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HEALTH REFORM IN THE 21ST CENTURY: EMPLOYER-SPONSORED INSURANCE

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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HEALTH REFORM IN THE 21ST CENTURY: EMPLOYER–SPONSORED INSURANCE

WEDNESDAY, APRIL 29, 2009

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to call, at 10:05 a.m., in Room 1100, Longworth House Office Building, Hon. Charles B. Rangel [Chairman of the Committee] presiding.

[The Advisory of the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
April 22, 2009
FC–8

CONTACT: (202) 225–3625

Hearing on Health Reform in the 21st Century: Employer-Sponsored Insurance

House Ways and Means Chairman Charles B. Rangel (D–NY) announced today that the Committee will hold another hearing in the series on health reform. This hearing will focus on employer-sponsored insurance. **The hearing will take place at 10:00 a.m. on Wednesday, April 29, 2009, in the main committee hearing room, 1100 Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND

Nearly 160 million people receive health benefits through their employer, making it the predominant form of health coverage in America. Employer-sponsored insurance expanded significantly during World War II as a way for employers to provide extra benefits to compete for scarce workers when the National War Labor Board (NWLB) froze wages. Clarifications of the Internal Revenue Code in the 1940s and 1950s established that employer-provided health insurance coverage is excludible from an employee's taxable income. As a result, the number of employers offering coverage and the number of people receiving health coverage at their place of employment grew. While the rate of employer-sponsored coverage has dropped in recent years and millions of workers are not eligible for coverage offered by their employers, it is still the primary source of coverage for nearly 63 percent of individuals under age 65. It is also a stable source of coverage for millions, with 98 percent of firms with more than 200 workers consistently offering coverage for the past ten years.

One advantage of employer-sponsored insurance is that workplaces pool large groups of people irrespective of health status, in order to balance the health risk of employees. Small businesses and their employees do not have the same advantage of large risk pools, tend to have higher administrative costs than large employers, and are exposed to premiums that can vary greatly from year to year. As a result, large firms are more likely to offer coverage than small firms, with an estimated 99 percent of firms with 200 or more employees offering coverage as compared to 62 percent of firms with 3 to 199 employees.

A challenge for employer-sponsored health insurance is that costs have risen faster than inflation or wages. Between 2001 and 2007, premiums for employer-sponsored health insurance rose 78 percent, while general inflation increased at a rate of 17 percent and workers' earnings increased at a rate of 19 percent over the same time period. These rising costs have forced some employers to reduce, alter or eliminate their offerings. Workers that still have offers for coverage from their employers must shoulder an increasing share of the cost. From 2006 to 2008, the percentage of workers facing deductibles of $1,000 or more increased from ten percent to 18 percent. A higher rate of individuals working in firms with less than 200 employees saw this rise in deductibles, with employees facing deductibles of $1,000 or more growing from 16 percent to 35 percent.

To minimize disruption for the overwhelming majority of those with private coverage today, health reform must preserve and encourage employer-sponsored insurance. In addition, reform must help slow the rise in health costs for all health care

purchasers, including employers and individuals, through delivery and payment system reform proposals, as well as other reforms.

In announcing the hearing, Chairman Rangel said, **"A healthier American workforce is a more competitive workforce in the global marketplace. Health reform efforts need to build on, and strengthen, employer-sponsored insurance, which provides coverage for approximately 160 million people in working families. American businesses should be lining up to help comprehensive health reform become a reality so that we can ensure that everyone has affordable care that meets their needs and work to reduce the rate of spending and control health care costs to enable economic growth."**

FOCUS OF THE HEARING:

The hearing will focus on trends in employer-sponsored health insurance and strategies to strengthen and build upon job-based coverage.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee Web site and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*Committee Hearings*". Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record.*" Once you have followed the online instructions, complete all informational forms and click "submit" on the final page. ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Wednesday, May 13, 2009**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at http://waysandmeans.house.gov.

Chairman RANGEL. Good morning.

This is the fourth in a series of hearings that we have had for national health care. We have a very exciting panel of witnesses. We hope, in working with Energy and Commerce, that we can combine their jurisdiction over Medicaid with our jurisdiction over Medicare; and at the end of the day make certain that no one falls between the cracks as we move on the President's wish to sign a mandate that we have quality care, lower cost and maximum coverage, for everyone.

Today we will be concentrating on the employer-sponsored insurance and making certain that we recognize how important it is and that we do everything to strengthen it. And as the President says, If you like what you have got, we are not thinking about doing anything except trying to lower the cost across the board.

We want also to make certain that the private insurance plans do take the high-risk people, that preconditions are not an issue. And we will be entertaining the question of employer mandate, we will be entertaining the question of a public plan. All of these things will be discussed.

And so, again, sometimes on our side, David, we believe that the hearings are the best that we can do. But it is almost not fair to the witnesses to prepare and then have 5 minutes and just the questions. But we do hope all of you will make yourselves available if we have a roundtable where you don't have the 5 minutes, where you can expand on your visions as to how we can make a healthier America.

I would like to yield at this time for Mr. Camp.

Mr. CAMP. Thank you for yielding, Mr. Chairman.

And before I make my opening statement, I just want to take a moment and recognize the chairman's commitment to the issue before us, health reform in the 21st century, and his receptiveness to working together to find the right way to reform health care in this country.

Now, last week, I requested additional witnesses so that we could fully vet the complexities involved in improving both health insurance and health care. And I just want to say that the chairman has granted the minority an additional witness. Mr. Chairman, I need not tell you, there are several new Members on this Committee, particularly on our side as well, and this is not an insignificant act on your behalf, and I want to thank you personally very much for that.

I look forward to continuing this approach to health care reform; and hopefully, this will spur further bipartisan talks and negotiations. I remain confident that we can find common ground.

Health care reform should not be a partisan issue. It is not a partisan issue; it is not a Republican issue or a Democrat issue. It is an American issue.

It is not to suggest we don't face difficult questions. In fact, today's hearing will explore one of the tougher challenges we face: How do we protect employer-sponsored insurance and the access to affordable health care it provides millions of Americans? And today we will hear from several employers, one of them Denny Dennis of the National Federation of Independent Business, which represents hundreds of thousands of small businesses, businesses that typi-

cally employ about five people, and collectively create 60 to 80 percent on the new jobs in America.

Of particular concern to these job providers and creators is a Federal mandate to provide insurance or pay a penalty. That tax, per Mr. Dennis' testimony, would harm small businesses, especially those operating at the margin, and disproportionately impact low-income workers.

Others today will suggest that a government-run health plan must be a part of the solution, though such an option carries significant risks. As Mr. Sheils at The Lewin Group will testify, their April 2009 study that found the introduction of a government-run plan that reimbursed providers at government-set Medicare rates would have significant ramifications for those who already have health insurance, one finding almost 120 million Americans would lose their current health insurance coverage. Inside that data we found that of the 120 million who lose their coverage, 108 million are those who have employer-provided insurance.

A total of roughly 160 million Americans have health insurance through an employer. That means seven out of ten people—workers, husbands, wives, children—will lose their health insurance provided by employers due to a government-run plan. I think my colleagues on both sides of the aisle will agree that it is difficult enough to provide access and coverage for the 30 to 45 million Americans without insurance without having to take on the responsibility of an additional 108 million individuals with employer-sponsored insurance.

Nor does an employer mandate which trades job creation for insurance coverage make our job any easier. Employer-provided insurance is under pressure and in many cases is already eroding. This is a trend we need to reverse, not accelerate. We need to improve upon our current health care system, not end it.

Now, I know some of the majority have suggested Republicans are making the government-run plan an issue. And as I noted last week, even the White House has said that reform does not hinge on the inclusion of this provision. And just yesterday the Washington Post opined, and I quote, "It is entirely possible to imagine effective health care reform changes that would expand coverage and help control costs without a public option." And the editorial went on to read in part, and I am quoting again, "It is difficult to imagine a truly level playing field that would simultaneously produce benefits from a government run system. Medicare keeps costs under control in part because of its 800-pound-gorilla capacity to dictate prices, in effect to force the private sector to subsidize it. Such power of exercising a public health option eventually would produce a single payer system. If that is where the country wants to go, it should do so explicitly, not by default."

And, Mr. Chairman, I ask that the Washington Post editorial be submitted into the record.

And with that, I yield back the balance of my time. Thank you.

Chairman RANGEL. Thank you. Without objection, Mr. Camp.

[The information follows:]

The Washington Post

Reforming Health Care

How a government-run plan could fit -- or not

Monday, April 27, 2009

OF THE many possible issues that could snarl health-care reform, one of the biggest is whether the measure should include a government-run health plan to compete with private insurers. The public plan has become an unfortunate litmus test for both sides. The opposition to a public plan option is understandable; conservatives, health insurers, health-care providers and others see it as a slippery step down the slope to a single-payer system because, they contend, the government's built-in advantages will allow it to unfairly squash competitors.

For liberals, labor unions and others pushing to make health care available to all Americans, however, the fixation on a public plan is bizarre and counterproductive. Their position elevates the public plan way out of proportion to its importance in fixing health care. It is entirely possible to imagine effective health-care reform -- changes that would expand coverage and help control costs -- without a public option.

President Obama has said that he favors a public option but has been sketchy on details. His nominee for secretary of health and human services, Kathleen Sebelius, said that she wants a public plan to "challenge private insurers to compete on cost and quality" but "recognizes the importance of a level playing field between plans and ensuring that private insurance plans are not disadvantaged."

The argument for a public plan is that, without the need to extensively market itself or make a profit, it would do a better job of providing good health care at a reasonable cost, setting an important benchmark against which private insurers would be forced to compete. Even in a system where insurers are required to take all applicants, public plan advocates argue, incentives will remain for private plans to discourage the less healthy from signing up; a public plan is a necessary backstop. Moreover, if the playing field is level, public plan advocates argue, private insurers -- and those who extol the virtues of a competitive marketplace -- should have nothing to fear.

We disagree. It is difficult to imagine a truly level playing field that would simultaneously produce benefits from a government-run system. While prescription drugs are not a perfect comparison, the experience of competing plans in the Medicare prescription drug arena suggests that a government-run option is not essential to energize a competitive system that has turned out to cost less than expected. Insurers and private companies have been at least as innovative as the federal government in recent years in finding ways to provide quality care at lower costs. Medicare keeps costs under control in part because of its 800-pound-gorilla capacity to dictate prices -- in effect, to force the

private sector to subsidize it. Such power, if exercised in a public health option, eventually would produce a single-payer system; if that's where the country wants to go, it should do so explicitly, not by default. If the chief advantage of a public option is to set a benchmark for private competitors, that could be achieved in other ways, for example, by providing for the entry of a public plan in case the private marketplace did not perform as expected.

Maybe we're wrong. Maybe it's possible to design a public option that aids consumers without undermining competition. If so, we certainly wouldn't oppose a program that included a public component. But it would be a huge mistake for the left to torpedo reform over this question.

Chairman RANGEL. In furthering an opportunity to make certain that we have maximum participation, even if we don't get maximum support, if the minority really feels that there are some things here that can be worked out without having formal hearings, there is no reason why we cannot get experts to take a look at that, whether we use the library, H–137, or even the hearing room.

But this is so important that even if you can't vote for it, we would like to be able to accommodate in terms of bringing the experts here that you might need or we might need to better understand some of the complexities that just may impede someone from wanting to receive the goal, but just not being able to support a bill that has it or doesn't have it. So we will work that out after.

We have an outstanding group of witnesses: Dr. Elise Gould; Randy MacDonald; Bill Pascrell from Jersey will be introducing a small business man from his district, Kelly Conklin; Denny Dennis, who is a research policy person from the National Federation of Independent Business; John Sheils is Senior Vice President of The Lewin Group; and our last witness will be Gerry Shea, who comes representing the President of the AFL–CIO. So this is going to be a good day for all of us.

We will start with Dr. Gould, who is the Director of Health Policy Research, an outstanding background, an author and lecturer; and she will give us some views on why a public health insurance plan would be able to help us.

Thank you for taking time to share your views with us. You may proceed. As you know, we have 5 minutes more or less, and we want to give the Members an opportunity to ask questions while you are here. Thank you. You may proceed.

STATEMENT OF ELISE GOULD, PH.D., DIRECTOR OF HEALTH POLICY RESEARCH, ECONOMIC POLICY INSTITUTE

Ms. GOULD. Good morning Chairman Rangel, Ranking Member Camp and distinguished Members of the Ways and Means Committee. My name is Elise Gould, and I am a health economist and

Director of Health Policy Research at the Economic Policy Institute. I appreciate the opportunity to appear before you today to share my views.

Employer-sponsored insurance—I will call it ESI from here on out—provides insurance for the majority of under-65 Americans. ESI, particularly among large firms, works because it pools risks, has low administrative costs and offers a stable source of coverage for a large share of the population.

Many of these people enjoy the benefits they receive and would like to keep them. However, we have seen a weakening in ESI over the last several years, and it is important to examine strategies—and I commend that Chairman Rangel in holding a hearing to examine strategies—to strengthen ESI and find ways to provide this high-value coverage to more Americans.

The employer-sponsored health insurance industry in the United States did not flourish until the middle of the 21st century. During World War II, employers offered health benefits as a way to attract workers when the National Labor Board froze wages. In 1954, Congress amended the Internal Revenue Code to clarify and expand a 1943 administrative tax ruling that granted tax exempt status to employers contributions for their employees' group medical and hospitalization premiums. Excluding premium contributions from taxable income made $1 worth of health insurance less expensive to provide than $1 worth of wages.

In general, this tax exemption, effectively a government subsidy, reduced aftertax insurance premiums enough to encourage even the healthiest employees to enroll. In that way, sustainable risk pools were formed and group policies became more attractive to insurance companies.

Over the latter half of the 20th century, employer-sponsored health insurance became increasingly popular. Workers have grown to rely on employers to provide insurance and employers have used it as a tool to attract and retain the best workers and improve the health of their workforce.

Employer-based coverage remains the most prominent form of health insurance today. About 63 percent of the under-65 population has insurance either through their own or a family member's employer. Over 80 percent of the college educated and 80 percent of those in the top half of the income distribution have ESI coverage. In fact, if you break the nonelderly population in fifths by household income, we would see that those in the top-income fifth are nearly four times more likely to have coverage than those in the bottom fifth. So we see that employer-sponsored health insurance is working well for tens of millions of American workers and their families.

That said, the problem remains that many folks who are left out are ill served by the employer-sponsored system. Further, while ESI remained the dominant form of health coverage through the 2000s, the share of people covered by ESI declined 5 percentage points since 2000. This erosion, or unraveling, was occurring even during the economic recovery.

During an expansionary period, we would have expected coverage to increase as employment grew, but it simply did not. High and rising health costs are mostly to blame. Average premiums for an

employer-sponsored family plan have risen nearly 120 percent since 1999, three-and-a-half times faster than workers' earnings and more than four times faster than general inflation.

Small business owners and their workforce face particular challenges in obtaining ESI. The coverage rates in firms with fewer than 10 workers is less than half that of workers in firms with more than 100 workers. Half of all the uninsured are employed by a business with fewer than 100 workers, and 36 percent work in firms with fewer than 25 employees.

Small firms that do offer health insurance face high costs, paying on average 18 percent more than larger firms for identical policies. This is due to higher and more variable health risks, a lack of competition amongst insurers and greater administrative expenses.

I know, in 2007, in the small firm where I work, with less than 30 days' notice, our insurer raised rates by 27 percent, forcing us to switch carriers at the last minute, which is not easy in the limited marketplace. It is these high and unpredictable costs that have made it increasingly difficult for small firms to provide the insurance they want to offer their workers.

So what does the future hold? The current economic downturn and forecasts of high employment indicate continued erosion of employer-sponsored insurance in the near future. I estimate that by the end of 2009, nearly 50 million nonelderly will be uninsured.

The link between insurance and work has been a tradition in this country. ESI, particularly in large group markets, can effectively pool risk, lower administrative costs and maintain stability. But we must recognize its limitations. There has to be a way for nonworkers, part-time workers and even those full-time workers that have been closed out of the current system to find affordable coverage.

Private market reform, such as community rating and guaranteed issue, can improve competition between insurance companies by ensuring that this competition takes place on the grounds of efficiency and not on a company's ability to sort the population for the lowest risk.

The best way to ensure that coverage is universally made available to those who do not have good ESI is to construct a national insurance exchange that includes a public health insurance option. A public health insurance option is an essential part of this exchange. While giving Americans more choices for coverage, it also has the added advantage of increasing competition to already limited markets, reducing costs and cost growth, driving quality advancement and innovation and serving as a benchmark for the insurance market.

As we move forward to a meaningful reform, we must be wary of quick fixes to our insurance system. One such fix involves taxing health benefits. Research shows that taxing high-priced health coverage will heavily burden two groups: workers in small firms and workers in employer pools with higher health risks, such as those with a high percentage of older workers. Small businesses are paying high premiums for the insurance they provide to their employees not because the plans are especially lavish, but because they have high administrative costs and include too few employees to

constitute the broader risk pool that would qualify them for lower premiums.

Capping the tax exclusion exacerbates the problem small firms already have. It would encourage the young and healthy to opt out of these pools, and upon their exit, premiums would likely rise for those remaining. Instead, we should build on what works well in today's American health care system, ESI for the bulk of the workforce, as well as extremely popular public programs like Medicaid.

Thank you, and I am more than happy to answer any questions you may have.

Chairman RANGEL. Thank you so much for your testimony.

[The statement of Ms. Gould follows:]

EPI TESTIMONY

TESTIMONY GIVEN BY

Elise Gould, Ph.D.
Director of Health Policy Research
Economic Policy Institute

IN A HEARING BEFORE THE
U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON WAYS AND MEANS

"Health Reform in the 21st Century: Employer Sponsored Insurance"

Wednesday, April 29, 2009

Longworth House Office Building, Room 1100

Good Morning Chairman Rangel, Ranking Member Camp, and distinguished members of the Ways and Mean Committee. My name is Elise Gould, and I am a health economist and director of health policy research at the Economic Policy Institute. I appreciate the opportunity to appear before you today to share my views.

Employer-sponsored insurance (I will call it ESI from here on out) provides insurance for the majority of under-65 Americans. ESI, particularly among large firms, works because it pools risk, has low administrative costs, and offers a stable source of coverage for a large share of the population. Many of these people enjoy the benefits they receive and would like to keep them. However, we have seen a weakening in ESI over the last several years and it is important to examine strategies – and I commend Chairman Rangel in holding a hearing to examine strategies – to strengthen ESI and find ways to provide this high-value coverage to more Americans.

The rise of employer-sponsored health insurance

The employer-sponsored health insurance industry in the United States did not flourish until the middle of the 20th century, although there were numerous early attempts to protect against the costs of medical care. During World War II, employers offered health benefits as a way to attract workers when the National War Labor Board froze wages.

In 1954, Congress amended the Internal Revenue Code to clarify and expand a 1943 administrative tax ruling that granted tax exempt status to employers' contributions for their employees' group medical and hospitalization premiums. Excluding premium contributions from taxable income made one dollar worth of health insurance less expensive to provide than one dollar worth of wages. In general, the tax exemption – effectively a government subsidy – reduced after-tax insurance premiums enough to encourage even the healthiest employees to enroll. In this way, sustainable risk pools were formed and group policies became more attractive to insurance companies.

Over the latter half of the 20th century, employer-sponsored health insurance became increasingly popular. Workers have grown to rely on employers to provide health insurance, and employers have used it as a tool to attract and retain the best workers and improve the health of their workforce.

The current state of employer-sponsored insurance

Employment-based coverage remains the most prominent form of health insurance in the United States. About 63% of the under-65 population has insurance either through their own or a family member's employer (Gould 2008). Let me take a moment to characterize the population which has access to this valuable insurance source (**Table 1**).

Americans, ages 25-64, are more likely to have employment-based insurance than children and young adults. White, non-Hispanics have coverage rates 20-30 percentage points higher than their non-white counterparts. Over 80% of the college-educated and 80% of those in the top half of the income distribution have ESI coverage. In fact, if you break the non-elderly population into fifths by household income, we would see that those in the top income fifth are nearly four times more likely to have coverage than those in the bottom fifth.

Not surprisingly, workers are more likely to have ESI than the non-working population. Over 70% of all workers and nearly 75% of full-time workers have ESI. As

with the general population, however, highly educated workers have high rates of coverage, as do those at the high end of the wage distribution.

If we look for a moment at only those with a strong labor force attachment, that is, private sector workers who get insurance through their own job, we find that white collar occupations have higher rates of coverage than blue collar workers and far higher rates than service sector occupations (**Table 2**). Workers in manufacturing, mining, and information industries have higher rates of coverage than those in other industries. Workers in large firms have much better access to coverage than workers in small firms. In a minute, I will explore in more depth the unique difficulties small businesses face in the current health insurance marketplace.

So, we see that the employer-sponsored health insurance system is working well for tens of millions of American workers and their families. We should ensure that they retain this high-quality coverage. That said, the problem remains that many folks are left out of or are ill-served by the employer-sponsored system. Given the pitfalls of the individual insurance market (which you heard about at last week's hearing), this leaves far too many Americans exposed to both health and financial risks.

To better understand the weaknesses in the system today, I want to explain what has been happening with ESI over the last several years.

Recent trends in employer-sponsored insurance

While ESI remained the dominant form of health coverage through the 2000s, the share of people covered by it declined every year since 2000. This erosion, or unraveling, has been occurring even during the economic recovery. During an expansionary period, we would have expected coverage to increase as employment grew, but it simply did not. High and rising health costs are mostly to blame. Average premiums for an employer-sponsored family plan have risen nearly 120% since 1999, three and a half times faster than workers' earnings and more than four times faster than inflation (KFF/HRET 2008).

As a consequence, the percent of people with ESI has fallen over 5 percentage points since 2000. In other words, over 3 million fewer people under the age of 65 had employment-based insurance in 2007 than in 2000. Taking into account population growth, it is fair to say that as many as 14 million more people under 65 would have had employer-sponsored health insurance in 2007 if the coverage rate had remained at the 2000 level.

Where there are disparities in coverage, they have only been exacerbated in the last several years. While no group has been immune to the declines in coverage, some are hit harder than others.

Those at the middle and bottom of the income distribution – already shut out from the employer system in large numbers – experienced losses much greater than those at the top. Children experienced some of the largest declines in employer-sponsored health insurance, a drop from 66% covered in 2000 to less than 60% in 2007. We know it is only the strength of public health insurance programs that has prevented even more children from becoming uninsured as ESI fell.

While some workers fared better than others in the most recent year of data, no category of worker has escaped the declines since 2000. Even full-time workers, workers with a college degree, and workers in the highest wage quintile experienced declines in coverage over the 2000s.

Small businesses struggle to cover their workers

So far, I have documented an unevenness of coverage by race, income, employment status, and firm characteristics. I want to take a minute to talk about one group of firms that have the hardest time providing insurance to their workers. These are small businesses. And, as we consider solutions to strengthen insurance coverage across the United States, we really need to pay attention to small business owners and their workforce.

The coverage rate in firms with fewer than 10 workers is less than half that of workers in firms with more than 100 workers (**Table 2**). No matter how you define it, workers in small firms are much less likely to have ESI coverage as those in large firms.

Small businesses offer insurance to their employees at much lower rates than larger firms (**Table 3**). Only 43% of workers in small firms (less than 10 workers) are in firms that offer health insurance, compared to over 95% in large firms (more than 100 workers) and 87% in all firms across the economy. While most workers who are offered ESI take it up, it is not surprising, given the lower offer rate, that a far smaller share of workers in small firms are eligible and actually enrolled in employer-sponsored health insurance plans.

In fact, half of all the uninsured are employed by a business with fewer than 100 workers, and 36% work in firms with fewer than 25 employees. That said, among offering firms, small firms actually contribute a higher share of the single plan premium than their large firm counterparts as a way to cover a larger share of workers and maintain at least a minimum sized risk pool (MEPS).

Small firms that do offer health insurance face high costs, paying on average 18 percent more than larger firms for identical policies due to higher and more variable health risks, a lack of competition amongst insurers, and greater administrative expenses (KFF/HRET 2008). You heard last week from David Borris, a small business owner in Illinois, who pays 13% of his covered employees' payroll on health insurance (Borris 2009).

I know, in 2007, at the small firm where I work, with less than 30 days notice, our insurer raised rates by 27%, forcing us to switch carriers at the last minute, which is not easy in the limited marketplace. This year, our new insurer increased our rate by 15% to 23%, depending on plan type. It is these high and unpredictable costs that have made it increasingly difficult for small firms to provide the insurance they want to offer their workers.

The future of employer-sponsored health insurance

So, what does the future hold? It is truly bleak unless there is action. The current economic downturn and forecasts of high unemployment indicate continued erosion of employer-sponsored insurance in the near future. I estimate that by the end of 2009, nearly 50 million non-elderly will be uninsured. The link between insurance and work has become a tradition in this country. ESI, particularly in large group markets, can pool risk, lower administrative costs, and maintain stability. But we must recognize its limitations.

As we move forward in what I hope to be ground-breaking steps towards meaningful health reform, we must be wary of quick fixes to our insurance system. One such fix involves taxing health benefits.

Tax exclusion

Some argue that a cap on the tax exclusion for ESI premiums would be a great way to raise money for health reform. They claim that it primarily would affect rich people with expensive plans – dare I say enviably high-quality plans. Research shows that taxing high-priced health coverage will heavily burden two groups – workers in small firms and workers in employer pools with higher health risks, such as those with a high percentage of older workers (Gould and Minicozzi 2009). Capping the exclusion would also disproportionately affect firms in certain industries and certain geographic areas.

Using the small business example, I'm going to take a minute to illustrate how a policy of taxing health benefits would weaken small business owners' ability to offer coverage to their workers.

Capping the tax exclusion exacerbates the problems small firms already have. It would encourage the young and healthy to opt out of these pools, and upon their exit, premiums would likely rise for those remaining.

Small businesses are paying high premiums for the insurance they provide to their employees not because the plans are especially lavish, but because they have high administrative costs and include too few employees to constitute the broader risk pool that would qualify them for lower premiums. Adding a tax on top of the cost of premiums they already pay will likely drive many more into the ranks of the uninsured. This disproportionately affects small business, in part because they face higher costs, but also because they are more sensitive to price increases.

It is worth noting that the high price of these plans may not stem from any bells and whistles in their coverage but rather from a fundamental inequity in the way that insurance for these groups is currently priced. A policy of taxing health benefits over a certain dollar amount is a blunt instrument that may do great harm to the very people we should be striving to help. Furthermore, these problems would only be exacerbated by a cap that fails to keep pace with future health care costs or one that does not take into account the relative costs of single and family plans.

Considering the negative impact capping the tax exclusion would have on insurance coverage, it is important to point out as well that the idea of taking from one group to pay for coverage for another ignores the dynamics of coverage. The insured, or just the population with ESI for that matter, is not a static group. We know that over one-third of the under-65 population is uninsured for some time over a three-year period (Kriss et al. 2008), and over half of those who lose ESI become uninsured (Gould 2009).

Despite all the reasons not to cap or do away with the tax exclusion, it remains true that doing so would free up enormous sums of money to defray the costs of fundamental health reforms. That said, changing the tax treatment should be the dessert not the appetizer, and it should not be considered until large-scale health reform is in place to cover everyone.

Solutions that work

Health reformers must join forces to strengthen ESI while insuring everyone and containing costs. Let us now examine approaches to health reform that can serve to shore up ESI and cover those who have fallen through the cracks.

Universal coverage means fundamental changes in the overall system where ESI sits as a leading member. There has to be a way for the non-workers, part-time workers, and

even those full-time workers who have been closed out of the current system to find affordable coverage.

One essential component of meaningful health reform is improving the health insurance marketplace. Private market reforms – such as community rating and guaranteed issue – can improve competition between insurance companies by ensuring that this competition takes place on the grounds of efficiency and not on companies' ability to sort the population for the lowest health risks. That said, even with regulations to prevent risk selection in place, research has shown that private insurers will still employ a number of strategies to push high-cost enrollees off their rolls, or keep such high-risk individuals from enrolling in the first place (Jost 2009). For example, rigorous utilization reviews and poor service can push high-cost enrollees to find alternative sources of coverage. Given the potential for this behavior, private market reforms would not be enough.

The best way to ensure that coverage is universally made available to those who do not have good ESI is to construct a national insurance exchange that includes a public health insurance option. A benefit of the exchange and the public option is that those employers who are having a hard time providing coverage to their workers can find a viable opportunity in the exchange.

A public health insurance option is an essential part of a new national exchange. While giving Americans more choices for coverage, it also has the added advantage of increasing competition to already limited markets, reducing costs and cost growth, driving quality advancement and innovation, and serving as a benchmark for the insurance market (Hertel-Fernandez 2009).

Let us take these reform options in the context of groups of workers who have been hardest to insure in the employer market. I have already mentioned workers in small businesses. About 70% (Main Street Alliance 2009) of small businesses want to provide insurance to their workers. A national exchange with a public health insurance option strengthens the ability of these employers to make an appropriate contribution for this coverage by slowing the rate of cost growth and reducing insurers' ability to charge discriminatory prices.

Low-wage workers and part-time workers are also groups we need to pay close attention to as we strengthen ESI and reform the health insurance system. While 87% of workers are in firms that offer health insurance, only 53% enroll (**Table 4**). This gap between offered and enrolled is a function of eligibility and affordability.

On the eligibility front, part-time workers are left in the dust. While part-time workers may be employed by a firm that offers insurance to some of its workforce, their part-time hours make them ineligible to participate. In offering firms with a high share of part-time workers, only one-third of workers are eligible, as compared to 85% of workers in firms with a small part-time workforce.

Turning to workers in firms with a low percentage of low-wage workers (earning at or below the 25th percentile for all hourly wages, or $10.50/hour in 2006), the rubber meets the road in the enrollment decision. While the vast majority enroll, only 65% of eligible workers in low-wage firms enroll compared to 82% of eligible workers in high-wage firms. This is evidence that they simply cannot afford the premium.

Health reform efforts must take into account both the difficulties of insuring part-time workers and the necessary subsidies required to insure low-wage workers. In

constructing policy, we need to be careful not to increase inefficiencies in the labor market, such as encouraging employers to switch from a full-time to a part-time workforce, while at the same time providing opportunities for universal coverage. Offering the possibility for low-wage firms to contribute a share of payroll as opposed to a flat premium contribution greatly relieves their burden.

Those concerned with an employer requirement to participate in the health insurance provision of their workers need to look no further than Massachusetts' experiment with providing universal coverage. Mid-2008 data from Massachusetts indicate strong support from firms and an increase in the number of offering firms from 73% to 79%. When asked in a survey, small Massachusetts firms (3 to 50 workers) bucked the national trend by answering that they were not likely to terminate coverage or restrict eligibility (Gabel et al 2008).

Containing health costs and cost growth through a national exchange with a public insurance option – while encouraging shared responsibility across firms and across sectors – may have the added benefit of improving competitiveness. The median contribution to health premiums is 11% of payroll for covered employees (KFF 2008). A full 25% of those firms had employer costs of at least 16.5% of payroll. There is striking unevenness in this burden across firms, particularly by industry (Table 2). Health reform that evens this burden across firms will insure that a businesses' competitiveness will rest on grounds that are amenable to their own actions – like how efficiently they run their business – and not on factors outside of their control – like the current health of their workforce.

Cost-containment is a crucial part of reform because high and rising health costs either crush workers' wages or raise prices for those firms that provide health insurance. Reducing overall costs and sharing the burden of providing coverage across industries would particularly help firms that disproportionately cover their workers already and benefit those firms that are exposed to international competition (manufacturing, most prominently) to remain competitive while also paying decent wages to all workers.

Conclusion

So, when we think of strategies moving forward, we want to consider those that strengthen people's access to affordable, consistent coverage. By building on what works well in today's American health care system – ESI for the bulk of the workforce as well as extremely popular public programs like Medicare – we can move with minimal disruption to universal coverage. Besides providing needed health and financial security, universal coverage is the first step we need to take toward restraining cost growth throughout the system. Failing to rein in costs will lead to falling living standards, lower wages, less competitive employers, and strains on public budgets. While the benefits to slowing health care costs are huge, many difficult decisions will have to be made on the way. Universal coverage assures that everybody will feel like a stakeholder in these decisions and that nobody need fear being left behind.

Thank you and I am more than happy to answer any questions you may have.

Table 1. Employer-sponsored health insurance coverage for non-elderly population and workers

Employer-sponsored health insurance coverage for non-elderly (under 65) population

	2000	2007	2000-2007
Under 65 Population	68.3%	62.9%	-5.4
Age			
0-17	65.9%	59.5%	-6.5
18-24	53.5%	48.4%	-5.1
25-54	72.9%	66.8%	-6.1
55-64	68.1%	67.8%	-0.3
Race			
White, non-Hisp.	75.6%	70.8%	-4.8
Black	56.1%	51.6%	-4.5
Hispanic	45.8%	41.4%	-4.4
Other	64.3%	61.7%	-2.6
Nativity			
Native	70.4%	65.1%	-5.3
Foreign Born	52.2%	47.4%	-4.8
Education*			
Less than H.S.	39.0%	30.1%	-8.9
High school	65.6%	56.4%	-9.2
Some College	73.3%	67.0%	-6.3
College	83.5%	80.0%	-3.6
Post-College	87.6%	85.8%	-1.9
Household income fifth			
Lowest	28.7%	21.9%	-6.8
Second	61.7%	53.6%	-8.1
Middle	77.4%	71.6%	-5.7
Fourth	85.6%	81.9%	-3.7
Highest	88.4%	86.4%	-1.9

Employer-sponsored health insurance coverage among workers

	2000	2007	2000-2007
All workers	74.8%	71.0%	-3.7
Race			
White, non-Hisp.	79.6%	76.4%	-3.2
Black	68.3%	65.6%	-2.7
Hispanic	53.4%	50.0%	-3.4
Other	70.6%	69.5%	-1.0
Nativity			
Native	77.4%	74.1%	-3.2
Foreign Born	58.7%	54.0%	-4.7
Education			
High school	71.8%	65.5%	-6.306
	85.3%	82.7%	-2.61
Wage quintiles			
Lowest	49.4%	44.9%	-4.431
Second	69.0%	62.5%	-6.444
Middle	80.7%	77.8%	-2.9
Fourth	86.9%	85.0%	-1.9
Highest	88.6%	85.9%	-2.6
Work time			
Full Time	77.6%	74.3%	-3.277
Part Time	60.4%	54.6%	-5.852

* Education reflects own education for individuals 18 and over and reflects family head's education for children under 18.
Source: Author's analysis of the March Current Population Survey, 2001-08.

Table 2: Employer-sponsored health insurance coverage for private sector workers*

	2000	2007	2000-2007
All workers	58.9%	55.4%	-3.4
Occupations			
White collar	65.0%	61.9%	-3.0
Blue collar	59.0%	53.9%	-5.0
Service	33.9%	29.5%	-4.4
Other	26.7%	22.2%	-4.5
Firm Size			
9 or fewer	30.6%	27.1%	-3.5
10 to 24	42.9%	38.4%	-4.5
25 to 99	56.0%	52.7%	-3.3
100 to 499	65.9%	63.1%	-2.8
500 to 999	67.1%	64.9%	-2.2
1000 or more	69.9%	67.5%	-2.4
Industry**	**2002**	**2007**	**2002-2007**
Agriculture, forestry, fishing, hunting	37.1%	27.1%	-10.0
Arts, entertainment, recreation, and accommodation	32.5%	31.9%	-0.6
Construction	47.5%	44.1%	-3.4
Education, health, and social services	59.4%	60.2%	0.7
Finance, insurance, and real estate and leasing	65.8%	65.1%	-0.7
Information	73.0%	72.7%	-0.3
Manufacturing	72.7%	70.2%	-2.5
Mining	78.4%	73.9%	-4.5
Other services (except public administration)	40.1%	37.4%	-2.7
Professional, scientific, management, administration	57.4%	56.0%	-1.4
Transportation and communication	66.9%	63.0%	-3.9
Wholesale trade	53.9%	51.6%	-2.2

* Private-sector, wage and salary workers, age 18-64, who worked at least 20 hours per week and 26 weeks per year.

** Industry classifications changes make it impossible to compare 2006 with years earlier than 2002.

Source: Author's analysis of the March Current Population Survey, 2001-08.

