Insurance Department. September 11, 2006. Available at: http://www.nh.gov/insurance/consumer_services/cons_small_grp.htm

[7] Table II.C.1. MEPS. Employee-Only Premium. 2004.

[8] Bunce, Victoria Craig, JP Wieske and Vlasta Prikazsky. "Health Insurance Mandates in the States: 2006." Council for Affordable Health Insurance. March 2006. Available at: www.cahi.org/cahi_contents/resources/pdf/MandatePub2006.pdf

[9] Haskell, Meg. "The Man behind the Milestones: Maine's insurance superintendent looks back at decade in office." Bangor Daily News. January 20, 2007. Available at: bangordailynews.com

Chairman KERRY. Thank you very much, Mr. Bragdon.

Mr. Kingsdale?

STATEMENT OF JON M. KINGSDALE, EXECUTIVE DIRECTOR, COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY

Mr. KINGSDALE. Good morning, Chairman Kerry, Senator Snowe. Thank you for the attention that you are paying to these important issues. I am Jon Kingsdale, executive director of Commonwealth Connector, and I thought I would describe to you briefly how we are tackling some of the problems you have identified in Massachusetts.

As part of an extensive reform to cover the uninsured in Massachusetts, the Connector contracts with private health plans and enrolls individuals and small employer groups in those plans. In the last 7 months, we have actually added 100,000 people, which is more than 25 percent of the uninsured in Massachusetts, newly to the private plans that the Connector contracts with and to our expanded Mass Health Program and to an insurance partnership program for small employers of low-wage workers.

Massachusetts health reform is based on five principles listed in my testimony. I am going to focus on three of those that I think are particularly pertinent to the issues under discussion here.

First of all, we require universal adult participation in health insurance as of July 1, 2007. Second, we require employers of more than 10 workers to help finance their employee health benefits. Third, we offer the small group and non-group end of the market for health insurance, more choice, and better information.

These building blocks address issues especially relevant to the small end of health insurance market. First, insurance is designed to pool risk. You have heard about that already from other witnesses. Carriers can identify and select relatively health individuals and small groups, leaving the unhealthy unprotected, and frankly, small employers and individuals can try to participate at times and in ways such that their own medical costs are likely to exceed the premiums they pay. So both sides can game this.

To protect against both forms of discrimination, our health plans are required, A) to issue and renew coverage, B) to ensure individuals and small businesses underrate formulas that cross-subsidize between healthier and sicker populations, and most adults will soon be required to have insurance. This protects the sick and it keeps the healthy in the insurance risk pool.

Second, while most large employers, 98 percent nationally, offer health benefits, some 40 percent of small employers do not, and in Massachusetts, small businesses actually represent and employ two-thirds of the working uninsured. Group health benefits are designed not only to pool risk, but, of course, to subsidize coverage and to encourage group insurance, Massachusetts now requires employers with 10 or more employees to make a fair and reasonable contribution toward their workers' health benefits, and we will soon require them to offer a Section 125 pre-tax payroll deduction plan.

Our requirement that adults, healthy or sick, buy a minimum level of insurance and that employers contribute are designed to

encourage employers not only to help subsidize, but to make both the young and healthy as well as the sicker and older populations accept those offers and participate.

Of course, medical care is expensive stuff no matter how you divide it and costs are especially burdensome for small business and low-wage employees. To assist them, our State's Insurance Partnership Program subsidizes premium costs for both small employers of low-wage employees and low-wage workers. I note the similarity to S. 99, the Small Business Health Care Tax Credit Act, sponsored by Chairman Kerry, among others. Moreover, S. 99 offers certainty and outreach associated with using the Federal tax code, which frankly would benefit our own State Insurance Partnership Program.

The third principle we are addressing is about individuals on their own in small employee groups who often lack choice of health plans. Limited choice is itself a cause of dissatisfaction, of course, but equally importantly, it blocks innovative efforts to control costs and add value to address that skyrocketing trend that Chairman Kerry pointed to. To provide more choice, Massachusetts will require health plans to offer to non-group individuals the same options and at the same prices that they offer small businesses, and the Connector will offer to individuals, those who work for small businesses and those who buy on their own, the kind of broad choice of qualified health plans that employees of many large organizations, including Federal employees, currently enjoy.

The following table, if somebody could put it up, illustrates the choice under the Connector. The small employer will make a defined contribution toward a benchmark plan. Then his or her employees would have the option of using that contribution among any of a broad range of comparable options. The Connector will eliminate hidden variations among the plans—how a plan defines durable medical equipment versus another plan's definition, for example—and highlight the important distinctions, for example, differences in premiums, cost sharing, which doctors and hospitals participate. This transparency is intended to stimulate competition among the health plans, much as FEHBP does. We are also working on state-of-the-art shopping tools, such as virtually test driving a health plan before finalizing the election to enroll in it.

The Connector also relieves small business of the burden of pricing, shopping, explaining, and policing a plan each year. Instead of reacting to their plan's annual premium increase, as so many employers do now, by shopping for a new one, they can leave it to the Connector to offer best in value and to their employees to comparison shop among pre-screened options. This promises significant administrative savings to small businesses, which hardly have the manpower, the expertise, or the time to go shopping for complex financial services like employee health benefits.

Thank you for this opportunity to testify and I would be pleased to answer your questions.

[The prepared statement of Mr. Kingsdale and an attachment follow:]

TESTIMONY OF JON M. KINGSDALE, Ph.D.

(Executive Director, Commonwealth Health
Insurance Connector Authority)

before the

SENATE COMMITTEE ON SMALL BUSINESS &
ENTREPRENEURSHIP

(February 13, 2007)

Good morning. I am Jon Kingsdale, Executive Director of the Commonwealth of Massachusetts' Health Insurance Connector Authority.

As part of an extensive reform to cover the uninsured in Massachusetts, the Connector contracts with private health plans and enrolls individuals and small employer groups in those plans. Since July 1, 2006, the Connector has enrolled 45,000 low-income, uninsured individuals, MassHealth (Medicaid) has added 55,000, and our expanded Insurance Partnership program added another 2,000 low-wage employees from small business. We have reduced the number of uninsured in Massachusetts by 102,000 or some 27%.

Massachusetts' health care reform is based on the principle of shared responsibility: that employers, individuals and government each participate financially in expanding coverage. Reform is built on these five pillars:

1. We require universal adult participation in health insurance;

2. We require employers of more than 10 workers to help finance their employee's health insurance;

3. We offer the small-group and non-group end of the market for health insurance more choice and better information;

4. We provide government-subsidized, private insurance for the uninsured who earn 300% or less of the federal poverty level; and

5. We are reducing the cost-shift from Medicaid onto private health insurance premiums.

The first three building blocks address issues especially relevant to the small end of the heath insurance market. First, insurance is designed to pool risk—pooling resources from many to support the few who really need them--but small-group and non-group insurance is susceptible to risk segmentation. Carriers can identify and select relatively healthy individuals and small groups--leaving the unhealthy unprotected--and small employers and individuals can try to participate at times and in ways such that their own medical costs exceed the premiums they pay.

To protect against both forms of discrimination, our health plans are required (a) to issue and renew coverage and (b) to insure individuals and small businesses under rate formulas that cross-subsidize between healthier and sicker populations; and all adults will soon be required to have insurance. This protects the sick and it keeps the healthy in the risk pool.

Second, while most large employers (98% nationally) offer health benefits, over 40% of small employers do not. (In Massachusetts, small business employs two-thirds of working, uninsured adults.) Group health benefits are designed not only to pool risk, but to subsidize coverage. To encourage group insurance, Massachusetts now requires that employers of more than 10 employees make a "fair and reasonable" contribution toward their workers' health benefits, and we will shortly require them to help workers with pre-tax, payroll deduction for the employees' share of premiums.

Our requirement that all adults, healthy or sick, buy a minimum level of insurance is designed to create a credible risk pool. The requirement that employers of more than 10 workers provide group health benefits and pre-tax, payroll deduction is designed to help finance coverage. Combined, these two provisions will encourage most employers to offer group insurance and most of their employees—even the young and healthy—to accept that offer.

Of course, medical care is expensive stuff, no matter how you divide it. Costs are especially burdensome for small business and low-wage employees. To assist them, our state's Insurance Partnership ("IP")

subsidizes premium costs for both the small employer of low-wage employees and his/her low-wage workers. I note the similarity to S. 99, the Small Business Health Care Tax Credit Act sponsored by Senator Kerry among others. Moreover, S. 99 offers the certainty and outreach associated with using the federal tax code, which would benefit our state program.

Third, we are addressing the problem that individuals, on their own and in small employee groups, often lack choice of health plans. Limited choice is, in itself, a cause of dissatisfaction. Moreover, it blocks innovative efforts to control costs and add value. To provide more choice, Massachusetts will require health plans to offer to (non-group) individuals the same options, at the same prices, that they offer small business, and the Connector will offer individuals—those who work for small business and those who buy on their own—the kind of broad choice of qualified health plans that the employees of many large organizations, including federal employees, currently enjoy.

The following table illustrates choice under the Connector. The small employer will make a defined contribution toward a "benchmark plan," and then his/her employees may apply that defined contribution toward any reasonably comparable option. The Connector will try to eliminate "hidden" variations among the plans and highlight important distinctions--for example, differences in premiums, costs to see a doctor, and which doctors and hospitals participate in each health plan.

The Connector's transparency is intended to stimulate competition among health plans, much as the FEHBP does. We are also working on state-of-the-art shopping tools, such as a way to virtually "test-drive" a health plan before finalizing an election to enroll in it.

The Connector also relieves small business of the burden of pricing, shopping, explaining and policing a plan each year. Instead of reacting to their plan's premium increase, as so many employers must do, by shopping for a new one, they leave it to the Connector to offer best in value, and to their employees to comparison shop through the Connector. This promises significant administrative savings to small business, while giving their workers truly informed choice.

Thank you for the opportunity to testify about the implications of health reform for small business in Massachusetts, and I would be pleased to answer your questions.

Small Employer's Options under Commonwealth Choice

hypothetical example

Benefit Level	XYZ Plan	Com Care	AAA Corp	ABCare
Premier	$480	$460	**$440**	$490
Value	**$360**	$370	$370	$390
Basic	$250	$240	**$210**	$230

Chairman KERRY. Thank you very much, Mr. Kingsdale. That is very helpful.

Mr. Sweetnam?

STATEMENT OF WILLIAM F. SWEETNAM, JR., FORMER BENEFITS TAX COUNSEL, OFFICE OF TAX POLICY, U.S. DEPARTMENT OF TREASURY

Mr. SWEETNAM. Chairman Kerry and Senator Snowe, I would like to thank you for this opportunity to testify before the Committee.

As you have stated before, there are problems with the small business market providing health insurance coverage to their employees. The availability of HSAs and high-deductible health plans makes it easier for small employers to provide their employees with affordable health coverage. The purpose of my testimony is to urge Congress not to cut back on any of the tax advantages that are afforded to HSAs and to provide additional changes to the HSA rules which will make HSAs and high-deductible health plans more attractive to employers and employees.

Small businesses are very cost sensitive when it comes to providing health insurance to their employees. As the cost of health insurance goes up, small business owners have few choices. One option is not to offer coverage if the cost of health insurance coverage is too large. Other options would be to increase the costs that employees have to bear to continue to have that health coverage.

That cost increase to employees could come in different ways. One way would be to increase the premium that the employee pays to participate in the employer's health care plan. This, of course, raises the likelihood that the employee will decide that he or she cannot afford health care coverage and not participate in the employer's health insurance plan.

Another method of controlling cost is to increase the amount of deductible under the health insurance plan or to increase the amount of copayments for each service or visit to the doctor. This helps keep the monthly premium down, but increases the cost for the individuals when using health care services under the plan. The fact that small businesses are already raising the deductible under their health plans is an important factor to remember when talking about Health Savings Accounts and high-deductible health plans.

HSAs are really a funded account, similar to an IRA. A contribution to an HSA may be made within specified limits by individuals who are not yet entitled to Medicare or by employers on behalf of such individuals. Contributions to the HSA by an eligible individual are fully deductible by the individual making the contribution, regardless of whether the individual is employed. Amounts in the HSA grow on a tax-free basis, and if used for medical expenses may be withdrawn on a tax-free basis. Amounts may be distributed for non-medical purposes, but such distributions are subject to income tax and be subject to a 10 percent additional tax.

In order to contribute to an HSA, an individual must be covered under a high-deductible health plan and may not participate in any non-high-deductible health plan, subject to certain exceptions. For 2007, a high-deductible health plan is defined as a plan with min-

imum average deductible of $1,100 for self-only coverage or $2,200 for family coverage. There is also an annual out-of-pocket cap for the HDHP. As with other traditional health insurance, premiums that the employer pays for the high-deductible health plan are excludable from the employee's income.

The premium for a high-deductible health plan is usually much less than the insurance premium for typical health insurance. With the lower premiums, employers have savings that they can contribute to an HSA. In 2004, the first year that HSAs were available, there were many examples of small businesses that purchased high-deductible health plans for their employees and with the savings due to the lower premiums made contributions to the HSAs for their employees. I give you two examples.

One, Activities Press of Ohio, a small business with 45 employees, switched to an HSA-HDHP arrangement. They contributed $2,000 to their HSAs for employees with family coverage and $1,000 for employees with individual coverage. Their total cost savings after this switch was $56,500.

Mercury Office Supply had 13 employees. They made contributions to the HSAs for their employees of $2,500 for those with families, $1,200 for those with individuals. They had savings of $12,000 in 2004.

