UNITED STATES HISPANIC CHAMBER OF COMMERCE
STATEMENT - ROUNDTABLE ON HEALTH CARE REFORM
SENATE COMMITTEE ON SMALL BUSINESS
JULY 9, 2009

Chairwoman Landrieu, Ranking Member Snowe and distinguished Members of the Committee: Thank you for inviting the United States Hispanic Chamber of Commerce to share our small business perspective on the current health insurance markets and health care reform. Please note that the views expressed today are the USHCC's and are not necessarily the views of individual chambers or their members.

It has been 15 years since the last serious conversation on federal health care reform. Since that time, the Latino population has burgeoned in America and now composes 15% of the total United States population, growing at a rate faster than any other racial or ethnic group. The same can be said about the Latino business community, which has also grown faster than any other demographic, and is estimated at 2.5 million.

Unfortunately, Latinos face significant challenges to the health care system that hinder their ability to get and stay healthy. They represent 32% of the uninsured population in the U.S., a statistic that will only grow if the barriers that keep them away from affordable health coverage and care are not addressed in the health care reform debate and remedied in the resulting reform policies. Equally, the small business community and its dependents represent 52 percent of the uninsured population.

The convergence of these two sizeable uninsured demographics compels the interest of the USHCC as an organization that represents both Latino and business interests.

There is little doubt that if current rates of uninsurance persist, uninsured Latinos in year 2050 will equal the entirety of the Latino population in 2005—42.6 million people. Equally troublesome, if current rates of premium growth persist, we may see soon see only a fraction of small businesses offering employer sponsored insurance. The number of firms under 200 employees in size offering insurance is down to 59 percent and 45 percent for firms under ten employees in size.

According to the Kaiser Family Foundation reports on employer sponsored insurance, the vast bulk of the reductions in employer health coverage from 1999 to 2007 occurred in firms between 3 and 49 employees in size. These are for the most part the same size of businesses the USHCC represents, putting our members in the center of this debate.

Take into account that small business health insurance premiums have risen 113% over the last 9 years, which amounts to an annual growth rate of nearly 9 percent. One member business in El Paso, Texas with 17 employees told us how their premiums per employee exploded when two workers sought care for their pregnancies. And, how they then were forced to consider HDHP type coverage, which in itself lowers cost but at the expense of attracting and retaining talented workers.

This example crystallizes the basic flaw of the current small group market – how small firms are penalized for their size and limited employment pool. There are others here today, like the Small Business Majority, that can better describe adverse selection as a cost driver, but we need to emphasize that the solutions for small businesses cannot be limited to the smallest of the small alone and must be broad in scope.

While those businesses with less than 10 employees may be the most reluctant to offer insurance coverage, it is all small businesses under 50 employees that are suffering from the broken small group market.

The ESI coverage within the smallest of the small tends to track closely with employee wage. Those businesses with low wages are the least likely to offer coverage, not only because of cost of premiums but also because of cost in relation to wages. The reality is that too many businesses with a high proportion of near-minimum wage workers are unlikely to provide coverage regardless of whatever inducements may be provided in health care reform.

This is why Congress ought to match provisions for small business coverage with an equal focus to reform individual purchasing in the non-group market. This, we believe, is best achieved through exchanges that provide access to small business and individual coverage options.

Additionally, we believe it necessary to protect the employer sponsor role by making the workplace the center by which enrollment takes place. This also allows us to avoid tricky and politically delicate issues related to eligibility due to the natural presumption over residency status that comes with being legally employed. To further preserve this principle, it is absolutely necessary to avoid any discussion of dramatically altering the employment verification process. There are plenty of legislative vehicles that should arise in this Congress to address that issue.

The reasons to bring that portion of the non-citizen population into the health care pool are clear – they are disproportionately young and healthy. This are exactly the types of workers we want in an insurance pool to mitigate risk within that pool. To exclude them from participation to accomplish some populist political goal is tantamount with cutting off the nose to spite the face. Further, with 22 percent of the uninsured population being composed on non-citizens, we cannot call any coverage options that exclude nearly a quarter of the uninsured as universal or near-universal.

Clearly, we are all here today because small and minority owned firms are facing the brunt of costs associated with a disorganized insurance structure that requires substantial change. Too often our small and minority firms who would like to buy coverage face significant barriers to doing so, including lack of affordability and discrimination based on health status.

In most private health insurance markets it is very difficult for individuals and employers to effectively compare options based on price, benefits, and quality of service. This lack

of standardized and easily digestible information on comparability of plan options limits the ability of purchasers to make cost-effective choices for their coverage. This is especially true with newer and smaller firms.

We must also protest that there is little competition between insurers, which is a consequence of a substantial amount of consolidation among insurers and health care providers in recent years. With little incentive on the part of large consolidated providers to negotiate over price with insurers, and insurers with large market shares being reluctant to pass on these costs to purchasers ... we have seen a continuing escalation in premiums.

