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INCREASING HEALTH COSTS FACING SMALL BUSINESSES

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

ON

EXAMINING INCREASING HEALTH COSTS FACING SMALL BUSINESSES

NOVEMBER 3, 2009

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C O N T E N T S

STATEMENTS

TUESDAY, NOVEMBER 3, 2009

ADDITIONAL MATERIAL

INCREASING HEALTH COSTS FACING SMALL BUSINESSES

TUESDAY, NOVEMBER 3, 2009

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 2:37 p.m. in Room SD–106, Dirksen Senate Office Building, Hon. Tom Harkin, Chairman of the committee, presiding.

Present: Senator Harkin, Murray, Brown, Casey, Hagan, Merkley, Franken, Bennet, Enzi, McCain, Murkowski, Coburn and Roberts.

Also Present: Senator Specter.

OPENING STATEMENT OF SENATOR HARKIN

The CHAIRMAN. The U.S. Senate Committee on Health, Education, Labor, and Pensions will come to order. Today's hearing is about the increasing health costs facing small businesses in America.

I might just say at the outset that about a week ago, on Sunday, I got a call early in the morning from Senator Specter. He asked me if I'd read the *NY Times*. And I said, "Well, no, quite frankly I just got up." It was that early in the morning.

And he said, "Well, there's a story on the front page you got to read." I don't get it delivered so I went down, got the *NY Times* and read it. It was about the plight of small businesses and health insurance.

Senator Specter and I talked about that later on. And Senator Specter suggested that this would be an apt subject for a hearing prior to the Senate debating and taking up the Health Care bill. I agreed wholeheartedly with him.

So, I asked Senator Enzi if we could have such a hearing and he most obligingly agreed to hold this hearing in this room and to invite some of our small business people and others to this hearing. And I've invited Senator Specter, who is not a member of the HELP Committee, but is a member of the Appropriations Subcommittee on Health, to join us. So I want to thank Senator Specter at the outset for that phone call and for the heads up and for actually asking for this hearing.

Well, we're on the verge of a historic moment in the U.S. Congress, and I think in the life of our country. Within a few days we'll begin debate on National Health Reform legislation—reform the

country has so desperately needed, but which has eluded our grasp for over half a century. This time we won't fail.

For the millions of small business owners across the Nation who are desperately struggling to provide affordable health insurance to their employees, this moment cannot come soon enough. Over the past decade the cost of health insurance for small business has spiraled by 123 percent. The most important reason cited among small businesses who have dropped coverage is the high cost of health insurance. In an August survey, 15 percent of small businesses reported being offered premium increases of over 20 percent to renew the same plan they had last year. And just over a week ago the *NY Times* ran this article, this front page article I just mentioned, with reports of premium increases of an average of 15 percent for the coming year.

To confirm these trends the National Association of Insurance Commissioners conducted a survey of State insurance commissioners. The regulators reported back that in most States requests for premium increases are averaging 11 to 16 percent for 2010. In some States requests for premium increases are as high as 20 to 35 percent. And in five States, regulators have already taken some form of action to respond to the unreasonably high premium increases.

As we will hear today from the small business owners on the panel, these general trends do not even begin to capture the crippling spikes in premiums that can occur for reasons beyond the control of the business. For premiums to skyrocket, all it takes is one diagnosis for one employee or even the spouse of an employee. All it may take is just one older employee. All it may take is a drop in the number of employees in the business or maybe all it takes is sometimes just one employee who happens to be a woman, especially if she's pregnant. All told, these arbitrary and discriminatory factors can jack up premiums for small businesses by 150 to 200 percent or more.

I do not believe that this is right in this country of opportunity. America's small businesses are woven into the fabric of the American dream. They reflect our pioneering and entrepreneurial spirit. And they are the engine of economic growth in our country.

Over the past decades small businesses have created over 65 percent of all new jobs in our country. But faced with such wild and unpredictable swings in the cost of health insurance how are small businesses supposed to budget? How can they take the risk of expanding? How can someone with a good idea and with the energy to go out on their own start their own family business if they are crippled by either no health care coverage or excessively high coverage?

Under the status quo small businesses are being forced to make choices they should not have to make. And the fear of crushing health costs is stifling the entrepreneurial spirit. At this hearing I would have liked to question health insurance companies about these trends and practices. We invited them. But not surprisingly insurance companies are not interested in discussing them. They declined to appear today.

So today I'm announcing my own investigation into the pricing practices of health insurance companies that sell policies to small

businesses. Health insurance companies should open their books. Explain to the American people why they support a health insurance market for small businesses that is so dysfunctional and so lacking in transparency.

Small businesses are desperately trying to do the right thing for their employees. And doing the right thing will also make them more competitive and profitable. They need some help.

Our legislation will create health insurance exchanges that pool small businesses together and increase competition. Under the status quo small businesses pay 18 percent more than large businesses for exactly the same insurance plan and coverage, same policy. The exchanges will enable small businesses to easily compare the prices, benefits and quality of health plans. In other words, they will make the market more transparent.

Our legislation will end the discriminatory insurance industry practice of jacking up premiums because an employee got sick or older or because the business hired a woman. This will also reduce premiums because insurance companies will no longer be allowed to investigate the health condition of employees, eliminating the wasteful cost of underwriting. Under our legislation an estimated 3.6 million small businesses nationwide will qualify for a tax credit of up to 50 percent of premiums to make coverage more affordable. In my State of Iowa 49,000 small businesses will be eligible for this premium tax credit.

As is well known, our legislation will ban arbitrary limits on benefits and place limits on out-of-pocket expenses. It will require coverage of recommended, preventative care with no cost sharing, no co-pays, no deductibles. These reforms will provide security and peace of mind to small business owners. They will make employees healthier and improve their productivity.

And finally, I'm very pleased that our legislation will increase competition by providing small businesses with a choice of a public insurance plan. A lot of times that's forgotten. Small businesses will be eligible for that public insurance plan.

As the GAO has found there's very little competition in the small group market. Under the status quo small businesses do not have much choice. And we'll guarantee that they do have more choices.

So to America's small businesses I have a simple message. We're fighting for you. And help is on the way.

The time has come to act. We will succeed because the status quo is not an option. It's time to make health insurance markets work for all Americans—not just the healthy and wealthy, but also the sick, the old and entrepreneurs in pursuit of the American dream.

[The prepared statement of Senator Harkin follows:]

PREPARED STATEMENT OF SENATOR HARKIN

We are on the verge of a historic moment in the U.S. Congress, and in the life of this great Nation. Within the next week or so, we will begin debate on national health reform legislation—reform that this country has so desperately needed, but which has eluded our grasp for over half a century. This time, we will not fail.

For the millions of small business owners across the Nation who are desperately struggling to provide affordable health insurance to their employees, this moment could not have come soon enough.

Over the past decade, the cost of health insurance for small businesses has spiraled by 123 percent. As a result, the percentage of small businesses offering coverage dropped from 68 percent to 59 percent. The most important reason cited for not offering coverage is the high cost of health insurance.

In an August survey, 15 percent of small businesses reported being offered premium increases of over 20 percent to renew the same plan they had last year. And just over a week ago, the *New York Times* ran a front-page article with reports of premium increases of 15 percent for the coming year.

To confirm these trends, the National Association of Insurance Commissioners conducted a survey of State insurance commissioners. The regulators reported back that in most States, requests for premium increases are averaging 11 to 16 percent for 2010. In some States, requests for premium increases are as high as 20 to 35 percent. And in five States, regulators have already taken some form of action to respond to unreasonably high premium increases.

As we will hear today from the small business owners on the panel, these general trends do not even begin to capture the crippling spikes in premiums that can occur—for reasons beyond the control of small businesses. For premiums to skyrocket, all it takes is one diagnosis for one employee—or the spouse of an employee; all it takes is one older employee; all it takes is a drop in the number of employees in the business; and all it takes is one employee who happens to be a woman. All told, these arbitrary and discriminatory factors can jack up premiums for small businesses by 150 to 200 percent or more.

That is not right in this country of opportunity. America's small businesses are woven into the fabric of the American dream: they reflect our pioneering and entrepreneurial spirit. And they are the engine of economic growth in this country: over the past decade, small businesses have created 65 percent of all new jobs.

But faced with such wild and unpredictable swings in the cost of health insurance, how are small businesses supposed to budget? How can they take the risk of expanding? How can someone go out on their own to start their own family business? Under the status quo, small businesses are being forced to make choices they should not have to make, and the fear of crushing health costs is stifling the entrepreneurial spirit.

At this hearing, I would have liked to question health insurance companies about these trends and practices. But not surprisingly, insurance companies are not interested in discussing them. So today I am announcing my own investigation into the pricing practices of health insurance companies that sell policies to small businesses. Health insurance companies should open their books and explain to the American people why they support a health insurance market for small businesses that is so dysfunctional, and so lacking in transparency.

Small businesses are desperately trying to do the right thing for their employees—and doing the right thing will also make them more competitive and profitable. But they need help. And with the release of the Senate's legislation within the next week or so, help is on the way.

As we'll learn today, our reforms will not only help families, they will also help the economy, too. Our plan for affordable, quality health care will save small businesses tens of billions of dollars in spending on health insurance premiums each year, saving tens of thousands of jobs each year. Now that's a prescription for progress.

Our legislation will create health insurance exchanges that pool small businesses together and increase competition. Under the status quo, small businesses pay a tax of 18 percent on health insurance because of exorbitant administrative costs. The exchanges will enable small businesses to easily compare the prices, benefits, and quality of health plans.

Our legislation will end the discriminatory insurance industry practices of jacking up premiums by up to 200 percent because an employee got sick or older, or because the business hired a woman. This will also reduce premiums, because insurance companies will no longer be allowed to investigate the health condition of employees—eliminating the wasteful cost of underwriting.

Under our legislation, an estimated 3.6 million small businesses nationwide will qualify for a tax credit of up to 50 percent of premiums to make coverage more affordable. In Iowa, 49,000 small businesses will be eligible for this premium tax credit.

Our legislation will ban arbitrary limits on benefits, and place limits on out-of-pocket expenses. And it will require coverage of recommended preventive care, with no cost-sharing. These reforms will provide security and peace of mind to small business workers, make them healthier, and improve their productivity.

And finally, I am very pleased that our legislation will increase competition by providing small businesses with a choice of a public insurance plan. As GAO has found, there is very little competition in the small group market: the market share of the largest small group insurer rose from 33 percent in 2002 to 47 percent in 2008. Under the status quo, small businesses do not have much choice, and we will guarantee that they have one.

So to America's small businesses, I have a simple message: we are fighting for you, and help is on the way. The time to act has come. We will succeed, because for you and for America, the status quo is not an option. It is time to make health insurance markets work for *all* Americans—not just the healthy and wealthy, but also the sick, the old, and the entrepreneurs in pursuit of the American dream.

Senator HARKIN. I'd now like to turn to our Ranking Member, Senator Enzi.

OPENING STATEMENT OF SENATOR ENZI

Senator ENZI. Thank you, Mr. Chairman. I appreciate you holding this hearing. I've had an intense interest in this since I owned a small business.

The CHAIRMAN. Yes, you are a small businessman.

Senator ENZI. It's been working like that for a long time, and the status quo in health care is unacceptable.

Health care costs are skyrocketing. Insurance premiums are increasing. And too many small businesses can no longer afford to offer health insurance to their workers.

While I agree that we need to change our current system, the approach reflected in the current health reform bills is the wrong answer. I object to the current health reform bills, not because I support the status quo, but because the bills really do little to address the problems of increasing costs and premiums for small business. These bills will not reduce health care costs and will actually increase insurance premiums for most Americans.

I fought for years to enact common sense reforms that will slow down health care cost growth and make the insurance market work better for small businesses. Before I entered politics, my wife and I had shoe stores. We know firsthand how hard it is to meet payroll and provide meaningful benefits for the employees.

I understand how the current insurance market fails to meet the needs of many small businesses. That's why I fought for real reforms that will actually help small businesses. In 2006 I introduced a small business health plan bill that would have saved the taxpayers about a billion dollars and would have provided health insurance to almost a million people. The bill would have made common sense reforms to the insurance market and given more leverage to small businesses to help them negotiate lower insurance premiums.

Incidentally, the idea from that came from Ohio because it was already happening in Ohio where they had a big enough population that they were able to do small business health plans. And the people doing that in Ohio said, "do you know how much we could save if we could cross State borders, if we could maybe go nationwide?" They were saving 23 percent just on administrative costs.

The insurance industry working closely with many of my Democratic colleagues fought to defeat my bill. And unfortunately they were successful on the motion to proceed. And the motion to proceed kept us from doing the amendment that would have cleared up probably about 30 more votes to solve the one outstanding issue that was still there which was the mandate issue. So we didn't get it in 2006. I know how tough reform is to get done.

Since 2006 little has changed in the insurance marketplace. Health care costs and premiums continue to spiral upwards. The Kaiser Family Foundation reports the cost for small businesses with less than 200 employees and I've got to tell you I think 200 employees is big business to me.

But nevertheless their study, said with less than 200 employees, rose by 4.7 percent from 2006 to 2007, 2.2 percent from 2007 to 2008, 5 percent from 2008 to 2009. And they're expected to rise again this year. Small businesses cannot continue to sustain these types of price increases.

They need and want reform. And Congress should deliver reform. Congress should pass a bill that decreases the cost of health care and reduces insurance.

As I said before, unfortunately the bills that Speaker Pelosi, Leader Reid and President Obama are pushing through Congress will do little to address spiraling health care costs. And will actually increase the insurance premiums most Americans pay for their health care. Even worse these increases in premiums will come at a time of rising unemployment.

The 2,000 page House bill and the 1,500 page Senate Finance bill and the 1,000 page HELP bill will drive up costs. They'll increase taxes and they'll expand the size of government. The nonpartisan Congressional Budget Office, the Administration's own official actuaries, the National Association State Insurance Commissioners and at least six other private studies have all reported that the Democrat leadership bills will drive up costs.

Actuaries at the consulting firm, Oliver Wyman, which did one of the studies, estimated these bills will increase premiums for small businesses by at least 20 percent. WellPoint which is the largest BlueCross/BlueShield plan in the Nation looked at their actual claims experience in 14 States in which they operate, and concluded premiums for healthier, small businesses will increase in all 14 States and in Nevada by as much as 108 percent.

Even the Congressional Budget Office has said, "Premiums in the new insurance exchanges would tend to be higher than the average premiums in the current law individual market." When the 85 percent of Americans who already have health insurance hear the term health care reform they want Washington to do something that lowers the cost of their insurance premiums. Unfortunately the bills that Congress has developed will do the exact opposite.

Our economy can't take the higher taxes, higher unemployment and higher mandates these bills impose. Taken together the new taxes, mandates and regulations will cumulatively increase health insurance premiums for millions of Americans who currently have health insurance. These higher taxes, higher premiums and higher costs are not the change that American people voted for.

Unemployment is higher than it's been in decades. The housing market is in distress. And more and more middle class Americans are feeling squeezed by irresponsible decisions being made here in Washington.

We all agree the health insurance market is broken and needs to be fixed. Everyone who wants health insurance should be able to get it. And they shouldn't have to spend all of their hard earned savings to get it. No American should be denied health insurance because they have cancer, diabetes or some other pre-existing condition. No one should be denied health insurance, period.

These reforms are very important and long overdue. We also need to enact common sense reform, similar to the reforms I advocated in 2006 with the small business health plans. And then in 2007 and 2008 with my Ten Steps to Transform Health Care in America which is on my Web site.

I look forward to hearing from our witnesses about the impact of these bills. I also hope that this information will encourage my colleagues to go back to the drawing board to develop bipartisan health care solutions that will actually reduce costs and make health insurance more affordable for small businesses. I thank the Chairman.

[The prepared statement of Senator Enzi follows:]

PREPARED STATEMENT OF SENATOR ENZI

Mr. Chairman, the status quo in health care is unacceptable. Health care costs are skyrocketing, insurance premiums are in-

creasing, and too many small businesses can no longer afford to offer health insurance to their workers.

While I agree that we need to change our current system, the approach reflected in the current health reform bills is the wrong answer. I object to the current health care reform bills, not because I support the status quo, but because the bills do nothing to address the problems of increasing costs and premiums. These bills will not reduce health care costs and will actually increase insurance premiums for most Americans.

I have fought for years to enact common sense reforms that will help slow health care cost growth and make the insurance market work better for small businesses. Before I entered politics, my wife and I ran a small business. We know firsthand how hard it is to meet payroll and provide meaningful benefits to employees. I understand how the current insurance market fails to meet the needs of many small businesses.

That is why I have fought for real reforms that will actually help small businesses. In 2006, I introduced a small business health plans bill that would have saved the taxpayers about a billion dollars and would have provided health insurance to almost a million people. The bill would have made common sense reforms to the insurance market and given more leverage to small businesses to help them negotiate lower insurance premiums.

The insurance industry, working closely with many of my Democratic colleagues, fought to defeat my bill. Unfortunately, they were successful, and 43 Senators voted to block our efforts to get the Senate to pass these reforms.

Since 2006, little has changed in the insurance marketplace. Health care costs and premiums continue to spiral upwards. The Kaiser Family Foundation reports that costs for small businesses with less than 200 employees rose by 4.7 percent from 2006 to 2007, 2.2 percent from 2007 to 2008, 5 percent from 2008 to 2009, and they are expected to rise next year.

Small businesses cannot continue to sustain these types of price increases. They need and want reform, and Congress should deliver reform. Congress should pass a bill that decreases the cost of health care and reduces insurance premiums.

Unfortunately, the bills Speaker Pelosi, Senator Reid, and President Obama are pushing through Congress will do nothing to address spiraling health care costs and will actually increase the insurance premiums most Americans pay for their health care. Even worse, increases in premiums will come at a time of rising unemployment.

The 2,000-page Pelosi bill and the 1,500-page Senate Finance bill will drive up costs, increase taxes, and expand the size of government. The non-partisan Congressional Budget Office, the Administration's own official actuaries, the National Association of State Insurance Commissioners and at least six other private studies have all reported that the Democrat Leadership bills will drive up costs.

Actuaries at the consulting firm, Oliver Wyman, which did one of the studies, estimated these bills will increase premiums for small business by at least 20 percent. WeIlpoint, the largest Blue Cross Blue Shield plan in the Nation, looked at their actual claims

experiences in the 14 States in which they operate, and concluded premiums for healthier small businesses will increase in all 14 States—in Nevada by as much as 108 percent.

Even the Congressional Budget Office has said: "premiums in the new insurance exchanges would tend to be higher than the average premiums in the current-law individual market."

When the 85 percent of Americans who already have health insurance hear the term "health care reform", they want Washington to do something that lowers the cost of their health insurance premiums. Unfortunately, the bills that Congress has developed will do the exact opposite.

Our economy can't take the higher taxes, higher unemployment, and higher mandates these bills impose. Taken together, the new taxes, mandates and regulations in these bills will cumulatively increase health insurance premiums for millions of Americans who currently have health insurance.

These higher taxes, higher premiums, and higher costs are not the "change" the American people voted for. Unemployment is higher than it's been in decades, the housing market is in distress, and more and more middle class Americans are feeling squeezed by irresponsible decisions being made here in Washington.

We all agree the health insurance market is broken and needs to be fixed. Everyone who wants health insurance should be able to get it, and they shouldn't have to spend all of their hard-earned savings to get it. No American should be denied health insurance because they have cancer, diabetes, or some other pre-existing condition. No one should be denied health insurance, period.

These reforms are very important and long over-due. We also need to enact common sense reforms similar to the reforms I advocated for in 2006 with small business health plans and then in 2007 and 2008 with my plan, "Ten Steps to Transform Health Care in America".

I look forward to hearing from our witnesses about the impact of these bills. I also hope this information will encourage my colleagues to go back to the drawing board to develop bipartisan healthcare solutions that will actually reduce costs and make health insurance more affordable for small businesses.

The CHAIRMAN. Thank you very much, Senator Enzi. Other statements will be made a part of the record.

I say to all of our witnesses, your statements will be made a part of the record in their entirety. We will go from right to left. Senator Specter wanted to introduce Mr. Rowen. I will honor that after our first witness.

I'd ask each of you to summarize your statements in 5 minutes or so. I don't hold fast to 5 minutes. If it goes over a little bit, fine. But once it starts getting near 7 minutes, I will start picking up the gavel.

But if you can keep it around that because we'd like to have a general discussion with most of you. I read all of your testimonies last evening.

We'll start on my right, first with Mr. Art Cullen. Art Cullen is the editor and part owner of the *Storm Lake Times*, a twice weekly newspaper of 3,300 in Storm Lake, IA. Art is a native of Storm

Lake, graduated from St. Mary's High School, the University of St. Thomas in St. Paul, MN.

He's been a reporter and editor at the *Algona Upper Des Moines* in Algona, IA. Managing editor of the *Daily Tribune* in Ames, IA. News editor of the *Mason City Globe Gazette*. In 1990 Art returned to Storm Lake and with his older brother, John, launched the *Times* in their hometown. Art and his wife, Delores, who also works at the *Times*, have four children.

A few weeks ago, I had my weekly press call. We were talking about the Health Care bill. Mr. Cullen was telling me about his situation. And I thought that just really typified what a lot of small businesses are going through. So I asked him if he would appear here today to share with us what's happening out in a small town in Western Iowa.

Mr. Cullen, welcome and please proceed.

STATEMENT OF ART CULLEN, EDITOR, THE STORM LAKE TIMES, STORM LAKE, IA

Mr. CULLEN. My name is Art Cullen.

Thank you, Senator. Indeed what's going on in Western Iowa is it's cold and windy. And it's beautiful here today. Thank you for inviting me.

As you noted my brother founded the *Storm Light Times* in 1990. And at the time he was working in public relations for a local college, Buena Vista University. And he had a very nice health care plan there.

But he missed the newspaper business terribly. And the existing newspaper in our town was lousy. So he wanted to start a good newspaper. And so we did.

We offered health insurance to our employees. If John said he had to do it today, he would stick with his TIAACREF pension plan and health insurance that he had at the college. And he'd view this, speaking for him, as a real impediment to starting a business in health insurance. If you've got good health insurance you're not going to want to go out on a limb and start a competing newspaper in your hometown.

I'd also note that I have two children in college. They're both getting their own health insurance. My daughter is getting hers through a very generous financial aid package at Drake University in Des Moines.

I have twin sons at home who are enrolled in the SCHIP program because we can't make enough money in a $10-an-hour economy in Western Iowa at a local newspaper. So my kids get SCHIP. I wish I could get SCHIP.

We had our sales manager, great worker, Mike Diercks is his name. And he just works like a dog. And he had to have a kidney transplant. And our insurance rates went up 100 percent in 2 years between 2004 and 2005.

Since 1992 our individual plan was $169. Now it's 626. That's a 270 percent increase. According to the Minneapolis Fed the rate of inflation during that same period was 65 percent. So our rates went up 270 percent versus the cost of living increase in the upper Midwest of 65 percent.

So I'm not sure if I heard Senator Enzi right. But he was saying something about 2 percent and 1 percent. Steve Hamilton, a local lawyer with three lawyers and about a dozen staff support, their bills are going up 20 percent this year. They're on Wellmark BlueCross/BlueShield.

We haven't been notified of our rate increase yet. But given double digit percentage increases every single year, including 59 percent 1 year, 28 percent in 2006, 15 percent in 2007, 11 percent last year and we expect our rates to go up, probably, if they say 11 then we believe it will be 22.

[Laughter.]

And that basically summarizes my remarks other than I have two other things to say.

One is I know that Senator Harkin has been working very hard on preventative measures. He talks about it at every single one of those conference calls, I can assure you. And I'd have to spend $3,000 out-of-pocket to get a colonoscopy.

I'm 52, getting old. And I can't afford it because we have a $5,000 deductible. And anything that's done at a hospital comes out of my pocket. And so a colonoscopy is done at the hospital as are mammographies. Neither of which would be covered under our deductible. So we have to drive to Sioux City or Fort Dodge which are more than an hour away to get simple, preventative measures done.

We have a cancer patient in our office, colon cancer. And if she got a shot at our local hospital, the Buena Vista County Hospital, it would cost her $2,500. If she drives to Sioux City, where it's done in a clinical setting, it would cost her $25. But she drives right past the Buena Vista County Hospital and drives all the way to Sioux City to get that shot because it's not covered under our health insurance plan. That's a deductible.

So you know, I could go on with horror stories for an hour. But, I only have four words for Senator Al Franken and that is, Joe Mauer for Governor. I have 3 seconds left.

The CHAIRMAN. Who?

Mr. CULLEN. Joe Mauer.

[Laughter.]

[The prepared statement of Mr. Cullen follows:]

PREPARED STATEMENT OF ART CULLEN

THREAT TO SMALL BUSINESS

My brother, John, founded The *Storm Lake Times* in June 1990 to make a difference in the community that reared us. He did not start the hometown newspaper to administer a health insurance plan and cover its escalating costs.

He started the newspaper with a small inheritance from our mother and an extra mortgage on his house. John believed that every employee should have health insurance and provided it. The *Times* paid the employee cost, and the employee was responsible for the family share. Back then, the family package was about $200 per month. Now it is more than $900 per month, with greatly decreased benefits.

The *Times* has grown from no circulation to about 3,300 paid circulation, twice a week, with 12 employees. We have our own press and production facilities.

The *Storm Lake Times* now pays nearly $50,000 per year for health insurance coverage. That's almost as much as we pay for newsprint.

Were it not for such high insurance costs we could add more employees and help to grow our local economy, plus publish an even better newspaper.

Our rates doubled when one employee, previously bankrupted by medical bills, had a kidney transplant in 2005. Rates have gone up by double digits every year

since. We cannot switch insurers because of employees with pre-existing conditions (cancer, diabetes, back surgery). And even if we could get around pre-existing conditions, one health insurance company controls about 85 percent of the local market.

To cope with increasing costs, we have accepted a $5,000 deductible on services provided by a hospital. Therefore, a cancer patient who needs to have a shot has a choice: have the shot done in Storm Lake at the hospital and pay $2,500 out-of-pocket, or drive to Sioux City and pay $25 for the same shot from the same doctor—in a clinic, and not a hospital. The same problem arises for many routine preventative types of tests—mammography and colonoscopy immediately come to mind. Each would be covered by health insurance if offered at a clinic. If offered by Buena Vista Regional Medical Center, a colonoscopy would cost about $3,000 out-of-pocket.

(Buena Vista County has the highest rate of fatal colorectal cancer in Iowa, possibly because of low screening to catch it early.)

Health reform will help small rural critical access hospitals like ours. Rather than having all that money flowing to Sioux City an hour away, we would have our services performed right here in Storm Lake. It would be a revenue boon for rural hospitals.

Wellmark, the leading insurer in Iowa, already announced an 11 percent rate increase next year for State employees—a far larger and more stable pool than ours. We anticipate that our rates will rise at least that much. We cannot "pass the cost" to consumers through subscription or advertising rate increases. Extra costs will come out of our business' bottom line, or out of our employees' pockets.

Buena Vista County has an average household income of $36,000 per year. The cost of most insurance plans—Cadillac by no means, more like a Hyundai—offered locally thus accounts for about a third of that household income. Hence, housing and health insurance costs consume about two-thirds of a working family's income in our rural, agricultural economy.

We need more insurance competition in the rural marketplace by knocking down State cartels. We need fair compensation for rural physicians, who are losing ground to their urban and specialist peers as costs ratchet down on providers. It's tough enough to recruit local doctors without discounting their pay. We need to maintain federally subsidized Community Health Centers, an important front door to the health care system for workers in the meatpacking industry, which dominates our local economy. We need to be able to switch health insurance companies or agents, which we currently cannot. We need to provide mechanisms under which the insured can get low-cost preventative tests such as mammographies or colonoscopies. We need to know that a single health catastrophe will not bankrupt us and bring down everything we have worked for over the past 20 years.

We want to invest in our business, and thus in our community with a thriving local newspaper that brings a community together. Rising health care expenses represent a significant bar to that dream.

Thank you.

The CHAIRMAN. Ok. Fine.

[Laughter.]

And now for purposes of introduction of our next witness, I turn to Senator Specter.

STATEMENT OF SENATOR SPECTER

Senator SPECTER. Thank you, Mr. Chairman. I'm pleased to introduce Mr. Walter Rowen from Lancaster, PA. He has a company which employs 35 people, a glass company. Been in business for 100 years and was faced with an increase in premiums of 128 percent.

I had hoped we would have his insurance company to come in because as we take a look at the issues on our legislation it would be my hope that we could find out whether the *New York Times* report was correct that the insurance companies are responding to Wall Street to raise their rates to show profits before there is legislation. And a number of companies were invited. And they all declined. But I'm not going to mention them publicly because I haven't gone into the reasons.

But it seems to me, Mr. Chairman, that these witnesses are fine. But I appreciated your statement that you'd like to question the insurance companies about the rising costs. And my suggestion would be subject to the Chair, that subpoenas would be a good idea to bring them in.

Why are they being raised 100 and some percent? What is the reason for it? We hear a lot about Wall Street greed. Well we ought to find out.

This is a good start, Mr. Chairman. I thank you and the Ranking Member for this hearing. And I hope we will proceed it with some tough subpoenas to get some hard facts. So we can expose wrong doing, if there is wrong doing, profiteering and take appropriate corrective legislative action.

Welcome, Mr. Rowen.

STATEMENT OF WALTER ROWEN, PRESIDENT, SUSQUEHANNA GLASS COMPANY, COLUMBIA, PA

Mr. ROWEN. Thank you for that introduction, Senator Specter.

And Senator Harkin, Mr. Chairman and distinguished members of the committee, thank you for inviting me to testify before you today on the rising costs of health care insurance for small businesses.

Senator Specter was slightly wrong. My business will be 100 years old in 2 months.

[Laughter.]

Senator SPECTER. That's the closest I've been in a long time.

[Laughter.]

Mr. ROWEN. I do own a family business. But I run my business like a family. For at least 40 years we have been offering health insurance coverage to our full-time employees. We employ about 35 people of which between 20 and 24 normally participate in our health insurance plan.

Many of my employees have worked for me for between 15 and 30, 35 years. In these difficult economic times I know all of you would agree that small businesses like mine, companies that keep employees for years because we treat them with decency and provide fair benefits should be encouraged, if not rewarded for our policies. Providing health insurance coverage to those employees who want and need it is one of those polices we believe in and hope we can continue.