There is really little recent Government data on how many HSAs have been opened. That information would be derived from a compilation of income tax returns and that information is only available years after the return is filed. Since HSAs have only been available since 2004, there has not been enough time for an adequate determination from Government sources of the number of HSAs that have been established. However, industry surveys have shown a growth in enrollment from 438,000 in 2004 to 3.2 million in 2006. In the small business market, enrollment growth is from 79,000 in 2004 to 510,000 in 2006.

The survey also found that in the small group market, 33 percent of the small group policies were purchased by employers that had previously offered no health care coverage for their workforce.

In another study from the United Health Group, it found that despite fears that HSAs would appeal only to the wealthy, HSAs, they found, are utilized by consumers across all income ranges.

Policy makers should not take from the current data that HSAs are not successful and that they should be curtailed. HSAs are a new product. There must be time given for them to be more fully accepted in the marketplace. You know, 401(k) plans were once new and untested, yet no one now believes that in the slow early years of 401(k) adoption we should have had Congressional action to eliminate the 401(k) plan as an alternative savings program. HSAs should have the same chance to mature in the marketplace as 401(k) plans did.

Finally, I just want to mention that Senator Snowe has recently introduced legislation that will make it easier for small businesses to establish a cafeteria plan. The legislation, called the Simple Cafeteria Plan Act, will provide small businesses another way to offer cafeteria plans for their employees by providing that the non-discrimination rules will be met if the employer provides a matching contribution on behalf of lower-paid employees. This will provide

one more way for small businesses to provide tax-effective health care coverage to their employees and Congress should seriously consider its enactment.

I thank you for the opportunity to testify and I am available to answer any questions that you may have.

[The prepared statement of Mr. Sweetnam follows:]

GROOM LAW GROUP

Statement of
William F. Sweetnam, Jr.
Principal, Groom Law Group, Chartered
Before the
Committee on Small Business and Entrepreneurship
United States Senate
Tuesday, February 13, 2007

Chairman Kerry, Senator Snowe and the other members of this Committee, I'd like to thank you for this opportunity to testify before the Committee on Small Business and Entrepreneurship about the problems – and some solutions – to the problem of small businesses and health care. My name is Bill Sweetnam and I'm a principal at the Groom Law Group here in Washington DC, a law firm that practices exclusively employee benefits law. I previously was the Benefits Tax Counsel in the Office of Tax Policy at the Department of the Treasury from 2001 to 2005. I was in charge of the legislative and regulatory issues surrounding employee benefits. One important area that I was involved in was the implementation of the new laws permitting Health Savings Accounts (HSAs). It is for that reason that I have been asked to testify.

As others who will testify here will state, there are problems with small business providing health insurance coverage to their employees. I believe, and statistics will confirm, that the availability of HSAs makes it easier for small employers to provide their employees with affordable health insurance coverage. The purpose of my testimony here is to urge the Congress not to cut back on any of the tax advantages that are afforded to HSAs and to provide additional changes to the HSA rules which will make HSAs more attractive to employers and employees.

Overview of Tax Treatment of Health Insurance

Under current law, if an individual receives health coverage from his employer, the entire amount of that coverage is excluded from income for both income and employment (Social Security/Medicare) tax purposes. An outgrowth of the exclusion for employer-provided health care is the favorable tax treatment of expenses paid from a flexible spending account under a cafeteria plan and the development of health reimbursement arrangements. Self-employed individuals who purchase health insurance are able to deduct the full cost of health insurance for income tax purposes. Those who are employed and purchase their health insurance on their own can only deduct their health care premiums for income tax purposes and only to the extent that they itemize their tax deductions and their health expenses exceed seven and one half percent of adjusted gross income. There is no payroll tax deduction for the purchase of individual health insurance policies; consequently, lower income individuals who purchase insurance on their own may not receive any tax relief on those purchases. Therefore, it is critical to try to get as many individuals covered under employer-provided health coverage as possible.

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Importance of Cost of Health Insurance in Small Business Market

Small businesses are very cost sensitive when it comes to providing health insurance to their employees. As the cost of health insurance goes up, small business owners have few choices. One option is to not offer coverage if the cost of health insurance coverage is too large. Other options would be to increase the costs that employees have to bear to continue to have that health coverage. That cost increase can come in different ways. One way would be to increase the premium that the employee pays to participate in the employer's health care plan. This, of course, raises the likelihood that an employee will decide that he or she cannot afford health care coverage and not participate in the employer's health insurance plan. Another method of controlling costs is to increase the amount of the deductible under the health insurance plan or to increase the amount of co-payments for each service or visit to the doctor. This helps keep the monthly premium down, but increases the costs for the individual when using health care services under the plan.

Health Savings Accounts as an Alternative

HSAs provide another way for small businesses to provide health insurance coverage for their employees in a cost effective manner. A HSA is a funded account, similar to an IRA.

Contributions to the HSA may be made within specified limits by individuals who are not yet entitled to Medicare and/or by employers on behalf of such individuals. For 2007, the contribution limits is $2,850 (self-only) or $5,650 (family) coverage. Contributions to the HSA by an eligible individual are fully deductible by the individual making the contribution, regardless of whether the individual is employed.

Amounts in an HSA grow on a tax-free basis and, if used for medical expenses, may be withdrawn on a tax-free basis. Amounts may be distributed for non-medical purposes, but such distributions are subject to income tax and may be subject to a 10 percent additional tax.

In order to contribute to an HSA, an individual must be covered under a "high deductible health plan" ("HDHP") and may not participate in any other non-high deductible health plan, subject to certain exceptions. For 2007, an HDHP is defined as a plan with a minimum annual deductible of $1,100 for self-only or $2,200 for family coverage. The annual out-of pocket cap for the HDHP must not exceed $5,500 for self-only or $11,000 for family coverage. As with other traditional health insurance, premiums that the employer pays for the HDHP are excludible from the employees' income.

The premium for an HDHP is usually much less than the insurance premium for typical heath insurance. With the lower premium, employers have savings that they can contribute to the HSA. In 2004, the first year that HSAs were available, there were many examples of small businesses that purchased HDHPs for their employees and, with the savings due to the lower premiums, made contributions to the HSAs for their employees. For example, Activities Press of Ohio, a small business with 45 employees, switched to an HSA/HDHP arrangement in 2004. [1]

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[1] HSA Insider, April 30, 2004.

They contributed $2,000 to an HSA for each employee that had family coverage and $1,000 for employees with individual coverage. Their total savings after the switch to the HSA/HDHP was $56,500. Similarly, Mercury Office Supply with 13 employees had savings of $12,000 in 2004 for switching to an HSA/HDHP arrangement and they made contributions to their employees' HSAs of $2,500 for those with family coverage and $1,200 for those with individual coverage.[2] These are just a few of the stories about small businesses using the HSA/HDHP arrangement as a way to provide health care to employees that I heard about while at the Treasury Department.

Current Market for HSAs

Unfortunately there is little recent government data on how many HSAs have been opened. That information would be derived from a compilation of income tax returns and that information is only available years after the return is filed. Since HSAs have only been available since 2004, there has not been enough time for an adequate determination from government sources of the number of HSAs established.[3] However, industry surveys have shown a growth in enrollment in HSAs from 438,000 in September 2004 to 3.2 million in January 2006.[4] In the small group market[5], the 2006 survey showed that the growth in covered lives under HSA/HDHP arrangements increased from 79,000 in 2004 to 510,000 in 2006, and the total coverage moved from 438,000 covered lives in 2004 to 3,168,000 covered lives in 2006. This survey also found that in the small group market, 33 percent of the small-group policies were purchased by employers that previously offered no health care coverage to their workforce.

A recently released study from UnitedHealth Group[6] provides further information. UnitedHealth Group, though its Definity Health business, is the largest provider of consumer-directed health plans in the country. The study found that, despite fears that the HSAs would only appeal to the wealthy, HSA are utilized by consumers across all income ranges. Most notably, 80 percent of low-income individuals (those earning $25,000 or less annually) open HSA accounts if the employer makes a contribution to an HSA. If the employer does not make a contribution to an HSA, however, lower income individuals are less likely to fund their own HSA accounts. In UnitedHealth's survey, those small employers that do contribute to their employees' HSA make on average a contribution of $1,109 annually.

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[2] HSA Insider, April 15, 2004.

[3] The Government Accountability Office (GAO) has issued a report in 2006 on HSAs (GAO Report 06-798) that was based on very limited consumer experience with. The report relied on 2004 data and the authors of the report concede that "[m]uch of the data ... cannot be generalized to all HSA-eligible plans and enrollees or HSA account holders." The GAO's analysis of specific employers' experience with HSAs was based on the experience of three employers.

[4] Center for Policy and Research, America's Health Insurance Plans (AHIP) 2006 Study of HSA enrollment. ("AHIP Study")

[5] The small group market in the AHIP survey was generally defined as employers with 50 or fewer employees.

[6] http://www.unitedhealthgroup.com

Congress Should Let the HSA Market Mature

Policy makers should not take from the current data that HSAs are not successful and that they should be curtailed. The AHIP study shows that approximately one third of the individuals that have an HSA/HDHP arrangement did not previously have health insurance coverage. HSAs are a new product and there must be time given to have them more fully accepted in the market place. 401(k) plans were once new and untested, yet no one now believes that the slow early years of 401(k) adoption should have resulted in Congressional action to eliminate the 401(k) plan as an alternative savings provision. HSAs should have the same chance to mature in the marketplace as 401(k) plans did.

Recent Legislative Changes to HSAs

In an effort to continue to promote HSAs and to make the transition to HSAs easier, Congress enacted the Tax Relief and Health Care Act of 2006 (H.R. 6111) (the "Act"). The Act includes several significant provisions that are generally effective in 2007, except where noted otherwise:

Modifies the limit on contributions to HSAs, so that it is not limited to the annual deductible of the high deductible health plan (HDHP); instead, contributions would be limited only by indexed dollar amount ($2,850 self-only; $5,650 family for 2007).

Under current law, HSA eligible individuals may make HSA contributions up to the lesser of (i) 100% of the annual deductible limit of the eligible individual's high deductible health plan ("HDHP") or (ii) $2,850 for self-only and $5,650 for family coverage for 2007 (indexed for inflation). Under this rule, it is unlikely that an individual who incurs any significant medical expenses could accumulate amounts in the HSA from year to year. Under the new provision, eligible individuals will be able to contribute up to $2,850 (self-only) or $5,650 (family) for 2007, regardless of the annual deductible under the individual's HDHP. Allowing an individual to contribute more than the HDHP deductible to his or her HSA increases the likelihood that some amounts in the HSA will carry over from year to year. This makes it easier for a small business to provide an HSA/HDHP arrangement to its employees.

Requires the Secretary of Treasury to announce the cost-of-living adjustments applicable to HSAs by June 1 of each year. This change is effective for tax years beginning after 2007.

Each year, certain key figures relating to the HDHP limits and the amount that an individual can contribute to an HSA are adjusted for inflation. Under current law, the cost-of-living increase is based upon information from the Bureau of Labor and Statistics (BLS)--specifically, the average consumer price index ("CPI") as of the close of the 12-month period ending on August 31. The IRS announces the new limits in a Revenue Procedure that is generally published in November each year, which is widely viewed as providing an inadequate amount of lead time for insurance companies and other HSA providers who are offering HDHP/HSA products and employers who are distributing open enrollment materials for the following year. The new provision changes the dates for which the CPI is measured for HSA purposes to the 12-month period ending on March 31st of the calendar year, allowing the

calculation to be performed earlier in the year. The new provision also requires the Secretary of Treasury to announce the cost-of-living adjustments applicable to HSAs by June 1 of each year. This will make it easier for employers to communicate the details of the HSA/HDHP arrangement earlier in the year.

Allows individuals who become covered by a HDHP after January to contribute up to the full annual limit, even if they were only eligible individuals for a portion of the taxable year.

Under current law, an individual who enrolls in an HDHP mid-year is subject to the minimum annual deductible under the HDHP, but such individual's maximum HSA contribution limit is reduced on a pro-rata basis for each month that the individual did not have HDHP coverage as of the first day of the month. The new provision corrects this disparity and provides that an individual who becomes an HSA-eligible individual in any month after January may make the full HSA contribution for the year (e.g., $2,850 for self-only coverage for 2007). If, however, an individual who becomes an HSA-eligible individual mid-year is no longer an eligible individual (e.g., is no longer covered by an HDHP) at any time during the 13-month period beginning with the last month of that year, the contribution amounts attributable to the months preceding the month in which the individual became HSA-eligible are includible in income and subject to a 10% additional tax. This makes it easier for an employer to change to an HSA/HDHP arrangement mid-year.

Permits an individual to transfer the balance remaining in his or her FSA or HRA account as of September 21, 2006 (or, if less, the balance on the date of the transfer) to an HSA. The transfer must be made before January 1, 2012.

Under current law, no transfer from a flexible spending arrangement ("FSA") or health reimbursement arrangement ("HRA") to any other type of account, including an HSA, is permitted. Making such a transfer would violate sections 106 and 105 of the Internal Revenue Code that apply to FSAs and HRAs, and would result in adverse tax consequences for the participant and the employer. Effective after the date of enactment, this provision allows a one-time transfer from an FSA or HRA to an HSA and specifies that transferred amounts are excludable from wages for income and employment tax purposes. Such amounts are not deductible as HSA contributions and are not subject to the maximum contribution limit (transferred amounts do not count against the maximum contribution limit). If, at any time during the 13-month period beginning with the month of the transfer, an individual is no longer an eligible individual (e.g., is no longer covered by an HDHP), the transferred amounts are includible in income and subject to a 10% additional tax. Employers allowing any employee to make the one-time transfer must make it available to all eligible individuals covered by an HDHP of the employer. This provision will generally be applicable to larger employers that are more likely to sponsor FSAs and HRAs.

