# EXPANDING ACCESS TO QUALITY HEALTH CARE: SOLUTIONS FOR UNINSURED AMERICANS

## HEARING

BEFORE THE

SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS

OF THE

COMMITTEE ON EDUCATION AND THE WORKFORCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

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**HEARING ON EXPANDING ACCESS TO QUALITY HEALTH CARE:**

**SOLUTIONS FOR UNINSURED AMERICANS**

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**Tuesday, July 9, 2002**

Subcommittee on Employer-Employee Relations

Committee on Education and the Workforce

U.S. House of Representatives

Washington, D.C.

The Committee met, pursuant to notice, at 2:05 p.m., in Room 2175, Rayburn House Office Building, Hon. Sam Johnson, Chairman of the Subcommittee, presiding.

Present: Representatives Johnson, DeMint, Ballenger, McKeon, Tancredo, Tiberi, Wilson, Payne, Kildee, Rivers, McCarthy, and Tierney.

Staff present: Kristin Fitzgerald, Professional Staff Member; David Connolly, Jr., Professional Staff Member; Dave Thomas, Senior Legislative Assistant; Ed Gilroy, Director of Workforce Policy; Jo-Marie St. Martin, General Counsel; Greg Maurer, Coalitions Director for Workforce Policy; Heather Valentine, Press Secretary; Scott Galupo, Communications Specialist; Patrick Lyden, Professional Staff Member; and, Deborah L. Samantar, Committee Clerk/Intern Coordinator.

Camille Donald, Minority Legislative Counsel/Labor; and, Michele Varnhagen, Minority Labor Counsel/Coordinator.

**Chairman Johnson**. The Subcommittee on Employer-Employee Relations will convene.

Today the Subcommittee will hear testimony on ways to expand health care access to uninsured Americans. And I am eager to get to our witnesses. So I am going to limit opening statements to the Chairman and the Minority Member. Therefore, if other Members have statements, they will be included in the record. With that, I ask unanimous consent for the hearing record to remain open 14 days to allow Members statements and other extraneous material referenced during the hearing to be submitted for the official record. Without objection, so ordered.

Let me extend a warm welcome to you and all of the Members who are here and my other colleagues. Mr. Fletcher, thank you for being with us.

## *OPENING STATEMENT OF CHAIRMAN SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE*

Today's hearing focuses on expanding access to health care for uninsured Americans. On June the 18th, this Subcommittee heard testimony about the rising cost of health care and how this impacts employers and employees. In the last year alone, employers' health care benefits costs have increased an average of 13 percent. This fact led economists at our last hearing to predict that a significant number of Americans would lose their health insurance if this alarming trend continues. Because of the close relationship between health care costs and employers' ability to offer health insurance to employees, today's hearing will investigate how we can increase access to health care.

We will hear testimony painting a picture of the uninsured, who they are, where they work, and why they remain without health insurance. Members of Congress, the Administration, and outside experts will highlight solutions for uninsured Americans; solutions they believe will help put an end to this problem once and for all.

In the year 2000, 39 million Americans were uninsured. That means that 1 in 7 Americans went without health insurance. You might ask who are these uninsured? Well, they are working people who certainly don't have access to insurance or can't afford it. Fifty percent of the uninsured Americans work in small businesses. Some of these people are offered insurance and turn it down because of the costs. But many other employees in small businesses are not offered health insurance, leaving them without employer-sponsored coverage, our nation's primary form of insurance.

Why is this the case? One basic reason is affordability. As we remember from our previous hearings, small businesses are subject to numerous state mandates and often have access only to very expensive health coverage.

By contrast, their large business counterparts bargain for health care with the clout of a much bigger group. Association health plans would solve some of these problems for small

employers, letting them band together to bargain as a larger group and giving them relief from costly state mandates.

Today, we will also hear about the Congressional and White House support for these plans. Additionally, we will hear testimony about other burdens that small employers face. Many times, these mom and pop shops simply don't have the time to investigate their health insurance options.

We will hear about projects such as the Main Street Initiative to help bridge this knowledge gap. Over the years, Congress has taken action to help the uninsured. For example, last year, as a part of the Patient's Bill of Rights, Congress passed association health plans and medical savings accounts, two measures that would greatly expand access to health coverage for uninsured Americans. Unfortunately, these important initiatives that would reduce the number of uninsured have languished, while difficult political issues of the Patient's Bill of Rights are being debated.