Unfortunately over the past several years, securing affordable health insurance has become increasingly difficult. From the years 2006, 2007, and 2008, we faced premium increases if we had not changed our policies of 22, 24 and 10 percent. In order to deal with these increases we constantly shopped for new carriers and changed our policies primarily by adding deductibles to the plan and then steadily each year increasing those deductibles in order to keep the costs of the premiums in line.

When we went to a deductible for the last 3 years the company fully funded that for our employees through an HRA policy. So we were paying the deductibles for our employees. However whatever problems we had in the last 3 to 4 years paled in comparison to this year.

Our initial cost increase from our insurer, if we kept the same policy, with the same deductibles, was quoted at 128 percent increase. When we shopped around the best we could find was a policy that increased our premiums by 43 percent. But this policy now carried a higher deductible than the previous year. The total amount of the increase in premiums alone to our company was a staggering $40,000 annually.

We were suddenly faced with a terrible dilemma. How do we divide up the added costs between the company and our employees? We decided the company would absorb all of the premium increase. But the trade off was we could no longer pay for our employees deductibles. Our costs to increase the policy was $22,000.

We will still beat last year's deductibles. Just to be clear, we paid in the neighborhood of $18,000. Now the real burden, unfortunately, of the deductible falls on our employees who will be at risk for a $2,000 individual, $4,000 family deductible. This will potentially put some of our employees, if they need to use their health insurance to any extent, at a financial risk that they will not be able to handle.

In talking to our insurance agent, the broker report they received from last year's carrier indicated that the huge premium increase was justified due to the changes in three areas.

First, there was a demographic or age change in my group. And as I've told you I've had people that have work for me for 30 and 35 years. Our average age of employee that is carried by our policy went from 45 to 49. And they claimed that created an 11 percent increase of our policy.

There were pricing trends within both our industry and our, I believe, geographical area that impacted the policy by somewhere around 21 percent.

But then the big one was the assessed risk of our group, our 20, 22 people because of some potential changes in their health created a 70 percent increase to our policy. Although this doesn't quite add up to 128 percent these were the risk areas and their relative percentages that were used to justify the 128 percent increase. When you look at my company as an insurance group it is abundantly clear that we will always struggle to get fair and affordable health insurance rates unless we can become part of a much larger insurance group or pool.

To me there are really two separate issues that are interconnected when you talk about health care reform.

The first is how do you create a better health insurance system that will provide affordable coverage to people? It's an insurance question.

The second is how do you start to control the spiraling costs of health care to the American population?

I am here today simply to bring my personal experience as a small business man as it relates to the insurance issue. How can we create a better insurance system to spread the risk for individuals of small businesses? To me creating a large, robust health insurance exchange that crosses State lines is a good first step toward distributing the risk.

Requiring all individuals to have some form of health insurance, enacting reasonable tort reform and putting in place some account-

ability by the consumer, my employees, when getting health care also is required to create a good solution.

What has surprised me as a small business owner is how long it has taken for any real work on health insurance reform to take place. As my insurance history shows we have been living with dramatically rising health insurance costs for the last 4 to 5 years which is evidenced by the current system is unsustainable. This year's increases are now proof that that system is absolutely broken. And without reform small businesses and the foundation upon which our economic system is founded is in real jeopardy.

I applaud this committee's efforts to it finally enacting health reform. And again, thank you for allowing me to share with you my company's history. Thank you.

[The prepared statement of Mr. Rowen follows:]

PREPARED STATEMENT OF WALTER ROWEN

Mr. Chairman, distinguished members of this committee, thank you for inviting me to testify before you today on the rising costs of Health Insurance for small businesses.

In 2 months, my company, Susquehanna Glass will be celebrating its 100th Year in business. For at least the last 30 years, we have been offering health insurance coverage to our full-time employees. We employ about 35 people, and 20–24 of them normally participate in the plan.

I own a family business, but I run my business like a family. Many of my employees have worked for me more than 15 years, a few more than 30. In these difficult economic times, I know all of you would agree that small businesses like mine, companies that keep employees for years because we treat them with decency and provide fair benefits, should be encouraged if not rewarded for our policies. Providing health insurance coverage to those employees who want and need it is one of those policies we still believe in and hope to continue.

Unfortunately, over the past several years, securing affordable health insurance has become increasingly difficult. From 2006–2008, we faced premium increases of 22 percent, 24 percent and 10 percent. In order to deal with these huge increases, we constantly shopped for new carriers and changed our policy, primarily by adding a deductible component to the plan and then steadily increasing the deductible amount. When we went to a deductible, the company fully funded an HRA for the employees for the last 3 years.

However, whatever problems we had in previous years paled in comparison to this year's problems. Our initial cost increase from our insurer was quoted at 128 percent. When we shopped around, the best we could find was a policy that increased our premiums by about 43 percent, but this policy now carries an even higher deductible than last year. The total amount of the increase in premiums alone is a staggering $40,000. We were suddenly faced with a terrible dilemma, how do we divide up the added costs between the company and our employees? We decided the company would absorb all the premium increase, but the tradeoff was we could no longer pay for our employee's deductibles. We will be paying $22,000 more without paying deductibles than our total spending last year when we paid all deductibles. But the real burden now falls on our employees who will be at risk for a $2,000 individual, $4,000 family deductible. This will potentially put some of our employees, if they need to use their health insurance to any extent, at a financial risk they will not be able to handle!

In talking to our insurance agent, the Broker Report they received from last years carrier indicated the huge premium increase was justified due to changes in three areas:

1. Demographic or Age change. The average age of our enrollee went from 45 to 49 years: 11.32 percent.
2. Pricing Trends for our industry: 21.09 percent.
3. Assessed Risk of our group: 70.29 percent.

Although this doesn't add up to 128 percent, these were the risk areas and their relative percentages used to justify the rate increase. When you look at my company as an insurance group, it is abundantly clear that we will always struggle to get fair and affordable health insurance rates unless we can become part of a much larger insurance group.

To me, there are really two separate but interconnected issues involved in "Health Care Reform."

1. How do you create a better Health insurance system that will provide affordable coverage to more people?
2. How can you start to control the spiraling cost of health care to the American population?

I am here today to simply bring to you my personal experience as a small businessman as it relates to the insurance issue. How can we create a better insurance system to spread the risk for individuals and small businesses? To me, creating a large, robust health insurance exchange that crosses State lines is a good first step toward distributing the risk. Requiring all individuals to have some form of health insurance, enacting reasonable tort reform and putting in place some accountability by the consumer when getting health care are also required if a good solution is to be found.

What has disappointed me as a small business owner is how long it has taken for any real work on health insurance reform to take place. As my insurance history shows, we have been living with dramatically rising health insurance costs for the last 4–5 years, which is evidence that the current system is unsustainable. This year's increases are now proof that the system is absolutely broken and without reform, small business and the foundation upon which our economic system is founded is in real jeopardy. I applaud this committee's efforts toward finally enacting Health Care Reform.

Again, thank you for allowing me this opportunity to share with you my company's story.

The CHAIRMAN. Well thank you very much, Mr. Rowan for that statement and thank you for being here today.

Next we'll go to Commissioner Sandy Praeger who was elected as Kansas' 24th Commissioner of Insurance in 2002, re-elected in 2006. Commissioner Praeger is responsible for regulating all insurance sold in Kansas and overseeing the nearly 1,700 insurance companies and 90,000 agent licenses to do business in the State. Commissioner Praeger is the immediate past President of the National Association of Insurance Commissioners. She serves as Chair of the Health Insurance and Managed Care Committee, Vice Chair of the International Insurance Relations Committee, Member of the Executive Committee for International Associations of Insurance Supervisors and a member of other NAIC Committees.

So, Commissioner Praeger, again, your statement will be made a part of the record in its entirety.

Senator ROBERTS. Mr. Chairman.

The CHAIRMAN. Please proceed.

Senator ROBERTS. Would it be appropriate that I give my glowing remarks on behalf of our Commissioner now or do you want to wait until you shut me down after 4 minutes?

The CHAIRMAN. I think you better give them now.

Senator ROBERTS. Alright.

[Laughter.]

STATEMENT OF SENATOR ROBERTS

Senator ROBERTS. Well, I want to truly recognize my home State insurance commissioner. It's not like insurance companies don't have oversight. They certainly do in Kansas. And they can do it in several ways, those who would increase premiums too much or those whose premiums would be so low that they would not benefit the company in terms of keeping in business.

Sandy, and the reason I call her Sandy is that she's a good personal friend and has done an outstanding job. She's been an invalu-

able resource to me, my staff, I know other Members in the Congress. And I'm always very proud to have her address this panel.

She has contributed significantly to efforts to educate. And I really think it's important to educate the American public about health care reform, something I wish all of Kansas should be grateful for. Kansas, like everybody else have the right to know, but they also have the right to be educated by professionals who can discern in regards to what the real effects, maybe even the law of unintended effects might mean in this exercise that we are now going through along the lines that Senator Enzi has already testified.

So I want to thank you Sandy, so much. And thank you for your contributions to our State and our country. And thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Roberts. Commissioner Praeger, welcome. Please proceed.

STATEMENT OF SANDY PRAEGER, COMMISSIONER, KANSAS DEPARTMENT OF INSURANCE, TOPEKA, KS

Ms. PRAEGER. Thank you. And thank you, Senator Roberts. I appreciate that.

Chairman Harkin, Ranking Member Enzi and distinguished members of the committee, I really appreciate the opportunity for being here. Thank you for holding this hearing on a very important subject of the rising health care costs for small businesses. As has been said, I am Sandy Praeger. I'm the elected Commissioner for the State of Kansas and Chair of the National Association of Insurance Commissioners, Health Insurance and Managed Care Committee. And I'm testifying today on behalf of the NAIC.

The affordability of health insurance coverage to small businesses is a critically important component of health reform. With lower profit margins small businesses have a much more difficult time affording insurance coverage than their larger competitors. Adding to the problem small businesses continue to face significant premium increases while inflation remains low and the economy slowly recovers. Even with reforms State regulators share the concern of the members of this committee that small businesses could see higher and higher premiums in the coming years.

In preparation for today's hearing the NAIC completed an informal survey of several States requesting information on recent rate filings in the small group market. Let me just give a sample of what requests the commissioners are receiving from these small group carriers.

Washington State received requests ranging from 9 to 20 percent.

Maryland received rate increase requests from its largest carriers averaging 15 to 16 percent.

New Mexico has received a request to decrease rates by 1 percent and another to raise rates by 9 percent.

Ohio has received a rate increase request ranging from 10 to 15 percent.

And in my home State of Kansas we've received requests ranging from low single digits to 13 percent.

Of course an increase in the base premiums is only half the story for small businesses. In most States carriers are allowed to vary

premiums charged to small businesses based on a variety of characteristics such as average age, health status, group size and on and on. If a single employee in a small business and particularly in a very small business, a micro business, should have significant change in their health status then the premium increase could be as high as an additional 15 percent on top of the base premium increase. If a company's work force decreases significantly and/or its average age rises the increase is compounded and the result can be what we've heard about already.

It must be noted however, that when State regulators review rates they not only must determine whether they're excessive or appropriate, but also whether they're sufficient, as Senator Roberts pointed out. One of the most important protections insurance commissioners provide consumers is the assurance that the insurance company will have the resources to pay claims when they are incurred. If a State regulator chooses to deny appropriate rates and place the company in financial distress consumers may be happy in the short term, but certainly not in the future.

So this, I know, begs the question are the rate increases being requested by carriers in the small group market appropriate or excessive? So for insight we asked the States what justifications the companies gave for their rate increases. And the answers were fairly consistent.

The No. 1 driver of higher premiums is medical cost trends, probably no surprise. In most States medical cost inflation is far outstripping general inflation. Companies are also seeing significant increases in utilization.

Some attribute this to the uncertainty that some have about their jobs and future coverage and in COBRA coverage which has always had a far higher medical loss ratio. Some carriers also point to small employers with healthier employees leaving the pool while others cite new Federal and State benefit mandates. All of these were reported in our survey.

For the most part State insurance departments with authority to review the rates have agreed with the actuarial analysis provided by the companies and have approved the rates. However this is not true in every case.

Connecticut, for example, determined that the poor claims experience a company was using to justify a 35 percent increase was an anomaly and denied the rate increase.

Rhode Island asked companies to resubmit their requests in 6 months or significantly reduce their request. And most of the companies chose to return in 6 months.

In my State of Kansas we're negotiating with a company right now to minimize the impact of a rate increase on renewals in the individual market, but allow it for new sales.

States have negotiated lower rates, rejected assumptions and threatened public hearings in their efforts to ensure carriers are not raising premiums unnecessarily. Most States also impose a minimum loss ratio to ensure premiums are not excessive compared to claims paid. In the end though the reality is that the cost of health care and the utilization of that health care are rising rapidly and insurance companies have little ability to address these issues.

Insurance is simply a tool to finance the underlying cost of health care. So unless spending is brought under control State and Federal reforms will shift the financial burden from one group to another, but not really solve the underlying problem. The challenge moving forward will be to overhaul the delivery system to promote prevention, quality and results-based care, to encourage healthy lifestyles, to eliminate waste and fraud in the system, providing insurers with the tools they need to truly manage care while protecting consumers and providers from some of the abuses seen in the past will also help bring about much-needed control to the system.

We also need to reform the rating system eliminating the factors that allow for unpredictable and unaffordable rate spikes and create greater stability for small businesses. Some reforms are included in the Health Reform bills passed by this committee and the Senate Finance Committee and are supported by the NAIC. The rates being approved by State regulators are allowed under current law, but that doesn't mean they're acceptable.

The laws do need to change. I know the committee is well aware of these facts. And NAIC pledges its expertise to assist in any way it can to help bend the curve in the future and create a more equitable marketplace for small businesses.

And again, thank you for the opportunity to be here today.

[The prepared statement of Ms. Praeger follows:]

PREPARED STATEMENT OF SANDY PRAEGER

Good afternoon Chairman Harkin, Ranking Member Enzi, and distinguished members of the committee. Thank you for holding this hearing on the very important subject of increasing health costs for small businesses and for the invitation to testify today. My name is Sandy Praeger and I am the elected Insurance Commissioner for the State of Kansas and Chair of the National Association of Insurance Commissioners' (NAIC) Health Insurance and Managed Care Committee. I am testifying today on behalf of the NAIC, which represents the chief insurance regulators from the 50 States, the District of Columbia and five U.S. territories, whose primary objectives are to protect consumers and promote healthy insurance markets.

PROBLEMS IN THE SMALL GROUP MARKET

The affordability of health insurance coverage to small businesses is a critically important component of health reform. With lower profit margins, small businesses have a much more difficult time affording insurance coverage than their larger competitors. As a result, only 59 percent of businesses with between 2 and 199 employees offered coverage to their employees. Among the smallest employers, those with between 3 and 9 employees, only 45 percent offered coverage.[1] For this reason, 28.7 percent of workers in firms with fewer than 100 employees went uninsured in 2006.[2] The recent economic downturn has only made matters worse.

Adding to the problem, small businesses continue to face significant premium increases, even while inflation remains low and the economy slowly recovers. As efforts continue to reform the health insurance marketplace, State regulators share the concern of the members of this committee that small businesses could see higher and higher premiums in the coming years. Determining whether and why the rates are rising is the focus of this hearing.

In preparation for today's hearing, the NAIC completed an informal survey of several States requesting information on recent rate filings in the small group market. As reported in the *New York Times*, States are receiving requests for premium increases in the small group market that far exceed general inflation—but not in every State, not from every company, and not without some justification in most cases.

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[1] Kaiser Family Foundation and Health Research & Educational Trust, 2007.
[2] EBRI, October 2007.

To give a sample of what requests commissioners are receiving from small group carriers: Washington has received requests ranging from 9 percent to 20 percent; Maryland has received rate increase requests from its largest carriers averaging 15 percent to 16 percent; New Mexico has received a request to decrease rates by 1.2 percent and another to raise rates 9 percent; Ohio has received rate increase request of 10 percent to 15 percent; and in my home State of Kansas, we have received requests ranging from low single digits to 13 percent.

The vast difference in filings depends greatly on the company's current situation. For example, a new company in New Hampshire was relying heavily on consultant data to set its current premiums that proved unrealistic, so they are requesting what amounts to a 30 percent increase in rates to match their experience. Meanwhile, a few companies are asking for a decrease. In Maryland, the high-deductible plans tied to Health Savings Accounts are asking for significant increases of 19 percent to 25 percent.

Of course, an increase in the base premium is only half the story for small businesses. In most States, carriers are allowed to vary premiums charged to small businesses based on a variety of characteristics, such as, average age, health status, claims experience, industry, etc. If a single employee in a small business, and particularly in a micro-business, should have a significant change in their health status, then the premium increase could be as high as an additional 15 percent onto the base premium increase. This is why the commissioners take seriously their responsibility to review rates and ensure that base premiums are appropriate, and why we support reforms that will make small employer coverage more stable.

It must be noted, however, that when State regulators review rates they not only must determine whether they are excessive or appropriate, but also whether they are sufficient. One of the most important protections insurance commissioners provide consumers is the assurance that the insurance company will have the resources to pay claims when they are incurred. If a State regulator chooses to deny appropriate rates and place the company in financial distress, consumers may be happy in the short term, but certainly not in the future.

So, this begs the question, Are the rate increases being requested by the carriers in the small group market appropriate or excessive? To retrieve some insight we asked the States what justifications the companies gave for their rate increases. The answers were fairly consistent.

The No. 1 driver of the higher premiums is medical cost trends. In most States medical costs are increasing by about 10 percent per year—far out-stripping general inflation. Companies are also seeing significant increases in utilization—some attribute this to the uncertainty some have about their jobs and future coverage—and in COBRA coverage, which always has had far higher medical loss ratios. Some carriers also point to small employers with healthier employees dropping coverage, impacting the health of the pool, while other cite new Federal and State benefit mandates.

For the most part, State insurance departments with authority to review the rates have agreed with the actuarial analysis provided by the companies and have approved the rates. However, this is not true in every case. Connecticut, for example, determined that the poor claims experience a company was using to justify a 35 percent increase was an anomaly and denied the rate increase. Rhode Island asked companies to resubmit their requests in 6 months or significantly reduce their request—most of the companies chose to return in 6 months. In my State of Kansas we are preparing to deny a rate increase for renewals, but allow it for new sales.

States have negotiated lower rates, rejected assumptions, and threatened public hearings in their efforts to ensure carriers are not raising premiums unnecessarily. Most States also impose a minimum loss ratio to ensure premiums are not excessive compared to claims paid. In the end, though, the reality is that the cost of health care and the utilization of that health care are rising rapidly, and insurance companies have little ability to address these issues. Therefore, rates will continue to rise.

Insurance is simply a tool to finance the underlying cost of health care, so unless spending is brought under control, all State and Federal reforms will shift the financial burden from one group to another, but not solve the underlying problem. The challenge moving forward will be to overhaul the delivery system to promote prevention, quality, and results-based care, to encourage healthy lifestyles, and to eliminate waste and fraud in the system. Providing insurers with the tools they need to truly manage care, while protecting consumers and providers from some of the abuses seen in the past, would also help bring much-needed controls to the system. I know that the committee is well aware of this fact and the NAIC pledges its expertise to assist in any way it can to help "bend the curve" in the future. To that end, we encourage you to grant States continued flexibility to experiment and find solutions that work.

MOVING FORWARD

Insurance Commissioners recognize the magnitude and importance of the problem and have been working hard to ensure that affordable coverage is available to small businesses in their States. States led the way in requiring insurers to offer insurance to all small businesses in the early 1990s, and the Federal Government made guaranteed issue the law of the land in 1996[3] for all businesses with 2–50 employees. Federal law does not limit rating practices, but 48 States have supplemented the guaranteed issue requirement with laws that limit rate variations between groups, cap rate increases, or impose other limitations on insurer rating practices. These rating laws vary significantly in response to local market conditions, but their common objective is to pool and spread small group risk across larger populations so that rates are more stable and no small group is vulnerable to a rate spike based on one or two expensive claims. In addition, most States have limited the extent to which changes in a business's claims experience can result in premium increases above and beyond the increases for all of an insurer's small group policies that result from medical inflation.

In addition to requiring insurers to pool their small group risk, States continue to experiment with reinsurance, tax credits and subsidies, and programs to promote healthier lifestyles and manage diseases as they pursue the twin goals of controlling costs and expanding access. As always, States are the laboratories for innovative ideas.

Despite our best efforts, however, we have come to recognize that this is a problem that the States alone cannot solve. The difficulties in the small group market, as in the individual market, are ultimately the result of medical spending that has outstripped the ability of most Americans to pay for it. Coupled with a voluntary insurance market where the healthiest tend to be the first to drop coverage, the high spending has resulted in volatile insurance markets with high risks of adverse selection. That is why we strongly support the adoption of Federal legislation that will help the States address this issue.

Over the years, the NAIC and individual State Insurance Commissioners have worked closely with this committee and individual Senators, to develop legislation to make coverage more affordable in the small group market. In 2006, we worked closely with Senators Michael Enzi and Ben Nelson to develop the Health Insurance Marketplace Modernization Act (S. 1955). More recently, we have worked closely with Senators Durbin, Lincoln, Snowe, and Coleman to develop the Small Business Health Options Program (SHOP) Act. While we have not agreed with every provision of these proposals, we have worked very hard to provide unbiased, nonpartisan advice to Senators on both sides of the aisle in order to develop legislation that will work for America's small businesses and their employees.

In the current push to enact comprehensive health care reform, the NAIC has attempted to work in this same spirit of State–Federal cooperation to help Congress draft legislation that will help all Americans purchase health coverage that is currently out of reach for millions of us and will make the health care system safer, more reliable, and more equitable.

The NAIC applauds the hard work of both the HELP and Finance Committees to enact long-overdue reforms. As adopted by the committees, the bills would extend guaranteed issue protections to the non-group health insurance market, eliminate pre-existing condition exclusions and annual and lifetime limits, and end the practice of rating policies based upon gender and health. In addition, they would initiate the creation of State-based health insurance exchanges that could streamline the process of purchasing coverage and make meaningful comparisons of health insurance plans much easier. We are very pleased to see that both committee-passed bills preserve State licensing, solvency, consumer protection, and market conduct review laws and regulations and maintain State oversight of health insurers.

However, State insurance regulators remain deeply concerned about adverse selection. While we strongly support making coverage available to everyone, we warn that implementing such a reform without an effective individual mandate, coupled with sufficient subsidies, will lead to severe adverse selection that could increase premiums further for individuals and small businesses. Simply, if a young or healthy person can choose to stay out of the pool and pay a minimal penalty, with the promise that he or she can purchase coverage without penalty when needed, then the insurance pool will be adversely affected. And, the tighter the rating rules, the more premiums for the young and healthy participants will be impacted, and the more an individual mandate and higher subsides are necessary to keep them in the pool. We do not believe the committee-passed mandates and subsidy struc-

[3] 42 U.S.C. 300gg–12.

tures will be effective enough and fear that the resulting adverse selection could undermine the overall reform effort.

CONCLUSION

Congress and the Nation have a critical opportunity to enact and implement comprehensive health insurance reforms that will dramatically improve the access to and affordability of, health coverage for small businesses and individuals. State regulators believe strongly that such reforms are far overdue and we offer our assistance to ensure passage, and implementation, of these reforms as soon as possible. However, we share the concern of this committee that those reforms may not have their full impact for several years, and that premiums will continue to rise in the interim.

More immediate transitional steps may be necessary to significantly reduce premiums in the coming years. Subsidies, reinsurance, funding for high-risk pools, reducing cost-shifting from Federal programs and the uninsured, are a few things that could be considered. State regulators and the NAIC offer our assistance to the committee as options are debated.

Again, thank you for holding this hearing, and for inviting me to testify here today. I look forward to your questions.

The CHAIRMAN. Thank you very much, Commissioner Praeger for being here again before this committee.

Now I want to turn to Mr. Holtz-Eakin, who is a Manhattan Institute fellow, President of DHE Consulting, and most recently served as Director of Domestic and Economic Policy for the John McCain Presidential campaign.

He's also been senior fellow at the Peter G. Peterson Institute for International Economics and Director of the Maurice R. Greenberg Center for Geo Economic Studies and the Paul Volker Chair in International Economics at the Council on Foreign Relations. Prior to that Dr. Holtz-Eakin served as the sixth Director of the Congressional Budget Office where he was appointed for a 4-year term beginning February 4, 2003. Also served for 18 months as Chief Economist for the President's Council of Economic Advisors.

Prior to that a Trustee Professor for Economics at the Maxwell School at Syracuse University. And served as Chairman of the Department of Economics and Associate Director of the Center for Policy Research. So certainly no stranger to us up here.

Welcome back, Mr. Holtz-Eakin. And your statement will be made a part of the record. Please proceed.

STATEMENT OF DOUGLAS HOLTZ-EAKIN, PRESIDENT, DHE CONSUTLTING, LLC, AND FELLOW MANHATTAN INSTITUTE, ARLINGTON, VA

Mr. HOLTZ-EAKIN. Thank you, Mr. Chairman, Ranking Member Enzi, members of the committee. It's a pleasure to be here today. I believe it's broadly understood that small business and entrepreneurs are crucial to the economy. That they employ half of America's workers. That they produce about half of America's output.

As a result they're about the third largest economy on this planet. And that they've created about 70 percent of the net new jobs over the past three decades. And one would hope then that in the policy process commensurate attention will be paid to the burdens and incentives for small businesses and entrepreneurs.

I think it's equally well understood that the recent trends in health insurance costs show a troubling pattern of burden to be placed on this crucial sector of the economy particularly when we

have such weakness overall in job creation and growth. So the most important issue that faces this committee and the Senate as a whole is how to go forward. And does pending legislation help this sector of the economy?

And the sad reality is that it hurts more than it helps. The most important thing about legislation in the Senate is that it does not bend the cost curve, the rising trend where health spending per person exceeds income per capita for decades on end in the United States. The House produced a bill in which new spending for health entitlements grew at 8 percent a year as far as the eye could see.

CBO Director Doug Elmendorf was asked to reply as to whether this legislation bent the cost curve. He said definitively, no.

The Senate Finance Committee produced legislation in which a new health spending entitlement program grows at 8 percent as far as the eye can see. These bills do not bend the cost curve.

CMS Actuary Richard Foster has said they've actually bent it in the wrong direction and made things worse.

And given that higher health costs inevitably lead to higher health insurance premiums these bills will not help the basic problem facing the small businesses on this panel. I think it's also true that at this point in time these are budgetarily dangerous bills. The CBO's analysis of the most recent Administration budget projects that over the next 10 years we will triple the national debt.

We will never run a deficit below 4 percent of GDP when it's widely accepted that 3 percent is the line of safety. We will arrive in 2019 after the economy is fully recovered. Receipts have risen to an above average 19 percent of GDP and have a deficit of $1 trillion, $800 billion of which would be interest on previous borrowing.

At this point in time it would be a step decisively in the wrong direction to set up a large new entitlement program which is paid for only through the most transparent of budget gimmicks. And that is exactly what the bills in the House and the Senate do. These will be burdens on future generations. They will send the message to the international capital markets that the United States is not serious about fixing its fiscal problems. And they will create an economic climate against which not even the best of these entrepreneurs can climb. It will be such headwinds they will inevitably be dragged down.

More narrowly the bills are front loaded with bad news for the costs of health insurance. They contain higher taxes on insurance policies which will be shifted forward onto the purchasers of those policies especially those who are not self insured which would be the small business community. They contain higher taxes on insurance companies which in the same way will end up in the premiums that people pay.

They contain higher fees which are in effect excise taxes on pharmaceutical companies, on medical device makers and on insurance companies again. In each case the analysis shows quite clearly that you're going to shift these costs forward. These are costs that insurance will have to cover. And we're going to see higher premiums as a result.

And finally there are medical or insurance market reforms guaranteed issue, community rating, which when combined with weak mandates are going to push premiums up. Now to date there's been a lot of displeasure over the messenger, the insurance companies who pointed this out. But that doesn't mean the logic is wrong. And we have seen the joint community on taxation, the CMS actuary, the CBO and the National Association of Insurance Commissioners embrace the fundamental analysis. The only question is how big this problem will be.

And so we've got bills which are front loaded with trouble. For people who have insurance, the majority of Americans, it will raise the premiums that they pay. The bills themselves will create a very unpleasant economic climate in which they will operate.

And those fundamental forces, I believe, outweigh the small bits of good news. Tax credits which last for 2 years in the House which are less generous than the HELP Committee and the Senate Finance version. And sort of one time improvements and load factors and other things that cannot possibly outweigh the inexorable upward trend in health care costs which these bills do not bend, but in the end push ever upward.

I thank you. And look forward to answering your questions.

[The prepared statement of Mr. Holtz-Eakin follows:]

PREPARED STATEMENT OF DOUGLAS HOLTZ-EAKIN

SUMMARY

The United States faces three important problems: health care costs too much, insurance costs continue to rise rapidly, and consumers receive too little for their money in quality of care and insurance. These pressing issues should be the focus of health care reform.

Unfortunately proposals under consideration do not ameliorate these pressures. Instead, they fail to bend the cost curve (or bend it the wrong way) and raise the costs of insurance for the majority of Americans who have insurance.

Fees imposed on the medical sector will result in families paying $200 billion in higher premiums.

Taxes imposed on health insurance will add another $200 billion to premiums.

Higher premiums will cut into the growth of wages and, for the lowest-wage workers, opportunities for employment.

Insurance market reforms will not decrease costs, but rather will raise average premiums.

The proposals under consideration will set up large new entitlement spending programs that will likely exacerbate an already-dangerous budgetary outlook. Small business owners will be placed at risk along with the rest of the economy.

Chairman Harkin, Ranking Member Enzi, and members of the committee I am pleased to have the opportunity to appear before you today to discuss the important issue of health insurance costs and small businesses in America.

THE IMPORTANCE OF SMALL BUSINESS

Small businesses and entrepreneurs are at the heart of the U.S. economy, although there is no single way to quantify their contribution. According to the National Federation of Independent Businesses, there were almost 29 million Federal income tax returns filed in 2004 with business income on them. Similarly, there were 16 million self-employed and working in their own businesses. Ninety-nine percent of employing businesses are "small" under prevailing definitions. Sixty percent of all businesses that employ people other than the owners have 1 to 4 employees; another 20 percent have 5 to 9 employees; and yet another 10 percent have 10 to 19 employees. Businesses employing fewer than 100 people (excluding the self-employed who employ no one but themselves) constitute 96 percent of all employers.