Table 3: Offer, eligibility, and enrollment, by firm size, 2006

	All firms	Less than 10 employees	10-24 employees	25-99 employees	100-999 employees	1000 or more employees
Percent of employees in offering firms	86.9%	43.3%	67.4%	88.8%	95.1%	98.7%
Percent of employees eligible	67.3%	35.5%	51.4%	62.7%	72.4%	77.3%
Percent of employees enrolled	52.7%	28.8%	39.4%	47.5%	56.6%	61.3%

SOURCE: 2006 Medical Expenditures Panel Survey, Insurance Component (MEPS-IC)

Table 4. Percent of private-sector employees offered, eligible, and enrolled in ESI, 2006

Characteristics	Offered	Eligible	Enrolled
United States	86.9%	67.3%	52.7%
Percent low wage employees			
50% or more low wage	75.5%	45.5%	29.4%
Less than 50% low wage	91.4%	76.0%	62.0%
Percent full-time employees			
Less than 25%	56.1%	20.5%	9.4%
25-49 %	80.7%	37.2%	23.4%
50-74 %	81.9%	53.2%	37.7%
75% or more	91.6%	77.8%	62.9%

SOURCE: 2006 Medical Expenditure Panel Survey, Insurance Component.

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Chairman RANGEL. We would now like to call on Randy MacDonald, who is a Senior Vice President for Human Resources at the IBM Corporation, and is the chairman of the board of the Policy Association, that represents more than 250 of the largest corporations in the United States. And he is committed to providing health insurance to employees, but he is concerned, as all of us are, with the rising health care costs.

So we are very anxious to get your views on how we can be helpful with our bill.

STATEMENT OF J. RANDALL MACDONALD, SENIOR VICE PRESIDENT FOR HUMAN RESOURCES, IBM CORPORATION

Mr. MACDONALD. Good morning, Chairman Rangel, Ranking Member Camp and Members of the Ways and Means Committee. My name is Randy MacDonald. I am the Senior Vice President of Human Resources for the IBM Corporation. As mentioned, I also serve as Chairman of the HR Policy Association, a group of chief human resource officers for more than 260 of the largest corporations in America.

Simply put, IBM is building smarter health systems with a more personalized experience for patients. A smart health care system will be better instrumented, interconnected and intelligent, centered around the patient. IBM intends to be a leading proponent of health care reform because it is both a competitive necessity and because it is good business for us.

We believe that broad systemic reform is necessary. A successful agenda will build on a patient-centered, accountable, competitive health care market that delivers effective outcomes in improving the cost.

I must say, adding millions of people to an overburdened, underperforming system is somewhat like diverting water into the Red River while you are piling up sandbags. Change must be structured, it must be planned and it must have incremental giant steps.

IBM has 450,000 reasons to be an active participant in this national discussion. Those reasons are employees, our retirees and their dependants, and the fact that we spent $1.3 billion on health care in 2008 alone.

Successful health care reform doesn't have to begin from scratch. Employer-based health care is a good starting point, but we need a broad-based approach to fix fundamental flaws, including effective incentives for wellness, prevention, primary care, better cost controls and higher quality outcomes.

Earlier this decade, IBM had double-digit cost increases. Accountability and transparency were nonexistent for employee decisionmaking. Real cost, prices and subsidies were actually hidden. Between 2005 and 2007, our assessment showed dramatic declines in employee health risk, including behaviors such as smoking. Participation in wellness programs rose sharply and more adopted healthy behaviors such as exercise and good nutrition. Program costs during this period were $81 million with a total savings approaching $200 million.

Today, our employee population is healthier, employee costs remain lower than our benchmarks. With this experience, we support a national health care reform agenda with seven recommendations.

First, strengthen the voluntary employer-based system of health care;

Second, adopt a comprehensive national reform agenda;

Third, significantly improve wellness, prevention and primary care;

Fourth, create a competitive and accountable marketplace;

Fifth, control cost, improve quality and reduce cost shifting;

Sixth, assure adoption of health care information technology; and

Seventh, ensure all Americans have health insurance.

Mr. Chairman, reform can only succeed with an approach built on shared responsibility. All stakeholders must come here with an open mind and share the burdens as well as the benefits of reform. In my written testimony and through the work of the HR Policy Association, I have detailed what we see as those stakeholder responsibilities.

In sum, we believe that the crisis in American health care is too complex for any one person, for any one organization or one sector of our society to figure out the best solution. We need a comprehensive solution. Not a Band-Aid here or there, but a solution.

The panacea in health care is a system that does more than just deliver quality care at reasonable cost. Our aim should be to make all Americans healthier and our economy stronger. Thank you.

Chairman RANGEL. Thank you, Mr. MacDonald.

And we will make certain that whatever we move forward we don't hurt what is already working for IBM and for America. So thank you for your contribution.

[The statement of Mr. MacDonald follows:]

Statement of J. Randall MacDonald, Senior Vice President for Human Resources, IBM Corporation

Good morning, Chairman Rangel, Ranking Member Camp and Members of the Ways and Means Committee. My name is Randy MacDonald and I am the Senior Vice President for Human Resources for the IBM Corporation. In the United States during 2008, IBM provided health coverage for 118,500 employees, 93,200 retirees, and 235,000 dependents—a commitment of some $1.27 billion in 2008 alone.

In addition to leading IBM's global human resources organization, I also serve as the Chairman of the Board of the HR Policy Association (HRPA), a group of the chief human resource officers of more than 260 of the largest corporations in the United States. Representing almost every industry, HRPA members employ more than 12 million persons in the United States.

IBM is also working to create smarter health systems, with an increasingly more personalized experience. A "smart" health care system will be better instrumented, interconnected and intelligence-centered around the patient. In a smarter, IT-enabled health system, a networked, collaborative team of care-providers will work with individuals and families with children at the center to build strong trusting relationships which promote wellness, prevent and control chronic disease and disability. This smarter health care system will enable behavior change and vastly improved health care decisions that produce better health outcomes and greater efficiency by eliminating waste, and needless administrative cost.

A successful health care reform agenda will build a patient-centered, accountable and competitive health care market place that delivers effective outcomes and improved unit costs. It will:

- build upon our employer-based system
- control costs and improve value in terms of quality and health status
- ensure all Americans have health insurance,
- enhance the focus on wellness, prevention and primary care, and
- accelerate the adoption of health information technology.

We believe the crisis in American health care is too complex for any one person, one organization, or one sector of our society to figure out *the* best option for reform. Our ideas are offered in the spirit of stimulating a discussion with Congress, the administration, and other stakeholder groups to figure out the best solution. We look forward to building consensus to achieve the collective goal of transforming the nation's troubled health care system and improving the health and productivity of our population.

There is growing consensus among all key stakeholders, including large employers that purchase billions of dollars of health care products and services, that the current system of health care in the United States will be further stressed by improving access without at the same time fundamentally reforming the system.

Large employers like IBM have become more active in this debate because we see pervasive deficiencies in the availability of comprehensive primary care; the lack of evidence-based use of medical technologies; insufficient transparency to allow con-

sumers to make informed decisions; and inadequate adoption of information technology that would make care safer and more efficient.

Coverage Provided to IBM employees

Let me explain how IBM has worked to tackle some of these problems. IBM provides coverage to both full-time, part-time, and long term supplemental employees of IBM, as well as retirees and dependents. IBM and our retirees participate in the Part D Retiree Drug program sharing in any subsidies provided by the government—splitting the subsidy in proportion to their respective contribution to the retirees' aggregate prescription drug costs.

We operate our plans for employees across the nation and there are no geographic differentials in employee/retiree contributions for our self-insured plans.

There are a number of innovative features in the coverage for IBM employees:

- Eligible full time employees have access to at least one health plan at no cost.
- Enrollees receive deductible-free coverage for preventive services
- Primary Care is covered deductible free and at a low coinsurance
- Employees are offered a Healthy Living Rebate Program (130K rebates earned in 2008)—employees earn up to $300/year to complete healthy activities such as physical activity-nutrition, preventive care and the cutting edge Children's Health Rebate for family-based activities to build healthy weight behaviors in children and youth
- Over 80,000 IBMers are now physically active and over half of our employees who were in a high health risk group have lowered their risk category
- From 2004 to 2008, IBM paid out over $133 million to the Healthy Living Rebate program.
- IBM offers all employees an on-line Health Risk Assessment (64,000 completed 2008) and Personal Health Record

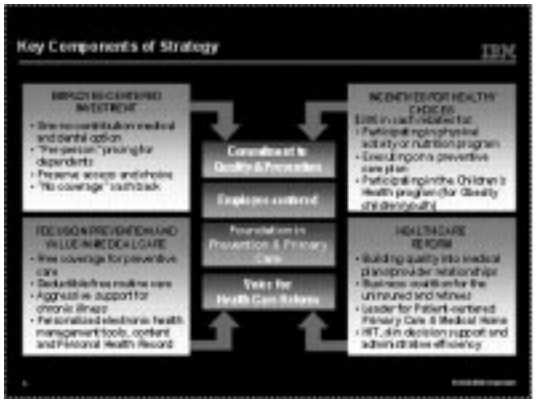
Our efforts to improve IBMers health and reduce costs

Earlier this decade, we were seeing double-digit increases in health care costs for IBM. Our contracting strategy was not optimized for quality, service, efficiency or price. Population health status and prevention, clinical care needs for chronic diseases, and coordination of care were absent in the marketplace. Accountability and transparency were non-existent for consumer decisionmaking—real costs, prices and subsidies were hidden.

IBM talked the problem through a new vision: healthy people for high performance.

Our strategy currently combines:

- Value (quality and cost)
- Meaningful choice
- Sustainable cost structures
- Prevention
- Primary care
- Smart decisions
- Privacy and HIT



Today, our employee population is healthier and our costs are lower. For both ***cost*** and ***trend***, IBM is routinely at or below market. Employee costs remain lower than benchmarks. In 2008, our costs were $8,585 per capita while the marketplace benchmark was $8,895. Between 2004 and 2007, our internal health assessments showed dramatic declines in employee health risks. Participation in the wellness programs rose sharply and our employee population reduced risky behavior such as smoking, while increasing healthy behavior such as exercise and healthy nutrition. Over 80,000 IBMers participate in our physical activity incentive program. Generic drug utilization has increased to 96% without reducing medication options. The reduction in health risks translates into savings in health care claims costs estimated at $79 million between 2004 and 2007 alone.

But we are only one company. Systemic problems are at issue and we need to ensure we are all focused on the right problems.

It's Not Just a Covered Problem; It's Also a Cost and Quality Problem

While some health care reform advocates believe that we can reform our nation's health care system by simply creating universal coverage through private insurance reforms or some form of a government-run single-payer system, we do not believe this would achieve our goals for health and health care. Above all, our society cannot afford to pay billions more into a fundamentally flawed delivery system to provide uninsured Americans access to the fragmented, episodic, procedure-oriented care that delivers poorer outcomes compared to other OECD countries. This is why we believe that broad, systemic reform is necessary. Our problems will only be exacerbated by bringing the uninsured into our current dysfunctional health care system.

Objectives of Health Care Reform

We support a national health care reform agenda that meets the following seven objectives:

1. Make Significant Improvements in the Voluntary Employer-Based System of Health Care In Order to Ensure Its Continued Existence

IBM and other HRPA members have expressed a commitment to maintaining the nation's voluntary system of employment-based health insurance if and only if major reforms to improve value, efficiency, and transparency can be achieved. The majority of Americans—more than 160 million—receive health care through employment-based coverage, and most Americans who do so are pleased with it. Even with its existing flaws, we believe our mix of employer-based coverage, private market, and public safety-net programs is superior to shifting to a government-run, single-payer system. Because of the lack of choice and stifled innovation that would result from a single-payer system, we are committed to working from the foundation of our current system to make significant improvements.

I know that there are questions about the proper balance between public and private insurance options as we look at health care reform. It is a fact that the government has long played a vital role in providing coverage for difficult-to-cover populations. Indeed, many IBM retirees already participate in Medicare Part D—a public plan, and expansions in the CHIP program this year will provide much needed assistance for uninsured children and youth. The question is how to strike the right balance between providing public options for those who truly need them, without undermining the bedrock of our U.S. health care system, which is voluntary employer-provided private insurance options.

We need to identify a balance that avoids problems like adverse selection for private sector plans, and we must proceed quite carefully as we consider the impact to the voluntary employer-based system of proposals that expand public coverage to those who are uninsured or disadvantaged in the individual group market like small

businesses and the self-employed. We need to be careful because public plans might change the pool characteristics of private sector plans in a way that could shift costs onto private, employer-sponsored plans that have been the force for many innovations in wellness and health promotion, care services, transparency and pay for performance.

The ability of large employers to continue providing voluntary coverage depends greatly on the near-term adoption of significant changes that would help contain skyrocketing costs, improve the effectiveness and efficiency of health care, improve health outcomes, eliminate waste, and transform quality processes and accountability throughout the health care system. Changes in the employer exclusion of health care costs would threaten that system by adding to the burden employers are already carrying in providing health care coverage without addressing the need for shared responsibility across all stakeholders.

2. Adopt a Comprehensive National Reform Agenda

While there is considerable experimentation underway at the state and local level, at present more than half of Americans are covered by employer-based health insurance; many of these workers are employed by companies doing business across state lines. Many large employers offer benefits that are regulated by the Employee Retirement Income and Security Act (ERISA), which provides uniform rules for the health benefits enjoyed by millions of workers and their families. ERISA preempts state laws that relate to ERISA plans in order to ensure uniformity among the states.

Pressure on ERISA is constant. States and localities relentlessly search for ways to penetrate its protective shield. For example, some states and localities have recently started to attach benefits requirements to public sector contracts—threatening to create the benefits patchwork that ERISA and the courts have long prevented.

The nature of health benefits offered by multi-state employers makes it unworkable—and unfair—to reform health care using a patchwork of state and local solutions. Rather, our health care system should have consistent and uniform guidelines to ensure that affordable and comprehensive benefits can be delivered to all Americans.

3. Significantly Improve Wellness, Prevention, and Primary Care

A successful national reform agenda must focus on maximizing the health status of individuals, not just treating the sick. Costly chronic conditions such as diabetes, coronary artery disease, obesity, and asthma account for a disproportionate share of health care costs. Half of the population spends little or nothing on health care, while five percent of the population accounts for almost half of the nation's health care expenditures.

Health care reform must build a strong primary care foundation for the health care delivery system. Many health care providers, especially primary care physicians, share the frustration of payers and consumers about our current health care system's focus on the delivery of acute and episodic care, high volumes of procedures, intensive use of high-cost technology, specialty services, and administrative overhead. Primary care physicians want to provide accessible, continuous, coordinated and comprehensive care, but to do this a payment model in which they do not have to suffer financially for providing evidence-based medicine and communicating and coordinating care that keeps their patients healthy. Payment reform and new models of care delivery with primary care providers, such as occurs within a "patient-centered medical home" model, can encourage providers to keep patients healthy and deliver timely, comprehensive, and appropriate care.

4. Create a Competitive and Accountable Marketplace

Two key elements that drive healthy markets—consumer information (transparency) and choice—are woefully lacking in our health care system. Providers operate under perverse incentives that reward the volume of services delivered, rather than the quality and efficiency of the care provided. Many consumers receive coverage through a third party that pays for their health insurance without knowledge of the cost of services. Health insurers compete based on the avoidance of risk (*i.e.*, individuals who are most likely to generate medical bills), leaving many people with individual policies without access to coverage or unable to afford it. The U.S. must inject market-based principles that foster competition among health care providers and choice among consumers to help lower overall costs and increase value within our health care system.

5. Control Costs and Improve Quality

A successful reform agenda must control costs and ensure that our health care system delivers consistent high quality care to everyone. While the United States pays $7,026 per capita on health care—more than any other nation—we rank near the bottom on a variety of health care indicators, including infant mortality, obesity, and potential years of lost life due to diabetes. Disparities in health care quality are pervasive, with minorities and low-income people often receiving lower-quality care across a variety of measures.

The business community has a record of banding together on quality and efficiency issues. For example, HRPA's Pharmaceutical Coalition is made up of 60 member companies who purchase pharmacy benefits for more than five million Americans. In 2005, they launched the Transparency in Pharmaceutical Purchasing Solutions (TIPPS) initiative. TIPPS is an effort by the Coalition to ensure the interests of a pharmacy benefit manager (PBM) are aligned with those of its employer clients. The Coalition has developed a uniform set of rigorous transparency standards for PBMs when contracting with Coalition members. PBMs are certified annually by completing a RFP process to ensure they are willing to meet the TIPPS standards.

Our experience with the TIPPS initiative has demonstrated that in some instances market reforms can be successful. When the program was first launched in 2005, only three PBMs were willing to meet the standards. Today, 15 PBMs have been certified, representing more than 50 percent of the market that serves large employer clients.

Another example of businesses banding together to solve health care problems is HRPA's Retiree Health Access (RHA). The Association developed RHA as an alternative solution to provide coverage to pre- and post-65 retirees. RHA was introduced in 2006 with five employers and 40,000 retirees participating.

At the time, carriers aggressively competed for post-65 retirees—a population that comes with significant employer contributions and government funding. However, no carrier would offer comprehensive, guaranteed issue coverage to early retirees without substantial employer subsidies and minimum levels of retiree participation.

As a result, the Association elected to place its RHA business out to bid in an effort to secure coverage for early retirees on a guaranteed issue basis without an employer subsidy or minimum enrollment requirements. The result of that bidding process was that a new RHA benefit offering guaranteed issue coverage for pre- and post-65 retirees became available January 1, 2008. This has proven to be a very popular solution. Since the new RHA solution was announced in 2007, more than 200 employers have expressed an interest in considering it. As of December 2008, 48 employers had decided to offer RHA with more than 80,000 retirees enrolled.

Reforms must include changes to the current provider reimbursement models within private reimbursement arrangements and in public programs such as Medicare and Medicaid to promote and reward value.

In addition, the business community must sponsor and support quality initiatives such as requiring providers and health plans to be involved in collecting and managing quality data. Enabling innovation to find new ways to treat patients, balanced with research into the comparative effectiveness and efficiency of various treatments, can be applied to improve care and lower costs.

6. Ensure All Americans Have Health Insurance

There is clear consensus that any successful health care reform agenda must result in the uninsured becoming insured. People who lack health insurance do not receive timely care and tend to use the most expensive care option—emergency rooms—when they are sick. Health care providers then shift the cost of the uninsured on to those paying for health care services, resulting in an extra $922 per year for family health insurance and $341 for individuals.

A successful solution has to take into account the different circumstances of those who are uninsured. This group includes low-income people eligible for public programs but who are not enrolled, those who make too much to qualify for public programs but still struggle to pay for coverage, employees of small businesses, individuals at high risk or with pre-existing conditions, and pre-65 retirees who are not yet eligible for Medicare. In addition, people who can access and are able to afford coverage, yet choose not to purchase insurance, make up another segment of the uninsured that must be addressed.

One of the greatest advantages of the employer-based system is that employees typically form large and diverse risk pools—an important factor that, when combined with significant employer subsidies, results in relatively stable and affordable premiums for workers. However, individuals faced with purchasing coverage on

their own in the individual market, especially those who are sick or high-risk, can face challenges in securing affordable coverage due to unaffordable premiums and policy denials. People without access to employer-sponsored coverage should be able to have guaranteed access to private coverage and comparable tax breaks to purchase coverage on their own.

7. Assure Adoption of Health Information Technology

Health care information technology (HIT) needs to be widely adopted by health care providers to improve patient safety, increase efficiency, and produce significant savings throughout our health care system. The potential for HIT to improve care and lower costs has been well documented when it has been put in place. It is clear that the technology is available. Other industries such as the airlines, finance, and consumer electronics have been able to achieve a level of interoperability for years, despite rapidly changing technology and constant innovation. Although the health care industry is not perfectly analogous to other industries, there is significant room for improvement to expand the adoption of HIT. Health systems can connect people to information, to experts and to each other and can act proactively to better manage and deliver preventative and therapeutic care. Strong incentives need to be put in place to encourage providers to consistently adopt this technology in a manner that benefits patients through safer and more convenient care, and in a way that lowers administrative costs.

Achieving the Objectives Through Mutual Responsibility

To achieve true reform of the health care system in the United States, we have adopted an approach of Mutual Responsibility. All key stakeholders must compromise and accept added responsibility, and share in the burdens as well as the benefits of reform. Our HRPA *comprehensive national reform agenda* includes the following mutually complimentary elements:

- ***Federal Government***. Public spending on health care, primarily for Medicare and Medicaid, accounts for approximately 46 percent of total health spending. Therefore, the federal government must play a critical role in health care reform. The federal government should, among other things, maintain the ERISA framework to enable the continuation of the employer-based system and not erode the employer based system by capping the employer exclusion of health care expenses; eliminate cost shifting from public programs to private payers; restructure public programs to move away from traditional fee-for-service reimbursement that pays providers based on volume of service toward value-based purchasing; stimulate the growth and availability of comprehensive primary care, pay providers to reward prevention and the delivery of evidence-based medicine; facilitate and promote prevention and wellness programs in the public and private sector; and; adopt uniform interoperability standards for health IT.
- ***Individuals***. The Congressional Budget Office estimates that 13 percent of the nonelderly accounts for 68 percent of health care costs. We will not realize higher quality and lower costs within our health care system without individuals being more responsible for managing their health. Individuals should:
  - maintain health insurance coverage through a private plan or a public program if eligible;
  - take greater accountability for their health care by living healthier lifestyles and participating in available prevention and wellness programs in order to receive public and private subsidies for health care; and
  - take steps to manage chronic conditions to avoid acute illnesses where possible.
- ***Health care providers***. Most health care in the United States is paid on a fee-for-service basis, which encourages providers to deliver a higher volume and intensity of services instead of providing the most effective treatments as efficiently as possible. Health providers should:
  - publicly report on quality and cost measures using uniform standards adopted by the federal government;
  - treat patients based on evidence-based medicine in accordance with uniform standards and the specific circumstances and needs of each individual patient;
  - transition away from fee-for-service reimbursement and embrace new reimbursement models that require accountability and reward superior quality and efficiency; and
  - focus on improving individual and population health and the delivery of high quality, cost-effective, evidence-based care.

- ***Insurance carriers***. Health insurers play an important role by covering people in fully insured arrangements or as third-party administrators for self-insured plans. Insurers are in a position to change misaligned incentives, disseminate quality and cost information, and give individuals access to the most cost-efficient benefit plans via individual and group coverage solutions. Insurers should:
  - cover all individuals seeking coverage on a guarantee-issue or modified guarantee-issue basis without regard to preexisting condition or risks;
  - shift away from fee-for-service reimbursement to pay providers to encourage quality and efficiency; and
  - report cost and quality measures for health care providers using national standards.
- ***Employers.*** Nearly 160 million Americans under age 65 receive coverage through an employer-based plan. While employer-sponsored coverage, especially coverage offered by large employers, provides some advantages over individual health insurance—including relatively lower premiums, more stable premium increases, and guaranteed access to coverage for eligible beneficiaries—there are steps that employers can take to improve our health care system. Under our plan, employers would:
  - design and offer benefit plans that encourage individual and population health by creating incentives to encourage individuals to establish continuous care in primary care practices, seek timely preventive care, participate in health assessments, and participate in prevention and wellness programs; and
  - push for benefit plans that reward providers for delivering high quality and cost-effective care.

Employer Play-or-Pay Mandate

We strongly believe in the voluntary nature of the employment-based health care system. Only when all other reforms discussed in HR Policy's reform position have been undertaken should Congress consider the possibility of implementing some form of a **federal** play-or-pay mandate for certain employers to contribute to the cost of providing coverage for certain full-time workers. The mandate to contribute a specified minimum amount toward the cost of coverage should apply only for W–2 employees who work more than 30 hours per week. Under no circumstances would it be acceptable to pursue a state-by-state or local play-or-pay mandate scheme. Moreover, any employer mandate should not discourage employers from designing and offering cost-effective health benefit plans. For example, an approach that requires employers to spend a minimum percentage of payroll on health care benefits could cause many employers to abandon efforts to contain costs.

Even under a uniform federal standard, there are instances in which unintended consequences might occur if employers were required to provide coverage. For example, companies that employ large numbers of low-wage, part-time, and seasonal workers may find it economically burdensome if subjected to an employer play-or-pay mandate. As such, Congress may carefully weigh all factors when considering proposals that include a play-or-pay mandate.

In reviewing those recommendations, we cannot stress too strongly that we see the interplay of all elements of the package necessary for reform. We do not intend for this reform position to be a menu for policy makers and other stakeholders to select the items they find most appealing. Highlighting individual elements without reference to the entire position would result in a misunderstanding of the systemic nature of the problems we are facing.

Mr. Chairman, we believe the crisis in American health care is too complex for any one person, one organization, or one sector of our society to figure out the best option for reform. Our ideas are offered in the spirit of stimulating a discussion with Congress, the administration, and other stakeholder groups to figure out the best solution. I hope the IBM experience I have discussed here today, and our ideas for reform, will be helpful to you and the Committee as you take on this most important task.

Thank you.

IBMs Employee-centered Health care Innovations
2004

- **IBM defines contribution for health care (50/50 share of trend)**
- **Employee-centric subsidy allocation strategy**
- **"Free" PPO & Buy-Up options**
- **Focus on prevention: no deductible, disease management, healthy living rebates: smoking cessation, physical activity**

- **Move toward strategic plan mix: eliminate Indemnity Plan, opt out credit**
- **Dependent de-subsidization**

2005

- **Improve purchasing efficiency via best in market vendor strategy**
- **Reach strategic plan mix (all PPO based)**
- **Introduce Health Savings Account**
- **Enhanced web-based total health management portal with quality, plan/provider and self-managed tools**

2006

- **Offer 100% coverage for prevention benefits (no co-pay)**
- **Primary Care: deductible-free**
- **Introduce new Healthy Living Rebate driving preventive care**
- **Update dollar features of plans (Deductibles, Out-of-Pocket Maximums, etc.) in keeping with cost inflation**

2007

- **Care coordination program to assist with rapid, effective services access**
- **Behavioral health care advocacy progam**
- **Expanded Healthy Living Rebate program**
- **Maintain full coverage for routine preventive services**
- **Patient-centered primary care pilot in Mid-Hudson Valley NY**

2008

- **Children's Health Rebate, helping parents & families with healthy nutrition, meals, physical activity for healthy weight**
- **Women's and Men's Health resources optimizer tool added to Preventive Care Rebate Program**
- **Primary care: reduced coinsurance employee pays for primary care**
- **Expanded flu shot coverage**

2009

- **Patient-centered primary care (medical home) pilots in Arizona, Vermont**
- **Generic drug Incentive Program**
- **Generics Advantage program drives efficient use of generic pharmaceuticals**
- **Program introduced to optimize safe usage of specialty medications**

Chairman RANGEL. Mr. Pascrell will have the honor of introducing his—a Member, outstanding Member of his community. I yield to Congressman Pascrell.

Mr. PASCRELL. Thank you, Mr. Chairman. I am proud that we have on our panel today Mr. Kelly Conklin, who both lives and works in my district. Mr. Conklin is the cofounder of Foley-Waite Associates, an architectural woodworking company in Bloomfield, New Jersey. He and his wife and business partner, Kit, started their business in 1978.

Foley-Waite Associates specializes in the fabrication of architectural woodwork and serves an exclusive high-end clientele in New York. He employs highly skilled experienced craftsmen in wood and related materials.

Mr. Conklin and his wife are lifetime residents of New Jersey. They currently live in Glen Ridge.

And, Mr. Chairman, if you will note during the testimony, if you haven't already read the testimony, it specifically zeros in on the question of transparency and where do our premium dollars go.

So Mr. Conklin thank you for joining us.

Mr. Chairman, thank you for allowing me to introduce him.

Chairman RANGEL. Mr. Conklin, the Chair anxiously awaits the comments of the business gentleman from New Jersey.

STATEMENT OF KELLY CONKLIN, FOLEY–WAITE ASSOCIATES, INC., BLOOMFIELD, NEW JERSEY

Mr. CONKLIN. Thank you, Mr. Chairman, Members of the Committee, Mr. Pascrell. My name is Kelly Conklin and I am here to talk about health care and its impact on small business.

I would like to make one thing clear right up front. I am not a policy expert on health care, but I deal with broken policy every day in my business. I own, with my wife, Kit, as the Congressman said, our business in Bloomfield, New Jersey; and my purpose today is to give you a window into small companies like mine and how the mess that is our current health care system impacts us. I will start with some background to try to explain where we are and finally lay out a few ideas as to where we might go.

A little history. My wife and I opened Foley-Waite in 1978 in a 700-square-foot shop in Montclair, New Jersey. In 1987, we expanded and hired four employees and we started offering health insurance. The premiums were about 5 percent of our payroll, and we paid it all.

Today, we employ 13 people, occupy 12,000 square feet of loft space and serve some of the most influential people in the world, and we fork over $6,000 a month in health insurance premiums. That is 20 percent of our payroll, one of the largest single expenses in our budget.

Why do I still offer coverage? Practically, it is necessary to attract and retain skilled employees, but I do it because it is the right thing to do for my people, it is the responsible thing too. If I didn't offer coverage, I just would be shifting costs onto someone else.

We have got to stop pretending that we can escape this cost. It is a fixed cost. When responsible employers offer coverage and others don't, it creates an unlevel playing field. If I am contributing for my employees and a competitor isn't, they have an advantage.

We would be much better off in a system where all employers contribute a reasonable amount instead of this game of cost-shifting. That is why a supported system of shared responsibility where employers pitch in their fair share.

April is a month that I dread, but not for taxes. Taxes are simple. I call my accountant. But health insurance renewal is a nightmare. Rising costs force us to cap our contributions for employees' coverage, and we are switching carriers each year. We had a rise in Blue Cross/Blue Shield, but they just raised our rates 25 percent, so we are switching to Health Net. That means new primary care physicians, and for my wife, who has a chronic illness, a new doctor who knows nothing of her medical history.

It is very frustrating as the person who writes and signs the checks every month to know that a lot of that money we spend isn't going to health and it isn't going to care. My shopping for health insurance, my choice, is who is the cheapest this year—3 years, three insurance companies. And over the past 2 months, as we transition to our new carrier, our premium bills are now $8,700 per

month. While I am writing the check for the new company, I am paying full freight for the old company.

This is efficiency? This is not bureaucratic? This is cost effective? Really?

The health insurance market has failed to deliver on its promise for small business. It fails to contain cost, enhance efficiency or improve outcomes. It fails to provide coverage to millions—our dry cleaners, our corner store owners, Joe the Plumber and Al the Mechanic. Something has to be done.

I think transparency is critical. It is time to have the insurance companies come clean and say up front what is covered and what is not. It is time to ensure everyone access to affordable health care based on shared commitment where employers like me, our workers, health providers and the government all pitch in.

We can take a big step by creating a public health insurance option. A well-designed public health insurance plan would finally give small businesses like mine real bargaining power, provide a guaranteed backup and introduce greater transparency. Most importantly, by creating genuine competition and restoring the vitality of the market, dynamic innovation in the private sector will occur.

I am not against private insurance; I am just saying we need more options. As a cabinetmaker by trade, I think about it like this: A toolbox holds a variety of tools, each perfected to perform a specific task. You can't drive nails with a screwdriver or cut wood with pliers. And in my experience, when a critical tool is missing, well, things can get ugly.

With health care, we have tried to do everything with a hammer. The public plan option is a critical tool missing from the toolbox, the one that could stem rising costs.

According to Commonwealth Fund, reform with a public option would save employers $231 billion between 2010 and 2020 and $3 trillion for the Nation. Without a public plan, we lose three-quarters of that. Billions for the little guy, imagine what we could do with that.

I have read about ideas I can't support. I don't think new tax credits are the solution to this problem. I would rather have real health reform that addresses costs rather than a tax credit that will only be consumed with skyrocketing premiums. We don't need to fiddle with taxes or jigger the Tax Code; we need policies to stabilize a health care system in critical condition.

I know I am not alone. I am a member of the New Jersey Main Street Alliance, a coalition of over 300 New Jersey businesses working for health reform that works. In a survey referenced in my written testimony, small business owners said three things:

One, we are willing to contribute, but we can't go it alone. Seventy-three percent said they would, 12 percent said they wouldn't; that is a six-to-one ratio.

We support reform that includes choice of a public health insurance plan, 59 to 26 percent, two-to-one.

We want government to play a stronger role in making health care work, 70 to 16 percent, four-to-one.

Businesses are looking to you for leadership. We need you to enact health reform that works for us and our employees this year so we can do our part for economic recovery.

Thank you, Mr. Chairman.

Chairman RANGEL. Thank you Mr. Conklin. Tell our friends in New Jersey help is on the way.

Mr. CONKLIN. Thank you, Mr. Chairman.

[The statement of Mr. Conklin follows:]

Statement of Kelly Conklin, Owner, Foley-Waite Associates, Bloomfield, New Jersey

Introduction

I would like to thank the Chairman and Members of the Committee for this opportunity to share my experience with and views on our employer-sponsored health insurance system as a small business owner. My name is Kelly Conklin, and I am a co-owner of Foley-Waite Associates, an architectural woodworking company in Bloomfield, New Jersey.

We've been in business for thirty years, and have worked for a wide range of commercial clients including Prudential Insurance, First Fidelity Bank, Shering Plough, Merck, and Citi Bank. For the past 15 years, we've focused on serving a high-end residential customer base in New York City. We have 13 employees, and currently we pay about $6,000 a month in health insurance premiums. Health insurance is close to 20 percent of our payroll at this point, and it's the third largest single expense in our budget. So this is an issue of great concern to me.

Small Businesses and Health Insurance: Responsibilities and Challenges

I share below a brief "health history" of my business to show what things are like on the ground level, but I'll first address the big picture of what small businesses are facing now with health insurance. It is often repeated in the public square that small business is the backbone of our economy. It sometimes looks from Main Street, that along with the economic and political well-being of the free world, the small business community is charged with the health and wellness of the American worker. But the skyrocketing costs of health coverage for small businesses are pushing us to the brink.

Why even offer health coverage? First, there's a strong business case: it's a critical benefit to attract and retain the skilled employees we need to succeed as a company. But there's more to it. I do it because I feel it's the right thing to do for my employees. Part of why we started our own business was to create an environment where we ourselves would want to work. I once had a business consultant advise me that I should tell my employees I had to drop their health coverage to ensure their job security, but I just couldn't do it—the ethics seemed questionable. It's also the responsible thing to do because if I didn't offer coverage, I'd just be shifting the cost of my employees' health care onto someone else.

It's counterproductive to try to escape the costs of health care. From my standpoint, it's a fixed cost, an inescapable cost. The way we're doing things now, where responsible employers offer coverage and others don't, that creates an incredibly unlevel playing field. If my employees and I are sharing the costs, then another employer who isn't contributing for health care has a competitive advantage over us. We'd be much better off in a system where all employers are contributing a fair share, instead of this game of cost-shifting we're stuck with now. Small business owners like me are willing to contribute—73 percent said so in the *Taking the Pulse of Main Street* survey I was a part of last year.

Small businesses who want to offer health coverage face a number of serious challenges. We have no bargaining power with the insurance carriers—it's "take it or leave it." We pay more in administrative costs—25 percent or more of our premium dollars, compared to around 10 percent for larger groups. Because of our small size, we can't spread risk effectively, and we get penalized for it. Because of rising costs, we're forced to reduce benefits by increasing deductibles and our employees' share of the premiums. And, we must contend with the great lack of transparency in the insurance market. It's so hard to know what you're buying and impossible to determine whether your dollars are being spent well.

April is a month I dread, not for taxes, but for health care. We struggle every year to find a way to make it work. We've been forced to cap our contributions for employees' coverage, and we've gotten used to switching carriers every year. We had Horizon Blue Cross/Blue Shield last year, but they raised our rates 25 percent, so

we're switching to Health Net. That means enrollment forms, discontinuation forms, finding new primary care physicians and, because my wife has a chronic illness, new specialists who know nothing about her health history. It's extremely frustrating, as the person who literally writes and signs the check every month, to know that a lot of that money is not going to provide care for the people I'm paying the benefit for—I pay thousands of dollars for a system that is inefficient and doesn't deliver the promise of decent care or financial security.