Allows coverage under a health FSA during the "2-1/2 Month Grace Period" to be disregarded for eligible individuals who have a zero balance in their HSA at the end of the previous calendar year.

Under current law, an individual covered under an FSA is generally precluded from contributing to an HSA. Pursuant to Notice 2005-42, FSA plan sponsors may allow FSA participants to continue to incur qualifying medical expenses up to March 15th following the close of the plan year (the "2-1/2 month grace period"). According to Notice 2005-86, an individual participating in an FSA that incorporates the 2-1/2 month grace period generally may not contribute to an HSA until the first month following the end of the 2-1/2 month grace period, even if the participant's account balance is "zero." Under the new provision, a participant in an FSA that incorporates the 2-1/2 month grace period may nonetheless contribute to an HSA during the grace period if his or her account balance is "zero" as of the end of the previous plan year. Alternatively, if the FSA participant maintains amounts in his or her account balance at the end of the plan year, the participant may make a one-time transfer of the balance to an HSA (in accordance with rules prescribed by Treasury and the rules discussed above). This provision is effective on date of enactment. Again, this provision will generally be applicable to larger employers that are more likely to maintain FSAs and HRAs for their employees.

Allows employers to make contributions to HSAs on behalf of non-highly compensated employees in higher amounts (or higher percentages of deductibles) than to highly compensated employees without violating the comparable contribution rules.

If employers make contributions to the HSAs of employees, those contributions must generally be either the same amount or the same percentage of the HDHP's deductible for the year. This is known as the comparable contribution rules. These rules do not apply to employer contributions that are made through a cafeteria plan.

The comparable contribution rules generally preclude an employer from making contributions to HSAs on behalf of non-highly compensated employees ("NHCEs") in higher amounts (or higher percentages of deductibles) than to highly compensated employees ("HCEs"). Under the new provision, employers are permitted to make greater HSA contributions on behalf of NHCEs, but must satisfy the comparability rules with respect to contributions to NHCEs.[7]

Allows individuals to make a one-time distribution to rollover amounts from an IRA to an HSA, subject to the HSA contribution limit.

Under current law, no amount may be rolled over from an individual retirement account ("IRA") to an HSA. The new provision allows a one-time rollover from an IRA into an HSA. Such amounts are not includible in income, nor subject to the 10% additional tax applicable to early withdrawals from an IRA. The transfer amount is not deductible and counts against the maximum HSA contribution limit for the year (e.g., $2,850 for self-only and $5,650 for family coverage for 2007). An individual with self-only coverage who transfers amounts from his or her IRA to an HSA may subsequently make an additional transfer if the individual switches to family coverage. The maximum amount of the additional transfer is equal to the difference between the amount transferred while the individual had self-only coverage and the maximum

[7] For these purposes, HCEs are defined under Internal Revenue Code section 414(q). In general, individuals who earn less than $100,000 (for 2007) are considered NHCEs.

deductible limit for family coverage for the year. Similar to the one-time rollover from an FSA or HRA, if, at any time during the 13-month period beginning with the month of the transfer, an individual is no longer an eligible individual, the transferred amounts are includible in income and subject to a 10% additional tax.

Legislative Proposals regarding HSAs

While the provisions regarding HSAs that were part of the Act will be very helpful in further developing the market for HSAs, the Bush Administration did propose other HSA – related legislative changes as part of its fiscal year 2008 budget proposal.

The Administration proposed the following changes:

Expand Qualifying High Deductible Health Plans. To make a contribution to an HSA, the individual must have a qualifying HDHP, which has a deductible of at least $1,100 for self-only coverage and $2,200 for family coverage in 2007 and a maximum out-of-pocket of no more than $5,500 for self-only coverage and $11,000 for family coverage. The proposal would allow plans with 50 percent or more coinsurance and a minimum out-of-pocket exposure to be considered a qualifying high deductible health plan if, under rules established by the IRS and Treasury Department, the resulting policy had the same (or lower) premiums than an already qualifying HDHP would.

Qualifying Medical Expenses. Under current law, qualifying medical expenses can only be paid out of the HSA tax-free if they were expenses incurred after the HSA was established. Under the Administration's proposal, medical expenses that were incurred on or after the first day the individual was eligible to contribute to an HSA (i.e., after the HDHP coverage was obtained) may be reimbursed tax-free as long as the HSA is established before the filing date of the individual's tax return for the year.

Larger Employer Contributions for the Chronically Ill. The comparable contribution rules generally preclude an employer from making contributions to HSAs on behalf of NHCEs in higher amounts (or higher percentages of deductibles) than to HCEs. Under the recently passed Tax Relief and Health Care Act of 2006, employers are permitted to make greater HSA contributions on behalf of NHCEs, but they must satisfy the comparability rules under which each NHCE must get the same dollar amount of contribution from the employer. The Administration's proposal allows contributions to an HSA on account of employees who are chronically ill or who have spouses or dependents who are chronically ill to be excluded from the comparable contribution rules to the extent that these contributions exceed the comparable contributions to other employees.

Deductibles in Family Policies. Under the current law, the HDHP deductible must be reached by the entire family, rather than on a per-family member basis. Plans that have an embedded deductible (where a lesser deductible applies to each family member) are not considered an HDHP for HSA purposes. The Administration's proposal would allow these embedded deductibles as long as the deductible is at least the minimum deductible for individual coverage and the overall family deductible is at least equal to the family HDHP minimum deductible.

Catch-Up Contributions. Individuals who are over age 55 are permitted to make an additional contribution to their HSA annually ($800 in 2007). The Administration's proposal would permit both spouses who are eligible individuals to make catch-up contributions to an HSA owned by just one spouse.

HSA Contributions of Individuals Covered by HRA or FSA. Generally, if an individual is covered by an FSA under a cafeteria plan or under a HRA, that individual is not eligible to make a contribution to an HSA. The Administration's proposal would allow such an individual to make a contribution to an HSA while still covered by the FSA or HRA; however, the allowable HSA contribution would be reduced by the FSA or HRA coverage amount. This should make it easier for an individual to transfer to HDHP/HSA coverage when he or she was previously participating in a FSA or HRA.

Use of Cafeteria Plans in Small Businesses.

As mentioned at the beginning of my testimony, cafeteria plans provide another tax-favored way to pay for health insurance coverage. With a cafeteria plan, an employee can elect to have a portion of his compensation used to pay for qualified medical expenses on a pre-tax basis. Some employers allow their employees to use cafeteria plan elections to pay for their health insurance premiums on a pre-tax basis. Other employers allow employees to establish FSAs where the salary reduction contributions are later used to pay for medical expenses, such as co-pay amounts and other medical expenses that are not covered under the employers' health plan. Because of the nondiscrimination rules regarding the use of cafeteria plans and FSAs, many small businesses are unable to offer them for their employees.

Senator Snowe has recently introduced legislation to make it easier for small businesses to establish a cafeteria plan. The legislation, The SIMPLE Cafeteria Plan Act of 2007, will provide small businesses another way to offer cafeteria plans to their employees by providing that the nondiscrimination rules will be met if the employer provides a matching contribution on behalf of lower paid employees. This will provide one more way for small businesses to provide more tax effective health care coverage to their employees and the Congress should seriously consider its enactment.

* * * *

I thank you for this opportunity to testify before this Committee and I am available to answer any questions that you might have.

Chairman KERRY. Thank you, sir. I appreciate it.
Ms. Sullivan?

STATEMENT OF ANN SULLIVAN, FEDERAL LEGISLATIVE CONSULTANT, WOMEN IMPACTING PUBLIC POLICY

Ms. SULLIVAN. Good morning, Chair Kerry, Senator Snowe. I am Ann Sullivan. I represent Women Impacting Public Policy in Washington. WIPP is a bipartisan public policy organization representing over half-a-million women and minorities in business nationwide, including 47 organizations as well as individual members. Thank you for holding this hearing. I am appreciative of the efforts that you have had in the past with regard to solving our health care issue and look forward to working with you this Congress.

Every year, WIPP conducts an annual issues survey to its members. We are still in the stage of getting preliminary results, but we see a significant shift among our members on the health care issues. In past polls, our members have identified national trends before the rest of us do, so I would like to share these results with the Committee.

There are two significant policy changes that we found in the health care questions in the survey this year. One, our members have shifted their thinking with respect to employer-sponsored health care. When we asked the question, "Do you believe that businesses, either large or small, should be the main provider of health care coverage for their employees", a majority said "no". Our members do not believe health insurance should be the sole responsibility of employers. They believe the conversation around health care needs to shift to individuals, as well.

When asked a question, a "proposal pending in Congress would allow uninsured individuals to shop for health insurance across State lines, do you believe this proposal would result in providing more individuals with health care coverage," 64 percent said "yes". This, I believe, is affirmation that changes have to occur to make the individual market strong enough to sustain the shift to individual coverage.

The second policy shift reflected in our survey was a willingness by WIPP members to consider a number of different health care proposals being discussed in the Congress. When a question described a proposal by Senators Lincoln and Durbin clearly stating that small businesses could opt into the pool and that the insurance would be provided by private insurers rather than a Government program, preliminary results overwhelmingly supported that proposal—84 percent.

When our members were asked whether States should require everyone to carry health insurance either by their employer or by themselves with State programs to assist those who fall below a set income level, 42 percent said yes and 39 percent said no. Small businesses who have operations in multiple States, even if it is one employee, find navigating multiple State requirements very difficult.

This policy shift from employer provided to individual introduces a different way of thinking about health care and how to obtain it. President Bush, in his State of the Union Speech, proposed a shift

from employer-sponsored health care to individual health care by proposing that the tax deduction be made available to individuals as well as employers. We note that States like California and Massachusetts, who are grappling with how to insure their residents, are proposing the responsibility of obtaining insurance lie with the individual.

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

The only solution for small businesses and their employees, as we see it, is to strengthen those two markets. One is achieved by encouraging individuals to purchase insurance, the other panelists have talked about how it increases the size and strength of the pool. The second is to strengthen the small business market by increasing the bargaining power of a small business. That involves establishing large pools that can negotiate better prices with the insurers, and the reason behind WIPP's support in the past of the creation of association health plans or SBHPs for many years.

Another proposal providing additional tax incentives to employers to offset the exorbitant price of premiums would be helpful to small businesses. I understand Senators Snowe, Bond, and Bingaman just introduced a bill to establish a simple cafeteria plan for small businesses and we welcome those changes to current law.

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

We are not as presumptuous to suggest that we have the solution, but we live with the problem every day. We believe it is a reasonable request from our membership that Congress take action to ensure that small businesses can offer health care to employees at reasonable rates or make it possible for employees to obtain individual insurance at rates they can afford. When large employers and small employers are saying the system is broken, when 46.6 million Americans are without health insurance, it is time for the Federal Government to adopt changes which will make the small business and the individual market work.

Thank you.

[The prepared statement of Ms. Sullivan follows:]

Statement of Ms. Ann Sullivan

On Behalf of
Women Impacting Public Policy

Submitted to
Senate Small Business and Entrepreneurship Committee

"Alternatives for Easing the Small Business Healthcare Burden"

February 13, 2007

Good morning Chair Kerry, Senator Snowe and Members of the Committee. I am Ann Sullivan. I represent Women Impacting Public Policy (WIPP) in Washington, D.C. WIPP is a bipartisan public policy organization representing well over a half million women and minorities in business nationwide, including 47 organizations as well as individual members.

Today's hearing touches on our members' number one issue – affordable and accessible healthcare. Before I go any further, let me thank the Committee for its efforts in past Congresses to find a solution to the rising cost of health care and for holding this hearing. This Committee is in a position to keep reminding the full Senate that action on this vital issue is essential to the continued economic growth of small business.

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

Every year, WIPP conducts an annual Issues Survey to its members. WIPP members are asked to rank policy issues and give input on policy issues. We formulate our policy based on the response from our members. We are still in the stage of getting preliminary results, but we see a significant shift among our members on the healthcare issue. In past polls, our members have identified national trends before the rest of us do, so I would like to share with the Committee preliminary results of WIPP's 2007 survey.

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

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

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

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

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

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

The only solution for small businesses and their employees, as we see it, is to strengthen these two markets. One is achieved by encouraging individuals to purchase insurance—thus increasing the size and strength of the pool. The second is to strengthen the small business market by increasing the bargaining power of a small business. That involves establishing large pools that can negotiate better prices with the insurers and the reason behind WIPP's support of the creation of Small Business Health Plans (also referred to as Association Health Plans) for many years. Another proposal, providing additional tax incentives to employers to offset the exorbitant price of premiums, would also be helpful to small businesses.

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

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

When large employers and small employers are saying the system is broken, when 46.6 million Americans are without health insurance, it is time for the federal

government to adopt changes which can make the small business and the individual market work.

Chairman KERRY. Thank you. Thank you very much, Ms. Sullivan.

I am trying to figure out where to begin because it is a big menu out there. Let me ask you, Mr. Sweetnam, if Senator Snowe and I said to you, look, we want to reach beyond just small business, you can write a health care policy for the entire country, would you just be content with HSAs?

Mr. SWEETNAM. I think the HSAs provide one way of getting people appropriate health insurance. I think that what we are seeing is that companies are moving to higher and higher deductibles. The problem right now with the way that our tax policy works with regard to the health insurance is that if I receive my health insurance through my employer, anything that goes through my employer is tax excluded, so I don't pay any tax on that at all. If I pay for it by myself, I don't get a deduction. I get an itemized deduction, but it is only if you are above 7.5 percent of adjusted gross income. That very rarely happens. So really, unfortunately, as the deductible goes up, you are pushing more and more costs onto the employee and the employee doesn't get the tax benefit of being able to do that.