Congress has also acted to provide health care assistance for dislocated workers. This was done by way of tax credit provisions in the House passed economic stimulus package, and recently passed Trade Assistance Act. As the trade bill conference gets under way, debate will continue over the best way to provide health care assistance to workers who are in danger of losing their health insurance.

While Congress debates these issues, 39 million Americans wait, wonder, and worry, hoping we will put aside our differences and offer them some help. This Subcommittee has jurisdiction over employer-sponsored health care coverage. And the vast majority of Americans, 65 percent, have employment-based health insurance coverage. Given this fact, I would like to think that this Subcommittee of all subcommittees could offer uninsured Americans some relief.

With that in mind, I look forward to working with my colleagues on the Subcommittee as we examine this issue and potentially move forward with solutions to help these Americans.

WRITTEN OPENING STATEMENT OF CHAIRMAN SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE – SEE APPENDIX A

**Chairman Johnson**. Right now, I would like to welcome all of our witnesses. Thank you for being with us, John, and we look forward to your testimony and the guidance it will offer.

I now yield to the Minority Member today, Ms. Rivers, if you desire to make a comment, please.

## *OPENING STATEMENT OF CONGRESSWOMAN LYNN RIVERS, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE*

Thank you, Mr. Chairman. I am pleased to be part of today's hearing on one of the most pressing problems facing this nation, the uninsured. Estimates range as high as 47 million people without insurance at any given time in this country. And CRS estimates that nearly 1 out of 7 Americans, or 39 million people, had no health insurance for all of the year 2000.

More than half of the uninsured were full-time workers or their dependents. Also in this country, we find that more than half of our bankruptcies are the result of unpaid medical bills, as families struggle to find ways to meet the health needs of their families.

This is an unconscionable problem in a country known for its wealth and its health care advantages. While many of us have access to the best health care available anywhere in the world, others must scrimp to cover basic care or forego needed care all together. This disparity is unacceptable and cannot be allowed to continue.

I used to be one of the uninsured. As a young mother, my family and I went without health insurance because if our jobs didn't provide it, we couldn't afford it. We were not alone in that unfortunate situation. And no one should have to endure the fear of falling ill at the wrong time, at being unable to afford recommended preventative care, or of financial ruin resulting from serious injury.

But anxiety is not the only side effect of foregoing health insurance. The Institute of Medicine found in a recent report that the lack of health insurance leads to delayed diagnoses and life-threatening complications resulting in 18,000 premature deaths each year. Researchers concluded, “Being uninsured for even a year appears to diminish a person's general health.”

I am encouraged that the problems facing the uninsured have gained increased attention in recent years. Awareness and national debate are essential to developing an effective national solution. However, the solutions proposed to fix the problem vary widely in both their approaches and their effectiveness.

I am concerned that some proposals appear to address the needs of certain uninsured Americans while leaving others without care, particularly those who, like my family, cannot afford the up-front costs of buying insurance. Partial assistance does not help those who cannot afford to pay the difference. And health plans limiting eligibility to certain groups do not help those who are excluded.

I hope that we will move toward a health care system that meets the needs of all Americans, not just certain constituencies. I know that my colleagues here today share my deep concern about the uninsured, and I appreciate their devotion of time to this issue.

I thank our guest panel members, as well as Representative Tierney and Representative Fletcher, for being here with us today. And I look forward to their remarks. Thank you.

**Chairman Johnson**. Thank you, Ms. Rivers. I appreciate your comments.

We have got three panels of witnesses today. Let me warn our Members that we will be called for two votes somewhere between 2:30 and 3 o'clock. And, therefore, I am going to ask the Members with unanimous consent if we can restrict questions for this panel to five minutes for each side.

With that, I want to announce our first witness who is my colleague from Kentucky, Representative Ernie Fletcher. Congressman Fletcher is a former member of the Employer-Employee Relations Subcommittee. Our other witness on the panel is the gentleman from Massachusetts, Congressman John Tierney. Mr. Tierney is currently a member of this Subcommittee.

Before the witnesses begin their testimony, I would like to remind the Members we will begin asking questions after the complete panel has testified. I know I don't have to explain the timer lights to you two gentlemen. We will hold you to five minutes.