A large concern should be the impact of policy choices on individuals, as these are the nascent entrepreneurs that are our next business leaders. Roughly 10 percent

of adults are interested in starting a business. My own research indicates that these entrepreneurs are sensitive to taxes and other aspects of the policy environment.

Finally, it is now well recognized that small business provides about 55 percent of all jobs in the private sector. Small business has created about two-thirds of the net new jobs in the United States, where "net" means the number of jobs created minus the number of jobs lost. In the process, these businesses also produce about one-half of the private-sector GDP in the United States.

SMALL BUSINESSES AND HEALTH INSURANCE

Small businesses display a lesser ability to provide health insurance benefits for their workers (see table):

Percentage of Firms Offering Health Insurance Benefits by Firm Size and Industry, 2008

	Percentage of Firms Offering Health Benefits (In percent)
Firm Size:	
3–9 workers	49
10–24 workers	78
25–49 workers	90
50–199 workers	94
200–999 workers	99
1,000–4,999 workers	100
5,000 or more workers	100
All Small Firms (3–199 workers)	62
All Large Firms (200 or more workers)	99
Industry:	
Agriculture/Mining/Construction	67
Manufacturing	73
Transportation/Communications/Utilities	89
Wholesale	74
Retail	40
Finance	81
Service	58
State/Local Government	97
Health Care	71
All Firms	63

Source: Kaiser Family Foundation, Employer Health Benefits 2008; excerpted from Exhibit 2.3, p. 37.

For those who manage to provide benefits, however, the challenge is getting greater. Small businesses and entrepreneurs have faced rising costs of health insurance premiums in recent years, as evidenced by the table below.

Average Annual and Growth in Premiums for Covered Workers with Family Coverage, by Firm Size, 1999–2009

	All Small Firms (3–199 Workers)	Percent Change
1999	$5,683	
2000	$6,521	14.7
2001	$6,959	6.7
2002*	$7,781	11.8
2003	$8,946	15.0
2004	$9,737	8.8
2005*	$10,587	8.7
2006	$11,306	6.8
2007	$11,835	4.7
2008*	$12,091	2.2
2009*	$12,696	5.0

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2009.

These rising costs of insurance place pressure on firms to reduce costs in other areas of operations, reduce cash wages, and impede their ability to invest and expand.

THE DESIRABILITY OF COMPREHENSIVE HEALTH CARE REFORM

These recent experiences in rising health insurance premiums highlight the need for effective reforms of U.S. health care. There are three major problems. First, health care costs too much. In 1970, national health expenditures were $1,300 per person and consumed 7 cents of every national dollar—7 percent of GDP. For the past three decades, health-care spending per person has grown roughly 2 percentage points faster every year than income per capita. That is, in the race between costs and resources, costs have been winning. The result is that health-care spending now exceeds 17 cents of every national dollar—and will rise to 20 percent by the end of next decade. Within the Federal budget, the rising cost of Medicare and Medicaid threatens a tsunami of red ink in the decades to come.

A dominant characteristic of health care in the United States is its fragmentation and focus on acute-care episodes. This system feeds the growth in spending per capita above and beyond that due to the factors outlined above. The Medicare program itself is important in this regard. It has programs for "hospital" (Part A), for "doctors" (Part B), for "insurance companies" (Part C), and for "drug companies" (Part D). These compartmentalized programs are dedicated to ensuring that various providers receive their payments in a fee-for-service system. Doctors and hospitals are paid for services provided to patients; and the more they do, the more they are paid. This system is focused on payments to providers, not on the health of families. This system is not centered on quality of care and gives scant regard to coordinating the decisions of the various medical providers, and it does not reward appropriate preventive care. Importantly, because it is such a dominant payer, Medicare reimbursement policies drive many of the inefficient practices in American medicine.

It is hardly surprising that a medical system focused on paying for acute-care episodes has spawned a reward to the innovation, adoption, diffusion, and utilization of new technologies for these episodes. Because the system is not oriented toward quality outcomes—particularly, paying for quality outcomes—a key feature of rising health-care spending is that it has not generated improved outcomes: the United States spends a greater fraction of its income on health care but does not have comparably superior longevity or health quality. The trends are most pronounced in Medicare, but the same broad characteristics prevail for the private system serving those younger than 65. Also, in both cases (but again larger for Medicare) in the United States, there are large regional differences in spending that do not lead to apparent differences in the quality of outcomes.

Second, because health care is becoming more expensive, the cost of health insurance is skyrocketing. Over the last decade, insurance costs have increased by 120 percent—three times the growth of inflation and four times the growth of wages. With higher costs has come reduced insurance coverage. It is important to solve the first problem—rising costs—before committing to large-scale coverage expansions. Dealing with the problems in the wrong order will be prohibitively expensive and will likely cause the reform effort to unwind.

Finally, health insurance and health-care systems underperform. A job loss typically also means loss of health insurance; workers would be better served by more portable options. Insurance companies would have better incentives if faced with life-cycle costs for a policyholder. Similarly, high spending has not yielded comparably high outcomes for infant mortality, longevity, or treatment of chronic disease. The delivery system can be greatly improved.

SENATE LEGISLATION AND HEALTH CARE REFORM

It is useful to examine proposed legislation before the Senate in light of the need for reform. Unfortunately, I believe that the existing efforts fall far short of what is needed and, in some instances, take unfortunate steps in the wrong direction.

Proposals to date do not "bend the cost curve." The most important first steps in health care reform are delivery system reforms that maintain or improve quality *and* reduce the pace at which health care spending grows. Rapid health care spending growth is the root cause of rising insurance costs. Rapid health care spending growth is a key part of the dangerous U.S. fiscal outlook. The existing proposals do not address this problem. Indeed, to the extent that they impact cost growth, they make the problem worse.

House legislation put forth earlier this year created a new health entitlement spending program that the Congressional Budget Office projected would grow 8 percent annually for the foreseeable future. CBO Director Douglas Elmendorf responded directly and negatively to questions about whether it (or HELP Committee legislation) would "bend the cost curve." Similarly, Health and Human Services Actuary Richard Foster concluded that the legislation would *raise* national health expenditures—exactly the opposite of the desired result. In sum, creating a new enti-

tlement spending program that grows at 8 percent annually is not bending the cost curve.

The Senate Finance Committee legislation creates a new health entitlement spending program that grows at 8 percent annually for the foreseeable future. It, also, does not bend the cost curve.

Proposals endanger the budget and risk broader economic stress. The Federal budget has entered dangerous territory. Under the Administration's proposals (as analyzed by the CBO), debt relative to GDP will rise from roughly 40 percent in 2008 to over 80 percent in 2019; at which time it will be spiraling north. Deficits will not fall below 4 percent of GDP during the next 10 years. In 2019, the Federal Government will borrow roughly $1 trillion dollars with nearly $800 billion necessary merely to pay interest on previous borrowing.

This outlook is not merely the residue of the financial crisis and recession, which have demanded tremendous resources in the near term. Instead, they reflect conscious policy choices that persist long after the financial crisis is assumed to be resolved and the economy restored to health.

International financial markets have long been presented with a U.S. fiscal picture that does not add up over the long term. Successive versions of the CBO's *Long-Term Budget Outlook* volume have documented the basic facts: spending that is on track to consume an ever-larger share of GDP and tax revenues that could never grow to match. These most recent policy decisions simply accelerate dramatically the underlying problems.

Analysts have long worried about the potential fallout of this budgetary outlook. At what point do rating agencies downgrade the United States. When do lenders price additional risk and charge higher interest rates to Federal borrowing. How quickly will international investors flee the dollar for a new reserve currency? If so, how will the resulting higher interest rates, diminished dollar, higher inflation, and economic distress manifest itself?

To date, one explanation of why these events have yet to transpire is that the same financial market analysts who understand the weak state of the U.S. books also believe that they will be rectified before serious distress arrives. Put bluntly, the United States is relying on the faith of others in its ability to undertake serious budgetary reforms.

A large new spending program that grows at 8 percent a year—faster than the economy will grow; faster than tax revenues will grow—is a dramatic statement to financial markets that the Federal Government does not understand that it must get its fiscal house in order. It is a statement that it is content to make things *worse*. It would be a risky move at a dangerous time.

Small businesses are a powerful economic force in the United States. However, they would find themselves swimming against even greater tides of higher borrowing costs, rising prices, and an economic slump. As in the current recession, many would be unable to hire, forced to lay off workers, or even shutter their operations. I believe it is a disservice to this important piece of the fabric of our economy to pursue legislation that puts their foundations at risk.

The current proposals will raise costs for the majority of Americans who have insurance. As noted earlier, if anything these proposals bend the cost curve in the wrong direction. Since health care spending is the ultimate driver of health insurance costs, this is a step in the wrong direction for those who have insurance. In addition, some specific policies will directly raise the cost of insurance.

Fees. A notable feature of the America's Healthy Future Act is a total of $13 billion in annual fees on health insurance companies ($6.7 billion), medical device manufacturers ($4 billion) and pharmaceutical companies ($2.3 billion). In substance, these fees are the economic equivalent of excise taxes whose burden will be shifted forward onto consumers. Due to the non-deductibility of these fees, the impact will be magnified, with the end result being $200 billion of higher premium costs over the next 10 years.

To see this, begin with the annual fee that applies to any U.S. health insurance provider. The aggregate annual fee for all U.S. health insurance providers is $6.7 billion, with the total fee apportioned among the providers based on relative market share. The fees would not be deductible for income tax purposes and would take effect in calendar year 2010.

The fee is tantamount to an excise tax on health insurance. For any company, as it sells more insurance policies it will incur a greater market share, and thus a greater share of the $6.7 billion. That is, with each policy sold, the total tax liability rises; precisely the structure of an excise tax. As such, it is important to understand the difference between the statutory incidence of the excise tax—the legal responsibility to remit the tax to the Treasury—and the economic incidence—the loss in real income as a result of the tax.

Insurance companies will have to send in the tax payments, so the statutory incidence is obvious. However, a basic lesson of tax policy is that people pay taxes; firms do not. Accordingly, the economic burden of the $6.7 billion tax must be borne by individuals. Which individuals bear the economic cost?

The imposition of a tax will upset the cost structure of the insurance companies, raising costs per policy and reducing net income (or exacerbating losses). Some might argue that the firms will "eat the tax"—that is simply accept the reduction in net income. For a short time, this may well be the case. Unfortunately, to make no changes whatsoever is tantamount to promising shareholders a permanently lower (risk-adjusted) rate of return. Because insurance companies compete for investor dollars in competitive, global capital markets, they will be unable to both offer a permanently lower return and raise the equity capital necessary to service their policyholders.

Interestingly, a similar logic applies to not-for-profit insurers, who rely on retaining earnings as reserves to augment their capital base. Bearing the burden of the tax means lower access to these reserves and diminished capital.

Accordingly, firms will seek to restructure in an attempt to restore profitability, with the main opportunity lying in the area of labor compensation costs. To the extent possible, firms will either reduce compensation growth, squeeze labor expansion plans (or even lay off workers), or both. Again, however, insurance firms will find their responses constrained by the realities of the market environment. Cutting back compensation is an invitation for the best-skilled workers to depart the insurance industry. Layoffs and labor squeezes make it difficult to attract the inputs to firm growth.

In short, there are sharp limits on the ability of firms to shift the effective burden of excise taxes onto either shareholders (capital) or employees (labor). Moreover, their ability to do so diminishes over time as capital and labor seek out better market opportunities.

The Congressional Budget Office and Joint Committee on Taxation revenue estimating conventions recognize these economic realities. Specifically, they apply a 25 percent "offset" to the estimated gross receipts of any excise tax. In terms of the discussion above, the convention recognizes the incentives to attempt to shift some of the burden of the tax in the form of lower dividends, capital gains, and wages. To the extent this happens, receipts of income-based taxes will fall; hence the need for an offset to the gross receipts of the excise tax.

There are three additional points about the 25 percent offset. First, while it recognizes the economic incentives to shift the burden of excise taxes, it is only a rough approximation to the case-by-case reality. Depending on the nature of the market setting, more or less of the tax may be shifted to taxable wages or profits and those resources may be taxed at either higher or lower rates.

The more important aspect of the offset is that it is not 100 percent. That is, the non-partisan consensus-based revenue estimators have concluded that the vast majority of the burden of excise taxes will not be borne by shareholders or workers. Who, then, bears the burden—consumers.

If competitive conditions make it impossible for insurers to absorb the economic burden of the tax, they will have no choice but to build the new, higher costs into the pricing structure of policies. In this way, the economic burden of the tax is shifted to the purchasers of health insurance. In particular, the more competitive are markets for equity capital and hired labor, the greater the fraction of the burden that will be borne by consumers.

This phenomenon leads to the third aspect of the 25 percent offset. If health insurance is more costly, firms will be forced to offset this higher cost by lowering the other aspects of compensation—namely cash wages. Lower cash wages throughout the economy are an important burden to workers, and provide a second avenue for reduced personal income tax receipts.

This line of reasoning is sometimes met with skepticism, and countered with the notion that consumers will simply be unwilling to accept a higher price. Evidence suggests that this is not true, but suppose the counter-argument is taken at face value. To the extent that firms accept a lower rate of return, they will be unable to attract capital. Similarly, to the extent they reduce employment in response to the tax (or cut wages and lose skilled employees to better opportunities), they will again suffer in their ability to raise their scale of operations. In short, for firms that attempt to adjust entirely on the cost side will be unable to maintain their operations at a competitive level, and will lose market share or even depart the industry entirely. For health insurance markets as a whole, this reduces competition. The bottom line for consumers is the same: higher prices.

The argument thus far suggests that $1 of fees would show up as $1 of higher health insurance premiums. Unfortunately, the Senate has chosen to make the fees non-deductible for purposes of computing income taxes.

This non-standard tax treatment matters a lot. If a firm passes along $1 in higher prices and cannot deduct the cost (fee), it will pay another $0.35 in taxes. Accordingly the impact on the firm is $0.65 in net revenue minus the $1 fee. Bottom line: a loss of $0.35. (The problem gets worse when you consider that the $1 of additional premium is also subject to premium taxes and in some cases a State income tax.)

To break even, the firm will have to raise prices by $1/(1-0.35) or $1.54. If it does this, the after-tax revenue is the full $1 needed to offset the fee. This has dramatic implications for the overall impact of $6.7 billion in health insurance company fees. Instead of imposing a burden of $67 billion in higher premiums over the next decade, the impact will likely be over $100 billion in additional costs on holders of insurance policies.

In sum, the health insurance fee will likely, quickly and nearly completely, be incorporated into higher insurance premiums at a greater than dollar-for-dollar rate. The same considerations apply to fees on pharmaceutical companies and medical device manufacturers. The economic impact of these fees are similar in character; the fees will likely result in higher costs for these products and services, which will in turn have to be covered by higher health insurance premiums.

These fees mean that American families, workers and small businesses will pay as much as $200b in higher premium costs for their existing health insurance policies. My personal estimate is that roughly 90 percent of this burden will be borne by those making under $200,000 per year—including small businesses and entrepreneurs.

Taxes. The Senate Finance Committee legislation also imposes a 40 percent excise tax on issuers of "Cadillac" plans (over $21,000 for a family; $8,000 for an individual). As with the fees discussed above, this tax will surely be passed to holders of insurance adding an additional $200 billion in premium costs over the next decade. Again, a fraction over 80 percent will be borne by those making less than $200,000.

It should be noted that this excise tax represents the notable feature of the proposed legislation that could contribute to bending the cost curve. I am among those who have argued that capping the open-ended tax subsidy to health insurance is a sensible part of comprehensive reform. Unfortunately, the inclusion of this provision appears to be a case of "too-little, too-late." The cost curve has not been bent and the resulting higher premiums will not be offset by a generally improved health care cost climate.

Insurance Market Reform. Finally, proposed legislation would include insurance market reforms—guaranteed issues, community rating/rating bands, restrictions on rating factors—that would raise insurance premiums on average.

I believe it is non-controversial that the combination of guaranteed issue and community rating would raise average premiums. Guaranteed issue invites the most costly of the uninsured to get insurance and community rating ensures that they will be charged less than their share of the increased costs. The remainder of the insurance pool—existing policyholders—must bear the additional cost. This is straightforward.

What apparently *has* been controversial is that insurance companies have been the carriers of this message. I urge Members to look past the industry's obvious self interest and recognize that there are now a handful of increasingly detailed and careful studies documenting the forces for higher premiums—often double-digit percentage rises in costs. In addition, it is useful to note that non-partisan analysts such as the CBO, JCT, CMS, and NAIC have recognized these forces, even if they have not yet done a comparable analysis of the impact on premiums.

A second issue in this area is the role of mandates. For some, a mandate "solves" the problem with these insurance reforms by forcing healthier, low-costs individuals into the insurance pool, where they would pay far more than their share of the health care costs.

While opinions vary, I believe this is a mistake. Forcing individuals to participate in a system that is already broken and will be getting more expensive is not reform. Guaranteeing insurance companies additional business without commensurate efforts on their part in the areas of pricing, quality of service, and product innovation is at odds with the basic recipe for economic success. I would urge Congress to instead undertake genuine, effective reforms that address the cost of care. These reforms would translate into lower insurance costs and greater take-up of insurance in the United States.

Thank you. I look forward to answering any questions you may have.

The CHAIRMAN. Right on the mark. Thank you very much, Mr. Holtz-Eakin. And thank you for being here.

Next we'll turn to Ms. Karen Bender, principal and consulting actuary in the Oliver Wyman Actuarial Consulting practice, works out of the Milwaukee office. Ms. Bender has over 35 years of experience in the health insurance market in general, has focused extensively on the small group market throughout her entire career. Twenty of these years were spent working for insurance organizations and the last 15 years spent as a consultant.

Her clients include government agencies, insurance companies, HMOs, provider groups and industry associations, has participated in many research projects surrounding health reforms over the years, has co-authored numerous papers, and is a frequent speaker at professional meetings.

Ms. Bender, welcome to the committee. Please proceed.

STATEMENT OF KAREN BENDER, FCA, ASA, MAAA, ACTUARY, OLIVER WYMAN, MILWAUKEE, WI

Ms. BENDER. Thank you for giving me the opportunity to testify today on the potential impact of health reform legislation on the small business community. My testimony is going to focus on three major areas.

First the challenges that are facing the small employer market pertaining to premiums.

Second, the need to bend the cost curve to make coverage more affordable to everyone.

And third, a review of proposed policy changes that will impact small employers.

The first point I will discuss is the challenges that are facing the small group market.

Historically small employers had two main challenges in obtaining health insurance, access and affordability. The access issue was primarily resolved in the 1990s via HIPAA. Federal legislation which required guarantee issue and guarantee renewability for small employers.

Similarly the States passed laws to address affordability issues for high cost employers by limiting the extent to which these groups premiums could vary based upon their health status. It also limited, as the Commissioner has previously indicated, the annual increase that can be charged to any single employer group because of change in health status which we often refer to as morbidity.

While these reforms make coverage more accessible to high cost firms. There is no doubt that they probably exerted upward pressure to all small employers to the total small employer market. Now I'm not going to defend the actions of the carrier to increase the small employer's premium by 70 percent in a single year due to a change in morbidity.

I would note that this is not permissible in 47 States and is also not permissible to the Blue plans in Pennsylvania. So it is definitely, and thank goodness, the exception rather than the rule. Nonetheless affordability does remain a central challenge for small employers given that health care costs continue to rise at a rate much higher than inflation.

However, a recent Kaiser Family Foundation report shows escalating premiums are not limited to small employers. This is an issue for large employers and individuals as well as small employers.

The second point I'm going to talk about is the need to bend the cost curve to make coverage more affordable for everyone. If we want to bend the cost curve for health insurance premium we need to bend the cost curve on health—on medical costs. Recent premium increases in the small group market are primarily driven by increases in the cost of medical care.

While the reform bills before Congress do take steps to try to bend the cost curve. This is likely a long-term endeavor. In order to be effective, insurance reforms must be coupled with concurrent effective changes in how medical care is delivered, liability reforms to reduce defensive medical costs, and efforts to improve wellness and health lifestyles if we are to make small employer coverage more affordable and coverage affordable in general.

My last point that I'm going to talk about is a review of proposed policy changes that will impact small employers. Last month Oliver Wyman released a report commissioned by the BlueCross/BlueShield Association on the impact of the Senate Finance Committee's recently approved health reform legislation. This legislation included what we believe is a weak individual mandate.

Now our analysis concluded the following.

First, average premiums for small employers will increase. And the increase will be up to 19 percent higher by year 5 of the reform. And this is above and beyond medical inflation.

Second, overall the number of small employers offering coverage will decrease. And as a result of that the number of members enrolled in small groups will decline by $2.5 million. Tax credits will help firms with low-wage workers. However, many small employers will not see these savings from the premium tax credits because they won't qualify and will face the full cost of any premium increases.

And finally, exchanges can provide value in helping small employers shop for coverage. But based upon my experience with State purchasing arrangements and what we used to call HIPEX it is unlikely that these exchanges will provide significant premium savings.

Once again, I want to thank you for giving me this opportunity to talk to you today.

[The prepared statement of Ms. Bender follows:]

PREPARED STATEMENT OF KAREN BENDER, FCA, ASA, MAAA

SUMMARY

My testimony addresses three key issues:

• **Challenges facing the small employer market.** Traditionally, small employers faced two major challenges in purchasing health insurance: access and affordability. During the 1990s, the States and the Federal Government enacted reforms to ensure access (guaranteed issue and renewability) for all small employers. Similarly, the States passed laws to address affordability for high-cost firms by limiting the extent to which small employer premiums could vary based on factors such as health status.

Nonetheless, affordability remains the central challenge for small employers given that health care costs continue to grow at a rate much higher than inflation. However, as a recent Kaiser Family Foundation report shows, escalating premiums are

not limited to small employers. In fact, average family premiums for covered workers in small firms have grown more slowly than those in large firms since 2004.

• **The need to "bend the cost curve" to make coverage more affordable for everyone.** To address the fundamental reason why small employer costs have increased over the past decade—growth in medical expenses—we must find a way to "bend the cost curve" in our health care system. While the reform bills before Congress do take steps to try to bend the cost curve, this is likely a long-term endeavor. Insurance reforms must be coupled with concurrent effective changes in how medical care is delivered, liability reform to reduce defensive medicine costs, and efforts to improve wellness and healthy lifestyles if we are to make small employer coverage more affordable.

• **A review of proposed policy changes that will impact small employers.** Last month, Oliver Wyman released a report commissioned by the BlueCross/BlueShield Association on the impact of the Senate Finance Committee's recently approved health reform legislation, which included a weak individual mandate. Our analysis concluded that fewer small employers would offer coverage due to higher premiums, notwithstanding new small employer subsidies.

- *Average premiums for small employers will increase.* As a result of the new modified community rating reforms and higher minimum benefit requirements, small employers purchasing policies in the reformed market will experience premiums that are up to 19 percent higher in Year 5 of reform (not including medical inflation). Proposed rating requirements will cause premiums to increase for low-cost small firms, causing some of them to exit the insurance pool and increasing overall costs. About 9.5 million small group employees who have coverage today will stay covered under the "grand fathered" block in the initial post-reform years, but will face premium increases when the grandfathering phases out.
- *Overall, the number of small employers offering coverage will decline.* After accounting for small employer tax credits, we estimate that 2.5 million fewer members will be insured through small employer policies as a result of premium increases, exchanges, and other factors.
- *Tax credits will help firms with low-wage workers.* The bills before Congress should be commended for including tax credits to help small firms with low-wage workers purchase health insurance. While these tax credits may increase coverage among those firms that are eligible, many small employers will not see savings from premium tax credits and would face the full cost of any premium increases.
- *Exchanges can provide value in helping small employers shop for coverage.* Based on my previous research on State purchasing arrangements, it is unlikely that exchanges will provide significant premium savings if they adopt a similar model where they negotiate with a limited number of health plans. However, exchanges can provide value by providing small employers with a new source of information on product options and prices.

INTRODUCTION

Thank you for the opportunity to testify today on the potential impact of health reform legislation on the small business community.

I am testifying today on behalf of Oliver Wyman Actuarial Consulting. I am a credentialed actuary who has specialized in small employer health insurance issues for more than 35 years. My comments today are based on my experience in actually working for and advising health plans, State governments and other clients on the implications of proposed public policy changes at the State and Federal level.

The focus of today's hearing—increasing health costs facing small business—underscores the need for reforms that expand coverage and improve affordability for small employers. With those goals in mind, my testimony today addresses the following issues:

• The challenges facing the small employer market, including a discussion of the factors that contribute to small employer premiums, and how those premiums are set;

• The need to "bend the cost curve" to make coverage more affordable for everyone; and

• A review of proposed policy changes that will impact small employers: specifically, insurance reforms, health insurance exchanges, and proposed taxes on insurance premiums.

CHALLENGES FACING THE SMALL EMPLOYER HEALTH INSURANCE MARKET

Research has consistently shown that a significant percentage of uninsured workers are either self-employed or working for firms with fewer than 100 employees. To understand the challenges that small employers face when purchasing health insurance, it is important to understand how this market functions and how it is regulated.

Traditionally, small employers faced two major challenges in purchasing health insurance: access and affordability. The issue of access has been addressed as a result of a combination of the enactment of State small employer health insurance reform laws in the 1990s and by HIPAA at the Federal level. Today, State and Federal law requires insurers to offer coverage to all small businesses (2–50 workers) regardless of their employees' health status. In all 50 States, small businesses cannot have their coverage turned down or cancelled if their employees become sick. Thus, small employers that can afford coverage are guaranteed access to coverage today.

The premiums that insurers charge small employers are now highly regulated. In all but three States (Hawaii, Pennsylvania and Virginia),[1] State laws limit the extent to which premiums can vary for individual small employers based on a variety of factors, including health status or claims experience. States typically prohibit health plans from charging premiums to small employers with high-cost workers that are no more than 25 percent–35 percent higher than the midpoint rates. States also limit rate increases at renewal due to changes in morbidity to no more than 10–15 percent if one or more employees become seriously ill during the year. Furthermore, a minority of States do not allow health status to be used at all in setting initial or renewal rates.

These reforms spread the medical costs of all small employers more evenly to generate more affordable premiums for employers with less-healthy members by requiring that small group experience be pooled together. However, this results in higher premiums for the employers with healthier members than otherwise would be justified based on actuarially supported risk classifications. Conversely, the employers with members that consume greater health care resources are enjoying lower premiums than they would absent the existing rating regulations. These groups are being subsidized by the first group, those employers whose premiums are artificially higher due to reforms. In order for the small employer pool to stay viable and generate sufficient premiums to fund claims and expenses, it is critical that enough of the lower-cost groups providing the subsidies remain. Otherwise, overall premiums for all participating employers increase.

These State rules are designed to improve access and fairness for small employers. This is an important objective, but these reforms may actually increase the average cost of health insurance. As an actuary with substantial experience in the small employer market, I have seen that some of the smallest employers make rational economic decisions about when to purchase insurance by taking advantage of these rules. The smallest firms make decisions much like individual purchasers. The National Association of Insurance Commissioners' (NAIC) rating manual states that "Individuals and small groups tend to select against an insurer when purchasing medical coverage. The purchaser generally knows the needs for insurance for each employee in very small groups and can select coverage in line with those individuals' needs."[2] This explains to some extent why small employer coverage can be more costly than coverage for other employers. In an environment where small employers can purchase any level of coverage at any time, there is an incentive to purchase the lowest level until such time they are aware of the need for medical services and then purchase increased coverage on a guaranteed issue basis.

Affordability is the central remaining challenge in the small employer market today. Since 1999, average health insurance premiums for family coverage for small employers have more than doubled from $5,683 to $13,375 in 2009, according to the 2009 Kaiser Family Foundation/HRET employer health benefits survey. As health care cost increases continue to outpace inflation, small firms have found it more and more difficult to provide or maintain coverage.

However, as the Kaiser Family Foundation report demonstrates, escalating premiums are not limited to small employers. In fact, average family premiums for covered workers in small firms have grown more slowly than those in large firms since

[1] In Pennsylvania, BlueCross/BlueShield companies and health maintenance organizations are subject to strict rate limitations in the small group market. However, these regulations do not apply to other insurers. In Virginia, rating rules apply to certain standardized policies. However, most small employers purchase other policies not subject to these rules.

[2] NAIC: *Guidance Manual in the Evaluation of Rating Manuals and Filings Concerning Small Employer and Individual Health Insurance,* 2003.

2004 (30 percent in small firms vs. 36 percent in large firms) and since 1999 (123 percent in small firms vs. 134 percent in large firms), according to the same survey. These premium increases are due to substantial growth in the underlying cost of medical care that impact premiums for all employers—large and small.

The causes for premium increases are due to many factors, including:

• *The price of medical services.* Price reflects the payment rates that health insurers negotiate with hospitals, physicians, pharmacies and other health care providers. Price also includes the increasing cost of purchasing prescription drugs, durable medical equipment, and other items. It is important to realize that insurers use their bargaining leverage to obtain the same price discounts for all of their customers—large employers, small employers, and individuals, so small employer and individuals do have access to the same provider reimbursement levels as large employers.

• *Utilization.* Utilization refers to the volume of medical goods and services that people use. Medical advances are continuously being introduced to improve care and outcomes. For example, a decade ago few people received a knee or hip replacement. Today, the procedures are commonplace. As new treatments are developed, manufacturers and providers advertise these new options, and consumers increasingly seek more care and have higher expectations regarding outcomes.

• *Intensity.* Intensity is when a treatment or procedure is replaced by a more expensive treatment. For example, magnetic resonance images (MRIs) are frequently used instead of less expensive X-rays, thereby increasing costs.

• *Aging of the population.* As we get older, we have greater health care needs and there is a greater demand for services. While this has the greatest impact on the Medicare program, it also impacts the under 65 population as well.

• *Government actions.* Many Federal and State Government actions also add to costs. These include mandated benefit levels, premium taxes, and regulatory requirements. Cost-shifting from government programs that provide below-cost reimbursement to providers also increase premiums for small employers. According to a recent report by Milliman, Inc., annual health care spending for an average family of four is nearly $1,800 higher than it would be if Medicare and Medicaid paid hospitals and physicians rates that were comparable to those paid by private plans. Expansion of the number of people on Medicaid and reductions in Medicare reimbursement may exacerbate this cost-shifting. Cost-shifting from the uninsured is similarly problematic.