Using an HSA, I can use that HSA and get the tax deduction when I use it for the——

Chairman KERRY. I completely understand the benefit of the tax deduction to the person who gets it. I obviously understand that. My question to you is, if you were tasked with the effort to write a plan that is going to cover everybody, would you just have a plan that had HSAs?

Mr. SWEETNAM. No. I would continue——

Chairman KERRY. What else would you do?

Mr. SWEETNAM. I would continue to give the employer the opportunity to offer all different types of health plans, depending on what their particular marketplace——

Chairman KERRY. So you would give them the opportunity——

Mr. SWEETNAM. Right.

Chairman KERRY. Would you mandate that opportunity? We want to get everybody covered.

Mr. SWEETNAM. I guess my personal background is not to mandate but to give incentives to have people—have employers get into coverage.

Chairman KERRY. Notwithstanding the fact that experience has shown that it won't necessarily cover people, because people don't always take advantage of incentives, do they?

Mr. SWEETNAM. Well, people don't always take advantage of incentives, but I think that the other side would be to require employers to provide coverage and then what you are really——

Chairman KERRY. That is what happened in Massachusetts with the support of the business community.

Mr. SWEETNAM. I understand. The issue that I think people are trying to wrestle with there is what are the costs that are then going to come out of requiring your employers to do things.

One of the other issues that you have to worry about is under ERISA, the Employee Retirement Income Security Act, there are restrictions on State mandates on various types of employee benefit plans so that you are going to see challenges under the Massachusetts law as you have seen challenges under other State law mandates. If Congress wanted to allow State law mandates, they would have to go in and they would have to change ERISA.

Chairman KERRY. Well, I mean, you have got to change what you have got to change here. There are going to have to be a lot of changes in order to effect this. But if deductibles, if the higher deductibles are increasingly what is happening, and that is what is happening, I think we are shifting from defined benefit to defined contribution and they are going out and getting higher deductibles because it is all they can afford because the premiums are such that it is the only way to bring the premium down. So they take their whack and they hope they don't get sick. If they get sick, they wind up paying a heck of a lot more.

The question is, how do you counter that trend without expanding the pool, and that comes back to what all of you have said. A broader pool with more participation means a lower cost, correct? If you leave it completely to the marketplace, you have no effective leverage over the size of that pool.

Mr. SWEETNAM. Well, there——

Chairman KERRY. Or even its makeup.

Mr. SWEETNAM. I mean, there have been a number of proposals that—and I believe, Senator Snowe, you worked with regard to AHPs, Association Health Plans, that have sort of looked to expand the pool of those being insured. One of the things that occur when you are expanding the pool in AHPs is what you are overriding State insurance mandates, which has been one of the reasons why people have been against expanding under AHPs.

So I guess one of the tough decisions that we have to make is whether we want a plan that is developed in Washington that sort of says, OK, we are going to set what the rules of the game are across all the various States, and that is pretty much what we have with employer-sponsored plans under ERISA, or do we want to let the States come in and do individual mandates that they want in the States.

I think the——

Chairman KERRY. Well, they are doing that now. That is what the States have now.

Mr. SWEETNAM. And I think that is one of the problems that you are seeing with high insurance costs in the individual marketplace. So if——

Chairman KERRY. Well, but there is a balance here. There is a public policy balance, and this is tricky. Senator Snowe and I worked very hard last year to see if we could get together on that and we certainly tried to bring in some colleagues outside of this Committee who are important to the health care debate. That issue of the mandate and standard quality that you are going to provide is really a key issue.

We all agree that we want to expand the pool. I mean, that is just common sense. Bigger pool, more people participating, risks

spread more intelligently, hopefully lower cost, and usually lower cost. So that makes sense.

The problem obviously comes in, and you are mentioning it, when you are trying to expand that pool across jurisdictions that have different requirements of what they think is quality care. In some States, people think that one screening for cancer or a mammary gland scan per year or one pap scan, one whatever is a fair standard of quality of care and then absent that, there is a history of people being ripped off, of plans that don't give you much and try to cherry pick and keep the healthy and get rid of the sick and push the sick onto the Government and we will charge good premiums to people who aren't going to wind up using our service, which is a really nice business, but it is not insurance.

Insurance is supposed to be that when you buy your home, you insure against fire, flood, theft, whatever. There is an actuarial table that figures out how often in that particular area that happens and the risk is spread. We don't do that in health care. It isn't insurance. It is called insurance, but it is not insurance.

So how do you sort of skin this cat of trying to maintain a high standard of care and still expand the pool—and I would like to get more people into this discussion—so that you are not lowering the quality of care? The unfortunate history of the marketplace is, and I am not saying everybody behaves this way, but there is a long history of people trying to get us to legislate their monopolies, a long history of people trying to scheme the market in a way that they are minimizing their costs and maximizing their profit. We all understand that is the nature of the beast. And so we eventually had the development of consumer standards, consumer protection at FDA, FTA, different kinds of things, because you wanted to prevent that kind of practice.

The same thing is true in health care. We have had fraud within Medicare, fraud within Medicaid. I mean, all these kinds of things happen because people try to walk away with profits unduly. So how do you balance that in terms of these pools, where you can expand the pool, maintain a high quality of care, not have the cherry picking, and not allow for a kind of dumbing down, if you will, of what is provided to people as a consumer choice?

Ms. Senkewicz?

Ms. SENKEWICZ. Thank you, Senator Kerry. Yes. I think that is a really important issue, but it raises a question that I think we need to address, and one is a serious dialogue between the Federal Government and States, which I don't really think has thoroughly occurred, because obviously we do have issues here with various State laws on mandates, on rating rules, a whole variety of things with respect to insurance.

But what we do need are larger pools. So in order to expand pools and maintain that quality of care, though, if we enter into a dialogue with the States to retain the partnership, because believe me, the Federal Government doesn't want to go taking over the regulation of insurance. The States do a lot of things very well in that regard. I believe the Senators need to sit down with the National Governors Association, the National Conference of State Legislatures, the NAIC, and begin to try to coalesce around standards that are acceptable nationally, but then a national standard could

be set that the States could then administer. And the same thing will work with regional pooling across State lines, as well.

Chairman KERRY. When you said national standards would be set, what happens when one State has a very high level of care and the national standard doesn't achieve it? Are they going to feel you are requiring something less than what we think our citizens ought to get?

Ms. SENKEWICZ. Yes. Clearly, compromise is involved here, and that is why I am saying a long dialogue and a fruitful dialogue and hopefully compromises can be reached. But clearly, you are not going to be able to satisfy—I mean, hopefully, you can reach the point where everyone is satisfied, but clearly, there will have to be compromises if we are going to be able to create larger pools across State lines, because that is an issue.

I worked in Wyoming. Wyoming has less than 500,000 people. I understand Senator Snowe's concern about competition, but on the other hand, there are only less than 300,000 or 200,000 people in Wyoming to be insured not through Medicaid or Medicare. There are only so many people among whom to spread that risk. That is why you need to cross State lines to create larger pools so that you can have more competition, because in States like that, it is not viable for many insurers to pick up 10 percent of the market and be able to compete.

Chairman KERRY. How do you feel about—I mean, I would like each of the others here to comment on the tax approach, as in how far do you see the tax approach being able to have an impact.

Ms. SENKEWICZ. I think that the tax approach in its variety of forms can nibble around the margins, nibble around the edges. For example, as you mentioned in your opening statement, Senator, President Bush's deduction proposal, sure, that would help me personally. I am not getting anything now being on my own, self-employed, but I think that, No. 1, it is not equal. No matter what, I could go out and shop for some really cheap high-deductible plan and still get the same deduction as somebody who has a more comprehensive plan. And secondly, as we have all mentioned, the way the individual market works today, we have got to be careful about pushing people into the individual market where they may not be able to get insurance. But tax credits, that is another thing that can help, obviously can help people.

The whole high-deductible issue and the tax incentives there, I think you hit it right on the head. That is a niche market. If I am a low-wage worker, which three-quarters, apparently, of the unemployed [sic] are connected to or are low-wage workers, a $10,000 deductible plan is not going to help me. If I still have to pay out of my pocket up to whatever hundreds of dollars a month and then still have to run through $3,000 or $4,000 or $10,000 to get coverage, I am not going to invest in that.

Chairman KERRY. One last question before I turn it over to Senator Snowe. Mr. Kingsdale, how does the Massachusetts experience address both of these issues, the tax piece that Mr. Sweetnam was talking about and this pool piece?

Mr. KINGSDALE. Well, to take the tax piece first, we are working hard in a, frankly, somewhat cumbersome manner to expand tax deductibility for employees by creating a pool, in effect, for cafe-

teria Section 125 plans and by mandating that employers with more than 10 employees offer, even if they don't pay for insurance for their employees, they offer this payroll deduction.

Frankly, it would be very helpful in dealing with the issue of affordability to have a clear, simple way for everyone, even individuals, to take advantage of the tax incentives available to employees typically to purchase insurance.

I would note that the question in my mind is why don't all employers offer a Section 125 plan? There is literally a 48 percent tax subsidy available to a dollar in premium contribution by the employee or the employer versus putting that dollar into wages. So I would like to see that made available to individuals and to smaller employers, as well.

On pooling, that is an important issue. This market, and I was 25 years on the insurance side of it, doesn't work very well at the small end. You don't have to have—when I say big end, you don't have to—a couple hundred thousand is a huge pool. That is perfectly fine, frankly, for spreading risk. But it doesn't work very well for 10, 20 employees or for an individual because of all the selection dynamics.

So you do need a set of regulations, and clearly, we need to either do it at the Federal level or at the State level. To refer back to your reference to Senator Kennedy, there must be 10 or 12 different ways to do this. We seem to have a pretty good consensus at the national level that we ought to have insurance. We have lots of different ideas at the State and local idea about how.

And so, since regulation is currently vested at the State level, since we have a lot of regional differences, I think that it makes a lot of sense to look at Federal encouragement but State pooling arrangements. Otherwise, there are a whole bunch of other issues that the Federal Government is going to have to take on if you want to structure effective pools across State lines, in terms of shaping participation and regulating the sale and purchase of insurance that you are just going to have to take on as part and parcel of cross-State regulation. And that may be the decision you want to take, but I think there are some good reasons to encourage Statewide and within-State efforts to do that.

Chairman KERRY. Thank you.

Senator Snowe?

Senator SNOWE. Thank you, and thank you all for great testimony.

Ms. Senkewicz and Mr. Bragdon, maybe you could just talk for a minute about minimum benefits. One key challenge, when we considered small business health plan legislation on the floor last spring was the minimum benefits package, and I know, Ms. Senkewicz, you were speaking to a national standard. Would you support a regional approach?

Ms. SENKEWICZ. Yes. I think anything that promotes better pooling with addressing the adverse selection issues is a reasonable way to go, and it could be regional or it could be national.

Senator SNOWE. We, and Mr. Bragdon, you were illustrating that point with New England and talking about the 55 benefits that were available in one or more States. Would you support a regional approach in that sense? You mentioned the Medicare Part D as

sort of a template for that, and that is an interesting thought in terms of crafting regions across the country. How would you design a benefits package for a regional approach?

Mr. BRAGDON. I think there are two things you can look at. You can look at the minimum provider and mandated benefits. But separate from that and where, in particularly, in Maine we have lots of challenges are the mandates regarding rate regulation and how much variation you can have in premiums depending on the age or gender of the workforce. So I think we need to separate these issues in the policy discussions. I think for provider and benefit mandates, it makes a lot of sense to have a regional approach. What I think you will need to separately look at, though, is how can you adequately provide flexibility so that premiums can be attractive, so if you have a business with lots of young employees, it is attractive for them to buy into the market and share risk with a small business that might have a lot of near-retiree employees.

Senator SNOWE. It is sort of interesting because the regional approach that Senator Kerry and I had designed required that minimum benefits package would include the majority of benefits that are offered within a majority of States in that particular region, which is one way of sorting through it. I had the amendment on a 26-State threshold, for example, that I would have offered to Senator Enzi's legislation on the floor, but we never got to that point. We couldn't get beyond cloture. But nevertheless, that was another idea to establish a minimum benefits package. I notice that you said there are 16 benefits in the New England region that essentially are in the majority of States, is that correct?

Mr. BRAGDON. Correct.

Senator SNOWE. So a minimum benefit floor would obviously minimize the discussion and the debate because it became controversial about preempting all benefits, so trying to establish that benefit either on a national basis or on a regional basis. Yes?

Ms. SENKEWICZ. Very briefly, Senator, one other way to approach it, aside from counting up States, is to benchmark it to an existing package, for example, the FEHBP or some other existing package that has a good solid benefit structure.

Senator SNOWE. No, that is a good point. I think we were within the realm, but that is an interesting measurement in making it competitive and attractive.

Did you want to say something to that point?

Mr. BRAGDON. I just think it is so important in this whole conversation about a minimum package or minimum benefits to recognize that people place very, very different value propositions on health insurance depending on where they are in life, and a lot of people who tend to be uninsured are young people who are not going to spend a lot of money for a package that they have a very low chance of using, regardless of what the deductible is.

There is a great example of this with Southern Maine Community College requires health insurance now for the first time for students taking more than 12 credit hours. They had a significant increase in the number of students enrolled at the campus, but a decrease in the number of credit hours. Students didn't want to pay the $250 a year for the health plan, so they took fewer classes.

Senator SNOWE. Was it offered by Southern Maine Community College?

Mr. BRAGDON. Through the community college.

Senator SNOWE. Through the community college.