Please begin your testimony, Mr. Fletcher.

## *STATEMENT OF CONGRESSMAN ERNIE FLETCHER, 6TH DISTRICT OF KENTUCKY, U.S. HOUSE OF REPRESENTATIVES*

I do miss serving on this Subcommittee. And I want to thank you and the Minority Member, as well as the other Members on the Committee, for allowing me to come here today.

As you may know, on May 9, 2001, I introduced H.R.1774, the Small Business Health Care Fairness Act. And I am pleased that 15 members on the Full Committee are co-sponsors, as well as five members of the Employee-Employer Relations Subcommittee. Also 24 members of the Full Committee, including 9 on the Subcommittee, voted last year for an amendment to the Patient's Bill of Rights that includes association health plans (AHPs). And this amendment, as you know, passed with bipartisan support and was included in the final version of the Patient's Bill of Rights.

America's growing health care dilemma now calls for our action. We must help the 40 million Americans that are currently without health insurance. Those without health coverage confront various and discouraged preventive care and delayed diagnosis. Consequently, studies reveal that morbidity and mortality rates among the uninsured are substantially higher than those with health insurance. And as double-digit health premiums increase and a weakened economy puts more and more small business workers in jeopardy of losing their health care benefits, we must turn our attention to the problem of the uninsured.

It is critical for Congress to take action. To include legislation like the bipartisan Small Business Health Care Fairness Act, we need to bring the Fortune 500 health benefits to the nation's "Main Street" small businesses and their employees. The Small Business Health Fairness Act creates AHPs for workers employed in small businesses and the self-employed. This bill provides working families employed by small businesses that make up 60 percent of the uninsured with more health benefits and more health plan choices.

Recently, the National Association for the Self-Employed announced research findings about self-employed Americans and their attitudes toward association health plans. According to their study, about three-fourths would be very likely, or somewhat likely to participate in AHPs if they offered more choices in health care benefits for themselves or their employees. And if insurance through AHPs were less expensive, 78 percent said they would be very or somewhat likely to participate. And even if AHPs just lessened paper work and administrative burdens, 72.7 percent said they would be very or somewhat likely to participate.

Also, a recent GAO study report shows that the five largest insurance carriers combined have 75 percent or more of the market share in 19 of 34 states, supplying information in more than 90 percent in seven of those states. Greater competition will benefit consumers by bringing premiums down and expanding access to coverage. The overwhelming trend in the state markets is less and less competition that leads to fewer choices, small benefit packages, and rapidly escalating premiums for small business workers. I believe H.R.1774 can help change that.

This legislation will inject competition into markets where it is lacking, thus further reducing premiums for workers. One independent study concluded that AHPs could reduce premiums by up to 30 percent. And it is estimated that up to 8.5 million uninsured workers employed by small businesses and their dependents would gain coverage if Congress enacted this legislation.

Small businesses should have the same advantages as do corporate and labor union health plans. In fact, small employers now pay 18 percent more for coverage than large employers. Moreover, corporate and union health plans operate under uniform national standards, and are able to take advantage of economies of scale. Lacking the bargaining power of large corporations, many businesses are priced out of the health insurance marketplace leaving their workers uncovered. AHPs addresses this problem by allowing those businesses to band together nationally into associations that can provide insurance at a lower cost to their members.

Let me briefly discuss the three main arguments against AHPs: First is cherry picking or adverse selection; second are inadequate solvency standards; and third is inadequate oversight enforcement. My statement for the record addresses each of these myths in more detail.

Under HIPAA, it is illegal for AHPs to deny coverage, so there is no cherry picking. The bill contains strict requirements that only bona fide professional and trade associations can offer AHPs. Adverse selections that currently exist in state markets will be greatly reduced when younger, healthier workers employed in small businesses who are uninsured are able to afford coverage that is affordable. This Act contains tough new solvency provisions that actually increase consumer protection. The bill gives federal and state authorities new enforcement tools to ensure

that they are enforced. Allegations that health care coverage obtained through AHPs will be anything less than secure ignore the protections contained in this bill.

I remind you AHPs are different than Multiple Employer Welfare Arrangements (MEWAs), which generally would not qualify as AHPs. This bill establishes new clear regulatory authority, whereas, many of the problems with MEWAs resulted from unclear regulatory authority and lax oversight by the state.