Back in '78 if you had told us that one day we would employ 13 people, occupy 12,000 square feet of loft space, serve some of the most influential people in the world and fork over $6,000 a month in health insurance premiums, we would have questioned your sanity. Like thousands of other small company owners we felt our way along, picking up sound business practices by the seat of our pants, usually preceded by a swift kick to the same. Not many graduates of the Wharton School work on Main Street, or make their living as plumbers or serving hamburgers and soda at the corner coffee shop or turning wrenches at the local auto repair. To this day I am appalled whenever I read on a health insurance document that if an employee should have a question or problem with their health insurance plan they should "first contact the company health insurance administrator"—that being me. Talk about "in the land of the blind a one-eyed man is king."

My "shopping" for health insurance consists of finding the least expensive policy—my "choice" is who is cheapest this year. Three years, three health insurance companies and over the past two months as we "transition" to our new carrier, our premium bills are $8,700 per month. Some of that premium money will be returned, but when my broker walks in the door with enrollment forms I have to write the check then and there for the new carrier, while maintaining current coverage with the "old carrier." This is efficiency? This is not bureaucratic? This is "cost effective"? Really?

Too often the "catastrophe" in catastrophic illness is not the disease, it's the devastation of medical bankruptcy in the aftermath. The lack of transparency in health insurance policies means that the insurance purchased in this case by your local cabinet maker (me) could be a financial disaster waiting to happen. What are the limits of our policy? How many Americans think they're covered but then find themselves destitute because their employer "shopped" for the cheapest coverage? How many of us actually know our policy limits and how that compares to what we might need? And how much of what I and my employees spend on health insurance goes to make up the system's shortfall because millions of our fellow Americans are too poor to afford any insurance at all and receive their care in the emergency room, where the costs are highest and the outcomes least certain?

The health insurance market has failed to deliver on its promise for small businesses. It fails to provide peace of mind or deliver quality care. It fails to contain costs, enhance efficiency or improve outcomes. It fails to provide coverage to millions of our poorest citizens, to our low-wage workers, to our sole proprietors, to our corner coffee shop owner, our local plumber and car mechanic. Something has got to be done.

Real Solutions for Small Businesses

We need to stop whistling past the graveyard and face this problem full on. There are no cheap or easy solutions. But there are things we can do.

We can promote transparency by having the private insurance companies come clean in plain English about where our premium money goes. We can have the private insurance companies produce policies that clearly explain and comparatively measure regional cost and probabilities so consumers can understand what it is they can expect and how secure they are from medical bankruptcy. We can assure everyone access to health care, preventative and therapeutic, and we can agree that this should be a shared commitment where employers like me, our workers, health providers and the government all contribute to make it so.

I believe we can go a long way toward these goals by creating a public health insurance option. The choice of a public health insurance plan would finally give small businesses like mine real bargaining power, it would provide a guaranteed backup, and it would promote greater transparency in the system. Perhaps most importantly, by creating genuine competition and restoring vitality to the market dynamic, this will bring about broad-based positive change in the private sector health insurance industry. According to the Commonwealth Fund, health reform that includes a public option has been estimated to save employers $231 billion over 2010–2020, and $3 trillion for the nation. Without the public plan option, those savings shrink from $3 trillion to less than $800 billion: we lose three quarters of the savings. I would submit that these are savings we cannot afford to pass up.

A word of caution about some things I believe won't help address the problems we face as small businesses. I don't believe new tax credits are a good solution to this problem. I would rather have real health reform that addresses the cost drivers in health care and bends the cost curve down than a tax credit that won't mean anything in two years after the costs just keep skyrocketing. That said, I'm against capping the employer exclusion for health benefits: this would only push more small businesses over the edge into dropping coverage. We need to create a more stable environment so businesses and employees can afford to contribute, not undermine that stability.

The Brief Health History of a Small Business: Foley-Waite Associates

In 1978, my wife and partner Kit Schackner and I formed Foley-Waite Associates in Montclair, New Jersey. Our shop, equipped with machines built between the Wilson and Eisenhower administrations, occupied 700 square feet. As a new enterprise, we aspired to furnish homes and businesses with fine woodwork and furniture. Working side by side and determined to survive, we realized anything made with our tools and talent that paid the rent and kept the lights on would have to suffice while we built a reputation and client base. The glory work would have to wait. Luxuries like plastic garbage bags and Coca-Cola would have to wait, too. Our gross receipts that first year were $27,000. Medical insurance, as it was known then, wasn't even on the radar. After all, we were young, healthy and broke.

We survive on Main Street by honing the specialized skills of our trades, by our reputations for dependability and a strong work ethic. Administration and paperwork, like payroll filings, workman's comp insurance and government mandated reports, are pretty well down the daily priority list. That's one reason that on Main Street so many small enterprises are the simplest and smallest, a "sole proprietor" or a "mom and pop" partnership that statistically will likely fail in its first year. For these, the hardest working, most at risk in business, medical insurance is an unattainable goal. There is something very wrong with that.

Along with our company's slow but steady growth came the ability to start a family and in 1984 our daughter Louisa was born. With Kit's pregnancy a new awareness of the cost of medical care came into clear focus. We bought medical insurance. As I recall, that insurance was "basic medical," meaning it would provide payment of medical bills for catastrophic illness and of course pregnancy. Primary care physicians, referrals, deductibles, co-pays and denial notices were all new to us.

We had previously had a relationship with our doctor. He knew us and more important our medical history, because he was writing it. Our first insurance policy changed all that: our doctor didn't take our medical insurance. With no awareness of what the future would hold, we began a long, expensive, frustrating journey into the mess that is modern health insurance.

Aside from Kit's OBGYN and Louisa's pediatrician, Kit and I didn't see a doctor for years. At the time, that did not seem unreasonable. For my wife and me, our health care insurance plan provided little in the way of health or care. We were still young and pretty healthy, but that would change.

We moved our little operation from Montclair to Bloomfield in 1987. Our enterprise evolved: it could no longer survive as a mom and pop. We would have to assemble a crew of skilled workers trained in our trade to meet the demands of a growing customer base. Our new shop was a vast space of 4,500 square feet and Louisa's bedroom no longer served its dual purpose as Kit's office. We now had 4 employees and our project list included a conference table for the board room of The Prudential Insurance Company's headquarters in Newark, New Jersey.

We offered health insurance to employees who were with our company for six months or more. There was no employee contribution. To find skilled workers and most importantly to keep them, Foley-Waite Associates had to offer health insurance. At that time, it wasn't easy but it wasn't impossible. Our health insurance premiums were about 5 percent of our payroll.

Health coverage is personally very important to me because my wife suffers from a chronic condition. She has Discoid Lupus: a chronic, disfiguring auto-immune disease of the skin, hard to diagnose and almost impossible to effectively treat. She lives with the symptoms of this disease every day, and has become a master of theatrical make-up and can paint out with brown spray paint the ever-more-difficult-to-hide signs of alopecia.

For nearly 10 years, general practitioners—our "primary care physicians"—were stumped. The local "in-network" dermatologists she saw seemed to quickly lose interest in her disease, when it became clear that the conventional therapies would offer no real relief. Instead they resorted to scolding her about lifestyle choices, like gardening. Her case is special, but that's no excuse for the clumsy and ineffectual way it has been handled by an overly complex, disconnected, impersonal and incom-

petent "health care system." Just in the last 3 years she found a dermatologist at NYU who has for the first time given her the sense that someone competent and caring will do everything he can to help her with this relentless disorder. There is only one problem—like many of this country's best and brightest doctors, he doesn't take "health care insurance"; period. Cash only, pay as you go.

Ten of Foley-Waite's eligible employees participate in our health care plan. One who does not is a permanent resident of the United States and a citizen of Great Britain. Before he came to work for us, he had a real scare a few years back when he discovered a lump on his leg and went to the doctor in New Jersey. A biopsy was taken and he was given the terrible news that he had aggressive melanoma. He was advised to get his affairs in order, the prognosis was terminal.

He decided to get a second opinion in England. He hopped on a plane and went to a doctor near his family's home in London, where a second biopsy was performed and the diagnosis of his American physician was confirmed. He did indeed have a rare, very aggressive form of cancer that would require immediate surgery and a relatively new but promising course of chemo-therapy. He agreed to the English doctor's recommendation, had the surgery within days of the diagnosis and began a rigorous course of chemo. As he says, "The chemo almost killed me, but with my faith in god, the help of my family and the British doctors, I survived." That was five years ago and after his most recent visit to his English doctor, his prognosis is excellent.

Another employee, one who participates in our health plan, had a simple but painful medical condition requiring a routine outpatient procedure. He went to his primary care doctor, got the diagnosis and with his HMO Blue Access card in hand showed up on the appointed day for his surgery. The person behind the reception desk in her white uniform, the nearest "expert," informed him he needed a referral. He called me and I told him he didn't, but to no avail. Back to the primary, the surgery appointment blown, he found that I was right, the expert was wrong and the surgery was re-scheduled. By this time the condition was too painful for him to come back to work while he waited for his surgery. He had the surgery on a Thursday. Over the weekend the stitches pulled, the surgical site became infected and my guy, now in great discomfort, was back at the doctor's office Monday morning. Ordered home with a new course of medication, he was told to stay home for the rest of the week. Out of work two weeks.

Compare the stories of these two employees: It took as long for his doctor to treat a hemorrhoid as it did for a doctor in England to perform a biopsy, diagnose a deadly cancer, perform surgery and begin a state-of-the-art course of chemotherapy. This is the health care system as my employees and I experience it. This is what I pay $6,000 a month for. This is the best health care in the world?

Looking to Congress for Leadership

My challenges with health care and my views on what needs to be done to fix it are by no means unique. Back home in New Jersey, I'm a member of a coalition called the New Jersey Main Street Alliance. We're a coalition of over 300 New Jersey small businesses that are working together to support health reform that works for us. Last year I was surveyed as part of a national small business survey project, where surveyors polled Main Street business owners door to door and asked face to face what we thought about the state of health care.

The results of this survey, reported in *Taking the Pulse of Main Street: Small Businesses, Health Insurance, and Priorities for Reform,* confirm that the views of my fellow business owners across America are quite different than those often attributed to us. The survey results challenge the conventional wisdom on small business and health care in three key areas:

1. *Our willingness to contribute:* When asked if we were willing to contribute for health coverage for our employees, more than two thirds (73 percent) of small employers said yes. Furthermore, 63 percent indicated a willingness to pay 4–7 percent of payroll (in some cases more) to guarantee effective, affordable coverage for our employees.

2. *Our support for real choices, including a public health insurance option:* When asked to choose between a proposal with a public insurance option and a proposal with more private options, respondents chose the proposal with a public alternative two to one (59 percent to 26 percent, with 14 percent undecided/other).

3. *The role of government in making health care work for us:* When asked about public oversight and the role of government, small business owners supported more public oversight of the insurance industry by a margin of almost six to one (75 to 13 percent), and a stronger government role in guaranteeing access

to quality, affordable health coverage by a margin of over four to one (70 to 16 percent).

We need Congress to act, and act swiftly, to advance real health reform, this year. In closing, I would like to thank the Chairman and Members of the Committee for allowing me to share my experiences as a small business owner. I am certain that if Congress can step back for a moment from the political blood battles that dominate the nightly news and instead keep Main Street in mind, you can craft the legislation we so desperately need to fix health care.

Chairman RANGEL. I would like to yield to Mr. Camp to introduce our next couple of witnesses.

Mr. CAMP. Well, thank you.

Our next witness is Denny Dennis, who is a Senior Research Fellow at the NFIB Research Foundation. And following that we will hear from John Sheils, Senior Vice President of The Lewin Group in Falls Church.

Thank you.

Mr. Dennis.

STATEMENT OF WILLIAM J. DENNIS, JR., SENIOR RESEARCH FELLOW, NFIB RESEARCH FOUNDATION

Mr. DENNIS. Thank you very much Mr. Chairman and Mr. Camp. This is an interesting day because Friday I start my 34th year in NFIB.

I would like to make two points initially in my testimony. The first one is, employer-mandated health insurance that is in the form of just funding premiums—pay-or-play, the payroll tax, they are all the same thing—they all become a mandate, are bad for small business, are bad for low-income people and they are bad for the economy.

The second point I would like to make is that health care costs must be addressed, preferably prior to coverage expansion, certainly no later than simultaneous to coverage expansion, and hopefully not later than coverage expansion.

As to the former, mandates are bad for small business because, initially—and I am going to underscore the word "initially"—in the short term, small business will absorb the brunt.

Now, since there is a direct correlation between the amount of income that a small business owner takes from the business and his propensity to provide health insurance, meaning that if you take a lot out, you tend to, almost always, provide health insurance; if you take a little bit out, you tend not to provide health insurance. Under those circumstances, the abrupt necessity to absorb additional costs, attack the most marginal and vulnerable of employers. The same is true not only with low-income employers, but low-margin businesses.

Second, an employer mandate effectively requires not only subsidization of low income, but also sometimes high income, which means it is a very blunt instrument, and you are looking for a targeted instrument.

And, finally, it really embeds an employer-based system on smaller firms when an employer-based system clearly does not work for smaller firms. One of the things we are going to have to

talk about is who the system works for and who it doesn't; and clearly, for small businesses, it doesn't.

The employer mandate is also bad for low-income people because they are eventually going to have to pay for this. They pay for it in lost wages, they pay for it in lost employment and they pay for it in other opportunities such as shorter working hours. This is generally understood by economists. This isn't new. In fact, I cite several prominent articles in my written testimony.

One of them is particularly interesting. It comes from the American Economic Review, 1989, written by someone I think most of us, or probably all of us, in this room have heard of, a fellow by the name of Larry Summers.

Recently, there came an article in the Journal of the American Medical Association, JAMA, also from some people we have probably heard of, Ezekiel Emanuel and Victor Fuchs, which concludes the same thing, that the cost of mandates is all passed back to low-income people.

And then, thirdly, it is bad for the economy because it is essentially a regressive tax, a very regressive tax, and supposedly we are concerned in this day and age about income inequality. Yet we are going to try and add more cost onto all our low-income people.

So your choice is this when it comes to the employer mandate: Make low-income people pay for their health insurance, effectively in a hidden, blunt and politically easy way under the guise of employer money on the table; or you can subsidize the health insurance of the low-income, target your subsidies, but do so in a politically more difficult way.

With regard to costs—I think we all agree that a major reason for the coverage problem is cost. I don't think that is in dispute. But what we are talking about here is a sequencing issue.

Let's take a look at Massachusetts. Massachusetts took up coverage first and now they are concerned with cost. So what happened? Between 2005 and 2007 Massachusetts cut its uninsured rate by about half. There is some argument about numbers, but it is about half. Meanwhile, costs, the entire costs of health care in Massachusetts, rose 23 percent. The entire health care cost in the United States comparatively rose 11 percent.

Now, if we do the same sequencing in the United States that they did in Massachusetts and have the same results that they had in Massachusetts, we are going to have a much worse problem, because Massachusetts started out with a very low uninsured rate, much lower than the Nation as a whole, plus they had a series of other advantages.

So your choice then is really to enact cost-control reforms before or simultaneous to coverage, because after there will be a huge new demand placed on the system for which there will be no offsets.

I thank you very much, Mr. Chairman. I would be more than happy to answer questions, and also to go more into the employer-based system and why it doesn't fit small business very well. Thank you.

Chairman RANGEL. Thank you.

[The statement of Mr. Dennis follows:]

NFIB RESEARCH FOUNDATION

Testimony of

WILLIAM J. DENNIS, Jr.
Senior Research Fellow
NFIB Research Foundation

Before

Committee on Ways and Means
U.S. House of Representatives

April 29, 2009

Thank you, Mr. Chairman.

I will summarize and ask that my complete testimony, including attachments, be entered into the record. I have also provided the subcommittee a rather lengthy study on steps to control rising healthcare costs prepared for the NFIB Research Foundation by Professor Louis F. Rossiter at William & Mary. Since the study is publicly available on the Research Foundation page of the NFIB Web site, I do not request its inclusion in the record. However, its concluding recommendations have been incorporated in my testimony as an attachment.

Mr. Chairman, I will direct my remarks to two issues – the employer mandate and the importance of cost control in healthcare reforms.

Employer mandates (offer and fund) to provide employee health insurance, or their equivalents pay or play and payroll taxes, are bad for small employers, bad for the low-income, and bad for the economy. They adversely affect small employers because they raise payroll costs, erode competitive positions, and increase start-up costs, making it particularly difficult for less profitable firms and those operating on small margins. Employer mandates adversely affect the low-income because they result in lost employment, depressed wages, and other unfortunate impacts, such as the lost work hours, for employees in general, but for the low-income in particular. They adversely affect the economy because they effectively levy a regressive payroll tax on the businesses and people least able to afford it.

The fallout from mandates, described above, is generally not in dispute. Only the details are, including the relative value of effectively taxing the low income to pay for their own health insurance, in a hidden way, that grabs the pool of "employer?" money on the vis-à-vis subsidizing coverage of the low income with transparent, but politically more difficult, funding.[1] Overlooked typically is the associated point that small employers who do not offer employee health insurance tend to be those operating marginally profitable businesses and businesses with low margins. There is great variation in the income/earnings that owners take from their firms and I previously have reported a direct relationship between owner income extracted from a business and the provision of employee health insurance.[2] Similarly, recent research conducted for the NFIB Research Foundation by a group at George Mason University, associated with Nobel Prize winner Vernon Smith, found a relationship between provision of health insurance under various mandate scenarios and profit margin regardless of firm size.[3] It was a finding not originally hypothesized or sought, but one that fell out of the data.

The attached paper, "The Case Against Mandated Employer-Provided Employee Health Insurance: A Small Business Perspective" delves into much greater detail about these issues from the perspective of small business owners. While the paper is well-documented, it focuses on the trade-offs and decisions small employers face under conditions of a mandate. And, then it follows with consequences of the adjustments they must make to comply with government requirements and market demands.

Recent rumblings suggest small employers may have changed their traditional opposition to employer health insurance mandates.[4] Let me settle the point once and for all. Small employers have not changed their collective views on the issue. A telephone survey of

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[1] An articulate summary of the idea's implications for healthcare reform appear in Ezekiel J. Emanuel and Victor R. Fuchs, "Who Really Pays for Healthcare? The Myth of "Shared Responsibility", *JAMA*, Vol. 299, No. 9, March, 2008, p. 1057. It reads in part,

> Employers do not bear the cost of employment-based insurance; workers and households pay for health insurance through lower wages and higher prices. Moreover, government has no source of funds other than taxes or borrowing to pay for healthcare.
>
> Failure to understand that individuals and households actually foot the entire healthcare bill perpetuates the idea that people get great health benefits paid for by someone else. It leads to perverse and counterproductive ideas regarding healthcare reform.

[2] William J. Dennis, Jr., "Wages, Health Insurance, and Pension Plans: The Relationship Between Employee Compensation and Small Business Owner Income," *Small Business Economics*, Vol. 15, No. 4, December, 2000, p.227.

[3] Stephen Rassenti and Carl Johnston, Health Insurance Reform in an Experimental Market, NFIB Research Foundation, Washington, 2009.

[4] For example, the Robert Wood Johnson Foundation conducted a survey of small business owners (released December 2008) that suggested small business owners are split on the issue. Unfortunately, the survey sampled only those with insurance, worded the question so those with insurance received a tax credit, and got a bare majority. In other words, half of small employers were omitted from the sampling frame, the ones most likely to oppose the mandate; the question included provision of a tax credit which meant everyone sampled would gain and no one would lose; and, it applied only to those with 10 employees or more. A similar pay or play proposal came in dead last as an idea that would help their smaller firm most.

1,000 small employers conducted for the NFIB Research Foundation by Mason-Dixon in December and January show 80 percent opposition. To determine whether NFIB member employers varied from the broader small employer population, the survey took 500 from each. As the appended graph shows, there is no statistical difference between the two. Both groups overwhelmingly oppose a mandate.

My second point is the critical position of healthcare costs in depressing health insurance coverage and making care affordable to many covered Americans. There is no dispute on this point, either. Yet, its discussion typically warps into questions of coverage, ignoring the proposition that much of the coverage problem originates with the cost problem. Hence, we continue to put serious consideration of coverage before serious consideration of cost. If that sequence becomes law, the healthcare system will be swamped with additional demand (assuming the uninsured are underserved) with little or no provision for curbing costs. That will only push costs higher, further straining the budgets of those who ultimately pay for it.

Blue Cross/Blue Shield reports that between 2005 and 2007, healthcare expenditures in Massachusetts rose from $20.8 billion to $25.5.[5] The associated percentage decline in the uninsured is uncertain, subject to survey and statistical issues,[6] but the number of uninsured has gone down by perhaps half from a low base. The number of newly insured is therefore comparatively small. The new demand, added to a sophisticated healthcare delivery system in a geographically compact state, with comparatively few illegal immigrants, and a population among the most covered in the country, was associated with health expenditure increases of 23 percent. National per capita numbers rose 11 percent in the same period.[7] The principal visible difference in the time span is new demand brought about by the Massachusetts experiment without accompanying cost-depressing measures. Imagine the parallel in states without those advantages.

Attacking costs cannot be a political throwaway line. It must be real and the first order of business in healthcare reform. To do otherwise would jeopardize everyone's healthcare.

Thank you, Mr. Chairman. NFIB looks forward to working with you on resolution of the critical healthcare issues we face.

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[5] Robert Seifert and Paul Swoboda, Shared Responsibility: Government, Business, and Individuals: Who Pays for What Health Reform? Blue Cross Blue Shield Foundation of Massachusetts Foundation, 2009, p. 8.

[6] Sharon Long, et al., Estimates of the Uninsured Rate in Massachusetts from Survey Data: Why are They So Different? Massachusetts Division of Healthcare Finance and Policy, Boston, 2008

[7] Kaiser Family Foundation. http://facts.kff.org/Chart.aspx?ch=854

Chairman RANGEL. Our next witness.
Mr. CAMP. Thank you.
Mr. Sheils, you have 5 minutes.

STATEMENT OF JOHN SHEILS, VICE PRESIDENT, THE LEWIN GROUP

Mr. SHEILS. Thank you. I am a Vice President with The Lewin Group. We are a nonpartisan health management consulting firm specializing in health care; we don't advocate for or against any legislation.

President Obama's proposal, while running for the presidency last year, was to create a public plan that would be available to people who are self-employed and small businesses that want to offer insurance to their employees.

Senator Baucus' proposal states that the new public plan would be similar to the Medicare Program. And implementing the program in a manner that is consistent with Medicare has some huge implications.

If you turn to page 4 of the testimony, right now, payment rates for providers under the Medicare Program are equal to about 71 percent of what private payers pay. For physicians' care, the payments are equal to about 81 percent of what private insurers pay. So you have a 25 to 30 percent lower price, lower premium, as a consequence of that.

In addition, there are some—in addition, administrative costs are lower under the program. For private insurance—for private-sector insurance, administrative costs average around 13.4 percent of claims. In the public program, we expect the costs to be about 7 percent of claims. So we have a premium that is 20 to 30 percent lower than the premium that you have in private insurance today.

And if you look at the chart on page 5, average private coverage premiums right now are about $970 per month per family for family coverage. That would drop to $7,600 per family, if you were to buy it through this public plan. That is a savings of about $2,500 over the course of a year. So it is going to be a very attractive option; lots of people are going to want to go into it.

On page 6, we show what happens under the proposal. But to give it a little better context, the public plan has been proposed as part of efforts to expand coverage. One of those requirements is a requirement that the employer either pay a tax or provide insurance.

Also, President Obama's proposal included some expansions of Medicaid and some new tax credits to help people buy insurance. So we ran the model, did our estimates with simply those assumptions.

If you look at the right side of the chart, we show first of all that there are about 28 million people who are uninsured today who would become covered under the program as a result of the program. That includes an increase of 16 million people on Medicaid.

The public plan would cover about 132 million people, but most of that is going to be people dropping their private coverage and moving into the public plan. That is about 120 million people and 70 percent of the private insurance market.

Just to—in our paper we also looked at the impact if you would limit it just to small firms, and that is on the left side of this page; and in that case, if you limit it just to small firms, overall there is a loss of private coverage of about 32 million people.

For employer coverage specifically, again on the right-hand side of the table, private employer insurance would go down by 107.6 million people. There would be an increase in the number of employers who are buying coverage for their workers through the public plan of 113 million. It is really a net increase in the number of employers contributing to the cost of the insurance for the worker that derives primarily from the pay-or-play requirement, which is to provide insurance or pay a tax. So this is a very large shift away from employer coverage.

On page 10 we have an estimate of what happens to provider income if we were to set up a program available to all firms, using Medicare provider payment rates. Hospitals would lose about $36 billion in net income, physicians would lose about $33 billion. If you limit it to small firms, actually hospitals come out a little bit ahead. And that reflects the fact that there is uncompensated care that is reduced by covering more people. These are net figures. But covering everyone under Medicaid with—under Medicare payment rates would have a fairly substantial negative effect.

The last thing I wanted to talk about is cost-shifting. This is a chart on page 11 which summarizes the payment system for hospitals in the United States. And we have arrayed people by their source of coverage and we have expressed the payments as a percentage of costs.

Right now, in the middle, Medicare—actually, in 2003, payments were equal to about 95 percent of costs. Medicaid payments were lower, about 89 percent. And then the uninsured accounted for a substantial amount of uncompensated care.

To recover those shortfalls, the hospitals, and physicians as well, will increase what they charge private payers. Private payers were paying 122 percent of costs. And the key to understand here is, when you put more people in Medicare where their payment rates are at this level, it will push down revenues for hospitals for those people and require the hospitals to increase their charges to privately insured people.

If you look at the final page here, we estimate that if we were to set up a program where all firms can go in using Medicare rates, there would be a cost shift to privately insured people of about $526 per person for a privately insured person, and maybe $1,500 for a family policy. But if you were to limit it to just small employers, small firms, the program would have less of a cost shift. In fact, because of the reduction on compensated care, it actually would be a small reduction in the cost shift.

So the point of the paper was to explain that there are different ways that you can construct this program. You don't have to use Medicare rates; you could use midpoints between private and Medicare.

There are a number of choices, and in our study, we look at the impacts, all of these impacts, under those various several scenarios. Thank you.

Chairman RANGEL. Thank you very much.

[The statement of Mr. Sheils follows:]

Statement of John Sheils, Senior Vice President, The Lewin Group, Falls Church, Virginia

The Lewin Group is a health care and human services policy research and management consulting firm. We have over 25 years of experience in estimating the impact of major health reform proposals. The Lewin Group is committed to providing independent, objective and non-partisan analyses of policy options. In keeping with our tradition of objectivity, The Lewin Group is not an advocate for or against any legislation. The Lewin Group is part of Ingenix, Inc., which is a wholly owned subsidiary of the UnitedHealth Group. To assure the independence of its work, The Lewin Group has editorial control over all of its work products.

The Cost and Coverage Impacts of a Public Plan

Thank you for this opportunity to address the committee on the coverage effects of a public plan. I am a Vice-president with The Lewin Group with 25 years experience in studying and analyzing proposals to reform health care and extend health insurance to the uninsured. We are committed to providing independent, objective and non-partisan analyses of policy proposals. The Lewin Group does not advocate for or against legislative proposals.

President Obama and Senator Baucus have proposed to create an "exchange" offering individuals and employers a selection of health plans. They also propose to create a new "public plan" that would compete for enrollment with private insurance plans in the exchange. Premiums under the public plan would be up to 30 percent less than private insurance plans if Medicare payment levels are used. Due to this substantial cost advantage, we estimate that up to 119.1 million of the 171.6 million people who now have private employer or non-group coverage would move to the public plan (70 percent).

Although the details of these proposals are still being developed, President Obama's health reform proposal from the 2008 presidential campaign states:

"The new public plan will be open to individuals without access to group coverage through their workplace or current programs. It will also be available to people who are self-employed and small businesses that want to offer insurance to their employees." [1]

The white paper on health reform developed by Senator Baucus would:

Create an exchange *"through which individuals and small businesses in the market for insurance could obtain affordable health care coverage"* and states that "the exchange would also include a new public plan option, similar to Medicare." [2]

Also, the Commonwealth Fund reform proposal would eventually allow employers of all sizes to purchase coverage in the public plan for their workers.[3]

To assist in designing the public plan, we developed estimates of the number of people enrolling in the plan under alternative design features. We estimated the effect of varying eligibility by firm size and provider payment levels under the program, which at this time seem to be the key design features.

Our estimates and methodology and results are presented in the following sections:

- Features of the public plan;
- Premiums in the public plan;
- Coverage effects;
- Employer Coverage;
- Provider impacts; and
- Cost-Shifting.

Features of the Public Plan

The public plan has been proposed as part of broad health reform proposals that would substantially expand insurance coverage. For illustrative purposes, we assume that the public plan would be implemented as part of a health reform program that includes coverage expansions similar to those proposed by President Obama in the 2008 campaign. Key elements of the President's proposal include: [4]

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[1] "Barack Obama's Plan for a Healthy America: Lowering health care costs and ensuring affordable high-quality health care for all."

[2] "Call to Action: Health Reform 2009," U.S. Senator Max Baucus, Chairman, Senate Finance Committee.

[3] "The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way," The Commonwealth Fund Commission on a High Performance Health System, February 2009.

[4] "McCain and Obama Health Care Policies: Cost and Coverage Compared," The Lewin Group, October 8, 2008.

- There would be a mandate for children to have coverage;
- Medicaid eligibility is expanded to include all adults living below 150 percent of the Federal Poverty Level (FPL), including able-bodied adults without custodial responsibilities for children;
- Tax credits are provided to people purchasing private insurance who live between 150 percent and 400 percent of the FPL;
- Medical underwriting and health status rating is eliminated in all insurance markets, but rating by age is permitted;
- Medium and large employers are required to offer insurance or pay a payroll tax; and
- Tax credits are provided to small employers (fewer than 10 workers) with low-wage workers for up to 50 percent of employer spending for worker coverage.

We assume that the benefits provided under the public plan are the same as those offered under the BlueCross/Blue Shield Standard Option offered to Members of Congress and Federal workers under the Federal Employees Health Benefits Plan (FEHBP) (as proposed by President Obama). These benefits include hospital care, physician services, prescription drugs, substance abuse, mental health services and dental care. For in-network utilization, there is a $15 copayment for office visits with no deductible. The plan includes a $250 deductible and higher copayments for out-of-network utilization, up to a maximum out-of-pocket limit amount of $4,000.

We used The Lewin Group Health Benefits Simulation Model (HBSM) to simulate the effect of such a program on coverage.[5]

Premiums in the Public Plan

For illustrative purposes, we begin the analysis by estimating the effect of creating a new public plan modeled on Medicare that is available to individuals and the self-employed. We began by estimating the effect of the plan assuming that it would use Medicare provider reimbursement levels. We then estimated enrollment and costs assuming enrollment is limited to small firms and under alternative provider reimbursement assumptions.

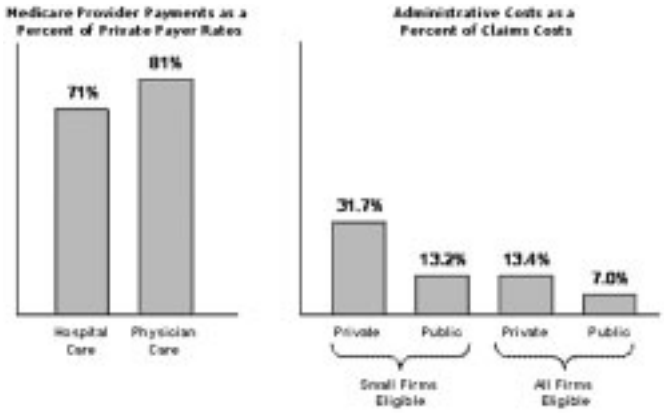
We estimate that premiums for the public plan under this scenario would be roughly 30 percent less than premiums for comparable private coverage (effects vary by firm size). As shown in ***Figure 1***, provider payment levels for hospital services under Medicare are equal to only about 71 percent of what is paid by private health plans for the same services. In fact, Medicare payments to hospitals are actually equal to only between 92 percent and 95 percent of the cost of the services provided by hospitals.[6] For physician services, Medicare pays only about 81 percent of what is paid by private health plans for the same services.[7]

[5] "The Health Benefits Simulation Model (HBSM): Methodology and Assumptions," The Lewin Group, February 19, 2009.

[6] American Hospital Association, "Trends Affecting Hospitals and Health Systems," TrendWatch Chartbook, April 2008.

[7] State Health Facts, The Kaiser Family Foundations (KFF), 2003 report.

Figure 1
Benefits and Administrative Costs under a Medicare-based Public Plan and Private Insurance Compared: 2010



Source: American Hospital Association, "Trends Affecting Hospitals and Health Systems," TrendWatch Chartbook April 2008; "Report to Congress: Medicare Payment Policy," Medicare Payment Advisory Commission (MedPAC), March 2008; and State Health Facts, The Kaiser Family Foundations (KFF), 2003 report.

Administrative costs are also expected to be lower for the public plan than under private insurance, reflecting that the public plan would not include an allowance for insurer profit and insurance agent and broker commissions and fees. Administrative costs, including profit and commissions, for privately insured firms are on average equal to about 13.4 percent of covered benefits. If implemented through Medicare, administrative costs would be equal to about 7.0 percent of covered services.

Our estimate of administrative costs is based upon a detailed analysis of administrative costs under insurance pools which we present in our model documentation.[8] These administrative costs are about twice what administrative costs currently are in the Medicare program (about 6.5 percent of benefits). Costs will be higher in the public plan than in Medicare because the program will need to process the movement of individuals across health plans when people decide to change their source of coverage. The plan will also need to collect premiums from individuals and employers who decide to enroll. These functions are not required for the current Medicare populations once enrolled.

Figure 2 presents our estimates of the average cost of insurance for individuals in the public plan and in the private insurance markets. Premiums for family coverage under the public plan would average $761 per month compared with $970 per month in the current private insurance market.

[8] "The Health Benefits Simulation Model (HBSM): Methodology and Assumptions," The Lewin Group, February 19, 2009.

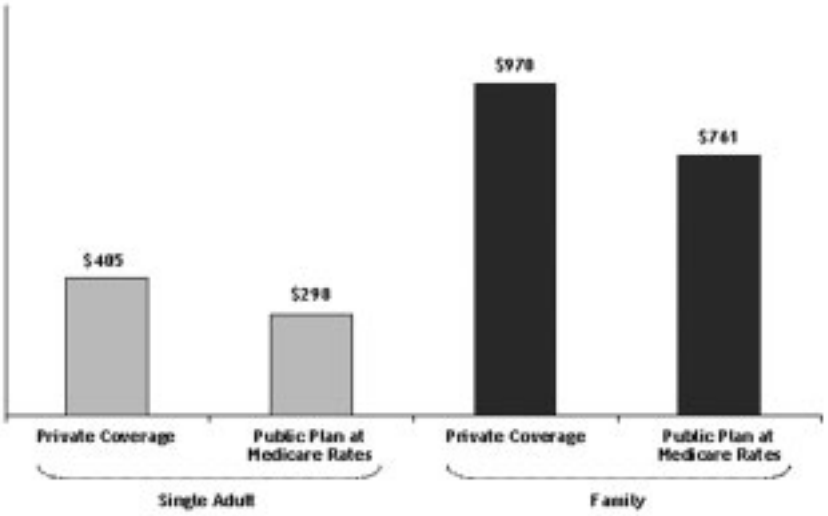


Figure 2
Impact of Using Medicare Provider Payment Rates on Premiums in the Public Plan in 2010

Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Coverage Effects

We estimate that the Obama-like health reform program described above would reduce the number of uninsured by about 28 million people. This reflects expanded eligibility under Medicaid/CHIP, and the tax credits under the proposal.

As discussed above, the President's campaign proposal would limit enrollment to individuals, the self-employed and small employers. Large employers would not be permitted to cover their workers through the public plan. Under this scenario, about 42.9 million people would be enrolled in the public plan (***Figure 3***). The number of people with private coverage would fall by about 32.0 million people.

If we assume that the public plan is open to all individuals, the self-employed and all firms, the public plan would enroll about 131.2 million people (includes some uninsured who become covered). The number of people with private health insurance would decline by about 119.1 million people (***Figure 3***). This is equal to about 70 percent of all people currently covered under private health insurance (excludes supplemental coverage for Medicare beneficiaries).