Chairman KERRY. Could I just interrupt for one second? But at the same time, that is where this issue of mandate comes in. Don't we have a responsibility to say, look, they pay into Social Security, too, but they have absolutely zero chance of using that until they are 65. So why shouldn't this be the same way? If you are going to spread risk, you spread risk appropriately and you may or may not use it when you are young. If you have a car accident or you fall off a building or something, you are going to use it, and you can't predict that. So why shouldn't we mandate it? That was the decision we made.

Mr. KINGSDALE. I am certainly not going to speak against mandating. I do think that it is important to distinguish two elements, though, Senator. One is asking everybody to participate in the program—that is what Massachusetts is doing—and deciding what it is they have to buy. So the question of participation in the pool is one, but what do they have to buy——

Chairman KERRY. But Senator Snowe was talking about a minimum package——

Mr. KINGSDALE. Right, and so I think it is important, thinking about the 25-year-old or the 22-year-old you just cited, and Massachusetts actually requires students to participate, but in a very, very slimmed down insurance package. It is important to think—underline the word "minimum."

Chairman KERRY. Thank you.

Senator SNOWE. I think the design of the 26-benefit mandate was tied to the Federal employees' three largest plans and how they were offered, but anyway, that is one of the obstacles.

The second obstacle is the at risk and the multi-State pooling and community rating and whether or not to create—what kind of standard do you create. Now, Maine has a modified community rating, as Mr. Bragdon knows. Other States have rate bands so it allows greater variations in the premiums. Does anybody want to tackle that question, because that is one of the other challenges in crafting legislation as to whether or not you go less or more in terms of how are you going to rate these products.

Mr. BRAGDON. I think it makes sense to probably have some sort of limitations on variation according to health status because you don't want to significantly punish people just because they happen to, in many cases, have bad genes, if you will, and have certain health conditions. So it makes sense to limit variation based on health status to some reasonable range. I think the NAIC standard is plus or minus 25 percent.

I think other than that, though, you need to recognize that that kind of premium variation reflects in many cases the value that the people buying the product will place on it. If it costs me as much to buy life insurance at 31 years old as it would at 61 years old, I wouldn't have it right now. Yet for some reason, when we get into the health insurance world, people so often assume that individuals aren't going to make those same economic trade-offs.

Senator SNOWE. Mr. Sweetnam, on HSAs, do you think there are any other changes that we should make to the HSAs to improve them? We made some technical corrections in the last Congress, but should we go further in any way to make them attractive? I like the idea of this whole auto-enrollment on health care, by the way. I think that is an interesting concept, comparatively speaking with the 401(k)s that we enacted, as well, to have people automatically enrolled. I think that that is really a good idea, frankly.

Mr. SWEETNAM. The legislation that you had recently passed at the end of last year went very far and did some really very good things in order to make it easier for companies to offer HSAs and to give them an ability to sort of move from a traditional model into an HSA model.

There are a few things that the President has proposed in his budget which would be helpful, such as saying that if you could give a higher contribution on behalf of someone that is chronically ill, then you can under the current laws, or ways that you can design a high-deductible plan that is not like our high-deductible is under current law. The high-deductible now is you get no coverage up until you reach a dollar amount and then you get coverage after that. It says, the type of qualifying plan could be—let us say that you pay 50 percent, the insurance pays 50 percent of the benefits up until a particular point. As long as the premium is about the same, people should get the same ability to go into an HSA.

I mean, those are little, incremental steps. I think that right now, I mean, we had such a sea change when we moved in 2004 and 2005 with HSAs and I think right now, let us try to see how they develop. We did an awful lot of regulation when I was at Treasury and trying to set these things up and give a lot of guidance. I think just little things, I don't think major wholesale changes, need to be made.

And just sort of as another point, you do make a very good point about automatic enrollment in plans. It is something that can be done under the Internal Revenue Code, and in fact, there were a number of rulings that we had given in the Internal Revenue Code allowing this sort of automatic enrollment.

One of the things that you have got to wrestle with is what happens if somebody doesn't remember that he decided that he didn't want to enroll, and so you have to map out the way that people can get out of those automatic enrollment, and that is, I think, a place where legislation could be helpful, much like last year's legislation, the automatic enrollment in 401(k) plans. As a retirement policy person, that was the best thing that you guys did in that bill and that is the sort of thing that I think really helps savings. If you did something like that in health care, and you gave people the way that they can back out—I think that would really help a lot, too.

Senator SNOWE. Thank you. Thank you very much, Mr. Chairman.

Chairman KERRY. Thank you, Senator Snowe.

Senator Thune?

Senator THUNE. Thank you, Mr. Chairman and Senator Snowe, one, for holding this hearing. I think it is a really important issue and I want to thank our panelists for sharing their insights and

experiences with us regarding solutions that would help quell the rising cost of health care for small businesses.

The estimates are that about half of the 45 million uninsured Americans are employees of or are family members of employees who work for small businesses. In 2003, only 43 percent of small businesses with 50 or fewer employees offered health insurance to their employees. In my State of South Dakota, only 34 percent of small firms offered health insurance. In contrast, firms with 50 employees or more offered health insurance to 95 percent of their employees.

So clearly, this is an issue which profoundly impacts small businesses and the No. 1 reason cited by small businesses for not offering health insurance is the high cost. Obviously, coming up with solutions that promote or put in place incentives for small businesses to offer their employees health benefit options is really important, and some of the things that have been discussed earlier today move in that direction.

I was disappointed, as were a lot of others, that we weren't able to bring to closure bipartisan legislation that we have talked about around here for a long time on small business health plans during the last session of Congress. I have supported that since my arrival here as a Member of the House back in 1996, and again, I think it is really important that we figure out a way for small businesses to drive down the administrative costs that they have to deal with when they offer plans and I think that the concept of small business health plans, or as they were once referred to, association health plans, really move us in that direction and so I would have liked to have seen that enacted and I hope we will get some action on it yet in this session of Congress.

Just a couple of questions. I appreciate some of the testimony that has been provided with regard to the Massachusetts plan. I applaud Massachusetts for taking the initiative to provide health care coverage for the uninsured and folks in your State. I guess my question has to do with, and I know it is probably a little early to determine whether or not and how that is working, but States that are taking initiatives to help the uninsured in their States, the one concern I have is, is there cost shifting that it creates between the State and Federal Government? Can you comment on how, if any, the new Massachusetts Health Insurance Connector Authority shifts costs? I guess that would be for Mr. Kingsdale.

Mr. KINGSDALE. Sure. I would be happy to. Thank you, Senator. There are a number of different ways cost shifting can occur and I am not sure I am going to hit exactly the right one that you had in mind. Let me try and you can point me in another direction if I am not addressing your question.

There is behind this reform a principle of shared responsibility, so we have individuals who have to participate, employers who have to participate financially, and significantly subsidized insurance available for low-income workers and others who are uninsured, and that is available through an expansion of the Medicaid program and the development of a new program that the Connector offers. Both of those, as you are well aware, are State and federally financed.

So in that sense, as we expand coverage—and this is expensive stuff, there is no question about it—there are costs to State and Federal Government for both tax subsidies for people and employers who buy it on their own and more direct subsidies through Medicaid and the so-called Commonwealth Care Program that we started, which inure to both the State and the Federal Government.

Senator THUNE. The Federal Government does have caps for total Medicaid spending in the individual States, is that correct?

Mr. KINGSDALE. Yes.

Senator THUNE. In your plan, how do you define the fair and reasonable contribution for employers?

Mr. KINGSDALE. Well, it is under draft regulations right now and it is defined as one of two tests. An employer must pass either one of the following two tests. One is that 25 percent of the employees actually participate in the employer-sponsored plan, and the other one is that the employer contribute a minimum of 33 percent towards individual coverage, 20 percent towards family coverage on behalf of his or her employees. So either test.

Senator THUNE. OK. And that 20 percent and 33 percent of the total cost of——

Mr. KINGSDALE. Health insurance.

Senator THUNE. OK. Let me just, if I might, direct a question to Ms. Senkewicz. You had mentioned in your testimony—cautioned against too much choice for individuals in choosing health care plans, and I think you did mention Medicare Part D as an example of that. I guess the thing that we—the experience at least so far, and this is fairly early on in terms of Medicare Part D, too, is that it does have the potential to drive health care costs down. We have seen the Part D premiums are about 40 percent lower than they had initially been estimated. And so far, knock on wood, there is about an 80 percent satisfaction rate of those participants who enrolled in the Medicare Part D program.

So I guess my question is, could you elaborate on how the competition promotes inefficiency? I mean, we would like to think of it as——

Ms. SENKEWICZ. Sure.

Senator THUNE [continuing]. Competition working to drive costs down and create——

Ms. SENKEWICZ. Actually, I was talking more about inefficiency of consumer output. I mean, anyone who had to deal with a parent in Part D, it was just enormously time consuming to actually try to go through every plan that was available, and I am just not sure that, while everyone is—the satisfaction rate is high, you really never do know, in fact, whether you have the best plan for you in Part D. You just don't. I mean, to a certain extent, it was just, let us hope. So I just think that there is a balance to be made. To have to choose from several tens of plans or a hundred plans, I just don't think is the most efficient use of consumer time in order to get them into the best plan for them. I mean, there is a balance.

Senator THUNE. Right.

Mr. KINGSDALE. If I may add a comment on that, we have actually done market research at the Commonwealth Connector, what kind of choice do people want who are uninsured, and what we

hear is they would like, to illustrate on this chart, different levels of coverage, so what we have labeled premier, which is pretty comprehensive, all the way down to very basic, and four to six plan options at each of those levels.

So I think it is a matter of striking a balance between overwhelming choice and what unfortunately is typical in the small business world today, which is your employer picks your health plan and you have no choice, which as I stated earlier—I think you were out of the room—leads to employee dissatisfaction and leads to a development or a design of plans to the lowest—to the single common denominator, so a narrow network plan or a plan with aggressive pharmacy management programs or other innovations that might appeal to Mary and not to Joe are not available for Mary and Joe to choose between when the employer picks only one.

I think we are trying to strike the right balance. In fact, we have prequalified plans and asked the employee to make some choices rather than make the employer, a three-person shop, go out and shop health insurance, which is a complicated selection every year.

Senator THUNE. Well, I know as a practical—go ahead.

Ms. SENKEWICZ. I am sorry, just one thing. But what he talks about, Senator, is you are talking about common elements, too, which is one thing that is not present in Part D. You are talking about the apples-orange comparison, which I think helps a lot when you are doing apples to apples.

Senator THUNE. As a practical matter, and I will say because my father is 87, my mother will be 86 here in a few months, as we went through the Part D thing, yes, it was numbing in terms of seniors trying to go through, but it does strike me, too, that having lots of choices is a high-class problem to have. But from a practical standpoint, when you are talking about an elderly and a senior population, you obviously want to make it as user-friendly as possible.

Thank you, Mr. Chairman, and I thank the panel.

Chairman KERRY. Thank you, Senator Thune.

Senator Cardin?

Senator CARDIN. First, let me apologize for missing your testimony. My staff was here and I assure you that I am very much interested in the issues involving small business and health care. I can tell you, I hear more about that from my small business community than any other single issue. We need to be more aggressive in how we help companies and their employees deal with the health care dilemmas that we have in this country. So, Chairman, I look forward to reviewing the testimony and I thank our witnesses for being here.

Chairman KERRY. Thank you very much, Senator Cardin.

Let me make clear that my reaction to the HSAs is not that it is a bad idea per se, but that it is sort of free-standing out there, that there is not a lot of other effort. You have got the health plan, the association health plan effort, and the HSAs have been the only really two things on the table for the last years. They really don't address the large uninsured population, the low-income population, or the cost reduction issue, or affordability issues for most people. Would you not agree with that fundamentally?

Mr. SWEETNAM. I think there have been a few other things like tax credits being provided both for individuals and——

Chairman KERRY. Well, I have recommended we put those out there, but we have never had a serious bite at them from any Committee or any budget.

Mr. SWEETNAM. But I would tend to agree with you, Senator, that there hasn't been a concerted effort.

Chairman KERRY. So my desire would be—you know, there are things that—I mean, I like a big menu and the more you can have people choose. That is America, and the marketplace ought to be that way. But what is happening is we are putting our focus and our energy into these narrow areas where the return on investment of that energy is not significant enough to the health care system, which is why the States are now jumping up and saying, we are going to do something. I mean, when California, the sixth largest economy in the world, steps up and says we have got to do this, it ought to ring some bells around here.

The Kaiser Family Foundation did a survey last year of enrollees in the high-deductible plans with HSAs. Are you familiar with that?

Mr. SWEETNAM. Generally.

Chairman KERRY. Sixty-four percent of the people who participated said that they participated to get the lower premium option. Sixty-one percent participated because it would be a savings account for future expenses. Now, would you agree that the savings account incentive is an important incentive?

Mr. SWEETNAM. That is one of the helpful things. I think people have been—they don't like cafeteria plans because when they put their money into a cafeteria plan, they lose it at the end of the year.

Chairman KERRY. This way, you have a pot of money at the end that you can use. Now, that said, let me ask you this. The tax code itself, we have created other savings incentives in the tax code. Wouldn't it be more efficient to provide tax relief that helps with the cost of insurance and let the incentives in the tax code for savings take care of themselves for future health care?

Mr. SWEETNAM. Well, really, you are in a way incenting lower cost, because the only way that you can make a contribution into an HSA is if you go into a high-deductible health plan and a high-deductible health plan has lower insurance premiums than the traditional insurance. So yes, I would say that you are——

Chairman KERRY. Fair enough, but that is really a cost shift. It is not a cost deduction, in fairness. It is a cost shift to the consumer. It hasn't done anything to reduce the fundamental cost or the rise in the premiums for the benefit you might get somewhere else. I don't accept that. It is not a cost reduction. It is a cost shift. It is a shift from the insurer or the business, where the cost of doing that business was, No. 1, deductible, and No. 2, transferred to the product, the cost of goods, to purely shifting it to the individual consumer who just picks it up willy-nilly. I don't think it is an efficient system at all.