This bill does not require an entire new bureaucracy. In fact, DOL already regulated AHPs for compliance. Bona fide trade and professional associations can be trusted to operate health care plans in the same manner as labor unions and large corporations.

I think it is very important that we pass this legislation this year. And I thank you for holding this hearing, Mr. Chairman.

WRITTEN STATEMENT OF CONGRESSMAN ERNIE FLETCHER, 6TH DISTRICT OF KENTUCKY, U.S. HOUSE OF REPRESENTATIVES – SEE APPENDIX B

**Chairman Johnson**. Thank you, Mr. Fletcher.

Congressman Tierney, it is always a pleasure to have one of our own Members testify before us. You may begin your testimony now.

## *STATEMENT OF CONGRESSMAN JOHN F. TIERNEY, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE*

Well, thank you, Mr. Chairman. There are a couple of things that I think we can agree on. One is that everybody looks at this problem with the utmost good faith. And I think whatever side of the aisle you are on everybody is distressed with some of the statistics that both the Minority Member and the Chairman mentioned earlier about the number of uninsured and the difficulty of solving this problem.

But the other thing besides everybody's good faith that we can agree on is we don't seem to be able to agree on much. I have a preference for a broader plan like that of Congressman Jim McDermott from the state of Washington, for a system that would be open to everyone and administered by the states that would have comprehensive benefit programs without deductions or co-pays, or co-insurance for preventative or acute care, thus cutting down on the costs that it takes to administer all of those things. This plan would override federal programs and transfer those

funds into a different fund from which expenses or expenditures would be made.

But I know that the difficulty we run into is that people argue about how to make up for the difference in those monies and what else might be needed whether you get those monies from an employer, from the employee, from accommodation of those, from a special assessment, from a general assessment out of the general revenues. We fight forever on that.

A system like that does have the benefits of global budgeting, keeping costs down. It does certainly allow people, including the providers, to be involved in the reimbursements discussions much differently. Now what we have is the arbitrary nature of insurance companies turning the screws it seems from time-to-time on hospitals, and doctors, and other providers. And, certainly, it would keep administrative costs substantially down.

But we don't seem to be able to get an agreement on that. We have had over 100 co-sponsors in some years in that plan and fewer in others. But we have seen other plans like Dr. Fletcher's here, association health plans, medical savings accounts, tax credits, and again we can't seem to agree.

We argue on tax credits. Will a credit be enough? Will it be refundable? How are we going to keep costs down, or will this be an open piggy bank for insurance companies to just keep jacking up the premiums? Are they going to be equitable? Are we going to encourage cherry picking, and so on down the line?

One of the things that I don't think is at issue here is the amount of money that we spend in this country on health care. The United States has a medical average cost per person of $4,358. It is a substantial amount. The average for 29 other industrial nations is $1,764. The next highest to the United States is Switzerland at $2,853. So it seems that we are spending quite enough money. The question is are our systems working or not working, and what can we do to maximize the use of that money, so that we cover more and more Americans with a comprehensive plan that they can afford?

I have a suggestion as to how we might try to break through the roadblock and the disagreement that we have, and that is H.R.1033. I hope that we could use our good faith and seek an affordable comprehensive health care system by a method that gives the opportunity to states to use innovative ideas to come up with a system that would cover all of the citizens within their area.

We would allow them to develop their own systems of universal care by clearing away the underbrush of federal regulations and providing assistance through the implementation of planning grants first, and helping them later to transition to universal care.

We would require the benefits and protections of federally funded health programs to remain fully in tact even under the waivers. The bill would allow up to ten states to receive grants. And they would have to provide a standard package of substantial benefits. They would have to show that they can control costs, and then they would be eligible for a second grant that would pay for transition costs, usually in the form of uniform information systems, or reaching out to enroll

eligibles.

Frankly, studies have shown that if these states can rationalize their systems, and thereby bring administrative costs into line with those of other industrialized democracies, states would save enough money to cover everyone in the state with more generous benefits than are currently available and still spend less overall on health care statewide.

So the bill, in summary, is planning grants to create demonstration programs to give waivers from federal requirements that might inhibit state innovation but always maintain the benefits and protections that existed in current federal programs, a comprehensive set of benefits, strong quality assurance requirements, and continual evaluation as we move forward on that.

