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HEALTH CARE COVERAGE FOR SMALL BUSINESSES: CHALLENGES AND OPPORTUNITIES

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BEFORE THE

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HEALTH CARE COVERAGE FOR SMALL BUSINESSES: CHALLENGES AND OPPORTUNITIES

THURSDAY, APRIL 6, 2006

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

The hearing was convened, pursuant to notice, at 10:40 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Hatch, Snowe, Thomas, Baucus, Bingaman, Lincoln, and Wyden.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. The hearing will come to order.

The Chairman is temporarily detained, and we will commence in his absence. He should be here any minute now. Just for the sake of efficiency, I think it would make sense for us to keep moving. I know that the Chairman would want that, so let us go ahead and proceed.

He will certainly have a statement when he arrives. I have one that I will give now, and then we will just certainly defer to the Chairman when he does arrive.

This hearing is partly as a consequence of the Senator from Arkansas, who asked for this hearing, and I thank her for that.

Today we discuss ideas to address the health insurance crisis facing small businesses, and, as we do this, we will see that what Lord Tennyson wrote of men and women is equally true of people covered by insurance. He wrote, "They rise or sink together."

America has a unique, fragmented system of health coverage. America is the only industrialized country without universal health insurance. Most Americans get their health insurance through their work.

Our employment-based system is a relic of World War II. Wartime wage controls prevented employers from competing for new workers by raising salaries, so instead employers competed for workers by offering health insurance. For the 60 years since, employer-based insurance has dominated Americans' health coverage.

But now the employer-based system is struggling. Today, only 60 percent of workers are offered coverage by their employers. That is down from 68 percent just 5 years ago. And, like Medicare and Medicaid, the employer-based health system is struggling under rising health costs and an aging America.

This is particularly true of small employers. Administrative costs are a greater burden for small businesses than for big businesses. Small employers run a greater risk of being priced out of affordable coverage when even one worker falls ill.

In Montana, only about 40 percent of the smallest businesses are able to offer coverage to their workers. These small businesses simply do not have the wherewithal to insure their employees that large corporations do.

At some point, God willing, we as a society will deal with health care costs and the uninsured. We spend twice what many industrialized countries do on health care, and yet our outcomes are worse.

One in six Americans has no health insurance. Our system simply cannot hold out in its current form over the long haul, and I suspect we will have to make some significant changes.

The current system is unfair and it is inefficient, and it is hobbling American competitiveness. American companies face a competitive disadvantage relative to firms whose governments insure their employees. Moreover, America suffers lost productivity when workers miss days because they are sick.

So what do we do about all this? Creating a new national pool for small employers like the Federal Employees Health Benefit Plan sounds like a good place to start.

It would provide a big pool for spreading risk among lots of small businesses and the self-employed. It would get more of us in one pool together. And, if it is good enough for members of Congress, it is probably good enough for small business and other Americans. It is a privately run system that benefits from free market forces to encourage better value for enrollees.

Tax credits or other subsidies are also important. Pooling can lower administrative costs and improve the quality of coverage small businesses can buy, but that may not lower costs enough to make coverage affordable. Studies have shown some small businesses would need a dramatic reduction in costs to join.

Targeting subsidies to help the neediest families also seems like a good idea. Nearly a quarter of the uninsured are in families making less than $25,000 a year. One might ask, why not help those most in need first?

Another good place to start would be not making the problem worse. In other words, we should "first, do no harm." Unfortunately, some of the bills before us in Congress may well do more harm than good.

As we consider reforms, we must let the rising tide lift all boats. Insurers should not be allowed to cherry-pick out of the healthy and leave the less-healthy, older workers behind. We must ensure that any final proposal does not undermine protections for consumers and States' ability to oversee insurers.

Finally, I am concerned that many proposals, like health savings accounts, follow the ownership of society model of putting more risk on individuals to solve society's problems. The idea is that society will benefit if we only give individuals more stake in their future.

To a large extent, I agree with this philosophy. I am a free trader. I believe in the ethic of individualism. The invisible hand can produce remarkable results. But I am not sure the individualistic ethic can be cleanly extended to health insurance. The nature of

health insurance is shared risk. We all pay into the pool, and we benefit from the pool when we need help.

I am concerned, generally, that the AHP concept, like health savings accounts, will lead to the healthiest individuals leaving the pool. I am concerned that this phenomenon will leave the sicker, older, and least able to pay behind.

In the end, what Tennyson said was good insurance policy. I am not sure he was thinking about insurance when he wrote this, when he said, "We rise or sink together." Let us seek a solution for small business health care needs that does not simply move the healthy out of the pool. Let us find ways to aid small business that does not sink the sicker and the older among us. Let us all try to rise together.

I might say, Mr. Chairman, your timing is perfect. I have just finished my statement, if you want to give yours.

The CHAIRMAN. No. I am going to put mine in the record.

[The prepared statement of Senator Grassley appears in the appendix.]

Senator BAUCUS. All right.

The CHAIRMAN. Thanks, all of you, for being here on time and getting this meeting started.

Senator Durbin, would you start out, please?

STATEMENT OF HON. RICHARD DURBIN,
A U.S. SENATOR FROM ILLINOIS

Senator DURBIN. Mr. Chairman, thank you, first, for giving me this opportunity. I know this is a busy committee. I will make my comments as brief and direct as I can.

Let me also thank Senator Baucus for his opening statement. I really think you summarized the challenge that faces us.

One thing I have learned in the time I have served in the Senate, when you have a good idea, it is good to have an ally on the Senate Finance Committee. The first ally that I have is Senator Blanche Lambert Lincoln. She has been terrific.

We have stood together to come up with an alternative—at least an alternative—for many millions across America who have no health insurance. I thank Senator Baucus and others who have expressed support for our concept.

Travel across your State and ask employers, large and small, the biggest challenge they face. I have found, year in and year out, it is always the same answer: the cost of health insurance, whether they can offer it, how much it costs, whether the owners of the business even have health insurance.

Then walk across the street from that favorite business to your favorite labor hall and ask the labor union, what is your big problem today? The cost of health insurance. We just got a dollar an hour more for next year's contract. Eighty cents is going for health insurance, and it means less coverage. They are upset and frustrated. We know the millions of uninsured Americans grow by the year.

So we have to ask ourselves, why have we not spoken to this issue? I am glad this hearing is taking place. I thank Senator Lincoln for bringing us together. Why have we not done anything major about health insurance in the years that I have served on

Capitol Hill? I think it is a failure of vision, it is a failure of leadership. We are not just facing a challenge to solve a difficult problem when we take up this issue. We are facing a challenge to our relevance to America.

You wonder why people are not engaged in this political process? If we can ignore the most important issue in their lives day in and day out, is it any wonder they have given up on us? Well, we have to accept this challenge, as tough as it may be. Senator Baucus has outlined the cost of health insurance which small businesses and others face, and that is a fact.

But I think we all come together, agreeing on fundamental principles. We should make premiums more affordable by giving small businesses a way to pool their purchasing power. We should encourage competition among health plans on the basis of quality, efficiency, and value, and we should help reduce the administrative and transaction costs in the small group market. It is the details that will make or break the effectiveness of any of these approaches.

I am glad that Senator Baucus reminded us of the Hippocratic oath: "First, do no harm." Some of the bills before us today, I am afraid, will do harm. If the answer to health insurance is to lower the bar to reduce coverage for Americans across the board, we certainly have not answered the challenge, as far as I am concerned.

If the answer to providing more health insurance is to give a nominal health insurance policy of little or no value when you really need it, then we have not done much to solve the problem.

Now, Senator Blanche Lambert Lincoln and I have produced a plan based on the Federal Employees Health Benefit Program, and it really looks at the fact that 8 million Federal employees and their families currently use the private market and come up with a pretty good level of protection.

I think anybody in my State would gladly trade their health insurance for mine any day; my wife and I have an open enrollment period as Federal employees every year, and in Illinois choose from nine different private insurance plans the one that is right for our family.

Across the United States, 278 different private insurance plans offer these opportunities to Federal employees. If this model works so well for 8 million Federal employees coast-to-coast in totally different circumstances, why would it not work for small businesses? It is that question which drove Senator Lincoln and I to the point of putting together this legislation, legislation which I think is very basic.

We know this is good insurance. We count on it for our families. But we believe every American family deserves health insurance as good as the insurance that members of Congress enjoy today.

Now, there is a question that will come before this committee: how will small businesses with limited means pay for it? How can families of limited means pay for it? That is where this committee will have to accept a challenge. If we do not prepare some type of tax incentive for these businesses and families, they may not be able to pay for it.

Is it worth the cost? Would it be worth the cost to say that, once and for all, every American finally has health insurance? I think

it would be. The State of Massachusetts recently moved on their own initiative.

My State, through Governor Blagojevich, is offering health insurance for all the children in our State. States are showing initiative on this, and we need to join them in this effort.

Now, the choice we have is stark. If we do not offer tax help to businesses and families that need health insurance, they will either go without or have health insurance which protects them in name only.

I commend to my colleagues the Small Employees Health Benefit Program that Senator Lincoln and I have put together. You will understand it quickly, because it is the same health insurance that protects you as a member of Congress.

We are honored that so many organizations have endorsed this effort, including the American Medical Association, the American College of Family Physicians, and numerous other small business and other consumer groups. So I hope that, when the committee considers this issue, they will consider the Lincoln-Durbin bill, as we call it, before the Senate Finance Committee.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator DeMint? Thank you for coming, both of you.

STATEMENT OF HON. JIM DeMINT,
A U.S. SENATOR FROM SOUTH CAROLINA

Senator DEMINT. Well, thank you, Mr. Chairman. I am honored to be here with this group today to talk about small business health insurance.

I had a small business for about 15 years, with from 5 to 15 employees. Most people in this country are employed in smaller businesses. Every year we sat down and we would get our increase notice from our insurance company and try to figure out whether to change or to pay more.

And you know when you change, you have preexisting conditions. It becomes a huge hassle, with very little leverage in negotiating for prices for insurance. So I know the pain of this, so I am very engaged in this issue and have been since I've been in Congress.

There are different ways to go with this. And I appreciate the thinking from my colleague, Senator Durbin, but I would just propose an alternative, because a lot of my clients were small businesses like myself and also did a lot of work with hospitals and physicians, and I am fairly familiar with how the health care reimbursement system works.

Folks, I have to tell you, if you are honest about, really, why we have many of the problems we do today, it comes back to government. Government is not the solution.

You find the tax incentives that we created, as Senator Baucus referenced, were for companies, not for individuals. We have made it very hard for individuals to have health insurance policies that they could afford, own, and keep.

Even we here in the Senate, once we leave, we cannot buy a health insurance policy here that we can take with us. We will be uninsured when we leave. That model makes no sense in an economy where people change jobs regularly.

The government set up this elaborate coding/billing fixed price system for Medicare, which Medicaid has adopted, and so has the private market, so that the third party payor system now is incredibly expensive to administer. Over half of the staff in every physician office and every hospital is administration. They are not health care.

I get 10 or 15 letters a week or more, sometimes a day, from Blue Cross, about, I went to the doctor, something has been paid, something needs to be paid. The administration is incredibly expensive, and there are better ideas on how to make health care work, and we can make sure that everyone is covered.

If we look at what was just done in Massachusetts, it is something we need to watch because it is universal coverage. The State has figured out that it is less expensive for them to pay for private health policies for individuals than to try to create a government administration system that covers everyone, because the model we are talking about for our Federal employees plan is different.

We know how many are here, we can rate it. The first thing I would have done as a company is turn it over to the government. Folks, that is the last place we need to go.

Let me just talk about an alternative in hopes that you might give it a chance. Health savings accounts are a new idea, and there is a lot of information going back and forth about who is buying them and not buying them, and I want to talk about that, too.

But what it does is, it turns patients into shoppers. It creates millions of people out there putting pressure on physicians for better information, more quality information. And it does not reduce coverage, it, in fact, increases coverage. We have seen it with many employers.

So I, first, before we get into a health savings account, want to encourage those of you on this committee, particularly the Chairman, who are dealing with the pension conference bill, we have a bipartisan bill—Ken Salazar introduced it with me—to allow employees to roll over $500 of a flexible spending account.

This is an opportunity that helps individuals cover things that are not covered by insurance. And, Mr. Chairman, we have the opportunity in this pension conference to have flexible spending accounts as a better tool for individuals to use to pay for health care.

But I think there are two ways that we can make health savings accounts work better. First, I think we need to confront the criticism that only the rich and the healthy will buy health savings accounts or that we will leave all the sick in plans and the healthy will not buy insurance.

Health savings accounts are the first insurance policies that encourage the healthy to actually buy them because you get to keep what you do not spend, and it grows and it rolls over and it begins the process of access to health care that is not covered by insurance.

You do not have to mandate an insurance company cover mental health if they have several thousand dollars a year that they can use for that, or any kind of chronic problem. We are finding people have more flexibility in covering things that insurance does not cover at all.

The average HSA owner—and keep in mind, these have just been around a couple of years—is 47 years old with one or more children. Almost a quarter of all health savings account purchasers have incomes below $35,000, and one-third of the individuals and families were previously uninsured. It is giving people access to the market.

But there are two things that we could do to health savings accounts that could make them work better that would cost very little for our country.

One, under current law, health savings accounts can be used to pay for the out-of-pocket expenses by employees, but they cannot use a health savings account to pay for a premium.

If we will just allow people to pay for a health savings account premium from their health savings account, we could have many more Americans insured. As a small employer, I could tell you how this could work.

Many of us cannot administer a health insurance plan, but if we could just put money in a health savings account that the employee could use to pay for a premium, either one that I offered or one that is offered through an association or some other model, then again, we would have many more people insured, and more employers would contribute if they did not have to administer a health plan.

Another thing that we could do, which is a bill that we introduced last year with some folks from the House, is we call it the Health Care Choice Act. The State-regulated insurance industry has set up a network of monopolies, for the most part, but there are many States where different insurance products are less expensive. They are all certified. They all come under the quality control of a different State.

But this Choice Act would simply allow individuals, through a local insurance broker, the Internet, or over the phone, to purchase a health insurance policy from anywhere in the country.

If they could do this, particularly out of their health savings accounts, we would open up the market for individuals to buy health insurance that they could afford, that they could own, and that they could keep. That is the model that I am encouraging today.

I think, before we give in and turn this over to the government, we first of all should have a clear evaluation. What the government is doing now is not working. Fewer and fewer physicians are even taking Medicare and Medicaid patients. If we think we can fix the price and ratchet down the price and physicians will continue to see patients, it is not going to happen.

But think of what happened with laser eye surgery, my colleagues, here. When individuals started shopping for it, the price went down, the quality went up, the physicians made more money.

I was in an outpatient surgery center/hospital in South Carolina 2 weeks ago and I said, how many of these procedures that you do could be done for less than $5,000 if you actually got paid for it? They said, over 90 percent.

I believe, within a few years, that Americans could be buying most of their health care out of health savings accounts, and we would drastically reduce the price and the complexity of our health care system.

Our dollars could go to pay for health care rather than administration, and you would see insurance be used for insurance. We need to push what we are spending for health care up to where we need it to be spent and not encouraging people to go to the physician every time they have the sniffles.

So, again, Mr. Chairman, we could significantly improve the health care system in this country while we are debating these other plans if we just allow roll-over for flexible spending accounts, if we allow health savings accounts to be used to pay for a premium, and if we allow individuals to buy health insurance from anywhere in the country.

Thank you, Mr. Chairman.

The CHAIRMAN. I would like to make some announcements. I want to announce a couple of things here. We are going to have deference to two of our members who have put a bill in, Senator Snowe and Senator Lincoln, to make short statements on their bill at this point. Then we will call the panel.

I may not be able to come back, so Senator Hatch will chair the meeting in my absence. If I come back, then obviously I will be back, but if I cannot come back, Senator Hatch will chair that.

So I would like to have Senator Snowe and Senator Lincoln do that before we go vote, if we can squeeze those in. If we cannot, then you will have to do yours after the vote. The voting has started.

Senator THOMAS. Could we file our statements if we are not able to come back?

The CHAIRMAN. Yes, please. Any statements will be submitted for the record. Yes.

[The prepared statement of Senator Thomas appears in the appendix.]

Senator Snowe?

Senator WYDEN. Just a quick question. Are we keeping the hearing going, so we can go and vote and come back?

The CHAIRMAN. Yes. Yes.

OPENING STATEMENT OF HON. OLYMPIA J. SNOWE, A U.S. SENATOR FROM MAINE

Senator SNOWE. Thank you, Mr. Chairman. I will be brief and include my entire statement in the record.

I do think it is critical to have this hearing today, and I want to commend you for your leadership in sponsoring this hearing today on behalf of small businesses and accessing affordable health insurance for themselves and for their employees. We know that the small business health insurance crisis is real. It is an undue burden on small businesses and their employees and families across this country.

This is not a crisis that developed overnight. It has been evolving over many years, where now health insurance costs are the foremost concern among small business owners in my State, that is a small business State, indisputably, and across this country. We have 45 to 46 million uninsured Americans, and 60 percent or more could be benefitted by what has been known as small business health insurance plans.

I have introduced legislation, and I know that Chairman Enzi and his committee have recently reported a bill. There have been other options available.

Suffice it to say that study after study, statistic after statistic has confirmed beyond a doubt that fewer and fewer small businesses are able to offer health insurance for their employees, and little has been done to alleviate this problem.

So, Mr. Chairman, the time for talking has long since passed. I do not think that we need to stall this issue any longer in the entire Congress. For the last few years in the House of Representatives, they have passed legislation concerning association health plans. I have introduced similar legislation here in the U.S. Senate, and I think the time has come for us to take action.

So, I am pleased that you are holding this hearing today, because I think it does illustrate and underscore this crisis that small business owners are facing across this country.

Regrettably, so much has been said in describing what is known as association health plans, or small business health insurance plans.

Let me tell you what it is not. It is not about cherry-picking or adverse selection. It is about offering plans to small businesses across this country and being able to join bona fide associations where they can offer competitive, affordable plans to small business owners in this country who can ill afford to pay for the skyrocketing premiums that they have experienced over the last 5 years, and in particular, I know in my State where premiums have increased from 30 to 50 percent.

So they cannot provide this important benefit to their employees. Association health plans will afford small business owners access to more competitive health insurance plans.

They will be able to offer it to all their employees. Cherry-picking and adverse selection would be prohibited. Also, it would be tailored to the needs of the membership and those who want to join these association health plans.

We have a number of provisions in the bill that will protect the type of plans that are being offered, protect the benefits for the employees, but most importantly it will give small business owners an option that they have not had in the past.

What has benefitted large corporations and unions has not been available to small business owners, so this is leveling the playing field with respect to this kind of option that would be available.

I hope we can reconcile the differences, Mr. Chairman. I know that Chairman Enzi has a modification of the bill I have introduced. I think it moves in the right direction. I think I do have some concerns with some of the issues, with respect to the fact that self-insured options would not be available, or having more harmonized national rating standards.

I think we have to discuss those issues, but I think it moves in the right direction to get us to where we need to go without creating a government-run program or a confusing, complicated bureaucracy that will not well serve the interests of small business owners across this country.

This will not be costly. In fact, it will not cost anything, for all practical purposes. But it will make an option and a tool available

to small business owners that is absolutely long overdue and will not create a new Federal bureaucracy to design this program.

It will already build into a system that protects the employees, it preserves options for the small business owners, and gives them a mechanism where they have no options now.

In small group markets, this is a crisis. I know in my State, and again, in many States across this country, we have seen a consolidation by the largest private insurers in this country.

That was illustrated and buttressed by a Government Accountability Office report that I requested that was recently released that indicated that we are seeing more market consolidation by health insurance companies, and that is adversely affecting small group markets, like my State, where there is very little, if no, competition because the health insurance plans are offered by few insurers.

So that is why this legislation is so vitally necessary, and that is why I appreciate the fact that you are holding this hearing today to illustrate the problems that small business owners are confronting.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Snowe.

[The prepared statement of Senator Snowe appears in the appendix.]

The CHAIRMAN. Senator Lincoln?

OPENING STATEMENT OF HON. BLANCHE LINCOLN, A U.S. SENATOR FROM ARKANSAS

Senator LINCOLN. Well, thank you, Mr. Chairman. I want to compliment my colleague from Maine. Senator Snowe, as Chairman of the Small Business Committee, has done a tremendous job in focusing on this issue and recognizing the challenges that small business faces and putting the kind of energy and devoting it to this issue, and I am grateful to her because it is a critical issue before this country.

And certainly with her leadership, the examples that States like Maine set in the programs that they put forward are critically important to our debate. So, I compliment her.

And, Mr. Chairman, I just want you to know how grateful I am to you, a man of his word, without a doubt. But it has been enormously important to me, this issue. It has been something I have worked on for several years, and I am so grateful to you for holding this hearing today. And in your usual form, not only do you make good on your word and you have a hearing, but you do it during National Small Business Week, which is critical.

As we focus on National Small Business Week, we see that the Chairman is looking at one of their most challenging of issues, and here we are in the committee looking towards that. So, I appreciate it, Mr. Chairman. Thank you so much.

Early this morning, or I guess it was earlier this week, I called and made an appointment with the pediatrician for early this morning so I could get my son to the pediatrician's office and get to work in time to be here.

When I left this morning, I saw the irony of it, because I walked out, and the woman in Bookkeeping said, thank you, Ms. Lincoln,

we will file this on your insurance. And I thought to myself, how grateful, how blessed I am to be covered by insurance, and my children to be covered by insurance.

And then as I got in the car, I remembered why I was so tired: because I had stayed up last night putting things in my garage for a yard sale that our PTA is having to raise money for the clinic, the free clinic, to provide free health care to the children in our school who are uninsured.

It made so much sense to me why this issue has been so important to me over the past several years, and certainly why it is important to the millions of Americans who are hard-working, day in and day out, and yet still uninsured. So, Mr. Chairman, again, thank you.

The small business health care crisis is, undoubtedly, the number-one issue I hear about when I am traveling in Arkansas, and I know why because of my own personal experiences.

I have been working very hard on this solution, to come up with something that makes sense, both fiscally responsible, but also something that is going to work and that is going to get at the heart of the problem and do it quickly enough that we can get enough of these uninsured into insurance programs where they can actually have good choice at lower cost. It is not a government program. It is a program that utilizes the private sector, the best things that both of us have to give, the private sector and government.

Two years ago, I introduced legislation with Senator Durbin called the Small Employers Health Benefit Program, and it came about because we were sitting together with staff, myself and the staff, talking and thinking, what in the world can we do about this?

I said, wouldn't it be wonderful if we could offer all of these hard-working Americans who are uninsured the same thing that we have? Then as we sat there and talked we realized, it is not that impossible.

It is not that impossible to duplicate what the Federal Government found to be its clearest and most cost-effective solution to insuring the 8 million Federal employees across this country.

It was to say, let us take the most productive and positive things about the private marketplace and let us look at how government can help steer those products in a way that we provide consumers the best product possible at the lowest cost. So what did we do? We fashioned it after the Federal Employees Health Benefit Program.

I believe that the bill we have put forward takes a moderate and balanced approach that combines the best of what government can do with the best of what the private sector can do, while preserving important State laws that protect our consumers.

Our States have done tremendous work in trying to make sure that they provide what consumers need and want. Like the Federal plan, our program does not promote government-run health care, but harnesses the power of market competition to bring down health insurance costs using a proven government negotiator.

By pooling small businesses across America into one risk and purchasing pool, similar to the same one we belong to, our new SEHBP program will allow employers to reap the benefit of group purchasing power and streamlined administrative costs, as well as

access to more plan choices, exactly what Senator DeMint was talking about, not government-run, but something that is done by the private sector in order to bring down costs.

This hearing is an excellent opportunity to discuss the various proposals to help small businesses purchase quality health insurance for their employees and help more working families become insured.

As we continue this debate, I believe that my colleagues will come to a very similar conclusion that I have, and that is: we can achieve our goal in helping to reduce medical costs and provide better care for a larger number of uninsured Americans by allowing them access to the very model that we enjoy ourselves, Mr. Chairman.

There are nearly 46 million Americans currently without health insurance, including 456,000 Arkansans whom I have a tremendous responsibility to. Small businesses are our number-one source of jobs in Arkansas, yet only 26 percent of businesses with fewer than 50 employees offer health insurance coverage. Workers at these businesses are most likely to be uninsured.

In fact, 20 percent of the working-aged adults are uninsured in Arkansas. Those who lack health insurance do not get access to timely and appropriate health care.

All that does, Mr. Chairman, is cost us more in the long run, because as they become less healthy they are going to be in emergency rooms, they are going to get out of work and get onto Medicaid, or as they continue through 15 or 20 years of not getting health care, when they do hit Medicare age they are going to be a more costly Medicare candidate.

We have a tremendous job before us, Mr. Chairman. Without a doubt, I know that you can provide the leadership to help us focus on how we tackle this issue and how we do it in a common-sense way that is fiscally responsible, where government can make an investment. It is not a large investment, but over 10 years it is less than a third of what the HSAs would cost.

We could make that investment, along with other products that would be helpful to Americans, whether it is HSAs or others, but something that will get at the bulk of these low-income working individuals who are in small businesses who are the predominant portion of the uninsured, and provide them a product that will really make a sizable difference in their lives.

Mr. Chairman, I appreciate the opportunity that you have given us today, and I will ask unanimous consent to include the remainder of my opening statement in the record.

I look forward to our ability to not just start this discussion today, but continue it, because I know from my experience and my personal feelings over the last 3 years I enjoy incredible coverage as a member of Congress, as a Federal employee. I look out at the people I go to school with, the people I see in my communities, and the people who continue to ask the questions, and I know we can do better in what we provide to those working individuals who are the fabric of this country. I know that, through your leadership and the work in this committee, we can make that happen. So I appreciate it, I thank you, and I look forward to the discussion.

[The prepared statement of Senator Lincoln appears in the appendix.]

The CHAIRMAN. We will be in recess while the three of us go vote, but I believe that Senator Hatch will re-start the hearing. I believe he is on his way back. So, I would ask the audience not to venture far from the room.

[Whereupon, at 11:16 a.m., the hearing was recessed. The committee reconvened at 11:21 a.m.]

Senator HATCH. We are going to now turn to Panel 2.

Let me welcome our second panel here. We will first hear from Mr. Joseph Rossmann, who is the vice president of Associated Builders and Contractors in Arlington, VA. We will then hear from Dr. Len Nichols, the director of the Health Policy Program at the New America Foundation.

Next, Mr. Todd McCracken, president of the National Small Business Association in Washington, DC, will testify. Finally, Deborah Chollet from Mathematica Policy Research will share her testimony. I think I am pronouncing that fairly close to right.

Dr. CHOLLET. Yes.

Senator HATCH. We are happy to have all four of you here. We appreciate your willingness to come. These are very important issues to everybody on this committee, and we want to find some reasonable ways of solving them, if we can.

So we will turn to you, first, Mr. Rossmann, and we will just go across the table.

STATEMENT OF JOE ROSSMANN, VICE PRESIDENT, ASSOCIATED BUILDERS AND CONTRACTORS, ARLINGTON, VA

Mr. ROSSMANN. Thank you, Senator Hatch and members of the Finance Committee. Thank you for holding this hearing to address the problems that small businesses are facing in providing quality health insurance coverage for themselves and their employees.

I am testifying before you today on behalf of the Small Business Health Plan Coalition, which consists of 180 national and regional organizations. The coalition represents over 12 million employers and 80 million small business workers throughout the United States.

It goes without saying that small employers have their backs against the wall, struggling to maintain a business, while at the same time being able to provide quality health insurance coverage to their employees and families.

The problem is exacerbated because they must mitigate the effects of annual double-digit rate increases that have hit them over the last 4 to 5 years.

At the same time, we have seen major insurance companies consolidating for what they call increased efficiencies and economies of scale, telling us that bigger insurance companies would have more clout to negotiate lower prices from hospitals, doctors, and drug companies.

According to an article in the *Washington Post,* this just has not happened. Instead, our reward seems to be the creation of local and national oligopolies, characterized by less competition, less choice, higher prices, and higher returns to insurance company stockholders.

The *Post* went on to report that James Robinson, a professor in Health Economics, calculates that the top three health insurance companies control two-thirds or more of the business in all but 14 States.

Robinson juxtaposes those numbers with the 2000 to 2003 financial results from five top national firms, and he shows a decline in the percent of each premium dollar that goes to pay medical claims, along with a stronger trend towards higher premiums, higher profits, and higher stock prices.

This appears to have been accomplished on the backs of small employers who have borne the brunt of double-digit rate increases over the past 5 years.

The bottom line, to me, seems to be that we need to create more competition in the health insurance marketplace and provide more options for small employers, not fewer.

I have been involved with Associated Builders and Contractors' health plan for over 18 years. During that time, I have been the vice president of Fringe Benefits for ABC. I have worked for trade associations, exclusively with their health plans, for over 28 years. I can tell you from experience that health plans through associations work for small employers.

ABC established its insurance trust back in 1957 by five contractors who could not buy insurance coverage because they were just too small. Since then, we have enjoyed a 48-year history of providing health and other welfare benefits to contractor members and their employees.

During the first 43 years, ABC Insurance Trust had only two different insurance carriers. That speaks very highly of the stability of our program, and also the confidence that the insurance companies had in ABC, and in our plan.

ABC is also a perfect example of the savings that can be made available to small employers. The total cost for the ABC health program varied from 13.5 percent to 16 percent, and those numbers included the insurance company expenses.

On the other hand, the sales, the administration expense, and profits of insurance carriers selling in the small group market today by one of the largest insurance providers is targeted at 35 percent.

The difference between their number and ours is 19 to 22.5 percent in premium savings, which could go directly to small employers this year, and in future years.

In 1999, ABC's insurance carrier told us that they no longer wanted to stay in the business of providing a group plan under the master trust concept. This was understandable because, in the previous 6 years to that, we saw our program being carved to pieces as the insurance carrier pulled out of one State after another because of the States' small group insurance legislative activity, pulling out of States like New York, Kentucky and Colorado because it became almost impossible for them to comply with the new State laws and continue to provide the master policy approach under ABC's insurance trust.

ABC had a strong and viable program, one which was gradually dismantled piece by piece by well-intentioned insurance reform. We talked to over 50 different insurance carries to take over the ABC

trust, which at that point was about $44 million in premiums, and there were no takers.

No insurance company wanted to be involved with our program, with all the State insurance requirements as they exist today. They are just too inconsistent and too piecemeal.

ABC even looked at the concept of going to a self-insured approach, but we have determined that the expense involved in complying with each and every State's separate filings would have actually cost more in the long run than it would have saved our members.

ABC is kind of like a poster child for small business health plans. We provided an affordable, comprehensive set of health insurance plans that were eventually eliminated because of the changes at the State level. We succeeded as a health plan, but we were legislated out of existence for our members.

Based on our history, we look forward to the passage of S. 1955 to bring new options back to our members, because it fosters competition and it is a model that works, and it is also a model that does not have its hand out for a government subsidy.

S. 1955 is a bill which has been negotiated in good faith by representatives of the insurance industry, the NAIC, and the business community through our coalition. It provides for fully insured plans with State oversight of insurance companies and patient protections.

S. 1955 has three fundamentally important components. It provides the ability to pool all small employer members together for experience rating purposes. It also provides for common rating techniques which are consistent across State lines, a set of rating techniques actually developed by NAIC, which are currently in use in a majority of States.

Third, it provides for consistency in benefits and plan designs, where small employers can select a high-option or Cadillac-style plan, plus have other, lower-cost options available, all based on actuarily developed rates, taking into consideration only the plan design differences. All the plans are then pooled together into the small business health plan for experience rating purposes and future rate development.

ABC's Insurance Trust offered a fully insured health care plan for over 43 years. We offered over 14 medical plans for members to select from. The plans were comprehensive in that they covered all licensed providers and any required benefits in our home State of Virginia, and these same plans were provided to members in all other States, even if that State had lower requirements.

Under this legislation, ABC Trust would take a similar approach. The insurance trustees, working with the carrier, would make sure that ABC provided coverage options stressing preventative care and cost-effective treatment of medical conditions.

The goal is to provide comprehensive and affordable health insurance to our members. Small employers must compete with large employers for their workforce. Because of this, small employers want to offer the same, high-quality, comprehensive benefits that large employers offer their employees today.

The ABC small business health plan would be on a level playing field also with all insurance companies. We would simply be an-

other health insurance option, if you will, for members, and we would have to earn our members' business by providing high-quality coverage at a reasonable cost.

I am very excited about Senator Enzi's bill, S. 1955, and the choices it can make available to ABC members.

I appreciate this opportunity to testify before the committee on an issue that is vitally important to our membership and small business owners across the country. We look forward to continuing a constructive dialogue on how to increase access to affordable health care coverage for small business.

Thank you, Senator.

Senator HATCH. Well, thank you, Mr. Rossmann.

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

Senator HATCH. Dr. Nichols, we will turn to you.

STATEMENT OF LEN NICHOLS, PhD, DIRECTOR, HEALTH POLICY PROGRAM, NEW AMERICA FOUNDATION, WASHINGTON, DC

Dr. NICHOLS. Senator Hatch, thank you for having me. My name is Len Nichols. I am the director of the Health Policy Program at the New America Foundation. I have a longer statement I will submit for the record.

Senator HATCH. Without objection, we will place it in the record.

[The prepared statement of Dr. Nichols appears in the appendix.]

Dr. NICHOLS. I am honored to have been invited to offer my thoughts as you consider how to make health insurance more affordable for more small employers and their workers, a goal I know every member of this committee shares.

We all agree the fundamental issue here is that health care and health insurance cost too much in this country. We also agree that large employers and large groups have cost advantages over smaller employers in three main dimensions: administrative economies of scale, risk pooling, and bargaining power vis-à-vis insurers and providers, as Mr. Rossmann just suggested.

Despite this general agreement, we have before us starkly different approaches to helping small employers in S. 2015, S. 1955, or Durbin-Lincoln and Enzi-Nelson, as I will refer to them.

While sharing a common goal, they differ in technical details. These details reflect profoundly different visions of what would be most helpful to small employers, and indeed, to our health care system as a whole.

Let me start with vision. Durbin-Lincoln manifests a vision of having all small employers, including those with fewer than 100 workers, and all of the self-employed together in one large purchasing pool that could lower administrative costs to a minimum, spread risk equitably and efficiently, and create the bargaining power that can finally be used on behalf of small employers and their working families to generate more affordable and sustainable choices.

In addition, the vision of Durbin-Lincoln includes a commitment to devote resources so that lower-wage workers and their employers can afford the health insurance that, today, is out of reach.

Finally, Durbin-Lincoln is forward-looking in the sense of laying a foundation, both in the large, efficient purchasing pool and in the courage to commit new resources to subsidizing health insurance, a foundation for further coverage expansions and for building a health care system that can deliver better value for the dollar in response to purchasing power that could, and should, be wielded wisely on behalf of all Americans, not just some of us.

Enzi-Nelson, by contrast, as well as the bill Senator DeMint was promoting a few minutes ago, seems to look at the world as if all small employers would have lower premiums somewhat magically if markets were completely unregulated, with no benefit mandates at all, with rating on health status permitted, and with no limits on age, gender, group size, and geographic rating factors.

If this were all true, Senators, why did 48 States pass and keep rating restrictions, and why have 50 States passed and kept various benefit mandates over the years?

The very fact that so much premium rate and benefit package variation is allowed, and indeed encouraged, in the Enzi-Nelson approach and in Senator DeMint's bill is prima facie evidence that some premiums are expected to go up by someone, even as premiums for the healthiest small groups might come down, at least in the short run. Thus, Enzi-Nelson conveys a vision that is manifestly about helping some at the expense of others.