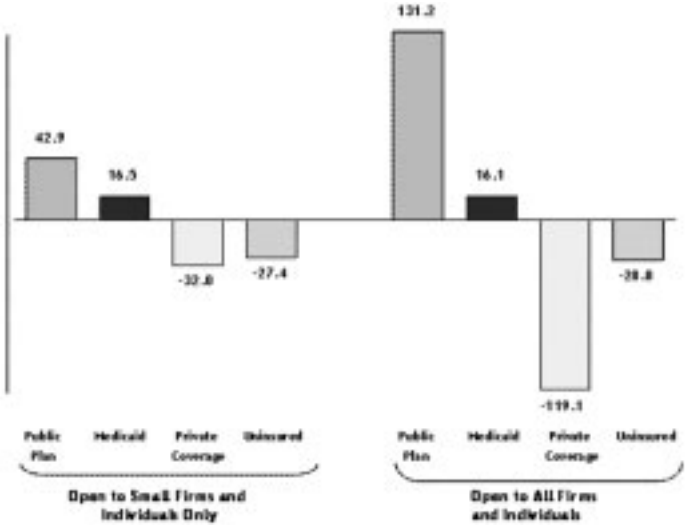


Figure 3
Public Plan Enrollment and Reduction in Private Coverage under a Public Plan Using Medicare Payment Levels 2010 (millions)

[a] Changes in coverage under Medicaid and other programs not shown.

Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The impact of the program on private coverage would depend largely on the levels of reimbursement under the program. While Medicare payment levels have been proposed, it would be possible to pay providers at other levels. To illustrate, we estimated the number of people enrolling in the public plan under two alternative payment level assumptions.

If the program is implemented using private payer rates (i.e., "negotiated" rates), premiums under the public plan would be only 6 percent to 9 percent less than in private plans, reflecting that the program would still have lower levels of administrative costs than private insurance. Public plan enrollment, assuming all firms are eligible to enroll, would fall from 131.2 million people with Medicare reimbursement levels to about 20.6 million people at private payer levels (***Figure 4***). We also show enrollment assuming payments are set at the midpoint between Medicare and private payment levels.

Figure 4
Enrollment in Public Plan Under Alternative Public Plan Scenarios

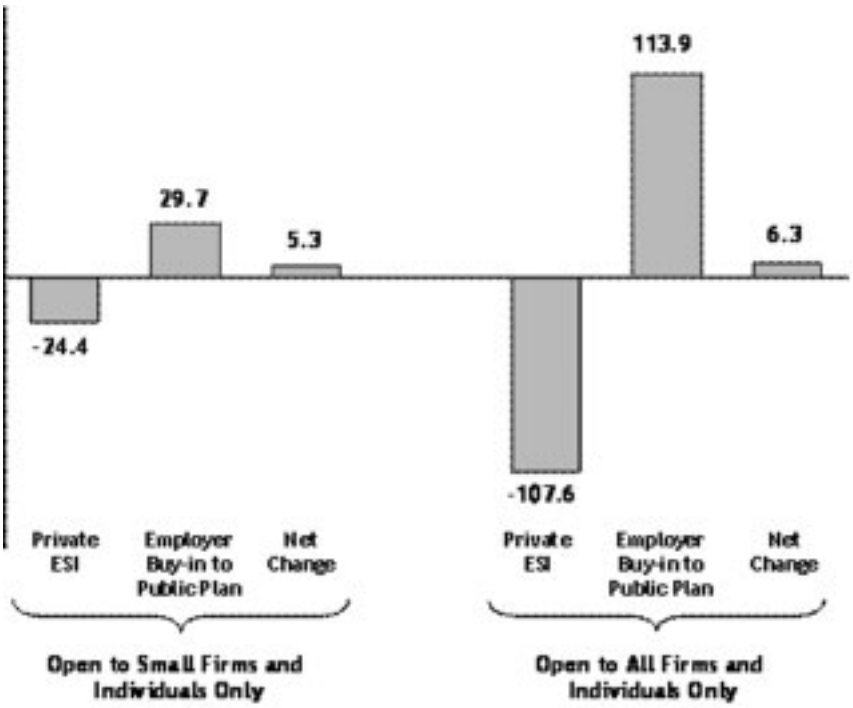
	Eligible Groups					
	Small Firms, Self-employed and Individuals Only			All Firms, Self-employed and Individuals		
	Private Payer Levels	**Midpoint Payment Levels**	**Medicare Payment Levels**	**Private Payer Levels**	**Midpoint Payment Levels**	**Medicare Payment Levels**
Public Plan Premiums as Percent of Private	−9% to −11%	−15% to −30%	−25% to −40%	−6% to −9%	−12% to −24%	−25% to −32%
Coverage Effects (millions)						
Reduction in Uninsured	23.8	26.1	27.4	25.1	26.7	28.2
Enrollment in National Public Plan	17.0	31.5	42.9	20.6	77.5	131.2
Change in Private Coverage	−10.4	−21.5	−32.0	−12.5	−67.5	−119.1

Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Employer Coverage

We estimate there will be about 157.4 million people with private employer-sponsored Insurance (ESI) in 2010 including workers, dependents and retirees. These include both private employer and government worker programs. In ***Figure 5***, we present our estimates of the changes in the number of workers and dependents where the employer contributes to the health insurance premiums.

Figure 5
Changes in Employer Participation in Worker Coverage Using Medicaid Payment Levels in Public Plan (millions)



[a] Assumes employers are required to either provide insurance or pay a 6 percent payroll tax.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

We estimate that if all firms are permitted to buy coverage for their workers through the public plan assuming Medicare payment levels, about 107.6 million workers and dependents would lose the private employer coverage they now have. However, employers would pay the premium for coverage under the public plan for about 113.9 million people. This would result in a net increase in the number of workers and dependents where the employer is contributing to the cost of insurance of about 6.3 million people. These include primarily workers in firms where the employer decides to cover their workers under the public plan rather than pay the payroll tax.

Figure 6 presents the impact of the proposal on employer participation in worker health benefits under alternative design scenarios.

Figure 6
Changes in Employer-Sponsored Insurance (ESI) under Alternative Public Plan Scenarios (thousands)

	Eligible Groups					
	Small Firms, Self-employed and Individuals Only			All Firms, Self-employed and Individuals		
	Private Payer Levels	**Midpoint Payment Levels**	**Medicare Payment Levels**	**Private Payer Levels**	**Midpoint Payment Levels**	**Medicare Payment Levels**
Currently with Employer Coverage	157,448	157,448	157,448	157,448	157,448	157,448
Changes In Employer-sponsored Insurance (thousands)						
Change Private ESI	(6,732)	(13,917)	(24,417)	(10,120)	(59,917)	(107,617)
Employer Pays Public Plan Premium	8,905	18,553	29,667	12,732	65,259	113,948
Change in Employer Participation In Coverage	2,173	4,636	5,250	2,612	5,342	6,331

Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Provider Impacts

The program would have a significant impact on provider net incomes. Expanding coverage would reduce uncompensated care for uninsured people and would result in increased health services utilization for the newly insured, all of which would represent new revenues to providers. These increases in revenues would be largely offset by reductions in payment levels for people who shift from private insurance to the public plan and the provider's cost of providing additional care to the newly insured.

Assuming the public plan is open to all individuals and all employers, total hospital margin would fall by $36.0 billion in 2010 (***Figure 7***). This is equal to about 4.6 percent of total hospital net revenues (i.e., gross revenues less contractual allowances) in that year. Physician net income would fall by about $33.1 billion, which is equal to about 6.8 percent of physician revenues. Thus, under this scenario, health care providers are providing more care for more people with less revenue.

The effect on provider income is substantially smaller under a scenario where large firms are excluded from participation in the public plan. For example, hospital margin would actually increase by $11.3 billion in 2010, assuming the plan is limited to only individuals, the self-employed and small firms. Thus, the increased revenues for newly insured people (including reduced uncompensated care) are greater than the loss of revenues for people who would become covered under the public plan. Physician income net of practice expenses would fall by $3.0 billion under this scenario.

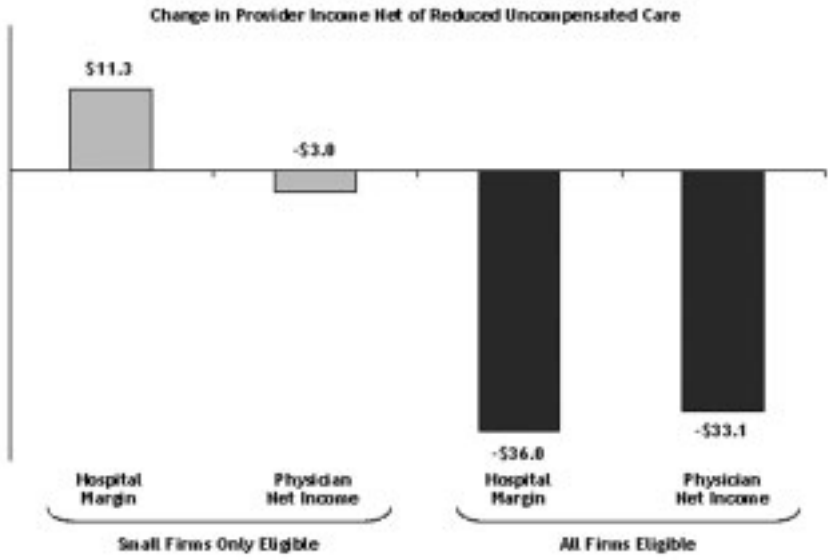


Figure 7
Impact of Public Plan on Provider Income if Medicare Provider Payment Rates Used

Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

In ***Figure 8***, we present estimates of the impact of the program on provider incomes under alternative payment level assumptions for the public plan.

Figure 8
Impact on Hospital and Physician Net Income in 2010 (billions)

	Hospital Income		Physician Income	
	Small Firms Only	All Firms Eligible	Small Firms Only	All Firms Eligible
Assuming Medicare Payment Levels				
Payment Level Reduction	−$10.7	−$58.0	−$6.0	−$36.1
Payments for Previously Uncompensated Care	$22.0	$22.0	$3.0	$3.0
Net Change	$11.3	−$36.0	−$3.0	−$33.1
Change as a Percent of Total Revenue	1.0%	−4.6%	−1.6%	−6.8%
Assuming Midpoint Payment Levels (i.e., between Medicare and Private Payer Rates)				
Payment Level Reduction	−$6.1	−$29.3	−$4.8	−$19.8
Payments for Previously Uncompensated Care	$22.0	$22.0	$3.0	$3.0
Net Change	$15.9	−$7.3	−$1.8	−$16.8
Change as a Percent of Total Revenue	2.0%	0.9%	−0.5%	−3.1%

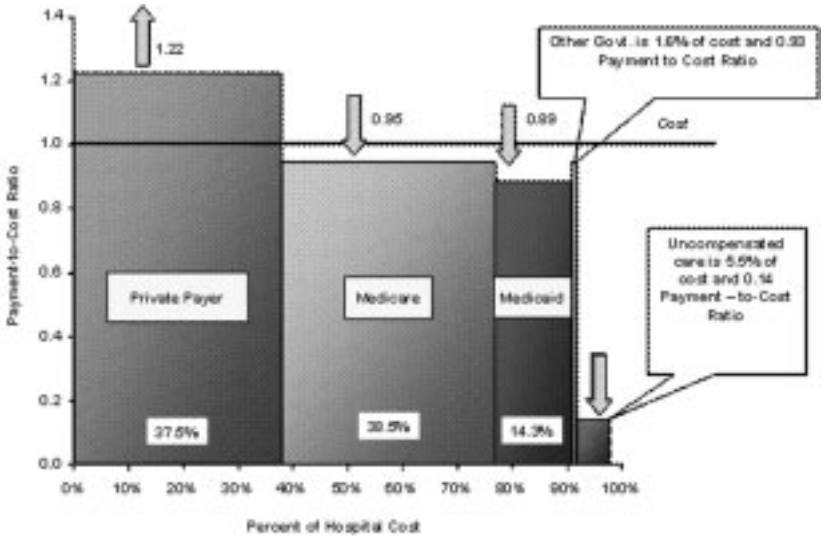
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Cost-Shifting

Provider payments under private insurance are inflated to cover uncompensated costs for the uninsured and underpayments for services under public programs. This added cost to the privately insured is known as the cost-shift. For example, ***Figure 9*** depicts hospital payments for various payer groups. In 2003, Medicare payments were equal to only about 95 percent of the cost of the care provided. Hospital payments under Medicaid were equal to 89 percent of costs and payments by the uninsured were equal to about 14 percent of the cost of their care.

To compensate for these shortfalls in payment, hospitals typically charge higher amounts to privately insured patients. In 2003, payments for privately insured people were equal to about 122 percent of costs. Thus, payments under private insurance are inflated by the cost of covering uncompensated care and payment shortfalls under public health coverage programs.

Figure 9
Average Payment-to-Cost Ratios for Hospitals by Payer Group Nationally for 2003



Source: Al Dobson, Joan DaVanzo and Namrata Sen, "The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implications," Health Affairs, January/February 2006, volume 25, number 1.

Data provided by MedPAC show that as the growth in provider payments under public programs is slowed, provider payments under private insurance increase. For example, Medicare hospital payment levels declined from 95 percent of costs in 2003 to 91 percent of costs in 2007. At the same time, private payer rates increased from 122 percent of costs in 2003 to about 132 percent of costs in 2007.

Not all of the shortfalls in payments are shifted to private insurers. The literature indicates that only about 40 percent of uncompensated care and payment shortfalls are passed-on as higher prices for the privately insured. The remainder (60 percent) appears to be absorbed through reductions in costs and net income. Similar effects also have been observed for physician care. The evidence on cost-shifting includes:

- There are two separate studies indicating that about one-half of hospital payment shortfalls are passed on to private payers in the form of higher charges.[9] Two other studies showed considerably less evidence of hospital cost-shifting, although they did not rule out a partial cost-shift.[10]
- One study of physician pricing by Thomas Rice et al., showed that for each one percent reduction in physician payments under public programs, private sector prices increased by 0.2 percent.[11]
- Our own analysis of hospital data indicates that about 40 percent of the increase in hospital payment shortfalls (i.e., revenues minus costs) in public pro-

[9] Dranove, David, "Pricing by Non-Profit Institutions: The Case of Hospital Cost-Shifting," *Journal of Health Economics*, Vol. 7, No. 1 (March 1998); and Sloan, Frank and Becker, Edward, "Cross-Subsidies and Payment for Hospital Care," *Journal of Health Politics, Policy and Law*, vol. 8., No. 4 (Winter 1984).

[10] Zuckerman, Stephen, "Commercial Insurers and All-Payer Regulation," *Journal of Health Economics*, Vol. 6. No. 2 (September 1987); and Hadley, Jack and Feder, Judy, "Hospital Cost-Shifting and Care for the Uninsured," *Health Affairs*, Vol. 4 No. 3 (Fall 1985).

[11] Rice, Thomas, et al., "Physician Response to Medicare Payment Reductions: Impacts on public and Private Sectors," Robert Wood Johnson Grant No. 20038, September 1994.

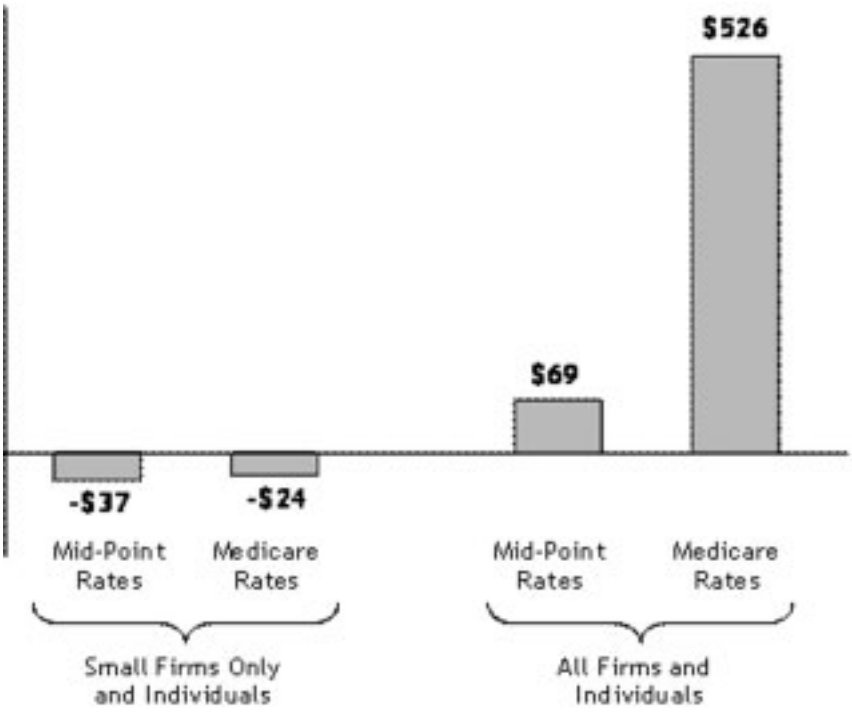
grams were passed-on to private-payers in the form of the cost-shift during the years studied.[12]

Based upon this evidence, we estimate that increasing the number of people covered under Medicare will increase the cost-shift for people who remain uninsured. This increase would be partly offset by reduced uncompensated care resulting from the expansion in coverage under the Obama proposal (28 million uninsured become covered under the proposal). Using existing research, we assume that 40 percent of the net reduction in provider payments would be passed back to private payers through the cost-shift.

Using these assumptions, we estimated the change in the cost-shift for each of the six scenarios presented above. The cost-shift would increase by about $526 per privately insured individual the scenario where Medicare payment rates are used and firms of all sizes are permitted to enroll their workers in the public plan (***Figure 10***).

These cost-shift assumptions are highly speculative, however. For example, the health plans most likely to survive in a system dominated by the Medicare plan are likely to be integrated delivery systems such as HMOs. Many of these systems have their own hospitals and would be able to avoid cost-shifting, because they serve only those enrolled in their plan. Thus, it is difficult to be sure of the extent of cost-shifting with the public plan.

Figure 10
Change in Cost-Shift per Privately Insured Person under Alternative Public Plan Scenarios



Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

[12] Sheils, J., Claxton, G., "Potential Cost-Shifting Under Proposed Funding Reductions for Medicare and Medicaid: The Budget Reconciliation Act of 1995," (Report to the National Coalition on Health Care), The Lewin Group, December 6, 1995.

Chairman RANGEL. Now we hear from Gerry Shea, who is the Special Assistant to the President, John Sweeney, right?

Mr. SHEA. Thank you, Mr. Chairman. I am Gerry Shea. I am the assistant to John Sweeney.

Chairman RANGEL. Let me ask you this. The Service Employees International Union, are they working with the AFL in terms of monitoring what we are going through and seeing what labor drink is best for their members?

Mr. SHEA. Very closely. My last meeting yesterday was at a meeting with a number of unions, including both the Service Employees and the United Food and Commercial Workers, neither of which are affiliated with the AFL–CIO, as well as a number of the AFL–CIO unions—and the NEA by the way.

Chairman RANGEL. That is very helpful. We anxiously await your testimony.

STATEMENT OF GERALD M. SHEA, ASSISTANT TO THE PRESIDENT, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

Mr. SHEA. Thank you, Mr. Chairman and Mr. Camp. We appreciate the invitation to share our perspective based on the union's bargaining experience with 40 million Americans, and I am honored personally to be before this Committee.

You have a tremendous responsibility in providing leadership on this crucial question, and I come to you both with a plea for help, which you have heard before, and also a pledge for cooperation and flexibility in terms of approaching this.

We have to solve this problem this year. And, in part, we have to solve this problem because even though the employer-based system, which is after all the backbone, as you pointed out, of our health care coverage and financing situation has served us pretty well, it is really hanging on, holding on, by its fingertips.

I can tell you that based on our experience monitoring bargaining situations across the country, this continues to be the most difficult issue in bargaining. I could give you examples today if I were free to share some confidential information about current large bargaining, where this is the only issue on the table and where strikes may ensue in short order in some very critical services because of this.

It is true that large firms still provide coverage. But when you look beneath those gross statistics, you see that there is very substantial cost-shifting to individuals. So that the studies are that the number of uninsured have gone, or the percentage of underinsured, have risen from 15 percent to 25 percent over the past 5 years. Those are people who have insurance, but can't afford to get the care that they are prescribed to get.

So we are just seeing the erosion of the employment-based system. And even if you didn't want to do national health reform and cover everybody, we would need your help to stabilize that system because it can't be done without government leadership.

I am involved many, many hours a day working with employers and with other unions on ways that we can restructure health care to make it higher quality and more efficient. Those are very, very

important conversations from our point of view. They are vital to the future of health care in this country.

One of the clear lessons from that is that we can't do it alone as the private sector. This has to be done by the private sector and the public sector, that is, with government, working together.

So what are the elements of stabilizing employment-based coverage in our opinion? One, it is controlling costs, because without controlling costs, whether you look at a private employment-based system or a public, say, single-payer system, without controlling costs, we can't afford the health system we now have. It is simply unsustainable for anybody. So that is priority number one in terms of employment-based coverage as well as other coverage.

Secondly, you have to have everybody in the system. If you are going to continue, if you want to rely on the employment-based system, we have to have all individuals and all companies participating in the financing of that care.

And then, thirdly, government has to play the role of making sure that there are fewer rules that are enforced across the board and, in our opinion, by sponsoring a public health insurance plan option.

So let me just elaborate a little bit, first, on costs. Long term we need to restructure the way we deliver and pay for care. The estimates from the Institute of Medicine are that $300 billion a year in this—of what we spend, go to care that is neither beneficial and sometimes downright dangerous for people. That is a lot of waste and inefficiency, and we know we can do better.

We have shown in many institutions that we can reduce hospital-acquired infections; we have shown that we can reduce the readmission rates in a number of hospitals by taking certain proven steps; we have shown that we can reduce the horrific problem of mistakes in surgery by simple protocols checklist and time-out kinds of procedures.

We can do this. It won't be easy, and it won't be overnight, but we can do it; and that is the most important thing, long term. Because while there are a lot of ways that you could control costs in health care we think that the best way and the most acceptable way to people in this country is going to be by improving the quality and efficiency of that care.

Secondly, the point about including a public insurance plan plays in here. Mr. Sheils has talked about the effect of a public insurance plan in terms of the savings that it could engender. We believe, while there is a lot of policy dispute about the number of people who would shift from the private insurance to the public insurance sector, Mr. Sheils has rather high estimates of that, in our opinion.

There is a clear understanding that this would reduce costs and save us money, so we think that is a critical step.

On the issue of cost-shifting, by the way, of the private sector—and this goes to the point about whether or not we should require everybody to pay—let me just give you our experience. Workers regularly trade off wages to keep health benefits. They make this decision on the ground every day, and their decision is consistently, we want health benefits, even if it means trading off wages and, in some cases, even trading off jobs. It is that important to Amer-

ican families for the simple reasons that you would all understand. We all hold the same position on this.

So people want everyone to participate. They are willing to pay their fair share in this as long as everybody else does.

And then, last, the government must maintain the rules to the road for everybody. And we are doing—we are starting this in a number of the quality improving areas by requiring reporting on uniform national standards of quality and making that information public to inform both purchasers, individuals and clinicians; and we need to extend that beyond this.

So, Mr. Chairman and Mr. Camp, I appreciate the opportunity to appear before you. I just want to make one last point if I could; and that is that the idea of taxation of health benefits has come up as a way to raise money. And I just want to say—going back to my point about what we need to focus on here is stabilizing the employment-based system—if we were to go to taxation of benefits, that would be the ultimate destabilizing step we could take.

You may consider the employment-based system, an accident of history in the United States; we heard some of the history from Dr. Gould. It is, however, composed of several core elements, one of which is the tax preferred treatment of benefits. You take that away and you are really pulling the rug out from under this system.

Now, maybe you want to change the system altogether. There are a lot of proposals to do that. But this taxation of benefits would certainly stabilize it. And in terms of the public support for health reform, asking people to pay again for the health insurance they already think they pay an enormous amount for is not going to wash. This is not going to get public support; it is going to get tremendous public opposition. So I would just caution against going down that road.

Thank you, Mr. Chairman.

Chairman RANGEL. Thank you.

[The statement of Mr. Shea follows:]

Statement of Gerald Shea, Special Assistant to the President, AFL–CIO

Good morning, Chairman Rangel, Congressman Camp and distinguished Members of the Committee. Thank you for the invitation to participate in this hearing and to offer our perspective, on behalf of working women and men, on the role of employer-sponsored health insurance in health reform. I would like to commend the committee for launching this series of hearings on health reform and for the commitment this Congress and our President have made to enacting comprehensive health care reform this year, in order to secure affordable, high-quality health care for all Americans.

Employer-sponsored insurance is the backbone of health coverage and health financing in America. Over 160 million people under age 65 have health benefits tied to the workplace. Despite its shortcomings, employer-sponsored insurance has proved remarkably successful and durable. It is widely considered to be the base on which health reform should be built, allowing working families to keep what they now have or choose from a new set of options to maintain coverage. Additionally, it is seen as the anchor for health reform, where all people would have affordable, high quality care.

But realizing this vision requires action to stabilize employment-based coverage and reverse the steady erosion in coverage caused by unsustainable cost increases. Our system of employer-sponsored health benefits is not falling apart but is tee-

tering on the brink. For several years coverage has been declining at an accelerating rate.[i] Without prompt, strong action, that rate is likely to increase dramatically.

Today, I want to share the AFL–CIO's view of what needs to be done to return employer-sponsored insurance to a successful path. Doing so will require the willingness to change by all parties—providers of care, insurers, consumers and employers, both those now providing benefits and those not.

The AFL–CIO represents 11 million members, including 2.5 million members in Working America, our new community affiliate, and 56 national and international unions that have bargained for health benefits for more than fifty years. Our members are among the most fortunate: through bargaining, they have good benefits from their employers. Yet even the well insured are struggling with health care costs hikes that are outpacing their wage increases and far too many working families increasingly find themselves joining the ranks of the uninsured or under-insured as businesses close or cut back. If we could take a snapshot of coverage at this point in our economic crisis, the number of uninsured would almost certainly be north of 50 million.

Between 1999 and 2008, premiums for family coverage increased 119 percent, three and one half times faster than cumulative wage increases over the same time period.[ii] Workers' out of pocket costs are going up as well, leading to more under-insured Americans who can no longer count on their health benefits to keep care affordable or protect them from financial ruin. Between 2003 and 2007, the number of non-elderly adults who were under-insured jumped from 15.6 million to 25.2 million.[iii] And skyrocketing costs are pushing more workers out of insurance altogether. About 18 million of the 47 million uninsured have a household income that exceeds $50,000.[iv]

Health costs are also straining American businesses. Globally, U.S. manufacturing firms pay more as a percent of payroll and as an hourly cost than our major trading partners.[v] Here at home, firms that provide good benefits to their workers and their families find themselves at a competitive disadvantage to firms that either don't offer affordable coverage or don't provide coverage at all. Their payroll costs are higher by virtue of being good employers who provide health benefits and they shoulder an additional burden picking up costs from their competitors that skimp on care. Even public employers that have typically provided good health benefits are struggling under growing cost pressures, especially as more states find their budgets hit by the economic crisis.

Without fundamental reforms aimed at substantially lowering the health care costs that are driving these growing gaps in coverage, we will continue to see a depression of wages and economic activity, as well as a federal budget increasingly consumed by health care costs. As then CBO director and now OMB director Peter Orszag has noted, health care cost trends are the "single most important factor determining the nation's long term fiscal condition."[vi]

The statistics we all regularly cite are broadly recognized signals of a system under severe strain. But this hearing and others in the series reflect your commitment to moving past simply a recitation of the problems to focusing on a comprehensive solution that will extend coverage to all Americans and curb health care cost hikes that are crippling families, business and government at all levels. Health reform done right is key to fixing our economy and putting future federal spending on a more sustainable track.

Our view of health reform builds on three primary principles: (1) everyone must participate in the system, both employers and individuals; (2) the government has a key role to play by setting and enforcing rules for a fair insurance market and by sponsoring a public health insurance plan to compete with private plans; and (3) costs must be constrained through delivery system reforms that link quality to payment and through the cost savings achieved with the efficiencies and purchasing power of a new public health insurance plan.

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[i] E. Gould, "The Erosion of Employer-Sponsored Health Insurance: Declines Continue for the Seventh Year Running," Economic Policy Institute, October 9, 2008.

[ii] Kaiser Family Foundation and Health Research & Educational Trust Employer Health Benefits 2008 Annual Survey, September 2008.

[iii] C. Schoen, S.R. Collins, J.L. Kriss and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008.

[iv] C. DeNavas-Walt, B. Proctor, J. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2007," U.S. Census Bureau, Issued August 2008.

[v] L. Nichols, S. Axeen, "Employer Health Costs in a Global Economy: A Competitive Disadvantage for U.S. Firms," New America Foundation, May 2008.

[vi] P.R. Orszag, "Growth in Health Care Costs: Statement Before the Committee on the Budget, United States Senate," January 31, 2008.

We believe the solution should build on what works in our health care system—public and private coverage—in order to close gaps, improve quality and lower costs. The majority of non-elderly Americans (62%) obtain coverage through employer-sponsored health plans. And despite its flaws—including higher cost sharing and the hassles and outright denials they've come to expect from insurance companies—most Americans are happy with their employer-based health benefits, in large part because they know it is still far superior to being on their own in the individual insurance market. Building on this core piece of our health care system will both minimize disruption and garner greater public support.

To be sure, employment-based health benefits have significant advantages. They provide a natural pooling mechanism, lowering costs and covering individuals who might not otherwise be able to afford coverage if they were subjected to medical underwriting or rating based on age. It makes plan choice convenient, facilitates enrollment, and lowers transaction costs. It has, in many cases, spurred innovation in workplace programs to promote healthy living, assist workers with family caregiving, and address problems related to chronic disease, substance abuse, and stress. And in unionized workplaces, it has also led to cooperation between unions and employers to advocate for improved quality and efficiency.

To build on the employer-based system, we must stabilize it by lowering costs that have driven the steady erosion of employer-sponsored benefits so that workers can retain the coverage they have and other workers now left out can gain health coverage. Doing so will reverse the trend to more and more uninsured: the share of Americans who obtain coverage through their employer is strongly and inversely correlated to the share of Americans who are uninsured.

Another significant component of stabilizing employer-based coverage would be to require employers to either offer health benefits to their workers directly or pay into a public fund to help finance workers' coverage, i.e. "pay or play." There are significant benefits of this approach. First, it will create a more level playing field between firms that offer health benefits and those that don't. It will also eliminate the cost shift that occurs when employers offering good family coverage see their costs rise when they provide coverage for spouses employed in firms that either offer too costly coverage or no coverage at all. To the extent policymakers may choose to construct pay or play in a way that allows families to be enrolled in the same employer plan, we believe one approach to consider would be to require a dependent's employer to make a contribution to the employer covering the whole family.

Furthermore, given other policy elements under consideration and the federal fiscal challenges affecting health reform, pay or play will be a necessary component if health reform is to succeed. If reform includes a new requirement that all individuals obtain coverage, expanding employer based health benefits will be key to making coverage affordable for workers that do not qualify for income-based public subsidies. It will also bring in a modest amount of revenue to help fund subsidies for low-income individuals and extend coverage to many of the uninsured since most are in families with at least one full time worker. Finally, without a requirement that employers participate in the new system, health reform that includes publicly subsidized coverage for low-wage workers will prompt many employers of low-wage workers to eliminate their coverage to take advantage of public subsidies. The resulting increase in federal costs may well doom reform efforts.

The design issues involved in a pay or play approach are critical, as they can create both opportunities and limits. Policymakers will have to define a "play" test, or the minimum amount employers must spend directly on job-based benefits, as well as the "pay" requirement for those employers not directly offering benefits.

Employers opting to "play" must be required to offer benefits that are at least adequate enough to allow their employees to meet an individual requirement to purchase coverage. The "play" test should also require employers to make a defined minimum contribution to the premiums for that coverage.

A "pay" requirement could be calculated from the costs associated with offering and subsidizing benefits that meet the "play" test. This contribution rate could take a number of forms, from a payroll tax to an amount per worker, and there are tradeoffs associated with each.

Setting the contribution rate based on payroll would lessen the impact on low-wage workers and would be a better measure of a firm's capacity to contribute to health benefits than the number of employees. Alternatively, a requirement tied to each individual employee will be more effective at reaching the entire workforce than a requirement tied to a percentage of total payroll, since it will protect against an employer meeting the percent of payroll test by offering relatively generous benefits to only a share of their workforce. However, such an approach, if applied only to full-time workers, would create incentives for employers in certain sectors to hire part time workers or reduce workers' hours to minimize the application of the con-

tribution rate. The contribution rate could be prorated for part-time workers, in order to protect workers and to ensure adequate revenue for subsidized coverage.

Another key consideration is how to index the contribution rate. To keep pace with actual costs, the index should be constructed to reflect health care inflation, so long as other reforms achieve cost savings and lower year-to-year cost increases. In the absence of reduced health care costs over time, the risk of future cost growth is not easily resolved in a manner that gives assurances to employers that they will have stable and predictable costs and to consumers that they will have access to affordable coverage to meet their requirement to purchase coverage.

Policymakers will also have to prescribe which firms are covered under an employer obligation to offer coverage. While many proposals exempt small businesses, since those firms face higher premiums in the current market, we believe this ignores important factors. First and foremost, the number of employees is a poor predictor of a firm's ability to pay: a doctor's office or small law firm may have more capacity than a larger restaurant or store. A carve out for small firms also creates a potentially costly hurdle for a firms near the threshold to hire additional employees. In addition, many health reform proposals under review would make it easier for small businesses to meet the "play" requirement by allowing them to buy coverage through a newly constructed exchange, including a public health insurance plan that would make coverage more affordable. If policymakers choose to treat small business differently, either in the application of pay or play or with additional help to purchase coverage (i.e., a tax credit for small employers), we believe the committee should consider phasing out that special treatment over time to eliminate disparities based on firm size.

Opponents to including an employer requirement in health reform will raise objections based on new costs for firms. However, the impact on businesses would vary depending on whether they are currently offering health coverage or if they are offering coverage that is inadequate. Those firms that do not offer health benefits would be directly affected by a new "pay" requirement, and others will have to spend more on the benefits they now offer in order to meet the requirement. These objections are misplaced.

Opponents may argue that employers subject to new health care costs may be less likely to raise wages in the short term; however, the widely endorsed economic view is that these employers would still raise wages over the long term. Opponents may also argue that employers subject to new health care costs may eliminate jobs or hire more slowly. However, we can expect results similar to the experience with raising the minimum wage. Recent studies of minimum wage raises have found no measurable impact on employment.[vii] Furthermore, economists often note that employers faced with higher costs under a minimum wage increase can offset some of the costs with savings associated with higher productivity, decreased turnover and absenteeism, and increased worker morale.[viii] We can expect similar results with a pay or play requirement.

There are other factors that will compensate for any increase in employer cost. First, the majority of firms that currently do not offer health benefits are in markets where their competitors also do not provide benefits, so they would see increases similar to those of their competitors. Second, firms that will pay more for health care than they currently do will see at least some of those costs offset by a healthier workforce. Third, broadening the pool of employers that would contribute to health financing could improve competition among firms within sectors by creating a more level playing field based on health benefit costs. Fourth, to the extent there is currently a shift of uncompensated care costs to employer-sponsored plans, all firms now offering coverage will see their costs decrease as we expand coverage. Finally, our economy as a whole will benefit from more rational job mobility and a better match of workers' skills to jobs when health benefits are no longer influencing employment decisions.

Finally, concern about new health costs to firms ignores a key element of reform that is not part of your focus in today's hearing but very much bears upon the success of efforts to stabilize the employer-based system. Creating a public health insurance plan to compete with private health insurance plans will lead to substantial savings throughout our health care system as a result of that competition. Employers that continue to provide benefits directly will benefit from these savings, as will

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[vii] A. Dube, T. W. Lester, M. Reich, "Minimum Wage Effects Across State Border: Estimates Using Contiguous Counties," Institute for Research on Labor and Employment Working Paper Series No. iiwps-157–07, August 1, 2007.

[viii] J. Bernstein, J. Schmitt, "Making Work Pay: The Impact of the 1996–1997 Minimum Wage Increase," Economic Policy Institute (1998); D. Card, A. Krueger, "Myth and Measurement: The New Economics of the Minimum Wage," Princeton University Press, 1995.

employers that will be able to purchase coverage for their workers through the exchange. Building a public health plan option into reform is essential to holding down costs for employers, consumers and government.