In this way, we should be able to tap into the great resources of the states. And I note that some states are already surprising us with some real innovation, not the least of which is the state of Vermont, which has a Dr. Dinosaur program for children with income three times the poverty level, so that families of four earning up to $72,900 still get care for their children; or the Vermont Health Access Plan which gives health coverage and prescription drugs at low cost to adults that aren't otherwise eligible under Medicaid; or Success by Six that gives every child health care and prenatal care for families, and prescription drug programs that stop unfair patent protection abuse, or explore buying power like the Veterans Administration program and group buying to keep costs down.

I think, Mr. Chairman, that if we allow states to use their innovative skills on that basis that we can perhaps get through the impasse that Congress seems to find itself in.

WRITTEN STATEMENT OF CONGRESSMAN JOHN F. TIERNEY, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE – SEE APPENDIX C

**Chairman Johnson**. Thank you, Mr. Tierney. I appreciate your testimony.

Mr. Fletcher, critics of AHPs have pointed to the lack of state regulation, and the impact on state insurance fraud laws and benefit mandates. Why do you believe that small businesses should be granted relief from state regulation? And do you believe federal standards would be sufficient for AHPs?

**Dr. Fletcher**. Mr. Chairman, as Ms. Rivers mentioned, there is an institute study about 18,000 folks dying prematurely because of lack of insurance. And it is estimated that about 8 1/2 million people may gain insurance. So I think clearly it is a benefit that will help reduce morbidity and mortality rates across the country.

We have in our bill provisions for the states to take over certification and enforcement of the provisions applicable to AHPs. We set up the ability for states to do that. That means that if someone has a problem, they can pick up the phone and call their state commissioner of insurance,

and there is somebody there to answer the phone.

Now, in addition to that, the Department of Labor already regulates exempt plans such as the self-insured, self-administered plans of the large Fortune 500 companies, as well as the union companies. The union health plans do qualify as AHPs. So I think this is a system where we are expanding fairness and the same benefits to small businesses that large corporations have. And on the economy of scale that we have seen, it can save up to 30 percent for small business. That means more people are going to be insured.

Another thing we also have to realize is that these associations are put together for reasons other than health care benefits. They are representing their members' interests, which means the benefits that they offer will probably reflect the desires of the members, just like union health plans reflect the desires of members.

So you have a health care plan that is put together representing members, and no overhead from an employer. I think you are going to get very rich coverage as seen in the union health plans, as well as some of the Fortune 500 companies.

**Chairman Johnson**. Thank you.

Mr. Kildee, do you care to question?

**Mr. Kildee**. Thank you very much, Mr. Chairman.

Mr. Tierney, I am a co-sponsor of your bill, H.R.1033. You describe universal coverage in it. Would that accommodate both public and private insurance coverage?

**Mr. Tierney**. It essentially would be up to the individual states, to develop a plan of what sources or resources they wanted to combine to use. That is why we are really asking for their imagination. They could take the resources of the federal programs that are used in their state and mix them with their own resources, as long as they didn't go beneath the threshold of benefits and the protections federal programs have.

So they could decide to fund their program or the extras on their program, any way a particular state chose to do it. And they could have a plan that extended out SCHIP, for instance, or had a new program, or use more Medicaid, use some of Mr. Fletcher's ideas, if that seemed to work in conjunction with others, so long as they reach the goal of covering everyone in their state with good substantial benefits.

**Mr. Kildee**. And it would include in that totality the private plans provided by, say, General Motors? Individuals would have a contract, and the state somehow would devise a plan to make sure that no one falls through the cracks?

**Mr. Tierney**. It would be up to the state to do that. That is correct.

**Mr. Kildee**. I am not sure what the status of Hawaii is right now, but at one time Hawaii had achieved basically 100 percent coverage. Do you think that could be replicated in other states?

**Mr. Tierney**. I think it can be replicated in other states. I had mentioned some of the programs of Vermont that have covered in excess of 90 percent of their people through a different variety of programs.

I think it may well be that urban states and rural states may have different ways of approaching this problem. It may be different for different parts of the country and different types of populations. And that is why we try to offer flexibility to create models that we can then build on.