Now, I suspect that the sponsors of these bills honestly believe that health insurance is actually just like most other commodities, say, for example, ice cream, in that market competition, properly unleashed, will naturally limit variation in price and quality to something far less than the nightmare scenarios which actuaries have pointed out would be permitted under the bills.

Now, this is a debatable proposition, that health insurance is close enough to ice cream to merit freedom from price and quality regulation. But there is one obvious distortion in that world view, in my considered opinion based on the research literature. That is that sellers of ice cream always want to sell more to every new customer.

In health insurance, because the sick are expected to be so much more expensive than the healthy, it can actually be profitable to not sell to that customer on the margin.

Thus, it can be profitable to set prices for some people so high they run away, or to offer benefit packages so lean that those with chronic conditions may just as well save their own money and depend upon the kindness of strangers and the safety net.

So I fear the proponents of Enzi-Nelson vastly over-estimate the disciplining power of unfettered market forces in voluntary health insurance markets.

Wrapping up my statement on key technical details, Durbin-Lincoln will create more administrative efficiencies than Enzi-Nelson because Durbin-Lincoln's single pool will be so much larger than the many association-specific pools of Enzi-Nelson. Durbin-Lincoln has subsidies that will pull in many more employers and self-employed; Enzi-Nelson has no subsidies.

Durbin-Lincoln will create serious bargaining power that could become a force for the value-enhancing efficiency in many local markets around the country, whereas Enzi-Nelson is much more

about seeking lower premiums for some than about creating bargaining power for all.

Finally, let me say one word about the self-employed. Durbin-Lincoln welcomes them into the large national pool with everyone else, in effect giving them the same treatment as other businesses, giving them access to modified community rating rates in their turbo-charged small group market, as well as subsidies for the low income.

Enzi-Nelson, by contrast, would allow them to join the association for the small business health plans, but would force them to face individual underwriting that will make the highest-risk self-employed want to stay away forever. Maybe that is the intent, maybe not, but that will be the consequence of this bill as it was reported out of the HELP Committee in March.

I thank you for your time, and I would be glad to answer any questions you might have.

Senator HATCH. Thank you, Dr. Nichols.

Mr. McCracken, we will turn to you.

STATEMENT OF TODD McCRACKEN, PRESIDENT, NATIONAL SMALL BUSINESS ASSOCIATION, WASHINGTON, DC

Mr. MCCRACKEN. Thank you very much, Mr. Chairman. I appreciate the opportunity to be here today.

Again, I am the president of the National Small Business Association, and we represent tens of thousands of small companies all across this country.

As has been said many times today, there is no greater issue facing the small business community than the affordability of and the access to health insurance.

I am going to take a different sort of tack here today than the first two witnesses have and take a much broader look at the health care marketplace and what our ultimate solutions may need to be, or some of the solutions we are talking about leading us in that direction.

The challenges that the health care system presents us with are so enormous and so intertwined, that we have come to the conclusion that we really need to look at a much more fundamental reform of the health care system, ultimately, and that we cannot look at this in a piecemeal way, at least without a larger vision of where we are going.

The challenges that small businesses face really are in three main areas. One is the insurance market they find themselves in. Let me talk about that just for a moment.

With the advent of ERISA—talking about ancient history now—in the 1970s and large employers pulling out of the insured marketplace and becoming self-insured, that meant there were many fewer folks for insurance companies to spread their risks across.

They, therefore, became much more risk-averse, much more likely to develop rules that could exclude people, rating practices that could keep people out, and all the rest that we know so well today.

Well, the reaction to that, in the 1990s, is the States began to put in place insurance reforms that would set limits on whether you could underwrite, how much you could vary the ratings on var-

ious factors for folks. Those ratings are what really create the pool of shared expenses among employers.

So I think we have to fundamentally understand that it really is those rules that create those shared risks rather than people just paying something very close to their actual expenses in a given year, and because those will have great variation in the small business community.

The employee demographics of one company, a very large corporation, can spread risk across huge numbers of people, and whether an employee comes or goes, maybe is old, young, sick, or healthy, really does not affect them in a global sense.

In a small business, it can affect them fundamentally. One employee changing can increase your average age from 30 to 50. It can make your workforce very unhealthy, or very healthy. So these are huge issues that have to be shared costs. They cannot be separated out. But States have various approaches. They are extremely diverse in how much they have set up these insurance rules.

Some States allow wide variation in rating, such that there is relatively less sharing of those various costs among different employers. However, the benefit is that the average premium, therefore, is much lower and those low-wage employers have much better access to affordable coverage.

There is a real trade-off here that we have to address. Other States have very narrow, community-rated bands, and that does help some older and sicker employees, but it also pushes the cost of health insurance well out of reach for many, many small businesses and their employees.

So that is a key thing I think we have to understand. We have come to the conclusion, as the people, I think, in the great State of Massachusetts have come to, that what we have to do is require folks, individuals, to have insurance.

Then we can change the rating rules, require insurance companies to take them, have narrow bands for how they can be insured, and then we have to subsidize people based on their income, not, we do not believe, based on the size of the business they work for, or any of these other factors. So that is key. We have to subsidize the people.

We have to change the incentives. That is the second important component here. Right now, small businesses are dramatically disincented to provide the right coverage. Large corporations get much more of a tax subsidy for the provision of health insurance.

Small companies who generally cannot afford that type of coverage, they not only do not get as much of a tax subsidy, their individual employees who may be left in the individual market get no tax subsidy whatsoever for the purpose of health insurance.

We have to bring equity both to the individual and employer markets on the tax side, and we have to bring equity between the purchase of insurance and the purchase of health insurance itself, because right now there is a fundamental disconnect there.

Finally, the key issue for small businesses is the overall cost of health care itself that we are talking about spreading in various ways. For that, my written statement goes into, I think, a good deal of detail about that.

But fundamentally, we have to change the incentives for health care providers. I would like to associate myself with the terrific testimony this committee heard about a month ago from former Treasury Secretary Paul O'Neill in that regard, and I think he clearly lays out a road map for how we can change the incentives for health care costs in this country.

With that I am going to stop, because I have run out of time, but I appreciate the opportunity to be here and look forward to answering your questions.

Thank you.

Senator HATCH. Thank you very much.

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

Senator HATCH. Dr. Chollet, we will turn to you. I understand you and Dr. Nichols are both medical doctors?

Dr. CHOLLET. No, PhDs.

Dr. NICHOLS. PhDs. Economists.

Dr. CHOLLET. We are both economists.

Senator HATCH. Somebody told me you were medical doctors. You did not look like medical doctors to me, you looked like PhD economists to me. [Laughter.]

Dr. Chollet?

STATEMENT OF DEBORAH CHOLLET, PhD, SENIOR FELLOW, MATHEMATICA POLICY RESEARCH, WASHINGTON, DC

Dr. CHOLLET. Good morning, Mr. Chairman and members of the committee.

I was asked to describe the cities' and States' efforts to stabilize their health insurance markets and make coverage more affordable to small businesses and their workers.

I have submitted written testimony, and this morning would like to make three points that echo many of the points that Dr. Nichols and Mr. McCracken have just made.

The first is that wide variation in premiums associated with specific characteristics of each small group, such as health status, age, gender, and group size, can make coverage unaffordable for some—that point has been made—but it also puts small employers at risk for large jumps in premiums when an employer or dependent becomes ill, or when even one employee is hired or leaves the business.

The unpredictability of premiums is a major reason that small employers do not offer coverage to their workers, and in States that have substantially loosened rating restrictions and permitted health rating, specifically in Minnesota and in New Hampshire, small groups have experienced very volatile premiums.

Minnesota abandoned community rating in a series of deregulation initiatives since 2001, and today a much lower percentage and an absolutely lower number of people are insured in the small group market. Significantly more rely on Medicaid and are uninsured in small groups. New Hampshire abandoned its deregulation of rating and has reinstated community rating and tight rate bands overall.

Second, when coverage is voluntary, insurance regulation, or the lack of regulation, determines who is favored in private health in-

surance markets. It is a choice that no State can avoid, whether they regulate or not.

When small group rates vary widely with health status and characteristics that indicate health status, working families with health care needs are more likely to be uninsured. The research literature is fairly clear on this.

Conversely, when States have required community rating and set narrow rate bands overall, working families with health care needs are more likely to be insured.

Some individuals who expect to use little or no health care may remain uninsured, but the research evidence indicates that there is no significant net effect on the total number of workers covered.

Finally, a number of States have developed programs to assist small employers and their workers to afford coverage. These programs take various forms: reinsurance programs in Arizona and New York; premium subsidy programs in Maine, and we expect, in Massachusetts; and standardization of benefits to encourage price competition in Maryland and in New Jersey.

All of these efforts rely fundamentally on a stable small group market and one that accepts and retains significant risk. If uninsured small groups are substantially less healthy than the population average, State reinsurance and premium subsidy programs that target uninsured small groups are too costly to maintain.

In summary, States that have enacted community rating and narrow rate bands view broad risk pooling as essential to stable health insurance markets. These States have made a choice to minimize premium volatility for small groups and to favor coverage of workers with health problems.

They have attempted to maintain broad benefits and avoid the market disruption and loss of coverage for critical health care services, such as maternity and mental health, that occur when broad risk pools are broken into pre-payment puddles.

All of the States that have put in place these kinds of regulatory reforms have been responding to specific problems. None of the States invented regulation around fiction; there were serious and specific problems that these regulations were intended to address, and have addressed, in these States.

So I thank you again for the opportunity to speak with you this morning, and I would be pleased to take questions now or later. Thank you.

Senator HATCH. Well, thank you so much.

[The prepared statement of Dr. Chollet appears in the appendix.]

Senator HATCH. We appreciate all four of you showing up and giving us your respective points of view.

Now, I am a member of this committee, but also I serve on the HELP Committee. I used to chair what was then called the Labor and Human Resources Committee, but is now HELP.

I am here to tell you that I believe providing affordable health care options to employees with small businesses, that happens to be a very important issue, and we have to find some way of resolving it.

I am pleased that the Senate HELP Committee has taken action to resolve this matter in such a way that those who work for small

businesses would have an option to purchase quality health insurance that hopefully will be affordable.

But let us remember that the HELP legislation is only one part of the solution. It may be a silver bullet. Frankly, it is probably not a silver bullet, and it is certainly not the total solution.

Now, our Finance Committee has the ability to provide assistance in other ways, such as in making health savings accounts more appealing to employers, their employees, and others who may not have health insurance. We need to examine other options which will make health insurance more affordable and encourage people to buy health insurance.

Now, I found the testimony of all of you witnesses to be extremely interesting, and I plan to work with both you and our colleagues on this committee, and the HELP Committee as well, and Chairman Enzi, in resolving this problem. As we all know, there are not any easy solutions, but it is so much easier to criticize proposals as opposed to being constructive and presenting solutions.

I know that the Chairman and our friend, Senator Enzi, are trying to present solutions here. I will say it again: these proposals may not be perfect, but they certainly are a step in the right direction. So I appreciate all the hard work that Senator Grassley, Senator Enzi, and those who are working with them are putting into trying to resolve these problems.

I would also like to clarify that the Durbin-Lincoln plan has nothing to do with the Federal Employees Health Benefit Program. I do not believe that that was made clear during the first panel's discussion.

The only thing that the Durbin legislation has in common with the FEHBP is that the small business health plans would be run by the government, and I do not think that is quite enough.

Now, I am not saying we should ignore these suggestions, because Senator Lincoln is a great member of this committee and feels very deeply about it, so we have got to look at all these things.

But let me ask one question for everybody on the panel. The FEHBP program is basically the government acting as a big self-insured employer. That is basically what it is. Again, I do not think that is going to help employers and small businesses get affordable health insurance.

But the actuaries at Mercer have run an analysis of the Enzi-Nelson bill, and they have concluded that it would reduce small business health costs by 12 percent and would increase the number of working uninsured by about a million, and all this without any appreciable Federal expenditure.

Now, I would like to know, comparing the two bills, how much would the Durbin-Lincoln bill reduce costs and increase access, and is there data available for that? Is the answer different where we would look at the Durbin-Lincoln bill without the accompanying $55 billion tax credit? And compare that with the Enzi approach from the HELP Committee, and give us the best you can on that. I think that is basically probably the question we are all interested in.

Mr. Rossmann, we will start with you.

Mr. ROSSMANN. Thank you, Senator. I think, from my perspective, the Enzi-Nelson bill has the greatest advantage to provide cost-effective health insurance to small employers, with minimal cost to the Federal Government. It keeps it in the private sector. I think you talked about savings from the Mercer report today, the 12 percent savings they estimate.

ABC personally would estimate 15 to 20 percent savings, and historically we have been able to prove that from our plan in the past, where our administrative, and marketing, and carrier expenses were about 13.5 cents on the dollar.

You look at small employers today, they are paying a dollar's worth of premium to an insurance company, but about 35 cents of that dollar is going to their administrative costs, their marketing costs, and their profits.

So the difference between those two, I think, is a true savings that we can bring to employers right now, and in the future. So, I would say that I feel that the most cost-effective is the Enzi-Nelson bill, and the one that is easiest to implement right now.

Senator HATCH. All right.

Dr. Nichols?

Dr. NICHOLS. Senator Hatch, I think it is pretty difficult to evaluate precisely, but I will certainly give you my best shot on the fly, and I will be glad to——

Senator HATCH. We found that around here to be true.

Dr. NICHOLS. I will be glad to work with you later for more details, seriously.

Senator HATCH. All right.

Dr. NICHOLS. But I would say, first, let us start with the Mercer report. It is interesting that the Mercer conclusion about the AHP bill that came out of the House was completely opposite.

This conclusion was different and the assumption was essentially that premiums would be lowered by a sufficient amount, I think you said 12 percent. I believe what that analysis did not take into account is how much premiums would go up for those firms that would end up worse off once the risk pool is resettled.

We are all talking about, any time there is no new money brought into the equation, you are just talking about shifting dollars around. So, I do not think there was adequate attention paid to the average premium increase for those who will lose. There will be some gains from that sort of thing, and where you come out on that really comes down to very detailed calculations.

As far as Durbin-Lincoln would go, I would answer in two ways. First, there are three sources of efficiency that that big pool would bring, I believe, that would lower costs. I cannot give you a precise estimate, other than to give you some ballparks.

Administrative efficiencies alone, you go from paying what loads are currently in the small group market, 25, 30 percent, that is, a difference between premium and claims cost, and look at what the load is in the FEHBP program, and I think you are looking at savings of 15 to 20 percent off the bat.

Second, you are talking about a bill with a subsidy for low-wage workers, a 25-percent premium subsidy, at least, and it can be larger depending upon family structure and how much the employer ends up contributing. If 40 percent of workers are low-wage

in small business, then 25 multiplied by 40, there is another 10 percent.

So I think you are talking about well more than 12 percent before you even get to, in some ways, the best advantages of the Durbin-Lincoln bill, and that is, the risk spreading very efficiently and the bargaining power you could have by having everyone in one pool. The limit on bargaining power, I would submit, is the sky, precisely because of what Paul O'Neill talked about in this committee a couple of months ago.

So I would submit to you, whatever the number is for Enzi, Durbin-Lincoln can beat it, and I can prove it to you in a little more time.

Senator HATCH. Mr. McCracken?

Mr. MCCRACKEN. Thank you. As you know, our association commissioned the Mercer reports both on the Enzi-Nelson legislation, as well as the House-passed legislation on AHPs 3 years ago.

It does show that premiums, on average, would go up for small employers under the AHP bill, and it would go down somewhat significantly, 12 percent, and the number of uninsured would go down slightly, by almost a million, under Enzi-Nelson.

The key thing to remember here, of course, is there are people whose premiums will go up, there are people whose premiums will go down under both scenarios, under any scenario we are looking at, because that is the nature of insurance. We have to remember that: that there will be winners and losers no matter what we do, including doing nothing.

However, the key thing that the Enzi-Nelson legislation has that the other two pieces that we are talking about today do not have is that it ensures that in every State, in every market, there is one market functioning. I think this is a point we cannot overlook the significance of.

The reason that the Mercer report said that the average premiums would go up under the AHP legislation is because of this cherry-picking phenomenon that goes on under that legislation, and over time it is going to increase the average premium because of the various gamesmanship that happens on both sides of that transaction.

We are concerned that the Lincoln-Durbin bill might have the same thing. Now, the cherry-picking would be on the other side, that is to say, because the pool would be operating alongside the current markets that already exist in the States.

The Small Employer Health Benefit Plan would not include everyone. I think Len's points are exactly right, if it included everybody. But the reality is, it would not include everybody. Employers would choose whether they wanted to buy insurance outside of that pool or not, choose whether they wanted to by insurance or not.

So we are concerned that the incentives that insurers have to decide whether to sell through the SEHBP or not, or sell outside of it or not, and individual decisions to buy that or not, could really confuse the marketplace, shall we say.

The Enzi bill is the only one of the three to make sure there is one market. And we can debate whether the rules are the right ones or not. I think obviously the debate about whether the rating

standards it sets up are the right ones. But to be clear, in a given State there ought to be one set of rules. I think that is necessary.

Senator HATCH. Thank you.

Dr. Chollet? You will be it. My time is up, so if you could be brief, I would appreciate it.

Dr. CHOLLET. It is useful to be at the end of two people with whom I largely agree.

I would like to make two points. First of all, reports like the Mercer report assume that the market settles, the status quo persists; whatever the first round of results is in the model is the round that continues.

What is striking about the Enzi bill is the amount of volatility in premiums that it sets up, the huge changes in the year-to-year that can occur with an illness of a worker or with the hiring or exit of a worker. Putting on one older worker, putting on one young woman can shoot premiums wildly above market trend, above medical trend.

So, I think we need to pay attention to the longer term the second and third year out, and that is the experience we saw in New Hampshire, for example. By the end of the second year, premiums were still hugely volatile, had not settled, and small employers were disgusted with it and the bill was repealed.

With respect to the Durbin-Lincoln bill, I have one comment. That is, for the last 10 years or so I have looked at the supply side of the market. I started out looking at uninsured people and decided that we needed to have a much better understanding of what was going on on the supply side.

When I estimate prices in health insurance markets, I am repeatedly reminded how efficient the FEHBP program is. The prices the FEHBP program has, adjusted for risk in the pool, are startlingly lower than the rest of the market.

In fact, I could argue that insurers are favoring FEHBP to be well over the small group market, in particular. So I think putting small groups in a large pool like FEHBP with government bargaining power behind them probably would do the most, the fastest to reduce health insurance prices for small groups.

Senator HATCH. Well, thank you.

Senator Baucus?

Senator BAUCUS. Well, thank you all very much, Mr. Chairman, and all of you.

I keep coming back to the basic question, what is best for Americans? Is it more individual choice or is it more pooling and wider, say, group coverage as a whole? I understand very much the desire for those who support the Enzi bill, because they are frustrated with insurance costs. They cannot afford insurance, in most cases.

Associations grouping together and marketed by association plans see an opportunity. Some of it is altruistic, some of it is profit-motivated. There are a lot of reasons. But I am bothered, frankly, that that sort of creates an additional, if you will, silo. It segments the market even more.

Now, my assumption, obviously, is that we do better if we are together. I kind of go back to Ben Franklin, "Either we hang together, or most assuredly we will hang separately," or "the whole is greater than the sum of the parts," and all the various things.

We do better working together than when we are not working together.

I would just like you, Mr. Rossmann, to kind of address that basic concept, if you would, please.

Mr. ROSSMANN. Thank you, Senator.

I think, from my perspective, what we are looking to do for small employers is being able to aggregate those folks together to look like one large employer, to be able to negotiate with insurance companies for good plans and good rates, and to be able to take advantage of good experience rating, good claim losses.

I think the panelists made a couple of comments just a moment ago, that that is one of the key features in an association plan, the fact that if you have profits or margins at the end of the year, if the claims are low for that total plan, those profits do not go to the insurance company, those profits stay in the health insurance plan for the benefit of participants going forward.

Senator BAUCUS. One slight problem I have, though, with the Enzi bill is Massachusetts, just yesterday, took a big, bold step. The Enzi bill would prevent States like Massachusetts from enacting those kinds of proposals, as I understand it. That is what the Senator from Massachusetts believes. That would be preempted. That is, the Enzi bill would prevent Massachusetts from adopting its form of universal coverage.

Mr. ROSSMANN. I think what the Massachusetts legislature did was to require employers to purchase insurance, basically.

Senator BAUCUS. I'm sorry?

Mr. ROSSMANN. Require employers to purchase insurance for their employees. If they do not, then they have to pay.

Senator BAUCUS. I am sorry. I missed the first part of your sentence.

Mr. ROSSMANN. I said, I think what Massachusetts did was to require employers to purchase insurance for their employees.

Senator BAUCUS. That is right. Everyone has to have insurance. If they do not, individually they are penalized.

Mr. ROSSMANN. Correct. I think association health plans would be a nice added feature to that equation, because now you are saying to small employers, you must purchase insurance or you have to pay a penalty.

Senator BAUCUS. But the bill prevents Massachusetts from enacting that proposal. That is what I understand.

Mr. ROSSMANN. I do not believe so, Senator. Not to my knowledge, it does not.

Senator BAUCUS. That is what the Senator from Massachusetts thinks. I may be wrong. I do not know. That is just what he thinks.

Mr. ROSSMANN. Yes. My feeling would be, it would allow associations in Massachusetts to pool those small employers together and get cheaper insurance, if you will, lower administrative costs, lower marketing costs, and still try to cover all its employees.

Senator BAUCUS. Dr. Nichols, could you just respond to my first question about pooling versus individual, and maybe your thoughts on what Mr. Rossmann said, please?

Dr. NICHOLS. Well, on pooling, sir, there is no doubt, if we do not pool, we will certainly all face, eventually, bad health and high premiums. We have a lot of information about that. It is called history.

You go back and look at what the States saw before these regulations existed, like I said, 47, 48, depending on the specific provision. The reason they all passed that stuff is because they saw what life was like without that, and it was pretty ugly.

Small business themselves were the ones clamoring for relief and help. I am sure these guys were either doing it, or their predecessors can tell them about it, no question about that. But we have had, since then, a stabilization, as Deborah talked about.

I mean, fundamentally, what regulations do is define the contours in which competition can work. There is nothing anticompetitive about regulation, as long as you let markets breathe.

That is where I think the reasonable regulation, like that coming out of NAIC—it is very fascinating to me that the Enzi approach adopted the 1993 model act which the National Association of Insurance Commissioners promulgated, which they themselves, the NAIC, has modified over the years, which States amended in very important ways over the years. So why are we ignoring the history? That is what I am sort of confused about.

Senator BAUCUS. I am just struck by the experience of Minnesota and New Hampshire. What does that tell us? I am not trying to drive a point here, except that a similar concept was attempted in those States and they changed their mind, basically, because it did not work. I mean, again, I do not have an axe to grind here. But what in the experience in those two States is relevant here? Anybody who wants to talk about that. I will start here, then go back to you.

Dr. CHOLLET. New Hampshire clearly abandoned that, if you will, experiment. In 2001, when S.B. 110 was legislated and became effective in 2001, effective rate bands in the State expanded from about 4 to 1 to about 12 to 1. Insurers were allowed to rate on health status. They were allowed to use proxies for health status, such as durational rating. They were allowed to use group size, industry.

Prior to 2001, there was no rating on health status. It was a community rating. It was a modified community rating and there were separate bands on rating around group size and rating for industry.

The premium increases were enormous. More than half of small groups in New Hampshire saw rate increases of 50 percent or more on a medical trend of about 16 to 17 percent. They were just huge.

The second year, the same kinds of rate increases occurred. So, that has been disbanded. It has been repealed. There is now, again, community rating in New Hampshire and rate bands set comprehensively across all rating factors of 3.5 to 1.

Senator BAUCUS. Again, I may be wrong, but I am told, in the Enzi band, the rating band is as wide as 26 to 1.

Dr. CHOLLET. Actually, that has been estimated by the Department of Insurance in New Hampshire, and exclusive of the geographic rate bands that are allowed. The safe harbor rate bands would be 25 to 1.

Senator BAUCUS. All right.

You raised your hand there, Mr. Rossmann?

Mr. ROSSMANN. Yes, Senator. I just wanted to kind of respond to that, if I could. I think hindsight, of course, is 20/20. When you

look at New Hampshire, that was a situation where they had gone to community rating and then determined that a little more competition in the marketplace was good, and went back to the concept of rate bands.

I think that the problem there was the fact that it was done all in one fell swoop: one year it was community rating, the next year it moved to a more liberal rating, if you will.

I think, under the Enzi-Nelson bill, there are specific provisions in there to handle outlier States that have a modified community rating today to implement this rate banding over a 5-year period so that you have very incremental changes to the rates, so you do not have what happened in New Hampshire where the market goes crazy, if you will.

One other State I would mention, would be the State of Colorado. Colorado went to community rating back in the late 1990s. I remember it well. Not the exact date, but I remember it very well.

Senator BAUCUS. Could you be very brief? Because I want to ask Dr. Chollet to respond to you. So be very brief, please. My time is up. I am over, but be just very brief here.

Mr. ROSSMANN. If I could just take 30 more seconds, if I could.

Senator BAUCUS. No more than 30.

Mr. ROSSMANN. All right. Colorado was a program that we had through ABC's trust, and at that point in time our carrier backed out of Colorado because they went to community rating.

So, basically we could no longer serve the members in that State up until recently, when they have now moved back to rate banding, and they have rating techniques similar to what is being done under the Enzi bill. I think there are differentiations, 10 percent up, 25 percent down. The Enzi bill is 25 up, 25 down. So, thank you.

Senator BAUCUS. All right. Thank you.

Dr. Chollet?

Dr. CHOLLET. Two things. I certainly respect the issue of one fell swoop in New Hampshire and the chaos that that caused, but in my written statement I focused on Minnesota for just that reason.

Minnesota did that in a series of steps, similar to what Enzi would do. The series of steps had the same result—probably a little less dramatic, but at the end of 4 years essentially the same—as the one fell swoop approach.

The fact that Minnesota has gone from being the most insured, the most privately insured, State in the country to the least privately insured State in the country in 4 years, is pretty startling and pretty sobering, even to the folks in Minnesota.

Senator BAUCUS. All right. We have about 10 seconds.

Dr. CHOLLET. Well, I will just leave it. That is fine.

Senator BAUCUS. Thank you.

Thank you, Mr. Chairman.

Senator HATCH. Thank you.

Senator BAUCUS. I am sorry for going over.

Senator HATCH. Thank you, Senator. That is fine.

Senator Lincoln, you are next.

Senator LINCOLN. Well, thank you, Mr. Chairman.

And I would just say, from your comments earlier, I think this debate is not about criticism of one bill or the other, it is about

seizing an opportunity where we have a tremendous issue in this country that is costing us resources and diminishing the quality of life of so many Americans, that our charge here is not to criticize one another, but to look for the most plausible solution.

Where is it that we, as a Nation, can invest a reasonable amount of dollars? Mr. Rossmann mentions that Enzi does not cost very much. That may be true. But does it accomplish as much as we want to accomplish?

Our bill costs a little bit because of the incentives it provides, but in turn the projections indicate that it would definitely ensure almost 20 times the individuals that you would see that are uninsured.

So I see it more as, what are we willing to do? What is important to us? What are our American values for those 46 million Americans who are uninsured? And compared to the kind of money that we spend around here, a $50 billion investment over 10 years to reach almost 20 million Americans that are uninsured seems somewhat reasonable, and a good investment, particularly if you look at what it does for the other types of health care products we have, the health care safety net.

So many, we find, in small business who, when something happens to that family, all of a sudden they have to leave a job in order to qualify for Medicaid in order to get the health care they need. What does that do to the cost for the taxpayer?

Or what happens if someone working in a small business, which is very traditional for us in Arkansas, for 20 years gets no health care or no consistent health care, and then enters the Medicare system?

Well, they are much more costly to us as a country because they have not gotten 20 years of health care that they would have, had we provided the incentive to that small business to provide that low-income worker the kind of coverage that would give them a day-to-day or month-to-month, responsible health care plan that is going to allow them to not only be a more productive worker, pay probably greater taxes, be more productive to that small business, but be less of a cost when they do hit the safety net programs that exist.

So I hope we will not see this as a process of criticism, but, more importantly, look at how we can productively reflect our American values in things that are really, really important to us.

And so I think I would kind of like to talk about that. I look at my office, or try to, oftentimes, as a small business, and recognizing that I have two of my staffers, one of whom is about to reach 25 years with the Federal Government, and one who is about to reach 30 years with the Federal Government. I have one end of the spectrum, while I also have two women on maternity leave.

So, if I look at that and I compare it to the mandates that the State of Arkansas requires, under which of these proposals am I more likely to find a plan that is going to be cost-effective and cover all of these employees in the diversity of needs that they have, in something that is going to be cost-effective to me as an employer, and more importantly, provide for them the kind of care that they need?

And so, that is the approach I have taken, which may be a little simplistic, but I think that is part of what we have to do here, is to go back to basics.

So I would like to ask you all. Dr. Nichols, since you are a native of Star City, I am going to start with you, home of one of the best rodeo parades in the whole wide world.

But the effect, I guess, on older workers is where I would like to begin. I think, as we are dealing with the Medicare debate right now, prescription drugs and otherwise, we see both Medicare and Medicaid consuming an enormous part of our budget in this day and age.

If any of this can provide the help that we need to prepare those individuals in those categories, maybe you could help us walk through some of the benefits currently mandated at State levels that might be lost if, in fact, we open up Pandora's box and do not maintain some of those. I have just named two in my office, but I know there are many more.

Dr. NICHOLS. Well, Senator Lincoln, I am certainly glad to speak to that. I think, fundamentally, what your bill does is preserve the benefits that all States have already decided are important, and what the other approach would do is basically repeal all of them, that is to say, allow products to be offered that had no benefit mandates present.

I also would like to pick up on the spirit of your opening comment there. This is not about criticizing specific people or specific bills. It is really about, what is the best deal?

I understand completely where Mr. Rossmann and Mr. McCracken are coming from. I have studied the decision to offer health insurance for at least 15 years, and I have two brothers who own small businesses. Trust me, they talk about this all the time. "Len, why haven't you all solved that up there in Washington yet?" I am sure you get the same thing.

Senator LINCOLN. Yes.

Dr. NICHOLS. So I understand the problem. The problem, I think, is that people are so desperate to avoid high costs, they are looking for any port in the storm. And a port in the storm when you do not have an older worker, and you do not have someone who might get pregnant, is a plan with no benefits.

But you might have heard this rumor: we are going to get older and most of us are going to be connected to folks who have babies. So at the end of the day, we are all going to be sharing these costs one way or another.

So the short answer is, your plan would basically preserve the benefits every State has decided on, and they make different decisions. It is a big country. There are very different views on some of these trade-offs out there.

But the other plan would essentially have no benefits, and therefore would allow any product to be offered. Basically, your small business office, if you will, would be a very high-cost plan in that world and you would get to pay for that.

Senator LINCOLN. Yes.

Senator HATCH. Senator, your time is up.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

Folks, this sounds to me an awful lot like the same debate we have had for 60 years, literally going back to Harry Truman. You see it in the dueling bills. They are offered by good people, by Senators Durbin, Lincoln and Enzi. They are all good people.

But what the fight has always been about is the role of the individual. If you really think about this, going back to Harry Truman, 1945, 81st Congress, our inability to solve this has been about these dueling views of the individual.

Senator HATCH. Would the Senator just yield for a second, without losing his time?

Senator WYDEN. Sure.

Senator HATCH. I have to leave for another appointment, so Senator Snowe is going to finish out the hearing as the Chairman.

Senator WYDEN. All right. I think I still have 4½ minutes.

We have dueling views with respect to the role of the individual. One side says it is primarily an individual kind of choice, the individual ought to drive the markets. The other side says we primarily ought to use government, it is a government matter to drive it. Sometimes I feel that I am one of a small group who thinks there is a role for both, both the individual and a role for government.

My question to you is not about the specifics in Massachusetts, but is the philosophy of what is being discussed in Massachusetts not something that could break the gridlock that we have had for 60 years?

It seems to me what they are talking about in Massachusetts has some of the appeal of the Enzi bill, which is to use an individual mandate, to let the individual be more involved in markets, but also a role for government, a role for the uninsured, a role for business, and it melds together these two separate kinds of camps.

So, set aside what you think about the Massachusetts bill, but with respect to the philosophy, rather than just having these dueling alliances go at each other, as we are going to do, apparently, this spring, would we not be better off to try to pick up on the kind of philosophy that might meld these two camps and give us a chance to finally do what Harry Truman envisioned?

Every year I give this speech, it just adds on. Now it has been 77 years. If I might just go down the row with respect to the philosophy of melding a role for the individual with a role for government.

Dr. CHOLLET. Shall I start?

Senator WYDEN. Yes.

Dr. CHOLLET. Senator Wyden, I agree entirely. I think that, in a system such as we have had, in a country such as this, individual responsibility is the bedrock of success. If you do not have a sense of individual responsibility, nothing will work. So, emphasizing that, I think, is absolutely critical.

However, in addition to a sense of individual responsibility, there has to be an affordable, meaningful, reachable product for people to buy, and that, I think, is as important. One cannot be put in place without the other.

So I agree that this is not about finger-pointing. It is about what will work best for this country. What achieves most quickly, most certainly, most stably access to an affordable product for everyone?

The two have to go hand in hand, and one will not succeed without the other.

Senator WYDEN. Do any other panel members want to get into it?

Mr. MCCRACKEN. I would agree. We may have some specific quibbles with some particular provisions of what Massachusetts has done, is doing, but in the broad framework of the reform, they have it exactly right. We think this is a model that not only could be used by other States, but hopefully could be used by Washington to look at how to address this problem long-term.

Senator WYDEN. Just so you get into it, it is very different than what we are talking about here today. We have these two bills, one bill with the individual, one bill for government. So apart from Massachusetts, I want the philosophical breakdown.

Mr. MCCRACKEN. I think the key is, what you can do incrementally is fundamentally different than what you can do if you are looking at a systemic change to this system. If you are tinkering with one part of the problem and you are not looking at a fundamental solution, you are going to create problems someplace else.

So all these bills are all designed to, well, this will make this better, but this might cause a problem over here, and we had better fix that with this. With something like what they are doing in Massachusetts, they are looking at the entire problem, and that enables you to do some very different things because you have everyone in the system.

I would point out to you that I am greatly encouraged politically as well, because what you have in Massachusetts is a Republican Governor with a very Democratic legislature coming together.

You have had similar interest on this, and a very similar approach, in the States of Maryland and California that are similarly situated. So, I am hoping it can be a bipartisan model.

Dr. NICHOLS. I want to pick up on the bipartisan point, and also say what we are talking about here with the level of philosophy is individual responsibility coupled with shared responsibility. It has to be an American plan. It has to be a plan consistent with American values. I think both of those are fundamentally American.

Individuals have to be required to fend for themselves, but the community has to be sufficiently involved to make sure all individuals can, indeed, take care of themselves. I think, fundamentally, what Massachusetts has done is squared the circle and brought the parties together, and it is built around that principle.

I would submit, you could build that off of Durbin-Lincoln, you could let Enzi be part of it, but I think you are going to want that pool to be the core of it.

Senator WYDEN. We have some circle squaring to do here, I can tell you that.

One last person. My time is up.

Mr. ROSSMANN. If I can make one comment, Senator. I think Senator Burr said, at a hearing not too long ago, that he realizes that the association health plan bill or the Enzi-Nelson bill is not the end-all, be-all, but it could be the bridge to the future.