• *Personal behavior.* Health care costs are also influenced by personal behaviors such as poor diet and nutrition, lack of exercise, alcohol and substance abuse, smoking, avoidable injuries, and failure to obtain proper vaccines or follow prescribed medication regiments.

According to the Congressional Budget Office (CBO), the bulk of rising health care costs over the past four decades can be attributed to our Nation's use of medical services made possible by technological advances (2008). In fact, CBO found that approximately one-half of all growth in health care spending during this time is associated with the emergence of new medical technologies and services and their adoption and widespread diffusion by the U.S. healthcare system.

II. BENDING THE COST CURVE

To address the fundamental reason why small employer health insurance cost have increased over the past decade—growth in medical expenses—we must find a way to "bend the cost curve" in our health care system. Policymakers, researchers, and industry experts alike have acknowledged that our current system includes misaligned incentives that drive increased health care costs, without regard to quality of care or outcomes. One result is unwarranted variation in medical practice that cannot be explained by patient demographics or severity of illness. This variation can be due to the underuse of tests and treatment known to be effective, the overuse of tests and treatments that may not have significant clinical value, and the misuse of tests and treatments that contribute to medical errors. The use of tests solely for the purpose of defending against the possibility of a lawsuit, commonly referred to as defensive medicine, also exerts upward pressure on health care costs.

To truly bend the cost curve, we must change processes and incentives in our current health care system to advance the best possible care, not just drive the use of more services. Properly aligned incentives can reinforce the adoption of evidence-based practice standards, which will facilitate the availability of transparent quality information for consumers to make informed choices about their care.

The bills before Congress do take steps to bend the cost curve over the long term. However, more emphasis must be put on changing the way that medical care is practiced to bring spending under control while improving quality for all. Insurance

reform must be coupled with effective changes in how medical care is paid for, liability reform to reduce defensive medicine costs, and efforts to improve wellness and healthy lifestyles if we are to bend the cost curve in a substantial way.

III. PROPOSED POLICY CHANGES THAT WILL IMPACT SMALL EMPLOYERS

Insurance Reforms

The key health reform bills before Congress include significant reforms to health insurance industry practices in the small group market. Last month, Oliver Wyman released a report commissioned by the BlueCross BlueShield Association on the impact of the Senate Finance Committee's recently approved health reform legislation on the individual and small employer health insurance markets. While the report did not specifically address this committee's reform legislation, its findings are still instructive. Our analysis concluded that under such reforms, small employers will face higher premiums, and that these higher premiums, coupled with a weak individual mandate will result in fewer small employers offering coverage.

All of the health care reform bills before Congress compress the rating factors that health insurers will be permitted to use in pricing products for small employers. The Senate Finance Committee bill would prohibit the use of health status in pricing products for small employers, limit the use of age to a 4:1 band, eliminate rating based on gender, restrict the use of group size as a rating factor, and limit use of family composition. Rate reform in the small employer market would be phased in over a 5-year period.

The rating reforms in the Senate Finance Committee bills will compress rates for firms with younger, healthier workers and firms with older, sicker workers. As a result, some younger and healthier firms will experience increases in premiums and older, sicker firms will experience rate decreases. The purchase of group insurance is a two-phase process. First, the employer must view the purchase as being of economical value and elect to offer insurance. The employer generally contributes a portion of the premium, requiring the employee to contribute the balance. So the second purchase is by the individual employee who must decide if his/her monetary contribution is of economic value. This is often referenced as the "take up rate."

As a result of the proposed premium compressions, groups with lower-than-average risks who today are enjoying lower than average premiums, may not perceive as much economic value in purchasing health insurance after reforms. The more restrictive the rating rules, the greater the subsidies required from the healthier groups, which means the higher the premium compared to current levels and the less attractive health insurance is for the exact market segment critical to creating a viable pool. While it is true that the higher cost groups will enjoy lower premiums, groups in the small employer market are not distributed equally between low-cost and high-cost entities. The distribution of employer groups by morbidity levels does not follow a bell-shaped curve. Rather, the distribution is skewed toward lower-cost groups, meaning that there are more employers that enjoy premium discounts than employers that pay higher rates. Therefore, the elimination of morbidity as a rating factor will cause a greater number of employers to experience premium increases than will enjoy premium reductions. Rate compression will cause some lower cost firms to drop health insurance coverage and/or cause some employees currently purchasing health insurance to no longer participate, causing the average morbidity to increase, and therefore raise costs for all firms that continue to provide insurance (and their participating employees). The absence of a strong individual mandate coupled with guaranteed issue with no pre-existing limitation will only exacerbate the incentive for individual employees who are lower cost to defer the purchase of insurance until they are aware of a health condition that will necessitate access to services that they can reasonably expect will cost more than the monthly premiums.

The Senate Finance Committee bill also includes certain minimum benefit requirements that apply to small employer coverage. The legislation would establish four defined levels of coverage, with the lowest level "Bronze" plan required to have an actuarial value of at least 65 percent. New coverage sold to small employers must provide certain minimum benefits, including some categories of services that are less commonly purchased among small employers today. New coverage would include specified limits on out-of-pocket costs and no annual and lifetime caps. Based on a review of products commonly purchased by small employers today, we expect that coverage for small employers would be 3 percent more expensive as a result of the minimum actuarial value requirements on average. However, many small employers buy coverage that is significantly below-cost the required actuarial value levels and would face much higher increases when they replace their current coverage.

We estimate that small employers purchasing new policies in the reformed market will experience premiums that are up to 19 percent higher 5 years after reforms

become more effective than they are today, not including the impact of medical inflation. While some smaller, low-wage firms will be eligible for tax credits that may offset the cost of these changes, the majority of firms that continue to provide health insurance will face higher premiums directly as a result of the proposed reforms. The government will also see its share of the costs for these reforms increase by having to provide higher subsidies per covered individual because of these higher premiums.

The legislation contains "grandfathering" provisions which allow currently insured small employers to keep the benefits they have today. Our model estimates that about 9.5 million small group employees (out of a total of 28 million small group employees) who have coverage today will stay covered under the "grand fathered" block in the initial post-reform years. These firms will avoid some of the cost increases as a result of reforms, but will face premium increases when the grandfathering phases-out. We can expect the firms whose grand fathered premiums are less than the post-reform premiums to remain under these plans until such time as these premiums are equal to or greater than the post-reform premiums due to the phase in, since groups whose premiums are higher will have economic incentives to purchase in the new post-reforms pools and take advantage of the lower rates.

The Senate Finance Committee bill will also create health insurance exchanges that will provide an alternative source of subsidized insurance coverage for employees of firms that chose to terminate health insurance coverage. The bill does not compel small employers to provide health benefits and exempts them from the "free rider" assessment that applies to larger firms that do not offer coverage. The combination of the exchange and new insurance rules that apply to the individual health insurance market may make it easier for small firms to drop coverage when faced with premium increases because they will know that their employees can obtain coverage—in some cases subsidized by the government—through the exchanges.

The absence of an effective individual mandate will also contribute to a reduction in the number of workers who obtain insurance in the small employer market. The individual mandate in the bill approved by the Senate Finance Committee was severely weakened. It does not include any penalty for individuals who do not purchase insurance in the first year of reform and then phases in nominal penalties that reach a maximum of only $750 per adult in 2017—15 percent of their expected premium. As a result, fewer low-cost individuals are likely to opt into employer coverage than would otherwise have done so if a strong individual coverage requirement were included in the legislation. However, high-cost individuals will have enhanced economic incentives to join, because their premiums may be significantly lower than current levels and/or benefits may be significantly richer. These are the individuals whose premiums do not totally fund claims. This combination of economic incentives—encouragement of higher cost individuals to join at premium levels less than sufficient to fund claims and the unintended economic encouragement of low-cost individuals to defer coverage until services are required, exerts significant upward pressure on premiums in the post-reform individual market.

The bills before Congress should be commended for including tax credits to help small firms with low-wage workers purchase health insurance. Small firms with low-wage workers have the lowest coverage rates of any segment of the employer sponsored health insurance market. While these tax credits may increase coverage among those firms that are eligible, many small employers will not see savings from premium tax credits and would face the full cost of the premium increases they are likely to experience as a result of health care reform.

Overall, the number of small employers offering coverage is likely to decline after reform. We estimate that even accounting for small employer tax credits, premium increases in the small group market will result in 2.5 million fewer members being insured through small employer policies 5 years after reforms become effective. These losses would have been higher had the legislation not included small employer tax credits.

Exchanges

The key health bills under consideration would establish health insurance exchanges that would be open to both individuals and small employers. Some proponents of these exchanges believe that they could lower the cost of health insurance by reducing administrative costs, "pooling" small employers to gain economies of scale similar to larger employers, and spurring competition among health plans.

As the author of several reports on State purchasing cooperatives and other purchasing arrangements for small employers, I have studied health insurance cooperatives extensively, and have found little evidence that previous models have reduced premiums and have in fact identified some situations where their presence actually

resulted in higher administrative costs. However, if properly structured, an exchange could potentially reduce distribution costs and increase competition by making it easier for consumers to compare products, although the savings would likely be limited by a number of factors I describe below.

While pooling of risks is an essential function of insurance, assembling many small groups or individuals into an exchange "pool" will not automatically reduce costs. While some think that health insurance costs can be lowered if purchased in bulk, like commodities or consumer goods, the economic and actuarial realities affecting the cost of health insurance are fundamentally different.

There are significant differences between a pool of many small employer groups and a large employer pool. For example, a single employer with 999 employees is not the same as 333 groups with 3 employees each. Similarly, an exchange will not be one big pool, like a large employer, but rather a collection of many small firms that must each be serviced separately and each of which are making insurance decisions separately. Insurers participating in an exchange will retain all of the health insurance risk of the groups they enroll; thus, the pooling of risk actually occurs at the insurer level, not at the level of the exchange. I have made these distinctions at several Capitol Hill briefings on behalf of the American Academy of Actuaries.

Exchanges will also have limited ability to reduce administrative costs. Many of the non-subsidy related functions they will perform will duplicate functions performed by the State insurance department, health plans, or insurance agents or brokers. When an exchange takes on enrollment functions, insurers must continue their own enrollment functions to assure appropriate services, claims payment, etc. Thus, while an exchange may assume certain administrative functions, it may not eliminate these functions or their related costs. While it has been argued that exchanges would save money by eliminating costs related to underwriting, any reduction in this area will be a function of changes in insurance rating and underwriting rules and not due to the exchange. Moreover, the costs attributed to underwriting are likely in the range of 1 percent of premiums in the small employer market.

One area where an exchange can provide value is in helping small employers shop for coverage and providing information on competing plans. Exchanges proposed by current health reform bills would provide small employers with information on prices and other important plan features on all health plans in the market.

New Taxes

The Finance Committee bill includes a number of fees and taxes on the health industry to help finance the proposal. These include a $6.7 billion annual assessment on insurers, as well as assessments on device and drug manufacturers that are likely to be included in the prices that insurers and their members pay. The bill also imposes an excise tax on high-cost benefit plans offered in the employer marketplace.

Our recent analysis did not include the impact of these fees and taxes on cost and coverage in the individual and small employer markets. However, it is important to note that the $6.7 billion annual insurer fee is likely to disproportionately impact individuals and small employers. Insurers will have little choice but to pass these fees on to their customers in light of statutory reserve limits. Larger employers that self-fund their benefits are not subject to the insurer assessment. Thus, the design of the insurer fee provision is likely to cause more employers to self-fund, causing small employers and individuals to shoulder an increasing burden from these fees over time.

Few small employers may have benefit costs that exceed the threshold for the excise tax on high-cost benefit plans today. However, because premiums have historically grown at a rate that exceeds the indexing formula in the bill (growth in CPI + 1 percent), more small employer plans are likely to become subject to the tax on high-cost plans over time.

Some have argued that the high-cost plan tax will cause small employers to purchase less expensive benefit plans to avoid the tax, thereby mitigating its impact. However, factors such as the worsening of the overall cost of the small employer pool after rating reforms, geographic cost differences (which may push plans in certain areas into the tax sooner than others), and the restrictions on benefit plan design in the bill may limit behavioral responses to avoid the tax.

CONCLUSION

Small employers are likely to judge the success of health care reform based on whether it improves affordability in the marketplace. While proposed insurance reforms may reduce costs for some firms, they will tend to increase costs in the aggregate by encouraging firms with low morbidity to exit the market in response to pre-

mium increases. The imposition of insurer fees and other assessments will also erode affordability.

As Congress considers health care reform proposals, it must carefully evaluate provisions of legislation that may have unintended impacts that result in increased premiums for small employers. Adequate rating flexibility will be important to assuring a balanced risk pool participates in the insurance pool to assure overall affordability. Congress should also consider the impact of assessments and fees that may disproportionately impact small employers and reduce affordability.

Thank you for the opportunity to testify today on the important subject of assuring affordable health insurance for small businesses.

The CHAIRMAN. Well, Ms. Bender, thank you very much. Thank you for being here and for your testimony.

Now we'll turn to Dr. Jonathan Gruber, Professor of Economics at the Massachusetts Institute of Technology where he has taught since 1992. He's also Director of the Health Care Program at the National Bureau of Economic Research. Dr. Gruber received his BS in Economics from MIT and his Ph.D. in Economics from Harvard.

He was also 1 of 15 scientists nationwide to receive the Presidential Faculty Fellow Award from the National Science Foundation in 1995. He also received the Kenneth Arrow Award for the best paper in Health Economics. Dr. Gruber was elected to the Institute of Medicine in 2005.

And in 2006, he received the American Society of Health Economists Inaugural Medal for the Best Health Economist in the Nation aged 40 and under. Dr. Gruber's research focuses on the areas of public finance and health economics, published more than 125 research articles, edited six research volumes and is the author of Public Finance in Public Policy, an undergraduate text. He was also, I am told, a key architect of the Massachusetts ambitious health reform effort and became an inaugural member of the Health Connector Board the main implementing body for that effort.

Dr. Gruber, welcome back to the committee. Thank you for being here. Your testimony will be made a part of the record in its entirety and please proceed.

STATEMENT OF JONATHAN GRUBER, PROFESSOR OF ECONOMICS, MASSACHUSETTS INSTITUTE OF TECHNOLOGY, DEPARTMENT OF ECONOMICS, CAMBRIDGE, MA

Dr. GRUBER. Thank you, Senator, for the kind introduction. And thanks for inviting me to testify today.

The House and the Senate stand on the verge of passing the most comprehensive health reform legislation in decades. And let me be clear and I'll try to make clear in my 5 minutes, this legislation is a clear winner for small businesses in America.

What I want to do in my testimony is talk about the problems faced by small businesses in America.

Why they're solved by this legislation.

And why Christensen's legislation really missed the mark.

I want to highlight four problems today.

The first is what I call entrepreneur deterrence. That is individuals who are afraid to start new small businesses because of the high and variable costs of health insurance. Consider the 50-year-old engineer at a large firm who has a great idea for a startup, who has a wife who is a cancer survivor, and is afraid of giving up his quality health insurance at that firm to start a new business. That

individual may not go start that new business and society loses from not having that source of dynamic job growth. Economic studies have confirmed the importance of this phenomenon suggesting, that as much, that reduction that individuals are reduced in their transitions of self employment by as much as a third because of fear of losing health insurance.

The second impediment is high loading factors. Small businesses pay as much as 20 percent more than large businesses for the same insurance products because of high broker commissions, administrative costs and the resource expend by insurance companies to make sure that they're not getting the sick employees and giving away the healthy ones.

The third problem is unpredictable premiums. One survey that was done, we've heard a lot of data today. But one survey that was done in 2008 found that 28 percent of small firms reported a premium increase of 20 percent or more.

If small firms don't know whether the costs of insurance is going to go down by 1 percent or up by 20 percent next year, they can't provide health insurance. That's too uncertain an environment for them to do that.

And then finally a key issue is the limited choices faced by employees in small businesses. Only 12 percent of firms with fewer than 200 employees offer their employees a choice of more than one insurance plan in contrast to 43 percent of firms with more than 5,000 employees.

How does reform help these problems?

Well, first of all, reform will help through reformed insurance markets with an individual mandate. Insurance markets will be reformed so that prices depend only on enrollee age and not health. And the pre-existing conditions cannot be excluded from coverage.

This resolves the entrepreneur deterrence effect because the engineer will now be free to be certain that he can get insurance for his wife if he wants to start that new company. It mitigates the enormous year to year swings in premiums because they're in a more predictable insurance environment. And prices fall because individuals are brought in to buy health insurance both healthy and sick and so insurers can be sure that they'll get a good distribution of risk when they offer that insurance.

Second, these bills introduce insurance exchanges as a medium for purchasing insurance. This will further address many of these problems. Small businesses will now be able to directly enroll their employees into the kind of marketplace that's enjoyed only by large businesses today.

This will substantially mitigate the 20 percent excess loading factors. They won't have to use brokers necessarily which is 4 to 11 percent of costs. Insurance companies will not be expending enormous resources trying to pick out just the healthiest firms because they'll be enrolling everybody for this exchange. So it will be a huge reduction in costs, as well as a huge improvement in the set of choices available to employees at small businesses whom instead of only facing one choice will now have a number of choices.

Finally, it's been mentioned about a small business tax credit which will reimburse up to 50 percent of the cost of health insurance for small businesses, offsetting their costs.

I also want to spend a minute debunking the claims that reform will hurt small businesses. For example, some people have claimed that insurance reform will raise costs. That ignores the fact that there's going to be an individual mandate that's going to help improve the risk of health pools and lower health care costs.

Some have claimed the benefit mandates will raise the costs of health insurance, in particular the level of minimum credible coverage that's put in these bills. The level of coverage that's in the Senate Finance Committee—for example, that's the minimum—is less generous than only about 10 percent of firms offer today. So very few firms will be forced to buy up.

Some have claimed that excise taxes will raise the costs faced by small businesses. But here the CBO has spoken. And CBO has reported that these excise fees in the Senate Finance bill will raise premiums by less than 1 percent. So that's really a red herring.

And then finally, we can—there's lots of studies that have talked about the effect on premiums. But we have authoritative evidence from the Congressional Budget Office. They've not spoken on small groups.

We're still waiting for that. But they have spoken on the premium effect for the individual/nongroup market. And unlike reports by Oliver Wyman and others which suggest that premiums in the nongroup market will go up by 50 percent or more.

The Congressional Budget Office estimates that under these exchanges premium in the nongroup market will fall by 30 percent by 2016 because of reform. So while we don't have numbers for small businesses, it's clear where it's going for individuals.

Let me conclude with some modeling results. I have a model that has been widely used by members on both sides of the aisle to look at analyzing various policies they want to consider. And I've used this model to analyze the effect of the status quo of no reform verses the alternative the Senate Finance Committee bill.

What I found is that the Senate Finance Committee bill will imply an enormous reduction in the health insurance spending of small firms. I estimate that in 2019, absent reform, small businesses will spend about $300 billion a year on insurance premiums. I estimate that with this reform that number will fall by 25 percent to about $225 billion a year. That has real consequences for small businesses and their employees. I estimate that by 2019 workers in small businesses will see their take home pay increase by $30 billion a year because of these reforms. And about 80,000 jobs will be saved in the small business sector.

So, in conclusion, let me highlight that small businesses have little to fear and much to gain under health reform. A reform market with efficient exchanges will both lower health insurance costs and offer the premium stability that is so critical to those who want to start new small businesses. And employees will be free to move from job to job and to start the business without fear of getting their coverage stripped away should they get sick and with having a larger array of choices.

Thank you very much.

[The prepared statement of Dr. Gruber follows:]

PREPARED STATEMENT OF JONATHAN GRUBER

The health reform legislation making its way through both Houses of Congress currently will benefit many different groups in society. One of the major winners from this legislation will be small businesses and their employees. Small businesses suffer in our current insurance system from high and unpredictable insurance prices; premiums can rise rapidly with little notice. The reformed system envisioned by Senate and House legislation would provide a more predictable and less expensive environment in which small businesses could purchase quality health insurance. This will promote small business formation and growth by removing this enormous source of uncertainty. Moreover, the legislation would allow small business employees to benefit from the broad range of choices now unavailable to them. In this testimony I will describe in more detail the gains to small businesses and their employees.

SMALL BUSINESS HEALTH INSURANCE TODAY

Small businesses and their employees face *four major impediments* in the employment-based system of health insurance in the United States.

Entrepreneur Deterrence

First, individuals are afraid to start small businesses, or to join new businesses, because of a fear of losing health insurance. Consider the 50-year-old engineer at a large firm who has a great idea for a new start-up company, but also has a wife who is a cancer survivor who now benefits from the high quality insurance at that large firm. This engineer may be unwilling to start that new company because of fear of being unable to obtain insurance coverage—or to obtain it only with preexisting conditions exclusions that would exclude coverage for his wife's cancer. As a result, the engineer will not start the new company, reducing a dynamic source of job growth for the United States.

Economic studies have confirmed the role of job lock in dissuading entrepreneurship. A number of studies over the past 15 years have shown that those who have access to health insurance outside their employment setting are more likely to start new businesses. For example, one recent study found that not having spousal insurance available, relative to those who do have such insurance, lowers the rate of transition to self-employment by 18–34 percent.[1] That same study as well as another recent study find that the reduction in the price of insurance for the self-employed led to a significant rise in transitions to self-employment, with the latter study finding that tax subsidies to the self-employed raised the probability of entering self-employment by 24 percent and reduced the rate of exit from self-employment by 16 percent.[2]

High Loading

The second major impediment faced by small businesses is the much higher loading factors that they must pay on their insurance, leading to higher costs and less purchase of coverage. Data on this point are hard to come by, but the best available data suggest that smallest firms pay as much as 20 percent more than large firms for the same insurance coverage.[3] These higher loads result from broker commissions (which can run from 4 to 11 percent of premiums), other fixed costs of administering and selling insurance that raise, per person, premiums more for smaller firms, and from resources expended by insurance companies in today's environment to try to screen and avoid the sickest firms.

Unpredictable Premiums

The third impediment is the unpredictable nature of those costs, which makes it difficult for small businesses to commit to offering insurance to their employees. For example, one survey found that in 2008, 28 percent of small firms reported a premium increase of 20 percent or more.[4] If small firms can anticipate the rate of premium increase, they can account for that in any business growth planning in deciding whether they can afford to offer health insurance. But if they cannot know

[1] Gumus, Gulcin, and Tracy Regan (2009). "Self-Employment and the Role of Health Insurance," Working Paper, University of Miami.

[2] Heim, Bradley and Ithai Lurie (2009). "The Effect of Health Insurance Premium Subsidies on Entry Into and Exit from Self-Employment," mimeo, U.S. Department of the Treasury.

[3] Chu, Rose and Gordon Trapnell (2003). "Study of the Administrative Costs and Actuarial Values of Small Health Plans," Small Business Research Summary #224, SBA Office of Advocacy, Washington, DC.

[4] National Small Business Association (2009). "Health Care Survey of Small Businesses."

whether costs will go up by 5 percent or 30 percent the next year, they will shy away from providing insurance in the first place.

Limited Choice

Most small firms in the United States do not offer their employees a choice of health plans: only 12 percent of firms with fewer than 200 employees allow their employees two plans to choose from, and only 1 percent of firms in that size range offer three or more choices. In contrast, among firms of over 5,000 or more employees, 43 percent offer two choices and another 29 percent offer three or more choices.[5] This reflects the fact that insurers do not want to insure small firms with segmented risk pools, and the higher administrative costs of small firms that want to offer an array of health plan choices.

HOW DOES REFORM HELP?

The types of reforms now making their way through Congress would help with all four of these major impediments to small businesses, through several key features.

Reformed Insurance Markets With Individual Mandate

Insurance markets will be reformed so that prices depend only on enrollee age and not health, and so that pre-existing conditions cannot be excluded from coverage. This resolves the entrepreneur deterrence effect because the engineer will now be certain that he can get insurance to cover his wife's cancer if necessary, freeing him up to start that new business. This legislation therefore removes an important deterrent to business formation and growth that will increase the productivity of the U.S. workforce.

Insurance market reforms also mitigate the enormous year-to-year swings in insurance premiums that are so common for small businesses and interfere with their ability to offer insurance. Moreover, the individual mandate ensures that prices in these new exchanges will be low because there will be a mix of both healthy and less healthy enrollees. This will allow insurance companies to issue insurance at the same cost, removing the need for screening on health and its associated administrative load.

The Exchange as a Medium of Insurance Purchase

Many of these problems will be addressed further through the ability of small businesses to use the new exchange as a medium for insurance purchase. Small businesses will be able to directly enroll their employees into a marketplace that provides a wide variety of choices over plan design and insurance company. This will substantially mitigate the high loading costs facing small businesses today because they will not be required to use brokers, because they will not face the administrative burdens imposed by focusing on their particular group for insurance sale, and because there will not be resources wasted on health screening. As noted earlier, small businesses pay up to 20 percent more for insurance today. There is no reason that figure couldn't be cut substantially in an exchange environment.

Moreover, the exchange will provide small business employees with the wide variety of choices that large businesses now provide their employees. This will make it more attractive for small businesses to offer coverage by making it more appealing to their employees. And it will allow small business employees to choose the plan that most appeals to them, rather than being forced into the plan that suits their employer's preferences.

Small Business Tax Credit

Health insurance is expensive in the United States, and even under these reform bills that will not change right away. As a result, all of the legislative proposals include a sizeable tax credit to help our Nation's smallest businesses afford coverage. This credit will offset up to 50 percent of the premium cost for the smallest and lowest wage businesses that are having the most trouble providing coverage today.

DOES REFORM HURT?

Those who argue that reform will hurt small businesses rely on several arguments, all of which are either incorrect or overstated.

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[5] Data from the Kaiser Family Foundation available at *http://ehbs.kff.org/?page=charts&id=2&sn=19&ch=1048*.

Insurance Reform Will Raise Costs

The first claim that is made is that insurance reform will raise costs to small businesses—particularly if there is not a strong mandate in place. In a generic sense, this statement is true—market reform without a mandate can raise premiums. We have seen in a number of States that imposing community rating on the non-group market without a mandate has caused a spike in premiums. But this has not proven to be a major problem to date in the small group market, where State reforms to market rating in the early 1990s did not much increase premiums.[6]

Moreover, there is a very strong mandate in place in legislation proposed by HELP and the House—and a reasonably strong mandate in the SFC legislation as well. This will offset any rate shock from community rating by bringing younger and healthier workers into the risk pool. Finally, the grandfathering provisions in these proposals will protect any small firms that would potentially suffer a rate shock from reform.

Benefit Mandates Will Raise the Cost of Insurance

While the details differ, the legislative proposals before Congress would add a series of requirements to ensure that insurance is providing real protection to consumers. Most notably, they would impose a "minimum actuarial value" that would require coverage at a certain level of benefits by small businesses. Yet the minimum actuarial contemplated by the Senate legislation, which would require that insurance cover 65 percent of expected medical costs, are not onerous relative to coverage among today's small businesses. Recent analysis by the Engelberg Center for Health Care Reform at the Brookings Institution finds that fewer than 10 percent of small firms in the United States today offer benefits packages less generous than this level.

The plans would also impose other restrictions on insurance coverage, such as no annual or lifetime limits and mandated preventive care. But once again these are not burdensome mandates for the vast majority of small firms. For those small firms who would have to change their benefits packages to meet the mandate, they can simply adjust other aspects of the package to stay at similar premium level.

Excise Taxes and Fees Will Raise Costs

These legislative proposals would impose a set of excise charges on both medical providers and the insurance industry. The final form of these excise charges is currently under debate. But to the extent they follow the form of the Senate Finance Committee proposal evaluated by CBO on September 22d, they will have a trivial effect on premiums; CBO reports that the excise fees will add up to less than 1 percent of insurance premiums.[7]

Employer Responsibility Requirements Will Hurt Small Business

The legislation being considered would include some financial consequences for businesses that do not offer insurance coverage. But these assessments would not hit the smallest businesses. The free rider assessment in the Senate Finance Committee bill, for example, would apply only to firms above 50 employees. Even past that point, the requirement would be quite modest, at most $400 per full-time employee. This is only about a 1 percent rise in the cost of compensation.

OBJECTIVE EVIDENCE THAT REFORM WILL LOWER PREMIUMS

Reports sponsored by the insurance industry have argued that reform will lead to higher premiums for small firms.[8] Unfortunately, I am aware of no objective party which has presented an analysis of the impact of reform on small business premiums. But there is some guidance as to the validity of existing analyses from CBO analysis of the impact of reform on the non-group market. The same reports that claim that reform will dramatically increase small group premiums have made the claim even more strongly with respect to non-group premiums, with estimated increases from reform of 50 percent or more. But the objective CBO analysis shows that these claims are clearly wrong—reform will *lower*, not increase, non-group insurance costs.

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[6] Simon, Kosali (2005). "Adverse Selection in Health Insurance Markets? Evidence from State Small Group Health Insurance Reforms" *Journal of Public Economics*, 89, 1865–1877.

[7] Letter from CBO Director Douglas Elmendorf to Senate Finance Committee Chairman Max Baucus on September 22, 2009.

[8] Oliver Wyman, "Insurance Reforms Must Include a Strong Individual Mandate and Other Key Provisions to Ensure Affordability"; PriceWaterhouseCoopers, "Potential Impact of Health Reform on the Cost of Private Health Insurance Coverage."

In their September 22d letter, the Congressional Budget Office reported that they estimated the cost of an individual low-cost "silver" plan in the exchange to be $4,700 in 2016 (this was later updated to $5,000). This is a plan with an "actuarial value" (roughly, the share of expenses for a given population covered by insurance) of 70 percent. In the same letter, the CBO projected that, absent reform, the cost of an individual policy in the non-group market would be $6,000 for a plan with an actuarial value of 60 percent. This implies that the same plan that cost $6,000 without reform would cost $4,300 with reform, or *almost 30 percent less*.

The CBO has not reported many of the details of their analysis, such as the age distribution of individuals in the non-group market or in the exchange. So these data do not provide a strictly apples-to-apples comparison of premiums for the same individual in the exchange and in the no-reform non-group market. Moreover, CBO's conclusion may change as legislation moves forward. But the key point is that, as of now, the most authoritative objective voice in this debate suggests that reform will significantly reduce, not increase, non-group premiums. This is in stark contrast to the critical reports from the insurance industry—and suggests a potential bias to their conclusions for small firms as well.