Mr. SWEETNAM. I think that it is driving individuals to be more efficient consumers. I mean, as a staffer, you always hated when somebody used themselves as an example, but I will do that any-

way. I just did my first HSA this year. I had to put my money where my mouth was. I regulated HSAs for 4 years. I probably should join one. And what I have found, I do take a lot of drugs, prescription medications——

Chairman KERRY. The right kind.

Mr. SWEETNAM. Yes, the right kind.

[Laughter.]

Mr. SWEETNAM. No, once I left Government, I didn't need as many drugs.

[Laughter.]

Mr. SWEETNAM. What I found is that I do get cheaper costs on my drugs because I have been doing generics. And, in fact, my pharmacist makes sure that he recommends the generics to me. So I would say that that is a cost savings and not a cost shifting. So by being a more effective consumer, I think that—and that is what HSAs and high-deductible health plans are intended for you to do—I think that that does bring some cost savings into the system.

Chairman KERRY. But here is the critical point, is you weren't uninsured before you did that.

Mr. SWEETNAM. No, that is for sure.

Chairman KERRY. That is the bottom line.

Mr. SWEETNAM. But as we found, a third of the people that take HSAs were currently uninsured before, so there must be something there for them. If it is just the low premiums on the high-deductible health plan, that is something. That is something.

Chairman KERRY. Well, the Employee Benefit Research Institute did a report which said only 1 percent of the privately-insured population ages 21 to 64 are enrolled in high-deductible plans including an HSA, and it said that they are no more likely to have been uninsured prior to enrolling in their plan than those in the comprehensive plan.

Mr. SWEETNAM. That is true, but look at the data that they are looking at. The data that they are looking at is the first year in which HSAs have been available and so I——

Chairman KERRY. Well, here is the bottom line. The bottom line is that I think you have agreed with me that it would be more valuable for us to put our energy into a broader-based effort to be more inclusive and to reach the uninsured and that HSAs may be part of the mix but they shouldn't be the sort of——

Mr. SWEETNAM. I think that HSAs are a very important thing, but yes, I think——

Chairman KERRY. The problem is, we keep considering them free-standing, not as part of a mix. And if they are part of a mix, I am a happy puppy, but I am concerned that they are not and are sort of out there as, boy, here is our plan for America. We are going to have an HSA. We are going to have association health plans, which just don't do what we need to do to broaden participation, access, and cost reduction. And access and cost reduction are going to come through a more comprehensive approach.

Yes, Mr. Kingsdale?

Mr. KINGSDALE. Just very briefly, and this may sound self-serving and parochial, but why not. You know, in Massachusetts we spent 3 years building a consensus to do health reform and we will spend another 2 years trying to define it and implement it. So it

is a 5-year process. This is 16 percent of GDP. It is a huge effort to refinance it.

There seems to be a consensus in this country that we ought to have broader access to financing health care, but lots of different approaches that necessarily have to take some local conditions into account. To the extent that Congress and the Federal Government were to provide incentives, encouragement, sticks and carrots, if you will, and they clearly did in Massachusetts—there was, as you well know, $385 million a year in Federal dollars on the table to be lost if everybody retreated to their corner rather than come to agreement. If similarly there were significant incentives for other States to act, I believe that, as you have noted, there are a lot of States that want to act. It will take a long time to do it and it has to be somewhat locally tailored. So that kind of Federal-State partnership, I would recommend, coming back to your concern, how do we deal with the whole issue, is a very good model.

Chairman KERRY. Do you think that in looking at the pools—take a State like Maine where the cost of living is less than Massachusetts, it also has a different income scale—that you ought to look at a different kind of pool, for instance, Maine maybe linking to more rural and alternative kinds of pools where you might find an easier marriage to the mandates or to the plans offered, or is that discriminating against them?

Mr. KINGSDALE. I think Mr. Bragdon should answer that, but I want to make two quick points. One is probably there are different circumstances in Maine than Massachusetts that justify a different approach, but more importantly, this is really tough political stuff and the solution has to be bought into by those who know and work in Maine.

Chairman KERRY. Mr. Bragdon?

Mr. BRAGDON. I think that it is OK to link those different regions if you are going to set up a system where you provide people with lots of different options so that they can then pick the option that makes the most sense given their own economic family situations.

I think you are absolutely correct. Maine is a low-income rural State. Hopefully, we won't always be, so maybe in a way, if you link us with other States, providing options, making health care more affordable, it will allow entrepreneurs and small businesses to flourish.

Chairman KERRY. That is why I raised the discrimination issue. So the key would be the menu that you provide, the options that you provide, but again, you would have to have some sort of affordability sliding scale, wouldn't you?

Mr. BRAGDON. I think ideally, yes.

Chairman KERRY. Senator Cardin?

Senator CARDIN. If I may follow up on that, one of my concerns, if we are dealing with affordability of health care, it is a national issue. We have to deal with the cost centers of the number of uninsured, the high cost of prescription medicines, how we get long-term care, and the whole gamut of issues. My own State of Maryland has small market reform to try to help small business and I believe it has been effective in Maryland. Is it solving the problem? No, it is not. Do we need national help? Yes, we do.

But one of my concerns is that if we look for models such as association health plans or over-reliance on Health Savings Accounts that it can compromise work done in my State of Maryland with small businesses that are benefitting from small market reform who will probably lose that if we go to association health plans, because the market, the adverse risk selections will be there and we won't be able to continue those plans.

So I think, Senator Kerry, you have raised a good point about uniqueness of our States. We have to be mindful that there has been reform done. There has been progress made in some States and some of the solutions that are looked at at the national level, if not taken on a comprehensive approach, if it is just taken as one option, as the solution, could very well be harmful to many of our States and the reforms that they have already moved forward. I welcome any of your thoughts in that regard. I know in Maryland, our small market reform is welcomed by our small business community.

Mr. KINGSDALE. Just one thought, which is that there are a whole bunch of issues about pooling and participation and segmenting markets and risk and so forth that we have discussed today that are all addressed currently by State regulation. The point I would make is that if you are going to talk about cross-State insurance options, you need to talk about cross-State insurance regulation and that is a big undertaking. So I would suggest there has to be a marriage and a synchronization of the regulatory framework that is so critical to these pooling and other issues with any effort to break down State regulation. You are going to have to then at the national level take up those same issues.

Ms. SULLIVAN. Well, representing the small businesses, we already have that system where every State does what they want to. It is not working. When we are talking about pooling, that is because we think we need more than just individual States acting. I would just say the worry about losing mandates or the coverage that maybe one State wants over another, the point is it is not working as it currently is structured. We would urge you to think broader and to think in a bigger way about how you can help us on a national level.

Senator CARDIN. I would just point out, it is working in Maryland. It is working. The small market reform overrides State mandates for our State. We have a commission that meets with small business and the advocacy community and works out an affordable product for small business. If the Federal Government were to come in and mandate association health plans, we would lose our small market reform in Maryland. We would lose our plan. That is why our Governor, our Republican Governor, urged against association health plans and we have opposed it in Maryland. So some States are moving in that regard.

Ms. SULLIVAN. It is working in some States, perhaps.

Chairman KERRY. An issue that I have been championing for a number of years now is reinsurance, that if we were to create a reinsurance pool, you know, 20 percent of the costs of health care are contained in 1 percent of the billings. That is basically the most catastrophic care. If we were to limit the exposure of every business and every individual in America to $50,000 of risk exposure,

then your premiums would drop per person in a business by about $1,500 and you could take care of those other cases out of your reinsurance pool at the Federal level, which would have a true cost reduction.

Then all of a sudden, if you coupled that with a tax credit for small businesses, say up to 50 percent, you would have a double-whammy premium reduction. You have the tax credit benefit coupled with the premium reductions by capping catastrophic. You would lower premiums across the country and make our businesses more competitive and have a certainty as to what the risk is that you are going to be exposed to in the marketplace.

Does it cost a little bit of money to create the Federal insurance pool? Yes, it does. It costs a fraction of what we are spending in Iraq, but it costs some money. So these are the choices we need to make.

How would you respond to having a reinsurance pool and lowering costs in that manner and making that available? Wouldn't that—if every business in America could say, whoa, my premiums are down by $1,500, every car in America would go down by $1,500 per car. That is the cost that goes into each car made in America to pay for health care for workers. All of a sudden, you are more competitive with foreign manufacturers, et cetera. It would be a plus for the economy, not a negative. Would any of you have any response? No response?

Ms. SENKEWICZ. Yes, Senator. Absolutely. I mean, reinsurance—essentially what you are talking about is, and I touched on it, how do we take care of the sick, and reinsurance for the highest claims is certainly one way to look at it. Healthy New York used a reinsurance mechanism. They have been very successful in reducing the uninsured rate. You just have to be careful about how you do it. That is what the States are doing now with high-risk pools. Essentially, it is trying to get—and that is financed, subsidized through premium payments, State tax money, a variety of ways, but that is exactly what you are doing. If you can cut off that most expensive risk off the top somehow and get that out of the pool so that the general pool can take care of itself, I think you can go a long way towards solving some of the problem.

Chairman KERRY. That is a different discussion probably in a different Committee, but at any rate. I appreciate all of your input today. It has been very helpful. We are going to leave the record open for 2 weeks for colleagues to be able to submit questions in writing, which you may receive.

We really appreciate you taking the time to come in here today. We are going to try to synthesize this. We will probably have some additional questions for the record just to fill it out a little bit. So thank you very much for being here.

We stand adjourned.

[Whereupon, at 11:54 a.m., the Committee was adjourned.]

APPENDIX MATERIAL SUBMITTED

Senate Small Business Committee Hearing
Alternatives for Easing the Small Business Health Care Burden
Statement of Senator Michael B. Enzi
February 13, 2007

Chairman Kerry and Ranking Member Snowe, thank you for holding today's hearing. I fully agree with you and the witnesses that will be presenting today that health care costs for themselves and their employees is the biggest challenge that small businesses, their workers and their families face.

I can appreciate the intent of the hearing to broadly examine what alternatives are available and how they may be combined to offer the most relief. As Ranking Member of the Health, Education, Labor and Pensions Committee, I am working to move forward on small business health care relief. We made great strides on this issue last year, and I am looking forward to starting down the road this year.

I am glad to see that one of the witnesses today has experience working with Wyoming's insurance industry. She will be familiar with the fact that 70,000 people in Wyoming do not have health insurance, according to a Robert Wood Johnson Foundation report.

I suggest that a serious health care alternative that the Senate was unable to pass in the last Congress is small business health plan legislation sponsored by myself and Senator Ben Nelson of Nebraska, which built on a tremendous foundation laid by Senator Snowe and Senator Jim Talent. Our small business health plan legislation will create more choices and more competition, and it will give business associations the right to negotiate more affordable health insurance options by leveraging the combined power of the small businesses they represent.

Our small business health plan legislation will give associations a meaningful role on a level playing field with other group health plans, preserve the primary role of the states in health insurance oversight and consumer protection, make lower-cost health plan options available, and achieve meaningful reform without a big price tag.

Over 500,000 people – Republicans, Democrats, and Independents – from all 50 states signed a petition last year in support of the small business health plan legislation. That overwhelming support for the bipartisan bill is something I hope to build upon this year.

The challenges are serious, and we should not sugar-coat them. But I do take encouragement from the fact that so many of my fellow senators and representatives have spoken to me about the messages they are hearing from small businesses in their states. As this hearing shows, all of us may come at this from different perspectives, but the need to act is a message we all hear, loud and clear. I am ready to act. Thank you Chairman Kerry and Ranking Member Snowe.

RESPONSES BY MARY BETH SENKEWICZ TO QUESTIONS FROM SENATOR JOSEPH I. LIEBERMAN

Question 1. In your testimony, you stated that Congress should create a more efficient national pooling mechanism to reduce the cost of health care for small businesses. Can you provide more details about your ideas to improve efficiency in pooling? How can the Federal Government achieve this goal?

Answer. [A response was not available at press time.]

RESPONSES BY WILLIAM F. SWEETNAM, JR. TO QUESTIONS FROM SENATOR JOSEPH I. LIEBERMAN

Question 1. The deductible of a qualifying health plan for a HSA (health savings account) sounds high to me—$2200 for a married couple. That deductible might help a middle income family in the United States, but I am concerned about our lower income families who would find it difficult to handle a deductible of that amount. In your testimony, you stated that HSAs are utilized by citizens of all income levels. Please provide the Committee with statistics to support your claim, including the percentages and numerical frequencies of HSA users, categorized by income level.

Answer. The statistics that I used in my testimony were based on an analysis conducted by UnitedHealth Group, which is the largest provider of HSAs in the country with nearly 1 million HSA members. The analysis was based on the saving and spending patterns of 25,000 individuals enrolled in its employer-sponsored HSA plans for all 12 months of 2005. This study paired health plan membership information with financial transaction data from the company's own health care bank, Exante Financial Services.

The study found that HSAs are utilized by consumers across all income ranges. Overall, the rate of account openings varies only from 80 percent to 84 percent across all income ranges. Most notably, when their employer makes a contribution to the HSA, 80 percent of low-income individuals (those earning $25,000 or less annually) open their accounts. However, income plays a clear role in account adoption when the employer does not make a contribution to the account. In those cases, accounts are opened by:

- 23 percent of those earning less than $25,000
- 39 percent of those earning $25,000 to $49,000
- 50 percent of those earning $50,000 to $99,000
- 58 percent of those earning $100,000 or more.