It is a step in the right direction to help small employers pool together to get the economies of scale that large employers have,

and it could match up well with what they are doing in Massachusetts.

Senator WYDEN. My time is up. My only concern is, if you go off and take one of these approaches in isolation, it is going to be very hard then to double back and come up with a sensible approach that involves a role for the individual and a role for government.

Everybody always says—and I do not mean any disrespect for you—start with mine, and then you can build on these other concerns later. I think what we have learned is that health care is an ecosystem; what you do over here affects everything you do over there. You really no longer can say, well, we will just start with that piece and hope that everything else works out.

You all have been a great panel. I have stood up all kinds of people in my office just because of your expertise, and I thank you for it.

Thank you, Madam Chair.

Senator SNOWE. Thank you, Senator Wyden.

Suffice it to say, we have a dysfunctional market, particularly as it affects small business owners and their employees and families. As I said earlier, that is the single greatest impediment for small business owners in offering health insurance plans to their employees, is the escalating costs, the rising costs, and it is a crisis.

I am just concerned in some ways that it will allow the perfect to be the enemy of the good, and there has been a track record with so-called association health plans, small business health insurance plans. The fact is, there is no competition in the existing market for small group markets like the State of Maine, Arkansas, or Montana.

That has certainly been buttressed by the recent GAO report, as I mentioned earlier, that shows that the five largest carriers now control more than 75 percent of market share in 26 States, up from 19 in 2002; more than 90 percent of market share in 12 States, as opposed to 7 in 2002.

In my State, Blue Cross/Blue Shield now has 63 percent of the market, up from 39.1 percent, and the five largest carriers have a 98 percent share. That is just an illustration of the problem that small business owners are facing. So they are at the point of $5,000, $10,000, $15,000 deductibles for, at best, the type of insurance they can offer, which is catastrophic.

So, there is no competition. There are no choices among any competitive plans. We essentially have a dysfunctional market. Mr. Rossmann, you have had an experience. ABC has offered health insurance plans and you, I guess, got out of the market a few years ago. Is that correct?

Mr. ROSSMANN. Yes.

Senator SNOWE. Well, can you speak to your experience? Because I know we have heard from others, like Dr. Nichols, who are saying, essentially it engages in cherry-picking. This is one of the issues we have heard. We have had prohibitions in my legislation, I know in Senator Enzi's legislation, against cherry-picking.

I mean, we are allowing the organizations to establish plans that are tailored to those who join a particular plan. Obviously they are going to devise a plan that is going to be attractive in terms of the

benefits so that you can encourage more people, more businesses, more employees to join that plan.

So what was your experience with the type of plans that you offered your membership? Were they generous? How would you describe them?

Mr. ROSSMANN. Our programs were all fully insured plans. We had about 14 different medical plans that we offered to our members to pick and choose from. The programs included all licensed providers around the country.

They included all the required mandates in Virginia. They also provided the same types of plans in other States, even if they had lesser benefits. So, they were very comprehensive plans that the employers could pick and choose from.

I would envision that we would have that same type of program in the future in the small business health plan legislation, because our small employers are fighting desperately to retain their employees, they are fighting more desperately to be able to provide them cost-effective health insurance coverage.

Senator SNOWE. Well, did you ever hear criticisms of your plan? Well, first of all, were complaints filed against your plans because you excluded certain individuals or you did not include certain benefits in your plan?

Mr. ROSSMANN. No. We had to make the plans comprehensive. It is not a mandate to small employers to buy from ABC. They can buy from whomever they wish to buy from. Granted, we do not have as much competition, but that is another issue. But we are an option for those employers, so if they do not feel our plans are good enough, they can go elsewhere.

We always had to provide comprehensive benefits because we had a group of trustees—and we still have a group of trustees—who are all contractor members that oversee the program, and they have their own families and their own employees insured under the program, so they want to make sure they have complete, comprehensive-type benefits that pay the expenses that are incurred.

Also, in addition to that, one last thing I would say is that you find that preventative care and maintenance care is very important in keeping the costs down on a health insurance program nationally.

Senator SNOWE. Right.

Mr. ROSSMANN. So it would only make sense for any program to have coverage for diabetes and other conditions to make sure that you control them currently so you do not have huge hospitals bills down the line. And the ABC programs have done that in the past, and they will do that in the future.

Senator SNOWE. And so exactly why did you withdraw from offering plans?

Mr. ROSSMANN. It certainly was not intentional, Senator. What happened is, in 1999, our insurance carrier came to us and said they no longer wanted to provide the insurance for our program because of the inconsistency and the complexity of State law, so they basically backed out. We looked at 50 different insurance companies to take over the plan, and nobody wanted it, based upon the variance in laws.

Senator SNOWE. How would you describe the plans that ABC offered? Do you think it was a successful program?

Mr. ROSSMANN. Very successful. The program was in operation for 43 years, and well-served by the members, and well-participated in by the members.

Senator SNOWE. That is an incredible track record.

Dr. Nichols, I would like to have you respond because you had said that supporters of small business health insurance plans think that somehow we are going to magically lower premiums.

The point is that small business currently has no ability, no options available in the current marketplace, certainly in small group markets like the State of Maine. That is a fact that is indisputable. That is where we are today.

I just hope that we can develop a strategy in this Congress to overcome some of the hurdles and to try to fuse some of these differences so that we can offer a competitive mechanism for small business owners. The time has come. We have heard so many different arguments about association health plans, and yet I think the reality does not square.

So I would ask you, with this past success of Mr. Rossmann and ABC for the last 43 years, why is it you think that small business health insurance plans would not work?

Dr. NICHOLS. Well, Senator, first of all, let me commend you for your hard work and leadership on this issue. As you know, I have testified before your Small Business Committee twice on this issue, and I have always been impressed with how engaged you are and how you want to solve this problem. We agree completely that the current small group market is broken; I am there, you are there, we are all there, everybody is there.

The question is, what is the best path out? My concern is not about Mr. Rossmann, Mr. McCracken, or a number of people who run these associations. As you know, I get to testify with him. I know these guys. I know they would never do all the bad stuff.

The problem is, the law permits it. The problem is, the freedom to do exclusion, the freedom to have unlimited rating on age, all that stuff makes it possible. The difference is really about, what path should we take?

Should we allow a path that is going to be available to members of associations that have been in place for 3 years so that they can then get out of the benefit mandates and get out of the rating rules and offer, certainly in the short run, favorable premiums with less coverage. These things are trade-offs.

But what about the firms that are not in these associations? What is going to happen to them? They are going to be stuck in that same small group market that is dysfunctional now, except a lot of what I would expect to be, and I think logic and experience would suggest to be, the healthier pools are going to get out.

What will be left in the small group market will be the less fortunate, and they are going to be paying even more and dropping off and becoming more uninsured. So that is my concern. It is not that the associations themselves would suddenly decide, this member is not worthy of inclusion. I know these guys would keep that together.

The difficulty is what happens to those who are not in the association. So we come back to the question, Senator, why not have everyone in the same pool? Why not have a pool which had real bargaining power? The problem with the market at the moment, if I could, is that there is not enough bargaining power vis-à-vis the insurers. Well, I submit, a larger pool is a better way to get bargaining power than carving up the existing market into more and more smaller pools.

Senator SNOWE. Mr. Rossmann?

Mr. ROSSMANN. The only comment I would make to Dr. Nichols, is the fact that an association, whether it be ABC or any other association, cannot condition membership in their association on health status. They cannot deny coverage to any employer, nor to any employee, under this bill.

Likewise, there are specific rating requirements in the program which say that all the States would operate under the specific set of guidelines that were outlined by NAIC and written into the plan.

The last thing I guess I would mention is the fact that, under this bill, it requires the association, the small business health plan, to offer a Cadillac-type plan which would provide all the benefits that people want or need, whatever those might be, and it could not be priced strategically against that group of individuals, it could only be priced actuarily, as far as the value of benefits goes, over and above some other plan.

So you would have a lot of options available, Cadillac plans, right on down the line. I think our members in ABC—some are healthy. I wish they were all healthy. But we all have a lot of sick folks. We are as healthy and sick, I guess you would say, as the rest of America is.

Senator SNOWE. Well, under my legislation, what you are speaking to, Mr. Rossmann, is correct. I mean, that is exactly right. It would be a prohibition against any type of selection or previous health status and, in fact, that mechanism would conform with the States' ratings.

So, I understand what you are saying, but it is sort of like, you have to get started someplace, Dr. Nichols. That is the problem we are facing. Maybe there is a way of addressing what you are saying about doing the entire national pool. I do not know what the implications are.

I am concerned about the fact that if we say that all these plans have to conform to all 50 States' mandates of some kind, then we are back to where we started. That is the issue that we are facing because of the crisis that characterizes this particular circumstance in the small group market. It is getting worse. It is not getting any better.

I just do not see how you get around some of these issues. You have to give them options. I mean, we have not heard these complaints with large corporations, even in terms of the self-insured or unions. They have all the options available to them. Yet, here we are, confining small businesses and restricting them in a way that really ill serves them and the people who work for them.

Dr. NICHOLS. If I could just have 20 seconds.

Senator SNOWE. Yes.

Dr. NICHOLS. I would just say, I agree with you, we have to do something. I applaud your commitment to this. But, first, let us do no harm. One thing you could do if you are going to go this way is to restrict the premium variance that is allowable outside the associations.

Let us talk about that. There are details about that. I would submit to you, the variance that is actually present, as the New Hampshire Insurance Department calculated, would permit 25 to 1. Mr. Rossmann and Mr. McCracken would never impose that, but others might. That is what you really need to constrain.

Senator SNOWE. I appreciate that.

Dr. Chollet? Then I will go to Senator Lincoln.

Dr. CHOLLET. Just a quick point. I would be concerned, actually, with a rate variation of 25 to 1 outside of an association plan, that the association plan itself could survive.

If there is no reason for small groups not to leave the association if offered a better rate, I would assume that you would be concerned about adverse selection in the association, that you would be left with a sicker pool because your healthier groups would leave when offered a better rate outside the pool, and it would come back when they had a health problem that was rated up in the regular market.

So I tend to think that the wide rate variation is exactly the thing that would make association plans infeasible if they were good players, if they did not do what the market does.

In fact, the experience of purchasing cooperatives has been just that. They have to do what the market does. They cannot do better than the market, otherwise they become, basically, a high-risk pool.

Senator SNOWE. Senator Lincoln?

Senator LINCOLN. Thank you, Madam Chairman. And thanks to the panel. You all are providing tremendous, I think, conversation and dialogue on a critical issue. I know everybody has many places to be, but I just have a few more questions.

I guess I would like, Mr. Rossmann, to just go a little bit further in terms of why the S. 1955 does not provide health insurance coverage to all small businesses. Unless you are a member of an association, you cannot access that.

So if perhaps you all have a great track record and a great program, the automobile dealers, the realtors, or whoever cannot really purchase into your pool. Yet, when you talk about what happened to your program when it was relinquished, that was really because of the quality of what you wanted to maintain from the State mandates that occurred. I mean, you met State mandates, did you not?

Mr. ROSSMANN. Yes, we did.

Senator LINCOLN. Well, in order to do that, it appears to me that you would want a bigger pool.

The other reason you said for the demise of the program, meeting those requirements, the paperwork, again, to me goes back to looking at not reinventing the wheel, but looking at what exists.

In a Federal program that we have for Federal employees, the Office of Personnel Management has done that. They have navigated those States. They have navigated the negotiation with the insurers to ensure that my staff that are in Arkansas have access

to Arkansas plans, as well as Federal plans, all of which meet the basic requirements.

So the problems that existed for you would technically exist for us, except for the fact that we have solved that problem through the Office of Personnel Management and their ability to navigate all of the kind of problems that your insurers saw.

So I guess that is a point I would like to make. But to that point, if you could have increased your pool, you probably could have maintained your program, could you not?

Mr. ROSSMANN. I think it was not so much the demise or the fact that the pool got smaller. It was the fact that the insurance company decided they no longer wanted to be in the State of Colorado, or they no longer wanted to be in the State of New York.

So they said to us, the folks you have insured in those States can stay there, but we are not allowing you to enroll any new members. The reason they did that was because it was difficult for them to comply with the rating laws and the mandated benefit laws of that State.

Senator LINCOLN. Which, for Federal employees, we have overcome. The park ranger that works in Montana or Colorado has access to the 274 plans that I have access to if he is single, or maybe he is married with children, maybe he has 35 years in the Service, or maybe he is right out of college.

So, we have overcome that barrier through what we have done with the Federal employees' plan. It seems like we would use that information as a way to be able to allow you to increase the pool and put yourself in a pool where there is greater risk that can be balanced out.

Mr. ROSSMANN. Right. I think the Federal Employees Health Benefit Plan is terrific, but it is a captive plan in that it is restricted strictly to government employees.

Senator LINCOLN. Yes.

Mr. ROSSMANN. What we are talking about under this new program is one that is open to small employers, open to individuals, open to everyone, but not required to be in one of the plans within that purchasing group.

So you are going to have adverse selection, in my mind, where you will have people going outside of the pool, going directly to insurance carriers as a small employer, rather than staying in the pool.

Senator LINCOLN. But that is the point of, again, the investment that we make. I mean, your bill does not cost a whole lot, but you do not make the investment to initiate getting a greater number of people into the pool.

By the incentives we provide, hopefully not only through an incentive to the employer to increase their share of the costs for the low income, but also giving them a bonus to sign up in the first year to increase that pool the first year enough that we can sustain ourselves, and then show a product that can grow and increase the pool.

Mr. ROSSMANN. I wish we had the ability to have those incentives for the association program. But in the absence of that, we are going out to keep the coverage for our small employers in the private sector and compete with insurance carriers as they are

today, and it will be a level playing field between the association plans and the insurance carriers, so we have to prove our worth. But we feel we have the administrative efficiencies and, I guess I should say, the infrastructure and the contact with our members to make them want to do business with us versus going to a local insurance company.

Senator LINCOLN. Yes. Well, this provides them the same thing. They are just a part of a bigger group of small businesses and have the ability to have negotiators go through that hassle for them instead of you having to go through that hassle and negotiate with those plans that do not want to work in Colorado, or do not want to work in Alabama, or wherever else you have members. I think that is what we try to point out.

I think Mr. McCracken pointed some of that out, why that is a problem, because of the transition with ERISA and self-insured plans limiting the insurance market. This way we have an opportunity, because this is not a government plan, this is just where the government negotiates for small businesses to get into the private marketplace.

I mean, mine is a Blue Cross/Blue Shield plan. There are multiple other plans in the Federal system that are private entities that have negotiated with the Office of Personnel Management to provide that product.

So you get two-fold. One, you get the pool, you get the size, you get the ability to cover all of those people and the mandates and the things that they need at different ages and schemes of their lives, but you also get an influx into the private marketplace that, as you mentioned, was taken out through the self-insured by the major corporations and people who were big enough to be able to be competitive in that sense and provide that market to their employees. So, I hope that we can look at some of those factors as well.

One of the things that I do have particular concern about, and Mr. Rossmann, when we talk about coverage, there are so many different things out there. If we look at our co-workers, our family members, neighbors, others, what have you, we see all of the variety of issues that people have in health care.

One that has been particularly important to me has been infant screening, newborn screening. There is one that we have seen in at least 33 States where there is a formula mandate for a condition called PKU.

A newborn gets screened. PKU is a condition where, if placed on formula in the first 7 to 10 days of life, you can avoid mental retardation, but if you do not, then oftentimes a child will grow up, become mentally retarded, and have very difficult circumstances.

I guess my concern is, when you have these plans, if there are not the State mandates, who is going to look to see if a plan carries this obscure coverage? I mean, if you are single, you get married, and all of a sudden you decide to start your family, you deliver a baby and find out that there is this obscure circumstance which 33 States have realized is cost-effective to mandate the coverage of, and it is important to the quality of life of families in this country, but insurers just do not cover it because it is not mandated, and

it is obscure. Who is going to look at that policy and say this needs to be covered?

Mr. ROSSMANN. I think our insurance trustees, in conjunction with the insurance carriers, who are well-aware of all these different benefits, I guess you would say, and the mandates that exist today would be the ones that would recommend to the program to make sure you have those things, because every insurance program, ABC especially, would want to have a program that provides the wellness benefits, the preventative care, the types of things that keep people healthy and viable long-term. You do not want a person who gets sick and has a huge medical claim, because that defeats the whole purpose of insurance. You want to keep people healthy.

Senator LINCOLN. This may be a bad example because it is very, very low in cost, it costs less than 1 percent, this particular coverage.

But say, for instance, you have a board, or trustees, or what have you. The question comes down to, are you going to mandate something that happens in 1 in 200, or 1 in 300 cases and costs are maybe not substantial, but something that is recognizable? I mean, who is going to make those decisions?

Is it going to be this board or is it going to be those who have experienced that type of an issue, like a legislature in a State where they have made a calculated decision that this is a value that we want to have?

Mr. ROSSMANN. I guess, from a practical standpoint, from my opinion, you have those in place today, all those various mandates in each of the States.

Senator LINCOLN. State mandates. Yes.

Mr. ROSSMANN. You have insurance carriers who are working with those today. So you would logically have these insurance experts, the underwriters, the actuaries, whoever, and the cost containment specialists to make recommendations to any employer, whether it be an association plan or a large employer, to include these types of benefits.

Senator LINCOLN. But it allows those plans to preempt all of those mandates.

Mr. ROSSMANN. Yes.

Senator LINCOLN. So you are just creating more work for yourself in having to go back and review all those mandates, or have your Board of Trustees figure it out in however many States you deal with, that you are going to cover PKU formula or you are not, or you are going to cover diabetes, or how much of diabetes you are going to cover.

It just seems common sense to me that, if we increase the pool, we use what already exists and do not reinvent the rules, that we can actually create something that is going to bring your costs down, provide your members greater coverage at a lower cost, with the assurance that you are not going to be liable if for some reason you have a member who decides to start their family and ends up with a circumstance like that.

Mr. ROSSMANN. I think the problem for any association plan is the fact that you need to have consistency across State lines on those benefit levels. There is so much diversity, if you will, or dif-

ference between each State now, that it is very difficult for an insurance company to serve an association, and sometimes even large employers, nationally.

That is the problem we are in, and we are trying to find a way to fix that problem. We think that the SBHP, S. 1955 legislation, is a way to do that, a way to get consistent benefits across State lines, maintain consistent rating, and still have a high level of benefits with a high-option plan available for anybody who wants that program.

Senator LINCOLN. Well, just in closing, we look at the special concerns, and they are tremendous. I do not know what the track record is for typical plans like you have had; yours particularly had to adhere to the State mandates.

But if not given that mandate or the requirement to do that, I look at the things that are mandated in the State of Arkansas, like diabetes, like maternity, and child well-care, a host of things that mean a tremendous amount.

And I just think, what does it mean to 21 million Americans with diabetes, many of those in our small businesses, hard-working people with other chronic illnesses, too, and those who want to employ them. I think if we pool all of those individuals, we have a much greater outcome in our ability to provide everybody what they really need.

So I hope that there will be more time to discuss this. I know the Chairlady has to get to a very important meeting, so I will conclude my questions, but I do want to thank a very thoughtful panel for bringing your discussion and debate to what I think, and I see personally every day, is a very critical issue to this country.

Thank you.

Senator SNOWE. Thank you, Senator Lincoln.

Just a couple of follow-up questions. I think the point is that we have to start someplace. The question is, what mechanism is going to draw the largest pool?

Obviously, a national pool would be optimal. The question is, what cost and which carrier is going to provide that type of health insurance, with all the restrictions, all the requirements, and all of the benefit mandates?

I do not think anybody disagrees that the ideal situation is to have as many benefits available as possible. On the other hand, if you are looking at where small businesses are today, which is virtually not being able to provide any type of health insurance for their employees, or, as I said, catastrophic, so where do we begin this process?

I just think we certainly could move ahead with some kind of mechanism on small business health insurance plans that does give, I think, some competitive choices to small business that otherwise are just simply not available.

I mean, we have had insurance carriers that simply are not providing for small business owners in the State of Maine. I think it is no surprise then as to why the cost of health insurance has been the single greatest impediment and of most concern for small business owners in terms of providing this valuable benefit. I think that is the real issue here, is how we can overcome that.

Now, some begin with a process, we are trying to get around something. We are trying to get around the benefit mandates. We are trying to get around offering generous benefits. This is trying to exclude those who are sick, or had previous illness, or various conditions.

So we are starting, I think, in some ways with the negative assumptions rather than starting from the premise, what can we do to help those who are without health insurance today, and what can we do to override the system in a way that does provide, as much as possible, generous benefits tailored to those who join these associations?

Now, there is some other way of doing it. I am concerned, as Senator Lincoln was talking about, in terms of offering that plan. It might be great to have a national pool, but what are the restrictions, what are the costs, and who is going to provide it? And whether or not it is going to be cost-effective and cost-competitive enough for small business owners to be able to participate. That is the issue.

When you are talking about who is in the market today, there are very few small business owners that have three to five employees. So, obviously, this is not the exclusive mechanism for helping them to have access to health insurance. It is one dimension to a wide-ranging problem. I believe in targeted tax credits and so on, but I will not get into that now.

But that is really the issue: where do we start, right now, to offer something to small business owners that I think that we could all agree is one step in the right direction and may not be the entire answer?

So that is my concern. If we go with an overall national pool through OPM, with restrictions, mandates, and all of that, we might be, at the end of the day, in the same situation where we are today, that we are not going to have a competitive enough plan for small business owners even to sign up.

So, I would be interested in hearing your views on this. I know under the Enzi bill, and even in my bill, we created the same rules for ratings and mandates for both the small group market and for the plans.

So I am still getting back to the original question, as to why we had these serious concerns, and saying you are going to have businesses fall outside of it and therefore going to be excluded, and they are not going to be able to join these plans. See, I just do not understand why we cannot address those issues in this instance, in the Enzi plan, for example.

Yes, Mr. McCracken?

Mr. MCCRACKEN. Senator, I think you make some really great points. I think it is clear that S. 1955 would dramatically increase competition, especially in many parts of the country where it is very limited right now. There is no question that has real benefits for the small business community.

The other thing that we like about that bill is that it retains a very strong role for the insurance commissioners in all 50 States. That is to say, every insurer, under S. 1955, would have to be licensed in every State in which they sell insurance, and while they may be able to rate on things like age, gender, et cetera, those in-

surance commissioners will be in a position, as they are today, to ensure that those ratings are based on actuarial data, that they are not just rating people up to keep those people out of the plan.

Not only that, but insurance commissioners will be in a position to make sure what they are selling is real insurance, not something that you pay a premium for and there is nothing there, but they really are covering real medical care. So is it perfect? Is it going to solve every problem that is out there for small business? No. And nothing short of a fundamental solution is going to.

The other point you made is having affordable coverage. It is nice to do something that solves all of these problems, to make sure everyone has every benefit they need, but the reality is, as we see coverage declining in the small group market today, year over year, it is an affordability issue.

If we put a plan in front of them that is totally unaffordable for them, we have essentially done nothing, even if it has all the bells and whistles that their people need.

So in the short term, it is clear this is an exercise in hard choices, but we think the framework that Senator Enzi has put together is the right place to start.

Senator SNOWE. Dr. Nichols?

Dr. NICHOLS. Senator Snowe, I would share the sense that we have to do something. I guess I would want to start with the question, though, what is the source of the high cost today?

Why is it that small business finds this so expensive? I submit to you, it has to do with the fact they are paying way more in loading costs, way more than all those profit figures that were talked about, and so forth, the difference between premium and claims, that load, is much higher in the small group market now.

So why is it high? Well, partly from lack of competition and partly from lack of bargaining power. It is high because of the high cost of selling and underwriting to those smaller groups.

Who has the lowest load in the country? OPM. So why not have large groups bargain on your behalf? And it may very well be. I think part of what came to mind as we were talking before, maybe one plan is not going to want to be in every State, but what OPM becomes is an agent to go find the right plans wherever you are. That is the beauty of it. That is the power of it.

That means that in Montana they have access to a lower load than they would ever have in the absence of it, which is why, if you are a working couple, one works for the Federal Government, one does not, the likelihood of buying Federal coverage over the other coverage is very, very high, especially if the alternative is in the small group market. Why? Because it is cheaper. That is what I am talking about. So let us figure out a way to get that cost down. I submit to you, a bargaining agent on the behalf of all firms is going to do better.

Senator SNOWE. But are you not taking a greater risk that way? That is the concern that I have. The greater risk is that you are going to have a very costly plan.

Dr. NICHOLS. Because of the mandates?

Senator SNOWE. Yes, because of the mandates. The current Federal employees' plan does not have to cover every State mandate. That is my concern if we move in that direction and we are where

we are today. So, that is the problem. I think we all would agree we would love to have every mandate in there.

But the question is, at this moment in time for small businesses, what can we offer them, at least to start this process and get access to probably a pretty generous plan in the final analysis? I have not heard that they would not be generous plans. I have not heard that they would not be tailored to those who join the plan and what their needs are and what their preferences are.

I think the question is, once you get into an overall national plan, running it through a Federal agency, mandating all State benefits, you are ultimately going to increase the cost. I mean, I think that is the risk that ultimately will be another deterrent and barrier for small businesses. Is that not a risk, or do you not think that that is a real risk?

Dr. NICHOLS. I think it is a real risk if what we do is make the plan include absolutely every benefit imaginable by every provider known to human-kind. As you know, human ingenuity is quite creative.

But I would also say, maybe what we want to have is a national conversation about what benefits should be everywhere. That may be a separate track you want to go on, because there are some benefit mandates, I would agree, and I am sure you would, too, we probably do not need.

On the other hand, as the Senator from Arkansas pointed out, there are some that are fairly obscure that may not show up very often unless you had a process whereby it was there.

But let me go back to the Montana case. Let us look at the price of the FEHBP offerings there versus what the small group market is. I submit to you, and I would be glad to do that for you and send it to you later because I think it is actually a good question.

Senator SNOWE. I would certainly welcome it.

Dr. NICHOLS. All right.

Senator SNOWE. Mr. Rossmann?

Mr. ROSSMANN. I would just make one other comment. I think OPM does a great job, but again, it is a captive market, in that it is all Federal employees or all government employees. When you get into this purchasing pool or this small employer pool that you are talking about, there is still the requirement to go out and market it.

You have to go out and entice those small employers to come to you, and I do not think a tax credit is necessarily going to do it. I know employers, in general, are scared of taxation, forms, and things they have to fill out.

So a small employer may not be so quick to jump into a plan because they may have read about it in a newspaper. They have to be sold on the concept. I think that is where associations, in the short term, do a great job because we have the infrastructure in place, we have the relationship in place.

Those folks, those little contractors like Gary Houston Electric in Little Rock, AR, they belong to ABC for other purposes than just buying insurance. But by purchasing insurance, that is one of the things that helps them along, too. So we have the connection with them, and that is what keeps our costs down, to deliver the product to the members.

Senator SNOWE. Well, did you ever hear complaints about your plans, as I asked earlier, about some benefits being excluded, or whatever you were offering?

Mr. ROSSMANN. No, ma'am, we have not. No. We pride ourselves in having great, comprehensive benefits for the members. Because Gary Houston Electric—Gary Houston, I mentioned. He happens to be a trustee under the ABC insurance program right now, and he participates in the program. So he is concerned for——

Senator LINCOLN. You had to meet the Arkansas State mandates.

Mr. ROSSMANN. Yes, ma'am.

Senator LINCOLN. Right. That is why you did not get the complaints.

Senator SNOWE. And that is true. For where it is being offered, you have to meet the mandates and the requirements within the State that is offering the plan.

Senator LINCOLN. It preempts the State mandates.

Mr. ROSSMANN. But that is the reason we lost the coverage back in 1999, because of all those mandates and all the rating changes. The insurance company said, we can no longer play the game with ABC to provide you insurance. So what we are trying to do is be able to get that back under some reasonable level of consistent rating and consistent benefits so that Gary could have a chance to come back in.

Senator LINCOLN. Right. With a greater pool and an existing system that has already invented that wheel, you could probably do that.

Senator SNOWE. Well, this debate is going to go on, is it not? [Laughter.]

Senator LINCOLN. Madam Chair, may I just ask one more question?

Senator SNOWE. Yes, Senator Lincoln.

Senator LINCOLN. Thank you. I appreciate that.

I guess, one last question would be, particularly, to Mr. Rossmann. The self-employed. They are treated very differently under your bill as a small employer. They are self-employed, which means they are going to be out of your group and they are going to have to kind of deal on their own. Is that correct?

Mr. ROSSMANN. No. Actually, they can be a part of the group. It is really important for an association like ABC to serve the self-employed individuals who are members, small employers between 250 and the large employers.

Senator LINCOLN. But they are rated differently, correct?

Mr. ROSSMANN. So the way the bill is structured at this point is to bring those self-employed individuals in under the same rating rules that are used by the insurance industry today.

Senator LINCOLN. The bill does not require that.

Mr. ROSSMANN. It does not require it. You could bring them in——

Senator LINCOLN. They are under different rating rules under the current bill, are they not?

Mr. ROSSMANN. Actually, the bill says that you can bring them in under the rules for individuals out in the open market as they

are today, or you could use the small group rating rules. It would be the choice of the association.

But the idea of the association is to bring those folks into the program so they have the advantages of more comprehensive plans, which we know, group insurance plans are much more comprehensive than individual plans, so they have the advantage of comprehensive health insurance plans that they do not have in the individual market today, plus they would have the experience rating so that their rate increase next year would be that 5 or 10 percent that every employer got nationwide.

Senator LINCOLN. But they do not get the same rating as your association group plan. You give them a rating under the small group market plan rating, correct, in the individual market?

Mr. ROSSMANN. The NAIC rating model is the one we are using for everyone. The only exception would be that, for large employers and single, self-employed individuals, you would bring those folks into the association plan or the small business health plan using the same rating techniques that insurance companies use today.

That is to keep a level playing field between the insurance industry and the small business health plan, because we do not want them to have an unfair advantage, and they do not want us to have an unfair advantage.

Senator LINCOLN. Right. Maybe I misunderstood that. I do not know if anybody else can explain that to me in a better way.

Mr. ROSSMANN. I am sorry if I have not clarified it.

Senator LINCOLN. To me, I understood the bill to mean that they were not rated under your group plan, that they were in the individual market, and they had to be rated that way.

Mr. ROSSMANN. When they come into the program, the SBHP, the association plan, can use the individual market rating techniques to calculate what their plan rate should be and bring them into the plan. But once they are in the plan, they have the same kind of increases that everybody else would.

Senator LINCOLN. But to get into the plan they have to meet those individual ratings from outside the plan. Correct?

Mr. ROSSMANN. Because you are trying to do the same thing that insurance companies are doing today for the benefit of, or the not-so-good benefit of——

Senator LINCOLN. So, quite frankly, it is no different. I mean, the self-employed are either going to meet the ratings of the individual market now as it is in order to get into your plan or to get into an individual market plan.

Mr. ROSSMANN. Right. But if you went to the individual market plan, you would not have near the comprehensive coverage that you have——

Senator LINCOLN. But they cannot get there without going through that. They cannot get to your plan without going through the individual market rating. Right?

Mr. ROSSMANN. It is the same thing, I guess. I am lost.

Senator LINCOLN. I do not know. Maybe somebody else can shed a little light on this.

Dr. NICHOLS. I think you are talking about related, but two different things. I think the issue is, will the self-employed person

have access to the same premium that a business group member of your association will have?

Senator LINCOLN. Same thing.

Dr. NICHOLS. The answer to that is no, because the individual we rated in the individual market by age, whatever else is allowable in that State. And some States, as you know, are quite creative about rating. So you could have quite a high rating, like 52-year-old overweight white guys like myself that pay more than some other people. So I come in at a higher level.

What Mr. Rossmann is suggesting, though, is that over time the rate of increase would be pegged to the association as a whole. The benefit package would presumably be exactly the benefit package that would be offered inside the association. But the high-risk individuals will come in at a higher premium, and that differential would maintain itself.

Senator LINCOLN. So they come in at this level compared to your other members.

Mr. ROSSMANN. Right. And if they do not come in at all, they are out there at the higher level, with lesser benefits.

Senator LINCOLN. Right. My plan would put them all together so everybody can enjoy that benefit.

Mr. ROSSMANN. We want to get those small, self-employed individuals into the——

Senator LINCOLN. But they are going to always remain above the other members of your association plan because they come in at a higher premium. It is kind of like agricultural subsidies.

Mr. ROSSMANN. I guess that is one I really cannot answer honestly right now. I think that would determine how the insurance company and the trustees of the SBHP would work it. That last thing, I really cannot answer. But I do know they get a better plan and they get the advantages of the experience rating.

Senator LINCOLN. At a higher cost. At a higher premium cost.

Mr. ROSSMANN. Yes. There are about 10 States that have rating requirements for individual coverage also. So, if that is the case in the rating requirement, you would have to bring them in under the basis of that.

Senator LINCOLN. Yes. I do not think Arkansas has those kind of individual rating mandates. But, yes. I think that becomes a real issue for the self-employed, because, as an individual looking for a marketplace to go to, they may not be all 46 million, but there are a lot of individuals out there who are self-employed who do not have insurance.

They are going to think that they can come into your plan and get the same benefit that your members do, and they cannot. They are going to have to pay a higher premium because they are going to be judged by a different rating system in order to get into your plan. Is that right? Am I saying that correctly? I think I am.

Yes, Mr. McCracken?

Mr. MCCRACKEN. May I put in a couple of quick plugs for something we could do with the self-employeds?

Senator SNOWE. Yes.

Mr. MCCRACKEN. Do you have time for that?

Senator LINCOLN. Well, Olympia and I might just invite you all for coffee another time, another place.

Senator SNOWE. Exactly.

Mr. MCCRACKEN. Because the self-employed right now, that is, the owners of a non-corporate entity, right now cannot participate in a cafeteria plan, for instance, today. So, surprise, surprise, they do not have them for their employees, either.

So those are very important mechanisms to get at a lot of these other health care costs that insurance does not get to. Senator Snowe has put in a bill just this week that would address that question, S. 2457, and it would be a big help to the self-employed.

Another issue that greatly harms the self-employed is they cannot deduct any of their health insurance expenses against their self-employment taxes. So they essentially pay 15-percent taxes on their health insurance costs that no other worker, for employment-based health care, has to pay in this country. That could add up to $2,000 or $3,000 in taxes that they have to pay that nobody else has to pay. Fortunately, Senator Bingaman and Senator Thomas have put together a bill, S. 663, that would address that issue. So, I hope those are some things that are in the direct jurisdiction of this committee that could be addressed, Senator.

Senator LINCOLN. Absolutely. Thank you.

Senator SNOWE. I think using the tax code is essential as well. I think that would be another critical component. In fact, I have introduced a bill that would help the real small businesses, with three to five employees, to help them with health insurance, and also a tax deduction for costs associated with insurers getting into small group markets so that we encourage more insurers, more competition in small group markets, and provide for a tax deduction in that regard.

This has been very helpful today and very informative, and we really appreciate your participation. It is obviously a very critical debate that will begin on the floor of the Senate in early May.

But in the final analysis, I hope that we will be able to reach a consensus on this vital issue for small business owners across this country. I mean, it is a preeminent concern, foremost concern among small business owners, as you well know.

So I hope this will be the year in which we can make a decision and do something that is concrete and effective for the interests of small businesses in America. So, I want to thank each and every one of you for being here today.

If any Senator has any questions for the record, they must be submitted to the committee by close of business, Monday, April 10.

This hearing is adjourned. Thank you.