THE PROSPECTS FOR SMALL BUSINESSES WITH AND WITHOUT REFORM: MODELING RESULTS

I recently provided background research for a study by the Small Business Majority of the impacts of reform options on small businesses.[9] I have undertaken similar calculations for this testimony for the Senate Finance legislation. These results draw on the Gruber Microsimulation Model (GMSIM), which has been widely used for policy analysis at both the State and Federal level. This model parallels the type of model used by the Congressional Budget Office in their analyses of health reform proposals.

I have used this model to project two scenarios for small businesses (with fewer than 100 employees): no reform (the "status quo") and the Senate Finance Legislation ("reform"). I conservatively assume that in both scenarios the underlying premium growth rate for small businesses will be 6 percent/year, which is below the recent trends, and which gives no credit to the reform for lowering the rate of health insurance cost growth. I do assume that reform lowers costs to small businesses by 5 percent on average through the set of policies I described above.

My modeling results show an enormous reduction in small business spending through health care reform. I estimate that in 2019, absent reform, small businesses will spend roughly $290 billion/year in health insurance premiums. Under reform, I see that number falling by about 25 percent to $225 billion/year.

This lower spending has real consequences for small businesses and their workers. I estimate that under reform, workers in small businesses will see an increase in their take-home pay of almost $30 billion/year, and that reform would save about 80,000 jobs in the small business sector by 2019.

These are only estimates based on a highly uncertain future. But the assumptions about cost growth in the small business sector are conservative so the gains could be even larger.

CONCLUSION

As this testimony makes clear, small business has little to fear, and much to gain, from health reform. A reformed insurance market with efficient exchanges will offer both lower health insurance costs and more premium stability for small firms. And employees will be free to move from job to job and start new small businesses, as well as to benefit from a much greater choice of health care plans in the small businesses in which they work.

The CHAIRMAN. Dr. Gruber, thank you very much for your testimony, for being here. And we'll now start a round of 5-minute questions.

First I'll start with you, Mr. Cullen. You stated that under your policy routine preventative care such as a colonoscopy would cost about $3,000 out-of-pocket in the local hospital. In fact we have figures that show that in Iowa 36 percent of men who are aged 50 have never had a colorectal cancer screening.

[9] Small Business Majority (2009). "The Economic Impact of Health Reform on Small Businesses," June 11, 2009.

The Senate legislation that we are anticipating bringing up will require coverage of recommended preventative care with no charge at all. Do you think that this might reduce the high rate of fatal colorectal cancer in Buena Vista County that you mentioned in your testimony and the rest of Iowa?

Mr. CULLEN. Yes, for the benefit of others in this room who haven't seen the written testimony, Buena Vista County has the highest rate of colorectal fatalities in the State of Iowa. And they believe it's because of a lack of screening, according to the University of Iowa epidemiologists. So I could hope that more screening would prevent these fatalities, but I'm not a doctor. I don't know.

One point I would like to make and it's not directly in response to your question. That is, I don't know where it's written that the *Storm Light Times* is required to provide insurance to its employees. It seems to me like our function is to put out a newspaper.

And we don't want to be health care plan administrators. We don't want to be dealing with our employee's bills. Did you send that bill back to the hospital? Did you do this? Did you do that? That should be for health insurance companies to do.

So I would ask the Senate to get health care off the backs of small businesses. And I would think that preventative care, as you're talking about would reduce incidence. But again, I'm not an epidemiologist.

The CHAIRMAN. Well, I think all the figures that we have, from NIH and CDC and everyone else, shows that colorectal cancer can be one of the most fatal. It can also be one of the most curable if it's detected earlier in that screening.

That is one of the preventative measures recommended by the U.S. Preventive Services Task Force.

Mr. CULLEN. May I add, Senator, that the woman who works next to me, our Associate Editor, Tina Donath, who has worked for us for about 15 years, I think, is suffering from colon cancer right now. And she's the one who needed the $2,500 shot. And she had never had screening because our insurance didn't cover it.

The CHAIRMAN. Yes, well, I think that's the point.

Mr. CULLEN. She's also about 60, I believe.

The CHAIRMAN. One other thing. I remember when you were telling me about your insurance and what was happening. And I said, well, why don't you get another carrier?

Mr. CULLEN. Hah.

The CHAIRMAN. And what was your response?

Mr. CULLEN. Well we can either have BlueCross or BlueCross.

The CHAIRMAN. So you only have one carrier?

Mr. CULLEN. Yes, we can't go anywhere. And with a kidney transplant, colon cancer, my wife just had back surgery and I'm apparently insane. Nobody would take us.

[Laughter.]

The CHAIRMAN. That's what caught me was the fact that I——

Mr. CULLEN. That I'm insane?

[Laughter.]

The CHAIRMAN. No.

Mr. CULLEN. Good.

The CHAIRMAN. Mr. Rowen, you discussed a report you received from your insurance company explaining its offer of a 128 percent

premium increase. Do you think the full 128 percent increase can be explained by the factors the company cited?

Mr. ROWEN. That's almost impossible for me to get a handle on. One of the reasons is we don't have access to all the health records of our employees. We're a small family business. So we know everybody. We, if somebody is having major surgery, we know about it.

I can tell you that there were no major surgeries. There was no major, major procedures from last year. What I don't know is if any of our employees have had some procedures that would indicate some type of major surgery is pending in the next year.

So I have no way of knowing that. I do know that our average age has increased somewhat. But our employees are stable. It's the same group of people that has been in the plan, essentially the same group of people, for the last 4 or 5 years.

The CHAIRMAN. Do you think that a requirement to have health insurance is important in making the health insurance pool as big as possible?

Mr. ROWEN. I do believe that, yes. I know for a fact that, by example, there are a fair amount of younger people, when they come into our company, who choose not to buy health insurance. Our policy right now, I think our latest one is something like $350 a month for the employee of which we share. But it is expensive.

A lot of young people choose not to participate because there's a risk. I mean, they choose not to. If it was quite a bit less expensive for them, I think they would.

The CHAIRMAN. Thank you very much, Mr. Rowen.

Senator Enzi.

Senator ENZI. Thank you, Mr. Chairman. I want to thank everybody for their testimony. That's been very helpful.

I know in the 5 minutes we have we won't get to ask questions of everybody or even all of the questions we'd like to ask of anybody. So I hope that all of you will agree to doing some written answers to some of the things. And some of which might be a little more technical. But I do appreciate what you shared with us.

Mr. Rowen, you mentioned that you've been contributing to the health savings accounts for your employees. And I assume those are the kind that the money that's not spent can roll over next year or is that——

Mr. ROWEN. That's not exactly true, Senator, because I don't think we set up specific HRA policies. Essentially what we were doing was that the company was reimbursing our employees for the full cost of whatever deductible they incurred. We did it a couple different ways in the 3 years that we were doing it.

It wasn't as if our employees were putting or that the company was putting funds into an account we drew down from. All that we did was take, in any given year—we said that if our health insurance is going to increase by say 20 percent. That's going to cost us X amount of dollars.

So, instead of increasing, we increased the deductible, took that at-risk money and put it toward paying those deductibles and most of the time that worked out for us.

Senator ENZI. OK, I appreciate that. I've always encouraged people to take a look at the regular health savings account and if that helps in some small businesses.

Commissioner Praeger, you mentioned that a part of your job is to see that the minimum loss ratio is available to companies. And you have some capability, I understand, on how much they can increase premiums. Are there some other tools that you need to be able to do the job that would help keep down health care costs?

Ms. PRAEGER. Well, Senator, getting rid of pre-existing condition exclusions would go a long way toward assisting people in getting affordable coverage. But we know coupled with that you need to have everyone in the pool so the young healthy folks are buying as well and sharing in the risk with others.

We don't have specifically in Kansas the tools that—I don't have the authority to just deny a rate increase because I think it's too much. If the company can demonstrate that it's based on medical trend, the base amount and then the other factors age, the demographic status of the company, the various other health statistics, we really—most State's hands are tied in terms of determining that the rate can't be administered.

Senator ENZI. Thank you. Thank you. Question for Mr. Holtz-Eakin.

Dr. Gruber, in his testimony said that CBO has said excise taxes in the bills will have a trivial impact on premiums. I wasn't aware that CBO had done a comprehensive analysis of how that bill will increase premiums. Is that your understanding?

Mr. HOLTZ-EAKIN. That is right for the three major bills, the Senate Finance bill, the HELP bill and the blended bill in the House. There's been no comprehensive analysis from CBO on the impact on group, small group and individual premiums.

Senator ENZI. And formally having done that kind of work, I think you said that these bills could increase premiums by $200 billion. Do you think that the impact of the excise taxes in the Finance bill will have a significant impact on premiums?

Mr. HOLTZ-EAKIN. Yes, I do. I think the analysis of both the Cadillac excise tax and the *de facto* excise taxes on medical devices and other medical providers are going to raise premiums.

Senator ENZI. And I've always concluded that that would be passed on to the workers. I'd be interested in whether that's your opinion as well. And how many families making less than $100,000 a year do you think will wind up paying that tax?

Mr. HOLTZ-EAKIN. Well we know from the work that's been done so far by the Joint Committee that about half will be paid by those making less than $100,000. And that some of the impact will be to shift people to lower wages and, you know, the incidence occurs that way.

Senator ENZI. I thank you. And Ms. Bender, you wrote in your testimony that groups in the small employer market are not distributed equally between low-cost and high-cost entities. Under the bills before Congress does this mean that while some high-cost groups could see slightly lower premiums and the majority of small businesses would see their premiums go up?

Ms. BENDER. That's exactly correct. What we call the distribution of small groups by morbidity is skewed meaning that currently more small employers are enjoying discounts than those that are facing surcharges. So when you eliminate the morbidity rating factor it will benefit some. And it will benefit the higher cost employ-

ers. But there's going to be many more small employers who receive increases than those who enjoy lower rates.

Senator ENZI. Thank you and my time is up. I will submit some other questions to you. You've been a very helpful panel. Thank you.

The CHAIRMAN. I intend to have another round after we finish this one.

Senator Merkley.

STATEMENT OF SENATOR MERKLEY

Senator MERKLEY. Thank you very much, Mr. Chair. And thank you to the panel for your testimony.

Mr. Cullen, I wanted to start with you. I gathered from your testimony that your rates doubled because an employee had a kidney transplant in 2005.

Mr. CULLEN. Certainly coincidental.

Senator MERKLEY. And that certainly is exactly what happens with small employers where the health of every individual is analyzed by the insurance companies. So would it benefit your company to be able to join a pool of hundreds of thousands of individuals so that you're not being rated just by the risks in your small group of employees?

Mr. CULLEN. You know it sounds attractive. But I honestly don't know. I don't know if it will be the same screwball insurance companies we're dealing with now.

Senator MERKLEY. OK.

[Laughter.]

Thank you. Well, your point does show.

Mr. CULLEN. I've grown jaded and cynical on the topic. And I don't know that it will help. I hope it will.

But my point is pretty to the point. And that is get it off our backs. If that means a public option, fine. If that means an insurance exchange of some sort, fine. But give us a way to get out from underneath this albatross.

It's become expected that small businesses will provide insurance even if they can't afford it. And we cannot afford it. Ours is a $10-an-hour economy. I'm telling you. It's a meat packing town. It's a tough town.

Senator Roberts knows full well about how these economies are structured. And there are a lot of people in Storm Lake running around without insurance or woefully underinsured like myself.

Senator MERKLEY. And the additional amounts you've had to pay for health coverage I assume either take away from hiring additional employees or being able to pay your existing employees' rates.

Mr. CULLEN. Because of health care increases we did not give anybody pay increases this year. And I would also note that our economy is a lot better off than the rest of the country. Our unemployment rate is just below 6 percent. The meat packing plants are running strong as I'm sure they are in Kansas and Minnesota as well.

And so we've been doing fairly well. But we cannot give a raise this year because it's all been eaten up by health care costs. And we would like to hire another employee and we can't.

It's costing us 50 grand a year. We spend as much on health insurance as we do on newsprint.

Senator MERKLEY. Yes. Well, Mr. Rowen, let me turn to you and your small company. You note you have increases over the last 3 years, 2006 through 2008, 22 percent, 24 percent, 10 percent. And initial cost increases this year, as quoted, at 128 percent.

Mr. ROWEN. That's correct.

Senator MERKLEY. I'm trying to picture you opening that letter or that e-mail and falling flat on the floor.

Mr. ROWEN. Yes, I had a real bump on my head from that one, I can tell you.

Senator MERKLEY. I would imagine. So do you feel like if we are able to set up exchanges where every small business can join a pool of hundreds of thousands of others and not be rated just on its immediate employees and not just be kind of at the mercy of the higher premiums charged to the smallest companies, do you think that would benefit your company?

Mr. ROWEN. Well, again, I'm not a health insurance expert, but what I do know is what I've been told. What my experience has been is when the insurance industry says that the average rate increases have been in the 10 percent range and then every small business I know is looking at 25 and 35 percent increases. There's something happening to small businesses.

The only thing I can conclude is that our pools are too small. And then when I look at the broker report that we received this year for the justification of the 128 percent, it was a 70 percent portion that was allocated toward the health of the future situation of our small group. So I can't conclude anything other than what you just said which is if we could be in a bigger pool our rates should be lower.

Senator MERKLEY. Have health care expenses had direct impacts on your ability to hire additional employees or to pay your employees more?

Mr. ROWEN. I think most small businesses hire employees because their business is doing well. And they lay off people or cut back because their business is not doing well. I've never been a believer that we hire because there's a better tax situation or that there are better government benefits that come to us.

When the economy does well, we do well. And when we do well, we hire more people. It is absolutely true, though, that if my expenses—something say in health care—or my expenses go up than I am not passing on increased wages to my employees. That is absolutely, directly true.

Senator MERKLEY. Thank you. Thank you. Do I have time or am I—I'm out?

Thank you very much. And thank you, Mr. Chair.

The CHAIRMAN. Thank you.

Senator McCain.

STATEMENT OF SENATOR MCCAIN

Senator MCCAIN. Thank you, Mr. Chairman. I thank the witnesses. Dr. Gruber and Mr. Holtz-Eakin obviously present starkly different views of this legislation. So maybe beginning with you, Mr. Gruber, you could give us a minute or two on your disagree-

ment with Mr. Holtz-Eakin. And then I'd like to have him respond and then if whatever time is remaining.

Dr. GRUBER. All right. Well, that will be fun. So basically I think there are lots of theoretical disagreements about what insurance market reform will do? How effective exchanges will be in lowering costs? I think that's really just the difference in perspective.

I think we should try to stick with the facts which is what CBO has told us. What they have said explicitly. They haven't, Doug is right. CBO has yet to tell us the answer we'd like for this hearing which is what will reforms do to small group premiums.

They've told us two things.

First of all they said the excise fees will raise premiums by less than 1 percent. They called out that one element. And they said that one element will raise premiums by less than 1 percent. That's in CBO letter.

Second they've said for nongroup plans, not for small groups unfortunately, but for nongroups, premiums will be about 25 to 30 percent lower in 2016 than they would be without this reform. Those are the facts——

Senator MCCAIN. All right. Why do you disagree with Dr. Holtz-Eakin that the curve will not be bent up or down?

Dr. GRUBER. I think, you know, Doug raised an excellent point about ultimately we really need to bend this curve. I think this legislation starts us down that path. But I don't think this legislation by itself, fundamentally, is going to bend the curve.

I think it starts us down that path. And I think the alternative is—what's the alternative? The alternative is doing nothing like we've done for 50 years and the curve continuing upward.

Senator MCCAIN. OK. Could I? I'd like to go back and forth one time in my 5 minutes.

Dr. GRUBER. OK. You bet.

Senator MCCAIN. Go ahead.

Mr. HOLTZ-EAKIN. So I think the fundamental disagreements are No. 1, a lot of John's analysis relies on an individual mandate that's very strong. And that's not what we've got. The Senate Finance Committee mandate got it completely.

I mean there's no penalty the first year. It's $400 the second year, $750 max. Anybody looking at this is going to pay the penalty and not buy insurance. House is similar.

So the sort of dynamics that come out of a world with guaranteed issue community rating and no mandate are the reality of these bills. And the theory of a strong mandate is missing.

The second thing is a lot of what would be benefited from exchanges and things, loading factors, things like that are one-time events. So suppose exchanges get rid of the 20 percent increase in loading factors in the small group market? Well at 80 percent a year growth, 3 years down the line that benefit will be gone and we're stuck with the same growth in costs, the same rising premiums and we're having another hearing in this room.

So the bills don't solve the problem.

Senator MCCAIN. Mr. Gruber.

Dr. GRUBER. I think Doug's got an excellent point. I think the point is you have to contrast it with what would happen without the bill. It is truth that 3 years later that gross 8 percent pre-

miums will be up. But they'll still be 20 percent lower than they would be without the bill.

I think you can't compare it to the ideal which is, "gee, it would be great if premiums didn't grow." Just because this bill won't solve all the problems doesn't mean it won't take us a long way toward solving some of the problems that we face. I think holding it to the standard of saying, "unless this bill ends cost growth it's not worth passing," is just the wrong standard to have.

Mr. HOLTZ-EAKIN. And I think the Congress set out this year to do fundamental health care reform which had two pieces. One is enhanced coverage. But the second was deliver quality care in America for lower cost. That's an achievable goal.

These bills don't do it. So to say that it's this or nothing, misses the point. Let's enact a genuine reform that changes the delivery system, slows the growth in costs, takes pressure off rising insurance premiums and delivers on the promise of health care reform.

There's no reason to say it's this or nothing. Let's do something good. You could extend protections to individuals who already had employer coverage by simply saying they don't have to be on COBRA until it's exhausted.

That's a simple reform. Doesn't take 3,000 pages. It doesn't cost a million dollars a page. Let's do things like that.

Senator MCCAIN. Am I out of time?

Mr. Gruber.

Dr. GRUBER. Yes, I think that, you know, Doug and I just have a fundamental disagreement about whether we should accomplish what we can accomplish or whether we should let the perfect be the enemy of the good. I agree. I'd love to have a bill which would end cost growth inflation in America with health care costs. We've tried for 50 years and never gotten it.

This is a bill which will cover the uninsured and which will lower the cost that individuals have to pay for health insurance and small groups have to pay for health insurance. I don't think we should because it won't achieve some, I believe, unachievable goal right now and we should kill the bill.

Mr. HOLTZ-EAKIN. I would say again this bill is dangerous to our economy. We are literally asking the Chinese to have forbearance against our fiscal malpractice. This sends the message that they will own a greater ability to control our future.

That is exactly the wrong thing to do at this time. It is larger than health care. It is about the track on which this Federal Government budget is going.

We cannot, because we're worried about the history of health care reform, do something which is fiscal malpractice at this moment. That is a mistake.

Dr. GRUBER. But I guess I don't see how you can call it fiscal malpractice when this bill is paid for the first 10 years.

Mr. HOLTZ-EAKIN. It's not.

Dr. GRUBER. And the CBO reports that will lower the deficit over the second 10 years as well.

Mr. HOLTZ-EAKIN. Mr. Chairman, I apologize for interrupting. But I hope at some point in this hearing there is a fair discussion of whether this budget balances or not. This does not, over any horizon, really balance the budget.

Senator MCCAIN. Mr. Chairman, you've been more than generous with the time. I think it's an excellent exchange. And it's been very helpful. And I appreciate all the witnesses being here—thank you, Mr. Chairman.

Dr. GRUBER. In my experience he likes fights.

[Laughter.]

The CHAIRMAN. Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Last week I met Linda Batterson from Bloomington, MN. She's got three daughters. She owns her own business. And her husband, Bud is a realtor.

The Batterson's have some relatively minor health problems, asthma, allergies, back problems. But even so their only health care option is Minnesota's high risk pool. And this year they're paying nearly $21,000 for health care. Neither the Batterson's business nor their family can sustain the cost.

Now in your testimony, Mr. Holtz-Eakin, states—and this is in the written testimony. And I think we just saw a discussion about this. But in your written testimony you say there's noncontroversial agreement that health reform will raise average premiums for families like the Battersons.

I'd like to ask Mr. Gruber, I think it's actually on the face, evident, that there is controversy, isn't there?

Just the fact that you disagree would be kind of controversial, wouldn't it?

Dr. GRUBER. Yes. Doug and I are actually friends despite the exchange. And there's clearly disagreement about that. I think once again, in the face of disagreement economists need to turn to empirical evidence. And the best evidence we have at this point is what the Congressional Budget Office has said.

Senator FRANKEN. But to put in your testimony that it's noncontroversial agreement is not accurate. And I wonder why I'm reading this kind of testimony.

Ms. Praeger.

Mr. HOLTZ-EAKIN. May I respond?

Senator FRANKEN. I only have a little bit of time. Maybe on the next round, ok. It just seems that it's controversial to me.

Ms. Praeger, Dr. Gruber talked about what he called entrepreneur deterrents which is job lock, right?

Ms. PRAEGER. Right.

Senator FRANKEN. Ok. Andrea Merkle spoke to a joint session of Congress today. She's the Chancellor of Germany. She was born in East Germany.

She said that while she was a kid people would smuggle in books and movies about America, from America. And she said in her speech that what most inspired her about those books and about those American movies was the American dream.

I met with a constituent who wants to do a small business as bad as anything. His wife has got cystic fibrosis. So she has a pre-existing condition. So he can't form a small business.

We're deferring the American dream for these folks until we get rid of pre-existing conditions. How would health care reform, that

we're talking about now, help make the American dream alive for people like this constituent of mine?

Ms. PRAEGER. Well, I think you've articulated that in your question, Senator. I think I do believe there probably is some entrepreneurial job lock. There's job lock in folks moving from company to company and not sure that the new company will offer the same level of benefits because those are——

Senator FRANKEN. But if you have a pre-existing condition—one of the things that this health care reform would do, is say that an insurance company can't charge you more because you have pre-existing conditions. So then you can start a business knowing that because your wife or your kid or you have a pre-existing condition you're not going to be charged more for it, right?

Ms. PRAEGER. Right. Correct.

Senator FRANKEN. So that's a benefit of this reform. And yet when Mr. Holtz-Eakin talked about the meager benefits of this health care reform he didn't mention that at all. And he didn't mention eliminating the annual caps or the lifetime caps.

And it seems to me that if—ok, so, that's valuable. That's really valuable. And my question to you is, if we're spending 8 percent more, as he said, CBO said on—I'm not sure, is that the current plan or is that a plan that's an old plan. Is that from an old plan?

Mr. HOLTZ-EAKIN. Both the current proposals in the House and Senate would have new spending programs to——

Senator FRANKEN. But that's not an 8 percent increase in premiums, is it?

Mr. HOLTZ-EAKIN. No, it's the new spending.

Senator FRANKEN. Yes, but you kind of imply that it was an 8 percent, that it was a growth in the premiums. Now if you're insuring so many more people. If you're insuring 30 million more people, which is 10 percent of our population, it seems to me that an 8 percent growth is pretty good considering what we have now.

When you were economic advisor to the President, to Bush, during those years, how much did premiums go up?

Mr. HOLTZ-EAKIN. I don't know exactly. But they certainly were rising far too fast.

Senator FRANKEN. They were, I think, during your time going up 15, 16 percent. And you were the economic—so I just want to make this clear that I think there are tremendous benefits to health care reform that weren't mentioned when you were talking about what you kind of call the meager benefits.

I'm out of time. I'm sorry, sir. Sorry, Mr. Chairman. Thank you. And thank you for calling this hearing. I know we'll have another round. I'll try—I'm sorry, to get you to respond. Thank you.

[The prepared statement of Senator Franken follows:]

PREPARED STATEMENT OF SENATOR FRANKEN

Thank you, Mr. Chairman. I appreciate the opportunity to participate in today's hearing, which touches on a topic that is crucial to the economic health and the public health of my State and our country. As others have already mentioned, small businesses are the engine of our economy. We have more than 120,000 small business owners in Minnesota and another 390,000 Minnesotans who are self-employed. These are people who make our State a great

place to live, and they're the reason we're a hub for innovation and creativity.

The problem we're facing today is that our current health system is stifling small businesses in this country. I hear from Minnesotans all the time who want to strike out on their own and start a new business. But they're scared. They're not scared that their idea isn't worthy, or that they won't be able to get the capital they need to get started. They're scared that they won't be able to afford *health care* for their workers, or their own family.

And their fear isn't unfounded. Last Wednesday, at my weekly breakfast with Minnesotans, I met Linda Batterson. Linda's got three daughters. She owns her own business and her husband, Budd, is a realtor. They're an active family, but like most people, they've got a few health problems. He has back injuries, she's been in a car crash, and their daughters have allergies and asthma.

The Battersons' only health care option is Minnesota's high risk pool, also known as the "insurance of last resort" because it's so expensive. The Battersons are paying nearly *$21,000* for health care this year. That's *$21,000*—and these costs keep going up. Neither the Battersons' businesses, nor their family, can sustain these costs.

We are an entrepreneurial society. But right now, we're putting small businesses at a serious disadvantage and stifling this entrepreneurial spirit. Right now, if you're self-employed, or have a small number of workers, you don't have any leverage with insurance companies, so you pay higher costs.

But with national health reform, we have the opportunity to make a real difference in the lives of millions of small business owners and their workers. After health reform, small businesses and self-employed individuals will be able to come together and leverage this power in the "exchange."

The exchange will be a new marketplace where small businesses can shop for affordable coverage and compare plans. There will be no annual and lifetime caps, so families like the Battersons won't be at risk of losing their business. Small businesses will also be eligible for tax credits so they can purchase more affordable insurance for their workers. In Minnesota alone, there will be more than 72,000 businesses eligible for these credits. Health reform will put small business owners on a level playing field—able to offer affordable coverage so they can attract the most qualified workers.

As our witnesses will describe today, small businesses are the foundation of a healthy economy. We must pass health reform this year so that small business owners and aspiring entrepreneurs can focus on innovation, and *stop* worrying about health care.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Coburn.

STATEMENT OF SENATOR COBURN

Senator COBURN. Thank you, Mr. Chairman. I apologize to not being here to hear all of your testimony. I want to go back to Mr. Doug Holtz-Eakin.

Is it not true that one of the reasons why CBO says this bill is deficit neutral is because it assumes a 25 percent cut to doctors under the SGR?

Mr. HOLTZ-EAKIN. That's correct.

Senator COBURN. And it never assumes that that will be repaired?

Mr. HOLTZ-EAKIN. That's correct.

Senator COBURN. Ok. That's No. 1. It also assumes that those cuts will be maintained.

Mr. HOLTZ-EAKIN. Yes.

Senator COBURN. Alright. In your experience at CBO have you ever seen that those cuts would be maintained under the history of Congress since SGR was developed?

Mr. HOLTZ-EAKIN. No.

Senator COBURN. Never has happened, has it?

Mr. HOLTZ-EAKIN. No.

Senator COBURN. So the first thing we know is the CBO is highly inaccurate in its estimate. Do you know of any other time that CBO got spending right on health care, within 15 percent?

Mr. HOLTZ-EAKIN. They're either too high or——

Senator COBURN. One time in the history of CBO?

Mr. HOLTZ-EAKIN. They're usually too high or they're usually too low. They've only been too high on the drug bill.

Senator COBURN. Yes. And why were they too high? Because they failed to consider what market forces would do when we competitively bid the purchases of drugs.

CBO also, I'd note for the record, just revised its estimated savings for medical malpractice caps. They were off by a factor of 10.

Look, we all know what the problem is. We don't have true indemnification in this country. We haven't spread the risk among everybody. And the fight is about how you get that done.

I want to go to Dr. Gruber for a moment. You've been very involved in the Massachusetts experiment in health care. I would like for you to tell me whether my facts are wrong. I'm going to read some facts and then I'd like you to comment on them.

First, the Commonwealth Fund reports Massachusetts premiums for an average family was the highest in the Nation, almost $1,500 higher than the national average. And that health insurance premiums have risen significantly faster than the national average.

Second, 8 in 10 people remaining uninsured in Massachusetts find cost to be the most significant impediment to purchasing insurance.

Third, the Boston Globe reports that of the individuals covered since the 2006 change, four out of five citizens of Massachusetts depend on taxpayer subsidies for their coverage.

Fourth, emergency department outpatient visits increased by 8 percent from 2005 to 2008, increased by 2 million people.

Fifth, overall only half the primary care doctors are accepting new patients. The average wait by a new patient for an appointment with an intern has rose to 52 days in 2007. That's up from 33 days in 2006.

So, the question is, since the majority of these bills in Congress envision many of the same grade in insurance changes as Massachusetts, can you truly predict that Americans would not see some

of these same troubling dynamics under the reforms that are in front of us?

Dr. GRUBER. Thank you. Thank you, Senator for bringing up the case of Massachusetts because I think in many ways it can serve as a model. Let me, you know, you certainly picked a particular set of facts and let me——

Senator COBURN. Well, I'd like for you to answer those facts and then make any comments.

Dr. GRUBER. Great. Perfect.

So the first fact. Massachusetts has very high health insurance costs. We always have. We did before this reform. We do after this reform.

The reform in Massachusetts was even less about bending the cost curve than these bills are. These bills have a number of things in them to set up comparative effectiveness commissions to try accountable care organizations. In Massachusetts we completely punted on cost control. It was unapologetically a bill about coverage.

That said, we do know that for individuals buying health insurance on their own premiums have fallen by 50 percent relative to the rest of the Nation since 2006.

Senator COBURN. And what percentage of that is the people in Massachusetts that are purchasing insurance on their own?

Dr. GRUBER. Basically what we see is of—this has come to your second fact. The increase has actually been half public and half private in health insurance coverage.

Senator COBURN. But what percentage of the people in Massachusetts that are purchasing——

Dr. GRUBER. Right.

Senator COBURN [continuing]. Insurance, what is the percentage of people in Massachusetts that are singularly purchasing insurance that have benefited from that decline verses the——

Dr. GRUBER. From that decline it's about 80,000 people.

Senator COBURN. Out of how many people insured?

Dr. GRUBER. Out of how many people insured, maybe 4 million. So it's, you know, on the order of half of 1.5 percent.

Senator COBURN. So 2 percent.

Dr. GRUBER. So basically——

Senator COBURN. So 2 percent of the people had a decline while 98 percent had an increase?

Dr. GRUBER. No. Once again, sir, in terms of the firms, large firms and small firms, they were not affected by our health care reform. There was nothing in our health care reform that affected them. We left them alone. There was not an employer responsibility component effectively.

This was just about reforming the nongroup market, making nongroup health insurance more affordable and covering the uninsured. And for that population, the one we try to touch with our law we saw an enormous reduction in premiums.

Senator COBURN. Well, why did they just recently throw 30,000 legal aliens out of the plan?