The study that UnitedHealth conducted did not have any analysis of the distribution for HSAs based on income levels.

RESPONSES BY TARREN BRAGDON TO QUESTIONS FROM SENATOR JOSEPH I. LIEBERMAN

Question 1. What is the rationale for not mandating participation in a minimal benefit health plan, if such widespread participation reduces the overall risk pool?

Answer. It is easy to propose in theory an individual mandate. However, it is very difficult to administer one. Almost all States have an auto insurance mandate, yet often upwards of 25 percent of all drivers do not have auto liability insurance.

Rather than mandate participation, I believe that the key is to have various affordable private health insurance options so that individuals can choose the best plan for themselves, given their own life and economic circumstances. One person's "minimal benefit" may be more comprehensive than what another person needs, wants or can afford.

Question 2. You testified that you would support auto-enrollment in a default health plan for employees that do not have health coverage. Please discuss how you think auto-enrollment should be structured to provide the best coverage to newly hired employees? Would a 21-year-old receive the same coverage as an older adult? Would gender affect default coverage? Who would make these decisions?

Answer. Auto-enrollment would be simple. A company could choose to auto-enroll employees in employee-only coverage. For companies offering more than one health plan, the company would choose the default plan for auto-enrollment, which would presumably be the most affordable plan (requiring the lowest employee share of the premium).

All employees would auto-enroll into the same default plan, regardless of age, gender or another other demographic.

Employees could select a different plan, if available, or opt-out of coverage entirely, if desired. But the default would be to opt-in. Currently, the default is to opt-out.

RESPONSES BY JON M. KINGSDALE TO QUESTIONS FROM SENATOR JOSEPH I. LIEBERMAN

Question 1. I understand that healthy competition is an incentive for lower cost insurance. Given this fact, I am puzzled by the fact that big insurers often compromise the market, raise health care prices, and provide less coverage without any intervention. What is Massachusetts doing to curtail the monopolization of the insurance market by large insurance companies?

Answer. Under Massachusetts' health reform, the Commonwealth Health Insurance Connector Authority has initiated competitive, open bidding and invited eligible health plans to respond to our requests for proposals. As a result, several developments have already occurred that tend to create more competition, especially on the part of smaller health plans, in the insurance market.

1. In response to an RFP issued by the Connector last August for our new subsidized private health plans for low-income uninsured, several Medicaid Managed Care organizations are becoming licensed to offer commercial insurance in the Commonwealth—adding to the number of smaller health plans (several hundred thousand members each) that can compete here for both low-income and regular commercial membership.

2. In response to an RFP issued by the Connector last December for non-subsidized health plans to be offered through the Connector to individuals and selected categories of employers, we approved for offering 42 health benefits plans offered by 6 carriers in Massachusetts. While none of the 6 are new insurance companies in the State, several are relatively small plans, which as a result of being offered through the Connector, will have access to many new members. The 6 carriers have proposed innovative, limited-network products, and are already experiencing membership growth as a result.

3. Because the Connector provides far greater transparency and ease of comparison shopping for health insurance than previously existed, and because the State's health insurance reforms tie carriers' non-group offerings to their commercial group offerings, options for non-group purchasers have expanded considerably. The Connector functions for insurers much like Travelocity for airlines, making it easier and more affordable to buy insurance and for smaller health plans to reach more potential consumers. As a result, we have already observed several promising competitive responses in the way health insurance carriers compete and market their products outside of the Connector as well.

COMMENTS FOR THE RECORD

STATEMENT FOR THE RECORD FROM

THE NATIONAL SMALL BUSINESS ASSOCIATION

Small Business Health Care Costs

Before the Senate Committee on Small Business

February 13, 2007

Small businesses are being pummeled by the increasing cost of health care. The small-business owners who make up the National Small Business Association repeatedly rank health care among their top concerns. NSBA is the nation's oldest nonpartisan small business advocacy group reaching more than 150,000 small businesses nation-wide. The Senate Committee on Small Business and Entrepreneurship surely must hear on a daily basis that something must be done.

In October 2005, NSBA conducted a survey on health care and found that 51 percent of members said that they are considering making changes to their employee health benefits plan during the next year. Of those, 66 percent are considering decreasing benefits or increasing the employee share of premiums—on top of the ones who have already done so. While the need for reform is clearly urgent, and while there are a number of more short-term reforms that can improve on the system, what small businesses deserve is broad, comprehensive reform that will not only address the symptoms of a failing health care system, but cure the underlying sickness.

The Realities of the Insurance Market

Implicit in the concept of insurance is that those who use it are subsidized by those who do not. In most arenas, voluntary insurance is most efficient since the actions of those outside the insurance pool do not directly affect those within it. If the home of someone without fire insurance burns down, those who are insured are not expected to finance a new house. But such is not the case in the health arena, where the costs of treating uninsured are split and shifted onto those with insurance in the form of increased costs. Moreover, individuals' ability to assess their own risk is somewhat unique regarding health insurance. People have a good sense of their own health, and healthier individuals are less likely to purchase insurance until they perceive they need it. As insurance becomes more expensive, this proclivity is further increased (which, of course, further decreases the likelihood of the healthy purchasing insurance).

Small businesses must function within the insurance markets created by their states. States have developed rules on rating and underwriting that attempt to establish the subsidies between the healthy and the sick. Most states require insurers operating in the small group market to take all comers and limit their ability to set rates based on health status and other factors. However, there is extensive variability among the states on these rules. Some states allow great latitude on rates, thereby limiting the cross-subsidies, but this makes insurance much more affordable for the relatively young and healthy. Other states severely limit rate variation, which often helps keep costs in check for many older, sicker workers, but drives up average premiums and puts insurance out of financial reach for many. These tight rating rules (known as "community rating" or "modified community rating") also can cause some insurers to leave certain markets they deem to be unprofitable. Problems in those states are then compounded by a lack of competitive pressures.

It is important to note the interplay between the small group and individual insurance markets, particularly in some states. In general, insurers in the individual market are not required to take all comers (at least not those not "continually insured") for all services and are allowed much greater discretion to underwrite and rate policies based on health history and a series of other factors. Individuals also can see their rates skyrocket if they get sick, usually to a much greater degree than in the small group market. In other words, there is far less of a cross subsidy in the individual market than the small group market. That means that relatively young and healthy individuals can get much cheaper insurance in the individual market (at least initially) than they can get through an employer—particularly in states that have community rating in the small

group market. In many of our smallest companies (under 10 employees but especially under five), it makes financial sense to increase wages to allow for the purchase of individual coverage. If the workforce becomes sicker, it may make sense to convert to the now-more-reasonably-priced small group market. This dynamic (and others) means that the "moribidity" of the under-ten market is much higher than the group market as a whole. Naturally, insurers often will seek ways to avoid serving an undue share of this market.

So long as we have in place a voluntary system of insurance, where individuals and businesses—at any given point in time—can choose whether or not to purchase insurance, this quest for the insurance rating "golden mean" will continue. While there has been endless debate about what the right set of rating rules should be, it is imperative that there be only one set of rules. Insurance markets where different players operate under different sets of rules are doomed to failure. Even in the interplay between the group and individual markets—which are different markets—we see the consequences of different rules. When two sets of rules operate within the same market, the self-interested gamesmanship that occurs among both insurers and consumers ultimately leads to dysfunction and paralysis.

Solution Principles

Any solution to the problem should abide by the following, most important principle - primum non nocere: first, do no harm. Often, legislation passed has hidden, unintended consequences that can create a larger problem than the bill initially sought to fix. Lawmakers must use a keen eye when considering any solution, no matter how incremental or sweeping, to ensure that the fix doesn't unearth an even bigger problem.

The second principle when discussing a health care fix for small business is to understand the real problems small businesses face. The biggest problem small businesses face is cost and competitiveness. Health insurance in the United States has transformed from a "fringe benefit" to a central component of compensation. The realities of the small group market make it much more difficult for a small firm to secure quality, affordable insurance than it is for a large business. The ebb and flow of workforce in a large company can be compensated for in their insurance pool simply due to the large number of workers. Whereas in a small business, that natural shift in workers can lead to extraordinary fluctuations in health premiums. Given these costs and general level of instability in the insurance market, the ability for a small business to effectively compete for good workers against large companies is exponentially more difficult.

There exists another competitiveness issue, and that is a global one. The U.S. boasts a unique entrepreneurial spirit and has been a leader in technological advances. A great deal of that innovation and creation comes from small businesses. According to the U.S. Small Business Administration's Office of Advocacy, small firms represented 40 percent of the highly-innovative firms in 2002, a 21 percent increase in just two years. Unfortunately, health insurance costs can serve as the deciding factor whether or not an individual will opt to continue with his or her business. A report released earlier this week by that same Office of Advocacy states that the presence of the health insurance deduction decreases the rate of exit from entrepreneurship for self-employed individuals by 10.8 percent for single filers, and 64.9 percent for married filers. What this tells us is that we are losing potential new advances and innovations due to the cost of health insurance, which holds serious implications to our overall global competitiveness.

The third principle is equity and common sense. While competitiveness does touch on fairness between large and small companies, equity in our mind is a different animal altogether. Any health care solution ought to provide the same benefits to a business owner as they do an

employee. Tax benefits should be extended fairly to whichever party is paying for the health insurance, be it employers or individuals. Continually providing tax benefits to companies and employment and not individuals perpetuates the current system where employers are practically forced into providing insurance to their employees.

NSBA's Comprehensive Solution

In attempting to create positive health care reform for small businesses, one quickly bumps up against the reality that small business problems cannot be solved in isolation from the rest of the system. Since small businesses purchase insurance as part of a larger pool with shared costs, the decisions of others directly affect what a small business must pay and the terms on which insurance is available to them. It has become clear to NSBA that—to bring meaningful affordability, access, and equity in health care to small businesses and their employees—a broad reform of the health care system is necessary. This reform must reduce health care costs while improving quality, bring about a fair sharing of health care costs, and focus on the empowerment and responsibility of individual health care consumers.

There is no hope of correcting these inequities until the U.S. has something close to universal participation of all individuals in some form of health care coverage. NSBA's plan for ensuring that all Americans have health coverage can be simply summarized: 1) require everyone to have coverage; 2) reform the insurance system so no one can be denied coverage and so costs are fairly spread; and 3) institute a system of subsidies, based upon family income, so that everyone can afford coverage.

Individual Responsibility
Small employers who purchase insurance face significantly higher premiums from at least two sources that have nothing to do with the underlying cost of health care. The first is the cost of "uncompensated care." These are the expenses health care providers incur for providing care to individuals without coverage; these costs get divided-up and passed on as increased costs to those who have insurance.

Second is the fact that millions of relatively healthy Americans choose not to purchase insurance (at least until they get older or sicker). Almost four million individuals aged 18-34 making more than $50,000 per year are uninsured. The absence of these relatively-healthy individuals from the insurance pool means that premiums are higher for the rest of the pool than they would be otherwise. Moving these two groups of individuals onto the insurance rolls would bring consequential premium reductions to current small business premiums.

Of course, the decision to require individuals to carry insurance coverage would mean that there must be some definition of the insurance package that would satisfy this requirement. Such a package must be truly basic. The required basic package should include only necessary benefits and should recognize the need for higher deductibles for those able to afford them. The shape of the package would help return a greater share of health insurance to its role as a financial backstop, rather than a reimbursement mechanism for all expenses. More robust consumer behavior will surely follow.

Incumbent on any requirement to obtain coverage is the need to ensure that appropriate coverage is available to all. A coverage requirement would make insurers less risk averse, making broader insurance reform possible. Insurance standards should limit the ability of insurance companies to charge radically different prices to different populations and should eliminate the ability of insurers to deny or price coverage based upon health conditions, in both the group and individual

markets. Further, individuals and families would receive federal financial assistance for health premiums, based upon income. The subsidies would be borne by society-at-large, rather than in the arbitrary way that cost-shifting currently allocates these expenses for those without insurance.

Finally, it should be clear that coverage could come from any source. Employer-based insurance, individual insurance, or an existing public program all would be acceptable means of demonstrating coverage. More and more health care policy leaders are realizing the need for universal coverage through individual responsibility and a requirement on each person to have health insurance. In testimony given to the Senate Finance Committee in March 2006, Former Treasury Secretary Paul O'Neill suggested such a requirement with financing mechanisms for low-income individuals.

Reshaping Incentives
There currently is an open-ended tax exclusion for employer-provided health coverage for both the employer and employee. This tax status has made health insurance preferable to other forms of compensation, leading many Americans to be "over-insured." This over-insurance leads to a lack of consumer behavior, increased utilization of the system, and significant increases in the aggregate cost of health care. Insurance now frequently covers (on a tax-free basis) non-medically necessary services, which would otherwise be highly responsive to market forces.

The health insurance tax exclusion also creates competitiveness concerns for small employers and their employees. Since larger firms have greater access to health insurance plans than their smaller counterparts, a greater share of their total employee compensation package is exempt from taxation. Further, more small-business employees are currently in the individual insurance market, where only those premiums that exceed 7.5 percent of income are deductible.

For these reasons, the individual tax exclusion for health insurance coverage should be limited to the value of the basic benefits package. But this exclusion (deduction) also should be extended to individuals purchasing insurance on their own. Moreover, the tax status of health insurance premiums and actual health care expenses should be comparable. These changes would bring equity to small employers and their employees, induce much greater consumer behavior, and reduce overall health care expenses.