[Whereupon, at 1:03 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Committee On Finance

Max Baucus, Ranking Member

NEWS RELEASE http://finance.senate.gov

Opening Statement of U.S. Senator Max Baucus (D-Mont.)
Health Care Coverage for Small Businesses: Challenges and Opportunities
Hearing Before the Senate Finance Committee

Today we discuss ideas to address the health insurance crisis facing small businesses. And as we do, we will see that what Lord Tennyson wrote of men and women is equally true of people covered by insurance. He wrote: "They rise or sink together."

America has a unique, fragmented system of health coverage. America is the only industrialized country without universal health insurance. Most Americans get their health insurance through their work.

Our employment-based system is a relic of World War II. Wartime wage controls prevented employers from competing for new workers by raising salaries. So instead, employers competed for workers by offering health insurance. For 60 years since, employer-based insurance has dominated America's health coverage.

But now, the employer-based system is struggling. About 60 percent of insured Americans get their coverage through employers. That's down from 68 percent, just five years ago. And like Medicare and Medicaid, the employer-based health system is struggling under rising health costs and an aging America.

This is particularly true of small employers. Administrative costs are a greater burden for small businesses than for big business. Small employers run a greater risk of being priced out of affordable coverage when even one worker falls ill. In Montana, only about 40 percent of the smallest businesses are able to offer coverage to their workers. These small businesses simply don't have the wherewithal to insure their employees as large corporations do.

At some point, God willing, we as a society will deal with health care costs and the uninsured. We spend twice what many industrialized countries do on health care. And yet our outcomes are worse. And one in six Americans have no health insurance. Our system simply cannot hold out in its current form over the long haul. I suspect we'll have to make significant changes.

The current system is unfair and inefficient. And it is hobbling American competitiveness. American companies face a competitive disadvantage relative to firms whose governments insure their employees. Moreover, America suffers lost productivity when workers miss days because they are sick.

So what do we do about these problems?

Creating a new national pool for small employers like the Federal Employees' Health Benefit Plan sounds like a good place to start. It would provide a big pool for spreading risk among lots of small businesses and the self-employed. It would get more of us in one pool, together. And it provides good quality health coverage to all of us Members of Congress. It is a privately-run system that benefits from free-market forces to encourage better value for enrollees.

Tax credits or other subsidies are also important. Pooling can lower administrative costs and improve the quality of coverage small businesses can buy. But that may not lower costs enough to make coverage affordable. Studies have shown some small businesses would need a dramatic reduction in costs to join.

Targeting subsidies to help the neediest families also seems like a good idea. Nearly a quarter of the uninsured are in families making less than $25,000 a year. Why not help those most in need first?

Another good place to start would be not making the problem worse. In other words, we should "first, do no harm." Unfortunately, some of the bills before us in the Congress may well do more harm than good.

For example, consider the Health Insurance Marketplace Modernization and Affordability Act, also known as "HIMMA." Senator Enzi has worked hard putting this bill together. And the HELP Committee has ordered it reported.

I know Senator Enzi and Senator Nelson are trying to thread a difficult needle here. And I appreciate that they are trying to make things better for small business. The legislation is aimed at pooling health insurance risk and letting like-minded folks band together for the common good.

That sounds good on its face. But the bill is more complicated than that. And I believe that the legislation may well make a bad situation worse in my state of Montana.

For example, Montana requires that insurers cover maternity services, diabetes care, mammography, and mental health. The Enzi bill would allow insurers to opt out of these requirements for the entire insurance market. Insurers could opt out as long as they offer an "enhanced" benefit package at least as good as a state employee plan offered in one the five most populous states: California, Texas, Florida, New York, and Illinois.

Mind you, these are all good states. But the people of Montana passed our own laws to regulate what health insurers should offer. And this bill would take away our rights to do so. Allowing insurers to make an end-run around these mandates undermines states' rights to locally regulate insurance. Congress gave the states the right to do so more than 60 years ago under the McCarran-Ferguson Act.

Opting out of state benefit requirements could also enable insurers to offer pared-down coverage to cherry pick out the healthiest and youngest workers. That would be more profitable for insurers. But that would leave sicker and older workers behind.

My second concern is over regulation of health insurers.

Montanans rely on their state officials — the insurance commissioner and attorney general — to enforce insurance laws. But the Enzi bill would create new federal standards for insurance. If states did not like the new standards, insurers could still come in and follow the federal requirements without proper oversight. This just looks like it would give insurers too much control. We need someone minding the store.

Finally, I am concerned that the Enzi bill — like health savings accounts — follows the "ownership society" model of putting more risk on individuals to solve society's problems. The idea is that society will benefit if we only give individuals more stake in their future.

To a large extent, I agree with this philosophy. I am a free trader, and I believe in the ethic of individualism. The invisible hand can produce remarkable results.

But I'm not sure the individualist ethic can be cleanly extended to health insurance. The nature of health insurance is shared risk. We all pay into the pool. And we benefit from that pool when we need help. I am concerned that the Enzi bill — like health savings accounts — will lead to the healthiest individuals leaving that pool. And I am concerned that this phenomenon will leave the sicker and least-able to pay behind.

In the end, what Tennyson said was good insurance policy: We "rise or sink together." Let us seek a solution for small business health care needs that does not simply move the healthy out of the pool. Let us find ways to aid small business that do not sink the sicker and the older among us. And let us all try to rise together.

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STATE REGULATION AND INITIATIVES TO EXPAND SMALL GROUP COVERAGE

Testimony submitted by

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In every state, workers in small businesses are the least likely to have employer-based coverage and the most likely to be uninsured. This situation has driven concern about the affordability of small-group coverage in every state. Many states have significant efforts underway to address problems of affordability in this market and maintain access to necessary health care services.

This testimony reviews the impetus for state regulation to address the affordability of coverage and summarizes specific efforts to improve small-group coverage in selected states—including Arizona, Maine, Maryland, Massachusetts, Minnesota, New Jersey, and New York. The states that have developed programs to encourage greater coverage rely heavily on the commercial small-group market accepting and retaining significant risk.

Several of these states (Maine, New York, and—anticipating enactment—Massachusetts) have developed programs to subsidize low-income workers and encourage employers to offer coverage. If higher-risk groups were forced out of the commercial market and systematically gravitated toward these programs, they probably would be too costly for the states to operate. In turn, many high-risk individuals who lost group coverage would turn to individual coverage or to Medicaid and SCHIP in greater numbers, disrupting the individual market and adding enrollment and cost to federal- and state-financed programs.[1] By ensuring that insurers pool risk more broadly, these states are able to make the average cost of good coverage affordable to low-wage firms and low-income families.

THE IMPETUS FOR STATE REGULATION OF HEALTH INSURANCE RATES

The states' concern about access to and affordability of coverage spans nearly three decades. In a wave of state small-group reforms during the 1980s and early 1990s, many states required guaranteed issue and renewal in the small-group market. Many also acted to limit rate variation among small groups, especially with respect to health status and other group characteristics that contribute significantly to the volatility of premiums for small groups.

In 1994, the model act governing small-group coverage developed by the National Association of Insurance Commissioners called for modified community rating in the small

[1] SCHIP is the general acronym used to designate the State Children's Health Insurance Program in each state. Most states have folded SCHIP into their Medicaid program, developed a separate child health program, or combined these two approaches.

group market. The model act prohibits insurers from rating coverage to reflect health status, claims experience, or duration of coverage,[2] but allows adjustment in rates to reflect demographic characteristics (such as age) that are broadly correlated with medical cost.

The states that enacted restrictions on small-group rating did so to address real problems in their markets. Rating on health status was seen as an important contributor to unproductive churning—as small groups changed carriers and coverage, in effect to restart duration—and high administrative cost. Not only does churning add to the complexity and time commitment that small employers bear in order to offer coverage, it also burdens employees whose insurance coverage (and potentially also their providers) would change in the course of a serious illness. In addition, it adds significantly to insurers' already very high administrative costs for small-group coverage, as greater resources are devoted to underwriting, and disenrolling and enrolling small groups displaced from coverage by the illness of a worker or dependent.

Because small-group claims experience necessarily is more volatile than that of larger groups, health rating contributes to substantial premium volatility for small groups, causing some small employers to drop coverage and many not offer it at all.[3] A survey of small businesses conducted in 1993 found that about 12 percent of small employers had given up coverage in response to large premium increases—and 75 percent did not offer coverage because of uncertainty about increases in premiums (Christianson et al. 1994).

States that prohibited or narrowly limited health- or durational rating viewed broader risk pooling and, therefore, greater premium stability as essential to retaining and building small-employer coverage. By prohibiting health- and durational rating and requiring guaranteed issue, these states forced insurers to pool risk more broadly in order to stabilize rates. At present, at least 11 states require small-group carriers to use adjusted or pure community rating.[4] The states that have adopted pure community rating of small-group coverage—New York and Vermont—restrict carriers from varying rates on any characteristics of a small group other than family composition and geographic location.

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[2] Duration of coverage is a proxy for the rising incidence of health problems that emerge over time in any insured group. Most states, but not all, prohibit insurers from re-underwriting either or both small-group or individual coverage at renewal. However, durational rating encourages small groups to seek new coverage and, therefore, to submit to re-underwriting.

[3] Firms that are community rated are charged premiums that reflect the average claims experience of all small groups in their insurer's book of business, not specifically based on the firm's own claims experience. Community rates may vary by other factors as allowed or constrained in regulation. In contrast, larger groups have a greater number of workers over which to spread a few employees' very high claims costs and, therefore, typically experience more stable premiums, even when their coverage is experience-rated.

[4] Connecticut, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New Mexico, New York, Oregon, Vermont, and Washington. In addition, Michigan requires its Blue Cross and Blue Shield plan and all HMOs to use modified community rates. At present, the nonprofit Blue Cross and Blue Shield carriers and HMOs in Pennsylvania (accounting for about two-thirds of the market, but eroding) also use modified community rates.

IMPACTS OF HEALTH INSURANCE RATE REGULATION

No research has directly observed the effect of the states' rate regulation on small group rates. Instead, the research literature considers impacts on coverage, assuming that (all else being equal) lower rates of coverage correspond to higher premium levels and that some small employers and/or employees would drop coverage if regulation caused an increase in premiums.

Most early studies of rate regulation found little or no effect on overall coverage in the small group market (Monheit and Cantor 2004). However, more recent studies have looked for and found differences by risk group. These studies conclude that, in states with community rating, higher-risk individuals (for example, married women of childbearing years with children) may have gained coverage (Simon 2002). Similarly, high-risk workers are more likely to find or retain coverage in community-rated states, especially in states with narrow rate bands overall (Monheit and Schone 2004).[5]

However, community rating predictably increases premiums for healthier and younger groups, and may discourage employers from offering coverage to such groups, or (when employers require significant premium sharing) it may discourage lower-risk workers from taking coverage. Indeed, one study concluded that low-risk workers (for example, single men under age 36) in small firms might be more likely to become uninsured in states with narrow rate bands, although the effect was slight (Simon 2002).

These research findings highlight the choices that all states must make, either actively or passively, when health insurance coverage is voluntary. When small-group (and/or individual) rates vary widely with health status, it is more likely that individuals with health problems will be uninsured, especially if they are in low- or middle-income families. Conversely, with community rating and narrow rate bands overall, individuals with health problems are more likely to be insured—although some individuals who anticipate few medical needs may remain uninsured.

Whether the state restricts both the extremes of rate variation and the volatility of premium increases at renewal has important implications for population health status, as well as implications for financing throughout the health care system. By forcing the small group market to accept and hold greater risk, community rating and narrow overall rate bands help people with health care needs to afford coverage and access needed care. In turn, this probably minimizes reliance on Medicaid and SCHIP and also minimizes providers' burden for bad debt and charity care. All payers—including Medicare and large employer plans—ultimately finance medical bad debt and charity care in higher charges for insured care.

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[5] A rate band is defined as the ratio of the highest to lowest rate offered to different small groups for the same product. States that regulate health insurance rates commonly set rate bands with respect to specific factors (such as health status or age), and they may also band rates for all factors taken together (called a comprehensive rate band).

STATE EFFORTS TO IMPROVE SMALL GROUP COVERAGE

A number of states have enacted programs to reduce the cost of small-group coverage and, therefore, encourage employers to offer it. Each of these programs also provides coverage for self-employed workers; many offer coverage to individuals as well. These states have taken alternative paths to subsidizing broad coverage for necessary services, as opposed to the less successful state efforts to develop less costly "bare bones" policies, stripped of most state-mandated benefits.[6]

These programs vary in their approaches, but all rely fundamentally on the small-group market holding substantial risk for health care costs. That is, these programs are feasible because they are likely to enroll groups with medical costs that are approximately at the population average. If carriers in the small group market were allowed to use health- or experience-rating, these programs would need also to health-rate coverage in the same way as carriers in the market. If they did not, they would become, in effect, high-risk pools, as groups that experienced a serious illness of a worker or dependent gravitated toward them to avoid experience rating. All of the programs that offer direct or indirect subsidies to small groups and/or individuals to encourage coverage probably would be forced to close if severe adverse selection accelerated their costs. The essential features of each program are summarized below:

- ***Arizona.*** Arizona's Health Care Group (HCG) contracts with insurers to offer coverage to small firms and self-employed individuals; HCG reinsures that coverage, but does not directly subsidize premiums and eligibility is not based on income or wages. To protect the program against adverse selection, HCG requires that 80 to 100 percent of a firm's employees participate. HCG premiums are age-rated (as in the general market), but they are not health-rated; carriers in the general market may rate up as much as 60 percent for health status. Participating carriers must guarantee issue of coverage to all HCG applicants and, in return, HCG reinsures the highest costs. As of November 2005, HCG covered nearly 17,300 lives, of which about 70 percent were sole proprietors who are not guaranteed issue in the commercial market. The legislature appropriated $4 million per year for this program from 2004 through 2006 (Chollet 2004; Chollet and Watts 2005).
- ***Maine.*** In mid-2003, Maine created the Dirigo Health Agency to design and administer a voluntary market-based health plan to help small businesses, the self-employed, and individuals afford health coverage. Called, DirigoChoice™, the health plan offers two high-quality health insurance options (distinguished only by the size of the deductible) through a private insurance carrier and competes with all products and carriers in the small group and individual markets (Rosenthal and Pernice 2004). It must comply with all insurance regulations—including guaranteed

[6] At least 11 states (Arkansas, Colorado, Florida, Maryland, Minnesota, Montana, New Jersey, North Dakota, Texas, Utah, and Washington) have considered or enacted legislation allowing insurers to sell limited-benefit policies to small groups. To date, these products have elicited very little employer interest and have not sold well. In contrast, low-income uninsured adults may be more likely to enroll in limited-benefit plans when offered through public programs and highly subsidized. For example, Maryland, Pennsylvania, and Utah sponsor limited-benefit plans for low-income adults that in some cases have hit their enrollment caps (Friedenzohn 2004).

issue and community rating adjusted only for age, geography, and industry within 1:5 rate bands. Employers must contribute at least 55 percent of the single premium for workers. Employees with family income less than 300 percent of the federal poverty level may approach the program for a reduced premium contribution and deductible, both calculated on a sliding scale relative to family income.[7] Otherwise, both DirigoChoice products are HSA-qualified. DirigoChoice opened enrollment in January 2005, and by December had enrolled more than 750 small groups. The claims experience of the program was generally comparable to industry norms in Maine, although inpatient hospital costs were somewhat higher than Anthem BCBS's commercially insured small groups. The anticipated cost of the program in 2006 is $43.7 million, financed as a 2.4 percent assessment on all paid claims in Maine [http://www.maine.gov/governor/baldacci/healthpolicy/news/11_22_05.htm].

- ***Maryland.*** Regulation in Maryland has standardized small-group products to facilitate comparison of small-group premiums among carriers and direct price competition, but it does not subsidize coverage. Carriers may offer only one small-group product, but they may offer riders to enhance the standard coverage. Most small employers in Maryland buy products that include one or more riders. Coverage must be offered without pre-existing condition exclusions, and it must be community rated, adjusted only for age and geography. The standard benefit is also subject to an affordability cap: the average annual premium for standard plans may not exceed 10 percent of the average annual wage in Maryland. A legislatively mandated evaluation of Maryland's small group regulation concluded that the cost of coverage, controlling for the benefits covered, was less expensive in Maryland than in all but one of six comparison states and 9 percent less expensive than the average. The standard benefit was generally comparable to that available in other states (Wicks 2002).

- ***Massachusetts.*** Legislation sent to Governor Romney for signature would require every Massachusetts resident to have health insurance by July 1, 2007. Those who do not get coverage would first lose their personal income tax exemption and eventually could face a yearly fee payable to the state and equal to half of the lowest-cost available insurance plan. Under the bill, the new insurance plans will be offered and run by private companies, but coverage for low-income families will be subsidized by the state. This strategy is likely to increase workers' demand for group coverage sharply, as a less costly way for individuals to meet their individual obligation to be covered. It is expected to cover an additional 215,000 people by creating incentives for insurers to offer low-cost products with fewer benefits and allowing individuals (like businesses) to purchase health insurance with pre-tax dollars. The premium subsidies are expected to result in coverage of an additional 207,500 people who will qualify for free or low-cost private insurance with sliding-scale premiums.[8] The plan calls for $58 million in new state spending through June 30, 2006, and $125 million per year in FY2007-2009. This bill was crafted in the context of strong small-group rate regulation and, therefore, market with relatively little premium volatility:

[7] Individuals who are not otherwise Medicaid eligible may also qualify for a reduced premium and deductible.

[8] In addition, the plan anticipates enrolling an additional 92,500 people in MassHealth (the state's Medicaid program) by expanding eligibility for children and enrolling all eligible adults.

Massachusetts requires small group carriers to community rate coverage, adjusted within 2:1 rate bands for age, industry, and group size.

- ***Minnesota.*** Minnesota has achieved the highest rate of voluntary health insurance coverage of any state, largely as a result of extensive participation in managed care, constraining health care costs, but also by sponsoring a series of public insurance programs available to individuals and families who cannot afford private coverage. Minnesota operates several programs that encourage coverage—including the Public Employees Insurance Program (which covers local government and school district employees and is operated by the state employee health plan), MinnesotaCare (a subsidized state program for low-income adults who do not qualify for Medicaid), and a uniquely large and affordable high-risk pool for individuals who are denied coverage in the individual market or quoted a high premium related to their health status (Chollet and Achman 2003). In a series of legislative initiatives since 2001, Minnesota relaxed its small group rating restrictions (including community rating) in response to the industry's argument more insurers would enter a deregulated market and that greater competition would drive down costs.[9] Since 2001, the small-group market has seen double-digit premium increases each year, despite significant growth in deductibles and other cost sharing for covered services, and the percentage of small-group workers covered by their own employer has dropped sharply.[10] Fewer people are now covered in the small group market, and insurer loss ratios have declined to the statutory minimum—suggesting that the small group market has in fact shed risk.[11] From 2000 to 2004, Minnesota (like other states) experienced significant growth in both Medicaid enrollment and the uninsured [www.statehealthfacts.org].[12] Enrollment in MinnesotaCare also accelerated sharply prior to cuts in the program (MDH 2006).

- ***New Jersey.*** Small-group carriers in New Jersey may offer any of four standard PPO products and one standard HMO plan. Each standard plans covers a comprehensive set of services, and they vary by co-insurance levels (ranging from 10 to 40 percent) and deductible options. Small group carriers must use modified community rating adjusted only for age, gender, and geography within overall rate bands of 2 to 1. At renewal, premiums may be adjusted for medical trend plus as much as 10 percent for health status, medical claims, or duration. In addition, New Jersey requires all small group carriers to meet or exceed a loss ratio of 75 percent. New Jersey estimates that

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[9] Currently, Minnesota insurers may rate for health claims, duration, and industry within rate bands of $\pm$ 25 percent (1.67 to 1); age within rate bands of $\pm$ 50 percent (3 to 1); as well as geographic area within rate bands of $\pm$ 20 percent (1.5 to 1)—cumulatively, rate bands of about 7.5 to 1.

[10] From 2001 to 2004, the percent of nonelderly workers in groups of 2 to 10 covered by their own employer declined from 34 percent to 28 percent; in groups of 11 to 50, the percentage declined from 60 percent to 50 percent. Coverage in other firm sizes also declined, but not as dramatically as in small groups. These changes were statistically significant (MDH 2006).

[11] A loss ratio is the ratio of medical claims incurred to insurance premiums earned by private health insurers. Minnesota requires the largest insurers to maintain a loss ratio of at least 80 percent in the small group market.

[12] The rate of uninsured increased from 12 percent in 2001 to 17 percent in 2004 among nonelderly adult workers employed in groups of 2 to 10; in groups of 11 to 50, the uninsured rate increased from 8 to 11 percent. These changes were statistically significant (MDH 2006).

it has caused carriers to return substantial funds to small employers during the years that it has been in effect (Sanders 2005).

- ***New York.*** Established in 2001, Healthy New York (NY) targets small employers (with 50 or fewer employees) as well as low-income sole proprietors and individuals. Healthy New York reinsures 90 percent of each enrollee's claims between $5,000 and $75,000 per year. Small groups may participate if at least 30 percent of employees earn less than $34,000 annually (indexed to inflation), and the employer did not offer or contribute substantially to comprehensive group coverage in the prior year.[13] To deter adverse selection in the program, at least half of eligible employees must participate and the employer must contribute at least half the premium. Uninsured sole proprietors and individuals may participate if they (or their spouse) are employed full- or part-time (or were employed some time in the prior year) and if their gross household income is 250 percent of the federal poverty level or less.[14] Healthy NY contracts only with HMOs; 24 currently participate. All are required to enroll all applicants and to community rate—consistent with New York's requirement that individual and small-group coverage throughout the state be guaranteed issue and pure community-rated.[15] Since the program began active marketing, enrollment has increased rapidly. In December 2005, Healthy New York was serving nearly 107,000 members. About one quarter of enrollees (26 percent) are small businesses (typically with 5 or fewer employees and having been in business 3 years or more), 18 percent were sole proprietors, and 56 percent were working individuals (EP&P 2005). In CY2004, Healthy New York spent $31.5 million—about 29 percent of participating plans' medical losses.[16] Premiums were 25 to 30 percent below market levels for Healthy New York products (United Hospital Fund 2005).

CONCLUDING COMMENTS

The states' efforts to encourage small group coverage fundamentally rely on a stable small-group market—and one that accepts and retains risk that is at least equal to population-wide average. In such markets, the uninsured population is expected to be at least as healthy as the insured population. Paradoxically, even state reinsurance programs—designed to cover the cost of unusually high-risk enrollees—are susceptible to adverse selection, if the market insures only the healthiest small groups and individuals.

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[13] Small employers that provide coverage may be eligible for the program if they contributed less than $50 (or $75 if the business is located in the Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, and Westchester counties) per month per employee.

[14] Individuals must have been uninsured during the past year, but may qualify if coverage during the past 12 months was terminated for such reasons as loss of employment, death of a family member or subscriber, change to a new employer without health insurance, change in residence, discontinuation of a group product, expiration or termination of continuation coverage (COBRA); change in marital status, loss of eligibility for group health insurance, or reaching the maximum age of dependency. Applicants with COBRA coverage or public program coverage in New York may enroll directly in Healthy NY (SCI 2005).

[15] In addition, participating carriers are required to set a single premium for small groups, sole proprietors, and individuals, regardless of enrollment category.

[16] New York finances the program from its tobacco trust fund.

When unregulated, health insurance carriers can shed or avoid risk by pricing and/or tailoring benefits to avoid specific medical costs. Both have precedent in the history of state health insurance markets. For example, if coverage cannot be denied (as under federal law in the small group market), it can be made unaffordable to groups that include workers or dependents with health problems. Carriers can use durational rating to force small groups to undergo re-underwriting, moving them into much higher rate classes. The potential for sharp increases in insurance premiums, in turn, discourages small employers from continuing coverage or offering it at all. Employees, when confronted with steep increases in their share of the premium, are less likely to accept coverage even when offered—especially if the plan's deductibles and copayments also are rising sharply.

In addition, unless required to offer some critical benefits, carriers can tailor benefit designs to avoid specific risks—for example, offering no or reduced coverage for maternity or mental health benefits, or for coverage of congenital problems in newborns, a benefit that every state currently mandates. Such latitude in developing insurance products presents at least two problems: By making benefits impossible to compare, it reduces price competition. In addition, it may in effect eliminate insurance for some benefits by breaking insurance pools into "puddles"; when the probability of using a benefit is very high in any insurance pool, the pool is in effect prepaying for care. Such prepayment schemes are unlikely to survive, and therefore the benefit they would cover is likely to disappear. State programs that work with the private market—such as those in Arizona, Maine, and New York—cannot offer good benefits with affordable premiums in an environment where carriers in the market do not do the same.

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Finance Committee Hearing
"Health Care Coverage for Small Businesses: Challenges and Opportunities"
Questions Submitted for the Record
Dr. Deborah Chollet
April 13, 2006

Senator Grassley

1. **It seems to me that a core issue here today is the role state mandates play in making health care coverage for small insurers unaffordable. I note with interest that various versions of the Durbin-Lincoln bill have gone from waving state mandates to applying them to small businesses. How significant are state mandates in making health insurance unaffordable for small businesses?**

   In investigating the impacts of mandated benefits on coverage, most researchers have estimated the cost to insurers of all services, providers, and populations covered by the mandates. However, the mandates themselves do not generate all of these costs, since some coverage would have been provided in the absence of a mandate.[1]

   Relatively few studies have measured cost at the margin—that is, the difference between actual costs and the costs that would have resulted without the mandates—although this is the correct way to view the real cost of mandates. Studies that measure the impact on total costs generally overestimate the impact of mandates on coverage. However, regardless of the measure used, the most sophisticated (and those least likely to be statistically biased) research studies generally have found that mandates have had little or no effect on either employer offer of coverage or the rate of coverage among workers, with some exceptions. For example:

   - Hing and Jensen (1999)[2] found no effect of mandates on either offer or coverage.
   - Gruber (1994)[3] found that mandated coverage for mental health treatment and chiropractic care affected neither coverage nor employer offer.

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[1] For example, mental health parity legislation does not increase claims by the total costs of covered mental health services. Nearly all workers with group coverage (93 percent) had coverage for inpatient mental health care when fewer than half of states had such legislation (Jensen G.A., and M. Morrisey (1999), "Employer-Sponsored Health Insurance and Mandated Benefit Laws." Milbank Quarterly, 77(4): 425-459).

[2] Hing, E., and G.A. Jensen (1999), "Health Insurance Portability and Accountability Act of 1996: Lessons from the States." Medical Care, 37(7): 692-705.

[3] Gruber, J. (1994), "State-Mandated Benefits and Employer-Provided Health Insurance." Journal of Political Economy, 55: 433-464.

- Gruber (1994) found that mandated coverage for comprehensive mental health may depress coverage by about 2 to 3 percent, and mandated coverage for alcoholism treatment may reduce offer by about 12 percent. But mandated coverage for drug abuse treatment was found to have no impact on coverage (Marsteller et al. 1998).[4]

- The only study that attempted to introduce a measure of the cost of mandates found negligible impacts on coverage (Gruber 1994).

Actuarial analyses of mandates have reached a similar about the impact of mandates at the margin, although they may add significant cost compared to a "bare bones" insurance plan. For example:

- In its mandated evaluation conducted for Maryland in 2004, Wm. M. Mercer, Inc. concluded that all Maryland's 40 current mandates represented about 15% of the cost of small group and individual premiums combined, but only 1.6% at the margin, compared to self-funded employer plans.[5] On a full cost basis, the most expensive mandates were mental illness and substance abuse (4.9% of premium for insured plans) and hospitalization benefits for childbirth and length of stay for mothers of newborns (3.1% of premium). On a marginal cost basis, the only mandate that the vast majority of employers with self-funded plans did not cover was coverage for *in vitro* fertilization (almost 1% of premium).

The general conclusion from the literature and actuarial analyses is that relief from mandates would, on the whole, have relatively little impact on premiums and, therefore, little impact on coverage—unless multiple major benefits (for example, mental illness, maternity, and prescription drugs) were omitted entirely from coverage. But omission of major benefits both reduces the appeal of coverage and can cause adverse selection into public insurance plans. In the 11 states that have authorized sale of "bare bones" policies, they have not sold well and have made no significant difference in rates of coverage.[6] Minnesota experienced significant adverse selection into MinnesotaCare, as private insurance without key benefits (such as maternity and mental health care) proliferated. MinnesotaCare was forced to eliminate buy-in participation because individual insurance plans often did not cover these benefits.

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[4] Marsteller, J.A., L.M. Nichols, et al. (1998), "Variations in the Uninsured: State and County Level Analyses." Washington, DC: Urban Institute.

[5] Maryland Health Care Commission (January 15, 2004), Study of Mandated Health Insurance Services: A Comparative Evaluation (http://www.statecoverage.net/statereports/multi32.pdf).

[6] Friedenzohn, I. (July 2004), Limited-Benefit Policies: Public and Private-Sector Experiences. State Coverage Initiatives Issue Brief, Vol V, No. 1. Washington, DC: AcademyHealth (http://statecoverage.net/pdf/ issuebrief 704.pdf).

2. Each state has at its disposal many tools to regulate its health insurance market. Certainly some of those can make it easier on small businesses to obtain coverage while others make it more difficult. What insurance regulations make it more difficult for small businesses to obtain health care coverage?

In general, small employers are more likely to offer coverage when the total cost of the proposition is low—including premiums, search costs, and administration of the plan. While the level of premiums is, of course, an important factor in an employer's decision to offer coverage, premium volatility substantially increases employers' costs associated with searching for coverage and administering the plan.

Insurance regulators walk a line between enacting regulation that may increase the level of premiums for some but would reduce premium volatility. Of all small-group regulations in force, only one—guaranteed issue—has been shown convincingly in the research literature to *reduce* small-group coverage, regardless of the accompanying rate regulation. This is presumably because of the increase in average premiums that results from accepting high-cost small groups, regardless of whether (or how narrowly) rating may be constrained. The most sophisticated (and empirically valid) research studies that have investigated the impacts of other forms of regulation on coverage have found very small effects, if any.[7]

On the basis of the research evidence, most researchers—and many state policy makers—have concluded that significant subsidies would be required, if premiums were to be reduced to a level that would significantly increase coverage. In the states that have initiated significant subsidy programs—Maine and New York—the programs rely heavily on stable and inclusive private markets to control adverse selection into the subsidized products.

3. 80% of the uninsured do work. However, almost 30% of those only work part-time. Do you believe that there is any proposal out there that would make it easier to cover part-time workers?

The challenge of covering part-time workers relates not only to the cost of coverage relative to their total compensation from any one employer, but also to a greater risk of adverse selection when the employer contribution is scaled to the hours that they work. Proposals that would make it easier to cover part-time workers must address both problems.

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[7] For example, T. C. Buchmueller and J. DiNardo (2002), "Did Community Rating Induce an Adverse Selection Death Spiral? Evidence from New York, Pennsylvania, and Connecticut." *American Economic Review* 92(1): 280-294; and A. C. Monheit and B. Schone (2004), "How Has Small Group Reform Affected Employee Health Insurance Coverage?" *Journal of Public Economics* 88(1-2): 237-254.

Two ideas for improving coverage for part-time workers seem to offer the greatest promise:

- Healthy New York (HNY) covers low-wage small groups as well as sole proprietors and individual workers below 250% FPL (including those who work part-time), if they are not offered employer coverage with a significant contribution. HNY is a reinsurance program: it compensates primary insurers for 90% of the cost of each enrollee's covered medical expenses between $5,000 and $75,000 per year. *Thus, HNY addresses insurers' concerns about adverse selection* from either full-time or part-time workers. In 2005, HNY covered 29 percent of the medical costs of enrolled sole proprietors and individual workers, and 26 percent of the cost of enrolled small groups.[8]

- During its reform efforts approximately a decade ago, Washington State considered developing a state-operated "benefits depository" to assist part-time workers by "banking" contributions to coverage from multiple employers. This idea ultimately slipped from Washington's agenda, but it continues to be of interest in some states. In practice, it would consolidate multiple employer contributions that could be scaled to hours worked and also function as a purchasing unit for coverage. This kind of program could be combined with HNY-style reinsurance to reduce the cost of coverage and address likely adverse selection.

4. My colleague from Montana raised concerns about SBHPs interfering with the Massachusetts effort to expand coverage to everyone in the state. Are these approaches necessarily exclusive? Why couldn't we pass a bill that gave states the option of an SBHP or going into the SEHBP as outlined in the Durbin-Lincoln bill?

The issue with S. 1955 is both the creation of SBHPs and the deregulation of health insurance that would support them. S. 1955 would allow SBHPs to have their claims experience segregated from the rest of the small group market. If SBHPs succeed in attracting employers with a healthy workforce, prices in the market outside the SBHP would increase making it harder for others to afford coverage in the state-regulated market. Ironically, it was the development of unregulated multiple-employer trusts (METs) in the late 1970s that ushered in the era of very aggressive rating by commercial insurers, to which many states responded by limiting or prohibiting rating on health status and other factors.[9]

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[8] Most members subscribing to Healthy NY under an individual policy pay between $125 and $200 per month for insurance. EP&P Consulting, Inc. (December 31, 2005), Report on the Healthy NY Program 2005, prepared for the State of New York Insurance Department (http://www.ins.state.ny.us/website2/hny/reports/hny2005.pdf).

[9] In the late 1970s (following ERISA's preemption in 1974 of state regulation with respect to employer plans), METs without insurance regulatory oversight developed quickly throughout the country. Insurers saw their small-group market share eroding fast to these unregulated third-party administered (TPA) arrangements, and responded

S. 1955 would also deregulate the rest of the market. At present, nearly all states limit the extent to which insurers may vary small-group rates to reflect health status, and 12 prohibit the use of health status altogether in setting small group premiums. S. 1955 would preempt those rules, and open the market to the volatility that occurs with health rating, in addition to rating on a number of other factors.

While authorizing *both* SBHPs and the SEHBP option in the same markets would be a formula for adverse selection into SEHBP, it might be feasible, as you suggest, to offer states the choice *between* the options. In this case, a state's small-group rules presumably would be preempted only if it did *not* elect the SEHBP option.

It would be important to consider, however, whether states would have a one-time choice, or they could later change their selection. In the latter case, states with the worst experience with SBHPs—those in which higher-cost groups were expelled systematically from the market by aggressive rating—would be the most likely to revert to the SEHBP option, with obvious implications for adverse selection into SEHBP. Various measures could be used to address this problem—for example, as a condition of SEHBP participation, states would require modified community rating (such as SEHBP likely would use) at least one year prior to participating.

5. **The most recent version of the Durbin-Lincoln bill (S. 2510) requires national plans under the SEHBP to conform to all state mandates. That means they either need to have a different plan in every state or a national MEGA plan would somehow have to meet all 50 states' mandates. Is that plausible and how does that structure lower costs for small businesses? How is that different than today's regulatory environment?**

This provision is the same that now applies to FEHBP plans: in every state, FEHBP plans meet all state mandates. As indicated in my response to question #1, these regulations impose relatively little cost on health insurance plans at the margin (relative to large employer plans). And though they can be costly relative to having no coverage of a specific service or diagnosis, specific exclusions can impose significant costs on public programs, uncompensated costs on providers, and adverse impacts on individual health status.