I want to offer one final note of caution. Some of your colleagues in the Senate are considering changes to the current exclusion of health benefits from income and payroll taxes. We believe this would be a step in the wrong direction. A cap on the tax exclusion would disproportionately affect firms with higher cost plans because of factors other than the level of coverage, including a higher percentage of older workers, higher risk in the industry and firm size. There is also likely to be some employer response even to capping the exclusion, including increases to employee cost sharing to a level where they may become unaffordable for low-wage workers. Finally, capping the tax exclusion would undermine the place where most Americans now get their coverage before we have built a proven effective, sustainable alternative to employer-based plans.

It is hard to imagine successful health reform that does not include a substantial role for employer-based coverage. To secure that, with a stable source of affordable coverage where workers can meet a coverage requirement and enhanced revenues for public subsidies, Congress must require employers to contribute to their workers' coverage within a well designed pay or play component. Failure to do so will undermine the "shared responsibility" that is the key to enacting effective, sustainable, equitable and broadly supported health reform.

Chairman RANGEL. Let me make it clear—I want to thank the panel and to make it abundantly clear that we recognize that you are not Republican and Democratic witnesses; it is just who invited you. But we know that all of you are concerned about improving the health care of Americans and that they get access to affordable health care.

I don't think it is necessary to say that, but I just want to make the record clear as I tear into Denny Dennis, the Republican witness.

Mr. Dennis, you made it abundantly clear that cost is a factor in terms of people having access to health care. We have, I guess, 45 million people, half of which work every day. And if they have a serious illness in this great country of ours, they have got to get care; do you agree?

Mr. DENNIS. Yes.

Chairman RANGEL. Where would they get this care?

Mr. DENNIS. Where would they get this care today?

Chairman RANGEL. If they are going to be treated, they have the swine flu, colds, broken legs; they don't have insurance. They work hard every day, their employer loves them, but can't afford health insurance. Where do they get it?

They don't ask whether they are Republican or Democrat. They say, Have you got insurance? They say "no." In some moral mandates, the people have to take care of these people, especially in our hospitals, especially in the emergency rooms.

Mr. DENNIS. Correct.

Chairman RANGEL. What do we do with these people? Do we allow them to continue not to be insured? They don't pay for it, the taxpayer pays for it. What would you suggest we do for them?

Mr. DENNIS. Well, one of the things that we suggested, as far as smaller firms are concerned——

Chairman RANGEL. No, no, I am talking about the employee. He is right now, as you and I talk, working every day, scared to death the kids are going to get sick. He can't afford insurance; the

employee can't afford insurance. They are here in large numbers, millions of people.

So we can't ignore them if we are talking about universal coverage. But for you, recognizing costs, what do we do?

Mr. DENNIS. In terms of making sure that they have coverage and care, yes, they do. The question becomes who is going to pay for it, and that is the issue.

There are certainly better ways to deliver care for the low-income folks who are not insured than we are doing today. We are doing it through emergency rooms. Why aren't we doing it through clinics?

Chairman RANGEL. Well, your contribution would be expand community health care clinics?

Mr. DENNIS. I am suggesting that would be—there are several steps that we could take, Mr. Chairman, that would——

Chairman RANGEL. Well, that is what we are here for, because we have a serious problem. It is going to cost money.

Many of us truly believe that the facts yell at us that it is going to save money. They kind of believe—I am no doctor and neither are you—that if these people have preventive care, have examinations, where they are tired of hearing, You should have come earlier; now you have to be admitted to the hospital, which is the most expensive type of care.

But if they knew that their kids could get examinations, if they knew they had the dignity to ask the employer, I have got to go for my check-up.

You just don't have to be a scientist to know you are saving money. And as a patriot and the chairman of this Committee, to me, it means they are healthy, they will be working, they will be paying taxes.

Mr. DENNIS. Yes, Mr. Chairman, we had a study done for us by Professor Rossiter at William and Mary to look at costs, precisely places that we can go to save costs, and we have given a copy to Committee staff.

Chairman RANGEL. Where? Well, I have already said, and you are not going to contradict, that 48 million people that don't have health insurance, if we give them, overall the country is going to save money. Forgetting productivity and all that economist talk, we have got to save money in terms of them not costing society——

Mr. DENNIS. Yes.

Chairman RANGEL. Health care that they don't have insurance to pay for.

What I want you to do is not to admit that we have a problem, but we are mandated today to move forward and resolve this problem, and we just need your expertise to say if I tell you that one of the things we are considering is having a public plan——

Mr. DENNIS. Yes.

Chairman RANGEL. If the employer has a plan, you keep it if you like it.

Mr. DENNIS. Yes.

Chairman RANGEL. But if indeed you have got a precondition, you can't get in the plan, or it is too costly, that the government would say, this is backup.

Mr. DENNIS. Yes.

Chairman RANGEL. This is backup for you. And you have got to do it. Could you go along with it?

Mr. DENNIS. No.

Chairman RANGEL. No?

Mr. DENNIS. No, not with that particular proposal. What we would suggest instead is to look at the Massachusetts——

Chairman RANGEL. Forget Massachusetts. Tell me how it works.

Mr. DENNIS. Essentially we have something called a connector or an exchange. It provides a central clearinghouse, we want to talk about a clearinghouse, where insurance companies register their plans, and people can go to them, particularly low-income folks can go to them, individuals can go to get their insurance. And so it is like a big, central marketplace where individuals and small business have more choices to shop for better plans.

Chairman RANGEL. And the government mandates that the employers must insure these people.

Mr. DENNIS. No.

Chairman RANGEL. Not with compassion.

Mr. DENNIS. No, it doesn't.

Chairman RANGEL. I understand that is the Massachusetts plan, that it is an employer mandate.

Mr. DENNIS. Well, it is $295 worth of mandate.

Chairman RANGEL. I don't care how much of mandate. I am saying an employer has to provide insurance for an employee.

Mr. DENNIS. Why would you want to put people out of work? Why would you want to depress wages? There has got to be a different way to approach this. The question becomes—there is an interesting issue here. It is called—you know, we use the politically really nice term of "shared responsibility."

Chairman RANGEL. You are using it.

Mr. DENNIS. I am just bringing it up. I am not using it. I am saying I don't know what that means. I know what——

Chairman RANGEL. You don't have to know, I didn't raise it. You can argue with yourself what it means. I am saying that——

Mr. DENNIS. Okay.

Chairman RANGEL.—we have to do something, and you are suggesting I don't know what.

Mr. DENNIS. No, no, I am not suggesting.

Chairman RANGEL. We are going to take care of these people, and if you don't help us to do it, we may have a way to do it that you don't like.

Mr. DENNIS. No.

Chairman RANGEL. We are going to say that the employer has a responsibility, and the employee has a responsibility, and the government has a responsibility. And we are not going to Massachusetts, we are staying right here and hammer this thing out. So when you think of something that you say, well, that makes some sense, I don't agree with it all, then come back and we will talk.

Mr. DENNIS. Well, let me say, Mr. Chairman, that the pooling and the whole idea of getting rid of being able to rate on claims experience and that sort of thing, which is all inherent in the system I am talking about, is certainly very much directed toward the type of thing that you are talking about. After all, the State cut its

insurance or its number of uninsured by half. That certainly gets to, I think, what you are looking at, isn't it?

Chairman RANGEL. I am talking about full coverage.

Mr. DENNIS. So I think, well, it would be nice, yes. But at least we are moving in the right direction. This is clearly, I think, a very positive suggestion, and we know there are other kinds of things that could easily be done. Excuse me, I take that back. I will get rid of the word "easily." Other things that can be done to lower costs which will bring in more people into the system. So I think indeed that we are proposing some very positive steps to directly go after the kind of concerns that you have.

Chairman RANGEL. Well, would you write an amendment to your written testimony and spell out what you think those are, and by unanimous consent I will have it put in the record. And once I see what your ideas are, then we will get back to each other. But it is not easy.

[The information requested by the Chairman follows:]

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Health Reform: Comments On Increasing Access And Affordability For America's Job Creators

America's current system of health insurance and healthcare is financially unsustainable and threatens the health and financial security of the American people. Small business owners and their employees are especially vulnerable to the weaknesses of our current system. More than 80 percent of small business owners say accessing affordable healthcare for themselves and their employees is a challenge. The National Federation of Independent Business (NFIB) supports comprehensive healthcare reform that addresses the needs of small employers, their employees and the self-employed. These comments were requested by Chairman Charles B. Rangel at the April 29, 2009 hearing on Health Reform in the 21st Century: Employer Sponsored Insurance hosted by the House Ways and Means Committee.

The small business community is all too familiar with the impact of high healthcare costs. For more than two decades, NFIB research has reinforced what small business owners across the country tell us every day – the most significant obstacle to gaining access to health insurance is the prohibitive cost of coverage. Since 1999, health insurance costs for small firms have increased 113 percent. In spite of the increases, the ever-escalating cost does not correlate with increased healthcare benefits. Instead, employees in our nation's smallest firms pay an average of 18 percent more in health insurance premiums for the same benefits than those in the largest firms.

The goals of reform are clear: to reduce cost in the system, increase affordability, lower costs for small business, provide an easier way to shop for insurance and expand the number of choices when buying insurance plans. Only then can small businesses, their employees and families have greater access to a competitive marketplace where private, quality healthcare is affordable and available to all consumers.

Delivery System Reform

Reducing long-term costs is essential to maintaining the quality of healthcare and to expanding its reach to those currently lacking coverage. Lower costs require us to fundamentally alter the delivery systems and the incentives that drive them. Our medical education system reflects early 20th Century realities; the result is an excess of specialists and a shortage of primary care physicians, nurse practitioners, and other physician extenders. Our models of treatment are driven by inflexible, outdated reimbursement systems designed nearly half a century ago and only moderately tweaked since then. The result is uncoordinated providers prescribing fragmentary care, rather than coordinated teams focusing as a unit on the good of the patient. Alternative models like those practiced by Geisinger and Mayo suggest possible approaches, though it is likely that real savings will come from, as yet, "undreamed" of models of care. We can see the beginnings of such reforms in programs already on the table: medical homes, outcome-based compensation, health information technology initiatives and alternative provider compensation schemes. Any lasting reform must permit and encourage such delivery system experimentation, because as we have seen from the industries like computers and telecommunications, the greatest advances will come from the most unexpected places.

Provide Advanceable Refundable Credits Or Other Subsidies For Low-Income Americans

All Americans, regardless of income, need access to quality affordable health insurance. This requires some form of assistance for those unable to afford such coverage. Steps should be taken to ensure people wanting private coverage can easily access all options available to them.

Guaranteed Issue In The Individual Market

In today's individual and small group market, individuals make choices about where to get their healthcare coverage. Having guaranteed issue in the group market and not in the individual market creates perverse incentives. For example, if an individual is searching for employment and happens to have a health problem, chances are that they will look for an employer offering group insurance. This is one manifestation of job lock – where one's employment decision is made on the basis of health insurance, rather than on the qualities of the job itself. Research by Gruber and Madrian shows how employer-provided health insurance plays a significant role in decisions on job change. Ensuring access to the individual market will go a long way to level the playing field for health insurance purchasers in all of the different marketplaces where they purchase policies.

Implement National Insurance Market Reform

National rating rules are long overdue for the individual and small group market. Currently, individuals in most states can either be denied coverage based on health status (rating) or can be priced out of the marketplace due to an illness. Under small group law in most states, the onset of illness in one enrollee can push the business's rates up by 50 percent at renewal. In both scenarios, people become uninsurable, they lose coverage due to cost, or the employer is hit with an excessive rate increase. Reformed rating will provide better parity between two marketplaces that are frequently visited by individuals and small group lives. While certain rating characteristics should be set nationally, states should retain significant discretion over some specifics, such as the width of rating bands.

Simplify the Shopping Experience

The current individual market makes it difficult for insurers to reach purchasers and makes it difficult for purchasers to rationally assess options. Today's small group market similarly limits choices by employers and employees. Employers are hamstrung by participation rate requirements. Shopping for policies excessively distracts them from running their businesses. Employees generally have only one employer-chosen policy available. Health insurance exchanges can reduce some of these shortcomings by serving as a clearinghouse of options for individuals, employers, and employees. An employer can voluntarily designate the exchange as its employer group "plan" for employees. This arrangement qualifies as an employer-sponsored plan for purposes of federal law, allowing employees to purchase coverage of their choice through the exchange on a pre-tax basis.

Make It Permissible For States To Enter Into Voluntary Multi-State Exchanges

GAO recently released its third study focused on marketplace concentration. The report confirmed a marked increase in the concentration in state markets. The report found that the five largest carriers in the small group market, when combined, represented at least three-quarters of the market in 34 of the 39 states responding to the survey, and they represent 90 percent or more in 23 of these states.[1] Allowing states to have the option to combine efforts in purchasing more affordable, quality coverage should be available as an option. Small states like Maine, Montana or Wyoming may see merit in combining efforts to increase the size of their pool and to attract more competition in the marketplace.

Enact Administrative Cost Savings Measures

Insurers must streamline the process of enrolling in an insurance plan or changing plans. Today's administrative inefficiencies render this process complicated, time-consuming and excessively expensive. Most of these inefficiencies lay at the state level. Congress should work with the states to implement models that promote streamlined regulatory structures.

Provide Greater Portability Of Coverage

People should be able to move from one job to another, between a job and no job, and from state to state without losing insurance coverage or encountering excessive cost increases, whether costs are borne by the individual or by an employer. In part, this goal can be met through more affordable, transparent policies and lower administrative costs. The goal is an insurance market in which subscribers experience relatively seamless transition when moving between group and non-group policies.

Tax Equity For Individuals And The Self-Employed

Tax laws should not push individuals into employer-provided or government-provided insurance programs and hobble the market for individually purchased policies. Tax laws riddle the health insurance market with inefficiencies. An employer who buys insurance for employees can write off the cost on their taxes. But if employees wish to purchase different policies on their own, they

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[1] GAO, Private Health Insurance: 2008 Survey Results on Number and Market Share of Carriers in the Small Group Health Insurance Market.

receive no tax benefit. Individuals should be allowed to utilize pre-tax dollars to purchase the health insurance policy of their choice. The self-employed should also have equal tax treatment for purchase of health insurance.

Danger Ahead: Roadblocks To Reform

Some reform ideas may sound appealing but, in fact, would have severe negative effects both on healthcare markets and on the economy in general. For example, employer mandates (with minimum contribution requirements), or equivalent pay-or-play requirements or payroll taxes, are bad for small employers, bad for low-income workers, and bad for the economy. They adversely affect small employers by raising payroll costs, eroding competitive positions, and increasing start-up costs, making it particularly difficult for firms operating on small margins. Employer mandates adversely affect the low-income employees because they result in lost employment, depressed wages, and lost work hours. They adversely affect the economy because they discourage production – often in firms with the most vulnerable employees and employers. Recent NFIB research data shows an employer mandate would cause the economy to lose over 1.6 million jobs.[2] Overall, mandates are bad for any size employer but this research shows small firms would be most adversely affected by the mandate and account for approximately 66 percent of all jobs lost.[3]

[2-3] Chow, Michael and Bruce Phillips, Small Business Effects of a National Employer Healthcare Mandate, NFIB, January 2009.

Examples Of Workable And Meaningful Reform: Learning From Existing Legislation

Insurance Market Reform: **The Small Business Health Options Program (SHOP) Act (H.R. 2360)** represents a bipartisan, common sense approach to small business healthcare reform in a voluntary setting. The goals of reform are clear: to lower costs for small business, provide an easier way to shop for insurance and expand the number of choices when buying insurance plans. It allows small employers to increase purchasing power by joining their state's purchasing pool, allows for a nationwide pool by 2012 and incentivizes small business participation with a targeted tax credit. The bill also seeks to increase premium predictability through national insurance rating reforms and, over time, allows the individual to select plans that best meet his or her needs. Finally, consumer protections are maintained at the state level and an appropriate time period for reform is adopted to ensure a smooth transition

Tax Equity for the Self-Employed: **The Equity for Our Nation's Self-Employed Act (H.R. 1470)** puts self-employed businesses on equal footing with their larger counterparts by permitting health insurance premiums to be deducted from both their income and payroll taxes – a practice currently allowed only for larger businesses. Under the current tax code, corporations are able to deduct health insurance premiums as a business expense and to forego FICA taxes on these costs. However, the self-employed are not allowed this same deduction and thus, are required to pay an additional 15.3 percent self-employment tax on their health insurance premiums. The self-employed are the only segment of the business population that pays this extra tax on health insurance. If enacted, a self-employed individual with a per-year premium of $10,880 would save $1,664.64 (15.3 percent) that he or she currently pays in taxes on their health insurance.

Affordability: **Pharmaceutical Market Access and Drug Safety Act (H.R. 1298)** would allow for the importation of prescription drugs while ensuring that appropriate safeguards are in place to protect the integrity of imported medications. Importation offers a means of reducing one of the most rapidly rising healthcare costs facing consumers today – spending on prescription drugs. This much-needed bipartisan legislation comes at a critical time for the small-business community, where firms pay an average of 18 percent more than their larger counterparts in health insurance premiums. With U.S. prescription drug spending expected to increase over the next decade, it is clear the small business community must pursue viable opportunities to improve affordability and access to health-care goods and services. Seventy-eight percent of NFIB members support allowing individuals to purchase FDA-approved drugs from other countries – similar to research affirming that 80 percent of Americans support importation.

Conclusion

Any successful reform must create a marketplace that works for all purchasers. Building on the strengths of the current system while ensuring new competitive marketplaces to purchase coverage will truly transform the system for the better. Getting overall healthcare costs down needs to remain a major priority in this reform effort. Balancing these two goals will go a long way toward enabling everyone to secure quality affordable coverage.

We appreciate the committee's interest and dedication to solving the healthcare affordability crisis. Healthcare reform is the NFIB's number one priority, and we are committed to working with Congress and the White House to develop solutions that decrease healthcare costs and increase access to quality healthcare – for small business and all Americans.

I yield to David Camp.

Mr. CAMP. Thank you, Mr. Chairman.

Thank you all for your testimony this morning.

Mr. Sheils, in your testimony you mention that if a new government-run health plan paid providers at private market rates, the

premiums in the government-run plan would be 6 to 9 percent below those in the private market.

Mr. SHEILS. Yes.

Mr. CAMP. You cite the reason as higher administrative costs in the private sector. And this has been a discussion we have had in the Committee over many months about comparing administrative costs between the government and private-sector health programs. And my comment is I believe it is an apple-to-oranges comparison. There are many programs that significantly improve the health and well-being of those in private health coverage that I believe are considered administrative costs, disease management programs, 24-hour nurse help lines. I think those serve critical functions, but they are considered administrative costs in this comparison that often occurs. And private plans also spend money building provider networks which can improve access, for example, to top-quality providers and exclude poor performers. And so this provides real value to the employees, but also falls into the category of administrative costs.

And similarly, antifraud programs which help reduce the cost of health care. I think those are irrelevant in private health plans, while government-run programs like Medicaid and Medicare have pretty poor records on fraud and abuse. In fact, there was a recent article in Congressional Quarterly, and it found that, and I am quoting, "The government has never done a particularly good job detecting fraud in Medicare much less preventing fraud in the first place. Most claims are never checked at all." But these antifraud programs and other costs are also considered administrative.

So I would ask unanimous consent to submit for the record a letter to the editor in the Wall Street Journal which was written by the former Administrator of CMS that highlighted some of the problems of trying to compare administrative costs between Medicare and private health insurance, and I would just like to ask your comment on that.

[The information follows:]

THE WALL STREET JOURNAL.
WSJ.com

APRIL 14, 2009

Is Government Health Insurance Cheap?

The false comparison between the costs of public and private medical plans.

By KERRY N. WEEMS and BENJAMIN E. SASSE

Congress is currently away on a two-week recess, but weighty work is occurring in its absence. Staff negotiators are trying to come to agreement on a budget framework for 2010 and beyond. Although this is happening behind closed doors, it appears likely that the budget deal will eventually include a government-run health-insurance option, or "public plan," to compete with private health insurance under the comprehensive health-care reform called for by President Barack Obama.

Some lawmakers support or oppose a government-run health-insurance option for purely ideological reasons. Others are open to it because they are pragmatic and -- laudably -- want to be persuaded by data and facts. Those moderates have been much influenced by the supposed fact that a public plan such as Medicare is more efficient than commercial insurance. Advocates of the public option routinely ask, "Aren't Medicare's administrative costs a fraction of those of private insurers?"

But the comparison between public and private plans is a false comparison. Private insurance and public benefits are not the same business. For all its warts, private insurance tries to manage care. Medicare is mostly about paying the bills presented to it.

Many who favor a public plan as part of comprehensive health-care reform dismiss the administrative "overhead" of private plans as having little or no value. Ways and Means Health Subcommittee Chairman Pete Stark (D., Calif.), for example, insists that "most private plans are poorly managed." Contrasting them with the supposedly sleek and efficient Medicare program, he labels commercial insurance "the General Motors of medical care."

In fact, the administrative expenses of private insurance plans represent money well spent for their members. Here are four reasons:

First, private insurers must build provider networks. These networks can include high-value providers and exclude low-quality providers. Except for certain circumstances, including criminal acts, Medicare is forbidden from excluding poor quality providers. It lets in everyone who signs up. So one question to ask is, will the public plan have Medicare's indifference to quality -- or invest in the cost of a network?

Second, private insurers must negotiate rates. Medicare just fixes prices using a statutory and regulatory scheme. And anyone who imagines a public plan would be less costly than private plans must keep the following issue front and center: In the many procedure categories where Medicare's statutory price does not cover full provider costs, shortfalls are shifted to private payers who end up subsidizing the public program. So, will a public plan negotiate rates or simply use fiat as a means of gaining subsidies from private insurance?

Third, private insurers must combat fraud -- or go out of business. Indeed, these payers have every incentive to invest in antifraud personnel and strategies down to the point where return and investment are equal. But anyone who thinks that a public plan could serve as a "yardstick" for the private sector needs to consider Medicare's dismal record with regard to fraud, waste and other abuse.

In fact, the total amount of Medicare fraud is unknown. The government does not measure or estimate fraud in its programs; instead, it measures payments made "in error." According to Medicare's own most recent data, payments made in error amount to over $10 billion annually. (Medicaid's payment errors in 2007 equaled a whopping $32.7 billion, according to a report by the Department of Health and Human Services.) Others have claimed Medicare's payments made in error are much higher. Even with the inclusion of the budget of the inspector general for the Department of Health and Human Services, Medicare spends less than one-fifth of 1% on antifraud measures -- a small fraction of what private plans invest in their efforts to build a network of honest providers.

Worse, in four of the past five years Congress has turned back Medicare's pleas for $579 million of additional antifraud funding, on the grounds that these dollars subtract from the budget funds for curing cancer and anti-obesity campaigns. Based on experience, Congress will always underinvest in fraud. Yet according to a House of Representatives Budget Committee hearing in July 2007, return on investment for certain Medicare antifraud measures were estimated to be in excess of 13-1. Will a public plan also hemorrhage from fraud because of chronic Congressional underinvestment?

Fourth, private insurers must incur the administrative cost of marketing. Medicare, of course, does not need to market. A public plan competing with other alternatives would have to market itself to the public, and this means tax dollars used to advertise against private plans. Or the public plan could "compete" by using heavily subsidized marketing channels not available to private insurers, such as Social Security mailings, welfare offices, unemployment check stuffers, and the constellation of government-funded "advocacy organizations."

None of these considerations should be interpreted as a defense of the status quo, or a denial of the fact that major health reform is needed. It is, and now.

There are indeed many places where commercial health insurance is inefficient -- for example, by trying to exclude the sick rather than compete for the business of managing their ailments more effectively. Moreover, the facilitation of a national insurance exchange could lower information and search costs for our increasingly mobile workforce.

But the impulse to "just pass something" -- a refrain heard often in the halls of Congress this spring -- is not good enough. There are more governmental paths to making things worse rather than better. As the case of Medicare's anemic anti-fraud efforts painfully illustrates, less management and lower administrative costs do not necessarily mean the program is really less costly. Fraud losses are just categorized as additional spending rather than as administrative expense.

Ultimately, the desire of many advocates of a government-run health plan to exaggerate Medicare's efficiency derives from the fact that the program does not make a profit. These folks are motivated by the naïve assumption that most of the health sector's ills could be cured if profit-seekers were excluded.

As the Congress continues the health-care debate, today behind closed doors, and soon in the open, there should be an honest discussion of administrative costs and their value. Those who believe that health care should have no profit should be open with their views and not hide behind the false economy of Medicare.

Mr. Weems, an independent consultant, served 28 years in the federal government and most recently headed Medicare and Medicaid. Mr. Sasse, former U.S. assistant secretary of health, advises private equity clients and teaches at the University of Texas.

Mr. SHEILS. Sure. There are management—utilization management functions that most private health plans have. Precertification. You might find on your insurance card you have got to call in to get permission to go get an MRI, you have to get

permission to go to the emergency room and so on. Those things are estimated to save costs between 4 and 8 percent. Our own study came up with something in the neighborhood of 4 percent.

The numbers we have on the cost of services are adjusted in here to roughly reflect that adjustment. So we are not really counting it—we are counting it where I think you should count it, the cost of the utilization.

The administrative costs are what they are. But then the differences in utilization and the impact that has on the premium is also part of it. So it accounts for that very roughly. I can't say—it roughly accounts for it.

Mr. CAMP. And, Mr. Sheils, Lewin Group has done work for hospitals and physicians, but you have also done work for the Economic Policy Institute, who is testifying here today, as well as for The Commonwealth Fund; is that accurate?

Mr. SHEILS. That is right.

Mr. CAMP. Mr. Shea, would it be a fair statement to say most of your members would like to keep what they have?

Mr. SHEA. That would be a fair statement, sir.

Mr. CAMP. And would it also be fair to say that a Medicare-like coverage would probably not be an acceptable replacement for the level of benefits that most of your members have now?

Mr. SHEA. We cover many retirees, including Medicare recipients, Mr. Camp, and we usually supplement the Medicare benefits to bring them to the standard of what active workers get.

Mr. CAMP. Particularly the nonretiree members would find a Medicare-like plan to be significantly below the benefit level they are receiving now; would that be fair to say?

Mr. SHEA. We strongly believe that with a public plan, you need to allow for a private insurance role, a private union fund role——

Mr. CAMP. Yes.

Mr. SHEA.—that would supplement or compete with. You want to have something not just a public plan.

Mr. CAMP. Yes, but comparing the two, a Medicare-like plan has much—the plan they have now has a much higher benefit level than a Medicare-like plan.

Mr. SHEA. That is true. And widely for many years people have said if we were to extend Medicare to other people, you would have to raise the benefits and modernize them.

Mr. CAMP. Yeah. And so that for your retirees, as you mentioned, you use a supplement.

Thank you all for your testimony. I yield back the balance of my time.

Mr. LEVIN [presiding]. It is interesting, Mr. Sheils, when Mr. Camp asked you about the administrative costs, you said that you were comparing apples and oranges. I think your answer was you are not.

Mr. SHEILS. You are correct. I would say that is correct.

Mr. LEVIN. Okay. So I don't think we can just pick and choose when we like your results and when we don't. But I think we can question your—some of your assumptions in terms of what would be the transfer from employer insurance to a public plan, because as people thought about transferring, the private sector might well respond to competition, to competing with the public plan, right?

Mr. SHEILS. Yes.

Mr. LEVIN. And so therefore, the private plan might become more effective, right?

Mr. SHEILS. We expect improvements, but we don't think that they will be able to—most plans won't be able to survive in that environment. The ones that will survive will tend to be integrated systems, HMOs. And where, for example, some of these HMOs own their own hospitals, they don't have to worry about the cost shift.

Mr. LEVIN. Let me ask you this: If you look at employer plans in the construction industry, which I used to know something about, you assume that the employers would shift to the public plan en masse.

Mr. SHEILS. Based on the price for coverage that they would be offered, it differs a little bit by firm size, but we basically figure out what the cost of insurance is in today's market for individuals, which is kind of an involved process. And then we figure out what the cost of the plan is for the plan, and then we use models of how people respond to changes in the relative prices of health care to figure out how many people go into the public plan.

Mr. LEVIN. But these employer-based plans are controlled by collective bargaining agreements, aren't they?

Mr. SHEILS. Well, 16 percent of——

Mr. LEVIN. I am talking about in the construction industry.

Mr. SHEILS. In the construction industry, I believe that is correct, yes.

Mr. LEVIN. Your assumption is there would be a massive shift, that they are subject to collective bargaining agreements, and that the employee representatives would decide to shift to a public plan?

Mr. SHEILS. Yes. There are two things to consider. First of all, in a competitive environment you would want—you know, you almost have to. I mean, if your competitor uses a public plan and is saving $2,500 a year for family coverage, then you are going to be at a competitive disadvantage unless you do the same thing.

Mr. LEVIN. Of course if——

Mr. SHEILS. I just want to add that Mr. Shea pointed out that workers explicitly make these trade-offs between costs and benefits, and it seems to me likely that when a family has a chance to save that kind of money, the workers may develop a considerable demand for the change.

Mr. LEVIN. Okay. Though one plan might be better than the other.

Mr. SHEILS. Yes.

Mr. LEVIN. Your figures assume that there would be a major reduction in the uninsured?

Mr. SHEILS. Yes.

Mr. LEVIN. Mr. Dennis, just to pick up what our Chairman was saying.

Mr. DENNIS. Yes, sir.

Mr. LEVIN. I reread your testimony, and the problem is you don't like a mandate, you don't like a public plan, but you have no plan. I mean, the problem with the opposition here, they don't like a public plan, they don't like the mandate, they have some other complaints, but coming up with a plan that will clearly reduce the

uninsured of close to 50 million people in this country, there is no plan. And I think you should take up our Chairman's offer.

I have your small business principles, but I think what you need to do if you don't like the mandate and you don't like the public plan is to come forth with a very specific proposal that would assure that there would no longer be 50 million uninsured in this country, and that in a reasonable period of time the number would be essentially zero or close to that, because otherwise simply trying to slug it out by critique doesn't work if there is no alternative.

My time is up.

Chairman RANGEL [presiding]. Thank you, Mr. Levin.

Mr. Herger from California.

Mr. HERGER. Thank you, Mr. Chairman.

As you know, at last week's hearing Ken Sperling testified on behalf of the National Coalition of Benefits. The Chair asked about the Coalition's view on a government-run plan. Since then, Members of National Coalition of Benefits Steering Committee, who collectively represent hundreds of employers that sponsor health benefits for tens of millions of Americans, sent a letter to you stating their position on a government-run plan.

In part the letter says, "Proposals to have a public plan compete in the private marketplace are of grave concern to employers who provide health insurance coverage. The public plan's unfair competitive position, both by size and regulatory authority, will merely shift cost to the private sector and employees covered by private plans."

The letter goes on to say, "Medicare's underpayment results in private payers and the people covered by these plans making up the shortfall, and increases the cost to employers of providing quality health-care coverage. A public plan option administered by the Federal government is inherently destabilizing to employed-based health insurance benefits," close quotes.

Mr. Chairman I would ask unanimous consent to enter the letter into the record.

Chairman RANGEL. Without objection, Mr. Herger.

[The information follows:]

April 23, 2009

The Honorable Charles B. Rangel
U.S. House of Representatives
Chairman, House Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Rangel:

The undersigned trade associations are steering committee members of the National Coalition on Benefits (NCB), and collectively represent hundreds of employers that sponsor health benefits for tens of millions of Americans. In yesterday's hearing before the Committee on Ways and Means on private insurance market reforms, you raised the important issue of the proposed "public plan" option that would be run by the government and compete with private and group health plans. Although our witness was not authorized to express an official position on behalf of the entirety of NCB's diverse membership, we steering committee members do share important reservations about the effect a public plan would have on existing employer coverage and want to respond quickly to your question. We believe there are more effective ways to reform the individual market that do not include the significant drawbacks we outline below.

Proposals to have a "public plan" compete in the private marketplace are of grave concern to employers who provide health insurance coverage, particularly given the history of Medicare's impact in the marketplace. A public plan, particularly combined with the impact of Medicare, Medicaid, and other public plans, cannot operate on a level playing field and compete fairly if it acts as both a payer and a regulator. The public plan's unfair competitive position, both by it's size and regulatory authority, will merely shift costs to the private sector and employees covered by private plans.

A public plan that would use government mandated prices would directly result in a cost-shift to other payers and thus would do nothing to address the underlying problems that make health coverage unaffordable for many. Improving the cost, quality and the efficiency of health delivery are key imperatives for reform.

We already experience that cost-shift today as Medicare, the largest payer in the United States, consistently underpays providers. Employers and our covered employees and families also see higher price tags in their medical plans because Medicare and Medicaid payment rates are set by law and are comparatively lower than rates for employer-sponsored group health plans. It is no secret that providers receive much higher payments from private insurance plans than from public plans.

Economists vary in their views about how much of the difference between employer-sponsored and public payments truly represents "cost shifting" from public to private plans. But, the fact remains that Medicare and Medicaid reimburse providers at much lower levels than commercial payers. For example, according to a 2008 Milliman actuarial study,[1] Medicare reimburses hospitals at an average of 70% of private plan reimbursements and pays physicians 78% of what they receive from private plans. Medicaid reimburses hospitals at an average of 67% of private plan rates and pays physicians at an average of 53% of private plan rates.

[1] Milliman, *Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid & Commercial Payers* study, December 2008.

Medicare's underpayment results in private payers and the people covered by these plans making up the shortfall – and increases the cost to employers of providing quality health care coverage. A "public plan" option administered by the federal government is inherently destabilizing to the employed-based health insurance benefit.

Employer plans continually innovate though technology, new programs that drive value and improve quality, while the Medicare system tends to rely primarily on the fee-for-service, volume based payment systems without a focus on care management and care coordination.

We hope the Ways & Means Committee will consider these concerns. We would like to work with you to put real reform in place in the private insurance market and improve the quality and efficiency of health care delivery, which would obviate the need for a public plan.
Sincerely,
American Benefits Council
Business Roundtable
National Business Group on Health
National Association of Manufacturers
National Retail Federation
The ERISA Industry Committee
U.S. Chamber of Commerce

Mr. HERGER. Mr. Sheils, you estimate that a government-run health plan paying Medicare rates would mean a $36 billion cut to hospitals and a $33.1 billion cut to physicians, and that is just in 1 year. Since it is paying below-market rates, the government-run plan could charge below-market premiums. While the government-run health plan might be cheaper, it doesn't mean it will be better.

I worry that people enrolled in the new government-run plan may find themselves with health coverage, but without access to care. Today half of physicians are no longer accepting Medicaid patients, and 28 percent of Medicare beneficiaries searching for a new primary-care physician are having a problem finding one.

Wouldn't a public option, that is a government-run plan, paying providers Medicare rates only exacerbate access-to-care problems?

Mr. SHEILS. I think you are correct, it would make it much more difficult for the providers. It is fair to say that our numbers are showing that the physicians under this plan and hospitals will be providing more services to more people for less money. And it is hard to imagine you can do that without something bad happening somewhere.

I think that we spend enough on health care in this country that through efficiencies we could get by on a level of spending. The question is will a system actually give us those efficiencies, or will it simply, as you say, cause some providers to stop seeing privately insured—the members of the plan and so on.

I don't think there would be a wholesale rejection of the plan by providers, however, because so many people would go into the public plan. Who would you care for; if you didn't accept Medicare, who would you care for? There would be 120 million people in it; 132

million people in it plus Medicare itself, so it is 170 million people. I don't think any provider will be able to walk away from what is probably 60, 70 percent of the whole marketplace that way.

Providers will have to somehow do it within the amounts they are being paid. Whether that compromises the quality of care or not is an open question. It could be done in ways which are bad for patient health. It could be done in ways, if we are careful, where it does not impact patient health so seriously.

But it is very hard to imagine taking this much money out of the system while at the same time increasing demand for services without something bad happening somewhere. So I guess that would be my answer. I am not terribly specific, I apologize.

Chairman RANGEL. Let me thank you and the panel and tell you where we are. The bells mean we have to respond. The budget bill is on the floor. It will take 15 minutes, roughly 10 are left, to answer that. And then two suspensions are there. That is roughly 5 minutes. And so if we could suspend and all return at 12 o'clock. I apologize to the panel for this break, but you might be able to get something to eat, and we will come back, start promptly at 12 o'clock, and we will try to proceed as expeditiously as possible.

Chairman RANGEL. Thank you, and we adjourn until 12:00.

[Recess.]

RPTS DEAN
DCMN NORMAN

Mr. MCDERMOTT [presiding]. If the witnesses will take their seats, we will resume the hearing. Although I took the Chair here, I also am the next one to ask questions so I will start.