Reducing Costs by Increasing Quality and Accountability
While the above steps alone would create a much more rational health insurance system, a more fair financing structure, and clear incentives for consumer-based accountability, more must be done to rein-in the greatest drivers of unnecessary health care costs: waste and inefficiency. Increased consumer behavior can help reduce utilization at the front end, but most health care costs are eaten up in hospitals and by chronic conditions whose individual costs far exceed any normal deductible level.

There is an enormous array of financial pressures and incentives that act upon the health-care provider community. Too often, the incentive for keeping patients healthy is not one of them. Our medical malpractice system is at least partly to blame. While some believe these laws improve health care quality by severely punishing those who make mistakes that harm patients, the reality is that they too often lead to those mistakes—and much more—being hidden.

Is it any wonder that it is practically impossible to obtain useful data on which to make a provider decision? Which physician has the best success-rates for angioplasty procedures? Which hospital has the lowest rate of staph infections? We just don't know, and that lack of knowledge makes consumer-directed improvements in health care quality almost impossible to achieve.

Health care quality is enormously important, not only for its own sake, but because lack of quality adds billions to our annual health care costs. Medical errors, hospital-acquired infections, and other forms of waste and inefficiency cause additional hospital re-admissions, longer recovery times, missed work and compensation, and even death.

In O'Neill's testimony last March, he cites this as a major cost-driver in the health care market, estimating a 30 to 50 percent decrease in costs if health care providers performed at the top, theoretical limits. Pointing to a pilot project based at Allegheny General Hospital in Pittsburgh, O'Neill highlighted a 95-percent reduction in a targeted area of infection prevention in less than 90 days, and cited $2 million in savings in the two-and-one-half year period since the project began.

What financial pressures are we bringing to bear on the provider community to improve quality and reduce waste? Almost none. In fact, we may be doing the opposite, since providers make yet more money from re-admissions and longer-term treatments. It is imperative to reduce costs through improved health care quality. Rather than continuing to pay billions for care that actually hurts people and leads to more costs, we should pay more for quality care and less (or nothing) when egregious mistakes occur.

Improved Consumerism:
Pay-for-Performance must be a policy goal for all providers. Insurers should reimburse providers based upon actual health outcomes and standards, rather than procedures. In some pilots, the Centers for Medicare and Medicaid Systems (CMS) already have begun this process. Evidence-based indicators and protocols should be developed to help insurers, employers, and individuals hold providers accountable. These protocols—if followed—also could provide a level of provider defense against malpractice claims.

Enhancing the use of electronic medical records and procedures should be a priority. From digital prescription writing to individual electronic medical records to universal physician identifications, technology can reduce unnecessary procedures, reduce medical errors, increase efficiency, and improve the quality of care. This data also can form the basis for publicly available health information about each health care provider so patients can make informed choices.

NSBA's policy is broad, but clearly not undoable. Five years ago the concept of requiring individuals to carry insurance was a non-starter, but that is no longer the case. With the Massachusetts legislature passing broad reform legislation that incorporates some of NSBA's key proposals, and California Governor Arnold Schwarzenegger proposing a similar kind of reform, it is becoming clear that broad reform is really the only way to fix the problem. On the federal level, Sen. Ron Wyden (D-Ore.) has introduced legislation that would be somewhat similar to the Massachusetts and California proposals. Though NSBA may disagree with each of these proposals on certain issues, the framework is quite similar to what NSBA has been pushing since 2004.

Targeted Solutions

While we argue that a comprehensive policy is truly the way to fix the health care market, we also realize that our plan is aggressive. In the mean-time, NSBA would support a series of more targeted solutions to provide some relief to small businesses and their employees.

Expansion of Health Savings Accounts
Health Savings Accounts (HSAs) are tax-free savings accounts that people can set up when they purchase a high-deductible policy to cover major medical expenses. Money from the HSA can be used to pay for routine medical expenses or saved for future health needs, while the major medical policy helps cover big expenses, like hospital stays. Unlike their predecessors, Medical Savings Accounts (MSAs), however, HSAs allow for both employer and employee annual contributions and unused funds to rollover. Individuals with an HSA can contribute up to 100 percent of the annual deductible of their health insurance program. HSAs also have lower minimum required deductible and out-of-pocket limits. Perhaps one of the most important changes from MSAs to HSAs is the fact that anyone can participate, and there are no longer restrictive limits on the program.

While HSAs have been available for nearly three years, there are still further actions Congress should take to expand the program. Individuals participating in an HSA should be allowed to deduct the premiums for the high-deductible health insurance policies from their taxable income in conjunction with an HSA. Increasing the tax benefit to these plans will increase affordability.

Pool Small Businesses Locally
There have been calls from various national small business groups to create Association Health Plans (AHPs). The push for AHPs are a reaction to the very dire circumstances small businesses currently face in the health insurance arena: huge premium increases, a lack of control and clout, the costly tangle of state and federal regulations, and fewer funding, carrier, and plan selection options than their larger counterparts.

Despite those good intentions, we are concerned that AHPs are not only a non-answer to the real issues driving cost, but will exacerbate the problems small businesses face. The primary focus and cost savings of AHPs is through circumventing state laws and rating rules. AHPs threaten to greatly worsen the market segmentation and risk-aversion that currently characterize the small group health insurance market, which are at the root of the health care crisis uniquely faced by smaller firms. AHPs might be good for small business associations (like NSBA) who want to run them, but NSBA believes that they will not be good for the small business community at-large, whose interests we are bound to represent.

One of the fundamental precepts that underpins the arguments of those advocating for AHPs is the idea that big pools will equal bargaining clout. In almost every market in the world, the larger the quantity you buy of something, the lower its per-unit price. In the health insurance market, however, the make-up and location of that pool are both far more important factors in establishing a price than size alone.

A pool of 1,000 people with an average age of 40 could demand (and receive) a much better rate than a pool of 50,000 people with an average age of 55. Moreover, when a plan is negotiating reimbursement with providers, a local hospital or physician will be driven by how many patients the plan will bring them. A local plan with a total of 100,000 lives will be able to drive a much better deal than a big national plan with 5 million lives, only 15,000 of which are local.

NSBA encourages the development of local employer health care coalitions that would assist small employers in obtaining lower rates for coverage through group purchasing. Such coalitions also would assist small employers in learning about existing local health insurance plan options, how to be a wise health insurance purchaser, the issues of health care costs, health care quality and the availability of health care providers within their communities. Local employer health care

coalitions would continue to be subject to their respective state laws. Therefore, there would continue to be a level playing field for all employers providing insurance in the small employer market. These coalitions already exist in many states, providing choice and savings for their members every day

Reform HRAs and FSAs
In 2002, President Bush and the Treasury Department highlighted Health Reimbursement Accounts (HRAs), which are similar to MSAs, but only can accept employer contributions, and employees cannot keep their excess funds. Though HSAs and HRAs are somewhat similar, HRA reform also would help those individuals seeking a low-deductible plan but also would like a savings account to help pay for medical costs. Reforming the HRA structure includes: allowing employees to contribute, allowing employees to roll excess funds into retirement plans, and, most importantly, allowing small-business owners to participate. Like so-called "cafeteria plans", HRAs specifically exclude owners of non-C Corporations from participating. This is a major obstacle that must be overcome if small companies are ever to take advantage of the potential of these plans.

On the subject of "cafeteria plans" (Section 125 plans), it should be noted that reforms of these plans also could be an important factor in increasing the ability of small-business employees to fund various kinds of non-reimbursed care. Two major roadblocks are in the way. First, small-business owners generally cannot participate in "cafeteria plans". Second, these plans have annual "use-it-or-lose-it" provisions, which cause some to spend money that did not need to be spent, but cause many more to never contribute to the plan in the first place. Fixing these two mistakes would be a real benefit to small-business employees struggling to meet their out-of-pocket medical bills.

Create Health Insurance Tax Equity
After 16 years of struggle and unfairness, small-business owners finally were able to deduct all of their health insurance expenses against their income taxes in 2003. Unfortunately, we are still only part-way to real health insurance tax equity for small business. Currently, workers are allowed to treat their contributions to health insurance premiums as "pre-tax," whereas business-owners are not. This distinction means that those premium payments for workers are subject neither to income taxes, nor to FICA taxes. While the self-employed owner of a non-C Corporation now can deduct the full premium against income taxes, that entire premium is paid after FICA taxes. Compounding matters, these business owners pay both halves of the FICA taxes as employer and employee on their own income for a total self-employment tax burden of 15.3 percent.

Right here in Washington, D.C., the cost of a Blue Cross/Blue Shield family policy in a small group plan has topped $12,000 per year. A business owner who makes $60,000 and purchases this plan for his or her family pays $2,000 in taxes on that policy. An employee who makes $60,000 and has the same plan pays nothing in taxes on that policy. By treating this business owner the same way that everyone else is treated in this country, we can give him or her an immediate 15-percent discount on health insurance premiums. Legislation was introduced last year by Sens. Jeff Bingaman and Craig Thomas (S. 663) that would bring this much-needed equity and tax relief to the nation's self-employed.

Reform the Medical Liability System
The enormous costs of medical liability and the attending malpractice insurance premiums are significant factors pushing health care costs higher and restricting choice and competition for

consumers of health care. Triple-digit increases in malpractice premiums over the last five years have been common in many states and specialties.

These costs have a distorting effect on the health care system by causing physicians to retire early, change their practices to serve lower-risk patients, move to states with reformed malpractice laws, and concentrate their practice in high-profit centers-making quality health care in rural areas and smaller towns increasingly difficult to access. All of these changes restrict competition and the ability of employers to negotiate lower reimbursement rates. But the most profound affect of the liability system is the "defensive medicine" that is practiced by many risk-averse providers. Unnecessary, purely defensive procedures, cost the health care system untold billions each year and drive up premiums for all of us.

Pay-for-Performance
NSBA is a strong advocate for pay-for-performance initiatives. One of the biggest usurpers of health care dollars is poor quality leading to further complications and cost. Quality health care is a major factor in reducing the cost of care, and providers must be compensated accordingly. The implementation of a third-party payer system has removed levels of accountability from all sectors of the current health care market where individuals, health providers and insurance companies have very different interests at heart. Individuals want ease and affordability, take very little responsibility in their care and do not generally make educated choices in terms of providers, procedures and costs.

NSBA strongly supports the CMS's new pay-for-performance policy change. CMS has taken the lead in implementing policy changes that will increase the importance of quality care. Through their reimbursements, CMS now will require hospitals to comply with certain quality standards. Those that do comply not will see a small percentage of their reimbursements withheld. This kind of thorough evaluating and monitoring is necessary in providing patients with the highest quality care possible.

Improvements in Technology
Improved and standardized technology is necessary to gauge provider quality and ensure simple mistakes are not made as frequently. Individuals all should have a privately-owned, portable electronic health record. This would enable individuals and their doctors to access the record without having to wrangle a massive paper trail.

The system currently used for prescriptions also is outdated. NSBA urges the use of technological devices when issuing prescriptions in order to avoid costly and dangerous mistakes. The medical industry needs to establish a set of protocols by which doctors, hospitals and other care-givers can be evaluated. Improved technology will help providers report their compliance with these protocols. Such information should be made widely available to health care consumers.

Protect the Small Employer Health Market from Gamesmanship
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 ensured that small groups could not be denied coverage by any insurer offering small group coverage in their state. The federal law, however, does not ensure that this coverage would be affordable, though states generally have implemented "rate bands" that provide some upper limit on rate increases for particular groups.

The individual market, however, is generally free of the guaranteed issue requirements enacted by HIPAA. Only those who had other insurance within the previous six months would be free of exclusion. This difference in rules between the individual market and the small group market

means that premiums for younger and healthier individuals almost are always lower in the individual market than in the small group market. The opposite is generally true for older and less-healthy individuals: their premiums are less in the small group market than in the individual market. This dynamic understandably leads some employers to purchase less expensive individual coverage on behalf of their employees, when they can qualify for low rates. When significant illness occurs, the individual premium escalates sharply, and the business will often switch to a small group plan, where they must be accepted and where the premiums will be much lower.

While this entire process is perfectly rational from the employer's perspective, it forces small group premiums to be higher than they otherwise would be under a different set of circumstances. Premiums would be lower and overall access to health insurance higher if this practice were discouraged, perhaps through a surcharge when the business re-enters the small group market (much like the penalty for early withdrawal of Individual Retirement Accounts (IRAs)). Another way would be to clarify that employer-paid premiums in the individual market are taxable to the employee.

Help the Uninsured through Tax Credits and Current Programs
Much of the question of adequate health insurance coverage boils down to affordability. There is probably no more efficient way to provide public subsidies for health insurance than through a system of tax credits-scaled to income, and targeted at individuals, such as those proposals that the president has put on the table. Further expansions of Medicaid and SCHIP programs to serve uninsured populations should also be considered.

It is NSBA's philosophy that, while these piecemeal changes will have a very positive effect on small businesses, there ought to be a long-term health market reform movement. A health care system that embraces individual choice, consumerism, recognition for quality services and affordability is paramount.

Substantial cost containment is embodied in the NSBA Health Policy. Limits on the tax exclusion will drive individuals to become less-dependent upon third-party payers in their medical transactions. More of a consumer-based market will develop for routine medical care, thereby putting downward pressure on both prices and utilization. Through both increased consumer awareness and specific quality-control methods, costs can be reined-in and small businesses can get back to doing what they do best rather than searching for affordable health care: creating jobs.

AARP Statement for the Record

On the

Health Care Costs for Small Businesses

Submitted to the

Senate Committee on Small Business

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

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

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

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

Tax credits

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

Association Health Plans (AHPs)

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

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

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

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

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

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

Health Savings Accounts

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

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

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

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

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

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

Health Marts

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

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

Conclusion

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

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