It might be possible to identify a subset of mandates that are both costly and relatively unusual in large group plans (such as *in vitro* fertilization, identified in the Mercer report to Maryland mentioned earlier), and target those benefits for review and possible exclusion. In effect, such a process would zero-base all state

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(continued)

by developing aggressive rating to retain the low-risk groups that the TPA arrangements were systematically selecting. In practice, at least a third of the small-group market prior to that time was written on a "franchise individual" basis, in effect using community rates with no re-underwriting at renewal.

mandates, and then reconsider them on an individual basis. The requirements governing legislative consideration of mandates in California (that is, formal evaluation by the nonpartisan California Health Benefits Review Board) could offer a model for this kind of process.

Senator Baucus

1. **How does forcing the small group market to hold and retain risk through tighter rating requirements help lower the public burden for Medicaid and CHIP? Are there any examples of cost impact that you can provide from states' experience?**

   Many Medicaid and SCHIP programs set eligibility levels so low that very few worker families (other than TANF families) can qualify. Moreover, families and individuals eligible for these programs often enroll only at the time they need health care. Therefore, to understand whether states with more inclusive health insurance markets have less adverse selection in Medicaid and SCHIP would require a clear picture of the health status of those eligible but not enrolled in the program. I am unaware of any research study that has investigated this question—and indeed, analytically it would be very difficult to do so: states with greater eligibility for Medicaid (likely to improve the distribution of risk in the program, all else being equal) are in general also more likely to regulate private insurance to improve access for high-cost groups and individuals. Nevertheless, anecdotal evidence suggests that inclusive private insurance markets are important in states that have attempted to bridge the significant gap between public program eligibility and financial access to private insurance.

   New York and Maine offer the clearest examples of states that have been able to expand Medicaid and CHIP coverage and also offer subsidized private coverage without experiencing unusual adverse selection. Other states that are considering programs like those in New York and Maine generally believe that, having forced the private market to accept and retain risk, regulation of insurance in these states is probably an important component of the programs' relatively low cost experience.

   - New York covers children and pregnant women to 200% FPL, parents to 150% FPL and childless adults to 100% FPL. Healthy New York (HNY) offers subsidized private insurance not only to low-wage small groups, but also to individual workers (sole proprietors or otherwise) below 250% FPL. Since HNY was implemented, the program has lowered its reinsurance corridor (increasing the subsidy to coverage) several times in order to spend the funding that was allotted—and premised on standard adverse risk selection into the program. The program's cost experience suggests that insurers in New York—required to guarantee issue and use pure community rating in both the small group and individual markets—are holding and retaining more risk than average. It follows that HNY is able to serve more people than it otherwise could, if the private market accepted and held less risk.

- Similar to New York, Maine's combined Medicaid and SCHIP programs—called MaineCare—covers children and their parents to 200% FPL, and adults without children to 125% FPL. Maine requires private insurers to guarantee issue in both the small group and individual markets, and also to community rate. Insurers may vary premiums by age and group size (as well as industry, smoking status, and wellness programs) in the small group market, and by age in the individual market.

  In January 2005, Maine's DirigoChoice program was opened. The program offers comprehensive insurance to all small groups and individuals, and subsidizes premiums and cost sharing for enrollees below 300% FPL. By December 2005, the program had served 8,676 members and had 7,436 currently enrolled—including 740 small groups. Anthem Blue Cross and Blue Shield underwrites the DirigoChoice products and sets premiums based on experience in its own book of business. However, as of January 2006, experience in DirigoChoice has been as good or better than that in Anthem's other insurance products. The program's loss ratio for claims incurred January through August and paid through October 2005 was 73.2% (78.4% for individuals and sole proprietors and 64.5% for small groups).

2. **What was the effect of a gradual change in the rating requirements for the small group market in Minnesota on cost and access to coverage based on your research? How does the gradual transition to new rating standards provided in S. 1955 compare with Minnesota's experience?**

   In 2001, Minnesota began a series of regulatory changes in the small group market that have limited regulatory oversight of health insurance rates and also generally eased rating rules.[10] With respect to oversight of health insurance rates, S. 1955 would reduce the states' regulatory oversight well below that which even now occurs in Minnesota. The timeframe for state reviews of rates and forms is to be determined by a commission, but in states that do not adopt federal rules, the states will have just 30 days notice that an insurer is introducing a federal policy in that state, and would have no authority to act on that submission.

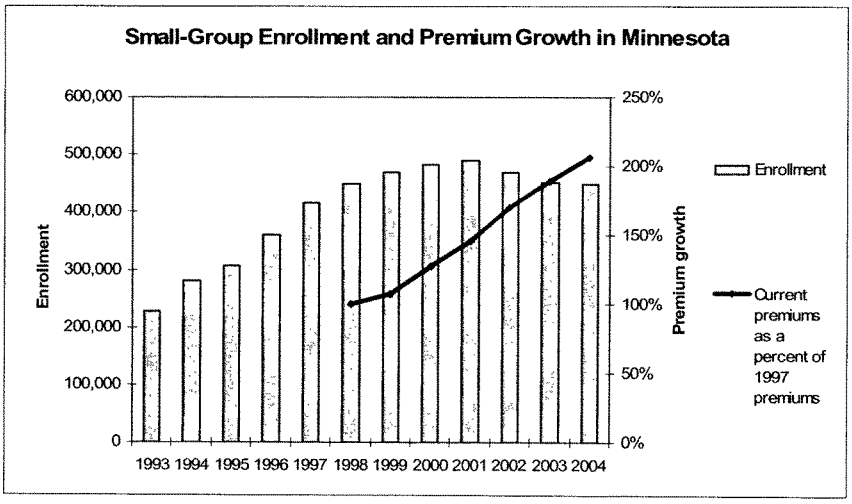
   The new federal rules also would permit much wider rate variation on a number of factors (such as health status) than is permitted in Minnesota, as well as variation of factors that are not now permitted (such as gender). S. 1955 would permit rate adjustments irrespective of insurer loss ratios; Minnesota and other

[10] Minnesota permits insurers to use health status to rate coverage; to account for both health status and industry or occupation, rates may vary ±25%. However, since 2003, companies may change rates and use the new rates as soon as they are filed; any rates not approved within 60 days are deemed approved. In addition, since 2001, Minnesota has generally reduced the minimum loss ratio required of Minnesota carriers, so that they may return less benefit to policyholders in the form of paid claims as a percent of premiums. Finally, Minnesota eliminated its requirements that limited insurer surplus to 3 months of claims for HMOs and 4 months for BCBS plans.

states with rate approval generally allow rate increases only if insurers meet a statutory minimum loss ratio.

Other provisions in S. 1955 make it difficult for states to enforce federal rating (or any other) health insurance standards. S. 1955 gives exclusive jurisdiction over federal standards to federal courts; and it gives insurers the right to sue state regulators in federal court if they disagree with the way states enforce federal standards.

No analysis of Minnesota's experience since loosening rate oversight and standards has been conducted. However, since 2001, small group premiums in Minnesota have accelerated, insurers' loss ratios have declined (i.e., their revenue margins have increased), and coverage has declined. In 2004, fewer Minnesotans were covered in small group policies than were insured in 2001. This pattern is starkly atypical of Minnesota's prior experience (see the Figure below). It has put the state squarely in line with the national trend of eroding coverage, whereas coverage in Minnesota had increased during the 1990s (with stronger oversight and regulation of small group premiums) much faster than the national average.



Source: Minnesota Department of Health, Health Economics Program.

S. 1955 allows for a transition, in consultation with the NAIC, over a 5-year period. During this period, the states will adopt yet-unspecified rules to transition to the new (and for many states, significantly looser) rating rules; "old" small group business will be transitioned over a period to be established in consultation with the NAIC and representatives of unspecified small-group insurers.

Both logic and the experience in Minnesota suggest that the timeline for transition will not mitigate the ultimate effects of the change in regulation in those states that now have stronger oversight and regulation of small-group health insurance premiums. That is, many small groups would see premium increases—and in states that require insurers to meet a minimum loss ratio or maximum surplus level, *all* could small groups could see rate increases well above medical trend. In states that now regulate premiums to achieve greater premium stability, all small groups would be subject to greater premium volatility. Moreover, small employers in all states would confront greater risk of their insurance carrier exiting the market—especially during the first two years after enactment, when insurers that exit the market are allowed to reenter in 180 days.[11] This scenario suggests that small employers' total cost of offering coverage—including premiums, search costs, and administrative costs—would increase, and (all else being equal) it is very possible that small-group coverage would decline quickly, not increase.

3. **New York appears to have had a positive experience using reinsurance for the small group market. Do you think reinsurance can be applied from the federal level for a positive effect?**

New York's experience with reinsurance has indeed been positive: reinsurance has reduced premiums as much as 40 percent relative to market rates. Moreover, the program has achieved significant rate stability: major carriers, such as Empire BCBS actually reduced HNY premiums in 2005 relative to 2004 levels; Excellus Health Plan charged the same premiums in 2005 as in 2004. These two plans accounted for 25 percent of HNY enrollment in December 2005.[12]

A federal reinsurance program could be developed, and it probably would achieve the same excellent results as New York's program—if it operated on a similar regulatory basis. That is, regulation of premiums in the larger market would need to be regulated to eliminate or tightly narrow use of health status, claims experience, or duration in setting premiums. Without such constraints on regulation, adverse selection into reinsured products could increase the public cost of the reinsurance program to levels that may not be sustainable. Alternatively, a federal reinsurance program could be designed explicitly to absorb adverse selection. But even in this case, regulation of private insurer rates would be indicated, in order to ensure that market rates for all other products are held in line with medical cost. Historically, New York regulators have reviewed and approved HNY rates in light of participating plans' medical loss ratios.

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[11] The Health Insurance Portability and Accountability Act (HIPAA) currently requires that insurers exiting the market (and shedding risk associated with guaranteed issue) may not reenter for 5 years.

[12] EP&P Consulting, Inc. (December 31, 2005), Report on the Healthy NY Program 2005, prepared for the State of New York Insurance Department (http://www.ins.state.ny.us/website2/hny/reports/hny2005.pdf), p. ii.

In short, a federal reinsurance program would be feasible in principle, and most Americans may prefer a system of indirect subsidies (via reinsurance) to support private insurance market, in lieu of significantly expanding conventional public coverage (such as Medicaid and SCHIP). However, a federal reinsurance program would need to establish rules in participating states for the private market that it supports, to encourage the market to accept and retain significant risk and ensure that the public receives a fair reduction in premiums for public funds expended.

Statement of Senator Jim DeMint of South Carolina
Senate Finance Committee
Small Business Healthcare Hearing
Thursday, April 6, 2006

I'd like to thank the Chairman and Ranking Member for holding a hearing on this important issue.

The difficulty small businesses have providing healthcare to their employees has always been an important concern to me. Before I ran for Congress, I was a small business owner myself, and experienced personally how difficult, expensive, and – at times impossible – it is for small business owners to offer healthcare to their employees.

It's no secret that healthcare costs have exploded and are continuing to rise. While I believe that the current employer-based healthcare system has done a relatively good job with meeting the needs of workers and businesses alike, skyrocketing healthcare costs strain businesses that provide health insurance to their employees. The higher the cost of health insurance goes, the more employers will be forced to increase payroll deductions or to drop coverage altogether.

Health Savings Accounts (HSAs) have been the critical first step down the long road to bringing down the cost of providing healthcare in America.

Americans spend $1.7 trillion annually on healthcare. That money is primarily spent by large employers through full-coverage health insurance plans. HSAs have been able to redirect control of healthcare dollars to individuals. Even if a business contributes to an employee's HSA, the individual makes the decision about how and where to spend that money. Primarily, the accounts have empowered patients to be more cost conscious and sensible in their use of medical services, thus helping to reign-in out of control healthcare costs. Furthermore, HSAs create a new dynamic where healthcare providers compete to earn individuals' business.

When HSAs took effect January 1, 2004, consumers were ready. Since their introduction, millions of individuals and thousands of small businesses have found relief from soaring healthcare costs through these tax-free savings accounts.

HSAs are already providing more Americans with access to affordable healthcare. Critics claimed HSAs would appeal to only the young, healthy, and wealthy. But, so far, the demographics of those opting for HSAs tell a different story. The average HSA owner is 47 years old with one or more children. Almost a quarter of all HSA purchasers have incomes below $35,000, and more than one-third of those individuals and families were previously uninsured. And 18 percent of all HSA purchasers have at least one pre-existing health condition. There are, however, ways to broaden HSAs' reach.

Yesterday, I introduced legislation that would further expand the use of HSAs. The Health Savings Account Affordability Act (S. 2549) allows for the use of health savings accounts for the payment of high-deductible health insurance premiums.

Under current law, individuals can use their HSAs to pay for out-of-pocket expenses, but they are unable to use them to buy insurance. My legislation would allow small business owners across the nation to provide tax-free contributions to their employees that could be used to purchase health insurance that is affordable, flexible, and portable. This would help level the playing field for those who currently do not have access to employer healthcare plans, including the self-employed, unemployed, and workers for companies that don't offer health insurance.

Americans should be able to take their health insurance with them when they change jobs, move, become self-employed, or leave the labor force. Americans should not have to worry about changing doctors, learning a new insurance bureaucracy, having their premiums go up if a family member is sick, losing their insurance tax advantage when leaving employment-based plans, or being subject to more costly mandates. The lack of portability can lead to "job lock" in which workers are hesitant to leave their job if anyone in the family is in less-than perfect health.

Since I came to Congress, I have fought against any move to a government-run healthcare system as a means to solving our healthcare woes. I am especially opposed to making millions of small business employees dependent on the federal government for their healthcare. According to a proposal (S.637) sponsored by U.S. Senator Dick Durbin (D-Illinois), small businesses could pool together as part of a government-run healthcare program to offer health coverage to their employees. The program, which is estimated to cost $73 billion over the next 10 years, would be paid for by American taxpayers though subsidies in the form of tax credits for employers.

Aside from the obvious problem that this would create an enormous tax increase for the American people, the Durbin proposal – if adopted – would eliminate competition in the healthcare market and prevent Americans from accessing the health benefits they truly need.

Proponents of the Durbin proposal argue that it would be similar to current health insurance program for federal employees. However, the proposed model is completely different from the federal employee program, which has a fixed pool that is known and can be properly rated. The pool envisioned by the Durbin bill is an open, voluntary pool that is completely unknown to the Office of Personnel Management, which would be required to regulate the program.

We need to stop relying on the federal government to answer our healthcare problems. It is through government regulations, price fixing and complex billing codes, that the federal government is controlling and undermining the delivery of healthcare in America.

One concept is Chairman Enzi's bipartisan proposal for Small Business Health Plans. This bill would allow small business owners to band together across state lines to purchase health insurance options for their employees.

A recent study found that the Enzi/Nelson proposal would reduce employer premiums by 12 percent and will reduce the number of uninsured Americans by 1 million.

These are important statistics and a good step in the right direction toward the goal of ensuring that every American has a personal health insurance policy.

The Durbin proposal undermines that goal by turning healthcare decisions over to Washington bureaucrats, instead of allowing American consumers to select the plan that best fits their needs.

But while the Enzi/Nelson bill would reduce the uninsured by 1 million, we need to look beyond small business solutions to address the other 44 million uninsured.

Last year, I introduced the Health Care Choice Act, a bill that would help Americans afford health insurance by allowing individuals to shop for health insurance the same way they do for other insurance products – online, by mail, over the phone, or in consultation with an insurance agent in their hometown. The Health Care Choice Act empowers consumers by giving them the ability to purchase an affordable health insurance policy with a range of options.

Consumers would no longer be limited to picking only those policies that meet their state's regulations and mandated benefits. Instead, they would be able to examine the wide array of insurance policies qualified in one state and offered for sale in multiple states.

Consumers should be able to choose a policy that best suits their needs, and their budget, without regard to state boundaries. The Health Care Choice Act would allow individuals looking for basic health insurance coverage to choose a low-cost policy with few benefit mandates. On the other hand, consumers with an interest in a particular benefit, such as infertility treatments, would be able to purchase a policy which includes that benefit.

The Health Care Choice Act would help the uninsured find affordable health insurance, while providing Americans with more and better health insurance choices. This concept harnesses the power of the marketplace to allow Americans to tailor their insurance choices to their individual needs.

For nearly 15 years, Congress has been debating health insurance affordability. The time has come for the Senate to *pass* reforms that work to the overall goal of reducing the uninsured. The time to act is NOW.

Thank you.

Small Business Health Insurance Hearing
Senate Finance Committee
Senator Richard J. Durbin Testimony
April 6, 2006

Everywhere I go in Illinois, the number-one concern I hear from business owners – large and small – is the high cost of health care.

No matter how hard they work, or what kinds of innovations they develop, much of their revenue is consumed by ever-increasing health insurance costs. Rising premiums are even making it difficult to hire new workers or purchase new equipment.

According to the U.S. Agency for Healthcare Research and Quality, Americans with employer-sponsored health insurance paid 79% more for coverage in 2003 than in 1996.

Hewitt Associates, a respected human resources consulting group, conducted a survey of insurers rates last August and found that even HMO premiums for 2006 rose four times the rate of inflation.

Small businesses are especially hard hit because they don't have the negotiating power of large businesses. The limited number of

people small businesses employ hinders their ability to command discounts, or to access choice in the insurance marketplace.

We all agree that small businesses need relief from double digit annual increases in health insurance premiums.

I believe we agree on some fundamental principles:

1) We should make premiums more affordable by giving small businesses a way to pool their purchasing power;

2) We should encourage competition among health plans on the basis of quality, efficiency and value; and

3) We should help reduce the administrative and transaction costs in the small group market.

Unfortunately, insurance is an extremely complicated field and it is the details that will make or break the effectiveness of a new insurance framework.

There are some key details that need to be addressed in a small business insurance proposal.

Most Important: Do No Harm

Health benefit mandates and rating rules were implemented by states to improve the availability of insurance coverage for small firms and to stabilize a quickly deteriorating small group market. States also wanted to address the discriminatory practices that insurers were using toward small groups.

In our effort to provide small businesses with some relief, we should not undo the progress states have made in protecting insurance consumers. Health insurance isn't much good if it isn't there when you need it.

We also shouldn't deny progress to groups outside of the small group market, which some in the Senate would like to do.

Bottom line: we shouldn't make anyone worse off in this process.

SEHBP

Senator Blanche Lincoln and I have introduced a bill that we believe achieves the twin goals of lowering cost while maintaining adequate oversight and benefits.

The Small Employers Health Benefits Plan is modeled after the

successful federal employees plan, which insures more than eight million federal employees and their families. SEHBP would allow small businesses to band together nationwide and choose from plans that would bid to offer coverage in the pool.

This year, 278 different insurance plans will offer coverage in the FEHBP pool. Imagine if small businesses could have access to those kinds of choices.

Plans participating in SEHBP would be subject to strict regulatory and solvency standards, and would be audited annually by the Office of Personnel Management.

Plans in SEHBP will be required to offer state-mandated benefits.

Finally, small employers would receive an annual tax credit to defray part of the employer contribution for low-income workers.

Senator Lincoln and I believe SEHBP is a common sense approach to lowering health insurance costs for small businesses while affording them adequate consumer protections and I hope the Committee will consider the bill.

Our bill is supported by the American Medical Association, American College of Family Physicians, National Association of Community Health Centers, National Osteopathic Association, American College of Pediatrics, National Mental Health Association, National Association of Women Business Owners, Small Business Majority, Federation of American Hospitals and the American Diabetes Association.

U.S. SENATE COMMITTEE ON
Finance
SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN
http://finance.senate.gov

Opening Statement of Sen. Chuck Grassley
Hearing, "Health Care Coverage for Small Businesses: Challenges and Opportunities"
Thursday, April 6, 2006

According to data from the Congressional Research Service there are about 45 million Americans without health insurance. It was the fourth year in a row that the number of uninsured grew. Here are some other important statistics from the report: Among the nonelderly, although employer coverage fell significantly, increases in public coverage prevented the number of uninsured from jumping significantly. More than half of the nonelderly uninsured were full-time, full-year workers or their family members. Young adults were more likely to be uninsured than any other age group. More than one of three of those who claimed Hispanic ethnicity were uninsured, the highest of the racial/ethnic categories who are uninsured.

These numbers paint a very disturbing picture. They paint a picture of a system that is not working for millions of Americans. As the CRS report notes, as more employers drop health care coverage, public programs end up covering more Americans. This is not good for businesses and it is not good for taxpayers. Given the cost pressures faced by the federal and state governments in paying for these programs, we ought to be asking if there are more efficient ways of encouraging employers to provide coverage than simply allowing government to take over.

Today's hearing is one of a series of hearings I intend to hold in an effort to examine the problem of the uninsured in America. The first hearing on March 8 focused on health care and the tax code. The hearing today focuses on the challenges faced by small businesses in America in their efforts to find and provide affordable health care coverage. The vast majority of American workers get health care through their employer. We encourage employers to provide that coverage through a tax deduction. While most employers do, the fact remains that for many employers that is not enough of an incentive. The majority of Americans who were uninsured in 2004 were full-time, full-year workers. Another 30 percent worked at least part-time. So 80 percent of the uninsured had some connection to the workforce. Our system is a voluntary system. We don't require employers to offer coverage. We don't require employees to accept coverage.

Some people say that our current problem is a reason to consider moving to a mandatory coverage system. I think we need to understand why the current incentives are not working. I also want to better understand what differentiates large and small businesses in the provision of health care. Is it really just as simple as health care coverage for 1,000 employees is cheaper than for 10 employees or is the answer much more complex? I am looking forward to hearing our witnesses explain why it is more complex.

Finally, the regulatory regime for health care coverage is most assuredly complex. There is both federal and state regulation of health insurance. What regulations increase the burden on small business to the point that they choose not to offer health care coverage? What regulations impede the marketplace from working? I certainly hope our witnesses today can help us understand the challenges faced by small businesses in covering the uninsured and suggest opportunities for us to improve the environment for small businesses. I also appreciate the time our distinguished colleagues are taking out of their schedules to talk about their proposals. Senator Durbin and Senator Lincoln have a proposal that combines an FEHBP-style proposal with a tax incentive. Senator DeMint has a proposal that would allow individuals greater access to health care coverage by allowing policies to be sold across state lines. We have some very useful testimony to look forward to, so let's begin.

U.S. Senator Blanche Lincoln
Senate Finance Committee Hearing:
"Health Care Coverage for Small Businesses: Challenges and Opportunities"

Thank you, Mr. Chairman, for holding this hearing today on the challenges and opportunities concerning health care coverage for small businesses and particularly the legislation I have introduced to address this problem. I am especially grateful to you for granting my request for a hearing on a topic that affects every community in our nation as well as millions of working families.

The small business health care crisis is undoubtedly the #1 issue I hear about when I am traveling in Arkansas, and I have been working hard on a solution. Two years ago, I introduced legislation with Senator Durbin called the Small Employers Health Benefits Program Act, which is based on a model all of us in this room are familiar with – the Federal Employees Health Benefits Program, or FEHBP.

Our legislation (S. 2510) has been endorsed by many groups, including the National Association of Women Business Owners, the Small Business Majority, the Consumers Union, the American Diabetes Association, the National Mental Health Association, the American Medical Society, and many more.

I believe our bill takes a moderate and balanced approach that combines the best of what government can do with the best of what the private sector can do, while preserving important state laws that protect consumers.

Like the federal plan, our program does not promote government-run health care, but harnesses the power of market competition to bring down health insurance costs, using a *proven government negotiator.*

By pooling small businesses across America into one risk and purchasing pool similar to FEHBP, our new SEHBP program will allow employers to reap the benefits of *group purchasing power* and *streamlined administrative costs,* as well as access to more *plan choices.*

This hearing is an excellent opportunity to discuss the various proposals to help small businesses purchase quality health insurance for their employees and help more working families become insured.

There are now nearly 46 million Americans currently without health insurance, including 456,000 Arkansans. Small businesses are the number one source for jobs in Arkansas, yet only 26 percent of businesses with fewer than 50 employees offer health insurance coverage. Workers at these businesses are most likely to be uninsured.

In fact, 20 percent of the working-aged adults are uninsured in Arkansas. Those who lack health insurance do not get access to timely and appropriate health care. They have less access to

important screenings, state-of-the art technology, and prescription drugs. Working families need help. The Institute of Medicine has reported that 18,000 people die each year because they are uninsured. The fact is, being insured matters.

Low-wage workers in small businesses are significantly more likely to be uninsured than high-wage workers, and firms with a high proportion of low-wage workers are much less likely to offer insurance. Our bill contains tax credits targeted to the firms and employees who need the most incentive to purchase health insurance coverage.

I think that while the main proposals we will discuss today may differ, our goals are the same: we want to help small employers offer health insurance to their employees. Doing so has a positive impact on recruitment, retention, employee attitude, company performance, health status, and the overall success of the business. Small employers are the backbone of our local economies. If they thrive and the working families associated with those businesses stay healthy, so do the communities that surround them.

Small businesses want more affordable health care, and their employees deserve coverage that is worth something. Even if you feel like you are young and invincible, you may be only one car accident or one diagnosis away from needing comprehensive health insurance for the rest of your life.

I am concerned that the other proposal we will consider today allows health insurance companies to preempt state benefit, service, and provider mandates that states have passed to protect consumers. The 19 health benefit mandates and the nine health care provider mandates in Arkansas make the insurance sold in our state meaningful. Mandates like coverage for maternity care and newborn coverage, diabetes supplies, children's preventative health care, and mental health disorders would all be preempted under S. 1955, and benefit package design would be left up to the health insurers.

This troubles me, because I think that many older, sicker people, especially those with chronic diseases, will be left behind with unaffordable coverage or a plan that fails to meet their needs. I just don't think that insurers will cover certain benefits if not required to. For example, the American Diabetes Association surveyed large and small health insurance plans in Ohio (one of the four states without a law mandating coverage) and found that they overwhelmingly do not provide coverage for necessary diabetes medications and supplies.

States, including Arkansas, have taken many steps to ensure that health insurance is meaningful for consumers. We should preserve state's rights while creating new pooling and affordable plan choices for small businesses. My goal is to help small businesses while not jeopardizing the quality of health care for the 68 million Americans in state-regulated group plans and the 16.5 million Americans with individual health insurance coverage.

Thank you again, Mr. Chairman, for holding this hearing today.

STATE OF ARKANSAS
THE ATTORNEY GENERAL
MIKE BEEBE

March 20, 2006

The Honorable Blanche Lincoln
355 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Lincoln:

I strongly urge you to oppose any effort in S. 1955 , known as the Health Insurance Modernization and Affordability Act of 2005, or other similar legislation that seeks to preempt the application of state law to such health-insurance offerings. As currently drafted, it appears that S. 1955 would preempt state insurance regulation, state consumer-protection laws, and potentially other laws, such as Arkansas' Any Willing Provider legislation. While insurers can always be counted on to argue that they should be allowed to escape oversight, there are no legitimate grounds for exempting this type of insurance plan from state laws that provide essential safeguards for persons covered by insurance. A bill, such as this one, which would preempt over 1,000 state laws, certainly warrants the closest possible scrutiny.

I ask you to consider this bill and other comparable legislation closely and, before casting your vote, work to ensure that it will, in fact, lead to more affordable health-care coverage and increase the number of our citizens with adequate health-care coverage, while maintaining the safeguards enacted by state legislators to protect their local citizenry. At the very least, no law should be enacted that dispenses with the important protections provided to consumers by existing state laws.

Thank you for your careful consideration of this very important matter.

Sincerely,

Mike Beebe

MB:jb

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Arkansas Insurance Department

Mike Huckabee
Governor

Julie Benafield Bowman
Commissioner

Wednesday, April 05, 2006

The Honorable Blanche Lincoln
U. S. Senator
355 Dirksen Senate Office Building
Washington, D.C.

Facsimile: 202-228-1371

RE: Health Insurance Marketplace Modernization and Affordability Act of 2006, S. 1955

Dear Senator Lincoln:

Thank you for asking for the Insurance Department's comments on the proposed "Health Insurance Marketplace Modernization and Affordability Act of 2006" ("HIMMAA"). Although I recognize that improvements and concessions have been made in the proposed Act to reduce objections to the bill by the National Association of Insurance Commissioners ("NAIC"), I do have concerns about the impact the proposed law would have in Arkansas on our small group employer market, possibly disturbing a similar program we already have underway for small employers as well as in the delegation of mandate controls from our state legislature to a national board. Although I recognize that the proposed Act points to and requires rulemaking to craft additional regulatory controls on the proposed small business health plan programs, I have concerns about the Act's lack of financial solvency requirements on small business health plan organizations ("SBHPs") and believe that the Act may delegate consumer protection and financial solvency regulation on the SBHPs to the federal government and away from the department and state legislature, both of which have more historical experience in regulating our small group health insurance market than a federal program or national board.

Effect On Arkansas Small Employer Purchasing Group Initiatives And State Mandate Rejection Laws

The base concepts proposed in HIMMAA related to permitting the "banding of small employers" to form a valid group association health plan and the permission of that group to design a flexible health plan not burdened by the expensive costs of state mandates is not new in Arkansas.

Arkansas already permits by law several avenues for the underwriting of association health plans for members, as a group, in an overall general design similar to that proposed under HIMMAA. It was one of the first states to design legislation permitting group health plans to reject state mandated health insurance coverage laws. Carve-outs and rejections of state insurance mandates have been allowed on state regulated group health plans since 2001, through two state legislative acts discussed below.

In 2001, Arkansas passed the "Small Employer Health Purchasing Group Act" ("HIPG"), Ark. Code Ann. §23-86-501 et seq, which permits the formation of a "health insurance purchasing group" to design a group health plan for its members not subject to state mandated health insurance benefits or services.

Arkansas has gone even further to permit the carve-out of state mandated benefits and services from group and individual health insurance polices, regardless of whether the health plan is formed under a HIPG, or under the Health Insurance Consumer Choice Act of 2001, pursuant to §23-79-801 et seq. Finally, legislative bills with proposed health insurance mandates must now be voted on by legislative committees reviewing a proposed bill, with referral to the Arkansas Advisory Commission on Mandated Health Insurance Benefits in Ark. Code Ann. §23-79-901, et seq. The Mandate Commission also annually reviews and reports on the impact of existing state mandates on health insurance plans.

There are interesting similarities between the proposed SBHP plan and Arkansas' HIPG plan, but there are also differences as well. In addition to permitting mandate selection or rejection, both programs attempt to prevent anti-selection by preventing discrimination on health-related status of the incoming member. Both programs operate the health plans through a board of directors or trustees. Both programs prohibit rejection of consumer protection laws. Arkansas' HIPG program however is not subject to the NAIC 1993 rating rules. In order to attract insurers to the program, we have permitted the private marketplace to establish the rates.

While the concept of permitting state mandate rejection on health insurance plans and the concern about the cost impact of mandates on health plans regulated in this state is already in our state law through the above-described programs, admittedly our state programs similar to HIMMAA are in their infancy. It has been our desire to attract small employers into our state programs. Although the proposed Act does not pre-empt existing state programs for small employer purchasing groups, I do have concerns that the proposed bill may act to disrupt or affect the programs we have underway.

To what extent may the department or state legislature provide incentives in benefit design or in rate controls for small employer health insurance, or in its own health insurance purchasing group law, without such actions being viewed as retaliatory to these proposed SBHPs? It is my understanding that HIMMAA permits injunctive relief against the state to the extent that such state laws act to prohibit or punish or retaliate against an insurer from offering coverage consistent with the proposed Act. It has been our experience with the Employee Retirement Income Security Act of 1974 ("ERISA") plans and pre-emption that the state is often unable to pass laws or promulgate rules related to state regulated plans where there exists any remote consequences or "relation" to ERISA qualified plans, even when the state law blatantly excepts ERISA plans.

Lack Of Financial And Market Conduct Standards on SBHPs

I also have concerns about the lack of financial solvency requirements and market conduct requirements imposed on the SBHP organization under HIMMAA. At this time, there appears to be no extensive set of financial solvency requirements on a SBHP, or regular examination requirements, which are as elaborate, regular, and extensive as those we impose on our insurers. Both the state and federal regulator would obviously have implied powers to examine financially troubled SBHPs; however, there needs to be more financial regulation on the SBHP under HIMMAA to ensure that each SBHP is operated in a legal and solvent manner.

As you know, in Arkansas we have been on the forefront in detecting and preventing insurance fraud. In order to continue to protect Arkansas consumers in this area, there needs to be more controls to prevent possible fraudulent activities concerning these plans.

Consumer Protection. Patient Protection Should Be Regulated At The State Level

I also have concerns as the proposed bill relates to the possible diminishment of the state legislature's role in deciding mandate requirements and the insurance regulator's role in regulating patient protection initiatives. My understanding of HIMMAA is that an SBHP plan would be free to provide a health plan to an enrollee in a state without the health plan providing the benefits or services mandated in that state, as long as the person is offered an enhanced policy containing the mandates in state employee health plans in one of the most populated states: California, Texas, New York, Florida, or Illinois. It is my further understanding that the Secretary of Labor is also authorized to establish "Benefit Choice Standards" to implement the benefit options provided or offered. It is my view that the decision of whether to impose in a health plan, a particular mandate should be left with state officials who are more aware of the concerns of the insureds in that state.

Our office has faxed to your office an extensive list of mandates we impose on health plans in this state. Under this proposed federal law, an SBHP would be able to legally provide a health policy to residents of this state, without providing the mandates for coverages or services the state imposes---which are not already federally mandated. I believe it is better for the state insurance regulator or state legislature to decide which mandates may be carved out by health plan programs. I believe that a state regulator is more aware of the particular benefits or coverages that are appropriate for its citizens.

Finally, although we understand that HIMMAA only proposes to pre-empt state rating rules and mandates for SBHPs and preserves state laws governing consumer protection and patient protection laws on SBHPs, I have concerns that the Act is not clear enough in this regard. Frequently, the issue of which services or benefits are mandated overlaps and becomes intertwined with consumer and patient protection issues. In addition, the proposed federal law may in the future eviscerate our role in overall regulation of health plan form filings, claims

handling, grievances, and external appeal regulations developed by the proposed "Harmonization Board." The department and state legislature have worked diligently over the years to develop laws and rules governing health insurance form filings, claims handling, and appeals. We believe we have more experience in deciding what is best for our insurers and consumers in these matters, rather than a national board which has no experience in enforcing or promulgating standards in this particular market.

In closing, despite the concerns I have with the proposed federal bill, I applaud the effort this proposed bill makes in addressing the importance of providing flexibility in small employer health plans in regard to state mandated benefit or service requirements. Expanding underwriting laws to permit associations to band together small employers for the purchase of group health insurance not subject to expensive mandates does not address the major component affecting the affordability of health insurance for small employers; the high cost of medical care imposed on health insurance carriers underwriting such plans. In my opinion, medical costs and utilization must be addressed for a more comprehensive solution to this problem.

Very truly yours,

Julie Benafield Bowman

Julie Benafield Bowman
Arkansas Insurance Commissioner

JBB:msc

TESTIMONY OF

Todd O. McCracken, President

NATIONAL SMALL BUSINESS ASSOCIATION

"Health Care Coverage for Small Businesses: Challenges and Opportunities"

Before the Senate Finance Committee

April 6, 2006

Good morning Chairman Grassley, Ranking Member Baucus, and members of the committee. My name is Todd McCracken, and I am president of the National Small Business Association. NSBA is the nation's oldest nonpartisan small-business advocacy group reaching more than 150,000 small businesses nationwide. I have been with NSBA for the past 18 years working with and for small businesses and myriad state, local and regional small-business groups. I thank you for this opportunity to speak with you today.

You don't need me to quote the national statistics we all know: bottom line, small businesses are being pummeled by the increasing cost of health care. In October 2005, NSBA conducted a survey on health care and found that 51 percent of members said that they are considering making changes to their employee health benefits plan during the next year. Of those, 66 percent are considering decreasing benefits or increasing the employee share of premiums—on top of the ones who have already done so.