I am having a little trouble understanding where a couple of you people are coming from. I can understand a big company having their employees and want to keep them in private, inside the company in some kind of a health plan, because you have got them trapped today. They are scared of losing their jobs so they will accept whatever you do, and you can keep off-loading the health-care costs onto the employees of the company. But what I am having trouble understanding is what happens to the smaller employer who sounds like they are represented by the NFIB.

But, Mr. Conklin, I don't understand; you started out paying 5 percent of payroll and now you are up to 10 percent of payroll?

Mr. CONKLIN. No, Mr. McDermott; it is 20 percent.

Mr. MCDERMOTT. So you are 20 percent of payroll. Now, I hear from your industrial organization there that if you have that kind of cost, you will have to lay off people. Have you laid off anybody?

Mr. CONKLIN. No, sir. In fact we just recently hired up. So the fact that health-care costs go up to the employer does not that you are going to lay off workers?

Mr. CONKLIN. No, we—I mean we have to offer that benefit in order to attract workers. It is an expectation.

Mr. MCDERMOTT. So at what point—I mean you are paying—I can't quite tell from your testimony—I read it all—you are paying $8,700 per person?

Mr. CONKLIN. No, $8,700 for the company. I have 10 people.

Mr. MCDERMOTT. Per month?

Mr. CONKLIN. Right.

Mr. MCDERMOTT. So that is $870 per person, per month?

Mr. CONKLIN. Right. And I want to make sure that this is understood for the record. This is during the transition. Now, what is happening is I have some employees coming off our old carrier and going on to a new carrier. And while that is happening I have to keep the old policy in place and pay a percentage of the new policy.

Now, this process is taking 2 to 3 months, so we will have $8,700 outlays for 2 to 3 months. And then at some point in the future, our old carrier, HMO BlueCross, will return the unused portion, so to speak. But like all insurances I have to pay it up front. In order to maintain coverage for everybody until this process is complete, that is my premium expense.

Mr. MCDERMOTT. Why wouldn't you want to have—given that story you just told, why wouldn't you want to have a public option that you could say to your employees, go to this public option, it is a generous program, it is as good as what I am able to buy for you, and be able to get it for, say, 10 percent of payroll?

Mr. CONKLIN. I have no difficulty with that. My hope is that if that option were available, and I would hope from this process that if it is done right, the public option would serve a couple of different purposes. One is—and it is very important—is that it would make it easier for me as an employer to understand and explain to my employees what they are getting for our money, because they are making a contribution too. I don't pay the whole freight on this. And if we could do that and there was a plain-language component of the public sector solution, whatever form that public sector solution takes, then the private sector, which I think has some conflicts of interest that it tends to camouflage, and the way it presents the products would be forced to reveal what the real costs are.

Mr. MCDERMOTT. Tell me how they camouflage.

Mr. CONKLIN. Well, they camouflage it by presenting me with a 3/4-inch thick booklet of arcane, legalistic language that explains what the policy really is. And what I am looking for is a very plain-English thing that says here is what you are getting. This is what the co-pays are, that is all there; and what the deductibles—this is how much you will spend each month, but here are the limits of the policy. If you go into the hospital and you have a serious problem and that problem is, let's say, cancer, the average cost of, say, a cancer treatment in the New York Metropolitan Area for a serious illness is, say—and am making all this up, like I said, I am not a policy expert but this is sort of my thinking—and that problem or that illness on average costs $1.5 million to treat in New Jersey, okay; our policy only covers 1.25 million. You are going to be on the hook for 250,000, because when you go in the hospital, you sign that document that says whatever the insurance company doesn't pick up, I will pay.

So one of the things I am hoping is if we have that sort of transparency in the process, then we can also have an honest discussion about medical bankruptcy. And then we are going to really know what insurance should cost and how we can fully cover everybody. Until we have that kind of transparency, I don't even think we know how much health insurance really costs.

Mr. MCDERMOTT. Do you have an idea what is a fair amount for a small businessperson to spend on the health care of their employees; 5 percent, 2 percent, 1 percent, 8 percent?

Mr. CONKLIN. Well, it would be great if it is 1 percent or it would be great if it was half of a percent. But if it costs 10 percent, then as an employer I want to pay 10 percent. And I want the guy down the street to pay 10 percent, I want the guy up the block to pay 10 percent. But if what we have to do to cover everybody is create a progressive payment system, I will live with that too.

When I started my business, and it was my wife and I, we had no health insurance, but we were young and we were healthy and, as I said in my written testimony, we were broke. So we weren't going to go out and buy any health insurance.

That is a problem that has to be addressed. I don't know whether you will be able to address that level of detail in the legislation you are considering now. And I hope that as this discussion continues, we realize that we are probably not going to get it right this time. It is probably not going to be perfect, whatever you come up with. If you come up with a public option, it is probably not going to be perfect.

And if we don't cast it into stone or steel and say that its a Federal program that can never be changed but we recognize that through this process we are going to have to make adjustments and improvements, then I think, great. Anything that gets it closer to a fair, equitable system that gets 100 percent coverage has to be reflected in my bottom line and reduce cost. That just—I am giving it to you from my perspective, which is on the street.

I was thinking earlier during the testimony that there used to be a TV program, "Homicide: Life on the Street," this is sort of like "Health Care: Life on the Street." And, you know, what I experience is something different than what I am hearing from the other panelists, which is not to say that their testimony is inaccurate or hasn't been well thought out. It is just not quite—it doesn't quite jibe with what happens in real life as I have experienced it.

Mr. MCDERMOTT. You would like a public option, you could pay 10 percent?

Mr. CONKLIN. Absolutely.

Mr. MCDERMOTT. Would you move tomorrow to that?

Mr. CONKLIN. Well, I would certainly give my broker the opportunity to convince me that it wasn't a good idea. And if he could do it at a competitive rate, and tell me why it wasn't a good idea, in clear language, and if he had a competitor who was giving me the real information, then he would be forced to do that.

Mr. MCDERMOTT. Thank you very much.

Mr. MACDONALD. The whole issue about migration to a public plan; I think if we took a real-life example that I have is migration is going to occur as quickly as others would suggest it is. A case in point would be a couple of years ago, through a consortium, several companies created what was called Retiree Health Access, and the actuaries in the IBM case thought that probably about 60,000 would migrate to that plan. The first year was 2,000 people.

I think there is a general reluctance for people to migrate away from an employer plan. So I think a lot of it will be driven off of

the design, the cost structure, the access. I don't think you will see that migration as quickly as some would suspect that you would.

I think the second thing is when you raise the issue around cost; is there an argument being made that you are laying off people because of health care costs? I think Gerry said it quite appropriately; there is a tradeoff of costs. If health care is rising at 20 percent or 10 percent, whatever the number is, then you make decisions around what are my raises going to be this year? What am I going to do in investing in human capital? What am I doing for training programs? There is always offset. Somewhere there is always offset. It is not incremental upward, it is always trying to create a level playing field. So I don't see the migration as quickly as others do.

Mr. MCDERMOTT. May I ask you one other question?

Mr. MACDONALD. Sure.

Mr. MCDERMOTT. If you lay people off at IBM, where do they go? Can they afford the COBRA option?

Mr. MACDONALD. First of all, we have a benefit continuation policy that is up to 6 months right off the bat. So we pay for that, and they go beyond that with COBRA.

Mr. MCDERMOTT. And at the end of 6 months they are on their own.

Mr. MACDONALD. Then they go to COBRA. They go to a continuation——

Mr. MCDERMOTT. And where you are operating, is COBRA enough money—I mean, can you make out of your unemployment insurance enough to pay COBRA and the house rent?

Mr. MACDONALD. Well, in the spirit of bluntness, IBMers tend to be at the higher end of the pay scale. And so in the spirit of honesty, our average wage is close to approaching $100,000. So you would assume there is some level of savings there to create that offset.

Mr. MCDERMOTT. Thank you very much.

Chairman RANGEL [presiding]. No one is thinking about IBM planning to go to any public plan.

Mr. MACDONALD. That is what I am suggesting.

Chairman RANGEL. I know you are. It just makes sense that every plan is not as good as yours, but the plan that we are talking about, when Mr. Conklin sees his competitor with nothing and he is paying this large amount, he wants everyone to get in there and share this so that his competitors would include health care as a part of doing business. It just makes—Mr. Sheils, are you here in Washington?

Mr. SHEILS. Yes, sir.

Chairman RANGEL. Talk with my buddy from New Jersey. Because, you know, you have got the theory and everything, but like he says, he has to deal with this every day. It is a cost on him. And I am not talking about compassion, I am talking about saving money. Having people working every day, not having to worry about their kids getting sick or their wife not being able to get medicine, but being able to concentrate on making some cabinets. But a person in trouble, with no health care, is not a productive person.

And so, you know, we have got to do something about it. And I would rather work with you so that we can get bipartisan support of this darn thing. You come in with something—you talk with Mr. Conklin and if he is convinced, we have got a deal.

Let me call on my hero of the Congress, Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Dennis, the Economic Policy Institute has proposed imposing a health care pay-or-play mandate on businesses. And their proposal would require employers pay 75 percent of individual premiums and 66 percent of family premiums for all employees working at least 20 hours a week. Employers who can't meet these requirements would be forced to pay 6 percent payroll tax.

The Lewin Group estimates this would represent a tax increase of nearly $1,600 per employee. Is this mandate the type of thing that small businesses could afford?

Mr. DENNIS. First, let me just say this, Mr. Johnson. Whether you call it paying for the premium, pay-or-play, or a payroll tax, it is the same thing. So we are talking about a generic group here where the parts are equivalent to one another.

If initially the business has to pay $1,600 per employee, and the business has 10 employees, that is $16,000. Sixteen thousand dollars, the question is where do you get that money? One place is to take it off your salary, the owner's income. I don't think any of us want to have $16,000 taken off our salary.

This is just another mandate. It is going to end up in lost jobs, it will end up—we have already talked about how employees' wages are depressed because of benefit costs.

Mr. JOHNSON. Well, it seems to me—and I had a small business at one time—if you are not making money or on the margin a little bit, you are going to have to—you can't afford another increase. What you will do is probably lease out your medical stuff. You know, fire the employees and work them out of a different organization, you know, I don't think any of you realize what it costs to run a small business. It is not a simple operation. And some of you know. You work sometimes, some months, just to make ends meet. And if we stick you with another tax, which is what that is, I don't think you are going to like it. Mr. Conklin, I don't think you would either.

Mr. DENNIS. I think, Mr. Johnson, there is one really important point in this, and that is we have about 5.9 million small employers in this country. Some of them are doing very well. It sounds like Mr. Conklin's business is doing quite well. That is great. I am all for that. There are some others that aren't doing so well, and there are some others that are just starting. The condition of each business is very different. And I am not talking about one business, I am talking about the group of businesses, all of them together. Some provide.

I think the very fact there is a relationship—and I repeat—there is a relationship between what you take out of the business and whether or not you provide employee health insurance, a direct relationship. That speaks volumes.

When business does well, the employer does well and the employees do well. When a business doesn't do so well, the employees don't do so well and the employer doesn't do so well.

Mr. JOHNSON. Yeah, I know. There are some companies who provide health insurance. Exxon is one of them. And about 20 percent of their people don't take advantage of the program they offer, because they think they are bulletproof. You understand that. The 21- to 35-year-old guys. In fact, one of you testified that you didn't have insurance; I think it was Mr. Conklin.

Well, I appreciate, Mr. Conklin, the efforts you have taken to continue providing health insurance for your employees. I have heard from a number of small business owners, just like you, are finding health insurance to be increasingly unaffordable. And we need to reverse that trend.

You mentioned the inability to pool employees and spread risk the same way large employers do. I wonder if you would support reforms that would allow small businesses to join together and pool their risk. Association health plans never have been passed up here. And the independent guys, i.e., Realtors, for example, are all for that kind of a program, and they don't have health care, a lot of them. So doesn't buying in bulk for supplies reduce cost?

Mr. CONKLIN. Yes, Congressman. Buying lumber bulk does reduce costs. I don't think you want the same model to determine what you are going to buy in health insurance. I think one of the problems we have in the discussion we are having about health insurance is we keep applying this business model as if we were talking about widgets. But what we are really talking about is people and the kind of care that is available to them.

And when these larger groups, the question I have and I can't—again, I am admitting I am not a policy expert—but the question I have is who is going to determine who my carrier is in this larger group. We are going to form an association and we are going to go out in this group and shop for health insurance. And then we are all going to somehow agree that the best provider of health insurance for us is the X, Y, Z company.

Now, I am not sure who makes that decision. I am not sure what that decision is based on. And we are still stuck with this sort of opaque process by which I don't really have a choice, I have an option: join the association, shop for health insurance in the open market.

Mr. JOHNSON. Well, association health plans don't have to be one provider; it can be five or six and they can pick.

Mr. CONKLIN. We are still there, though. We may be saving a few dollars on the side, but the group and the way the group is structured and the available selections are still limited within this organizational model. So I don't see that as being a vast improvement over the system.

Mr. JOHNSON. Well, it is because they don't have any insurance right now.

Mr. CONKLIN. Well, look, I said earlier that all the solutions—I used the tool-box analogy. If that tool functions the way some people are saying it might function, then it may be useful to add it, but it is not going to solve the problem.

Ms. GOULD. Congressman, do you mind if I respond, as you brought up my employers?

Mr. JOHNSON. Mr. Chairman? Go ahead.

Ms. GOULD. Thank you. You brought up the estimates of what it might cost, 6 percent of payroll for small employers to contribute. But what wasn't also brought to light in that research that the Lewin Group did analyze is that the national exchange with the public plan, small employers who are currently offering insurance would actually experience windfall savings with that kind of a framework. In fact, firms with 10 or fewer workers would save about $3,500 per worker compared to even lower savings that you would see across all firm sizes. So small firms stand to gain a lot from that kind of structure.

Chairman RANGEL. Mr. Pomeroy.

Mr. POMEROY. Thank you, Mr. Chairman. I commend the panel. It has been a very interesting discussion. And Mr. Conklin, you are the guy off the street; you have had compelling testimony today, absolutely delightful.

I will start with Mr. MacDonald. In your capacity as a leader within the HR world, let alone IBM, you would have an expert view on the notion of whether or not the employer platform ought to be a base for the delivery of health benefits in the first place. Some believe it is time to move off of that.

I would tell you I disagree with that. I believe there is still enormous value, let alone the fact that we have got 65 percent, as Dr. Gould told us, covered with the employer model, the platform. I believe we keep that part and build out, not blow it up and start all over.

What are your thoughts on that?

Mr. MACDONALD. Clearly, as I think I said in my opening statement, we shouldn't start from scratch, and that the employer plan is a base or a foundation. As I look at whether we want to talk about it in terms of a public plan or some individual mandate, you know, perhaps we have to migrate there over time. And I think part of the issue has to be that you use employer-based plans as that model. Employer-based plans typically have a foundation for wellness, they have a foundation for preventive care, and a foundation for primary care. Those are, I think, absolute critical components to any plan that is designed, whether it be at a large employer or a small employer.

Mr. POMEROY. Mr. MacDonald, how about Medicare? I am dismayed that those elements did not seem to be advanced effectively in present Medicare reimbursement incentives. Have you been able to achieve a greater role for primary care, preventive care, wellness and impacted your cost curve? If so, you have got information that we desperately need to consider as we develop Federal reinvestment policy.

Mr. MACDONALD. I would agree with you on the inefficiency and the lack of effectiveness in the Medicare arena. And the answer is yes. For instance, in the 3-year study that we did where we fundamentally created what we call a healthy living rebate, where we focused on nutrition, childhood obesity, physical exercise and smoking cessation, we invested around $81 million. And in that 3-year period we saved $200 million.

At the same time we had a high-risk population that we identified at about 13 percent of our population; 55 percent of that high-risk population is now down to less than 7 percent. So we see a

direct correlation for making investments in areas of preventive care, primary care that yields returns.

Mr. POMEROY. Did you elevate the role of primary care in your interaction with your insureds? Is that how you were able to maintain the behavioral modifications that produce this positive health result?

Mr. MACDONALD. It is a two-prong approach. Yes, working with our carriers and other insurers that we work with, was one way we created designs. But part of that investment was a significant investment in making the employee and their dependents educated consumers.

Let me just give you an example on childhood obesity. You say why childhood obesity, they are not your workers. Well, it is also a statement of society, but more importantly, it really reflects that if an employee goes to work and feels good about their family situation, there is not an issue there, they will be more productive and more satisfied.

One of the things we did is created IT tools, not surprisingly, for people to go on and look at what does it mean to have nutrition for children and exercise programs. One of the interesting byproducts was that coming back in the surveys, we found it was more family friendly. People began to discuss what they were eating at dinner and what they were doing during the day. A simple thing like not watching TV more than hour, and the type of TV that the child was looking at, not being a couch potato. All those things helped immensely in intervening in those costs.

Mr. POMEROY. Your confidence in your plan indicates perhaps to me that IBM would be one in a new insurance world where large employers could continue to offer what they had been offering or send their employees to shop in an insurance exchange. You may very well continue to do what you have been doing.

Mr. MACDONALD. Regardless of your aspiration about a public plan or not, the thing that I would caution us as patriots, using Chairman Rangel's approach, describing us appropriately so by the way, we have to ensure that we are still engines for information and transformation. I mean, what I was just describing was a sense of transformation within the health-care arena. And I think that has to be a fundamental premise of what we are doing going forward.

I agree, by the way, with Gerry. The whole concept of taking out the exclusion for tax deferral, we would completely agree; and I think there would be a mutiny at the gate, so to speak, if that were to occur. I think there are fundamental things we have to maintain.

Mr. POMEROY. Mr. Chairman, may Mr. Shea also respond?

Mr. SHEA. Thank you, Mr. Chairman. I just wanted to piggyback on Mr. MacDonald's comments and to make the point that I really don't think it is useful for us to see this as either/or—either Medicare is good or private is good.

If you look at the experience of people who have been working together—I am talking about large employers, small employers, purchaser groups, consumer organizations—and I would put us in that category—or AARP, physician groups, hospital groups, how you restructure the system to get better value—a key component

of that is what the government does. We can do these things if we do them together. That is the lesson from what has gone on in the last 10 years.

I think Mr. MacDonald would probably agree. Medicare has led the way in terms of quality measures and quality reporting. They, with a fairly modest investment, have got every acute-care hospital in the country reporting on a standardized set of measures. And one of the things that the hospitals will tell you and the employers will tell you is, we don't want to have one measure set over here and one measure set over there. Medicare instituted a uniform set of measures that everybody reports on. And we know from the statistics, even in the first 5 years of that, that has improved quality. The performance has really improved on those measures. That is something Medicare did that the private sector wants to emulate and be part of.

One of the things that bothers me about the debate over the public insurance is it is like we are back to yesteryear this is a polarized debate, in my humble opinion, which has prevented us from straightening out our health care mess now for decades. It is that precise kind of thing.

The only reason we talk about the public insurance program is we think it is a good cost-containment mechanism. If the private insurers want to come up and present a credible case that they can control costs, then we would be very interested in hearing it. But their history does not indicate that they can make that case based on what they have done in the past. So, therefore, we simply say, well let's try the public insurance alternative and see if competition might get us someplace that the private insurance market has never been able to do. This is not—we are not enshrining a public insurance program. We are trying to get these costs under control.

Mr. POMEROY. Thank you, Mr. Chairman.

Chairman RANGEL. Thank you. Mr. Brady from Texas may inquire.

Mr. BRADY. Thank you, Chairman. I agree with Mr. Conklin the churning of the health insurance adds to the problem a great deal, not just in the private sector. We had Texas Childrens Hospital and Texas Medical Center trade a nonprofit health insurance program to try to lower costs, and they failed, as they told me, mainly because small businesses have to churn, move from insurance plan to insurance plan every 1 year, 2 years, 3 years, as they did in my small business, to try to contain costs. The point from the leaders of the Childrens Hospital is that until you connect behavior of that patient to their health-care plan prevention, other initiatives, won't really help.

I want to describe to you a model that I found in a small town in east Texas; Evadale, Texas, just north of Orange. There they have a papermill, and 7 years ago the papermill management and the union there, the steelworkers, agreed that the steelworkers would run the health-care plan. What they did was they put together a very commonsense patient consumer model that had three parts to it. One, they built a clinic at the front gate of the plant so that every union—and there are 3,000 workers—and their family had immediate access to preventive care. When the family, child, whatever got ill, immediate access.

Secondly, they went out to bid for imaging and specialty services, and even had insurance companies bid on that; put together a list of good, qualified specialty imaging services.

Thirdly, they hired Navigator, a group that would help their members navigate the health-care system to the point where if you had a chronic disease or multiple illnesses, they would send a nurse along with them to go from doctor to doctor, and then sit down with that steelworker and work through the options to continue the medication and make the right decisions. It was a very basic process. The company pays an average health-care costs. This group who I visited with, toured the center, sat down with the groups, haven't had a health-care premium increase in 7 years.

When you talk to union workers, they say, look, if my child gets sick I take them to the clinic immediately, because if I don't, not only do they not get well but that money comes out of my pocket. When they needed to even blacktop the front of the clinic, the union workers said, no, don't use our money for that; just buy the materials, we will do it because that is our health-care money.

You talk to the doctor who is there, who is hired by the steelworkers, said I am practicing medicine the way I always hoped to. Instead of spending 15 minutes with the patient and 15 minutes with paperwork, spends the whole 30 minutes providing quality care; one, because he loses his job if he doesn't. But second, he said, I don't have to worry about them suing me. They are not anxious to sue themselves, because this is their health-care money.

And then talked to the PA and they are all cross-trained in the office. And their point was that one had worked at another institution, at a hospital, and if someone came in with a sore neck, they checked the insurance policy, and if this imaging was allowed and that imaging was allowed then everything was run, mainly because they could; and, second, because they lost money on the ER and uncompensated care in Medicare. So we don't do the cost-shifting here. We don't shift cost.

Bottom line, there was a direct connection between the behavior of the patients, of those who were being covered, and the health-care costs. I am convinced that no matter what model we create—that was for 3,000 workers, so it wasn't a big model. In fact, smaller may be better if we are going to try to connect the consumer to the health care they get and the ultimate cost of it.

My question is, regardless of what model we pick, how do we really change behavior to prevention, to immediate action, to quality care, if we don't, in whatever we do, connect that informed consumer, provide them easy access to prevention, and make sure they understand that those are their health-care dollars. And I would open it up to the panel for any comments you have.

Mr. CONKLIN. Can I get a job at that mill? It sounds great. You know, if you could come up with a workable model for a company of 13, I would say we are in. Again, I would say these are the kind of examples and the kinds of ideas that we really need to think through carefully and see how they might apply within the broader marketplace.

One the problems I see with that example in our part of the country is that——

Mr. BRADY. It isn't geographic. That model works wherever you take it.

Mr. CONKLIN. It may or may not. And it may work at 3,000 and not work at 20.

Mr. BRADY. Obviously, a model like that—I don't want to cut you short—but let's get serious. We are not talking about that model for 13 workers or 20. You are talking about putting together an amount that can create that synergy and do that bidding. Any other comments?

Mr. MACDONALD. Congressman, I might suggest that one of the ways of doing that is to focus on—some of us are old enough to remember this—I am not suggesting that we go back that far—but when the physicians visited us at our homes in the young years.

But I would also argue that now one of the things that we have done to incent that behavior that you discussed is really trying to focus on the primary care physician, making the doc—if you will, using a sports analogy—the quarterback, the ability to coordinate care, the ability to take that medical home approach.

You talk about paperwork, the inability of either the doc or hospitals or the insurers to have a coordinated effort around the IT function that needs to be brought into the system. Those are three or four things that could be done readily and we already have experience that have actually proved to be very beneficial to an awful lot of people.

Mr. BRADY. Chairman, thank you.

Chairman RANGEL. It would help if the members shorten their questions, so that within the 5-minute period we might get the benefit of our distinguished guests who are here, because it is embarrassing for the Chair to cut off the guest when he was asked a question and time wouldn't permit it.

But having said that, we will go now to the gentleman from New Jersey who brought the guest here, Mr. Pascrell.

Mr. PASCRELL. I thank the Chairman. I thank the panelists. Excellent, all of you.

Mr. Conklin, I have a question for you and I have a question for Mr. Dennis. I contend that an important part of health reform is providing at least the minimum benefit to ensure that individuals have meaningful coverage. Without this component, I fear we will have a race to the bottom that leaves many sick people behind and others with coverage that fails to meet their needs.

Some have argued that a health-reform package that provides for minimum benefit will restrict employers' ability to tailor the benefits to the employees' needs. In your testimony you highlight the experience you faced each year when you were shopping for coverage, to use your word.

As I understand it, there is relatively no choice in either what you are able to offer your employees and, consequently, no choice in the options among what your employees can choose.

Now, this is a problem that is not just unique to your business. I think you would agree with that. My question is this: Given your experiences in shopping for coverage that meets your employees' needs, do you really believe that a minimum benefit standard

would impede your ability to provide adequate coverage to your employees?

Mr. CONKLIN. No, Congressman, I don't. I think it would be one of those very useful tools in helping us evaluate and understand what that minimum—we don't know what that minimum is, I don't know what it is, and it would be great if somebody could inform me in that way—and the employees.

Mr. PASCRELL. Thank you very much. Mr. Dennis, in your position paper, one of the primary points made against an employer mandate is that it fails to address the real problems of the health-insurance market for small businesses, which is primarily affordability. I agree with you to a point. An employer mandate alone will not even begin to solve the problems. I would like to make it perfectly clear that no one here has claimed that making any single change will solve the problems of our health systems. You haven't heard that from anybody on either side. In fact four of President Obama's eight health-reform principles address cost growth and affordability. So I venture to say affordability is the single most important issue in this debate.

On that note, I would like to point out that some of the options you have provided us in reducing health-care costs include expanding high-deductible plans—this is in your testimony—preempting State laws that serve to provide assurances of adequate insurance coverage. It is there. It attempts to allow employers to offer the most bare-bones policies.

Now let's get down to the nitty-gritty, because I have heard some folks from the other side, my good friends, you would almost think that Medicare was a bare-bones plan. So my question to you is this: How do more bare-bones policies that ignore State laws and fail even to cover reasonable benefits provide protections for individuals, particularly those with chronic conditions or complex health-care needs?

Are you suggesting therefore, Mr. Dennis, that we ration—that we ration health care? Is that what you are suggesting.

Mr. DENNIS. When you are talking about a minimum benefit, minimum benefit plans, you could have one with virtually nothing in it; or you could have Cadillac-after-Cadillac-after-Cadillac of plans.

Mr. PASCRELL. No, we are not talking about that kind of distinction. Nobody on either side, sir, has ever said it is an either/or proposition.

Mr. DENNIS. Oh, no, I'm sorry. I didn't mean to leave you with that impression.

Mr. PASCRELL. Good.

Mr. DENNIS. Without saying there are two extremes to this, you can go either very small and very bare bones, or you can go to very expensive, let me put it that way. And there are all kinds of gradations in between. Whenever you set a minimum policy, whatever that policy is, there will be—that is the level from where you start, and that is obviously the minimum benefit. It can be either a very good policy or a very poor policy.

Chairman RANGEL. It could be a good policy or a bad policy. I want you to take notes.

Mr. DENNIS. My point is it is directly tied to cost.

Chairman RANGEL. I understand. It makes a lot of sense.

Mr. DENNIS. Directly tied to costs. And so what we are talking about here is a cost issue. I am not sure, maybe I don't understand the question.

Chairman RANGEL. No, we can't go through the question again.

Mr. PASCRELL. I thought the question was pretty clear, Mr. Chairman.

Chairman RANGEL. Well, anyway, we have to move on. We certainly appreciate that on our side.

We have Mr. Ryan waiting.

Mr. RYAN. Thank you, Chairman.

Mr. Shea, I enjoyed the point you made before. I actually agree with a lot of what you had said, which is the current system is not getting costs down. We are not attacking the root cause of health inflation. I don't think anybody is trying to defend the current system from that perspective.

I guess there are just going to be two big different approaches here on how best to attack the root cause of health inflation. We need to do a better job of offering an alternative, if we don't think that this is the plan to go with.

On that, Mr.—is it Sheils or Sheils?

Mr. SHEILS. Sheils.

Mr. RYAN. I have been on the floor with the budget all day. I apologize, I just arrived.

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Mr. RYAN. I want to get into your actuarial analysis of the EPI plan, and Ms. Gould, if you want to jump in, because I don't want to unfairly characterize your plan, walk me through what it seems to me is sort of a death spiral of private plans that occurs. How do you arrive at the $119 million or $120 million figure whereby people lose their private health insurance and go onto the government plan, as you have done in your analysis? What is the dynamic that occurs that makes that happen.

Mr. SHEILS. The dynamic that occurs is that people are going to gravitate to the lowest-cost plan. The difference here for a family in annual coverage cost is $2,500 a year. That is shoes for kids. It is getting the car fixed, so you can go to work. For uninsured people and people living, those things are very, very important, so it is a huge amount of money.

Mr. RYAN. And that is because the payment rates are set at the Medicare rates?

Mr. SHEILS. That is right.

Mr. RYAN. Which are lower on average than the private pay rates.

Mr. SHEILS. Substantially, yes.

Mr. RYAN. And because of the cross-subsidization that inevitably occurs with these lower rates than the private rates, more people going toward the lower public rates will push up prices in the private rates, making private insurance that much more expensive——

Ms. SCHWARTZ. Will the gentleman yield?

Mr. RYAN. Not right now.

Go ahead.

Mr. SHEILS. This isn't the EPI policy. This is the public plan. EPI is a different——

Mr. RYAN. Okay. Got you.

Mr. SHEILS. It is not the public program that people are talking about, no.

Mr. RYAN. So your $120 million estimate is based upon the assumption that we apply Medicare rates to the public plan.

Mr. SHEILS. Yes, if you were to do that. We also show what happens if you are less aggressive in the pricing, use private pay rates or use something in between.

Mr. RYAN. That is crossover, right?

Mr. SHEILS. Right. And the idea is to sort of give people a smorgasbord of options so that you can look at what the impact is on providers, on cost shifting, and arrive at some decision of your own where you want to place things.

Mr. RYAN. Dr. Gould, let me ask you then about your plan. Tell me if I am wrong, please. Your payment rates here are income below 200 percent of poverty, premiums fully subsidized; above 200 percent of poverty, you phase in between 200 and 300 percent of poverty, $70 for an individual, $140 for a couple, $200 for a family of four; nonworkers, different payment schedule; but the same for everybody based upon their income qualifications. Is that essentially——

Ms. GOULD. You are talking about the subsidy structure for low income?

Mr. RYAN. Yes.

Ms. GOULD. That is correct.

Mr. RYAN. And that caps it out of pocket, right, when you throw in co-insurance and everything else, right?

Ms. GOULD. That is correct.

Mr. RYAN. So here is my question and concern. That is why I want to ask Mr. Sheils and yourself, if we are going to pay the same for the services, regardless of the quality of the services, how are we going to expect the quality to improve, meaning not all doctors are the same, not all hospitals are the same? They don't give us the same quality of care. But if we are going to be paying the same rates for the services, regardless on the quality of these services; if a person has the same health insurance, which regardless of whether you are a smoker or you have bad behavior, if you are going get the same deal, aren't we basically having a system where the good cross-subsidize the bad in the health care provision of services based on quality? And aren't we having a system where we are making it harder for us to incentivize healthy living and wellness management and those kinds of things if we had such a standard plan and the same fixed rates applied against providers regardless of their quality?

Ms. GOULD. I think you are neglecting the employer-sponsored insurance will continue. And what we will see is what we see with the examples of IBM and other large corporations that are able to innovate with their delivery system and change those incentives. Those can continue. There is no question that those kind of innovations can continue.

Mr. SHEILS. I don't think we have talked today yet about the things that are really wrong with the health care system, the things that would really control costs. Controlling payments, controlling what we pay providers, it reduces your cost, but it doesn't affect the basic inefficiencies in the system.

Mr. RYAN. Right.

Mr. SHEILS. We don't do anything here to correct the underlying problem in the system, and that is that the incentives for providers are way out of whack. We know that in some parts of the country, you get twice as much health care as you do in other parts of the country; yet it has been proven that there is no correlation to your health status as a result. So there is a great deal of suspicion, and much of what we do is just plain unnecessary. None of these proposals—the public plan proposal does not fix that.

Mr. RYAN. Right.

Mr. SHEILS. It does mean we pay less for the services that we use.

Mr. RYAN. But it doesn't address the root cause of——

Mr. SHEILS. No. In California, we worked on a workers comp problem, and people said, you know, our utilization in workers comp is four times what it is in the neighboring states. Well, we looked at it, but it turned out the costs were pretty much the same in the neighboring States. The difference was that, in California, the payment rates were much, much lower. I mean, dirt cheap, low rates. And there was an increase in utilization that was generating the increase, the revenues, so they are able to maintain that kind of revenues.

We don't want to move to a system like this. And I don't think that we have at all, whether a public plan or whatever, I don't think we have gotten to the nub of the issue at all here.

Mr. RYAN. He is about to bang the gavel on me. There it is. Thank you.

Chairman RANGEL. Soon and very soon the bells will ring, and we will have a 15-minute vote, two 5-minute votes, but also a new member is being sworn in. And so it will be at least an hour that we will be away from the hearing.

We have ten members who have not yet had an opportunity to inquire. And I would like at this time to see how many of those here that haven't asked questions will be willing to come back at 2:00. And I can't hold the witnesses to have to stay here, but those that can, depending on the number of members that would respond, would make a difference.

So by hands, those who haven't had an opportunity, how many would be coming back at 2:00? So I think at this time after Mr. Blumenauer gets his 5 minutes that we will then ask everyone that is left in order to ask a question and ask who they would want to answer, and I would ask the panel to submit an answer in writing, and apologize to all of you for the awkwardness of this time, but I can't thank you enough for the valuable information that you have given to us.

And I may have to see Mr. Pascrell's friend in New Jersey to get this all straightened out, because you told it like it was, and we understand that.

So, Mr. Blumenauer, we are going to stay as long as we can, and you are recognized.

Mr. BLUMENAUER. Thank you, Mr. Chairman. And I will try and adhere to your admonition in terms of short questions.

I would just say that I was very impressed with the track record of IBM as being creative, promoting wellness. We have got some legislation we have introduced on a stand-alone basis to try and further incent that.

And I appreciate the clarification that was made that a private, even if we have a public plan, there will still be tens of millions of people through the private sector driving those issues of cost containment and promotion.

I have one specific question, Dr. Gould. The reference that I am hearing about people that are going to be crowded out that we are going to be seeing; if there is an employer mandate, that it is going to lead to significant job losses or reductions in wages. This is reminiscent to me of what we heard when it was argued that we shouldn't increase the minimum wage because that was going to have a massive negative effect.

In my State of Oregon and others around the country, the higher-minimum-wage States actually appeared to be growing, not shrinking. Does the research on minimum wage have any application to having an employer mandate for health care?

Ms. GOULD. It absolutely does. When we think about how firms paying for health care are going to be offset, you can think, at the high end, there would be different forms of compensation that could give perhaps. At the low end, you are right, you are constrained by the minimum wage. But what we are talking about here perhaps is something like a 5, 6, even 7 percent payment that would be required. Compare that to the minimum wage, we have seen in the last 2 years that 27 percent increase in the minimum wage.

We don't know yet really what the effects are of that unemployment. But if we look again, as you say, to the minimum wage literature in the 1990s, we can see that there were no employment effects of that kind of increase. And in fact, I would go one step further in saying, if we were to chart really contained costs, and I think one thing that hasn't really been mentioned here is that the introduction of the public plan would actually do a good deal to contain costs and bend that cost curve; if we were to do that, it actually can increase the competitiveness of our firms.

Mr. BLUMENAUER. Thank you.

Mr. SHEILS. And I would challenge that.

Mr. BLUMENAUER. Excuse me. My time. I asked the witness a question. I would like to ask another witness a question, if you don't mind. Is that all right? I would like to——

Mr. SHEILS. I apologize if I have offended you, sir.

Mr. BLUMENAUER. That is fine.

I just want to ask my question to Mr. Conklin. You had referenced the byplay, that you are on sort of a merry-go-round having to switch plans, you are going back and forth trying to, what impact does that have on you and your employees being on this health care merry-go-round?