Dr. GRUBER. We recently had to throw 30,000 people off our plan who were called aliens with special status. With a State fiscal crisis, which is a drop in 25 percent in State tax revenues, calling for

across the board cuts in every program in the State. The legislature decided that our program, one of the biggest in the State—the way to cut it was to throw these people off because they were purely State-funded instead of shared between the Federal and State Government.

Senator COBURN. Ok. How about the wait for an internist?

Dr. GRUBER. The wait for an internist has actually not gone up. It's very high. But it was actually high beforehand. If you look at the studies——

Senator COBURN. It's actually gone up, according to my statistics. I'd be happy to give you the reference. It's gone up from 33 days in 2006 to 52 days.

Dr. GRUBER. If you actually—I notice how you're referring. If you look at the set of doctors in that study overall, some categories have gone up, some categories have gone down.

Senator COBURN. But I specifically meant for internists?

Dr. GRUBER. Specifically for internists that does show them going up. And it shows those other specialties going down. Other studies show no change.

Senator COBURN. Whoa, whoa, whoa. Internist is not a specialty. They're a primary care doctor.

Dr. GRUBER. Right.

Senator COBURN. So the wait for primary care doctors has gone up 24 days, 23 days in Massachusetts in 1 year, in 1 year, under the Massachusetts plan. I would put forward to you that care delayed, is care denied.

Because if, in fact, you can't get into a doctor for 52 days and you have a condition that is time dependent, then what you in fact have done, you've increased it. I know that the access to specialists is probably better under that because you probably have less utilization. And that's one of the reasons you're seeing a slowdown in primary care, why you're seeing an increase in primary is because you're decreasing utilization of subspecialists.

So tell me why you would see, as an economist, that this would have resulted in this kind of an increase in delay? What's the factor behind that?

Dr. GRUBER. Once again, Senator, there's been two studies both financed by and supported by physician's organizations. One found no change. Yours found the 19-day change over a 2-year period.

The reason for that is because we've insured 430,000 new people in the State of Massachusetts, about a 5 percent increase in the base of uninsured in the State and given existing set of primary care arrangements that is going to put more pressure on the primary care system. That's why as far, I'm not an expert in this area, but I know legislation addresses primary care shortages. But the thing—emphasizes that's a problem today. Under one study it got worse in Massachusetts on another study it didn't.

But I agree, if we're going to cover 30 million new people in America, we are going to have to try to increase use of primary care access. I completely agree with that.

Senator COBURN. Do you think that's the reason why we saw the emergency room visits go up as well?

Dr. GRUBER. The emergency room visits did not fall. I don't know if that's on the rising. And that's partly because we've been slow in changing people's pattern of use of care.

Senator COBURN. Alright. I went way over my time. Mr. Chairman, I'm sorry. Thank you.

The CHAIRMAN. Senator Bennet.

STATEMENT OF SENATOR BENNET

Senator BENNET. Thank you, Mr. Chairman. Thank you for holding the hearing and the panel, thanks very much for being here.

To our small business people everything that you've said are things that I've heard in Colorado over the last months as people have, even before this recession started, grappled with the question of how to cover people in what are often family businesses. People have relationships with one another. And desperately would like to provide insurance.

Mr. Rowen, one of the things that struck me in your answer to the Chairman's question was that you said you really didn't know why the premium was going up by 128 percent. Is that right?

Mr. ROWEN. What I meant, if I said that, was that I didn't know based on the current pool of people that we insure, based upon what their history was, utilizing health insurance doctors over the previous year. And knowing to a limited degree what they might be facing in the next year, why that overall understanding interpreted to 128 percent increase or why I interpreted it to a 70 percent increase in the health risk of our pool itself.

Senator BENNET. Were you able to get other bids on the policy that might have explained what the deferential was?

Mr. ROWEN. Well we were——

Senator BENNET. Or suggested the reason why?

Mr. ROWEN. Over the last, say, 10 years, we've probably had eight different health care carriers. I think we've only had 2 years where we were able to carry the same carrier for the second year. So what has happened to us is that absolutely every year, virtually, we go out and try to rebid our health care.

This year we were able to. We ended up with a policy that essentially is costing us about 43 percent increase rather than the 128 percent increase. I think part of it was that the health insurance, which is the policy that we had last year, knew what our group was.

I don't know that our group went through the audit process. I think they simply just took our age group and everything and gave us a new policy.

Senator BENNET. I've had people in Colorado refer to it as a game of musical chairs that rolls around once a year when people have to rebid this. And my hope is that we're going to have a much more transparent marketplace for small businesses going forward than the one we have.

Mr. ROWEN. We did have underwriting though with our rebid and the 43 percent. And it was under it by the new insurance company.

Senator BENNET. Thank you.

Mr. Holtz-Eakin, I wondered. You had a list of things that you said would be real reform that we should make sure we attend to. And on that list you talked about the reform of the delivery system.

I do believe that the most important thing we should be doing here is figuring out how to lower costs for everybody no matter, or at least reduce the rise in cost no matter where you come down on various other choices here that's what's strangling our working families and small businesses in the country and defeating coverage. And I wonder if you could just, on that subject alone—the delivery system—in your view, what is it that you'd like to see that's not in the legislation?

And then I'm going to ask Dr. Gruber the same question.

Mr. HOLTZ-EAKIN. I'd like to see that be a primary focus of the legislation so that when these reforms are undertaken the Congress looks to see if they work. If they do, we will see Medicare/Medicaid rise more slowly. Resources will be freed up in the Federal and in the State budgets, quite frankly.

And coverage expansions can be followed along in a fiscally responsible fashion. So one is simply sequencing.

The second is what do you do? I would urge you to do things that are in bills, but do them more aggressively. One of the primary drivers of bad medicine and expensive care in America is the Medicare payment system which has four siloed payments to make sure that hospitals get their money, doctors get their money, insurance companies get their money and drug companies get their money and the beneficiaries know we're in there.

There's no coordination. There's no emphasis on paying for quality outcomes or making sure people are well to begin with. The Federal Government pays half America's health care bills. And that system drives a lot of bad medicine.

We pay doctors more to do more. We pay hospitals, fix them out because they do less. Doctors practice in hospitals. It's utterly schizophrenic.

Senator BENNET. Right.

Mr. HOLTZ-EAKIN. So I would start there. I know you're running out of time.

Senator BENNET. I'm sorry. And I am. I wanted Dr. Gruber, who I think made an interesting point that you No. 1, don't want to let the perfect be the enemy of the good here. But if, in your judgment, you are looking for improvements in the parts of the bills that deal with delivery system reform, what would you be looking for?

Dr. GRUBER. I mean, I think that what Doug's laid out is exactly right. And there's a lot of people out there that know that that's what we need to do. The promise is not a lot of people out there are willing to put that in legislative language.

And the issue is, basically, if we wait for that to be in legislative language we won't get reform. Basically, what we have now is a reform that will do what we can do today. And I think actually does a lot of things that starts us down the road toward those reforms.

There are pilots of the kind of cannibal-care organizations Doug advocates and I think are very smart. There's a comparative effectiveness institute to study what works and what doesn't. There is sort of a Med PAC on steroids committee to try to take a look at our physician reimbursements.

I agree with Doug. I'd like to go further. I just haven't seen those ideas on paper to go further. I don't believe we should kill this bill which CBO says is deficit improving over the next 20 years because those ideas haven't yet been written down.

Senator BENNET. Thank you, Mr. Chairman.

The Chairman [off mic]. Thank you.

Mr. Roberts.

Senator ROBERTS. Thank you, Mr. Chairman. I belong to that special fraternity; if you look in the bios it says Roberts, Journalist, that is an unemployed newspaper man.

Mr. CULLEN. It's a high fallutin word.

Senator ROBERTS. It's a high fallutin word. You're right, Art.

You don't look insane to me?

[Laughter.]

Mr. CULLEN. I certainly feel it.

Senator ROBERTS. Well, you're wearing a nice coat and that bow tie matches. And you look a lot like Sam Clemons. And you know, he's got the bottom of the point.

Mr. CULLEN. If only I could write like him.

Senator ROBERTS. My time, not yours.

Mr. CULLEN. Alright.

[Laughter.]

Don't knock the bow tie. My wife made it, alright?

Senator ROBERTS. There you go.

Mr. CULLEN. Thanks. It's lovely.

Senator ROBERTS. I need her and don't tell my wife.

[Laughter.]

Your brother John, founded the *Storm Lake Times* in June 1990 to make a difference in the community. That regardless, he didn't start the hometown newspaper to administer health insurance plans and cover its escalating costs. Amen, to that.

In 1856, John Wesley Roberts came to Kansas. He had a flat bed press, a team of oxen, a Bible and a six gun. And he was fighting for the cause between Kansas being a free State or a slave State. I don't think he even considered health insurance. And if he did, he didn't think it was an entitlement. He thought he probably ought to provide it or just put it in the cash drawer in case somebody needed it.

Well times have changed. I'm struck between the testimony because as Senator Enzi pointed out right at the start, in a letter to Chairman Baucus, the CBO has stated that the premiums in the new insurance exchanges would tend to be higher than the average premiums in the current market.

Now we've got other nonpartisan entities, the Joint Committee on Taxation to the CMS Office to the Actuary of the National Association of Insurance Commissioners have all come to the same conclusion. The Health Care Reform bills, as currently before Congress, will actually result in higher premiums and higher cost for small businesses and individuals. This is additional to the cost that we are going through now.

So I have a question for Ms. Bender, who helped author the Oliver Wyman Actuarial firms premium impact study which is the only study, as I understand it so far, to try to estimate the impact on premiums at the State level, i.e. small business. And my ques-

tion for Ms. Bender is—as compared to the current law—will the Health Care Reform bills currently before Congress likely make insurance premiums for small business like Kansas more or less expensive? We're in cluster four. I think we're No. 2 in less regulation which probably tells you a lot and also the work of Sandy Praeger.

Ms. BENDER. The short answer is yes.

Senator ROBERTS. I'm sorry?

Ms. BENDER. The short answer is yes. It will make it more, for small employers in the type of State that Kansas is that has implemented what we call the NAAC model.

Senator ROBERTS. I like the short answer.

Ms. BENDER. OK. Yes. It will.

[Laughter.]

Senator ROBERTS. The estimates project that Kansas small businesses could see increased premiums all the way up to 28 percent over 10 years. As you are aware both the HELP and Finance Committee bills provide limited tax credits for small businesses to help them provide coverage for their employees. But they are very limited.

The HELP Committee bill provides credits on a sliding scale to small businesses with 50 or fewer employees with an average wage of no more than $50,000.

While the Finance Committee bill limits its credits to small business with 25 or fewer employees with an average wage of no more than $40,000.

Kansas has a lot of small businesses, 60,000 in fact, probably 10,000 under Iowa there. But at any rate a major driver of the Kansas economy. But under these health care reform bills I believe most small businesses in Kansas will be saddled with a higher premium cost, possibly without having the benefit of the tax credits.

Ms. Bender, have you estimated what percentage of small businesses will be able to take advantage of these credits?

Ms. BENDER. We did, as you indicated, by clusters so we can—I can state what it is for the cluster that you're in, of which Kansas is in, which is about 11 percent. Now it could vary with any——

Senator ROBERTS. Eleven percent?

Ms. BENDER. Eleven percent.

Senator ROBERTS. Eleven percent on the tax credits and yet most people are testifying that the costs go up. Well how much more affordable will these credits really make the premiums? And how many years will they be available?

Ms. BENDER. I'm sorry?

Senator ROBERTS. I said how much more affordable will these credits really make premiums? And how many years will they be available?

Ms. BENDER. The premium credits, I'd have to look at the technicalities of all the bills. But I think they go from 25 percent to 50 percent.

Senator ROBERTS. Yes, that's correct.

Ms. BENDER. And I believe now some of the bills like are from 2 years, 3 years.

Senator ROBERTS. It's 2 to 3 years, right. That's so we just hope for the best after that. They will not cover 100 percent or a substantial percentage of the premium cost for many businesses who

do qualify. Their credits are only for 2 to 3 years as I've indicated and as you had stated.

Could the wage limitations adversely affect workers earnings by creating a disincentive to raise wages?

Ms. BENDER. Yes, it could. I mean, we didn't say this in our report. And we did not model this in our report. I don't want to lead anyone to believe that this was part of our report.

I want to clarify that. But it could almost put a purpose incentive in order to keep the tax credit, that you might want to keep your eligibility for the tax credit, that you would want to keep your average employee wage below whatever the trigger point is.

Senator ROBERTS. I'm about a minute over, Mr. Chairman. Thank you.

The CHAIRMAN. Thank you, Senator Roberts.

Senator Specter.

Senator SPECTER. Thank you, Mr. Chairman for scheduling the hearing. And I thank the witnesses.

Mr. Rowan, the *New York Times* featured your situation in the article 9 days ago. And the *Times* points out that the high rates are—no question the insurers are under pressure from Wall Street and the threat of an overhaul may be part of the reason. And one of the expert brokers said that he was mystified by the size of the increases.

Now you've testified by a number of factors, demographics, price trends, excess risks of the group. Would you like to see your insurance company, by the way they declined to come in along with the other insurance companies contacted by the committee with excuses. Would you like to see them come in and produce their books and justify their reason for the 128 percent increase that they asked you for?

Mr. ROWEN. As I testified earlier everything that I can see relative to the history that I know about my employees and our health care usage in no way gives us the sense that 128 percent increase would seem to be appropriate.

Senator SPECTER. Commissioner Praeger, I understand that you have some views on the subject as to the rise in premiums occasioned by the likelihood of some legislation to be enacted soon.

Ms. PRAEGER. We, through our surveys that we've done and talking with other commissioners around the country, we know that, and this is, stating the obvious. Health insurance premiums are going up. I think they are the result of probably several factors.

But most of——

Senator SPECTER. Do you think the likelihood of legislation is a factor?

Ms. PRAEGER. There may be some companies that are trying to get out ahead of the curve. But I do think health care costs are probably the big driver. We would look, I mean part of our review is we do have the authority—if we think a rate that is coming into us is excessive, we do have the ability to deny it.

Senator SPECTER. When you testified that they asked for increases based on medical trends based on demographics, that you really can't challenge them.

Ms. PRAEGER. Right.

Senator SPECTER. If you had evidence at the same time that the rates were being increased because Wall Street is putting pressure on insurance companies for more profits in anticipation of legislation. Would that give you a little bit more——

Ms. PRAEGER. I would be——

Senator SPECTER. Excuse me, the question is not finished. Would that give you a little more basis for saying no rate increases?

Ms. PRAEGER [continuing]. We would call that company in. And we would look very closely at what was driving their—what was their motivation behind that rate increase.

Senator SPECTER. Would you like to see this committee get to the bottom of that question with use of the subpoena power?

Ms. PRAEGER. Yes.

Senator SPECTER. Well, that's a good, concise answer. The issue of regulation is very uneven. Pennsylvania and Hawaii for example are the only two States that do not have a review for small market insurance plans. And in my State there are no rating restrictions for health insurance plans at all.

And it may be that the States ought to be looking at more regulation to have more authority. One of the issues which the Congress is considering is to repeal the McCarran-Ferguson Act to eliminate the added trust exemption and another proposition looking for the possibility of insurance companies doing business in more than one State. I'd like your view as to whether you think McCarran-Ferguson has outlived its usefulness and be good to have more weapons available for people who collude to raise rates.

Ms. PRAEGER. Well, Senator, I've heard the discussion about McCarran-Ferguson. And we, as regulators, don't believe we've seen collusion among companies. But certainly having some additional tools in terms of the kinds of information——

Senator SPECTER. You don't see the collusion, but are you equipped to investigate for it?

Ms. PRAEGER. Yes, we can now.

Senator SPECTER. Have you?

Ms. PRAEGER. And we would not. I mean, if we had evidence that companies were coming together and colluding to set rates we would. We have the authority now to stop that practice. And we would take action.

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

The CHAIRMAN. Thank you, Senator Specter. If it's alright, I'll begin my second round. I'm sorry that Mr. Coburn had to leave but regarding his exchange with you, Dr. Gruber, I think one thing I would like to point out is that in our bill we include a strong workforce title.

We all know that we lack primary care practitioners throughout this country whether they're physicians or PAs or nurse practitioners. We lack a number of community health centers that we need more of in this country also. Now Massachusetts doesn't have the ability by itself to do that. We do.

Obviously, it's going to take some time. But we do have a strong program in the bill—scholarship programs to get more people through and primary care to address rural areas and places that have a lack of primary care people, programs to train more faculty

members so we can get more nurses and nurse practitioners. Again, this is going to help, I hope, address that waiting period to see doctors. But that's something that Massachusetts didn't have. And that's something that we're doing in our bill.

Ms. Bender, the findings in your testimony, if I'm not mistaken came from a report that was paid for by the BlueCross/BlueShield Association. Is that true?

Ms. BENDER. That's true.

The CHAIRMAN. In the interest of transparency would you be willing to share with this committee the underlying data on which you base the study so that it can be independently analyzed by objective actuaries and economists? Would you be willing to share with us the underlying data and provide that to this committee?

Ms. BENDER. That data is considered proprietary by each of the companies that were willing to participate in the study. That was one of the conditions, where we signed confidentiality agreements with each of them. In fact, I don't even have the data.

The CHAIRMAN. So what you're asking this committee to do then is just take the word of BlueCross/BlueShield that the data are reliable and sound. Is that what you're asking us to do?

Ms. BENDER. No. I guess I'm asking you to take the word of credentialed actuary that they would, that the modeling that we have done is in conformance to——

The CHAIRMAN. But how can we rely on something when the data is kept secret? We need the data. We've got to look at it.

All the studies that Dr. Gruber does, they're out there. We can look at it. We can take apart every little bit.

Why should we just take their word for it?

Ms. BENDER. I don't believe that, as we've heard here from others, that our study is necessarily inconsistent with other ones that have been done. But the data that we based it on is considered proprietary and——

The CHAIRMAN. Well, I'm sorry. I won't accept it until we can have the data analyzed.

In your written testimony you state that the small group market is highly regulated. There was a little bit of exchange going on with Commissioner Praeger about that. Could you please explain to Mr. Cullen and Mr. Rowen how current regulations are working well for them and their employees?

Ms. BENDER. As I said in my opening statement, I'm not going to defend the actions that occurred in Pennsylvania. And unfortunately Pennsylvania is one of the minority States that does not have enabling legislation to allow and prevent exactly those kinds of abuses. And I certainly am not going to defend that.

The CHAIRMAN. Well, obviously they're not well regulated when they can have those kinds of price spikes.

Dr. Holtz-Eakin, in your testimony you state that we should look to the insurance industry studies since CBO has not done an analysis of the impact of reform on premiums. Well, I looked it up. In fact, it has.

CBO estimated that a single policy in the current individual market will cost $6,000 in 2016. By contrast, CBO estimated that a policy in an exchange, like we're setting up, will cost only $4,700 in 2016. And the exchange policy would be even more generous.

That means that the reform will save at least $1,300 even before the tax credits.

So my question is this. Should our standard be the CBO, the agency you used to head, and not the studies bought and paid for by the insurance industry?

Mr. HOLTZ-EAKIN. I certainly would prefer to have the CBO do a comprehensive analysis on each of the market groups, small group, individual, in the context of the reform bills that are currently before the Congress. That is information that I think is central to this debate. And as I said in my written testimony I don't think you should view industry paid studies with anything but the appropriate skepticism. I mean, there's an obvious self interest there.

The point is simply that those in the National Association of Insurance Commissioners, the Joint Committee, CMS Actuaries, CBO, myself, agree on the fundamental logic of what goes on if you have these kinds of reforms in the absence of a strong mandate. And the question now is how big will they be? I encourage you to get the CBO to answer that question.

The CHAIRMAN. Well, the CBO did.

Mr. HOLTZ-EAKIN. They didn't answer the question for the bills currently in front of the Congress what would be the comprehensive impacts of all the provisions on those three different markets because the individual and small group markets often don't move the same way. I think that's very important for people to understand and for the CBO to analyze.

The CHAIRMAN. Mr. Gruber.

Dr. GRUBER. I think that Doug is absolutely right. The CBO has not opined on the effect on small group premiums. What the CBO has done is given us some guidance to the reliability to the industry studies because the CBO has said for nongroup markets where industry studies have said premiums will go up by 50 percent or more. CBO says they'll go down exactly you've cited the facts there.

So I think Doug is absolutely right. And I think we're in absolute agreement. We hope that CBO will come out and talk about each market.

CBO is pretty busy now with a lot of stuff. So I think we have to rely on what they've given us so far.

The CHAIRMAN. Senator Enzi.

Senator ENZI. Thank you, Mr. Chairman. Going back to Ms. Bender, the data that was evaluated for that study, wouldn't that involve medical claims information?

Ms. BENDER. Oh, definitely.

Senator ENZI. And isn't it true that public disclosure of claims data would violate privacy protections in HIPPA?

Ms. BENDER. Well, you know, I am not an attorney. So I will defer that to the attorneys.

Senator ENZI. Ok.

Ms. BENDER. There could be some cause of concern. But I can't legally speak about that.

Senator ENZI. Well that's usually why somebody hires another firm to go into this and sign this privacy information. One of the biggest concerns for me, as I travel Wyoming and other parts of the country, is that we have given people the impression that with this

Health Care Reform that they're not only going to have their costs go down. I'm surprised at how many people think it's going to be free.

I mean I have businessmen come up to me and say, "Well when this Health Care Reform goes into effect I'm going to have a lot more money to spend because I'm not going to have to pay those insurance things." It's incredible to me that businessmen would do that. But that's an impression that we, as Congress, have given. And it's really, really wrong.

There are parts of this—Senator Franken mentioned the lifetime caps being lifted and the pre-existing conditions. It seems to me like the insurers are going to charge a higher price premiums to cover those costs of benefits. Ms. Praeger, would you think that that would be the case?

Ms. PRAEGER. Well, if we can get rid of—they'll be charging based on currently as the bills stand, an age rating of somewhere between 2 to 1 or 4 to 1, depending on which of the bills you're looking at and some geography. But other than that, the rating will have to and the premium charge will have to be pretty consistent. That's where you get into some of the issues with the small group market because some younger, healthier groups will pay more. And older, sicker groups will pay less.

And the thought is over time, there will be rate stability that will come into play so you won't have experiences like Mr. Rowen had where a couple of people getting sick in a small group can really dramatically impact the rates. So they'll be some rate stability. And I think that will be a good thing.

Senator ENZI. I'm familiar with how that works because my own small businesses had been through the trials and tribulations that Mr. Rowen has been through with wanting to provide insurance and seeing the prices go up and up and up because we have a small group, because some of the people are older in that group. The rating would effect that a little bit. But a lot of how that would affect it is that the price for the younger ones is going to go up.

The older ones have come down, the younger ones will go up. So it, I guess, encourages you to hire older, sicker people.

[Laughter.]

Mr. ROWEN. Unfortunately now we have an encouragement to hire younger, healthy people.

Senator ENZI. Absolutely. And you have to look at the potential of some costs from fines for not providing under the HELP bill, it's 60 percent of the insurance for your employees. And then there's a fine that kicks in after you have 25 employees.

So one of the things that concerns me is this bill is so comprehensive.

It doesn't just bite off small business and solve some small business problems.

It doesn't bite off the individual market and solve the individual.

It doesn't bite off Medicare and solve Medicare problems. That piece alone would give seniors a little bit more confidence that what we were doing was actually going to help them out instead of being all nervous about what's going to happen.

But as I've spent time on the HELP Committee and as I spent time on the gang of six and as I spent time going through the Fi-

nance Committee the biggest thing was the number of "Oh, wow, is that really how it works," that we had to do because we were biting off so much. And I think that's a problem that CBO has as well, which is trying to take a look at so much. And under the HELP bill there's 214 references where we weren't willing to go into the details. So we just said, don't worry, the Secretary of Health and Human Services will cover that.

I don't know if the Secretary can cover 214 areas of doing regulation all at the same time, even if she had until 2013 to do it, when a lot of this kicks in. So again, I really appreciate all of the information that you shared with us today on the small business health plans. I think if those went in where people could group together across State lines so that they could have these bigger pools, that it would bring down the cost significantly.

Again, what I rely on of that is the Ohio experience because they came to me. They wanted to make sure that they weren't going to be excluded from any kind of a small business health plan. They found some significant benefits.

The piece that we didn't have worked out was the mandate piece. Every disease group out there is interested in making sure that their—all the tests, as well as any treatments are covered under every mandate that you can think of. And the number of mandates varies from Wyoming with I think, 23 mandates to some States that have 1,200 mandates that these small businesses have to pay the insurance on.

We had a way of working that out, but we never were able to get to that amendment. And I ask the Ohio folks, "how do the mandates work?" They said, "Well, it's mandates. But we've been able to save enough money that we don't just cover those. We've added ones that the State doesn't even require," which I thought was very admirable.

I do hope that somewhere in the legislation we'll take a look at the small business health plans. There's a slight version of it in the co-ops. That, of course, gets government funded. And none of these small business health plans had to be government funded.

So, I don't think that started with my time.

[Laughter.]

I think it just continued on from your time, I hope. So, but at any rate, I'll submit some questions that I need a little bit more specific information on than what you might have with you or that would be interesting.

I was at a hearing once with every living accountant with the FCC, Head Accountant at the FCC. And I was asking him accounting questions because I'm the only accountant in the Senate. And my staff was watching on television and laughing because behind each person there's a wedge of people that are on TV and they're all asleep.

So I'll submit them in writing. Appreciate your answers.

The CHAIRMAN. Sorry about the clock.

Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman. And I think that's a good strategy. I'm going to submit some questions in writing too because I have to go to the floor and deliver a speech pretty soon.

Ms. Praeger, we all know that small businesses that try to do the right thing and provide health care for their workers are sharing a big part of the burden or shouldering a big burden now. So it's really no surprise that a lot of small businesses have questions about how this bill will affect them. And I was recently in touch with Jennifer Brigham, President of the Minnesota Chapter of the National Association of Women Business Owners. And Jennifer had gotten these questions from her fellow small business owners on what health care would mean to them.

We know that this Health Reform bill will invest unprecedented resources in small businesses so that they can affordably cover their workers. And do it with less administrative burden. But since small businesses don't have big human resources departments how can we make sure that they're able to access the new resources to help them and their workers?

Ms. PRAEGER. Senator, I think the exchange really can provide that function. It will take on some of the administrative burden. I think Mr. Cullen mentioned that.

It is frustrating for the small businesses. Large companies have built in human resource departments that can negotiate. A small business is, you know, lucky to find one company that is willing to write them especially if they have an older, sicker workforce.

I think the exchange is an opportunity for companies to put their products on a side-by-side comparison. And that small business owner will have an opportunity to go to that exchange and make some good comparisons.

Senator FRANKEN. So, and the exchange will allow you to be covered or be part of a larger risk group and spread the risk over?

Ms. PRAEGER. Well, no. The exchange—you're still buying for your individual company. But if you get rid of some of these rating restrictions that are currently in place, everyone will be rated on the same characteristics. So you, in a sense, have that benefit.

You'll no longer be rated higher because of the age. Well, except for the age rating that is currently in the proposals. But you won't be rated higher based on the other.

Senator FRANKEN. It won't be as far a spread, right.

Ms. PRAEGER. And health status and all of the other rating factors, so that being able to buy in a larger pool is really much less important.

Senator FRANKEN. Mr. Holtz-Eakin, I have to agree with you completely on the need to bring down, well to deliver health care in a more efficient way. I don't think any of us are arguing this. Now when I heard both you and Mr. Gruber talk about this I didn't hear any reference to the value index that Senator Cantwell presented in the Finance Committee.

Minnesota is a State that I think gets a little over $6,000 per Medicare patient compared to Texas that gets something like $8,000 to $10,000 or something. We actually get punished for delivering high quality care at a low cost. So it seems to me that this is something that neither of you mentioned, but is really important.

I'm hoping that it ends up in the final bill because what this will basically do is change Medicare reimbursements and change them to reflect the value which is the quality over the cost that plans are giving. For example, there was the famous article in the New

Yorker where Mayo does it for a third of the cost that McAllen, TX does. Now McAllen has a different demographic, but El Paso is the same demographic as McAllen and is doing it at almost just about half the cost. I just want to make sure that everyone understands that this is actually in a bill. And it's in this bill.

I don't think that it's wrong to try to do both things at the same time which is make sure that people get covered.

Make sure that people with pre-existing conditions can start a new business.

Make sure that people don't go bankrupt if they get sick.

At the same time attack the way we deliver health care in this country so that we do it more efficiently and reward good care and penalize bad care and couldn't have agreed with you more. I will submit some written questions. I'm sorry that my time has run out. But, I want to thank all of you for being here today.

The CHAIRMAN. Ms. Bender, I'm told that if you de-identify the data that that will meet the HIPAA requirements. So why can't we get the data and de-identify it?

Ms. BENDER. I don't think that the issue of keeping the data confidential was necessarily associated with HIPPA. I said I am not a HIPPA lawyer. In order for us to obtain the data we had to sign confidentiality agreements with all the different companies. There is proprietary data included in this regarding rating and that would be very advantageous to competitors.

Let me emphasize that, the strength of the data is that it's based upon real groups. That is very important and critical when we're trying to model the impacts of proposed legislation to really look at what is going to happen to real, live groups.

The CHAIRMAN. Well, Ms. Bender, I hope you excuse me, but I am simply going to be highly skeptical of any findings that come out and we can't have transparency on the data. I'm sorry, I'd just be highly, highly skeptical. That leads to another point of course. And that is transparency, you know.

Again, I'd ask Commissioner Praeger. I haven't asked you a question, but should there be a little bit more transparency in the provisions of how insurance companies arrive at premiums? How they base those premiums? And what the data is that they use on which they maybe implement premium increases? Should that all be transparent?

Ms. PRAEGER. I think any information that can help purchasers of health insurance make a good decision is valuable information. So I, perhaps through the exchanges, that will be a way of making more of that information available and transparent so that people can make good, informed decisions. If we want a robust marketplace you have to have people competing on good information.

The CHAIRMAN. I'd like to know from insurance companies, I mean, how much of this is for meeting Wall Street's needs for profits? How much to meet new buildings? How much to meet CEO pay and all the other kinds of stuff, administrative costs? I'd like to know, why.

What goes into those factors that raise those premiums? I think which raises another point that I hadn't gone over with any of you.

We haven't talked about the public option that would be available to all small businesses in this country and the self employed.