I am sure each of you hears, on a daily basis, from small businesses about the need for relief from high health insurance costs. While the need for reform is clearly urgent, and while there are a number of more short-term reforms that can improve on the system, what small businesses deserve is broad, comprehensive reform that will not only address the symptoms of a failing health care system, but cure the underlying sickness.

The Realities of the Insurance Market

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

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

I believe it also is important to note the interplay between the small group and individual insurance markets, particularly in some states. In general, insurers in the individual market are not required to take all comers (at least not those not "continually insured") for all services and are allowed much greater discretion to underwrite and rate policies based on health history and a series of other factors. Individuals also can see their rates skyrocket if they get sick, usually to a much greater degree than in the small group market. In other words, there is far less of a cross subsidy in the individual market than the small group market. That means that relatively young and healthy individuals can get much cheaper insurance in the individual market (at least initially) than they can get through an employer—particularly in states that have community rating in the small group market. In many of our smallest companies (under 10 employees but especially under five), it makes financial sense to increase wages to allow for the purchase of individual coverage. If the workforce becomes sicker, it may make sense to convert to the now-more-reasonably-priced small group market. This dynamic (and others) means that the "moribidity" of the under-ten market is much higher than the group market as a whole. Naturally, insurers often will seek ways to avoid serving an undue share of this market.

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

Solution Principles

Any solution to the problems we all know exist should abide by the following, most important principle - p*rimum non nocere*: first, do no harm. Often, legislation passed has hidden, unintended consequences that can create a larger problem than the bill initially sought to fix. I urge members of this committee to use your keen eye when considering any solution, no matter how incremental or sweeping, to ensure that the fix doesn't unearth an even bigger problem.

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

costs and general level of instability in the insurance market, the ability for a small business to effectively compete for good workers against large companies is exponentially more difficult.

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

The third principle is equity and common sense. While competitiveness does touch on fairness between large and small companies, equity in our mind is a different animal altogether. Any health care solution ought to provide the same benefits to a business owner as they do an employee. Tax benefits should be extended fairly to whichever party is paying for the health insurance, be it employers or individuals. Continually providing tax benefits to companies and employment and not individuals perpetuates the current system where employers are practically forced into providing insurance to their employees.

NSBA's Comprehensive Solution

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

There is no hope of correcting these inequities until 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 coverage; 2) reform the insurance system so no one can be denied coverage and so costs are fairly spread; and 3) institute a system of subsidies, based upon family income, so that everyone can afford coverage.

Individual Responsibility

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

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

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

Incumbent on any requirement to obtain coverage is the need to ensure that appropriate coverage is available to all. A coverage requirement would make insurers less risk averse, making broader insurance reform possible. Insurance standards should limit the ability of insurance companies to charge radically different prices to different populations and should eliminate the ability of insurers to deny or price coverage based upon health conditions, in both the group and individual markets. Further, individuals and families would receive federal financial assistance for health premiums, based upon income. The subsidies would be borne by society-at-large, rather than in the arbitrary way that cost-shifting currently allocates these expenses for those without insurance.

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

Reshaping Incentives

There currently is an open-ended tax exclusion for employer-provided health coverage for both the employer and employee. This tax status has made health insurance preferable to other forms of compensation, leading many Americans to be "over-insured." This over-insurance leads to a lack of consumer behavior, increased utilization of the system, and significant increases in the aggregate

cost of health care. Insurance now frequently covers (on a tax-free basis) non-medically necessary services, which would otherwise be highly responsive to market forces.

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

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

Reducing Costs by Increasing Quality and Accountability

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

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

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

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

On March 8, O'Neill's testimony to this committee cites this as a major cost-driver in the health care market, estimating a 30 to 50 percent decrease in costs if health care providers performed at the top, theoretical limits. Pointing to a pilot project based at Allegheny General Hospital in Pittsburgh,

O'Neill highlighted a 95-percent reduction in a targeted area of infection prevention in less than 90 days, and cited $2 million in savings in the two-and-one-half year period since the project began.

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

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

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

As I stated before, our policy is broad. Five years ago the concept of requiring individuals to carry insurance was a non-starter, but that is no longer the case. As you know, the Massachusetts legislature on Tuesday passed a bill that incorporates some of NSBA's key proposals. That bill would require all Massachusetts residents to carry health insurance with tax penalties on those who do not purchase a plan and are above a certain income level. Another key piece of the legislation is a subsidy for low-income individuals. It is projected that this bill will get approximately 95 percent of Massachusetts' residents covered. Granted, the Massachusetts bill may not be perfect – but it is a start.

Targeted Solutions
While we argue that a comprehensive policy is truly the way to fix the health care market, we also realize that our plan is aggressive and likely would not happen over-night. In the mean-time, NSBA would support a series of more targeted solutions to provide some relief to small businesses and their employees.

Expansion of Health Savings Accounts
Health Savings Accounts (HSAs) are tax-free savings accounts that people can set up when they purchase a high-deductible policy to cover major medical expenses. Money from the HSA can be used to pay for routine medical expenses or saved for future health needs, while the major medical policy helps cover big expenses, like hospital stays. Unlike their predecessors, Medical

Savings Accounts (MSAs), however, HSAs allow for both employer and employee annual contributions and unused funds to rollover. Individuals with an HSA can contribute up to 100 percent of the annual deductible of their health insurance program. HSAs also have lower minimum required deductible and out-of-pocket limits. Perhaps one of the most important changes from MSAs to HSAs is the fact that anyone can participate, and there are no longer restrictive limits on the program.

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

Pool Small Businesses Locally

Though certain national pools can provide increased access to affordable health insurance, it is important that they not have an unfair advantage over local pools. NSBA encourages the development of local employer health care coalitions that would assist small employers in obtaining lower rates for coverage through group purchasing. Such coalitions also would assist small employers in learning about existing local health insurance plan options, how to be a wise health insurance purchaser, the issues of health care costs, health care quality and the availability of health care providers within their communities. Such local employer health care coalitions would continue to be subject to their respective state laws. Therefore, there would continue to be a level playing field for all employers providing insurance in the small employer market. These coalitions already exist in many states, providing choice and savings for their members every day

Reform HRAs and FSAs

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

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

mistakes would be a real benefit to small-business employees struggling to meet their out-of-pocket medical bills. I would like to commend Sen Olympia Snowe for having introduced legislation (S. 2457) just this week, that would, among other things, correct this gaping hole in the availability of "cafeteria plans" to small businesses and their employees.

Create Health Insurance Tax Equity

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

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

Reform the Medical Liability System

The enormous costs of medical liability and the attending malpractice insurance premiums are significant factors pushing health care costs higher and restricting choice and competition for consumers of health care. Triple-digit increases in malpractice premiums over the last five years have been common in many states and specialties.

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

Pay-for-Performance

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

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

Improvements in Technology

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

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

Protect the Small Employer Health Market from Gamesmanship

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

The individual market, however, is generally free of the guaranteed issue requirements enacted by HIPAA. Only those who had other insurance within the previous six months would be free of exclusion. This difference in rules between the individual market and the small group market means that premiums for younger and healthier individuals almost are always lower in the individual market than in the small group market. The opposite is generally true for older and less-healthy individuals: their premiums are less in the small group market than in the individual

market. This dynamic understandably leads some employers to purchase less expensive individual coverage on behalf of their employees, when they can qualify for low rates. When significant illness occurs, the individual premium escalates sharply, and the business will often switch to a small group plan, where they must be accepted and where the premiums will be much lower.

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

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

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

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

Thank you again for this opportunity to testify and I look forward to answering your questions.

Finance Committee Hearing
"Health Care Coverage for Small Businesses: Challenges and Opportunities"
Questions Submitted for the Record
Mr. Todd McCracken

Senator Grassley

1) **It seems to me that a core issue here today is the role state mandates play in making health care coverage for small insurers unaffordable. I note with interest that various versions of the Durbin-Lincoln bill have gone from waving state mandates to applying them to small businesses. How significant are state mandates in making health insurance unaffordable for small businesses?**

According to a report by the Council for Affordable Health Insurance, benefit mandates can lead to increases in cost for insurance plans anywhere between 20 percent in the least mandated state to more than 50 percent in the highest mandated state. Individually, each benefit mandate adds an average of 1 percent to the cost (most cost less than 1 percent, but some can add up to 10 percent for one benefit alone) which, when by itself, is not a significant amount. However, when you look at a state like Minnesota that has 59 mandated benefits, those costs add up. That being said, estimates vary broadly on the actual cost of benefit mandates.

Another important piece to consider is the fact that consumers, given the appropriate level of involvement, aren't likely to purchase "empty" plans. Furthermore, insurers are today offering plans that far exceed what is mandated by state. One of your colleagues, Sen. Enzi, chairman of the Senate Health, Education, Labor and Pensions Committee highlighted a perfect example of this in his opening statement for the April 15th mark-up session, which I've included below:

> "In Cleveland, there's a small business organization called COSE. It's the small business division of the Greater Cleveland Partnership, one of the nation's largest metropolitan chambers of commerce. COSE offers group purchasing programs, including health benefit plans, to its members.
>
> "Of COSE's nearly 17,000 member companies, some 80 percent are enrolled in their health insurance programs. COSE sponsors 19 different health insurance plans, from fully comprehensive to high deductible plans. Members of COSE can even offer their employees up to three different plans. This allows people who work at COSE member companies the opportunity to choose the plan that's right for them, whether it's a basic, affordable plan or an enhanced option. The bottom line is that the employee gets to choose. And COSE offers its members

very comprehensive plans, including a wide variety of benefits and services.
Here's a partial listing:
An annual physical, including laboratory tests
An annual hearing exam
Maternity coverage
Prostate cancer screening
Colorectal cancer screening
Annual tests for cholesterol levels, kidney and liver function, and blood glucose levels
Home health care
Hospice care
Physical and occupational therapy
Speech therapy
Oral contraceptives
Weight loss surgery
A second surgical opinion
Ambulance services
Allergy testing and treatment
An annual flu shot

I'd say that's a generous list of benefits. But NOT ONE of those benefits is mandated by Ohio state law."

As Sen. Enzi so eloquently noted benefit mandates are not the primary pressure behind why insurers offer benefits: consumers are.

2) **Each state has at its disposal many tools to regulate its health insurance market. Certainly some of those can make it easier on small businesses to obtain coverage while others make it more difficult. What insurance regulations make it more difficult for small businesses to obtain health care coverage? Any of you may answer that as well.**

It is important to note that the very nature of how health insurance works and the characteristics of a small business are the driving factor in why it is so expensive for small businesses. Consider a business with only 4 employees with an average age of 25. In one year, one staff change could bump that age to 45 which would automatically mean a significant increase. Because small businesses don't have hundreds or thousands of staff members to maintain a relatively static age average, they are at a disadvantage.

While not necessarily a regulation (yet), the general sentiment of the public is that health-insurance delivery is a function of employers. Not it "should be" or "shouldn't be", it just is. Because that onus is on the employer, his or her competitiveness is negatively impacted if they happen to be a small employer. The absence of individual responsibility and consumerism in health care

perpetuates the problem small businesses face in getting the most qualified workers.

3) **80% of the uninsured do work. However, almost 30% of those only work part-time. Do you believe that there is any proposal out there that would make it easier to cover part-time workers?**

During the hearing, we all talked about the new Massachusetts health care bill. While I certainly wouldn't call it perfect, it is a significant step in the right direction, and something we all ought to pay close attention to. NSBA would argue that when you put the responsibility on the individual to purchase health insurance, the market will respond to their needs and wants. By moving the health insurance policy into the hands of the individual, you increase significantly the portability of a plan and reduce the amounts of time between employers when a person is uninsured.

Another good way to address part-time workers is through Health Savings Accounts. Offering individuals the ability to save their own money and deduct health care costs as an individual is a great way to provide some type of insurance to those currently uninsured.

4) **My colleague from Montana raised concerns about SBHPs interfering with the Massachusetts effort to expand coverage to everyone in the state. Are these approaches necessarily exclusive? Why couldn't we pass a bill that gave states the option of an SBHP or going into the SEHBP as outlined in the Durbin-Lincoln bill?**

I don't believe the Massachusetts legislation would be superseded entirely by S. 1955. Cost-sharing/payer language isn't included in the Enzi/Nelson approach so the requirement of every individual to carry health insurance and the tax-subsidies for low-income shouldn't be impacted. The benefits piece and what the Massachusetts low-benefit for younger individuals could be impacted, however, but without having clear regulatory language, it's difficult to pin-down what exactly the potential for preemption would be in S. 1955.

Certainly, there's been a great amount of work put into both the SBHP and SEHBP plans, but NSBA remains convinced that allowing two or more sets of rules will be problematic. Anytime you allow one insurer to operate in a state under a certain set of rules and another insurer to operate under a different set of rules you will get gaming of the market. Insurers make profit by attracting low-risk (healthy) individuals and providing disincentives to high-risk (less healthy) to join their plan. Two sets of rules will exacerbate this no matter how many ways you try to prevent it.

5) **The most recent version of the Durbin-Lincoln bill (S.2510) requires national plans under the SEHBP to conform to all state mandates. That means they either need to have a different plan in every state or a national MEGA plan would somehow have to meet all 50 states' mandates. Is that plausible and how does that structure lower costs for small businesses? How is that different than today's regulatory environment?**

If the insurer chose to operate under every individual states' benefit mandate requirements, there wouldn't be much change. There also wouldn't be any increased competition among insurers and there wouldn't likely be decreased prices for insurance.

However, if the insurer chose, for purpose of ease, to create one mega-plan to offer in all states, it would be very costly. Few, if any insurers would choose this, simply for the fact that if they were operating in a state like Alabama that only has 18 mandated benefits and they were offering 65 under their "MEGA" national plan, they'd attract the less-healthy individuals. The polar opposite of what we know insurers want to do.

Senator Baucus

1) **One of the challenges of considering a cap on the tax exclusion for employer-provided benefits is how to deal with premiums and reimbursement accounts like FSAs and HRAs. How would you structure an exclusion cap? How would the cap interact with accounts?**

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." 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' employees have greater access to health insurance plans than their smaller counterparts, a greater share of their total employee compensation package is exempt from taxation. Further, more small business employees are currently in the individual insurance market, where only those premiums that exceed 7.5% 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. We haven't yet gotten to the level of specificity in determining exactly what that value will be.

Moreover, the tax status of health insurance premiums and actual health care expenses should be comparable, be it FSA, HRA, HSA or a traditional plan. Individuals should be able to chose what kind of plan they want and then that cap would extend to all types of insurance and/or health insurance savings mechanisms.

2) **Do you envision including a certain amount of medical reimbursement from an FSA or HRA? Or would you propose a separate cap for premiums and for out-of-pocket expenses or through an account?**

Basing our policy on individual empowerment, our vision is that these employer-based accounts wouldn't be necessary because the individual would be allowed to get the tax-preferences in health care costs regardless of the employer-based account.

3) **S. 1955 treats the self-employed differently than other small groups, requiring SBHPs to apply state rating requirements in enrolling the self-employed and barring guaranteed issue requirements unless the state requires it. What is the rationale for these different rules? Are there ways to structure a proposal so that the self-employed could be included under the same rules as other small businesses?**

Addressing the self-employed is a difficult problem. Because the self-employed are ultimately viewed as an individual in the eyes of most state laws, it is important that the nuances of the individual market are considered. It could create significant adverse selection if individuals were allowed to participate in the group market with the same rating rules as the small businesses. Individuals are the highest-risk group because their health could change at any point and there is no other person in their "group" to off-set the risk. What you'd likely see are self-employed individuals entering into the group-market when less-healthy via their SBHP because the rates are generally more strictly controlled. By requiring the SBHP to rate that self-employed individual under the rules in the individual market, you would eliminate some of that adverse selection.

There are other ways to address this problem, however. In Michigan, for example, self-employed individuals can participate in the group market. Insurers are allowed to incorporate consistent business substantiation rules for those individuals to ensure they are a true small business. Individuals that join the small-group market are assessed an automatic "load" or fee on top of their premium to help prevent some of that risk selection. This is an excellent example of why an individual requirement for carrying insurance is so important to solve these many inequities.

Statement of Len M. Nichols[1]

Director, Health Policy Program
New America Foundation

Before the
United States Senate Committee on Finance

Small Employer Health Insurance: First, Do No Harm, Then, Do the Right Things

April 6, 2006

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[1] I am grateful to Mary Beth Senkewicz and Mila Kofman for elucidation of some of the finer points of the NAIC Model Law of 1993, and to Preethi Guniganti for research assistance.

My name is Len M. Nichols and I am the Director of the Health Policy Program at the New America Foundation, a non-partisan, non-profit public policy research institute with offices in Washington, DC and Sacramento, California. I am honored to have been invited to offer my thoughts as you consider how to make health insurance more affordable for more small employers and their workers, a goal I know every member of this committee shares.

Our health care system is in crisis today, primarily because health care cost growth is pushing health insurance and access to timely health services out of reach for more and more working families. One statistic sums up the trajectory we are on: In 1987, the ratio of family premium to median family income was 7.7%.[2] Today, to purchase a family premium requires a sacrifice of 18% of median family income.[3] Simply put, an increasing fraction of our workforce cannot afford health insurance and access to health care as middle class Americans have come to expect it. This dynamic is neither economically nor politically sustainable, but few are willing to talk about this openly, and I applaud this committee and you in particular, Mr. Chairman, for taking up the challenge of looking for real solutions to the very real problems before us, and in a manner consistent with the time-honored, bi-partisan tradition of the Senate Finance Committee.

The cost problem is particularly acute for small employers, who face three disadvantages relative to large firms: (1) neither they nor the insurers serving them can achieve the administrative economies of scale associated with larger employer groups; (2) they cannot easily spread and pool the costs of high risk workers or family members over a large number of healthy workers; and (3) they have virtually no bargaining power vs. insurers and health providers. Given these disadvantages, and somewhat lower wages on average, it is not surprising that small firms are less likely to offer health insurance, and, as a consequence, workers in small firms are less likely to have access to employer sponsored health insurance, the primary source of coverage in our American system. According to the most recent data from the Medical Expenditure Panel Survey, which is carefully conducted annually by the Agency for Healthcare Research and Quality, only 43% of private establishments with fewer than 50 workers offered health insurance, and only 61.6% of workers in small establishments work for firms that offer health insurance as part of their compensation package. These rates compare with 95% of large establishments and 97% of workers in large firms, respectively.[4]

Since the advantages of group size for purchasing health insurance are so compelling, it is only natural for small firms to seek ways to join together to create opportunities to achieve similar efficiencies for themselves. We have before us two competing visions of how policy can facilitate this achievement; S. 1955 (Enzi-Nelson) and S. 637 (Durbin-Lincoln). These bills both represent significant improvements over the recently and often passed approach popular among the majority in the House (H.R. 525), which would

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[2] In combined employer and employee premium payments. I include the employer share since most economists agree that most employer payments are paid for in reduced wages in the long run.
[3] Author's calculations using Kaiser Family Foundation premium data and median income data from the Census Bureau.
[4] MEPS-IC data tables, downloaded April 1, 2006.

create self-insured Association Health Plans that would be exempt from the many state laws and consumer protections which hold the fragile small group market together. So S. 1955 and S. 637 share similar goals, and while not polar opposites, their key differences do merit serious analysis before final decisions are made.

Much has been written on the general subject of association health plans and subsidized broader purchasing pools, for policy research has long focused on how to enable the small group market to work better for more participants.[5] My testimony today draws upon my own research in this area over the last 13 years, that of others that has been published in the professional literature, and my own interviews and conversations with small group market participants, including my two older brothers who are both small businessmen in Arkansas and Texas, respectively, and who struggle to provide health insurance for their workers like virtually every other small businessperson in America today. I will focus on the implications of key features of S. 1955 and S. 647 that seek to address the three main sources of size advantage in purchasing health insurance: administrative economies of scale, risk pooling, and purchasing power.

Administrative economies of scale

S. 1955 would permit members of associations that have been in existence for 3 years to purchase insurance together through a fully insured Small Business Health Plan. The potential economies of scale, then, would result from similar firms in the same industry or belonging to the same association banding together to purchase insurance. However, as Rick Curtis and Ed Neuschler of the Institute for Health Policy Solutions have written after extensive study of the design and effects of joint purchasing vehicles, merely putting

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[5] A partial list of my publications on this subject include: A. Davidoff, L. Blumberg, and L. Nichols. "State Health Insurance Market Reforms and Access to Insurance for High Risk Employees," *Journal of Health Economics* 24 (2005); L. Nichols, "Improving State Insurance Market Reform: What's Left to Try?" in *State Health Insurance Market Reform: Toward Inclusive and Sustainable Health Insurance Markets.* Alan C. Monheit and Joel C. Cantor, eds. (Routledge Press: New York) 2004; J. Holahan, L. Nichols, L. Blumberg, and Y-C Shen, "A New Approach to Risk Spreading via Coverage-Expansion Subsidies," *American Economic Review* v. 93, #2 (May 2003); L. Blumberg, L. Nichols, and J. Banthin, "Worker Decisions to Purchase Health Insurance," *International Journal of Health Care Finance and Economics*," v. 1 # ¾ (September/December 2001); L. Blumberg and L. Nichols, "The Health Status of Workers Who Decline Employer-Sponsored Insurance," *Health Affairs* 20(6), 2001; L. Nichols, "Policy Options for Filling Gaps in the Health Insurance Coverage of Older Workers and Early Retirees," in *Ensuring Health and Income Security for an Aging Workforce.* P. Budetti, R. Burkhauser, J. Gregory, and H. Hunt, eds. Upjohn Institute: Kalamazoo, MI 2001; L. Nichols and L. Blumberg, "A Different Kind of New Federalism? The Health Insurance Portability and Accountability Act," *Health Affairs* v. 17 # 3 (May/June 1998); L. Nichols and L. Blumberg, "First, Do No Harm: Developing Health Insurance Market Reform Packages," *Health Affairs* v. 15 # 3 (Fall 1996).

firms together in the same plan may do little for the firms' own administrative efficiencies unless the *local* scale of the association's own SBHP enrollment is large enough that enrollment functions can be transferred from the individual firm to the new Plan.[6] SBHPs would likely lower selling costs per enrolled life for insurers offering the SBHP compared to selling to each member of the association individually, at least in the long run after the members understand the benefit package that will be exempt from current state law. These efficiencies could get passed along in lower premiums if enough insurers compete for SBHP business. CBO has, however, long concluded that both these sorts of efficiencies are likely to be non-existent or negligible within Association Health Plan/SBHP type arrangements, especially when compared to potential gains from avoiding state benefit mandate and premium variance restriction regulations,[7] a point I address in the next section on risk pooling.

The administrative scale economies that might ensue were S. 637 to become law are potentially much larger for 3 main reasons. First, the purchasing pool is not limited to members of a long-standing association, but would be open to all employers with fewer than 100 employees. This could easily exceed 40% of the private sector workforce in most locales. Second, the tax-credit subsidies for employers who provide coverage to lower wage workers would attract entry from firms that might otherwise remain indifferent, and this could swell the pool to a very large scale. Third, the S. 637 pool is to be administered by the federal Office of Personnel Management (OPM) which currently oversees the Federal Employees' Health Benefit Plan (FEHBP), and OPM already has in place a highly efficient enrollment, premium collection and health plan selection operation for employees with different agency employers in locations all over the country.

Thus, on the criteria of administrative economies of scale, S. 637 has much more potential and likely positive effects than S. 1955.

Risk Pooling

Two dimensions are most important here: benefit mandates and premium variance restrictions. I discuss each in turn.

Benefit mandates

All states have some mandates; some states have many, and, while controversial, they are also hard to repeal. This last fact implies that there is a substantial constituency that prefers certain kinds of protections and is presumably willing to bear what they see as the relatively small cost these protections impose for the coverage they or their loved ones might need some day. Differences of opinion about the marginal cost imposed on all and

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[6] R. Curtis and E. Neuschler, "Insurance Markets: What Health Insurance Pools Can and Can't Do," Institute for Policy Solutions, for the California Health Care Foundation, November 2005, downloaded from the CHCF website, April 1, 2006.

[7] CBO cost estimate for HR 660, 7/11/2003.

about the likelihood of personally needing certain coverage lead to disagreements about which mandates are most important.

Except for the national plan that would be offered in every state, S. 637 would not change state-specific benefit mandates in or outside the new pool. Thus workers in each state would continue to have products available that reflect their own legislature's judgment about which mandates are "worth it" in their state. The national plan would be selected by OPM as it does now for FEHBP, and thus would likely have a benefit package that was broadly comparable to the benefit packages mandated by most states and competing for business around the country within the national pool. National plan enrollment in FEHBP is driven far more by premium level comparisons with local competitors rather than benefit package differences, which are kept to a manageable minimum actuarial value variation (less than 6%) by OPM's oversight. Presumably OPM would do the same for the national plan in the SEHBP program.

S. 1955 would exempt SBHPs from all state benefit mandates, a long-standing goal of mandate opponents. While this might lower premiums for SBHPs on average roughly 5% from the actuarial value reduction,[8] the larger potential short-run benefit to SBHP premiums would be from favorable selection. In effect, SBHP benefit packages could be reduced in generosity in order to draw association members out of the mandated packages that were previously required to be sold outside the SBHP. This is a well-known and well-documented recipe for favorable selection within the SBHP and adverse selection against more generous packages. This will surely drive premiums down inside the SBHP, at least in the short run, and it will correspondingly drive up premiums for those who try to maintain the old levels of coverage. The market dynamic unleashed could easily result in a race to bare bones benefit packages, since all more generous packages would risk extreme adverse selection and could likely not survive in a competitive marketplace. This may be a goal of the legislation, or an unwelcome surprise an unintended consequence, but much logic and experience would suggest this effect is very likely to occur, and relatively quickly.

S. 1955 has a novel feature that is designed to address concerns about adverse selection outside the SBHPs, and that is a requirement that insurers who offer SBHPs without mandated benefits also offer plans that include all the benefits in at least one plan offered to state employees in one of the five largest states. While the provision is well-intentioned, offering this second product will do nothing to change the selection dynamics that will make the SBHP product more attractive to healthy groups. This "enhanced product" then will prove to be a shadow promise that cannot sustain itself in the face of withering selection effects. In short, it can and will be priced to attract no buyers, and thus will evaporate in practical fact if not in literal truth, since "offering" it is a requirement of remaining in the SEHBP business.

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[8]Congressional Budget Office, "Increasing Small Firm Health Insurance Coverage Through Association Health Plans and Health Marts," January 2000; L. Blumberg, L. Nichols, and D. Liska, "Choosing Employment-Based Health Insurance Arrangements: An Application of the Health Insurance Reform Simulation Model," Final Report, 06571-001-00, Department of Labor, Pension and Welfare Benefits Administration, March 1999; Texas Department of Insurance, www.dti.tx.gov, downloaded 2/1/03.

The continued focus on exemption from benefit mandates is curious, given the amount of scholarship devoted to this issue (see note 7 and the references in those references cited therein), and given the consistency of the analytic literature's conclusion that benefit mandates do not add much to the cost of major medical/comprehensive health insurance policies. Perhaps the methodological arguments and studies about the precise effects of mandates on premiums are too technical to be believed, since the academic research seems to contradict apparent common sense. I understand that reaction. So consider the following. If mandates that increased cost substantially were being added year after year in most states, employer offer rates would be falling over time. The following table shows the best and most precise time series data we have on small employers' offers, and their workers' eligibility and coverage.

Table 1. Small Employer Offer, Eligibility, and Worker Take-up Rates

	1996	**2003**
Percent of small establishments (fewer than 50 workers) that **offer** health insurance to at least some of their workers	41.7%	43.2%
Percent of **workers** in small firms **whose employers' offer** to some workers	62.3%	61.6%
Percent of workers in small firms who are **eligible**, given that their firm offers	82.2%	78.5%
Percent of workers in small firms who **take up** offer, given that they are eligible	81.1%	81.1%
Percent of workers in small firms who are **enrolled**, given that their establishment offers	66.7%	60.7%

Source: AHRQ, MEPS-IC data tables, various years, downloaded April 1, 2006.

These data support two conclusions: (1) small firms are not less likely to offer than they were in the mid-1990s; and (2) the primary reason workers in smaller firms are less likely to be insured by their employers than in 1996 is not a decline in offer OR in worker-take-up, but a reduction in the percentage of workers in offering firms who are eligible. The major point is not that adding benefit mandates does not matter, but that they cannot be the major driver of cost growth and declines in coverage that some advocates of their repeal would have us believe.

Premium variance restrictions

With the possible exception of benefit mandates, no area of insurance market regulation is more contentious and complex than premium rating rules, which vary considerably from state to state and essentially determine the range of premiums which insurers may charge different groups for the same product. This is where the proverbial rubber meets the road in insurance market regulation, because *all* restrictions on premium variance by definition force more risk pooling than an unfettered market would produce. The fundamental question is this: would you rather live in a society with no rules, loose rules, or tight rules on premium variance? Another way of asking this is, how much more than the healthy *should* the sick pay? *Should* questions involve value judgments, and are never easy to answer. There are inherent tradeoffs in any approach, since most of us are healthy most of the time, all of us will get sick and die, some of us will get really sick but survive with expensive chronic conditions for quite a while, and none of us know *a priori* when and with what we will be stricken. Not surprisingly, different people and state legislatures view these inherent tradeoffs differently, and that is why there is so much variation in state regulation of small group health insurance premiums. This variation in regulation reflects our federalist system allowing differences based on local preferences, a tradition as old as the original 13 colonies, and made possible by Congress' decision in 1945 with the McCarran-Ferguson Act to leave regulation of health insurance markets to the states.[9]

Quite a lot of scholarship has addressed these questions since states have provided a veritable laboratory for health insurance market reform experiments since 1991, and researchers love natural experiments as much as they love grant money (well, almost). An excellent set of summaries and syntheses of this literature can be found in the book edited by Alan C. Monheit and Joel Cantor, *State Health Insurance Market Reform: Toward Inclusive and Sustainable Health Insurance Markets.*[10] The bottom line consensus on small group reforms, as stated in my contribution to that volume,[11] is that their effect on overall coverage is statistically unobservable. This may surprise those who had hoped market reforms alone would expand coverage, and it may surprise those who feared that market reforms would ruin private insurance markets forever. But it does not surprise people who really understand and study market reforms, for it is increasingly clear that there were really three specific goals of health insurance market reforms: (1) to make health insurance premiums more stable; (2) to make health insurance markets stable and sustainable in the long run; and (3) to make health insurance more affordable for the sick.

The data in Table 1 above imply that reforms, specifically premium variance restrictions in conjunction with guaranteed issue laws, present in over 45 states prior to HIPAA, have indeed helped make small group health insurance markets more stable in the last seven years, as judged by the statistically identical percentages of firms that offer and workers that still take health insurance when they are eligible. However, nothing in insurance

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[9] Nichols and Blumberg, 1998, op cit.
[10] Routledge Press, 2004.
[11] Nichols, 2004, op cit.

market reforms, nor in either one of these bills we are considering today, actually addresses the underlying sources of health care cost growth, and, thus, premium growth was not contained. Still, premium variance was surely dampened, since premium variance restrictions limit how much rates can vary across groups and over time.

Since the vast majority of states (48) have premium variance restrictions of some kind,[12] another way to think about the effect of premium variance restrictions is to see if current small firm offer rates are higher in states with "loose" rules than in states with "tight" rules. Precisely characterizing the totality of a given state's premium regulations as "loose" or "tight" is a very time consuming, state-specific exercise best not tried at home, but respected researchers like Rick Curtis and his colleagues at the Institute for Health Policy Solutions have been doing this for at least 10 years. They published a paper in 1999[13] in which they discussed the evolution of state reforms since 1991, discussed lessons states had learned, and provided examples of states doing various things. In that paper is a chart, Exhibit 2, on p. 153, in which 6 states are specifically labeled as having "loose" or "tight" premium rating rules. My Table 2 lists those states, along with AHRQ's estimate of the percentage of workers in small firms that offer, the key barometer, in most analysts' minds, of how the overall small group market is performing in any given state.

Table 2. Rating rules and percent of small firm workers in firms that offer, 2003

Rating rule regime and state	Percent of workers in small firms that offer
Loose	
Ohio	61.1%
North Dakota	54.8%
Tight	
California	61.3%
Connecticut	68.4%
Massachusetts	76.3%
New York	65.5%
US average	61.6%

Source: Curtis et al, *Health Affairs*, May/June 1999; AHRQ MEPS-IC tables, downloaded April 1, 2006.

Now I am well aware that the decision to offer health insurance is a complex outcome of many forces,[14] and I am certainly not trying to argue that this table proves that tight rating rules *caused* more workers to be offered health insurance by their small employers than would otherwise have been the case. But what Table 2 does show is that tight rating is at least consistent with offer rates that are at least as high as those observed in looser rating states, and that is the fundamental point. Insurers and employers adjust to the market

[12] Georgetown University, "Small Group Health Insurance Reforms: State-by-state Comparison" 2006.
[13] Curtis et al, "Health Insurance Reform in the Small Group Market, *Health Affairs*, May/June 1999.
[14] L. Nichols, L. Blumberg, P. Cooper, and J. Vistnes, "Employer Decisions to Offer Health Insurance: Evidence from the MEPS-IC Data," presented to American Economic Association, January 2001.

rules in place, insurers who do not like some rules leave those states, but offer rates remain as strong as they are likely to be in the small group markets, as data from these tightly regulated states show.

By and large, firms offer health insurance, if they do, because they must in order to attract the kind of labor force they want, or they do not offer because it is not necessary for them. All the rest is commentary, more or less. Specific rating rules, benefit mandates, etc., matter on the margin, but not much to the basic decision to offer a standard package in the locale where their workers live, because the total compensation package with health insurance included is more attractive to the workers they want than an equal additional amount of cash would be. The attractiveness of this package, in turn, hinges on the underlying demand for health insurance on the part of workers, which is of course, highly correlated with income and earnings.[15]

Recall that the third goal of small group health insurance reformers was to make health insurance more affordable for the sick. Research on this question lagged the overall coverage and market stability questions, for these latter questions were simpler to measure and answer, but in recently published work I and colleagues addressed the risk pool issue directly. We used National Health Interview Survey data with superior measures of chronic conditions and econometric analysis to control for other factors. Our results suggest that pre-HIPAA guaranteed issue plus premium rating reforms did indeed increase coverage a bit for small firm workers and their family members with chronic conditions.[16] The results also suggest that some low risk workers lost coverage as a result of the reforms, which is both evidence of the tradeoffs I mentioned earlier, and a partial explanation of why so many studies of the overall coverage impact of reforms found no net effect.

With this background, I now turn to the specific premium rating rules in each bill. The approaches could hardly be more different.