Mr. CONKLIN. Well, it has various impacts. One of them is uncertainty for me and my employees. So these transition periods cover a quarter of the year, in essence. And during that quarter of the year, people still get sick. They don't stop getting sick because we are changing our health plan. So there is always the question of, which card do I use? And then there is the question of, and what am I getting, you know? Is it going to be 25 bucks when I go to the drugstore this time, or is it going to be 40 bucks, the copay?

But really one of the more significant impacts of the constant shifting is, who is your doctor? And who is choosing your doctor, because you are not choosing your doctor? The health insurance provider is choosing the doctor. I have got a stack—I almost wanted to bring them for you so you could see it. I got a stack about this high that I have collected over the last 5 years of the list of doctors for each insurance company.

Now, sometimes they cross over, and you will find them in there, and sometimes they don't. So if you are going to go to the doctor and get care, you are going to get it from somebody who is as familiar to you as the guy who drives a taxicab. And how would, you know, how do you feel going to the doctor sharing some of the most intimate aspects of your life with a perfect stranger?

I mean, there is a disincentive to go to the doctor that is part of the system. And I think, and this I think is a really important part of this discussion, it leads to the perception that they are doing this on purpose; they are doing this to keep me from going to the doctor. They are doing this because it keeps their costs down, and there is an element of distrust that now has completely permeated the private insurance system. So there is a lot of repair work to do.

Mr. BLUMENAUER. Thank you, Mr. Chairman.

Chairman RANGEL. Let's see what we can accomplish with the time that is left.

Mr. Boustany, why don't you inquire for a minute?

And we ask the panelists to respond in a minute, so that we can move on, okay?

Oh, I am sorry. No. Mr. Boustany arrived earlier, John.

Mr. Boustany.

Mr. BOUSTANY. I am sorry. Am I on? Okay.

Thank you, Mr. Chairman.

Mr. Dennis, President Obama promised, if you have got health care already, and probably a majority of you on the panel do, then you can keep your plan if you are satisfied with it. But you have research that shows employers, and especially small businesses, that would stop offering private coverage because employees could receive coverage under a government plan. So wouldn't a bill that forces workers to lose existing coverage, as has been described by Mr. Sheils, be contrary to the President's campaign promise?

Mr. DENNIS. I am not going to get into that about campaign promises.

But, clearly, I mean, we have a situation that the current system itself, the current employer-based system does not work for smaller firms. While you can start with the employer-based system as a

system from which you work around, clearly something has to be done at the bottom to help us in that regard.

From the small employer perspective, the costs of the system are relatively high, and this gets to your point. There was a cite offered earlier about an 18 percent difference in relative effective cost between small and large. There is another study that shows you get 78 to 83 percent of insurance equivalent, which is effectively the same thing. You have greater volatility of premiums because you are a small group. Owners face real hassles. This was brought up with your experience. Everybody agrees on this. A series of people who are business owners, who are not experts in insurance, although unfortunately they are having to become one.

We are talking about wellness and prevention. In a small business, a 13 person firm, I don't think so.

And then we have bizarre things that happen in this system. For example, you will see that the small businesses are much more likely to pay 100 percent of the premiums than the large ones; 40 percent of small businesses with insurance pay the whole fare.

Chairman RANGEL. I am sorry to interrupt you, but Mr. Kind would you inquire for 2 minutes.

Mr. KIND. Thank you, Mr. Chairman.

I will try to be brief. But first of all I want to thank Mr. MacDonald for kind of showing us the IBM way of what up-front preventative investment does to drive down costs in a larger employer setting. And I think the testimony was real impressive. And hopefully, as we move forward on reform, we will figure out ways to further incentivize what IBM and others are doing across the country. Because a lot of this is a lot of common sense, you know, in the free market working to drive costs down.

Mr. Dennis, let me, agree with you in your opening testimony, where I am afraid that if coverage gets out ahead of cost, this could become politically very dangerous, and the system could be very tough to reform. But I don't want NFIB to walk away leaving the impression you don't stand for anything. Because I know over the last few years, I have worked closely with NFIB. But not just NFIB, but AARP, SEIU, a restaurant association, of realtors, to come up with what I think is a very viable national purchasing pool plan that we have introduced in a bipartisan basis with tax incentives, with prohibition against risk-rating, and also virtual HR managers for small businesses that could answer a lot of the problems small businesses encounter in the free marketplace right now. Could you comment on the wisdom of such an approach?

Mr. DENNIS. Surely. And the answer is yes. We have distributed an outline, I believe, to the dais of what the basic current SHOP act contains. But essentially, what we are looking at is a pooling mechanism, a very large pooling mechanism, where we are going to draw employers in, and we are going to cap or control the ability to rate on the basis of experience, health experiences, and claims, claims histories and that kind of thing. So it is a program that I think is effective, could work for small businesses. It won't solve every problem that the world has ever come up with for us, but clearly is a step forward. I think I can speak for our legislative staff, of which I am not one, that it would welcome any Member to join you in cosponsorship of this bill.

Mr. KIND. Mr. Dennis, I think you would also agree, wouldn't you, if we do the proper health insurance reforms the right way, such as eliminating underwriting or rating based on health experience, that, too, could benefit small businesses?

Mr. DENNIS. Absolutely.

Chairman RANGEL. Mr. Heller, could you inquire for 2 minutes?

Mr. HELLER. I will. And I had a prepared question, but I will make it brief.

Mr. Sheils, what else are we not doing here on this panel?

Mr. SHEILS. Well, I guess the basic concerns for me are the incentives in the system. For physicians, the incentives are to just provide as many services so that you can crank out as many bills. We know, for example, well documented, that if you slow the rate of growth in physician payment under Medicare, you get a 30-cents-per-dollar offset from increased utilization. Those are the things that are out of control.

We know what works in terms of cost containment. We have done this—we have seen it twice. Once is in the 1990s. There was a terrific investment in managed care that was made by employers in the early 1990s. The rate of growth in spending per worker declined from 18 percent a year in 1989 down to 8/10ths of 1 percent by 1996. Adjusting for inflation, that is a net reduction in what we spend on health care.

And then with the Medicare Part D program, this was a competitive market-based approach as well, and we are all gratified to hear that the program came in costing a great deal less than what we had projected it would cost. And again, this has to do with the competition that results. So I think that the idea that has worked in the past is performing integrated systems where everybody has an incentive to keep people healthy, everybody has an incentive not to do things that are unnecessary. And those models have worked.

They are very unpopular. I am talking about managed care. They can be pretty unpopular. But there are ways to build on that platform. If we have done it once or twice, we can do it again. So that is the direction I have tended to think in terms of.

Mr. HELLER. Thank you very much, Mr. Sheils.

Mr. Chairman, I yield back.

Chairman RANGEL. Thank you so much.

Ms. Schwartz, would you please inquire for 2 minutes?

Ms. SCHWARTZ. Thank you very much.

And I do want to point out, I know there has been some frustration I think I hear from the panelists that you haven't been allowed to or been asked very much about all the other actions we should take to help improve quality, improve efficiency and contain costs. We have had other hearings, and maybe we can invite you back to discuss some of those things.

But the fact is my understanding was this was purposefully set up to discuss employer-based health care.

I do want to say that I acknowledge Mr. MacDonald, particularly speaking to health IT. We have done great work on that in this administration already in investing in health information technology. This Committee has done great work on that under Medicare.

And primary care, we are very, very aware of the increased need for primary care providers, and in fact, I am circulating a bill today

that is going to address many of those issues and I hope answer many of those questions. And I do want to also just second Mr. Kind's really good work and important work in terms of the market reform for small businesses, the agents who have joined together to purchase care.

The question I have has to do with other market reforms. And I think I would ask Dr. Gould to start with his reaction to the fact that we have talked about community rating, we have talked about of course maintaining the employer-based system of care. I don't think that we are all talking about that, most of us anyway. But we do—I actually do that. It is really hard for people to enroll.

I think that, Mr. Conklin, you talked about this, that even when you have coverage, many employees don't take employer-based coverage. And either they don't sign up, forget to sign up, miss the 30-day notice and didn't have to have a life-changing experience to sign up later; there are waiting periods for 6 months, so even if your employer covers you, you can't sign up. I think I want to change the playing field on this.

So my one question is, could we—quick question—maybe it is a yes or no answer, if I could. What do you think about doing automatic signup if your employer offers you health insurance?

Dr. Gould, do you think we ought to do like we did for 401(k) fees and just have people automatically signed up? Of course, they could opt out if they have health insurance elsewhere——

Chairman RANGEL. The two-minutes have expired. If someone wants to answer yes or no.

Ms. GOULD. I think auto enrollment would be a great idea.

Mr. MACDONALD. It is wrought with problems.

Chairman RANGEL. Congressman Roskam from Illinois will be recognized for 2 minutes.

Mr. ROSKAM. Thank you, Mr. Chairman.

Anticipating the falling gavel, just maybe a word, not really time for a question, but just to follow up with the exchange between Mr. Dennis and the gentleman from New Jersey.

I served in the State legislature in Illinois for 13 years and served on the insurance committee. What was interesting was, take Mr. Conklin's situation, assume for the sake of argument that he and his wife, his business partner, decide that they are going to put a salesperson out on the road, and they need to get a vehicle to do that. Let's say that the vehicle is sort of the analogy for a health insurance policy. The government comes in and says, you have got to have a really safe vehicle. You may say, well, Ford Taurus is pretty safe, but there is a government standard that says, no, no, no, Ford Taurus, not safe enough, you have got to put them in the best Volvo possible. And if you don't put them in a Volvo, you can't put them on the road. So you are in a situation then, as the owner of a company, that says, well, we can't really afford the Volvo; we can give them a Schwinn, but they are not going to let us do a Ford Taurus.

And that is not unlike what insurance is like in the State of Illinois and other places where mandate after mandate after mandate after mandate comes in. You listen to the testimony, and it is sympathetic. Legislatures end up voting in favor of these mandates but are really blind to the cumulative cost that goes up. So I think that

having a legitimate no-frills policy has to be a part of this conversation.

And with that, I yield back.

Chairman RANGEL. Thank you.

Bob Etheridge.

Mr. ETHERIDGE. Thank you, Mr. Chairman.

Mr. Chairman, I would like to submit a couple of questions for the record.

I will only ask one question in the expediency of time.

Mr. MacDonald, we have heard from a number of employers, not just you but others, that how valuable it is as part of your health benefits to really have a prevention and wellness program. And in your testimony, you talked about your healthy choice that translated into about an estimated $79 million in savings in health care claims between 2004 and 2007.

And I happen to believe that preventative medicine has to be a part of any health system we put together. I just think that, without doing that, we don't get to where we need to get to. My question to you is this: Can you talk just very briefly about your program, about the specific cost savings? And secondly, do you have any data on this that you could share with this Committee?

Mr. MACDONALD. I won't give you the specifics. I will respond in writing on the data, but there is an enormous amount of data that we are willing to share. And I really think that the primary issue that we have focused on is trying to connect the employee and their dependants with the primary care physician. I think that begins to drive behavior faster than anything. The preventative wellness programs help, but the single most important focal point for us is the primary care, the medical home approach to medicine.

Mr. ETHERIDGE. Thank you, Mr. Chairman. I yield back.

Chairman RANGEL. Thank you so much.

John Linder, thanks for your patience.

Mr. LINDER. Thank you, Mr. Chairman.

Mr. Sheils, how many Americans choose their health care provider or their health care insurance?

Mr. SHEILS. How many choose their provider?

Mr. LINDER. How many choose their insurance?

Mr. SHEILS. I think it is 80 percent or more of those that are offered it. Most of those people have coverage from some other source.

Mr. LINDER. How many of those people have it chosen for them by their employer?

Mr. SHEILS. Probably 30 or 40 percent.

Mr. LINDER. Don't the employers make most of the health care decisions in this country?

Mr. SHEILS. They have done, yes, sir.

Mr. LINDER. Mr. MacDonald, what percentage of your payroll does IBM pay for health care?

Mr. MACDONALD. As a percentage of payroll, it runs about 7 percent. But you have to remember that we have almost 300,000 lives, and therefore a lot of people, not a lot, but several thousand people opt out, so it actually could be higher. And plus our wage, as I indicated before, tends to be at the higher end, so that percentage is a little deflated.

Mr. LINDER. How much does the employee pay? Does the employee pay X percent of the premium?

Mr. MACDONALD. We are one of the few corporations in America today that give a free PPO plan to all employees.

Mr. LINDER. If we had a public plan to compete with, what percentage of employees do you think might opt for it?

Mr. MACDONALD. Before I mentioned to you, in my opinion, that there would be little migration to a public plan initially; I think that people are very reluctant to change as it relates to health care. As evidenced with HSA, they have been reluctant. I think a lot of it is really driven off of design, access and pricing. And so for me to opine directly on a public plan, I don't have the details yet.

Mr. LINDER. Thank you, Mr. Chairman.

Chairman RANGEL. Thank you.

Mr. Yarmuth of Kentucky.

Mr. YARMUTH. Thank you, Mr. Chairman.

Mr. Sheils, you mentioned earlier that, you were talking about why people would move to a public plan, you talked about cost savings and so forth, and seemed to imply that the only reason, at least the only one we discussed, was that you could pay lower rates to providers and that had a deleterious effect on the system. Aren't there other factors involved that may make it cheaper, like there is no profit component to the cost? There is also the potential of lower administrative costs like those achieved by Medicare that would allow the public plan to be less expensive.

Mr. SHEILS. We showed earlier in the testimony that the cost to private insurance administration, including profits, et cetera, is around 13.5 percent of benefits. Under this plan, it probably would be closer to 7 percent under this public plan.

Mr. YARMUTH. Thank you.

Mr. Conklin, first of all, thank you for saying a couple of things which I have been saying, and that is why I applaud you for saying them. And one is, we aren't going to get it right the first time. There are going to be thousands of unforeseen consequences that we will have to work on, but we need to start on this effort.

And secondly, that we are trying, I think this is the way I interpret it, that we are trying to apply business concepts to something that is not necessarily a pure business. If you wanted to leave your business right now, if you wanted to shut it down, if you had a better opportunity somewhere else, given unfortunately the condition of your wife, would you have an easy time getting insurance if there weren't some kind of a public plan?

Mr. CONKLIN. No, I don't think we would have an easy time getting insurance, and the insurance we got would be expensive, and I don't think paying more in that scenario would yield better results for my wife. Right now, we have a pretty decent HMO, and she, we, are paying for the best care she has ever gotten 100 percent out-of-pocket.

Mr. YARMUTH. Thank you.

One final question. Did under the Lewin Group, Mr. Sheils, estimate the, or what did the Lewin Group estimate is the 11-year savings to national health expenditures under the commonwealth plan?

Mr. SHEILS. I believe it was $4.8 trillion.

Mr. YARMUTH. So a significant amount. Thank you very much. Thank you, Mr. Chairman.

Chairman RANGEL. Mr. Reichert is recognized.

Mr. REICHERT. Thank you, Mr. Chairman.

Would everyone on the panel agree that if an employee today is happy with and satisfied with their health plan, that they should be able to keep it? Is there anyone who disagrees with that comment?

Mr. Sheils, if a new government-run health plan was created and it paid providers Medicare rates, how many Americans would lose their employee-based health insurance that they currently have?

Mr. SHEILS. It would be about 108 million people.

Mr. REICHERT. And Mr. Chairman, I have one other concern. I fortunately have been blessed to work with King County for King County in Seattle, Washington. A great wellness activities, preventative health care plan. I am concerned about saving $18 million over the last few years promoting prevention, health prevention programs; Microsoft does the same thing. I am concerned that if we move to a public health plan, a government-run health plan, I should say, that we may lose some of those innovative ideas.

And I yield. Thank you, Mr. Chairman.

Chairman RANGEL. Thank you. Mr. Meek is recognized.

Mr. MEEK. Thank you so very much, Mr. Chairman.

Anyone on the panel, one of the main reasons that we are—I mean, one of the main issues that we run into with this whole health insurance issue is preexisting conditions. And I just want to ask anyone that wished to answer, what kind of incentives should be out there as it relates to government incentives to not only take on preexisting conditions when we look at overall insurance?

Mr. SHEA. Congressman, the word comprehensive is often associated with reform in our discussion these days. And I really think it is worth bearing in mind that there are very concrete parts of that. One of those pieces is that we have to accept everybody into coverage. We can't exclude people because of preexisting conditions.

But the correlate of that is if we get everybody in and if we get them in from birth, we need to provide them with the kind of preventative care, with the kind of early detection, with the kind of management of chronic diseases that come up. That is where the real cost savings are going to be in terms of managing health care. So it is one piece of the overall puzzle, and it is important that we address all of them together.

Mr. DENNIS. Congressman, you have not only the preexisting condition in the sense of someone coming into a job, but you have a similar situation when someone is in a job and faces, job lock, which happens quite frequently in smaller firms. Someone will be in a job, have insurance, and then can't move to another job because of the health insurance situation.

Mr. MEEK. Well, that is something definitely we are going to have to tackle, because I can see it even going down to almost health care employment discrimination saying, well, if you have a preexisting condition, I don't need you in my group or in my company because you are going to cost us all more.

Thank you, Mr. Chairman.

Chairman RANGEL. Thank you.

You have been one of the best panels that we have had. I cannot begin to tell you how many members who have so many things to do with so many other pieces of legislation how they have stopped by to say what a great panel this has been and how important it has been.

I yield to Mr. Camp before we adjourn.

Mr. CAMP. Well, I would just agree with the chairman's comments.

Thank you all for being here. I appreciate your testimony very much.

Chairman RANGEL. And with that, most of you veterans know how it works here. We regret the awkwardness here, but you made a great contribution toward our thinking. We have got to have a health bill. And hope all of you would feel that your input has been a part of what we are doing. Thank you so much. The Committee stands adjourned.

[Whereupon, at 1:27 p.m., the Committee was adjourned.]

[Questions for the Record follow:]

CHARLES B. RANGEL, NEW YORK,
CHAIRMAN

Congress of the United States

U.S. House of Representatives

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JANICE MAYS,
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JON TRAUB,
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May 13, 2009

Elise Gould, Ph.D., M.P.Aff.
Director of Health Policy Research
Economic Policy Institute
1333 H Street, NW
Suite 1000, East Tower
Washington, DC 20005-4707

Dear Dr.Gould,

Please provide answers to the following questions for the record from the 4/29/09 Full Committee Hearing on employer-sponsored insurance:

Questions from Representative Sanchez

I have been a strong supporter of employer-based coverage. For those in union jobs, the college-educated, or who work for large corporations like IBM, the employer-based system has worked quite well. Surveys show that the majority of those lucky enough to have employer-sponsored coverage are satisfied with their health plans.

Those who are not as satisfied with the current system include not only those who do not get coverage through their workplace, but also those who lose coverage when they lose a job. A constituent recently wrote me about the struggles she has gone through as a cancer patient after losing her job and the health insurance that went with it. While COBRA coverage exists, the reality is that most unemployed people cannot begin to afford it.

Please share ideas about how we might reform the system so that losing a job does not mean losing high quality, affordable coverage, even if we retain our current employer-based system? For example, how might the newly unemployed access the health insurance "exchange" to retain or obtain health insurance?

Hearing on Health Reform in the 21st Century: Employer Sponsored Insurance
U.S. House of Representatives
Committee on Ways and Means
Wednesday, April 29, 2009

Response to a question posed after the hearing
Elise Gould, Ph.D.
Director of Health Policy Research
Economic Policy Institute

Question by Representative Linda Sanchez: *Please share ideas about how we might reform the system so that losing a job does not mean losing high quality, affordable coverage, even if we retain our current employer-based system. For example, how might the newly unemployed access the health insurance "exchange" to retain or obtain health insurance?*

Promoting High Quality, Affordable Coverage

Meaningful heath reform ought to ensure quality, affordable coverage for all Americans. There are many ways to accomplish this goal, but given that the current reform initiative is expected to build on the existing employer-sponsored insurance system, health reform must include the following components:

- *National Health Insurance Exchange*: An insurance exchange is an essential component of any comprehensive health reform initiative. It would help organize and regulate the often disparate, inefficient, and uncompetitive system of insurance providers, driving cost-control and system efficiencies. An exchange (also referred to as "connector" or "marketplace") would regulate the sale of health insurance (for example, ensuring that companies do not discriminate on health status and offer plans to all who apply), promote healthy competition between insurers, and facilitate the comparison and purchase of policies by consumers.
- *A Public Insurance Plan Option*: An exchange must include a public insurance plan that would compete directly with private insurers within a new national insurance exchange. Some have argued that a well-designed exchange with sufficient regulations would make a public plan option unnecessary. This is unlikely to be the case as a public plan provides crucial benefits to the U.S. health care system even within a well-designed exchange. A public plan would ensure competition between private plans, particularly in markets where there are one or only a few insurers, drive down administrative costs, spearhead quality advancements and innovations that private insurers do not have an incentive to pursue, and serve as a benchmark for the insurance industry[i]. The public insurance plan must be able to use its size to bargain lower rates from providers to achieve meaningful cost control and containment, and must be publically administered, rather than a plan contracted from a private insurer, so that it can effectively incentivize delivery system improvements.

(and lowest-cost) enrollees and firms rather than on quality or cost control. An exchange should promote competition on quality and efficiency.

- *Ensure affordability for all individuals*: The exchange must ensure that all plans comply with a minimum level of affordability and financial protection. Individuals who cannot afford even the minimum level of coverage but do not qualify for public programs (such as Medicaid and Medicare) ought to be provided with subsidies so that they may purchase coverage.
- *Provide a public option in addition to private plans*: The exchange must include a public plan option in addition to private insurers. While the exchange itself is an important first step, previous research has shown that meaningful cost containment, innovation, and protection is only achieved with a publically-provided alternative[iii].

Administrative Models for a National Exchange

A national exchange could be similar to the existing Massachusetts Connector, an agency established during that state's health reform process. The Connector acts as an intermediary between insurers, the state, and individuals, facilitating the purchase of insurance or enrollment in public coverage programs, delivering subsidies to qualifying households, and overseeing insurer compliance with state regulations. This is accomplished through two distinct programs. The first offers a choice of three "tiers" of state-subsidized private insurance to low-income individuals who do not qualify for existing public insurance (such as Medicare or Medicaid). The second offers a selection of four standardized "tiers" of coverage (labeled bronze, silver, gold, and young adult) to individuals and small businesses.

Six private insurance companies offer plans through the connector. The plans that private insurers offer must conform to actuarial standards for each tier. An actuarial value is a measure of an insurance plan's generosity and is expressed as the percentage of charges paid by the insurer for a common set of expenses for an average population. A gold plan through the Massachusetts connector must have an actuarial value of 93%, with no deductible and low co-payment rates. A silver plan must have an actuarial value between 67% and 81% and can higher co-payments and a deductible. A bronze plan must have a value of 56%. It is crucial to note that while actuarial values provide an estimate for plan generosity, they are by no means sufficient. A recent study has documented the fact that even plans in the same tier of coverage can have drastically different out-of-pocket burdens for conditions such as breast cancer, diabetes, or a heart attack[iv]. Therefore, more detail is needed to document the true expected out-of-pocket burden for each policy.

The Connector is managed by a board of directors that decides the criteria for a number of Connector activities, including levels of subsidies for low-income individuals, approving insurance plans for sale within the exchange, determining whether or not individuals have "creditable coverage" given a new law requiring most to obtain coverage, and designating exemptions and fines for non-compliance with the "creditable coverage" mandate. A similar board could be appointed to manage a national exchange.

CHARLES B. RANGEL, NEW YORK,
CHAIRMAN

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JON TRAUB,
MINORITY STAFF DIRECTOR

May 13, 2009

Gerald Shea
Special Assistant to the President
AFL-CIO
815 16th Street, NW
Washington, D.C. 20006

Dear Mr. Shea,

Please provide answers to the following questions for the record from the 4/29/09 Full Committee Hearing on employer-sponsored insurance:

Questions from Representative Sanchez

Currently, many employees who lose their jobs have the option to purchase COBRA coverage, but as you know, because of the expense, for many, this is really only a paper option, and not a real solution. Moreover, not all employed Americans have the option to buy COBRA coverage when they lose a job. How would the AFL-CIO recommend we strengthen the health insurance system for those between jobs? For example, do you believe that a health insurance "exchange" that many experts have proposed would help the newly unemployed?

Memorandum

American Federation of Labor and Congress of Industrial Organizations
815 Sixteenth Street, N.W., Washington, D.C. 20006 / (202) 637-5000

To: Andrew Dawson

From: Eileen Grobecker

Date: May 20, 2009

Re: Representative Sánchez's Question

Please see attached for Gerald Shea's response regarding the April 29th Ways and Means Full Committee Hearing On Employer Sponsored Insurance per Representative Sánchez's request.

If you have any questions you can contact me at 202.637.5375.

Thank you.

American Federation of Labor and Congress of Industrial Organizations

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May 20, 2009

Honorable Linda T. Sánchez
U.S. House of Representatives
1222 Longworth House Office Building
Washington, D.C. 20515

Dear Representative Sánchez:

The cost of COBRA coverage is unfortunately financially out of reach for the vast majority of Americans who lose their job.

To provide working families coverage through work requires:

1. Affordable (and high quality) coverage be available to all workers and their families. Doing so necessitates that all employers would pay a substantial share of premium costs, that government subsidies be available based on income, and that cost-sharing, e.g., co-pays and deductibles be part of what's included in "affordable coverage" when the government subsidy is calculated.

2. Workers who lose their jobs should be allowed to purchase subsidized coverage according to their ability to pay for themselves and their families through a robust insurance exchange that guarantees affordable coverage through comprehensive consumer protections and market regulations and that offers a public health insurance plan option.

As Congress writes health reform legislation, provisions such as these need to be specified so that people out of work don't fall between the cracks of coverage. As the current economic crisis shows, we must be prepared to subsidize coverage for extensive periods of time and not time limit the benefits.

Finally, the AFL-CIO believes that for health care coverage to be sustainable, health care cost inflation must be substantially lowered. Cost savings can be realized through a combination of delivery system reforms that increase quality and value of health services, payment reforms that tie payments to quality, strong insurance market reforms and a public health insurance plan option.

Thank you for your support for health care that works for working families and for the opportunity to provide the views of the AFL-CIO before your committee.

Sincerely,

Gerald M. Shea
Assistant to the President

GS/eg

[Submissions for the Record follow:]

Written Testimony of Joe Solmonese, Human Rights Campaign

On behalf of the Human Rights Campaign and our over 700,000 members and supporters nationwide, I thank Representative Rangel for convening this hearing on employer-sponsored health insurance. The Human Rights campaign is the nation's largest civil rights group advocating for the lesbian, gay, bisexual and transgender community. Employer-provided health care is of great concern to our community, as it is to most Americans.

Over 60 percent of Americans under age 65 receive their health insurance from their employers, who contribute a portion of the premium for the employee and, often, for family members covered under the employer's plan. Nationwide, employers are increasingly covering same-sex couples in their insurance plans. As of this hearing, over 57% of Fortune 500 companies now offer equal health benefits to their employees' same-sex domestic partners—up from only one in 1992.[1]

Unfortunately, our tax system does not reflect this advance toward true meritocracy in the workplace. Under current federal law, employer-provided health benefits for domestic partners are subject to income tax and payroll tax. As a result, a lesbian or gay employee who takes advantage of this benefit takes home less pay than the colleague at the next cubicle. Some families have to forego the benefits altogether because this unfair tax renders the coverage too expensive—adding them needlessly to the millions of uninsured Americans in this country.

The following example illustrates how this tax inequity affects a same-sex couple with an average income: In 2006 Steve earned $32,000 per year and owed $3,155 in federal income and payroll taxes. Steve's employer also paid the monthly premium of $907 for the insurance coverage for Steve and his wife. Of this amount, $572 was the amount in excess of the premium for self-only coverage. None of this coverage was taxable under current law because employer contributions for the worker and a spouse or dependent child are excluded from taxable income. Steve's co-worker, Jim, earned the same salary and had the same coverage for himself and his same-sex partner. However, the value of the coverage provided to the partner is subject to federal income and payroll taxes. As a result, $6,864 of income is imputed to Jim and his federal income and payroll tax liability increased from $3,155

[1] The federal government, the nation's largest civilian employer, does not provide these benefits. As a result, hardworking civilian employees with same-sex partners do not receive equal compensation for their service to the government.

to $4,710. This represents nearly a 50% increase over Steve and his wife's tax liability.

For many families, especially those with modest incomes, the tax hit is more than they can bear. In the example above, a family earning $32,000 would most likely find that the additional $1,555 in tax liability puts coverage beyond their means.

Taxing these benefits also raises costs for employers. The benefits are not only considered imputed income, but also wages for payroll tax purposes. As a result, the employer must pay additional payroll taxes on these benefits that they do not pay for spouse and dependent child coverage.

The high—and increasing—cost of health insurance is of particular importance to LGBT people. Nearly one in four lesbian and gay adults lack health insurance and these adults are more than twice as likely as their heterosexual counterparts to be uninsured.[2] For some of these people, unfair taxation of employer-provided health benefits is partly to blame. Furthermore, the additional tax burden could dampen the incentive for employers to choose to offer equal benefits to their employees with same-sex partners.

It is imperative that the federal government not pile unfair taxes onto some families who are coping with the spiraling cost of health care. The Tax Equity for Health Plan Beneficiaries Act, which as H.R. 1820 in the 110th Congress, would eliminate the tax inequity and render health insurance more affordable for many American families.[3] Regardless of which approach Congress takes to health care reform, tax incentives relating to family health coverage must treat all families equally. As this Committee considers the role of employer-provided health insurance in the future of health care, we strongly recommend that it support eliminating the tax on employer-provided health benefits.

Statement of Judy Waxman

Chairman Rangel and Members of the Committee on Ways and Means, thank you for this opportunity to provide written testimony on behalf of the National Women's Law Center. As a non-profit organization dedicated to expanding the possibilities for women and girls in this country since 1972, we would like to express our concerns to the Committee regarding the harmful practices of insurance carriers in the individual and group health insurance markets and the disproportionate impact that such practices have on women in the United States.

Introduction

Women have much to gain from carefully-implemented insurance market reforms. Regardless of whether they receive coverage from an employer via the group health insurance market or are left to purchase health insurance directly from insurers through the individual market, the harmful practices of health insurance companies can hinder women's ability to obtain affordable and comprehensive health coverage.

The majority of American women have health insurance either through an employer or through a public program such as Medicaid. In 2007, nearly two-thirds of all women aged 18 to 64 had insurance through an employer, and another 16% had insurance through a public program.[1] In contrast, a very small percentage of non-elderly women—just 7% in 2007—purchase health coverage directly from insurance companies in what is known as the "individual market."[2] Because this is the least common way to get health insurance, few people have any idea just how difficult it can be to purchase coverage in the individual market. For the 18% of women who are currently uninsured[3]—those who lack access to employer coverage, or who earn too much to qualify for public programs—the individual insurance market is often the last resort for coverage.

While women who get health insurance from their employer are partially protected by both federal and state laws, states are left to regulate the sale of health insurance in the individual market with no minimum federal standards. In the vast majority of states, few if any such protections exist for women who purchase individual health coverage. Furthermore, those seeking health coverage in the indi-

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[2] *http://www.harrisinteractive.com/NEWS/allnewsbydate.asp?NewsID=1307*

[3] A similar bill was introduced in the Senate in the 110th Congress__the Tax Equity for Domestic Partner and Health Plan Beneficiaries Act (S. 1556).

[1] National Women's Law Center analysis of 2007 data on health coverage from the Current Population Survey's Annual Social and Economic Supplement, using CPS Table Creator, http://www.census.gov/hhes/www/cpstc/cps__table__creator.html.

[2] *Id.*

[3] *Id.*

vidual market are often less able to afford insurance without the benefit of an employer to share the cost of the premium.

The individual health insurance market presents numerous problems for women, but even those who obtain group health insurance from their employer are affected by some of the same harmful practices that impede access to affordable coverage in the individual market

Women Face Many Challenges in the Individual Insurance Market

To learn more about the experiences of women seeking coverage in the individual insurance market, between July and September 2008, the National Women's Law Center ("NWLC" or "the Center") gathered and analyzed information on over 3,500 individual health insurance plans available through the leading online source of health insurance for individuals, families and small businesses.[4] The Center investigated two phenomena: the "gender gap"—the difference in premiums charged to female and male applicants of the same age and health status—in plans sampled from each state and the District of Columbia (D.C.), and the availability and affordability of coverage for maternity care across the country.[5] In addition, NWLC examined state statutes and regulations relating to the individual insurance market to determine whether the states and D.C. have protections against premium rating based on gender, age, or health status in the individual market, and to determine whether states have any maternity coverage mandates requiring insurers in the individual market to cover comprehensive maternity care (defined as coverage for prenatal and postnatal care as well as labor and delivery for both routine and complicated pregnancies).

Based on this research, NWLC found that the individual insurance market is a very difficult place for women to buy health coverage. Insurance companies can refuse to sell women coverage altogether due to a history of any health problems, or charge women higher premiums based on factors such as their gender, age and health status. This coverage is often very costly and limited in scope, and it often fails to meet women's needs. In short, women face too many obstacles obtaining comprehensive, affordable health coverage in the individual market—simply because they are women.

Women often face higher premiums than men. Under a practice known as gender rating, insurance companies are permitted in most states to charge men and women different premiums. This costly practice often results in wide variations in rates charged to women and men for the same coverage. The Center's 2008 research on gender rating in the individual market found that among insurers who gender rate, the majority charge women more than men until they reach around age 55, and then some (though not all) charge men more.[6] The Center also found huge and arbitrary variations in each state and across the country in the difference in premiums charged to women and men. For example, insurers who practice gender rating charged 40-year-old women from 4% to 48% more than 40-year-old men.[7] The huge variations in premiums charged to women and men for identical health plans highlight the arbitrariness of gender rating, and the financial impact of gender rating

[4] This source is eHealthInsurance, available at http://www.ehealthinsurance.com. Notably, eHealthInsurance may not represent all insurance companies licensed to sell individual health insurance policies in every state. However, the company bills itself as the leading online source of health insurance for individuals, families, and small businesses, partnering with over 160 health insurance companies in 50 states and D.C. and offering more than 7,000 health insurance products online. NWLC chose to use eHealthInsurance for this study because it presents the clearest available picture of the individual market across the country, and because it is the most readily available tool for individuals seeking private insurance who do not wish, or cannot afford, to employ the services of an insurance agent. Any limitations in eHealthInsurance's scope—in tandem with the basic fact that its services are only available online and therefore may not be accessible to individuals without a computer or internet access or who are not web savvy—simply underscores the challenges women (and men) face seeking coverage in the individual market without a government-sponsored system to help facilitate their search.

[5] While NWLC's review of health insurance plans examined coverage for maternity-related care, it was much more difficult to determine whether other pregnancy-related benefits, such as contraception or pregnancy termination, are covered under a plan; accordingly, our review did not include these important reproductive health benefits. For example, in many plan brochures, if information about either of the above benefits is available at all, it is visible only as part of a long list of exclusions. This obfuscation reflects another challenge women face in assessing the adequacy of a plan's coverage.

[6] Lisa Codispoti, Brigette Courtot and Jen Swedish, Nat'l Women's Law Ctr, *Nowhere to Turn: How the Individual Market Fails Women* (Sep. 2008), http://action.nwlc.org/site/PageServer?pagename=nowheretoturn.

[7] *Id.*

is compounded when insurers also charge more for age and health status when setting insurance premiums.

It is difficult and costly for women to find health insurance that covers maternity care. The vast majority of individual market health insurance policies that NWLC examined do not cover maternity care at all. A limited number of insurers sell separate maternity coverage for an additional fee known as a "rider," but this supplemental coverage is often expensive and limited in scope. Moreover, insurers that sell maternity riders typically offer just a single "one size fits all" rider option. Typically, a woman cannot select a more or less comprehensive rider policy—her only option is to purchase the limited rider or go without maternity coverage altogether.[8] Individual market insurers may also consider pregnancy as grounds for rejecting a woman's application for coverage, or as a "pre-existing condition" for which coverage can be excluded.[9]

The dearth of maternity coverage in the individual health insurance market has been documented elsewhere. In California, for example, the California Health Benefits Review Program found that only 22 percent of the estimated 1,038,000 people in the individual market in California in 2009 had maternity benefits—a dramatic decrease from the 82% of people with individual policies that covered maternity in 2004.[10]

Insurance companies can reject applicants for health coverage for a variety of reasons that are particularly relevant to women. For example, it is still legal in eight states and D.C. for insurers to reject applicants who are survivors of domestic violence.[11] Insurers can also reject women for coverage simply for having previously had a Cesarean section.[12]

While both women and men face additional challenges in the individual insurance market, these problems compound the affordability challenges women already face. Insurance companies also engage in premium rating practices that, while not unique to women, compound the affordability issues caused by gender rating. These include setting premiums based on age and health status.[13]

Women Face Similar Challenges in the Group Insurance Market

While there has been significant recent attention on gender rating among insurers in the individual market, it is important to recognize that this practice also occurs in the group health insurance market where employers obtain coverage for their employees. Insurance companies in most states are allowed to use the gender makeup of an insured group as a rating factor when determining how much to charge the group for health coverage. From the employee's perspective, this disparity may not be apparent, since employment discrimination laws prohibit an employer from charging male and female employees different rates for coverage. Yet gender rating in the group insurance market can present a serious obstacle to affordable health coverage for an employer and all of its employees. If the overall premium is not affordable, a business may forgo offering coverage to workers altogether, or shift a greater share of health insurance costs to employees.