And what that might do for competition. And what that might do to help people like Mr. Cullen or Mr. Rowen. They may want to take it, but they may not. But at least it may be an option.

And I just wondered if any of you have any views on that?

Mr. CULLEN. We need it. We need the public option, period.

The CHAIRMAN. Alright.

Mr. CULLEN. Because then that will get health insurance and all that administration and all that stuff off our backs. We can go say, look to all our good employees we can, with complete piece of mind, say here's the solution to all these problems that we list.

The CHAIRMAN. Commissioner Praeger.

Ms. PRAEGER. As long as the public option competes fairly in the marketplace and I think the bills, at least two of them, do allow for a level playing field negotiating for rates, charging premiums sufficient to pay claims, having solvency standards that are the same. It would add another element of competition. But I think it's important that it's fair competition and that it not be using the Federal Government as a backstop, especially in terms of premium rates and solvency standards.

The CHAIRMAN. Right.

Mr. Holtz-Eakin, you said in your testimony, I believe it is noncontroversial that the combination of guaranteed issue and community rating would raise average premiums—well, but for the individual mandate.

Are you for or against the individual mandate? I'm just curious.

Mr. HOLTZ-EAKIN. I personally don't favor the individual mandate. It's one of the more difficult calls that people make in this area. I understand those who, having gone down the route of guarantee issue and community rating, feel they have to have that mandate to make sure you don't get the spiral that I believe is noncontroversial in the absence of it.

The bottom line is I don't believe we should guarantee the insurance existence in America business by making me buy their product. I want them to earn my business. And so, I would prefer to not have an individual mandate, but to have reforms that force insurers to compete on the basis of price, quality of product and service to consumers, as they do elsewhere. I don't see that in the current marketplace, not too wild about what I see out there. And I'm certainly not in favor of having them guarantee my business by fiat.

If I could say about the public option, I believe, you know, there's lots of politics. And let's just acknowledge that. But from a substantive point of view the public option is a red herring.

If it does Medicare reimbursements, it's a bad thing because Medicare reimbursements are a problem in our health care system. And spreading them more widely will only spread that problem.

If it is something that competes on a level playing field with private insurers, genuinely, and that's hard to construct, I would argue. It raises the question, why don't we have genuine competition now? We should be looking at what is wrong with our insurance markets that doesn't generate sufficient competition because if there's not good competition, adding another noncompetitive level playing field isn't going to help.

So I'm sympathetic to the idea that people should have good choices. I'm sympathetic to the fact there should be strong competition. I'm unconvinced the public option brings anything to the table in that regard.

The CHAIRMAN. I have a response to that, but I see Mr. Gruber also has a response.

Dr. GRUBER. Well, actually in some sense, I want to agree with what Doug is saying in the following sense which is I think for the public option to really have the biggest effect, we need to set up an exchange that's strong. I think what's ironic about the current debate is people talk about the public option providing competition. But they don't talk, as Doug mentioned, about setting up a competitive environment which allows the public competition to maximize its potential.

That's why, based on our experience in Massachusetts, I believe we need strong exchanges that can selectively contract with private insurers and the public option to provide real competition among insurers to provide products to individuals and not just a yellow book exchange where anybody can sign up. And I think in some sense I'm surprised that issue hasn't been raised more. We need strong exchanges to make a public option really realize its potential.

The CHAIRMAN. Well I would respond to both of you that we do have in our bill very strong exchanges either State or regional. They can form regional exchanges which have a lot of authority and will have power. And I believe that will be in the final bill.

But the idea of a public option is that since we have it in our bill, in the HELP bill, we had it not based on Medicare. But we had it based on the Secretary negotiating reimbursements and rates.

As the Secretary then figures out how to set premiums, the Secretary doesn't have to take into account paying a CEO $12 million a year. They don't have to take into account responding to Wall Street's demands for profits to answer its shareholders. The Secretary doesn't have to respond to the needs for new buildings and nice accoutrements and all of that that goes into all of the administrative overhead.

So that provides, I think, pretty darn good competition.

Yes, sir?

Mr. HOLTZ-EAKIN. And I hear you at that. And I, you know, I can visualize a world where that might occur. But in the world that I've experienced working with the Congress it's also true that that same public option is going to hear from the hospital that didn't get their business and was given to another hospital in the local area.

My experience in Congress is, that will matter. And the administrator of that public option will have to be responsive to that and split the book between the two hospitals, thereby limiting their ability to negotiate effectively. And in a million other ways I am concerned that the public option will be subject to the same kinds of pressures that have riddled Medicare with special carve outs and favors and have diminished its ability to be a health insurance product.

So there's a world that I can write down on paper and you and I can sketch out where effective competition is enhanced. But there's also a serious downside risk that that public option will be handicapped in its mission by the dynamics of regular politics.

The CHAIRMAN. Well, I suppose that's always a danger looking down the road and saying that we're going to respond to all these different needs and stuff. But I think if we structured it correctly and we have these strong exchanges and we make the system more transparent which I keep harping on, then we can find out those hospitals that aren't very effective, that aren't very cost-effective.

The last thing I would just say is that I think, Ms. Bender you and I agree on this. You talked a lot in your statement about wellness and prevention. You talked about that. And I think you're right on target right there.

CBO, now this is where I disagree with CBO. They can't give us a score on it on savings. They say it just costs money.

So I said to them why don't you talk to Pitney Bowes. Why don't you talk to Safeway? Why don't you talk to a lot of private businesses out there that have implemented good, solid, preventative wellness programs and their bottom line is they save money. They can prove it.

But CBO won't look at that. The more that we put into prevention, up front prevention and coverage, the better. And that's why in our bill we have no co-pays and no deductibles for screenings, annual physicals, vaccinations, things like that. No co-pays for deductibles for anything that the U.S. Preventive Services Task Force says is rated an A or a B because we want to incentivize people to take advantage of that.

And then we have a trust fund that we're going to have, I hope, a lot of money in that will go to encourage more prevention and more wellness programs. Tax breaks for small businesses to be able to have wellness and prevention programs.

You can talk all you want about bending the cost curve. There's only one way you're going to bend the cost curve. And that's getting ahead of it. By keeping people healthy in the first place and cutting down on the number of doctor's visits, the number of hospitalizations in this country.

Other countries have done it. It's not a secret. Other countries have done that. Do it much better than we do.

I'm going on too long. I know you've got to go. And you've been very kind to be here this long. And I'll stop with Mr. Rowen.

Mr. ROWEN. If I could say one final thing when you talk about cost prevention or cost, trying to keep the costs down, one of the things we believe about our company and our employees is that although we're very, very concerned that with a $2,000 and $4,000 deductible some of our people are not going to be able to make it through the year.

The flip side of that is that our experience showed that as we paid the full deductible for our employees the usage increased every year.

The CHAIRMAN. Sure.

Mr. ROWEN. Which meant that more and more people were seeking health, you know, going to the doctors, but not necessarily for the right things. So we believe that you need to have some partici-

pation by all users in the cost system. If you just give somebody a complete, free ride, yes, they will go to prevention which is the good side of it. But they potentially will also go to overuse.

The CHAIRMAN. Well, the co-pay—when I mentioned about no co-pays and deductibles it's only for prevention.

Mr. ROWEN. I understand that. And I think some of those areas are very appropriate. Absolutely.

The CHAIRMAN. Obviously I agree. People ought to have some skin in the game. Absolutely.

Anybody else have any views or thoughts or suggestions or comments before I close this up?

Commissioner.

Ms. PRAEGER. I would just like to say I applaud the work that's been done. I think it's still, there's still a lot of work to do. I do believe it is about health care costs.

And while reforming the market is going to help. And I know you understand that. It is about changing the incentives from a system that pays for volume verses value and quantity verses quality.

The CHAIRMAN. Yes.

Ms. PRAEGER. Every chance I get I want to mention that because I think that's a key element to really changing the health care system in this country.

The CHAIRMAN. I thank you for that. As someone once said, if you reimburse on the basis of quantity, you get quantity. If you reimburse on the basis of quality, you'll get quality. And that's where I think we've got to be headed.

Ok, Mr. Cullen, since you're my constituent, I'll close with you.

Mr. CULLEN. I appreciate that. Well, everybody here is talking about being fair to the insurance companies. When have they been fair to us? And why do we have to provide a level playing field when they've obviously, by our rate history been screwing us for the last 20 years?

Why do we have to be fair to them? It just incenses me when people talk that way. These people are legal thieves with anti-trust protection and we want to treat them with kid gloves. It drives me nuts. And that's all I've got to say.

The CHAIRMAN. Well, on that note, I will request that the record remain open for 10 days for submission of statements for the record. I thank you all very much for being here and being so patient in answering our questions.

The committee will stand adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF SENATOR DODD

I'd like to thank our distinguished Chairman for convening this hearing, and our witnesses for joining us.

Some have argued that, with our economy still hurting, it's the wrong time to tackle health care reform. I hope today's discussion can serve as proof positive that there has never been a more urgent time to reform our broken health care system.

Small businesses are the best job creators we have. When our economy finally begins to pick up momentum again and gets back on the track towards prosperity, it will be small businesses driving the locomotive. If you're concerned about unemployment, and in my State of Connecticut we are extremely concerned about unemployment, then freeing small businesses to grow and expand is a critical priority. In fact, from 2004 to 2005, small businesses created 100 percent of Connecticut's net new jobs.

We will hear it in living color from our witnesses today—but the black and white facts make it clear that rising health care costs are disproportionately burdening small businesses.

On average, small businesses pay as much as 18 percent more than larger businesses for the exact same health insurance policy. Administrative costs are three to four times as high. In Connecticut, the variance in premiums among businesses with 10 or fewer employees is so great that one might pay up to four times as much as another, similar firm of the same size. As a result, fewer and fewer businesses are able to offer health insurance to their employees, with nearly three in four small businesses that forgo benefits doing so because it just costs too much.

Someone who works at a small business is 50 percent more likely to lose job-based coverage than an employee at a larger business. And young adults, who are more likely to be employees of small businesses, are being hit extra hard. One in four young adults at a small business lost their employer-based coverage in the last 2 years.

Small businesses have special relationships with their employees. They're like family. Sometimes they ARE family. And good-guy employers are being forced to choose between laying off workers and cutting benefits.

One constituent of mine is self-employed and has a small group policy. He was told that his premiums will be going up 21 percent for the exact same policy—but with higher deductibles. He'll be paying more for less. That's life as a small business owner.

Health care reform is one of the most important things we can do for small business.

By creating health insurance exchanges, small businesses will be able to pool together, increasing competition and cutting premiums—according to the Congressional Budget Office, by as much as 25 to 30 percent. It will also cut administrative costs by making it easier for employers and employees to shop for the plan that works best for them.

On top of those savings, health care reform will include a generous tax credit for 3.6 million small businesses to make it easier to cover their employees. In Connecticut, up to 37,611 small busi-

nesses would be potentially eligible for the small business tax credits in health reform.

We'll also outlaw insurance discrimination based on health status, so that small businesses won't see their premiums jacked up if just one employee gets sick.

And by expanding insurance coverage to every American, we'll eliminate the "hidden tax" of more than $1,000 that everyone pays to cover the cost of caring for the uninsured.

All of these steps will allow small businesses to put their money where it belongs—creating jobs and growing our economy—rather than wasting it on an inefficient and unfair health care system.

If you're an employee of a small business, reform will help you, too.

If you have insurance through your job, that insurance will be more stable—insurance you can be sure of. It'll cost less, too, because you'll be able to comparison shop to get the right deal for your family.

And even if you lose that job, or change your job, or move to another State, or retire, you'll still be able to find affordable insurance.

If you're a young adult, you'll be able to stay on your parents' insurance until you turn 26, giving your family even more choice and security.

And no matter who you are or where you work, no insurance company will ever be able to cut off your coverage or deny it to you altogether because of a pre-existing condition.

There are more than 37,000 small businesses in my home State of Connecticut. I am counting on them to lead the charge to create more jobs and grow our economy. And they are counting on us to pass health care reform this year so that they can do so without being strangled by the skyrocketing cost of health care.

Thank you.

PREPARED STATEMENT OF SENATOR BURR

Good morning. I want to thank Chairman Harkin for chairing this morning's hearing. I also want to thank each of our witnesses for traveling to be with us today to discuss the importance of lowering health care costs for small businesses and Americans across North Carolina and our Nation. I hope this morning's roundtable hearing can be a frank and honest discussion about meaningful solutions to ensure self-employed Americans and small businesses across our country have access to quality and affordable health care.

As I have said many times before, I agree that we need meaningful health care reform. I was proud to join Senator Tom Coburn earlier this year to introduce the Patients' Choice Act, comprehensive legislation to fundamentally reform our healthcare system. The status quo is unsustainable and, unfortunately, nobody knows this better than the small business men and women across our Nation that have felt the brunt of rising health care costs for far too long. For over 20 years, small businesses have cited health insurance costs as their No. 1 concern. A recent survey by the National Small Business Association found that 67 percent of small businesses surveyed expect premium increases of more than 10 percent

in the coming year. This survey only reaffirms what each of us knows all too well from meeting with constituents across our States: for years individuals and small businesses have demanded reforms that will drive health costs down and make health insurance more affordable. Unfortunately, I fear that Congress is pursing the wrong reforms that will actually drive up health care costs. My concerns have only been reinforced by the Congressional Budget Office, the Joint Committee on Taxation, the Centers for Medicare and Medicaid Services Office of the Actuary, and the National Association of Insurance Commissioners' recent conclusions that the Democrats' bills will drive costs up.

Over the past week we have learned that the Majority intends to pursue government-run health care in both the Senate and the House. As I have said before, I believe there is a better way forward that avoids this one-size-fits-all approach and offers real solutions to advance the goal of making health insurance more accessible and affordable. The Patients' Choice Act puts affordable coverage and choice within reach for all Americans regardless of their income or employment by providing tax credits to individuals and families to purchase the health insurance that fits their needs and the needs of their families. Under our bill, Americans are empowered with flexibility to move or change jobs without risking losing their health care. Our bill also creates State Health Insurance Exchanges that give Americans a one-stop marketplace to compare different health insurance policies and the ability to select the one that meets their unique health needs.

Small businesses are our Nation's economic engine. We need to pursue policies that help these entrepreneurs thrive, including legislation that will actually make health care more affordable and accessible. Pursuing misguided policies that lower worker wages, eliminate jobs, and make the tough economic environment even worse are not the solution. I look forward to continuing to work with my colleagues on health reform to ensure that individuals and small businesses across North Carolina and our Nation have access to quality and affordable health care.

I thank the Chair.

RESPONSE TO QUESTIONS OF SENATOR ENZI AND SENATOR COBURN BY SANDY PRAEGER

SENATOR ENZI

Question 1. Ms. Praeger, what is the primary factor driving premium increases for small employers? Are insurers simply trying to increase their profits in anticipation of health care reform, as some Democrats have suggested?

Answer 1. According to our survey of the States, the primary factor driving premium increases is medical trend. This includes medical inflation, increased utilization, increased risk of the pool and other factors. States have not seen major changes in medical loss ratios, which means roughly the same amount of premium is going to medical costs. There is no indication at this point that profits are rising due to the increase premiums.

Question 2. Ms. Praeger, what do you think the impact of an exchange will be on the small employer market? Will some firms drop coverage entirely given that their employees could obtain subsidies through the exchange?

Answer 2. The experience in States that have developed purchasing cooperatives in the small group market in the past is that they increase choice and provide more comparative information to small businesses. However, they have not been effective in reducing premiums or significantly increasing the number of small employers offering insurance. Of course, past State efforts (except Massachusetts) have not in-

cluded an individual market cooperative through which subsidies are available. This could create an opportunity for small employers to forego providing health benefits altogether. However, it is also true that it would provide a real opportunity for small businesses to provide a cash subsidy for individuals to purchase their own coverage. While this would provide a greater degree of choice to individual small business employees, Senators should also bear in mind that such an arrangement would mean that each employee would be charged a different premium based upon their characteristics and choice of insurer and plan.

Question 3. The Senate HELP Committee-passed health care reform bill includes a government-run health insurance plan that would be offered through the State exchanges. What State laws would not apply to the government-run plan? Who would enforce consumer protections and assist consumers who choose the government-run plan?

Answer 3. According to the language adopted by the HELP Committee, the government plan would be required to comply with State consumer protections and meet solvency standards that are consistent with State laws. However, since the plan is not licensed in the States, the States would have no authority to enforce any laws. Enforcement would be the sole responsibility of the Federal officials. Consumers would be required to file complaints and submit questions to the Federal agency, much like Medicare and Medicare Advantage plans, or ERISA self-insured plans.

Question 4. What do you think the impact of the bills before Congress would be on small employer premiums in States that have adopted reforms recommended by the NAIC in the past?

Answer 4. Most States currently allow rating based on health status, within rating bands, and actuarially justified rating based on age, geography, industry, class of business, and other factors. The modified community rate rules envisioned in the current congressional proposals would increase premiums for those small businesses with relatively healthy and young employees, and decrease premiums for those with relatively sick and older employees. The grandfathering provisions, along with subsidies, could help limit premium shock, but rates will increase for some small businesses.

On the positive side, the new rules will also limit rate increases for individual employers in the future. Under current rules, a negative change in health status, average age, or gender mix, combined with medical trend, can result in annual premium increases of over 100 percent. Removing many of these factors, and limiting age rating, will limit such increases in the future.

Question 5. Do you see anything in the bills that could cause premiums for small employers to decline by the 25 percent that Dr. Gruber suggests?

Answer 5. No, we see no justification for such a prediction. We foresee no influx of healthy groups into the marketplace or significant cost containment that would result in overall premiums decreasing by such an amount.

SENATOR COBURN

Question 6. The majority's health bills would (a) impose federally defined minimal benefit packages, (b) dictate that every American purchase health insurance or be taxed, (c) tax companies to provide health insurance, (d) tax insurers, (e) tax insurance plans, and tax medical devices.

Wouldn't Federal mandates which define health insurance, determine the essential benefit package, make coverage determinations and set rating rules effectively neuter the roles of State Insurance Commissioners and State Legislatures?

Answer 6. The legislation under consideration would preserve State consumer protections and benefit mandates (though a State may be required to reimburse the Federal Government for subsidies that are attributable to State mandates beyond the essential benefits package), and require all plans—other than the government plan—to be licensed in the States and meet State solvency standards. However, the legislation does impose minimum standards for State access and rating rules which would require State legislatures and governors to modify State laws or face preemption.

Question 7. Oklahoma's Insurance Commissioner, a Democrat, Kim Holland, said: "I think we need to focus on those things that are broken and leave alone those things that are working in our State-based regulatory system . . . State regulators across the board are on the ground in their States responding immediately when consumers call."

What is the National Association of Insurance Commissioners doing to promote better State regulation which will lower costs to consumers?

Answer 7. The NAIC continues to develop model regulations and "best practices" guidelines to help States implement regulations that protect consumers but do not place unnecessary and costly burdens on carriers. For example, the NAIC has developed a uniform rate and form filing process that is used by most States and has developed uniform models for external review that we are hopeful States will adopt, reducing administrative costs to multi-state carriers. In addition, States coordinate market conduct reviews and solvency regulation through the NAIC to enhance State effectiveness and curtail costs.

Question 8. You mentioned in your testimony that medical costs are the primary factor driving premium increases for small employers.

What has been your experience with insurers—are they really just trying to increase their profits in anticipation of health care reform?

Answer 8. That has not been my experience or the experience of the other States surveyed by the NAIC. Some rate increases have been challenged by commissioners and some have been reduced. However, for the most part, rate increases are consistent with medical trend and medical loss ratios remain consistent.

Question 9. What do you think the impact of an exchange—as currently proposed by the majority's bills in Congress—will be on the small employer market?

Will some firms drop coverage entirely given that their employees could obtain subsidies through the exchange?

Answer 9. The existence of an individual market exchange, combined with the new access and rating rules and the subsidies, could create an opportunity for small employers to forego a health benefit altogether. However, it is also true that it could provide a real opportunity for small businesses to provide a cash subsidy for individuals to purchase their own coverage. Competitively, there will remain a desire on the part of small businesses to provide some assistance, especially if there is a real individual mandate. More small employers may, however, decide not to be the direct conduit of coverage, preferring to just provide subsidies.

Question 10. If consumers in a State with numerous State mandates or constrictive rating rules like Massachusetts or New York were allowed to purchase health insurance in States with relatively few mandates like Oklahoma or Wyoming, would their health insurance costs be significantly lower?

Answer 10. Young and healthy individuals could find cheaper coverage. However, if they need medical assistance there may be no network for them to access and nobody to help them if they have a complaint. And, when their age or health status change, their rates would skyrocket and they would be forced back into their own market, which would be devastated by the loss of healthy and young participants.

Question 11. If every American had a generous tax credit which could only be used for purchasing health insurance and/or medical care, and a State could develop and utilize auto-enrollment mechanisms to enroll Americans in a State pool of some kind (allowing for an individual op-out provision)—what do you estimate the impact of such an arrangement would be on covering the uninsured?

Answer 11. It would be effective, but could also be very costly if the sick and aged are placed in a separate pool with a government plan, like high-risk pools. It could also result in adverse selection and inferior care and coverage for those who are most at risk. We would need more information on this proposal to determine the total impact.

Question 12. What is your estimate as to the single greatest factor which plays the largest role in Americans choosing to not purchase health insurance? Cost, pre-existing conditions, or the opportunity to purchase coverage?

Answer 12. Most surveys point to cost of coverage as the primary reason a person does not purchase coverage. This is particularly the case for those who have no subsidy from the government or an employer and for the young and healthy, who place less value on health insurance coverage. Of course, if the person waits until they are sick to decide that coverage is now affordable it may be too late as they may be excluded due to a pre-existing condition.

Question 13. What is NAIC's position on using auto-enrollment and risk adjustment mechanisms at a State level—potentially with a high risk pool or a reinsurance mechanism—to create and manage a stable risk pool?

Answer 13. The NAIC has taken no position on such proposals.

RESPONSE TO QUESTIONS OF SENATOR FRANKEN AND SENATOR COBURN BY DOUGLAS HOLTZ-EAKIN

SENATOR FRANKEN

Question 1. As I mentioned at the hearing, your written testimony stated that there is "non-controversial" agreement that premiums would go up under the Senate health reform bill. However, Dr. Gruber testified that, for small businesses, premiums would go down under health reform. This seems to suggest that there is some controversy on this issue. At the hearing, time limitations did not permit you to provide a response to this seeming contradiction of your testimony. Please provide a response to this comment.

Answer 1. My testimony says "I believe it is non-controversial that the combination of guaranteed issue and community rating would raise average premiums." My concern is that the Senate bill comes close to this situation because of the extremely weak enforcement of the individual mandate.

In contrast, Dr. Gruber stated that he felt that the mandate was strong, which clearly leads him to a different analysis. I respectfully cannot agree that a mandate with no penalty in the first year and a maximum penalty of $750 is "strong."

His testimony seems to rely as well on an incomplete reading of a CBO letter. He says:

> "In their September 22d letter, the Congressional Budget Office reported that they estimated the cost of an individual low-cost 'silver' plan in the exchange to be $4,700 in 2016 (this was later updated to $5,000). This is a plan with an 'actuarial value' (roughly, the share of expenses for a given population covered by insurance) of 70 percent. In the same letter, the CBO projected that, absent reform, the cost of an individual policy in the non-group market would be $6,000 for a plan with an actuarial value of 60 percent. This implies that the same plan that cost $6,000 without reform would cost $4,300 with reform, or almost 30 percent less."

However, in the very same CBO table it indicates that family premiums will be substantially higher after reform—about 30 percent higher ($11,000 under current law, but $14,700 under proposed reforms). It strikes me as difficult to come to the generic conclusion that premiums are lower. Moreover, CBO cautioned that they hadn't estimated the all of the different factors that would impact on premiums:

> "In light of those complexities, quantifying the net effects of the Chairman's proposal on the amounts paid by individuals and families to obtain health care is very difficult. CBO has not modeled all of those factors and is unable to quantify them or calculate the net effects at this time."

Most significantly, CBO did not estimate the impact of guaranteed issue and modified community rating, two of the key factors that potentially lead to higher premiums.

Question 2. In your testimony, you asserted that the excise tax on insurance companies will be passed on to the consumer in increased premiums. However, you did not mention the Congressional Budget figures that estimate insurance companies will receive approximately 30 million new customers under health reform. Please comment on whether the revenue from these new beneficiaries (much of it paid by taxpayers in the form of Federal subsidies) could offset the excise tax for insurance companies in such a way that they will not pass the tax on to consumers?

Answer 2. Adding additional customers (which I believe total only 15 million under Senator Reid's version) does not change the basic insights. It will still be the case that the additional costs must ultimately be borne by workers at the affected companies, the shareholders of the companies, or the customers of the companies. As I noted in my testimony (and the Joint Committee on Taxation supports), there is good reason to believe that it will be less feasible to shift the excises to workers and shareholders. Accordingly, one would expect it to be shifted to consumers, albeit spread across a larger customer base.

Question 3. Do you anticipate any benefit for small businesses from participation in the exchange? If so, can you please provide an assessment of the potential benefits and drawbacks of the exchange for small businesses?

Answer 3. Properly designed exchanges offer the potential for improved price transparency, easier comparison shopping, cross-state purchases and pooling, and stronger competition. That is, exchanges could provide small employers with information on their health insurance coverage options; provide a mechanism for consumers to compare, choose, and enroll into a health insurance policy that meets

their unique needs; provide a State-established uniform online application for all insurers; and provide real-time estimated and final premium quotes.

Question 4. As you know, Americans who are over 50 years of age, women and those with pre-existing conditions pay more for health insurance on the small group and individual market. Do you believe that a small business that employs a higher proportion of older workers and/or women should pay more for their health insurance?

Answer 4. I believe that comprehensive health care reform should include genuine reforms of the delivery system so as to lower the pace of health spending growth, with corresponding reduction in the upward pace of premiums for those in the small group market and others. In addition, reforms to improve competition among insurers, broaden risk pools, and strengthen high-risk pools could serve to further reduce premiums among these groups.

SENATOR COBURN

Question 5. Many small business owners may question how raising taxes and cutting budgets to generate a trillion dollars and then spending a trillion dollars is budget neutral. Yet, this is exactly what CBO has said about the Baucus bill. As a former CBO Director, can you help us understand the assumptions behind CBO's estimate that the Baucus bill will be deficit neutral, as well as your personal perspective on the validity of those assumptions?

Answer 5. The key to understanding the CBO estimate is that they are required to estimate the Federal budgetary (and only the Federal budgetary) impact of the legislation as written. Thus, for example, the CBO must take at face value the Baucus bill provision that permits the sustainable growth rate mechanism to cut physician reimbursements in Medicare by over 20 percent. It must take at face value provisions that cut other providers by over $400 billion. It must do its calculations within the conventional budget framework in which up-front tax increases are permitted to offset out-year spending to reach balance over the 10-year window. In short, CBO must accept at face value the wide array of budget gimmicks that are used to deliver the appearance budget balance in the Baucus bill.

As a corollary, CBO is not permitted to anticipate the actions of a future Congress. However, after years of working with and for the Congress I believe it is beyond implausible that Medicare physicians will experience the proposed cut. As I write this answer, the House has already passed a deficit-financed bill of over $200 billion to avoid the cut. The Senate will likely do the same. It is equally unlikely that the $400 billion in other provider cuts will come to fruition. There are not substantive changes in delivery systems for business models that would permit such cuts, so Congress will inevitably reverse them.

My judgment is that the Baucus bill will significantly worsen a fiscal situation that is already dangerously dark.

Question 6. Some would point to subsidies in the Senate Baucus bill as the key to offset for rising costs. Yet, in your written testimony, you said that Senate proposals "do not 'bend the cost curve'" and "will raise costs for the majority of Americans who have insurance." Are you saying that premium costs and Federal expenditures will increase—despite subsidies?

Answer 6. Yes. It is the judgment of the CBO and the CMS Actuary Richard Foster that the House bill did not "bend the cost curve." Mr. Foster's analysis actually suggests it was bent up (worse). The Senate bill's entitlement spending growth (8 percent annually for 20 years in CBO's judgment) is identical to the House. The Senate bill, too, does not on balance bend the cost curve.

If health care costs continue to rise, there will be unremitting upward pressure on premiums. A decade of growth at an 8 percent rate will increase a $14,000 policy to $30,224. The scale of these increases will vastly outweigh any subsidies contemplated by the Senate.

Question 7. Are the majority's health bills financially sustainable in the short or long term? Why, or why not?

Answer 7. No. They create two new entitlement spending programs (the coverage subsidies and the CLASS Act) financed largely by debt issuance. This burden would add to the existing shortfalls in Social Security and Medicare and the legacy of the financial bailout and stimulus efforts. At a time when every effort should be made to reassure international capital markets regarding the budget outlook, these bills send the immediate signal that the United States is willing to move further out of balance and raises the ultimate costs of getting our house in order.

Question 8. There are now six different independent studies which show the Democrats' health bills will increase premium costs to Americans. What amount of time, and what other information, would CBO need to make its own assessment about increasing premiums?

Answer 8. I am unable to judge the time or resources that would provide CBO with the capacity to draw a judgment on this issue. However, as a general practice CBO takes advantage of the broad research literature in developing its basis for estimates, including supplementary information such as the impact on premiums. There is an increasing number of studies showing that the proposed legislation would raise premiums, which will presumably assist CBO in this valuable effort.

Question 9. You said in your written testimony that there are "sharp limits on the ability of [companies] to shift the effective burden of excise taxes onto either shareholders or employees." You also said that "firms will reduce compensation growth, squeeze labor expansion plans, or even lay off workers, or [all three]." When unemployment is over 10 percent, can you elaborate on what you think the job impacts of the current health bills in Congress would be for small businesses?

Answer 9. The bills under consideration in Congress share certain features. First, through the combination of industry fees, taxes, and insurance market reforms, they will place upward pressure on insurance premiums. This increase in labor costs will force cutbacks in the offer of insurance, other compensation, the number of employees, or some combination of all three.

Second, some legislation imposes employer mandates requiring the provision of insurance. Provisions of this type raise costs and restrict the ability of firms to adjust compensation packages, with detrimental impacts on the number of jobs.

Third, both the House and the Senate envision partial financing through a surtax on incomes or payrolls above a particular threshold. In both cases, the threshold is not indexed for inflation. Thus, over time both bills would subject an increasing number of small businesses and entrepreneurs (many of whom are organized as pass-thru entities) to higher taxes, leading to fewer jobs.