S. 637 would use modified community rating inside its SEHBP pool, allowing specified and limited variation in rates based only on age, family structure, and geography. Furthermore, the minimum sized geographic unit is the MSA, and as such it is not open to insurer self-definition, which could facilitate red-lining of specific areas suspected of having high cost enrollees. This rating approach expressly prohibits the use of health status or the presence of chronic conditions or claims experience to differentiate among groups, and thus is consistent with current NAIC model acts and research-based thinking on this subject.[17]

S. 637 then would impose tighter premium variance regulation than in some states' small group markets at the moment, since many states allow health status or claims to drive premiums within specified rate bands, and S. 637 would impose looser regulations than in other states with very tight age limitations, for example. This would not yield a purely

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[15]Blumberg, Nichols, and Banthin, 2001, op cit.
[16] Davidoff et al, 2005, op cit.
[17] Curtis et al, 1999.op cit.

level playing field with the existing small market, and could cause selection against the new SEHBP pool. However, S. 637 includes a key safety valve preventing serious adverse selection against the SEHBP pool, and that is the availability of tax credit subsidies for firms that sponsor coverage for their low wage workers, i.e., those who make less than $25,000 per year. These subsidies indicate that this bill is intended to actually expand coverage, for the sponsors are willing to use resources to enable those who cannot afford coverage today to purchase it. These subsidies are at least 25% of employer premium costs, and rise with more expensive family structures and with higher employer shares of premiums. Importantly, these subsidies are available *only* if small employers – remember S. 637 defines small to be fewer than 100 employees – enter the SEHBP pool to purchase health insurance. Thus, the incentives would be very strong for all small firms with any low wage workers to join the SEHBP pool. Since the self-employed could also join the SEHBP pool and have access to tax credit subsidies if they are low income, and since their alternative is the non-group market, most of them would probably join the SEHBP pool as well. Rick Curtis, widely recognized as the country's foremost authority on how to make purchasing pools work, has written that one key to enabling pools to offer bargains to their participants is to subsidize the low income within the pools so that critical mass, economies of scale, and requisite bargaining power will result.[18] I will return to the bargaining power point, a portent of future reform possibilities, in the next sub-section.

S. 1955, by contrast, appears intent on taking a step back in time by basing its premium rating restrictions on NAIC's 1993 model act, which permitted the use of health status and claims within business classes, and also allowed specified variance across classes. Interestingly, the NAIC amended that 1993 act within 2 years, precisely in the period of the greatest state activity in passing market reform laws, and tightened its model variance recommendations over time, until today the model act specifies modified community rating, as employed in S. 637.

Now S. 1955 as currently drafted is certainly mindful of the fear of extreme rate variations, unlike HR 525, and seems on the one hand to protect against them. The bill provides that rates within a class cannot vary by more than +/-25% from the index rate, and among classes they cannot vary by more than +/- 20%. However, the rating variation rules (the same as those in the NAIC 1993 small group model law) are tied to a "base rate" and an "index rate." Those definitions are tied to "similar case characteristics" and "similar coverage." Allowable case characteristics include age, gender, group size, geography, and industry. For example, an older small employer group would not have a similar case characteristic as a younger small employer group. All of the apparent "within class" and "across class" restrictions on rating in the bill, therefore, can be eluded by the imposition of a higher "rating factor" to older groups, groups that are predominantly women, etc. This could be particularly devastating to older workers, as they have the greatest health needs in the workforce as they near retirement age. Individuals between 55-64 are over three times as likely to be in fair or poor health as individuals between 18-34.[19]

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[18] Curtis and Neuschler, 2005, op cit..
[19] MEPS HC data, downloaded April 1, 2006.

S. 1955 merely requires rating factors to be applied consistently. An insurer could consistently apply a higher rating factor based on age, an allowed case characteristic. Thus, the bill is likely to lead to higher premiums for older workers (and older dependents as well), groups dominated by women, very small groups, and groups from industries with higher expected claims costs, among others. There is no limit on how much rating factors for age and other factors can vary in S. 1955, and so this could be used to make sure firms with an older work force do not want to buy SBHPs. Actuaries from the Department of Insurance in New Hampshire believe that S. 1955 permits rates to vary among groups by as much as 25:1, if actuaries use conventional ranges on variable factors.[20] The danger then in S. 1955 is that with no limits on age, gender, geography (and geography can be defined by the insurer), family size and group size adjustment factors, premiums could vary far more than the bill sponsors intend or expect.

Now some associations may well want to effectively community rate their members, and may instruct their SBHPs to do so. In that case, they would be imposing rules more like the tightest state regulations do now, but over a much smaller pool than at present. In short, it is hard to argue that anyone would gain from SBHPs in the long run but young and healthy associations or members of associations with a commitment to community rating of their own members, a commitment that they do not exhibit now in their zeal to escape tighter premium variance restrictions in most small group markets.

Bargaining power

Part of the frustration of being a single small employer seeking health insurance is the absolute lack of control, the absence of ability to do anything but react on a take-it or leave-it basis to what insurers offer to them, as costs increase year after year. That understandable frustration is surely part of what is driving the movement to find a way to "act" more like large firms in purchasing health insurance, to be more demanding of insurers, and, in turn, of the providers who ultimately determine the real costs of care and the insurance which finances that care. What small employers may not know is that large employers are also extremely frustrated by continuing cost growth and low clinical value for dollar, but that is a larger point for another day.

Being more demanding is essentially about exercising more market power, more bargaining power. Simply put, the more bargaining power in the hands of employers, the more likely that health care cost growth will be brought under control in the long run, the absolute key to sustaining our systems ability to provide high quality care for all. So the last, simple, and most important long run question for the two bills before us today is: which type of structure, SBHPs or the SEHBP, is more likely to transfer more bargaining power to employers and the working families who depend upon them?

S. 637 is much more likely to create a larger pool, as we discussed in the Administrative Economies section. The fact that it is open to all with fewer than 100 workers, offers

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[20] Letter from New Hampshire Department of Insurance to Brian Webb of NAIC, March 13, 2006, commenting on S. 1955.

subsidies to those who pay at least 60% of the premium of low wage workers, and preserves existing benefit package mandates means that the SEHBP is likely to become the de facto small group and self-employed market in each state and, therefore, in the nation. This could lead to 40% of the workforce having access to the SEHBP, the fraction of workers in firms with fewer than 100 workers.[21]

Thus, in its totality, S. 637 not only creates a viable pool that will likely serve all participants in the small group market at least as well as they are served today, it sets the stage for the next steps towards a reformed health care system, one that can use bargaining power, information systems *and* consumer choice to achieve efficiencies in service and care delivery – through extensive use of pay for performance and comparative technology assessment -- that could make it possible for us to afford to cover all Americans someday and forever.

S. 1955, it must be said, exhibits less ambition about creating a pool with bargaining power that can help drive system-wide reform in the long run, and envisions instead a large number of much smaller pools that are expected to offer all existing association members a lower premium than they pay today. That is a reasonable outcome to desire, and I applaud the sponsors for trying to make it happen. But if all small firms do now or could join some association which could qualify to offer an SBHP, then the long run dream of S. 1955 could be realized only if all premiums are being artificially propped up today by unnecessary benefit mandates and misguided and counterproductive premium variance restrictions and other insurance market reforms. I believe a fair reading of the evidence of the health insurance market reform literature strongly contradicts this world view, but I must admit its proponents hold onto it with tenacity nevertheless. I fear the world view behind S. 1955 ignores or denies the inherent tradeoffs most students of the small group market see. In some ways I wish the world was that simple. I fear and believe it is not, and to act as if it is puts our already fragile small group markets in more jeopardy than they can likely withstand.

[21] AHRQ, MEPS-IC data, downloaded April 1, 2006.

Finance Committee Hearing
"Health Care Coverage for Small Businesses: Challenges and Opportunities"
Questions Submitted for the Record
Dr. Len Nichols
April 13, 2006

Senator Grassley

1. It seems to me that a core issue here today is the role state mandates play in making health care coverage for small insurers unaffordable. I note with interest that various versions of the Durbin-Lincoln bill have gone from waving state mandates to applying them to small businesses. How significant are state mandates in making health insurance unaffordable for small businesses?

   As a practical matter, mandates are not nearly as important as many think. The Texas Department of Insurance concluded that their mandates, which include 28- day inpatient treatment for alcohol and substance abuse, add only 3% to small group premiums in their state. The CBO and researchers at the Urban Institute have concluded that 3-5% was the range that seemed most reasonable (citations for these reports are in my written testimony). Mercer in a 2006 study for the National Small Business Association assumed 5% as well (that report was cited in Todd McCracken's testimony). Three reasons that benefit mandates are not more important are: (1) relatively few patients need the expensive ones, so the extra cost spread over many covered lives is small per person; (2) often times mandated coverage of, for example, preventive and maintenance diabetes care, can REDUCE expensive hospitalizations; and (3) the reality that doctors just want to treat patients, view all insurance coding rules as arbitrary, and find creative latitude to prescribe and perform the services they think are appropriate, regardless of what the "condition" was called for billing purposes.

2. Each state has at its disposal many tools to regulate its health insurance market. Certainly some of those can make it easier on small businesses to obtain coverage while others make it more difficult. What insurance regulations make it more difficult for small businesses to obtain health care coverage? Any of you may answer that as well.

   All insurance market regulations produce tradeoffs, in that they help some small businesses get insurance and raise the premiums offered to others. Guaranteed issue, portability, guaranteed renewal, and premium variance restrictions all force more risk pooling than the free market alone would achieve. This helps those groups with older and sicker workers and hurts those groups with younger and healthier workers. The basic rough justice theory is that the young and healthy will become older and less healthy over time, which holds true to a large degree. The reality that we know, history without serious insurance market reforms, was such that between 1988 and 1994 47 states

passed versions of the big four reforms before HIPAA set a minimum federal floor on regulation in 1996. And despite all the arguments that are being brought before you this spring, no state that had gone further has rolled back their market regulations to the level that HIPAA permits. So I think the right answer is, market reforms help the sick a lot by raising premiums a bit on the more numerous healthy, and that is a tradeoff most state legislatures (and policy analysts) are comfortable with.

3. 80% of the uninsured do work. However, almost 30% of those only work part-time. Do you believe that there is any proposal out there that would make it easier to cover part-time workers?

   The best way to cover part-time workers and the self-employed and those others without access to employer-sponsored insurance would be to create a common purchasing pool which they could join, like the Massachusetts Connector just invented by Gov. Romney and the legislature or like the FEHBP-like pool in the Durbin-Lincoln bill. This pool will give them access to economies of scale, the surest way to lower premiums and increase actuarial value per premium dollar from what they face now in the non-group and the small group markets on their own. Subsidies based on family income would also go the largest distance toward increasing coverage short of comprehensive solutions with mandates, etc. Since many part-timers also work for more than one employer, you might facilitate multiple pro-rata contributions to one person's plan within a purchasing pool by amending coordination of benefit rules for part-timers, in effect, treating them like Taft-Hartly union plan members. I am not aware of specific proposals that would do any of this for part-time workers per se today, but I would be happy to work with your staff to construct one if you or they would like.

4. My colleague from Montana raised concerns about SBHPs interfering with the Massachusetts effort to expand coverage to everyone in the state. Are these approaches necessarily exclusive? Why couldn't we pass a bill that gave states the option of an SBHP or going into the SEHBP as outlined in the Durbin-Lincoln bill?

   Congress could certainly pass a law that would allow and encourage state choices, and indeed I think a bi-partisan one is about to be introduced (Bingaman-Voinovich). The Enzi-Nelson bill is not that, however, and it would render the Connector (purchasing pool) in Massachusetts less robust, since it would allow opting out of the pool to join a SBHP. Enzi-Nelson would also render plans with benefit mandates inside the Connector far more expensive – due to adverse selection effects – and that would frustrate the ability of Massachusetts to achieve universal coverage at the budgeted state cost they have assumed. Thus, Enzi-Nelson would make the Massachusetts agreement and goals harder to reach and maintain, but not impossible, I think it is fair to say.

5. The most recent version of the Durbin-Lincoln bill (S.2510) requires national plans under the SEHBP to conform to all state mandates. That means they either need to have a different plan in every state or a national MEGA plan would somehow have to meet all 50 states' mandates. Is that plausible and how does that structure lower costs for small businesses? How is that different than today's regulatory environment?

   I think the national plan of Durbin-Lincoln was originally intended to be comprehensive in its scope of coverage, like the national plans in FEHBP. The latter don't conform to every state's mandates (they don't have to since they are for federal employees, not the regulated small group market), but they are attractive to workers on the ground just the same. The latest version of Durbin-Lincoln does require conformity with each state's mandates, and I believe you are correct that either 51 different plans or one plan with the mandates of all states combined must be offered. But since small employers are buying products with those mandates in effect today, this alone should have no effect on premium cost. Either way, the gains to small business in Durbin-Lincoln are two-fold: economies of scale in administration and risk pooling, and the subsidies/tax credits that would flow to firms with lower wage workers. These gains could range from 10-25% in administrative loads and another 5-25% from the subsidies. So the potential gains to individual small employers and their workers could be substantial.

Senator Baucus

1. S.1955 allows insurers to offer stripped down plans that don't comply with state benefit mandates, as long as they offer an "enhanced" plan like one offered to state employees in one of the 5 most populous states. Are there standards in the bill to ensure the "enhanced" plan would be comprehensive? Could an HSA qualify? Are there standards to ensure affordability?

   A high deductible plan like those eligible for HSAs could qualify, but enhanced plans will have to cover services that state employees have access to in at least one of the 5 most populous states. However, a SBHP would be compliant by picking the least generous plan in the 5 states. The larger point about enhanced plans, though, is that they will be extremely expensive, since all who are relatively healthy will prefer to be in the stripped down no mandate plans. Thus, those left for the "enhanced" plans will be those with chronic conditions, and so the risk pool left for the enhanced plans will be far worse than the risk pool for the no mandate plans. I would expect the enhanced plans to be priced deliberately to attract no customers, since the risk pool seeking them will be so bad.

2. Will the pre-emption of state benefit mandates regarding maternity care in S. 1955 increase the number of women relying on Medicaid to pay for health care during and after their pregnancies?

Yes. Quite a few women who are eligible for Medicaid also have access to employer sponsored insurance, but their husbands are no eligible for Medicaid, so they often take ESI as a family. Those who work for small firms will rarely find maternity covered under Enzi-Nelson, so they will be far more likely to take Medicaid than they are at present.

3. Senator DeMint testified in support of his bill, the Health Care Choice Act. Do you agree with Senator DeMint's view that this proposal will improve access to coverage by increasing the availability of plans that can offer coverage at a national level? Will allowing more insurers to offer national plans have an anti-competitive effect on the market? Are there other factors to consider in moving towards this type of regulatory environment?

The DeMint approach is quite possibly the worst idea in insurance market reform to get the Senate's attention in quite some time. I realize this is a strong statement but I believe it to be true. It would essentially deregulate small group insurance markets overnight. Nothing could be more disruptive or contrary to the expressed wishes of the vast majority of state legislatures. It would allow insurers licensed in one of the two states with no premium variance restrictions to sell in all states, effectively forcing all insurers to do the same or risk losing all lower risk employer groups. It would also allow all insurers to price those to whom they do not want to sell – those with sicker employees with chronic conditions – completely out of the market. Thus, this approach would drive the range of premiums charged for the same product to the maximum imaginable amount. We would not be able to observe the worst of it, however, since at some point sales are choked off at the high end, indeed that is the intent of such extreme market freedom. It would make insurance cheaper for very healthy groups in the short run, until someone in them got sick. Then nothing could stop all insurers from pricing high and in effect, dropping sick groups like proverbial hot potatoes. This would effectively end most risk pooling that occurs today. This approach to health insurance makes sense only if one thinks the market for insurance is essentially like ice cream, wherein normal market forces limit price and put a competitive floor on quality. The fallacy in this world view is that in insurance markets, sellers do NOT want to sell to each new customer, especially if that customer is high risk. Price increases and benefit/quality decreases are effective tools to avoid selling to undesirable customers. DeMint would give insurers infinite price flexibility. They are business enterprises, and they will naturally use the tools policy makers make available. A wiser set of policies, chosen by the vast majority of states, accepts the tradeoffs and limits the use of such tools, for the greater good of risk pooling to make coverage more affordable for those who need it most.

4. Small business owners are concerned about the lack of competition among insurers in the state-regulated small group insurance market. Do you agree that this is a problem? How could Congress increase market competition without preempting state oversight of insurance?

There is some evidence of increased seller concentration in the market for small group health insurance in a number of states, but it is important to remember that most insurers that have exited states are very small and thus their loss is not important to the true state of competition. I note that in the recent GAO report prepared at the request of Senators Snowe, Bond, and Talent (October 13, 2005), the median number of licensed carriers in the small group market was 28, so on average competition is still potentially vigorous. In my view the "proof" of competition is in the outcomes of the market, not in the number of competitors per se. My written testimony (table 1, p. 6) reported the facts that percentages of small firms that offer and of workers in small firms who are offered to (more important) have been virtually unchanged since 1996, thus it is hard to see the effect of the increased concentration on market outcomes. I also used those same AHRQ-MEPS data to compute the average annual growth rate of premiums paid by firms with 50 or fewer workers vs. the average annual growth rate of premiums paid by firms with more than 1000 worker (the vast majority of the latter are self-insured and immune to the fluctuations in the small group market). The small firm premium growth rate was slightly higher, 8.3% vs. 7.9%, but not enough higher to affect the bottom line offer rate, as I reported earlier. Thus it is hard to make the case that the small firm market performance is getting worse over time vis-à-vis the large firm market. What is undeniable is that health costs in general continue to outstrip economy-wide productivity growth, and that is precisely why we need to develop public-private partnerships to reign in cost growth and enhance clinical value per dollar spent for all patients, whether they are insured through large firms, small firms, or governments.

The best thing Congress could do to enhance competition in the small group market itself would be to create or enable the creation of a large purchasing pool -- or exchange or "connector" a la Massachusetts – in which the rules of competition were clear and uniform and to which all small firms and the self-employed had unrestricted access. The Durbin-Lincoln bill has a promising version of this, which includes subsidies to entice more firms to offer insurance to their workers. Recognize that insurance markets need some structure and rules to deliver top quality performance – rules of issue, basic benefit package standardization and some limits on premium variance – and that economies of scale benefit small firms the most. The buying power that a large pool would have vis-à-vis insurers and providers would further advantage small firms compared to today. Combining state or federal employees, Medicaid enrollees, and other purchasers of health care services into one large insurance purchasing pool will only enhance the effective buying power of individual participants and make it increasingly impossible for insurers to avoid this market, thus achieving maximum possible effective competition for all.

Statement of Associated Builders and Contractors

United States Senate - Committee on Finance

"Health Care Coverage for Small Businesses: Challenges and Opportunities"

Statement of Joseph E. Rossmann, Vice President of Fringe Benefits, Associated Builders and Contractors, Inc.

On behalf of the Small Business Health Plan Coalition

SPEAKING FOR THE MERIT SHOP

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Introduction

Chairman Grassley, Ranking Member Baucus and members of the Senate Finance Committee, thank you for holding this very important hearing which will address the problems that small businesses face in providing quality health insurance for themselves and their employees.

My name is Joseph E. Rossmann, and I am Vice President of Fringe Benefits for Associated Builders and Contractors (ABC). ABC is a national trade association representing over 23,000 general contractors, subcontractors, material suppliers, and related firms from across the country and from all specialties in the construction industry in a network of 79 chapters. Our diverse membership is bound by a shared commitment to the merit shop philosophy of awarding construction contracts to the lowest responsible bidder, regardless of labor affiliation, through open and competitive bidding. With more than 85 percent of construction today performed by merit shop contractors, ABC is proud to be their voice.

I am testifying before you today on behalf of the Small Business Health Plan (SBHP) Coalition (membership list attached), which consists of over 180 national and regional organizations that support S. 1955, the Health Insurance Marketplace Modernization Affordability Act of 2005 sponsored by Senators Michael Enzi (R-WY), Ben Nelson (D-NE) and Conrad Burns (R-MT). The SBHP Coalition represents over 12 million employers and over 80 million small business workers throughout America. I also am secretary and past president of The Association Healthcare Coalition, which consists of bona fide trade and professional associations that currently operate association-sponsored health plans, or have done so in the past.

Mr. Chairman, today's hearing is extremely timely. The problem of small business workers not having access to affordable health benefits is reaching epidemic proportions across the nation. Since over 60 percent of all uninsured Americans are employed by a small business, or are dependents thereof, the current trend of skyrocketing premium increases threatens to greatly expand the number of uninsured Americans, which now stands at approximately 45 million.

Indeed, massive premium increases of 30 percent and higher, and/or benefit reductions, are typical of what small businesses throughout the nation are experiencing today. Clearly, current initiatives aimed at expanding access to affordable health care are not working. As such, Congress must take action to address this critical issue this year to prevent thousands of small business workers from losing their health benefits, and to expand coverage to millions of uninsured Americans.

Our coalition strongly urges Congress to enact the Health Insurance Marketplace Modernization Affordability Act of 2005 (S. 1955), bipartisan legislation which would bring much needed competition to the small group health insurance market. Congress should approve the SBHP bill this year to expand access to health benefits for small businesses and the self-employed.

The Need for Small Business Health Plans

The Health Insurance Marketplace Modernization Affordability Act of 2005 would help achieve the goal of providing Fortune 500-style health benefits to working families employed by small businesses. Through this legislation, SBHPs will empower our nation's entrepreneurs with the similar tools that large employers and unions currently enjoy under the Employee Retirement Income Security Act (ERISA) making health coverage affordable for working families. These tools are:

- ⇨ Economies of scale and increased bargaining power for small employers;
- ⇨ Administrative savings from having one uniform set of rules;
- ⇨ Health benefit design flexibility;
- ⇨ Increased competition in health insurance markets.

SBHPs can reduce health insurance costs by 15–20 percent by allowing small businesses to join together nationwide to obtain the same economies of scale, bargaining clout, and administrative efficiencies now available to employees in large employer plans. New coverage options will promote greater competition and more choices in health insurance markets.

The Small Business Health Plan bill is the most viable proposal currently before the U.S. Senate, and will put small business workers on a level playing field with employees of large corporations. Right now, small business workers are second-class citizens when it comes to health benefits. On average, workers in firms with less than 10 employees pay 17 percent more for a given health benefit than workers employed in a large company. This is because small businesses don't have access to the type of economies of scale, bargaining power and administrative savings that corporate plans now have. The SBHP legislation will help rectify this inequity by leveling the playing field between workers in small and large businesses.

We estimate that SBHPs, through the enactment of S. 1955, can reduce the cost of health benefits by 15 – 20 percent for small business workers. We know this because health plans administered by associations have already proven they can deliver savings compared with the cost of small employers purchasing directly from an insurance company.

For example, the health plan sponsored by ABC for nearly 45 years, which operated nationally, had total administrative expenses of 13 ½ cents (13.5 percent) for every dollar of premium. These costs included all marketing, administration, insurance company risk, claim payment expenses and state premium taxes. Alternatively, small employers who purchase coverage directly from an insurance company can experience total expenses of 25 to 35 cents (25 – 35 percent) for every dollar of premium.

Moreover, any profit generated by the health plan in a given year does not go to the stockholders of the insurance company, but rather stays in the plan and inures to the benefit of participants by keeping costs lower in the future.

ABC successfully operated its health plan through the ABC Insurance Trust. Because of the overwhelming costs in trying to comply with overlapping, inconsistent and often incompatible state laws, our health insurance carrier was forced to drop their health care coverage. Today, ABC continues to provide a full array of insurance benefits, but has been forced to work with multiple health insurance providers. ABC now serves as a broker, providing our membership with the most competitive carriers and rates in their area. ABC is a perfect example of how a trade or professional association, serving as a purchasing pool for employers, can have a significant impact upon the small employer health insurance market in both price and design.

The ABC Insurance Trust was founded in 1957 by five contractors who could not afford group health insurance for their employees in the open market due to their size. Until 1999, the ABC Insurance Trust served as a voluntary purchasing pool for members of the association. An important component of the plan's long-term success was that it was guided by contractor members who serve as trustees and fiduciaries under the plan. As participants in the program, they acted in the best interest of their fellow members and their employees. Participation by the board of trustees is a key ingredient in aggregating the voice of employers to negotiate price and coverage with insurance carriers and other providers.

ABC's health plan program offered HMOs, PPOs, and traditional health insurance plans. All of ABC's plans provided wellness benefits with coverage for physicals and annual check ups. ABC continues to offer dental coverage, group life insurance, and disability programs to serve members of the association. A majority of those covered work for small construction firms with 10-20 employees.

ABC's Insurance Trust operates in full compliance with ERISA reporting requirements, with the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 and with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Complying with the federal HIPAA legislation requires ABC and other associations to provide open access to all members and provide credit for prior coverage. In fact, health plans administered by associations are specifically referenced and defined in the HIPAA legislation and are required to take all members under HIPAA guidelines.

The inability of states to provide a regulatory environment in which associations can serve as a source of affordable health benefits for small business workers is a real tragedy. Bona fide trade associations have an established infrastructure that allows them to communicate with members more effectively because of their pre-established relationships. This unique structure allows associations to add value to their members and workers that other organizations or purchasing pools cannot duplicate. SBHPs are capable of offering valuable options by providing additional benefits over and above what many insurance companies provide today. Associations can successfully tailor the products and services specifically for the needs of their members.

Workers in small businesses desperately need a viable mechanism to band together to increase their bargaining clout and create more competition in health insurance markets. This is true more so today than ever before due to the huge wave of consolidation among health insurance companies and hospitals. Recent mergers of health insurance companies have reduced competition and alternatives for small employers who seek access to quality and affordable health insurance. In fact, a survey of state insurance commissioners conducted by the General Accounting Office (GAO) at the request of Senator Kit Bond (R-MO) found disturbing levels of concentration on the small group health insurance markets, with market shares of nearly 90 percent among the five largest companies in 7 states.

Dr. James Robinson, Professor of Health Economics at the University of California, Berkeley, calculates that the top three health insurance companies control two-thirds or more of the health care business in all but 14 states. (Robinson, James C., Consolidation and the Transformation of Competition in Health Insurance, Health Affairs, Vol. 23, No. 6 (Nov. /Dec. 2004)). Robinson compares those numbers with 2000-2003 financial results of the top five national insurance firms. His research shows a decline in the percent of each premium dollar that goes to pay medical claims, while insurance companies have enjoyed double digit growth in premiums, earnings and equity share prices. Ultimately, Robinson contends that the health insurance industry will only be revitalized through product innovation and further competition.

Today, there is a great need to bring more competition back into the system rather than continually reducing it. By providing more options and choices for small employers, the SBHP legislation will inject greater competition in health insurance markets, thus bringing down premiums and expanding health plan benefits and plan options to more small business workers and their families.

Rebuttal of Criticism of SBHP Legislation

I would like to address some of the criticisms being raised about S.1955, the Health Insurance Marketplace Modernization Affordability Act of 2005. The main criticism being raised by opponents of this legislation is that SBHPs will remove important, hard-fought patient protections on the state level. But the assumptions under which this argument is made do not hold up to scrutiny.

Opponents claim that SBHPs will offer inadequate benefits.

Non-profit trade associations, such as Associated Builders and Contractors, exist to serve their members. If they attempt to not offer attractive benefit options, their mission is fundamentally compromised and they will not be able to compete in the marketplace. Small employers must compete with large employers for their work force. Because of this, small employers want to offer the same high quality comprehensive benefits that large employers make available to their employees today.

ABC's Insurance Trust provided comprehensive benefits for members and their employees for over 48 years. The same comprehensive benefits and coverages that were available to

members in the Commonwealth of Virginia for example, were also available to ABC members in Iowa, Montana and Wyoming. Benefits for insured members are not reduced because of lower state requirements. The same comprehensive coverages were available nationwide.

It is important to remember that SBHPs will be an alternative for ABC members to select from, not a mandate. Employers have the opportunity to choose between their association plan and other products available direct from insurance carriers. Associations will compete with insurance carriers for their member's business so the SBHP must offer high quality options, the same as insurance carriers offer, if they wish to earn their members participation in the plan.

Opponents claim that SBHPs would cherry pick the healthiest employers and employees.

Associations, Chambers of Commerce and franchisees can not condition membership in their respective organization based upon health status. The Enzi-Nelson-Burns legislation mandates that SBHPs must be in full compliance with federal HIPAA requirements. In addition, the small business health plan (SBHP) sponsored by one of the above entities must make all coverages available to all members of the organization. Rating of employer groups is on equal footing with insurance carriers.

Opponents' allegations about adverse selection rest on the **mistaken assumption** that small businesses will offer only "bare bones" benefit packages through SBHPs. There is broad agreement that "bare bones" plans, wherever they have been tried, have failed due to lack of demand. This is because small business workers want Fortune-500 style benefits like those enjoyed by workers in large companies. Also, small businesses **must** offer benefit options comparable to those offered by large companies if they are going to attract and retain quality employees.

Adverse selection that **currently exists** in state markets will be greatly reduced when younger, healthier workers employed in small businesses who are now uninsured are able to obtain coverage that is affordable

Opponents claim that Small Business Health Plans will not offer savings.

The savings in SBHPs comes from the administrative efficiencies and marketing economies inherit within the associations' relationship with its members. A recent study conducted by Mercer Oliver Wyman Actuarial Consulting, Inc. (Mercer) on behalf of the National Small Business Association (NSBA) indicates the SBHPs will provide a 12 percent overall cost savings for members. ABC's actual results indicate a savings of close to 20 percent over the small employer market as offered by insurance carriers. In addition, SBHPs must offer high quality benefits to earn the participation of their members.

Opponents claim that SBHPs will have an unfair advantage over insurance carriers.

Both insurance carriers and SBHPs will be on equal footing in products and rating methods for the plans made available for small employers. Under the Health Insurance Marketplace

Modernization Affordability Act of 2005, only fully insured plans are available which provide for continued state insurance commissioner oversight of both plans and insurance carriers. All consumer protections for fully insured plans are in place for employees and their dependents.

Conclusion

In conclusion, the 12 million employers and more than 80 million employees represented by the SBHP Coalition strongly urge the Senate to pass the Health Insurance Marketplace Modernization Affordability Act of 2005. Small Business Health Plans provide affordable health coverage to small businesses, and extend coverage to uninsured people. While SBHPs are not the only solution to America's health care crisis, SBHPs are an **essential** component of the solution. SBHPs are important for many working families employed in small businesses who otherwise could not afford coverage. Passage of the Health Insurance Marketplace Modernization Affordability Act of 2005 will ensure that employees of small businesses receive the affordable, high quality health care coverage they both need and deserve.

I appreciate this opportunity to testify before this Committee on an issue of vital importance to our membership and small business owners across the country. We look forward to continuing a constructive dialogue on how to increase access to affordable and competitive health insurance for small businesses. I would be happy to answer any of the questions the Committee may have.

Organizations Supporting Small Business Health Plans

The following organizations, representing over **12 million employers and 80 million workers, strongly support S. 1955, the Health Insurance Marketplace Modernization Affordability Act of 2005**, bipartisan legislation to strengthen and expand Small Business Health Plans (SBHPs). This legislation will provide workers employed in small businesses and the self-employed gain access to Fortune 500-style health benefits now enjoyed by workers in corporate and labor union health plans.

Adhesive and Sealant Council
Air Conditioning Contractors of America
American Alliance of Service Providers
American Apparel & Footwear Association
American Association of Advertising Agencies
American Association of Engineering Societies
American Association of Franchisees and Dealers
American Association of Small Property Owners
ABL – America's Wine, Beer, and Spirit Retailers
American Bakers Association
American Concrete Pumping Association
American Council of Engineering Companies
American Disc Jockey Association
American Electronics Association
American Foundry Society
American Furniture Manufactures Association
American Institute of Chemical Engineers
American International Automobile Dealers Association
American Hotel and Lodging Association
American Lighting Association
American Nursery and Landscape Association
American Rental Association
American Road and Transportation Builders Association
American Small Businesses Association
American Society of Association Executives
American Society of Civil Engineers
American Society of Home Inspectors
American Society of Mechanical Engineers, Board on Member Interests & Development
American Staffing Association
American Textile Machinery Association
American Veterinary Medical Association
American Wholesale Marketers Association
Americans for Tax Reform
AOMALLIANCE
Archery Trade Association
Associated Builders and Contractors

Associated General Contractors of America
Associated Prevailing Wage Contractors, Inc.
Association for Manufacturing Technology
Association of California Water Agencies
Association of Equipment Manufacturers
Association of Independent Maryland Schools
Association of Ship Brokers and Agents
Association of Suppliers to the Paper Industry
Automotive Aftermarket Industry Association
Automotive Aftermarket Association Southeast
Automotive Service Association
Automotive Undercar Trade Organization
Automotive Wholesalers Association of New England
Automotive Parts & Services Association
Bowling Proprietors' Association of America
California Motor Car Dealers Association
California Society of CPAs
California/Nevada Automotive Wholesalers Association
Center for New Black Leadership
Central Service Association
Chesapeake Automotive Business Association
Cleveland Automobile Dealers Association
Club Managers Association of America
Christian Schools International
Coca Cola Bottlers Association
Communicating for Agriculture
Construction Management Association of America
Consumer Specialty Products Association
Deep South Equipment Dealers Association
Electronics Representatives Association Insurance Trust
Far West Equipment Dealers Association
Farm Equipment Manufacturers Association
Financial Executives International
Financial Planning Association
Food Marketing Institute
GrassRoots Impact
Hearth, Patio and Barbecue Association
Hispanic Business Roundtable
Independent Electrical Contractors
Independent Office Products & Furniture Dealers Association
Independent Stationers, Inc.
Institute of Electrical and Electronics Engineers - United States of America
International Association of Professional Event Photographers
International Foodservice Distributors Association
International Franchise Association
International Housewares Association
Iowa Automobile Dealers Association

Iowa-Nebraska Equipment Dealers Association
The Latino Coalition
Mason Contractors Association
Material Handling Equipment Distributors Association (MHEDA)
Metal Manufacturers' Education and Training Alliance
Midwest Automotive Industry Association
Midwest Equipment Dealers Association
Motor & Equipment Manufacturers Association
NAMM, the International Music Products Association
National Association for the Self-Employed
National Association of Chemical Distributors
National Association of Community Health Centers
National Association of Computer Consultant Businesses
National Association of Convenience Stores
National Association of Home Builders
National Association of Manufacturers
National Association of Plumbing-Heating-Cooling Contractors
National Association of Realtors
National Association of Theatre Owners
National Association of Wholesaler-Distributors
National Association of Women Business Owners
National Automobile Dealers Association
National Black Chamber of Commerce
National Burglar and Fire Alarm Association
National Cattlemen's Beef Association
National Club Association
National Concrete Masonry Association
National Council of Agricultural Employers
National Federation of Independent Business
National Franchise Association
National Funeral Directors Association
National Lumber and Building Material Dealers Association
National Newspaper Association
National Office Products Alliance
National Paint and Coatings Association
National Portable Storage Association
National Precast Concrete Association
National Rental Association
National Retail Federation
National Restaurant Association
National Roofing Contractors Association
National Spa and Pool Institute
National Society of Accountants
National Society of Professional Engineers
National Sporting Goods Association
National Systems Contractors Association
National Tile Contractors Association

National Tooling & Machining Association
National Utility Contractors Association
Nebraska New Car and Truck Dealers Association
New Mexico Automotive Parts and Service Association
New York State Automotive Aftermarket Association
North American Die Casting Association
North American Equipment Dealers Association
North American Retail Dealers Association
North Dakota Automobile and Implement Dealers Association
Northeastern Retail Lumber Association
Office Furniture Dealers Alliance
Ohio Valley Automotive Aftermarket Association
Outdoor Industry Association
Piano Technicians Guild
Precision Machine Products Association
Precision Metalforming Association
Printing Industries of America
Printing Industries of Maryland
Process Equipment Manufacturers' Association
Professional Detailing Technicians Association
Professional Golfers' Association of America
Professional Photographers of America
Retailers Bakery Association
Service Station Dealers of America and Allied Trades
Self Insurance Institute of America
Small Business Survival Committee
Society of American Florists
Society of the Plastics Industry
Society of Professional Benefit Administrators
Southern Equipment Dealers Association
Southeastern Equipment Dealers Association
Southeastern Farm Equipment Dealers Association
Southwestern Association
Specialty Equipment Market Association (SEMA)
Snack Food Association
Student Photographic Society
Textile Rental Services Association of America
The Association Healthcare Coalition
Timber Operators Council Management Services
Timber Products Manufacturers Association
Tire Industry Association
United States Federation of Small Businesses, Inc.
U.S. Chamber of Commerce
U.S. Hispanic Chamber of Commerce
U.S. Pan Asian America Chamber of Commerce
Vermont Automobile Dealers Association
Virginia Bankers Association

Washington Area New Automobile Dealers Association
Western Growers Association
Women Impacting Public Policy
Wisconsin Automobile & Truck Dealers Association
World Wide Insurance Services, Inc.