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[8] *Id.*

[9] Ed Neuschler, Institute for Health Policy Solutions, Policy Brief on Tax Credits for the Uninsured and Maternity Care 3 (March of Dimes 2004), http://www.marchofdimes.com/TaxCreditsJan2004.pdf.

[10] California Health Benefits Review Program, *Executive Summary: Analysis of Assembly Bill 98: Maternity Services, A Report to the 2009–2010 California Legislature* (Mar. 16, 2009), http://www.chbrp.org/documents/ab_98_fnlsumm.pdf.

[11] Women's Law Project & Pennsylvania Coalition Against Domestic Violence, FYI: Insurance Discrimination Against Victims of Domestic Violence, 2002 Supplement 2 (2002), http://www.womenslawproject.org/brochures/InsuranceSup_DV2002.pdf. In the early 1990s, advocates discovered that insurers had denied applications for coverage submitted by women who had experienced domestic violence. *See*, *e.g.*, 142 Cong. Rec. E1013–03, at E1013–14 (June 5, 1996) (statement of Rep. Pomeroy) ("the Pennsylvania State Insurance Commissioner surveyed company practices in Pennsylvania and found that 26% of the respondents acknowledged that they considered domestic violence a factor in issuing health, life and accident insurance"). Since 1994, the majority of states have adopted legislation prohibiting health insurers from denying coverage based on domestic violence, but nine states and D.C. offer no such protection to survivors of domestic violence. Even though Vermont lacks legislation specifically prohibiting discrimination against domestic violence survivors, the state requires guaranteed issue of all individual insurance plans. *See* infra note 94 and accompanying text. Though the report identifies nine states, as well as the District of Columbia, which do not prohibit this practice, Arkansas Gov. Beebe recently signed into law ACT 619, which amends Arkansas Code § 23–66–206(14)(G), to add "status as a victim of domestic abuse" to the list of attributes that insurers may not use as the sole justification for denying an individual health insurance coverage.

[12] Denise Grady, After Caesareans, Some See Higher Insurance Cost, N.Y. Times, June 1, 2008, at A26, available at http://www.nytimes.com/2008/06/01/health/01insure.html.

[13] *See supra* note 6.

Gender rating may affect health premium costs for large employers. As a result of important state and federal anti-discrimination protections that apply to employer-provided health insurance, gender rating—while still present in the group market—manifests itself differently than in the individual market. Under federal and most state laws, employers unlawfully discriminate if they charge female employees more than male employees for the same health coverage.

At the same time, when a business applies for health insurance, the majority of states allow insurance companies to determine the premium that will be charged using a process known as "medical underwriting." As part of this process, an insurer considers various criteria—such as gender, age, health status, claims experience, or occupation—and decides how much to charge an applicant for health coverage. In the large group market, insurers underwrite the group as a whole rather than considering the health-related factors of each employee—but this limitation provides little relief for employers with a high proportion of female workers.[14] Under the premise that women have, on average, higher hospital and physicians' costs than men, insurance companies that gender rate may charge employers more for health insurance if they have a predominantly female workforce. This can raise premiums for all employees and potentially move the employer to forgo providing health coverage all together.

Gender rating is a particular problem for small businesses and their employees. Though insurers may use gender rating when setting premiums for a group of any size, the smaller an insured group is, the more harmful gender rating becomes. It may create insurmountable barriers to coverage for women who own and work for small businesses, in particular. When compared to their larger counterparts, small businesses are considerably less likely to offer health coverage to their workers, most often citing cost as the reason.[15] Obtaining affordable group coverage is a problem facing many small businesses, and gender rating makes health insurance even more expensive for those with predominantly female workforces. Indeed, small employers that do not offer health coverage tend to have larger proportions of female workers.[16]

Some States Have Taken Action to Protect Consumers in the Individual and Small Group Markets

Some states have taken action to address the challenges that women, and employers with female employees, face in the individual and small group markets.

Protections against gender rating: Because the regulation of insurance has traditionally been a state responsibility,[17] no federal law provides protections against gender rating in the individual and group markets. Overall, 40 states and D.C. allow gender rating in the individual market, with two of these states limiting the amount premiums can vary based on gender through "rate bands."[18] However, even states that ban gender rating allow some plans to use this practice, such as the bare-bones basic and essential plans offered in New Jersey.[19] There are three basic approaches to prohibit or limit gender rating in the individual market:

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[14] *Id.*; Henry J. Kaiser Family Foundation, *How Private Health Coverage Works: A Primer, 2008 Update* (Apr. 2008), http://www.kff.org/insurance/upload/7766.pdf.

[15] Kaiser Family Found. and Health Research and Educ. Trust, *Employer Health Benefits 2008 Annual Survey* 5 (2008), http://ehbs.kff.org/.

[16] Paul Fronstin & Ruth Helman, Employee Benefit Research Inst., *Issue Brief No. 253, Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey* 11 (Jan. 2003), http://www.ebri.org/pdf/briefspdf/0103ib.pdf.

[17] McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015 (2008).

[18] *See supra* note 3.

[19] N.J. Dept. of Banking & Ins., N.J. Individual Health Coverage Program Buyer's Guide: How To Select a Health Plan—2006 Ed. (2006), http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcbuygd.html ("carriers may vary the rates for the B&E plan based on age, gender and geographic location").

Explicit Protections against Gender Rating: Four states in the individual market—Minnesota,[20] Montana,[21] New Hampshire,[22] and North Dakota[23] have passed laws prohibiting insurers from considering gender when setting health insurance rates.

Community Rating: Currently, six states prohibit the use of gender as a rating factor under community rating statutes: New York imposes pure community rating[24]; while Maine,[25] Massachusetts,[26] New Jersey,[27] Oregon,[28] and Washington[29] impose modified community rating that, in addition to prohibiting rating based on health status, also bans rating based on gender.

Gender Rate Bands: Some states have passed laws limiting insurers' ability to base premiums on gender by establishing a "rate band," which sets limits between the lowest and highest premium that a health insurer may charge for the same cov-

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[20] Minn. Stat. § 62A.65(4) (2008) ("No individual health plan offered, sold, issued, or renewed to a Minnesota resident may determine the premium rate or any other underwriting decision, including initial issuance, through a method that is in any way based upon the gender of any person covered or to be covered under the health plan.").

[21] Mont. Code Ann. § 49–2–309(1) (2008) ("It is an unlawful discriminatory practice for a financial institution or person to discriminate solely on the basis of sex or marital status in the issuance or operation of any type of insurance policy, plan, or coverage or in any pension or retirement plan, program, or coverage, including discrimination in regard to rates or premiums and payments or benefits."). Montana's "unisex insurance law" is not limited to health insurance; it prohibits insurers from using gender as a rating factor in any type of insurance policy issued within the state. *See* Mont. Code Ann. § 49–2–309(1) (2008) ("It is an unlawful discriminatory practice for a financial institution or person to discriminate solely on the basis of sex or marital status in the issuance or operation of any type of insurance policy, plan, or coverage or in any pension or retirement plan, program, or coverage, including discrimination in regard to rates or premiums and payments or benefits").

[22] N.H. Rev. Stat. Ann. § 420–G:4(I)(d) (2008) (allowing insurers to base rates in the individual market solely on age, health status, and tobacco use).

[23] N.D. Cent. Code § 26.1–36.4–06(1) (2008) (imposing a rate band under which age, industry, gender, and duration of coverage may not vary by a ratio of more than 5 to 1, but providing that "[g]ender and duration of coverage may not be used as a rating factor for policies issued after January 1, 1997"). Despite the statutory prohibition on gender rating in North Dakota, the only company offering individual policies through www.eHealthInsurance.com does use gender as a rating factor. In an attempt to understand this seeming inconsistency, NWLC contacted the North Dakota Insurance Department, which indicated that this company is a "hybrid situation" and thus permitted to rate its individual policies as if they were sold on the group market; gender rating is allowed within limit for groups in North Dakota. Telephone Interview with North Dakota Insurance Department (Sept. 12, 2008).

[24] N.Y. Ins. Law § 3231(a) (McKinney 2008) (defining community rating as "a rating methodology in which the premium for all persons covered by a policy or contract form is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status or occupation").

[25] Me. Rev. Stat. Ann. tit. 24–A, § 2736–C(2)(B) (2008) (prohibiting insurance carriers from varying the community rate due to gender or health status). Me. Rev. Stat. Ann. tit. 24–A, § 2736–C(2)(D)(3) (2008) (imposing a rate band under which insurance carriers may only vary the community rate due to age by plus or minus 20% for policies issued after July 1, 1995).

[26] Mass. Gen. Laws ch. 176M, § 1 (2008) (defining "modified community rate" as "a rate resulting from a rating methodology in which the premium for all persons within the same rate basis type who are covered under a guaranteed issue health plan is the same without regard to health status; provided, however, that premiums may vary due to age, geographic area, or benefit level for each rate basis type as permitted by this chapter"). Mass. Gen. Laws ch. 176M, § 4(a)(2) (2008) (imposing a rate band under which the "premium rate adjustment based upon the age of an insured individual" may range from 0.67 to 1.33).

[27] 2008 N.J. Sess. Law Serv. Ch. 38, page nos. 12, 15 (Senate 1557) (West) (amending N.J. Stat. Ann. § 17B:27A–2 (West 2008) to define "modified community rating" as "a rating system in which the premium for all persons under a policy or a contract for a specific health benefits plan and a specific date of issue of that plan is the same without regard to sex, health status, occupation, geographic location or any other factor or characteristic of covered persons, other than age," and amending N.J. Stat. Ann. § 17B:27A–4 (West 2008) to require individual health benefits plans to "be offered on an open enrollment, modified community rated basis"). New Jersey law excludes bare-bones basic and essential plans from the modified community rating requirement.

[28] Or. Rev. Stat. § 743.767(2) (2008) ("The premium rates charged during a rating period for individual health benefit plans issued to individuals shall not vary from the individual geographic average rate, except that the premium rate may be adjusted to reflect differences in benefit design, family composition and age.").

[29] Wash. Rev. Code § 48.43.005(1) (2008) (defining "adjusted community rate" as "the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities"); Wash. Rev. Code § 48.44.022(1)(a) (2008) (allowing insurers to only vary the adjusted community rate based on geographic area, family size, age, tenure discounts, and wellness activities).

erage based on gender. In the individual market, two states—New Mexico[30] and Vermont[31]—use rate bands to limit insurers' ability to vary rates based on gender.

In the small group market, twelve states have banned gender rating all together. Three states have applied gender "rate bands," and one state prohibits gender rating unless the carrier receives prior approval from the state insurance commissioner.

Explicit Protections against Gender Rating: California,[32] Colorado,[33] Michigan,[34] Minnesota,[35] and Montana[36] specifically prohibit insurers from considering gender when setting health insurance rates in the small group market.

Community Rating: New York[37] imposes pure community rating in its small group market, while Maine,[38] Maryland,[39] Massachusetts,[40] New Hampshire,[41] Oregon,[42] and Washington[43] ban gender-based rating under modified community rating.

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[30] N.M. Stat. § 59A–18–13.1(A) (2008) (allowing gender rating); N.M. Stat. § 59A–18–13.1(B) (2008) (providing that "the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rates in the age group by more than twenty percent of the lower rate").

[31] Vt. Stat. Ann. tit. 8, § 4080b(h)(1) (2008) (prohibiting the use of the following rating factors when establishing the community rate: demographics including age and gender, geographic area, industry, medical underwriting and screening, experience, tier, or duration); Vt. Stat. Ann. tit. 8, § 4080b(h)(1) (2008), 21–020–034 Vt. Code R. § 93–5(11)(G), (13)(B)(6) (2008) (providing that upon approval by the insurance commissioner, insurers may adjust the community rate by a maximum of 20% for demographic rating including age and gender rating, geographic area rating, industry rating, experience rating, tier rating, and durational rating).

[32] Cal. Ins. Code §§ 10714(a)(2), 10700(t)–(v) (West 2008) (prohibiting small employer insurance carriers from setting premium rates based on characteristics other than age, geographic region, and family size, in addition to the benefit plan selected by the employee).

[33] Colo. Rev. Stat. §§ 10–16–105(8)(a), 10–16–102(10)(b) (2008) (prohibiting small employer insurance carriers from setting premium rates based on characteristics other than age, geographic region, family size, smoking status, claims experience, and health status).

[34] Mich. Comp. Laws § 500.3705(2)(a) (2008) (prohibiting commercial small employer insurance carriers from setting premium rates based on characteristics of the small employer other than industry, age, group size, and health status).

[35] Minn. Stat. § 62L.08(5) (2008) (prohibiting the use of gender as a rating factor for small employer insurance carriers).

[36] Mont. Code Ann. § 49–2-309(1) (2008) ("It is an unlawful discriminatory practice for a financial institution or person to discriminate solely on the basis of sex or marital status in the issuance or operation of any type of insurance policy, plan, or coverage or in any pension or retirement plan, program, or coverage, including discrimination in regard to rates or premiums and payments or benefits").

[37] N.Y. Ins. Law § 3231(a) (McKinney 2008) (requiring all small employer insurance plans to be community rated and defining "community rating" as "a rating methodology in which the premium for all persons covered by a policy or contract form is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status or occupation").

[38] Me. Rev. Stat. Ann. tit. 24–A, § 2808–B(2)(B) (2008) (prohibiting small employer insurance carriers from varying the community rate based on gender, health status, claims experience or policy duration of the group or group members).

[39] Md. Code Ann., Ins. § 15–1205(a)(1)–(3) (West 2008) (allowing small employer insurance carriers to adjust the community rate only for age and geography).

[40] Mass. Gen. Laws ch. 176J, § 3(a)(1), (2) (2008) (allowing small employer insurance carriers to adjust the community rate only for age, industry, participation-rate, wellness program, and tobacco use).

[41] N.H. Rev. Stat. Ann. § 420–G:4(1)(e)(1) (2008) (prohibiting small employer insurance carriers from setting premium rates based on characteristics of the small employer other than age, group size, and industry classification).

[42] Or. Rev. Stat. § 743.737(8)(b)(B) (2008) (providing that small employer insurance carriers may only vary the community rate based on age, employer contribution level, employee participation level, the level of employee engagement in wellness programs, the length of time during which the small employer retains uninterrupted coverage with the same carrier, and adjustments based on level of benefits). Overall Rate Band: ± 50%.

[43] Wash. Rev. Code § 48.21.045(3)(a) (2008) (providing that small employer insurance carriers may only vary the community rate based on geographic area, family size, age, and wellness activities).

Gender Rate Bands: Three states—Delaware,[44] New Jersey,[45] and Vermont[46]—limit the extent to which insurers may vary premium rates based on gender through a rate band.

Other: One state, Iowa,[47] prohibits gender rating unless a small group insurance carrier secures prior approval from the state insurance commissioner.

It is important to note that these regulations apply only to health insurance sold to small groups, which states generally define as a group of 50 people or fewer. Even in the 16 states with group market protections against gender rating, premiums for larger groups are still subject to this unfair practice.[48]

Maternity mandates: A handful of states have recognized the importance of ensuring that maternity coverage—including prenatal, birth, and postpartum care—is a part of basic health care by establishing a "benefit mandate" law that requires insurers to include coverage for maternity services in all individual health insurance policies sold in their state. Currently, just five states have enacted mandate laws that require all insurers in the individual market to cover the cost of maternity care. These states are: Massachusetts,[49] Montana,[50] New Jersey,[51] Oregon,[52] and Washington.[53] In New Jersey and Washington, individual insurance providers are allowed to offer bare-bones plans that are exempt from the mandate and exclude maternity coverage.[54]

Beyond this short list of five, other states have adopted limited-scope mandate laws that require maternity coverage only for certain types of health plan carriers, certain types of maternity care, or for specific categories of individuals. Limited-scope mandate laws address the provision of maternity care but may fall short of providing women with full coverage for the care they need. In California,[55] Illinois,[56]

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[44] Del. Code Ann. tit. 18, § 7205(2)(a) (2008) (allowing small employer insurance carriers to vary premium rates based on gender and geography combined by up to 10 percent). Age: Del. Code Ann. tit. 18, §§ 7202(9), 7205 (2008) (allowing the use of age as a rating factor if actuarially justified).

[45] N.J. Stat. Ann. § 17B:27A–25(a)(3) (West 2008) (providing that the premium rate charged by a small employer insurance carrier to the highest rated small group shall not be greater than 200% of the premium rate charged to the lowest rated small group purchasing the same plan, "provided, however, that the only factors upon which the rate differential may be based are age, gender and geography"). Rate Band for Age, Gender & Geography: ± 200%.

[46] Vt. Stat. Ann. tit. 8, § 4080a(h)(1) (2008) (prohibiting the use of the following rating factors when establishing the community rate: demographics including age and gender, geographic area, industry, medical underwriting and screening, experience, tier, or duration); Vt. Stat. Ann. tit. 8, § 4080a(h)(2) (2008) (providing that upon approval by the insurance commissioner, insurers may adjust the community rate by a maximum of 20% for demographic rating including age and gender rating, geographic area rating, industry rating, experience rating, tier rating, and durational rating). Overall Rate Band: 20%.

[47] Iowa Code § 513B.4(2) (2008) (prohibiting the use of rating factors other than age, geographic area, family composition, and group size without prior approval of the insurance commissioner).

[48] Nat'l Women's Law Ctr, "Women and Employer Sponsored Insurance," *Reform Matters Toolkit* (2008), at 9–10.

[49] Mass. Gen. Laws ch. 176G, §§ 4(c), 4I (2008) (requiring health maintenance organizations to include maternity coverage); Mass. Gen. Laws ch. 176B, § 4H (2008) (requiring medical service corporations to include maternity coverage); Mass. Gen. Laws ch. 176A, § 8H (2008) (requiring non-profit hospital service corporations to include maternity coverage).

[50] Mont. Ins. Or. (Feb. 16, 1994); Bankers Life & Casualty Co. v. Peterson, 866 P.2d 241 (Mont. 1993). Mandated maternity coverage is not always imposed by state legislation or via administrative regulations. Montana's mandate is the result of a 1993 state Supreme Court decision which held that a health plan excluding maternity coverage unconstitutionally discriminated based on gender.[74] In response to this court decision, the Montana Insurance Commissioner issued an order that all insurers in the state must include maternity benefits.[75]

[51] N.J. Stat. Ann. § 17B:26–2.1b (West 2008) (requiring all individual plans, except the bare-bones basic and essential plans, to include maternity coverage). N.J. Dept. of Banking & Ins., N.J. Individual Health Coverage Program Buyer's Guide: How To Select a Health Plan_2006 Ed. (2006), http://www.state.nj.us/dobi/division–insurance/ihcseh/ihcbuygd.html ("carriers may vary the rates for the B&E plan based on age, gender and geographic location").

[52] Or. Rev. Stat. § 743A.080 (2008).

[53] Wash. Rev. Code § 48.43.041(1)(a) (2008) (requiring all individual plans, except the bare-bones catastrophic plans, to include maternity coverage).

[54] *Id.*; N.J. Dept. of Banking & Ins., supra note 8 ("B&E Plans do not provide comprehensive benefits like the standard plans described above," which include prenatal and maternity care).

[55] Cal. Health & Safety Code § 1367(i) (requiring health care service plans to provide basic health care services); A.B. 1962, 2007–2008 Sess. § 1 (Cal. 2008) (recognizing that, in practice, health care service plans are required to provide maternity services as a basic health care benefit).

[56] Ill. Admin. Code tit. 50, § 5421.130(e) (2008).

and Georgia,[57] for example, only Health Maintenance Organizations (HMOs) are subject to state laws that mandate maternity benefits in the individual insurance market.

In a few instances, state governments have stepped in (at taxpayer expense) to fill gaps in private health insurance by establishing programs to assist pregnant women who have private coverage that does not meet their maternity care needs. At least two states have such programs: California's Access for Infants and Mothers (AIM) program is a low-cost coverage program for pregnant women who are uninsured and ineligible for Medi-Cal (the state's Medicaid program).[58] New Mexico's Premium Assistance for Maternity (PAM) program is a state-sponsored initiative that provides maternity coverage for pregnant citizens who are ineligible for Medicaid.[59] According to program officials in New Mexico, PAM was established expressly because of the gaps that existed in private market maternity coverage. If maternity care was included as a basic benefit in comprehensive and affordable health insurance policies, such programs would be unnecessary.

Recommendations for Health Care Reform

To address the harmful practices of insurers in the individual and group markets, health reform must:

Eliminate the individual market;

Impose strict regulation on the sale of health insurance in all markets, including: a prohibition on premium rating based on gender, age, and health status; guaranteed issue and renewal; and a prohibition on pre-existing conditions exclusions; and

Ensure women have access to the full range of reproductive health services, including maternity care.

Conclusion

The individual insurance market is irredeemable; adequate alternatives must be developed to eliminate the need for people to resort to its use. This can be accomplished by making employer-sponsored coverage easier to obtain and afford and by creating a health insurance exchange or new market place with purchasing pools that are large enough to accommodate everyone who needs coverage. In addition, to ensure that comprehensive health coverage is easier to obtain and afford, insurance carrier participation in all markets must be subject to strict regulation. In particular, the harmful practices of gender rating and rating based on age and health history should be prohibited. Finally, all health insurance policies should cover the full range of reproductive health services, including maternity care.

Without these changes, health reform will be meaningless for far too many women; rather than improve women's access to health care, reform that does not address these flaws in the individual market will leave women in the exact same place where they are today. Too many women will have nowhere to turn for health coverage or will be left on their own at the mercy of health insurers. Inadequate and unaffordable coverage may be their only choice, if they can find coverage at all.

National Small Business Association Letter

Dear Chairman Rangel:

On behalf of the National Small Business Association (NSBA), the nation's oldest nonpartisan small-business advocacy group reaching more than 150,000 small businesses nation-wide, I would like to provide comments to a recent hearing held by the House Ways and Means Committee titled, "*Health Reform in the 21st Century: Employer Sponsored Insurance*."

Attached is a document, *Small Business Health Care Reform: A Long-Term Solution for All*, that NSBA has worked on for several years with small-business owners and health care experts to address problems with the U.S. health care system. The principles outlined in this document would benefit the group and non-group market by making the necessary and appropriate reforms to the entire U.S. health care system. We trust that you will take them into consideration as the Committee continues to engage in the health care reform discussion.

[57] Ga. Comp. R. & Regs. 290–5–37–.03(4) (2008).

[58] Managed Risk Medical Insurance Board, Access for Infants and Mothers, http://www.aim.ca.gov/english/AIMHome.asp (last visited Sept. 17, 2008).

[59] Insure New Mexico, Premium Assistance for Maternity (PAM) Frequently Asked Questions, http://www.insurenewmexico.state.nm.us/PAMFaqs.htm (last visited Sept. 17, 2008).

As 99 percent of all employers, small-business owners are a very important piece to the overall health insurance puzzle. Of the 47 million uninsured people in the U.S., roughly half are small-business owners or employees. The trend of spiraling health care cost, and the current financial markets crisis provides for an unfortunate incentive to achieve health care reform in 2009. The ability to offer health insurance is creating a significant competitive disadvantage for small firms, as 99 percent of large businesses offered health insurance in 2008. Sixty-nine percent of small businesses surveyed in 2008 said they want to offer health insurance, however only 38 percent were able to do so—down from 67 percent in 1995.

NSBA's health care proposal addresses the health care delivery system, health insurance market and tax code to deliver the fundamental reforms needed by small businesses to provide affordable, quality health care to their employees and their dependents. However, several items have garnered exceptional attention since NSBA first developed *Small Business Health Care Reform: A Long-Term Solution for All,* including the current discussion on a public health insurance option and the concept of "shared responsibility." Due to the unrivaled challenges that small business currently face in the health insurance market, these proposed reforms could prove to be challenging to the goals that small business seek in providing quality, affordable health insurance. Thus, NSBA would like to provide the following comments on each concept.

Public Health Insurance Option

NSBA is engaged in continual dialogue with small business owners on the proposal to establish a public health insurance option to compete in the private health insurance market. In general, the concept of including a provision that would ensure honesty and trust in the private insurance market is commendable. In addition, NSBA believes that competition is good, and should be directed to lower cost for consumers. However, NSBA urges the Committee to address these goals within every aspect of the current health care system, and not simply through the creation of a new public health insurance option. Furthermore, NSBA is concerned that a public health insurance option could do more to undermine than enhance needed market reforms.

With respect to the June and July goals to present legislation on comprehensive reform, NSBA urges that the Committee present details expeditiously to allow for appropriate feedback from the small business community. We look forward to maintaining dialogue with the Committee as more information is made available.

Shared Responsibility

NSBA is opposed to mandated 'pay or play' provisions in any health care reform proposal. Although mandating a 'pay or play' provision may not impact larger businesses that can already afford to offer health care to their employees, small business would be forced to make extremely difficult decisions to absorb the financial blow during the current economy. In addition, proposals that provide cookie cutter categories to justify pay or play participation simply fail to recognize the diversity and unique goals of every small business. Establishing mandates on small businesses based on gross sales, number of employees, percentage of payroll, or other methods could prove detrimental to some businesses.

Small employers are running out of options when trying to balance their employee's needs with the livelihood of their businesses. The combination of record annual increases in health costs and an economic recession are forcing small employers to choose between reducing or eliminating benefits or employees in order to sustain their businesses. Now is not the time to add additional costs or burdens on small businesses by mandating their participation in a 'pay or play' scheme for health insurance.

NSBA looks forward to working with Members of Congress to find appropriate and reasonable streams of revenue to finance comprehensive health care reform. However, NSBA opposes any mandates on small business employers to provide health insurance to their employees. The notion of a 'pay or play' scheme on employers is riddled with complex financial challenges and repercussions that could have a devastating impact on the ability of small businesses to be productive and create jobs.

It has become clear to NSBA that, to bring meaningful affordability, access, and equity in health care to small business and their employees, a complete reform of the health care and health insurance systems is called for. The small business community needs substantial relief from escalating health insurance premiums. This level of relief can only be achieved through a broad reform of the health care system with a goal of universal coverage, focus on individual responsibility and empower-

ment, the creation of the right market-based incentives, and a relentless focus on improving quality while driving out unnecessary, wasteful, and harmful care.

For the last decade, health care reform has ranked number one or number two on the list of priorities for small-business owners, and continues to be among the top challenges facing the future growth and survival of their business. Instituting more administrative and financial constraints on small businesses in the form of mandates is not the reforms that small businesses deserve, particularly in light of the current economy. In addition, reforms that could result in the deterioration of the private health insurance market should be avoided. A pragmatic approach to health care reform would commence with making the appropriate changes to the insurance market, delivery system and tax code that have been outlined in NSBA's proposal for comprehensive health care reform.

Thank you for the opportunity to provide comments on behalf of the small businesses the comprise NSBA. I welcome the opportunity to be at the table representing the needs of small business as the Committee works to find solutions to American's health care needs.

Sincerely,

Todd O. McCracken
President

Small Business Health Care Reform
A Long-Term Solution for All

In attempting to create positive health care reform for small businesses, one quickly bumps up against the reality that the small business problems cannot be solved in isolation from the rest of the system. Since small businesses purchase insurance as part of the overall small group (2 to 50 employees), 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 and health insurance systems is called for. 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.

The Realities of the Insurance Market

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. It is estimated that this practice, known as "cost-shifting", adds another 8.5 percent to the cost of health care for those who purchase insurance. Second is the fact that millions of relatively healthy Americans choose not to purchase insurance (at least until they get older or sicker) due to cost. Almost four million individuals aged 18–34 making more than $50,000 per year are uninsured. The absence of these 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 reductions to current small business premiums.

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. If the home of someone without fire insurance burns down, those who are insured are not expected to finance a new house. Not so in the health arena. Any individual with injuries or illnesses will receive care from an emergency room, regardless of whether or not the individual is insured. It is simply sound business sense that the hospital will then look to other avenues to ensure the cost for that uninsured injury or illness is recouped. 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.

Individual Responsibility

There is no hope of correcting these inequities until we have 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 a basic level of 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.

Required Coverage

Of course, the decision to require coverage would mean that there must be some definition of the insurance package that would satisfy this requirement, as well as a system of penalties for those who chose not to comply. Such a package must be truly basic to ensure both affordability and choice are inherent in the overall system. The required basic package would include only evidence-based, scientifically sound benefits that would be determined on a federal level. The process for defining the basic package must be nonpolitical and incorporate an appropriate array of stakeholder involvement including state insurance commissioners, state legislative representatives (governors or legislators), insurers, actuaries, small and large businesses, consumer groups, providers, and those insured. This group shall be responsible for not only defining the initial package offering, but also for evaluating, on an ongoing basis, a broad cost-benefit analysis of benefits offered, as well as evaluating such analysis of any proposed additional benefits.

Fair Sharing of Costs/Market Reforms

Incumbent on any requirement to obtain coverage is the need to ensure that coverage is available and affordable to all. In coordination with the requirement that all individuals have coverage, insurance companies would operate on a guaranteed issue basis—the requirement to provide coverage to all seekers. A coverage requirement on individuals would make insurers less risk averse by broadening the makeup of their covered individuals, thus bringing to fruition the goal of health insurance being paid for through fair-sharing rather than through cost-shifting. The importance of a penalty for individuals who seek not to purchase health insurance is imperative in preventing individuals who only purchase health insurance when they get sick. The guaranteed issue requirement on insurers must be accompanied by safeguards in the form of an individual mandate and penalty systems that prevent such behavior.

It follows, then, that the methods by which insurance companies price or "rate" their product could reasonably withstand more rigorous standards. The rating for the basic package would be based on a modified community rating system with defined rate bands and only limited allowable actuarially-sound rating characteristics, including defined geographic regions. In addition, insurance companies would be allowed to provide certain, limited discounts or benefit enhancements to individuals or companies, or both (depending on who pays for the cost of the plan) who implement a certified, evidence-based and actuarially-sound wellness program. Insurance companies would operate within narrow rate-bands and no additional charges or discounts could be given outside that band.

Modified community rating would apply only to the federally-defined basic package, any additional services purchased above the federal package would be subject to market-based rating rules and would not be eligible for preferred tax treatment. Although not subject to the modified community rating rules, those additional services should not be used as a means to game the system.

While the onus should no longer reside with employers to provide health insurance, the option ought to remain open to those employers who chose to carry out the administrative work for individuals in securing health insurance. All market rules and regulations would apply equally to the insurance plan regardless of who does the administrative work.

As another method to balance the market and infuse a greater level of choice, higher deductibles for those able to afford them would be implemented. 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.

Subsidies

Due to the requirement that individuals purchase health insurance, without exemption for low-income individuals, there would be available federal financial assistance for individuals and families based upon income.

Finally, it should be clear that coverage could come from any source. Employer-based insurance, individual insurance, or an existing public program would all be acceptable means of demonstrating coverage.

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 equity concerns for small employers and their employees. Since larger firms experience less volatile rate increases, and have greater bargaining power than a small firm, their health insurance packages are typically richer than what a small business can afford. Therefore, a large firm can build very rich benefit packages which are tax exempt for the business and are considered a piece of the employees' compensation package. This gives large employers a significant competitive edge over small businesses with regards to both their tax treatment as well as their ability to recruit employees. Furthermore, many small business employees are currently in the individual insurance market, where only those premiums that exceed 7.5% 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) should also be extended to individuals purchasing insurance on their own. Moreover, the tax treatment of both health insurance premiums and actual health care expenses should be the same. These changes would bring equity to small employers and their employees, eliminate the federal subsidy for over-insurance, 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, much more must be done to rein-in the greatest drivers of unnecessary health care costs: waste and inefficiency. More accountable consumer behavior can help reduce utilization at the front end, but most health care costs are consumed in hospitals and by chronic conditions whose individual costs far exceed what any normal deductible level is likely to be.

Health care quality is enormously important, not only for its own sake, but because medical mistakes, waste and inefficiency add 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, increased strain on family budgets and, in the most severe cases, death. In fact, medical errors are the eighth leading cause of death in the United States. The medical costs alone probably total into the hundreds of billions of dollars.

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.

Insurers should reimburse providers based upon actual health outcomes and standards, rather than procedures. Evidence-based indicators and protocols should be developed to help insurers, employers, and individuals hold providers accountable. These protocols—if followed—could also provide a level of provider defense against malpractice claims.

Through digital prescription writing, individual electronic medical records, and universal physician IDs, 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, helping patients make informed choices. The implementation of electronic patient records played a significant role in the seismic shift in the Veterans Health Administration from being a highly criticized system to being one of the best around today—receiving a 67 percent rating for overall quality as compared with the 51 percent ranking for a sampling of non-government health care providers in a recent report from the Annals of Internal Medicine.

The U.S. medical system can also benefit from thinking outside the box. While traditional doctors' offices and hospitals remain the primary mechanism of health care delivery, creative and effective alternatives should also be taken into consideration. There are myriad programs in existence today, such as Volunteers in Medi-

cine, community and retail clinics, urgent-care and 24-hour clinics, that can offer near-term relief to many individuals in underserved communities, and to uninsured individuals.

Availability of Information

Small businesses are particularly disadvantaged when it comes to being able to access information. While large businesses that self-insure conduct quality studies and compile provider information, small businesses are at the mercy of their insurance carrier to provide them with such data. As a result, little to no provider information with regards to cost or quality is made widely available. This disadvantage will be a heavy burden on individuals as well, if they are not armed with the information needed to make important health care decisions.

Insurance companies and health care providers should take the lead of the Centers for Medicare & Medicaid Services (CMS) in compiling provider information and quality rankings, and making them publicly available, easily accessed and understandable. Also included in these rankings should be common-sense pricing lists. Increased information flow to consumers will ensure better decisionmaking and improve the long-term health status of Americans by empowering them as a partner, with their primary care provider, in their own health. Engaging consumers in their own care requires accurate and abundant information that will help individuals evaluate the options and make their own best decision.

With the increased attention many health providers are paying to prevention and wellness programs, quality measurements must be a key part to ensure their success and scientifically-proven benefit. Prevention and wellness programs ought to be held to the same high standards regarding the tracking and reporting of outcomes. Additionally, health care providers should carefully track chronic disease management and report on the risk-adjusted outcomes of such programs. Tracking this data should enable doctors nation-wide to share best-practices and adjust treatments for optimum outcomes in their patients.

NSBA calls on hospitals and doctor's offices to make publicly available, a plain-language list of the top 20 in-patient and out-patient procedures' costs and risk-adjusted outcomes. This information should be updated at least annually and the number of procedures included incrementally over time until all procedures' cost and outcomes are publicly listed. Under the lead of CMS, all health care providers will compile the data in universal forms enabling the consumer to easily compare providers against each other.

Reform Medical Liability

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 simply lead to those mistakes—and much more—being hidden.

In addition to instituting reasonable limits on medical liability awards, NSBA supports the creation of so-called "health courts." Health courts would serve as administrative courts to handle medical injury disputes. Judges would be health-care trained professionals assisted by independent experts to settle malpractice disputes between patients and health care providers.

Plaintiffs would receive full economic damages, as well as non-economic damages based on a compensation schedule. This new process for medical liability would also provide the injured party with an avenue to appeal with further review in the traditional court system. In addition to easing the medical liability burden, health courts would establish a mechanism that clear and consistent standards be developed based on cases and the opinions of the judges.

Conclusion

The small business community needs substantial relief from escalating health insurance premiums. This level of relief can only be achieved through a broad reform of the health care system with a goal of universal coverage, focus on individual responsibility and empowerment, the creation of the right market-based incentives, and a relentless focus on improving quality while driving out unnecessary, wasteful, and harmful care.

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