All of these earlier concerns could be addressed through a health insurance exchange. Such an exchange can be developed to organize the insurance market and to provide guidance and oversight in achieving reform goals. Providing additional lower-cost coverage options for purchasers in those markets where there is little competition can further promote competition in insurance markets and could be an effective strategy for slowing health care cost growth.

In a context of near-universal coverage that includes subsidies for the low-income population and possibly for the high-risk population and prohibits insurer discrimination by health status, an exchange can play an important role related to ensuring the broad-based spreading of health care risk.

An exchange can penalize or exclude from participation companies that violate insurance market regulations, establishing market conduct rules to prevent evasion of regulations through informal means. Requiring enrollment through a centralized place, for example, can prevent carriers from denying coverage to particular groups with poor risk profiles or actively marketing only to the healthy.

An exchange can also provide for risk adjustment to account for any uneven distribution of enrollee risks across insurers, requiring participating insurers to provide sufficient data on their health plan enrollees. With more accurate risk adjusters, exchanges can maintain a more diverse group of plan options, including highly managed and less tightly managed plans.

Further, the exchange could exclude plans not meeting minimum coverage standards, ensuring that all have access to meaningful coverage. Such minimum coverage standards will also reinforce risk spreading. If a common set of benefits are covered by all plans, but some variation in cost-sharing requirements is allowed, individuals will be less likely to choose plans based upon their health status.

Exchanges can also play an important role in cost containment. The lack of competitive pressures in the current insurance market leads to higher prices and less cost-efficient practice patterns. Insurance markets are dominated by a small number of larger insurers. In 2003, in all but 14 states, three or fewer insurers accounted for 65 percent of the commercial insurance market.

Also, 34 states had Herfindahl-Hirschman Indices of greater than 1,800, the level at which the Department of Justice and the Federal Trade Commission guidelines deem markets of antitrust concern. While medical care costs grew significantly faster than inflation during the 2000 to 2003 period, private insurer revenue grew even faster. In other words, the insurers' market empowered them to pass on health care costs to purchasers and also increase their own profitability at the same time.

An exchange can be given the authority to negotiate with health insurers over premiums. They could also be allowed to exclude insurers from exchange participation based upon premium price or growth. Both of these tools would provider greater incentives for insurers to negotiate lower prices with providers and to hold down premium rates relative to current trends. Such rate negotiation is not done by state insurance departments. If an exchange required plans to offer similar insurance packages, this would also promote greater competition, as purchasers would have the ability to more easily compare price differences across plans. Understanding of plan options could be further enhanced by the exchange providing improved information materials to consumers.

To ensure that small businesses participate in such an exchange, we propose that targeted tax benefits be provided, especially aimed at those businesses with a high proportion of low and median wage workers, phased out by size of business and average salary.

As for methods of financing, there are a number of options being discussed – many of them controversial. Without getting into a discussion over the broader subject, we would like to address three specific issues: regressive consumption based taxes, employer mandates, and capping the tax exclusion of employer sponsored health insurance.

There are several consumption-based and product specific taxes being considered to help finance health care reform, those being soft drinks and alcohol. Spirits, wine and beer are already among the most heavily taxed consumer goods in the United States, with 59% of the retail price for spirits, and 41% for beer and wine, going towards taxes and fees. As for both sugar and alcoholic drinks, the regressive nature of such taxes cannot be ignored. These excise taxes will negatively impact consumers' pocketbooks, prove detrimental to various ancillary industries, and ensure negative repercussions on the hospitality industry.

As for employer mandates, our belief is that pushing back the size categories of businesses that fall within it significantly lowers the adverse impact on the small business community. Clearly, there is curve on adverse impact and, while the USHCC does not support and employer mandate, we believe in the concept of shared responsibility and motivating large employers to participate in the health care system. Mind you that within shared responsibility, we also believe individuals have a role in health care and there are strong arguments for individual mandates if purchasing can be steered towards an exchange.

Capping the tax exclusion of employer sponsored health insurance is another financing option that is being considered. Our belief is that the current structures are regressive and put upward pressure on health care costs. If such tax exclusion is considered, we would suggest that it force insurance markets to operate at a mean, and tax those above it.

Additionally, we would restate the correlation between wages and health coverage. Therefore it stands to reason that the exclusion could also be phased in according to the salary of workers.

In sum, the significant shortcomings of current health insurance markets mean that the list of goals for reform is lengthy. Serious cost-containment measures will be critical to ensuring the long-run stability of any comprehensive system of reforms. Establishing a health insurance exchange can facilitate the spreading of health care risk, delivering health care subsidies, ensuring meaningful coverage, and containing health care costs. Further, these exchanges must be structured to not limit participation only to the smallest of the small in order to not leave a large number of small businesses unaffected by health care reform and therefore subject to continuing steep rates of premium growth and unreasonable costs of providing employer sponsored insurance.