Responses to Questions for the Record From Joe Rossmann
Senate Finance Committee Hearing of April 6, 2006 on
"Health Care Coverage for Small Businesses: Challenges and Opportunities"

Senator Grassley

Question #1:
It seems to me that a core issue here today is the role state mandates play in making health care coverage for small insurers unaffordable. I note with interest that various versions of the Durbin-Lincoln bill have gone from waving state mandates to applying them to small businesses. How significant are state mandates in making health insurance unaffordable for small businesses?

Answer:
State mandates are a significant component in overall insurance cost making health insurance more expensive for small businesses. Estimates from the General Accounting Office (GAO) value the cost of mandates anywhere from five to 22 percent of medical claims. Other estimates target the cost of mandates to be even higher up to 45 percent of claims. One of the key factors for any small business health plan or for any insurance carrier is the consistency in the interpretation of mandated benefits. More affordable health insurance coverage can be made available to small employers through the consistency in application and the reduction of mandate benefits.

Question #2:
Each state has at its disposal many tools to regulate its health insurance market. Certainly some of those can make it easier on small businesses to obtain coverage while others make it more difficult. What insurance regulations make it more difficult for small businesses to obtain health care coverage? Any of you may answer that as well.

Answer:
There are a number of well intentioned state insurance regulations which make it more difficult for small employers to obtain affordable health insurance coverage. The variance in rating laws by states, to regulate large insurance carriers in the delivery of insurance products is a factor hindering affordable health insurance plans. As the rating requirements in an individual state become more restrictive, competition in the number of insurance products and carriers reduce. States which have more flexible rating techniques generally enjoy more competition with a wider number of insurance carriers providing more affordable insurance to small employers and their employees. S. 1955 attempts to strike a balance utilizing a NAIC model for rating which is currently in use in a majority of states and one which will provide consistency across state lines in rating techniques. It will also afford markets which have had reduced competition, the potential for increased competition with more cost effective options for small employers.

Question #3:
80% of the uninsured do work. However, almost 30% of those only work part-time. Do you believe that there is any proposal out there that would make it easier to cover part-time workers?

Answer:
By making health insurance more affordable we have an opportunity to make insurance coverage more available to part time employees. In today's insurance environment health insurance can be made available to employees working as few as 20 hours per week. The industry generally says that an employee worker 30 hours a week is considered full time and is eligible for health insurance coverage. So there are mechanisms available to provide coverage to part time employees but cost of coverage is still a major hurdle.

Question #4:
My colleague from Montana raised concerns about SBHPs interfering with the Massachusetts effort to expand coverage to everyone in the state. Are these approaches necessarily exclusive? Why couldn't we pass a bill that gave states the option of an SBHP or going into the SEHBP as outlined in the Durbin-Lincoln bill?

Answer:
The Massachusetts effort to expand health insurance coverage to everyone in the state is a laudable effort and one which we hope is successful. However, mandating coverage or requiring individuals to have insurance coverage does not in itself make health insurance more affordable. Increased competition with more cost effective alternatives for employers and employees to select from will make the insurance coverages more affordable. Under the Massachusetts model, it is left to the government and the insurance companies to provide more affordable health care options. S. 1955 provides the opportunity for small businesses to join together under the small business health plan and negotiate with insurance companies for the benefit plans for small employers and employees. It is doubtful that the insurance industry will provide more affordable health insurance plans simply by requiring insurance. If they haven't brought the most cost effective plans to the table today there is no reason to believe that they would in the future by mandating that people purchase their products.

Question #5:
The most recent version of the Durbin-Lincoln bill (S.2510) requires national plans under the SEHBP to conform to all state mandates. That means they either need to have a different plan in every state or a national MEGA plan would somehow have to meet all 50 states' mandates. Is that plausible and how does that structure lower costs for small businesses? How is that different than today's regulatory environment?

Answer:
We have found historically that the insurance industry is unable to provide cost effective products nationally for small employers providing the mandates of all 50

states. The variety and complexity of the state laws has made it very difficult for insurance carriers provide products in each and every market. As such, it would be difficult for the SEHBP to provide cost effective alternatives on a national basis using the 50 state mandates. Since this concept is not working effectively in the current regulatory environment, it does not appear that it would work any better under the new the new Durbin/Lincoln proposal. One of the keys in providing a more cost effective health plans to small employers is to have consistency in rating techniques across state lines combined with consistency in benefit levels for employees and their families nationally.

Senator Baucus

Question #1:
Why was the NAIC 1993 Model Act chosen as the standard for premium rating rules in S.1955? Why were more recent NAIC models rejected? If the 1993 model is the right federal standard for more protective states, why are less protective states not also required to bring their standards up to the 1993 model?

Answer:
The NAIC model act selected for rating requirements under S. 1955 was implemented at the recommendation of NAIC and the insurance industry. The model selected is the same model that closely represents or is currently used in 61 percent of the states, (a total of 31 states). Because it is used in a majority of states, it provides the best opportunity for increased competition and minimizes changes at the state level. The states have implemented rating techniques that are both more and less restrictive than the model in S.1955. In most cases, the rating techniques that are more flexible than those in S. 1955 are states in which there is more competition, more insurance alternatives, and thus generally more cost effective coverage available to employers. It appears that those states have not adopted the stricter requirements because they realize that further restrictions in the rating techniques for small employer groups will not expand the market but rather restrict the market and reduce coverage options available to their constituencies.

Question #2:
S. 1955 treats the self-employed differently than other small groups, requiring SBHPs to apply state rating requirements in enrolling the self-employed and barring guaranteed issue requirements unless the state requires it. What is the rationale for these different rules? Are there ways to structure a proposal so that the self-employed could be included under the same rules as other small businesses?

Answer:
Changes in rating techniques for self-employed and large employers are not a component of the harmonization process under S.1955. As such, the SBHP is required to rate the self employed and large employers on the same basis as the

insurance market does today. That being said the major advantages for the self employed are the fact that the availability of the SBHP will provide them with more comprehensive coverage than they would ever have available today in the individual market. And at the same time it provides them the security in rating found in the larger SBHP pool. The self employed will have the same coverage features and advantages that all other small businesses will have by participating in a SBHP. On the other hand, they can still choose to continue coverage through the individual market. The SBHP is an option for the self employed, not a mandate.

Question #3:
Your written testimony states that, under S. 1955, "any profit generated by the [small business] health plan [SBHP] in a given year does not go to the stockholders of the insurance company, but rather stays in the plan and inures to the benefit of participants by keeping costs lower in the future." Why would this be the case? If each SBHP must be fully insured, wouldn't that mean that insurers are being paid premiums of which they could keep any excess amounts if claims were lower than expected? What part of the bill (section, page number) would require that any insurer profits be reinvested in the plan and lower costs for all members?

Answer:
In the insurance industry, large employers can be self insured or fully insured. If a large employer is fully insured they generally purchase in experience rated policy. Premium is paid to the insurance carrier; the carrier pays claims and expenses throughout the policy year. At the end of the policy year, the carrier does a margin/deficit calculation, where the insurance carrier compares the premium paid by the large employer to the expenses in the plan (composed of paid claims, expenses and reserves). Any margin or profit that remains at year end is either refunded to the large employer are used to reduce the large employer's cost in the coming year. This is the same rating technique which an SBHP would utilize by aggregating all small employers together so that they resemble a large employer group. This experience rated policy is an industry standard which has been around for more than my 30 years in business and is typical of the coverage provided to large employers. It is the negotiations between the insurance carrier and the SBHP that determine the type of policy issued to the small business health plan. This standard insurance industry practice is not outlined specifically in the bill, but is covered under Section 805(2)(B)(i).

Question #4:
Your written testimony states that "[r]ecent mergers of health insurance companies have reduced competition and alternatives for small employers." Are you concerned that the new national insurance standards in S. 1955 might increase the likelihood that more insurers would merge to operate at the national level, thereby reducing competition even further?

Answer:
The passage of S.1955 will add increased competition in the market place. Associations and Chambers of Commerce will be able to negotiate with all insurance companies in order to provide coverage to their members both regionally and nationally. It is my belief that carriers who have exited the in various states, because of their rating and mandated benefit requirements will again be able to enter those markets through the purchasing groups under the small business health plans. I believe it will increase the number insurers. It will expand the possibilities for those carriers who over the last ten years have become regional rather than national carriers.

Question #5:
You testify that S. 1955 would put insurers and SBHPs "on equal footing in products and rating methods for the plans made available for small employers," but the bill clearly treats insurers offering SBHPs differently than other insurers for products sold to small employers. For example, while the bill limits insurers to establishing only 9 classes of business in the small group market, insurers offering coverage to SBHPs appear to be able to set up as many classes of business as they choose. Can you explain how this constitutes equal treatment?

Answer:
Currently, under the NAIC Model Acts, insurance carriers are limited to nine separate classes of businesses in providing coverage to small business employers on a direct basis. Under S. 1955 they would still be limited to nine classes of businesses in providing coverage directly to small employers. However, the small business health plans could be considered a separate class for the insurance company in providing insurance to small employers through the SBHP. This does not say that insurance companies can set up an infinite number of classes but rather it states that a carrier can have nine classes for business it sells on the direct basis plus as many additional classes as needed, accounting for one per small business health plan. This provides for the flexibility for the small business health plan to act like a large employer aggregating all of the small employers together under the SBHP.

Insurance carriers still have the ability to sell the same types of plans that would be available under the small business health plan on a direct basis. They are strictly limited to the nine classes of business so as not to fragment the existing market. Equal treatment for insurance carriers is the fact that they can offer the same types of plans on a direct basis that a small business health plan will be offering to its member employers.

STATEMENT OF SENATOR GORDON H. SMITH
U.S. Senate Finance Committee
"Health Care Coverage for Small Businesses: Challenges and Opportunities"
April 6, 2006

Thank you, Chairman Grassley and Senator Baucus, for holding today's hearing. As a small business owner, this topic of increasing small business' access to affordable health insurance coverage is of special interest to me, as I know it is for many of my colleagues.

The small business community forms the backbone of the American economy, representing over 99 percent of all the nation's businesses. Only a small fraction of the nation's 24.7 million businesses have over 500 employees. Often, we fail to recognize the integral role small businesses play in the American economy. Each year, they provide approximately 75 percent of new jobs; account for over half of private sector output; and provide 40 percent of private sales. Small businesses represent the realization of the American dream, but even with all their successes, there are many challenges that threaten their continued vitality.

As the United States further integrates into the global economic market, our small businesses face heightened competitiveness from similar enterprises in developing countries. While Congress has made much progress in better supporting the small business community in the last decade, there is still much work to be done in terms of reforming outdated and complicated tax provisions and easing regulatory restrictions that larger firms can more easily manage. Factors such as these contribute to a gloomy outlook for our nation's small business community. Each year, it has been estimated that just as many small businesses close as open. This trend underscores both the challenges small businesses face in the global marketplace and the determination of the American entrepreneurial spirit to press forward in spite of those challenges.

Apart from the need for further tax and regulatory reforms, the number one challenge facing small businesses today in recruiting and retaining a qualified workforce is the lack of access to affordable health care coverage. This is an issue I hear about from my small business owners in Oregon frequently, and I know it is a message my colleagues have heard as well. Nearly 60 percent of the 40 million uninsured Americans are employed by small businesses. The problem of the uninsured has been further exacerbated by rising costs of coverage in the small group market. Firms that have been fortunate enough to secure affordable coverage for their employees may find that they have to drop it just so they can keep their doors open. If cost trends continue to hold, thousands of more individuals employed by small businesses will join the ranks of the uninsured in coming years.

Throughout the 1990s, several states passed hard-fought reforms, such as community rating guidelines that sought to stabilize the small group insurance market and increase access to coverage. Unfortunately, those gains have been overridden by skyrocketing costs of coverage and more and more small businesses—especially those with as few as

one employee with a pre-existing health condition—must confront being priced out of the market.

Small businesses deserve every opportunity as larger firms to purchase affordable, comprehensive health coverage. Extending such access is paramount to solidifying American small businesses' preeminence in the global marketplace.

Currently, there are a number of proposals before the Senate that attempt to address the problem of small business health insurance access, but from a variety of different perspectives. Most all of them center upon the concept of pooling so that groups of small firms are able to collectively improve their risk and achieve more affordable coverage rates. Allowing small businesses to band together also generates additional economies of scale and administrative efficiencies that can reduce costs of coverage even further.

Despite this common policy vein, the pending proposals do have their differences—some more controversial than others—that have made the process of achieving consensus rather difficult. I am hopeful Congress is close to passing a measure that provides small businesses greater access to quality health insurance coverage within the framework of existing state guidelines that have been enacted to better support the small group insurance market. Perhaps it is time for Congress to recognize that this is not a problem that warrants a "one size fits all" approach and move toward a solution that draws upon the merits of many of the current proposals before us.

I look forward to a thoughtful discussion of the challenges small businesses face in accessing health insurance coverage and hope the witnesses Chairman Grassley and Ranking Member Baucus have invited can provide us with their perspective on where we should go from here.

Thank you.

Senator Olympia J. Snowe
Senate Finance Committee
Health Care Coverage for Small Businesses: Challenges and Opportunities
April 6, 2006

Mr. Chairman, thank you. The small business health insurance crisis is real and is an undue burden on entrepreneurs throughout America. This is not a crisis that appeared overnight. Nearly 46 million Americans are now uninsured. And for the past decade—as health insurance premiums have increased at double-digit percentage levels and far outpaced inflation and wage gains—Congress has failed to act. Even when study after study confirms beyond a doubt that fewer and fewer small businesses are able to offer health insurance to their employees, little has been done to alleviate the problem. Quite simply, that's outrageous.

Mr. Chairman, the time for talking has long since passed. No more excuses, no more laments, no more complaining, no more describing a problem and doing nothing about it. I think we all can agree that we must provide small businesses in Maine, Montana, and Iowa—and in every State across our great land—with access to quality, affordable health insurance.

The time has come for action—not words that have long surpassed their usefulness—to deliver small businesses from this crisis. I hope my colleagues on the other side of the aisle don't just recite more partisan rhetoric and more misleading claims that have led reasonable people to believe the only way we can solve this crisis it to greatly expand and further complicate and confuse our Nation's already-complicated and confusing health care bureaucracy.

Unfortunately, the approach espoused by Senators Durbin and Lincoln would create a national health insurance plan, operated and administered by the Federal government. Their approach represents a major expansion of the Federal administrative state, and would create an unfair, unlevel and unintelligible playing field for small businesses and insurance companies. Who is going to pay for this new Federal bureaucracy?

I believe that we need to focus on solutions that are achievable, tested, and fiscally prudent. I have introduced legislation, the Small Business Health Fairness Act, that would achieve this goal, through a common-sense approach that would allow small businesses to pool together nationally, through Small Business Health Plans (SBHPs) that provide employees with quality health insurance at affordable costs. SBHPs will bring fairness to employer health coverage by giving participating small businesses the same advantages of Federal law currently enjoyed by larger businesses and unions.

Contrary to opponents of this concept who have engaged in a pattern of myths, distortions, and outright falsehoods in claiming that SBHPs would lead to "cherry picking" of only the young and healthy, SBHP legislation specifically requires that association plans must be open to all members. Let me repeat that: SBHP legislation specifically requires that association plans must be open to all members. And each employer who participates in the plan must offer the plan to every eligible employee—at the risk of fines and even imprisonment of up to 5 years.

I am encouraged by the considerable progress that has been made on SBHPs in this Senate—we're further along on this issue than we have ever been. But we need to go the distance, which is passing

legislation that President Bush can finally sign into law. I would like to commend Senator Mike Enzi for his ongoing commitment to the SBHP issue, and for successfully marking-up SBHP legislation in the Health, Education, Labor, and Pensions Committee.

I believe that Senator Enzi's bill is a good step forward so that we can consider this important issue on the Senate floor. I do, however, have a number of concerns with Senator Enzi's approach. First, Senator Enzi's bill fails to include a self-insured SBHP component. The ability for an SBHP to self-insure, like a large employer can, is a key component of my bill. It would inject much-needed competition into stagnant, dysfunctional small group insurance markets. It would also provide more options for small businesses when it comes to providing quality, affordable health insurance for their employees. To opponents of this approach I ask: What's wrong with competition? What's wrong with giving small businesses more choices when it comes to purchasing health insurance?

Second, I am concerned that a national rating standard would preempt the States' rights to regulate insurance within their borders. Under my SBHP legislation, the State insurance commissioners would rate insurance products sold in their States. Many States, including my home State of Maine, have opted to rate insurance products based on the most recent standard put out by the National Association of Insurance Commissioners.

I also have some concerns with the way Senator Enzi's bill addresses the benefit mandate approach. I believe that associations ought to be able to tailor their SBHPs to the wants, needs, and desires of their members, but I have concerns that the high-option, low-cost option approach might lead to adverse selection and an unlevel playing field. And that the high-option approach might be priced far beyond the reach of a typical small business.

In the final analysis, I strongly believe that SBHPs are an idea whose time has finally come. And I look forward to debating the SBHP issue on the Senate floor in the coming weeks, and to working with my colleagues on both sides of the political aisle to fashion a bipartisan solution to this crisis.

While SBHPs are a crucial solution, they are not the entire solution. Today I would like to discuss several additional steps that this Committee can take, in addition to SBHPs, to help reduce the ranks of America's nearly 46 million uninsured. These steps are common-sense. They are achievable. They don't add layer upon layer to a health care bureaucracy that has no shortage of red tape. And they don't call for a national health insurance program, operated and administered by the Federal government.

Instead, we should use the tax code to help resolve the small business health insurance crisis. Just last week I introduced the Small Business Health Insurance Relief Act (S. 2457), a bill that would both (1) provide targeted tax incentives that would encourage our Nation's smallest businesses to offer health insurance; and (2) inject much-needed competition into dysfunctional State small group markets.

Our Nation's smallest businesses—the "micro" businesses—are the ones least likely to offer health insurance as a workplace benefit. According to the Kaiser Family Foundation's *Employer Health Benefits 2005 Annual Survey,* only 47 percent of the smallest businesses, those with 3 to 9 workers, now offer health insurance as a workplace benefit. This is down from 52 percent in 2004, and 58 percent in 2002. Clearly, for small businesses, things are trending in the wrong direction. In sharp contrast, 98 percent of larger businesses, those with 200 or more workers, offer health insurance as a benefit.

My legislation would establish a targeted tax credit that would encourage the smallest businesses—those most desperately in need of relief—to purchase insurance coverage for their employees. The maximum tax credit under the proposal would be $1,500 for single coverage and $3,000 for family coverage. The tax credit would phase out as a business increases in size and is neutral between types of

insurance: either traditional employer-sponsored health insurance or funding health savings accounts (HSAs) of their employees.

Under my legislation, a small business with 5 employees would be eligible for a per-participant tax credit of $3,000 for a family health insurance plan, and a potential total tax credit of $15,000. Small businesses cite escalating cost as the number-one impediment to providing health insurance. Putting $15,000 in the hands of a small business owner could certainly help to overcome this barrier.

Second, my legislation would increase competition in State small group health insurance markets. There is no competition among insurers in the small group markets, with coverage and affordability the real problems. A Government Accountability Office (GAO) survey I recently requested, along with Senators Christopher Bond and Jim Talent, reported a frightening consolidation of control over State insurance markets. The five largest carriers now have more than 75-percent market share in 26 States (up from 19 in 2002) and more than 90-percent market share in 12 States (as opposed to 7 in 2002). Blue Cross and Blue Shield carriers now control 43 percent of the small group markets (up from 33 percent in 2002).

In my home State of Maine, Anthem Blue Cross now controls 63 percent of the small group market, and the five largest carriers put together dominate 98 percent.

To counter this market consolidation, my legislation would provide insurers with a 50-percent tax deduction for claims and expenses incurred in serving the small group market or Small Business Health Plans (SBHPs) and would provide a per-State tax credit to defray the cost of State licensing requirements. These incentives are open to all insurers, and would motivate new insurers to enter and compete in the dysfunctional small group market and service SBHPs.

Together with SBHP legislation, I believe that these proposals could help solve the small business health insurance crisis. Simply put, our small businesses need choices as they seek to obtain affordable health insurance. In the coming weeks, I look forward to working in a bipartisan fashion, with my colleagues on both sides of the aisle, to push these proposals through the Senate.

I look forward to hearing the ideas and reactions of this distinguished panel.

Thank you, Mr. Chairman.

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United States Government Accountability Office
Washington, DC 20548

October 13, 2005

The Honorable Olympia J. Snowe
Chair
Committee on Small Business and Entrepreneurship
United States Senate

The Honorable Christopher "Kit" Bond
United States Senate

The Honorable James M. Talent
United States Senate

Subject: *Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market in 2004*

As a follow-up to our 2002 report on the competitiveness of the small group health insurance market,[1] you requested updated information on each state and the District of Columbia. Specifically, you asked us to identify—for each state—the number of carriers[2] licensed in the small group market, the largest carriers, and their market share.

To obtain this information, we sent an electronic survey to the office responsible for regulating insurance, health plans, or both in all 50 states and the District of Columbia (hereafter referred to as a state). We followed up with nonresponding states by e-mail and by telephone and received responses from 47 states. However, not all 47 states had the information needed to answer all of the questions. For example, 40 states reported the largest carrier and 34 states provided market share data. Also, the responding states varied in how they defined the size of a small group. Most—35—defined a small group as 2 to 50 employees, 10 defined a small group as 1 to 50 employees, and 1 had another definition.[3] We did not verify the information provided by the states. We performed our work from August through October 2005 in accordance with generally accepted government auditing standards.

The following summarizes our findings:

- The median number of licensed carriers in the small group market per state was 28, with a range from 3 in Rhode Island to 75 in Georgia.

[1] GAO, *Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market*, GAO-02-536R (Washington, D.C.: Mar. 25, 2002).
[2] A carrier is generally an entity (either an insurer or managed health care plan) that bears the risk for and administers a range of health benefit offerings.
[3] Missouri defined small group as from 3 to 25 employees.

- The median market share of the largest carrier in the small group market was about 43 percent, with a range from about 19 percent in Texas to about 93 percent in North Dakota.

- The five largest carriers in the small group market, when combined, represented three-quarters or more of the market in 26 of the 34 states supplying information, and they represented 90 percent or more in 12 of these states.

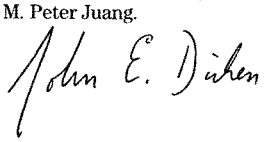
- Thirty of the 40 states supplying information identified a Blue Cross and Blue Shield (BCBS) carrier as the largest carrier offering health insurance in the small group market, and in all but 1 of the remaining 10 states, a BCBS carrier was among the five largest carriers.

- The median market share of all the BCBS carriers in the 34 states supplying information was about 44 percent, with a range from about 6 percent in Wisconsin to about 93 percent in North Dakota; in 13 of these states BCBS carriers combined for half or more of the market.

- The market share of the largest small group carrier has increased since our 2002 report. The median market share of the largest small group carrier was about 43 percent, compared to the 33 percent reported in 2002. The combined market share of the five largest small group carriers represented three-quarters or more of the market in 26 of 34 states, compared to 19 of 34 states reported in 2002. Finally, the median market share of all the BCBS carriers in 34 reporting states was about 44 percent, compared to the 34 percent reported in 2002.

The enclosure summarizes by state the number of licensed carriers, the largest carrier and its market share, and the market share of the five largest carriers in the small group market. In addition, the enclosure shows the rank of the largest BCBS carrier and the combined market share of all BCBS carriers.

As arranged with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days after its issue date. Copies will then be made available upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Please call me at (202) 512-7119 if you have any questions. Major contributors to this report were Randy DiRosa, Assistant Director; Iola D'Souza, and M. Peter Juang.



John E. Dicken
Director, Health Care

Enclosure

Enclosure Enclosure

Number of Carriers, Largest Carrier, and Market Share Data for Small Group Health Insurance Carriers by State

State	Number of licensed carriers	Largest carrier	Market share of largest carrier (percentage)	Market share of five largest carriers (percentage)	Rank of largest BCBS carrier	Market share of all BCBS carriers (percentage)
Alabama	NA	BCBS of Alabama	78[a]	NA	1	NA
Alaska[b]	12	Premera Blue Cross	66	100	1	66
Arizona	53	United Healthcare Insurance Co.	29	66	2	19
Colorado	27	United Healthcare Insurance Co.	24	72	3	13
Connecticut	25	Anthem BCBS	NA	NA	1	NA
Delaware	16	BCBS of Delaware	58	99	1	58
District of Columbia	13	Group Hospitalization & Medical Services (BCBS)	43	97	1	65
Florida	29	United Healthcare Insurance Co.	22	78	3	31
Georgia	75[c]	BCBS Health Care Plan of Georgia[c]	27[c]	65[c]	1[c]	41[c]
Idaho	16	BCBS of Idaho	45	97	1	87
Illinois	51	NA	NA	NA	NA	NA
Iowa	60	Wellmark BCBS of Iowa	56	91	1	68
Kansas	28	BCBS of Kansas	NA	NA	1	NA
Kentucky[b]	10	Anthem BCBS	43	93	1	43
Louisiana	35	Louisiana Health Service & Indemnity (BCBS)[d]	29[d]	85[d]	1[d]	54[d]
Maine	12	Anthem BCBS	48	98	1	63
Maryland	16	Carefirst Bluechoice, Inc.	43	90	1	59
Massachusetts	25	BCBS Massachusetts	32	86	1	39
Michigan	45	BCBS of Michigan	62	78	1	69
Minnesota	11	BCBS of Minnesota[d]	45[d]	98[d]	1[d]	45[d]
Missouri	38	Healthy Alliance Life Insurance Co.	46	87	3	8
Montana	13	BCBS of Montana	36	85	1	36
Nevada	35	Health Plan of Nevada	NA	NA	NA	NA
New Jersey	16	Aetna Health, Inc.	37	86	2	27
New York[e]	29	Oxford	21	63	2	36

Enclosure

Enclosure

State	Number of licensed carriers	Largest carrier	Market share of largest carrier (percentage)	Market share of five largest carriers (percentage)	Rank of largest BCBS carrier	Market share of all BCBS carriers (percentage)
North Carolina	32	BCBS of North Carolina	54	89	1	54
North Dakota	9	Noridian Mutual Insurance Co. (BCBS)	93	99	1	93
Ohio	63	Community Insurance Co. (BCBS)	32	79	1	32
Oklahoma	36	Group Health Service of Oklahoma (BCBS)	30	71	1	49
Oregon	12	Lifewise Health Plan of Oregon	25	79	5	14
Rhode Island	3	Blue Cross and Blue Shield of Rhode Island	NA	NA	1	NA
South Carolina	29	BCBS of South Carolina	49	87	1	49
Tennessee	41	BCBS of Tennessee	49	85	1	49
Texas	58	United Healthcare Insurance Co.	19	59	3	17
Utah[b]	22	Regence BCBS of Utah	40	93	1	40
Vermont	12	BCBS of Vermont	73	100	1	84
Virginia	45	Anthem BCBS[c]	NA	NA	1	NA
Washington	12	Premera Blue Cross	57	92	1	85
West Virginia	33	Blue Cross Blue Shield, Inc.	43	77	1	43
Wisconsin	50	United Healthcare of Wisconsin[a]	20[d]	49[d]	3[d]	6[d]
Wyoming	15	BCBS of Wyoming	40	74	1	38

Source: GAO survey of state insurance regulators.

Legend: NA = not available.

Notes: Reported data are for December 2004 unless otherwise noted.

Ranking and market share data are based on the number of covered lives unless otherwise noted.

Four states did not respond to the survey: California, New Hampshire, New Mexico, and Pennsylvania. In addition, six states did not provide data on small group carriers or on market share: Arkansas, Hawaii, Indiana, Mississippi, Nebraska, and South Dakota.

[a]The Alabama Department of Insurance estimated that BCBS of Alabama represented about 75 to 80 percent of the small group market. Seventy-eight percent represents the rounded midpoint of that range.
[b]Data are for December 2003.
[c]Georgia reported that there are no standard reporting sources on the number of carriers and the total number of covered lives in the small group market, but estimated the number of carriers at about 75, and estimated the total number of covered lives to be 851,365. We used the estimated number of covered lives to calculate rankings and market share.
[d]Ranking and market share are based on gross premiums.
[e]Data are for January 2005.
[f]Total premium data or number of covered lives are not collected for the small group market. A Virginia Bureau of Insurance official reported that Anthem BCBS was clearly the largest carrier in the small group market.

(290490)

Senate Finance Committee:
"Health Care Coverage for Small Business: Challenges and Opportunities"

Senator Craig Thomas (R-WY) Statement for the Record

April 6, 2006

Mr. Chairman, we are here today to talk about the challenges faced by small businesses in providing health care coverage for their employees. Over the past five years, this country has seen double-digit growth in insurance premiums. Since 2000, family coverage costs have grown almost 60 percent. This is bad for businesses that want to attract high quality employees. It is also bad for families who need jobs to pay their bills. In fact, Wyoming recently ranked 47th in the percentage of businesses that offer health insurance to their employees. It is clear that small businesses need relief.

Congress has been hard at work to draft an effective, and yet reasonable strategy to help small and low-wage businesses to offer health insurance to their employees. The Health, Education, Labor, and Pensions (HELP) Committee recently passed legislation that would allow small businesses to pool together to purchase health insurance at rates that larger companies now enjoy. The goal of S. 1955 is to give small business owners the power to negotiate for the high quality benefits they want – at prices they can afford.

I understand we will hear from Members of the Senate as well as consumer and provider groups who have quite a bit of expertise in this area. They will tell us about two very different legislative proposals aimed at helping small businesses access quality, affordable health care coverage options: 1) The Small Employers Health Benefit Program Act sponsored by Senator Lincoln and Senator Durbin; and 2) the Health Insurance Marketplace Modernization and Affordability Act sponsored by Senator Enzi, Senator Nelson, and Senator Burns. I look forward to hearing their testimony.

As we work toward making informed policy decisions in this area, I think it is very important that we also find solutions that help us more effectively and efficiently manage health care spending. Frankly, I want to see a renewed commitment to increased personal financial responsibility and flexibility. That is why I support strengthening Health Savings Accounts (HSAs) to give more Americans control over their health care costs. This way, individuals have personal financial freedom and flexibility while small businesses can make health care more affordable and accessible for their employees. This is just one more option we should explore to expand market driven health care coverage and lower costs.

Finally, I am the lead Republican sponsor of S. 663, the "Equity for Our Nation's Self-Employed Act of 2005" with my Finance Committee colleague, Senator Bingaman. Our legislation would correct an inequity in the tax code forcing self-employed workers to pay payroll taxes on the money they used to pay for their health insurance – while larger businesses do not. Self-employed workers spend more than $9,000 per year on family health insurance. Folks cannot deduct this as an ordinary business expense, so the self-employed pay a 15.3 percent tax on their premiums which results in almost $1,400 in taxes annually. This inequity causes health insurance to be more expensive for the self-employed. As this committee looks at reasonable ways to help the small business community with their health insurance costs, I believe our bill is a good first step. It reduces the burden on working families – particularly those in rural areas. I look forward to working with Senator Bingaman and the Chairman and Ranking Member of the Senate Finance Committee to see this important measure passed and signed into law.

COMMUNICATION

Written Statement of
The Coalition to Protect Access to Affordable Health Insurance
1875 Eye Street, NW, Suite 440
Washington, DC 20006

Providing access to affordable healthcare for all Americans continues to one of the most challenging issues of our time. The Coalition to Protect Access to Affordable Health Insurance (CPAAHI) shares Congress' desire to address this critical issue. However, the Coalition believes that action must be comprehensive, fair and equitable for all Americans.

That is why the Coalition strongly opposes Senator Michael Enzi's bill, S.1955 – the Health Insurance Marketplace Modernization and Affordability Act of 2006. While the goals of Senator Enzi's legislation are laudable, its impact on the health care for many Americans and in many states would be disastrous.

The Coalition to Protect Access to Affordable Health Insurance is a growing group of regional health insurance plans including GHI, HIP, Excellus Health Plan, Independent Health Association, MVP, CDPHP, Univera in New York State, and many more health plans across the country, concerned that S. 1955 would actually diminish access to affordable health care and have a destabilizing and destructive effect on state insurance markets. The impact of the Enzi bill would be particularly harmful in states such as California, Rhode Island, Maine, Massachusetts, New York and New Hampshire, where strong regulatory structures and/or community rating ensure access to comprehensive healthcare for all citizens, including the sick and most vulnerable.

S. 1955 Will Reduce Coverage

State insurance laws require a wide variety of important consumer benefits and protections, including cancer and mammography screening, well-child visits, diabetes monitoring, and the right to seek independent review of claim denials. Senator Enzi's bill would disregard those state laws and millions of Americans would be at risk of losing coverage for a host of needed benefits.

S. 1955 Will Encourage "Cherry Picking"

If passed, the Enzi legislation would permit discrimination in health insurance based on age, sex, occupation and health status. In essence "cherry picking" of the most healthy groups would become commonplace. This would result in employers with sicker and more vulnerable populations having to pay significantly more for coverage. In addition, older Americans would be particularly at risk of losing health care coverage. Ultimately, many of these employers, mostly small businesses, would find the coverage unaffordable

and be forced into no longer offering health benefits – obviously defeating the stated goal of S.1955.

S.,1955 Will Increase, Not Decrease, Health Insurance Costs

Our analysis indicates that this proposal would likely result in *increased costs*, rather than reduced premiums for most small businesses, further jeopardizing access to health insurance coverage for most citizens. In our view, it is difficult to imagine legislation that would be more harmful to state health insurance markets

The permitted rate variation under theses small group market rules is extreme. Our analysis shows the total permitted variation between the highest rated group and the lowest rated group for the same health benefit plan is 2540%. That is, if the lowest rated group is paying $100 per member per month for plan X, then the highest rated group could be paying $2540 per member per month.

S.1955 Will Increase Government Healthcare Costs

As more employers decline to offer health coverage to their employees, the ranks of the uninsured will increase. This will likely result in increased Medicaid caseloads with the additional costs borne by American taxpayers. It will also increase the amount of charity care and bad debt cases, adding further financial pressures on hospitals

Conclusion

State governments have been the incubator for many of America's most innovative solutions to the problems we face, especially in the area of providing access to health care services and coverage. S. 1955 ignores this fact, circumvents states' authority to regulate the health insurance market and undoes the strides many states have made to provide greater access to care. Under this bill, health insurance would likely become even less affordable and millions of Americans would lose coverage for critical services. The Coalition shares the goal of providing affordable health coverage for the employees of America's small businesses, but feels that this legislation, while well intentioned, clearly misses the mark and could dramatically and disastrously impact health care across this country.

For these reasons, the Coalition to Protect Access to Affordable Health Insurance joins the National Conference of Insurance Legislators, and a host of State Insurance Commissioners in voicing strong objection to S. 1955, and we urge you to work to prevent its passage.