Fourth, none of the bills under consideration reduce the growth of national health care spending; indeed, it may even rise. Thus, there will be continued cost pressures that will harm the ability of small businesses to expand hiring.

Finally, by expanding the already-significant budget deficits in the next decade, the bills raise the probability of significantly higher interest rates. The upward movement in borrowing costs would harm the ability of small businesses to grow and expand.

Question 10. As a former director of the Congressional Budget Office and student of congressional budgetary history, how likely do you think it is that the proposed package of taxes and cuts in the majority's health bills hold together as a coherent whole, and thus not add a single dime to the deficits.

Answer 10. I have no faith at all that these bills are deficit-neutral in either the near-term or the longer-term. The shared fiction that doctors will receive a double-digit reduction in their Medicare reimbursements is an immediate indictment of their near-term deficit neutrality. The bills simply exclude inconvenient spending that will total at least $250 billion over the next 10 years. Over the longer terms, the bills rely on reducing the growth of traditional Medicare by 25 percent (from 8 percent annual growth to 6 percent annual growth) by the stroke of a pen. There are no reforms present that will support this lower growth of spending and the long-term deficit will be increased.

Question 11. What is your professional estimate of the reasonable likelihood of what the majority's health bills will do to Americans' premiums?

Answer 11. I expect premiums to increase markedly compared to the path under current law. Depending on the source of insurance—employer-provided, small-group, or individual market—and the age of the purchasers, there will be double-digit increases that may be as much as 20 to 30 percent.

Question 12. What is your professional estimate of the relative incentive the majority's health bills would give for relatively healthy Americans without chronic/ongoing conditions to drop coverage and only purchase health insurance when they are already sick or injured?

Answer 12. The incentives will be overwhelmingly in favor of this strategy. The combination of guaranteed issue and modified community rating ensures immediate access to insurance upon onset of a serious medical condition. Prior to that, individuals can choose to pay the modest fine (maximum of $750 in the Senate) instead of purchasing thousands of dollars of insurance.

RESPONSE TO QUESTIONS OF SENATOR ENZI AND SENATOR COBURN BY KAREN BENDER

SENATOR ENZI

Question 1. Ms. Bender, the Senate Finance legislation requires small employers to only offer plans that have deductibles of less than $2,000 for individuals and $4,000 for families. I regrettably note that Mr. Rowan would have to buy a more expensive plan to meet this new requirement. Additionally, I am curious, of the employers who currently offer more than one plan, do you know how many employees pick plans with deductibles higher than $2,000 or $4,000 for family coverage? Do you have a sense of how this new requirement will impact prices for insurance premiums?

Answer 1. The deductible limitations would limit the availability of more affordable coverage with higher deductibles for small employers. Based on data from a survey from America's Health Insurance Plans (AHIP), over 20 percent of the coverage sold in the small employer market in 2008 already had a deductible of $2,000 or above. Limiting the deductible at this level will only increase cost for small employers purchasing higher deductible plans. Generally in the small group market, employees are not offered more than one plan. The exception is when a federally qualified high deductible plan (HDHP) is offered. Then, (according to same AHIP survey referenced in the preceding paragraph) about one-third of employers offered another plan. When an HDHP was offered along side a more traditional plan, over 40 percent of employees in the small employer groups elected the HDHP. Sixty-nine percent of those electing HDHPs had deductibles equal to or exceeding $2,000 deductible for single coverage.[1]

Another survey by AHIP that focuses only on federally qualified HDHPs shows that there are over 2.4 million lives enrolled in small employer HDHP products as of January 2009 and that the deductibles for the best selling plans were slightly greater than $2,000 for single coverage and slightly under $4,000 for family coverage.[2] These two surveys show that there are currently many employees of small employers and their dependents enrolled in these types of plans. Further more, the same AHIP HDHP survey shows that enrollment in the small employer HDHP market had increased by 34 percent between 2008 and 2009.

Based upon our proprietary rating model using national average premiums, this deductible would not meet the minimum actuarial value of 0.65. The actual value will vary by carrier and geography. Premium increases in the 5 percent to 10 percent range to meet the standard under the Senate Finance bill would not be unexpected.

Question 2. Ms. Bender, what are the advantages and disadvantages of an exchange for small employers? Can the exchange substantially lower costs?

Answer 2. The creation of an exchange is not likely to lower health insurance costs for small employers. There have been numerous studies researching the premium levels for State purchasing groups that are similar to exchanges, including the health insurance purchasing corporations (HIPCs) popular in the mid-1990s through mid-2000s, including a paper I co-authored in 2008.[3]

More than a dozen States have enacted State-sponsored purchasing entities, generally referred to as Health Insurance Purchasing Cooperatives (HIPCS) during the 1990s. These HIPCs contracted with multiple insurers to offer benefit plans to employees of small employers. The HIPCs performed a number of administrative functions, such as contracting with insurers, marketing, and enrollment. It is well-established that HIPCs failed to offer premiums lower than premiums employers could obtain outside of the purchasing arrangement.[4]

Most of these purchasing arrangements never achieved a significant market presence because they failed to offer better rates, the key factor influencing purchasing decisions in the price-sensitive small employer market. For example, one study found that among employers that offered coverage in three States, only 2 percent

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[1] AHIP Small Group Health Insurance in 2008, AHIP Centers for Policy Research, March 2009. *http://www.ahipresearch.org/pdfs/smallgroupsurvey.pdf.* Accessed November 20, 2009.

[2] AHIP, January 2009 Census Shows 8 Million People Covered by HSAs/High-Deductible Health Plans, AHIP Centers for Policy Research, May 2009. *http://www.ahipresearch.org/pdfs/2009hsacensus.pdf.* Accessed November 22, 2009.

[3] Karen Bender, FCA, ASA, MAAA and Beth Fritchen FSA, MAAA, "Government-Sponsored Health Insurance Purchasing Arrangements: Do They Reduce Costs or Expand Coverage of Individuals and Small Employers?" 2008. *http://www.blueadvocacy.org/uploads/health-insurance-purchasing-arrangements-report.pdf.*

[4] Long and Marquis, 1999; Long and Marquis, 2001; Wicks, et al., 2000; Yegian, et al., 2000.

to 6 percent of eligible employers purchased coverage through a purchasing pool.[5] As a result, most government-sponsored HIPCs were disbanded.

The Massachusetts Connector has served as a model for health reform in Washington. However, little is known about the impact on small employers premiums because small employers are just now being enrolled in the Connector under a small pilot. Premiums for individuals have increased 16 percent for unsubsidized plans offered in the bronze coverage tier inside the Connector since 1997, according to the Massachusetts Division of Health Care Finance and Policy. The Massachusetts reforms, in total, were actually likely to increase the premiums for small employers as a result of a provision that required the costly Massachusetts individual market to be pooled with the less expensive small employer market.

There are several reasons why purchasing pools have failed to lower premiums: inability to lower aggregate administrative costs; inability to lower provider reimbursement levels; and inability to expand pooling of risk. One area where an exchange can provide value is in helping small employers shop for coverage and providing information on competing plans. Exchanges proposed by current health reform bills would provide small employers with information on prices and other important plan features on all health plans in the market. However, if an exchange is set up in a regulatory fashion, as in the proposed Senate bill, it will be unlikely to stimulate market competition or reduce costs for small employers.

Question 3. Ms. Bender, will an exchange provide the same economies of scale that major U.S. corporations enjoy when purchasing health insurance?

Answer 3. No, an exchange—as a collection of many independent small employers and individual purchasers—will never be able to achieve economies of scale similar to major corporations today. One of the underlying assumptions behind various purchasing arrangements is that bringing many small groups together to purchase health insurance will increase their purchasing power, giving them the same ability to negotiate lower health insurance premiums that large employer groups enjoy. *However, there are significant differences between a pool of many small employer groups and a large employer pool.*

The American Academy of Actuaries stated this principle well: "A single employer with 999 employees is not the same as 333 groups with 3 employees each."[6] The NAIC used the following analogy: grouping many small employers does not create the equivalent of a large employer any more than grouping three 12-year-olds creates a 36-year-old.[7]

An insurance company is still going to have to bill the 333 individual groups of 3 as opposed to generating a single bill for a group of 999. While the employer with 999 may offer two or three benefit options, the benefit portfolio for small groups as a whole is very broad, to meet the various needs of a very diverse market. Thus there are many more products to maintain, forms to file, more products for customer service associates to learn, more products to be adjudicated, etc. Also, in some States, health plans are required to submit rate filings for small groups, which requires time and resources. This is not necessary for large groups. So the economies of scale will always be different for small employers as long as there are many product options and no employer mandate.

Moreover, the large employer acts as the "glue" that holds the group together. Small employer groups are some of the most price-sensitive purchasers of health insurance. As such, these groups tend to move in and out of small group pools, by either switching carriers or dropping insurance, on a regular basis. This ability to enter and exit the insurance market makes the pool less cohesive than large group pools, which makes the small group market one of the most volatile health insurance markets. Since none of the Senate bills apply any penalty for a small employer for not offering coverage, this ability to enter and exit the insurance pool still remains.

Generally, the smaller the group, the higher the claims per member, because smaller groups tend to behave more like individuals. That is, among the smallest groups, those who have a greater need for health insurance (because of a known health risk) are more likely to purchase coverage while those with the lowest expected need for health insurance are less likely to obtain coverage. As such, the risk of adverse selection is very high in the small employer market.

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[5] Long and Marquis, 2001.

[6] Bender, Karen, et al., "Wading Through Medical Insurance Pools: A Primer." American Academy of Actuaries Issue Brief, American Academy of Actuaries, September 2006.

[7] Testimony of Joel Ario, Acting Commissioner of Insurance, Commonwealth of Pennsylvania, representing the National Association of Insurance Commissions before the U.S. Senate Committee on Finance on "Small Business Health Insurance: Building a Gateway to Coverage." October 25, 2007.

Since States require pooling of risk in the small employer market, higher-risk or less healthy groups enjoy some level of premium subsidies from groups with lower-than-average health care costs. However, healthier groups with lower-than-average risks may not perceive an economic value in health insurance because they are required to provide subsidies to these higher-risk groups. The more restrictive the rating rules, the greater the subsidies required from the healthier groups, and the less attractive health insurance is for the exact market segment critical to creating a viable pool, the healthy groups.

In order for any pool to be viable in the long run it must be self-supporting. Therefore, there must be enough healthy individuals to subsidize the medical costs associated with less-healthy individuals. This is generally not a problem for the large employer since the "glue" holding the pool together is independent of health insurance decisions. However, this is not the case for the 333 independent small groups in our previous example. Therefore, it is critical to have rating flexibility to ensure there are sufficient numbers of healthy groups to provide subsidies for the sicker groups.

Question 4. Most States today permit health plans to vary premiums based on the characteristics of each small employer with certain limitations. Some have suggested that using community rating, which is required in a smaller number of States today, would lower costs for small employers. Based on your experience, which States have more affordable premiums for small employers, those with community rating or those without?

Answer 4. Community rating will increase average premiums for small employers. In 2008 there were 12 States that did not allow for any variation in small group rates for morbidity[8]: Colorado, Connecticut, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Oregon, Rhode Island, Vermont and Washington.

According to the AHIP study of small employer premiums for 2008, the following States had the highest small employer premiums in the country A[9]: Alaska, Massachusetts, Rhode Island, New Hampshire, Maryland, Wyoming, West Virginia, New York, New Jersey, Utah. Of these top 10, 6 States do not allow any variation in premium for morbidity. So half of the States that do not allow any variation for morbidity are in the top 10 when it comes to premium levels. This would appear to support the theory that allowing for variation in premium levels for morbidity results in lower average premiums for the market in any given area.

These results are consistent with a 2001 U.S. General Accounting Office (GAO) study which found that even after adjusting for geographic cost differences, average annual premiums for fully insured small employer plans were about 6 percent higher for single coverage and about 7 percent higher for family coverage in States that prohibited premium variation in the small employer market due to health status. This same study found that these differences were not attributable to a greater concentration of higher-risked groups in those States that disallowed health status.[10]

Question 5. Can you explain why the data Oliver Wyman used in its analysis cannot be made public?

Answer 5. Oliver Wyman is unable to disclose the data used in the study because it is owned by the BlueCross/BlueShield companies that contributed it for that purpose and Oliver Wyman is bound by confidentiality commitments. Furthermore, the data is commercially valuable and contains sensitive competitive information about premiums, claims, and demographics that is proprietary to these companies. In our experience with actuarial studies, insurers typically retain their ownership rights and the underlying data is kept confidential by those involved, even when such work is performed under contract with State insurance departments.

As an independent firm, one of the important roles that Oliver Wyman performed in this study was determining whether the data is credible and representative—which we believe it is. The study's database has information on 6 million insured members in the individual and small-employer markets, almost one-eighth of all members covered by all insurers in the individual and small employer markets. The database includes information from 12 States and covers four distinct geographic rating rule clusters. Data from at least two States were included for each geographic

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[8] National Association of Health Underwriters, State Level Individual and Small Group Market Health Insurance Reforms. February 2009. *http://www.nahu.org/legislative/charts/market_reforms_chart_state.pdf.* Accessed November 20, 2009.

[9] Small Group Health Insurance in 2008.

[10] U.S. General Accounting Office, "Private Health Insurance Small Employers Continue to Face Challenges in Providing Coverage." U.S. General Accounting Office. October 2001. *http://www.gao.gov/new.items/d028.pdf.*

rating cluster. Overall, we believe that these data are representative, or even conservative, relative to the benefit plans and rating practices of the rest of the health insurance industry.

We also note that the use of actual policyholder data is a unique, distinguishing feature of our study—in contrast to other health reform models that lack access to such real-world information and instead use population survey data to create artificial individual and small employer purchasers for their economic simulations.

Question 6. Ms. Bender according to the Oliver Wyman study, what will happen to small group premiums if the current health reform bills are enacted?

Answer 6. Our study of the Senate Finance bill shows that the average increase, before any consideration of medical trend will be 19 percent, of which 16 percent is attributable to changing rating and underwriting rules and 3 percent is attributable to increasing the minimum actuarial value of the policies being purchased.

SENATOR COBURN

Question 7. Senator Harkin expressed concern that the data and/or methodology of the Oliver Wyman analysis referenced in your congressional testimony. Did the proprietary insurance data or the study's methodology differ significantly from the majority of other studies Oliver Wyman and other actuarial firms have conducted? If so, how? If not, please explain.

Answer 7. The best way of measuring the impacts on small group premiums attributable to the proposed reforms is to use a database comprised of actual small groups that are currently purchasing insurance. Given the scope of the proposed reforms, detailed rating criteria on a group level needed to be available in order to measure the impact on premiums of either modifying or eliminating certain rating factors. Any study that does not consider actual small groups and insurance rating factors could significantly understate the upward pressure on premiums that will result from insurance reform.

I have the advantage of years of experience in the small employer health market. I remember in the 1990s, when health reforms were being seriously considered at the national level as well as among the States. Many studies were done using "simulated groups." By "simulated groups" I mean that data for a large group population would be used to randomly assign members to simulate groups of various sizes. These studies consistently understated the "tails" at each end of the risk spectrum when compared to actual small group experience. In retrospect, this should not be surprising since these simulated groups were formed using random assignment techniques. In the real world, groups are not formed randomly. Selection is very real. Also, in the small group market, the distribution of groups by morbidity (i.e., aggregate health status of the group's insured members) is not the bell shape curve most of us are familiar with through our experience with basic statistics. In the real world, the distribution of groups by morbidity is skewed toward healthier groups, which means in those States that currently provide for premiums to vary from the midpoint rate due to morbidity, there are more groups enjoying discounts from the midpoint rate than groups paying surcharges. Any modeling that does not reflect these types of distributions will be, in my opinion, fatally flawed.

There is wide variation among the States regarding the amount that small group rates can vary from a midpoint rate which in turn, drives differences in the distribution of groups by morbidity. Any study that does not consider these differences at some level, could significantly understate the upward pressure on premiums that will result from insurance reform.

So while the data that Oliver Wyman used to model the impacts of the proposed reforms is proprietary, we strongly believe that the advantages of being able to start with real, live groups and having access to the underlying rating factors that are currently being used to develop existing premiums and therefore being able to directly measure the impact of eliminating/modifying these rating factors, far outweigh any disadvantages of not being able to release to the public the actual underlying database.

Question 8. The Senate Finance legislation requires small employers to only offer plans that have deductibles of less than $2,000 for individuals and $4,000 for families. This would effectively eliminate HSAs and Walter Rowan (glassblower business owner, witness) would have to buy a more expensive plan to meet this new requirement. I am curious, of the employers who currently offer more than one plan, do you know how many employees pick plans with deductibles higher than $2,000 or $4,000 for family coverage? Do you have a sense of how this new requirement will impact prices for insurance premiums?

Answer 8. The deductible limitations would limit the availability of more affordable coverage with higher deductibles for small employers. Based on data from a survey from America's Health Insurance Plans (AHIP), over 20 percent of the coverage sold in the small employer market in 2008 already had a deductible of $2,000 or above. Limiting the deductible at this level will only increase the cost for small employers purchasing higher deductible plans. Generally in the small group market, employees are not offered more than one plan. The exception is when a federally qualified high deductible plan (HDHP) is offered. Then, according to America's Health Insurance Plans (AHIP), about one-third of employers offered another plan. When an HDHP was offered along side a more traditional plan, over 40 percent of employees in the small employer groups elected the HDHP. Sixty-nine percent of those electing HDHPs had deductibles equal to or exceeding $2,000 deductible for single coverage.

Question 9. What are the advantages and disadvantages of an exchange, as currently proposed in the majority's legislation, for small employers? Will the exchange substantially lower costs? Will an exchange provide the same economies of scale that major U.S. corporations enjoy when purchasing health insurance?

Answer 9. The creation of an exchange is not likely to lower health insurance costs for small employers. There have been numerous studies researching the premium levels for State purchasing groups that are similar to exchanges, including the health insurance purchasing corporations (HIPCs) popular in the mid-1990s through mid-2000s including a paper I co-authored in 2008.[11] More than a dozen States have enacted State-sponsored purchasing entities, generally referred to as Health Insurance Purchasing Cooperatives (HIPCS) during the 1990s. These HIPCs contracted with multiple insurers to offer benefit plans to employees of small employers. The HIPCs performed a number of administrative functions, such as contracting with insurers, marketing, and enrollment. It is well-established that HIPCs failed to offer premiums lower than premiums employers could obtain outside of the purchasing arrangement.[12]

Question 10. For more than 20 years, small-business owners have listed health costs as their No. 1 concern. But leading "reform" bills would make things worse. In fact, the head of the National Federation of Independent Business, Dan Danner, said the reform bill's huge cost "will ultimately come out of small business owners' pockets and prohibit them from growing, investing in their business and hiring new employees." As an expert with 35 years of experience in the health care industry, experience as an actuary, and someone who has studied these issues closely, do you think this is an accurate statement?

Answer 10. As a health actuary, my expertise is focused on the impacts health care reforms will have on health insurance premiums. Our modeling shows that the *average* increase on small employer premiums will be 19 percent, before consideration of trend. [Please remember this is an average increase. Some employers will experience higher increases and some will experience lower increases as well as potential decreases.] We could not identify anything in the various Senate bills that would have any material downward pressure on trend. On the contrary, we could identify several factors that could have the opposite effect. However, we have not included any of these in our modeling to date. Obviously, if premiums increase at this magnitude and then are further compounded by trend increases, the cost will have to ultimately be paid by small businesses, since the premium subsidies are only temporary. If the subsidies are extended, then the cost of the bill will exert upward pressure on the country's deficit, which has not been incorporated into the scoring of the bill. While I cannot assert as a health actuary whether or not the additional premiums will prohibit small employers from growing, investing in their businesses and hiring new employees, it seems like only common sense that if funds that otherwise would be available for innovation, growth and expansion are being diverted to fund health premiums, then there will be less innovation, growth and expanded employment.

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[11] Karen Bender, FCA, ASA, MAAA and Beth Fritchen FSA, MAAA, "Government-Sponsored Health Insurance Purchasing Arrangements: Do They Reduce Costs or Expand Coverage of Individuals and Small Employers?" 2008. *http://www.blueadvocacy.org/uploads/health-insurance-purchasing-arrangements-report.pdf.*

[12] Long and Marquis, 1999; Long and Marquis, 2001; Wicks, et al., 2000; Yegian, et al., 2000.

RESPONSE TO QUESTIONS OF SENATOR ENZI AND SENATOR COBURN BY JONATHAN GRUBER

SENATOR ENZI

Question 1. In your testimony, you state that small business costs would decline relative to what they would be in 2016. However, this appears to be based on an assumption that medical cost inflation would be more than cut in half—from an assumed 9 percent to 4 percent—in the first year after reform. Both CBO and the CMS office of the actuary have been skeptical of the ability of current reform proposals to bend the "curve" of national health expenditures. What assumptions did you include in your analysis that led to your conclusion on medical cost inflation which appears to differ significantly from the statements of both the CBO and the CMS actuary?

Answer 1. My analysis is conservative in that I assume *no* impacts on health care cost growth. I simply assumed that in the first year after reform there would be a 5 percent savings for small firms as a result of the efficiencies of purchasing through the exchange in a reformed market. That has the effect of making growth rates 4 percent rather than 9 percent in that year, but really it isn't a growth rate assumption—it is just an assumption about savings levels.

Question 2. You assert that small employers could save 25 percent based on CBO data. However, an examination of CBO reports indicates that CBO has NOT suggested reform will reduce premiums. To the contrary, the same CBO letter of September 22d referenced in your testimony states that premiums in the new insurance exchanges would tend to be higher than the average premiums in the current-law individual market. Isn't it correct that CBO has not issued a comprehensive report on premiums and the selective use of certain quotes does not reflect CBO's full view on premiums which may be impacted by many different factors?

Answer 2. I never asserted in my testimony that small employers would save 25 percent. I simply pointed out that the CBO analysis implies that the cost of an insurance plan in the exchange would be 25 percent lower than the average cost of a plan in the non-group market with the same actuarial value.

The CBO letter *does not* say that premiums would tend to be higher in the non-group market—that is a misleading citation of just one point of several where they discuss forces that would tend to move the nongroup premium up or down. They don't draw a bottom line conclusion, but they do provide numbers that allow one to do so, as I did in my testimony. But it is true that CBO has not issued a comprehensive report on non-group premiums, nor have they spoken at all about the impact on group premiums.

Question 3a. Your testimony before the Senate HELP Committee stated,

> "In their September 22d letter, the Congressional Budget Office reported that they estimated the cost of an individual low-cost 'silver' plan in the exchange to be $4,700 in 2016 (this was later updated to $5,000). This is a plan with an 'actuarial value' of 70 percent. In the same letter, the CBO projected that, absent reform, the cost of an individual policy in the non-group market would be $6,000 for a plan with an actuarial value of 60 percent. This implies that the same plan that cost $6,000 without reform would cost $4,300 with reform, or *almost 30 percent less*."

Can you please explain your conclusion that a plan that costs $6,000 without reform would cost $4,300 with reform? Does the plan you assume will cost $4,300 meet all of the requirements mandated in Senator Baucus' bill?

Answer 3a. I simply used the fact that the $5,000 estimate refers to a silver plan, which has an AV of 0.7. To compare to a 0.6 non-group plan costing $6,000, I multiply the $5,000 by (0.6/0.7) to get $4,300.

Question 3b. CBO has not estimated the cost of a bronze plan. Have you estimated the cost of a bronze plan? If so, what is your estimate?

Answer 3b. I have not estimated the cost of a bronze plan but I assume it would be the $5,000 silver premium multiplied by (0.65/0.7), or $4,640.

Question 3c. Additionally, can you confirm what CBO stated in the same letter that the cost for a family purchasing coverage in the non-group market in 2016 will be $11,000 without reform and $14,700 with reform? Can you confirm this is a 34 percent increase in the cost of coverage for a family if the Baucus bill becomes law?

Answer 3c. This is not a valid comparison because the types of families in the non-group market and the exchange must be dramatically different—otherwise it is implausible that a family premium could be less than twice the single premium.

CBO hasn't spoken clearly to this, but I assume families in the non-group market are mostly couples, while in the exchange it would be a mix of couples and families with children.

Question 4. Dr. Gruber, your testimony mentions "there is a very strong mandate in place in legislation proposed by HELP and the House—and a reasonably strong mandate in the SFC legislation, as well." Can you please explain what you mean by a "reasonably strong mandate?" Do you think the SFC legislation will bring enough younger and healthier workers into the risk pool?

Answer 4. The strength of a mandate is related to two features: the strictness of the penalty and the ability of individuals to be exempt from the mandate. The House has a stronger mandate because there exemption level is higher (12 percent of income rather than 8 percent of income in SFC) and the penalties are larger. Nevertheless, even the SFC mandate will have a real impact on individual behavior and bring millions of young healthy consumers into the exchange.

SENATOR COBURN

Question 5. Today the average family of four pays an additional $1,800 each year in health premiums, due to the cost-shift from Medicare and Medicaid, according to a 2008 Milliman study. Since the majority's health bills in Congress envision hundreds of billions of Medicare cuts during a decade when the population of Medicare is projected to increase by a third (from 45 million to 65 million), and roughly half of the uninsured are put in Medicaid, what do you project will be the increased cost shifts which will burden the average American family with higher costs?

Answer 5. I am not familiar with the Milliman study and so cannot validate that result. But it is not proper to discuss cost shifting without also considering the reduced cost shifting that will result from less hospital spending on the uninsured. Hospital uncompensated care amounts to more than $40 billion/year, and that would be greatly reduced under either the Senate or House legislation. I do not know on net whether there will be an increase or decrease in cost shifting under this legislation, or the magnitude of those shifts.

Question 6. What clause or article in the Constitution gives the Federal Government the right to legally require that all Americans have health insurance?

Answer 6. I am not a constitutional scholar so I don't have a basis for answering this question.

Question 7. Do you believe that an individual mandate for health insurance is analogous to requiring drivers to carry auto insurance?

Answer 7. In many ways it is analogous, as it is a government requirement designed to improve the functioning of insurance markets. In other ways, it is not, because the product and the population mandated are quite different. In addition, all of the bills under consideration have some exemption mechanism from the mandate, whereas this is not true for auto insurance.

Question 8. You have been very involved in Massachusetts' experiment in health care. You acknowledged at the hearing that Massachusetts has experienced an increase in waiting times to see physicians—primary care and specialists. The 2009 Massachusetts Medical Society Physician Workforce Study and numerous Boston Globe reports confirm this. Since the majority's bills in Congress envision many similar rating and insurance "reforms" as Massachusetts, can you predict that Americans would not see increased waiting times to see a physician under the majority's reforms?

Answer 8. The change in waiting times in Massachusetts has varied by type of provider. Using the 2009 report and comparing pre-reform (2005) to the most recent data (2009), we find that waiting times have *fallen* for internal medicine, gastroenterology and orthopedic surgery, and *risen* for ob/gyn. It is unclear whether the reaction would be the same nationwide—I imagine it would vary by market conditions initially. But I agree that boosting primary care should be an important goal of reform.

Question 9. You said last September (07/31/08) before the Finance Committee:

> "The tax exclusion of employer expenditures from individual taxation . . . is a regressive entitlement, since higher income families with higher tax rates get a bigger tax break . . . this tax subsidy makes health insurance, which is bought with tax-sheltered dollars, artificially cheap relative to other goods bought with taxed dollars, leading to over-insurance for most Americans."

Are you convinced that the bills being considered in Congress effectively transform and improve this regressive tax system?

Answer 9. The bill before the Senate takes the most important step of the past 60 years to deal with this problem, which is to impose an offsetting tax on high cost insurance plans. Your question highlights that this "Cadillac tax" is not in fact a tax but just an offset to the existing tax bias in our system.

Question 10. Your testimony focuses heavily on your interpretation of CBO's analysis of premium costs. What is your estimation of the cumulative additional tax increases and cost-shifts which individual Americans and American families would experience under the bills?

Answer 10. I have not estimated these.

Question 11. A *National Journal* article on October 24th says:

> "One worried expert is Jonathan Gruber, a Massachusetts Institute of Technology health economist frequently consulted by Democrats. Gruber has calculated that the Schumer-Snowe approach will reduce the number of uninsured people the bill covers by about 3 million—and raise premiums for those it does cover by 10 percent. 'You'll lose the 35-year-old who doesn't go to the doctor,' Gruber frets."

The individual mandate in the Senate Finance Committee bill is significantly weaker than in the House bill. What impact will a weaker individual mandate have on younger, healthier Americans leaving the market?

Answer 11. The strength of a mandate is related to two features: the strictness of the penalty and the ability of individuals to be exempt from the mandate. The House has a stronger mandate because their exemption level is higher (12 percent of income rather than 8 percent of income in SFC) and the penalties are larger. Nevertheless, even the SFC mandate will have a real impact on individual behavior and bring millions of young healthy consumers into the exchange.

Question 12. Massachusetts does not have a public plan/full-blown State-run government health insurance company. In their score of the House bill, CBO said that the government plan would "typically have premiums that are somewhat higher than the average premiums for the private plans in the exchanges." Do you think a public plan is necessary for real health reform?

Answer 12. I do not believe that a public plan is *necessary* for real health reform, but it can be an important part of reform if designed and implemented appropriately.

Question 13. What is your professional estimate of the reasonable likelihood of what the majority's health bills will do to Americans' premiums?

Answer 13. I think it is most likely that the Senate bill will lower the premiums paid by Americans for their health insurance.

Question 14. What is your professional estimate of the relative incentive the majority's health bills would give for relatively healthy Americans without chronic/ongoing conditions to drop coverage and only purchase health insurance when they are already sick or injured?

Answer 14. I don't see the incentives for this behavior being very strong. First of all, the Senate bill includes an annual open enrollment period, so individuals could not simply purchase insurance when they are sick. Second, the bills include an individual mandate penalty which will penalize those who wait to buy insurance.

Question 15. Six independent studies and four government studies have each reported that the majority's health bills will increase premium costs. Do you disagree with these studies? If so, why? Will premiums increase under any of the majority's bills proposed thus far?

Answer 15. I am not aware of all these studies. The only ones of which I am aware that suggest the Democratic health care bills will raise costs are those funded by the insurance industry, and therefore I would not treat them as fully independent. The only objective evidence of which I am aware is the CBO analysis that shows that premiums in the exchange will be lower than they would be in the non-group market absent reform.

[Whereupon, at 5:10 p.m. the hearing was adjourned.]

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