**Mr. Kildee**. In my own state of Michigan, in some parts of my district I have a microcosm of America. I have two older industrial cities and agricultural areas. Very often in the industrial cities there is good coverage because of the GM/UAW contracts, and then there are people who do not have coverage. The state could craft a system where insurance provided by corporations and union contracts remains in place. Somehow in a variety of ways it could fill in the gaps, so there would be universal coverage.

**Mr. Tierney**. Yes, that is pretty much what Vermont has done.

**Mr. Kildee**. And H.R.1033 would do that?

**Mr. Tierney**. It would allow for that.

**Mr. Kildee**. Thank you. Thank you, Mr. Chairman.

**Chairman Johnson**. Thank you, Mr. Kildee.

Mr. DeMint, do you care to question? You've got a little over two minutes.

**Mr. DeMint**. Thank you, Mr. Chairman.

Dr. Fletcher, as you know, the large majority of uninsured Americans are working for companies that don't offer health insurance, about 25 million Americans. As a small businessman myself, I understand why that is. It is the cost, the unpredictability of the prices, the difficulty of finding choices in a group market, not having a benefits manager, and the need to negotiate every year. It became a costly and cumbersome process. And that is why lots of small companies are getting out of the health insurance business.

How could AHPs address this list of problems for small businesses?

**Dr. Fletcher**. Let me give you an example. Either a Chamber of Commerce, the Farm Bureau, NFIB, or any association that has existed for three years previously for purposes other than offering health care, could put together a standard insurance package that would represent the needs of their members. It would be negotiated on a national level, and every employee in a small business could

participate in it. It is guaranteed.

AHPs average up to a 30 percent reduction in costs. It may be less than that. But, certainly, small businesses pay 18 percent more on average than companies that are self-insured, or large companies that are able to take advantage of this sort of policy.

So rather than doing all of the paper work to negotiate a plan every year, AHPs would allow small business to participate in a national plan if they were a member of the Chamber of Commerce, or the Farm Bureau as examples. And that goes for the self-employed farmer who has to find a plan in the individual market, which is very, very difficult to find at a reasonable cost.

**Mr. DeMint**. Thank you.

**Chairman Johnson**. Thank you, Mr. DeMint.

Ms. Rivers, you have a little over a minute.

**Ms. Rivers**. Thank you.

Representative Fletcher, you note that your bill would prohibit AHPs from refusing to cover older or sick individuals. Is there any prohibition on increased premiums associated with those conditions? In other words, will people have the ability to come into this system in the same way everyone else does, or will they have to pay more if they are older, or sicker, or represent greater risks?

**Dr. Fletcher**. What we have is "guaranteed issue". They are on the rating system. An individual group would certainly have a rating, but not the individual within the group, so that is guaranteed issue. They don't pay based on experience rating. And that allows us to bring more young people in, and actually reduce the rates for those high-risk people who probably have insurance because they need it through some other means. It would reduce their costs actually.

**Ms. Rivers**. But say, for example, in one group there is a sicker person, someone who has a chronic or a catastrophic condition, does that then raise the price for everyone in that group?

**Dr. Fletcher**. As far as the group, yes. Actuarially, any time you have the total cost raised, you would probably have the costs for the entire group or the entire association raised. But, the individual would not see a rate higher than their co-worker that was sitting next to them based on experience rating. At least that is the way we set up the bill. And if does not do that, we will change it.

**Ms. Rivers**. But, I mean, we have small businesses today that are struggling under similar problems if they have older workers, or if they have people who are ill working for them. If they lose their insurance and have to by more, one of the problems with a higher risk group is that the costs are so high you can't participate.

**Dr. Fletcher**. No, that is why we set up the economies of scale based on much larger national and association pools, so that small businesses would be able to buy into a plan at a guaranteed issue, and avoid the problems you are talking about. It prevents cherry picking, and it also allows people at high risk to get the kind of insurance they need. And one of the things we wanted to prevent was the very problem you were talking about, spiraling, escalating costs.

**Ms. Rivers**. Okay, thank you.

**Chairman Johnson**. Thank you both for your testimony, I appreciate it. You may step down.

I would ask now that Dr. McClellan to come forward and take his seat. And, again, I wish to remind Members that we will ask questions after he has testified. Dr. McClellan is our only witness on the second panel. He is a member of the Administration's Council of Economic Advisors.

I think you understand how our timer light system works. And I would ask that you adhere to the five-minute rule for your opening statement, if you don't mind.

## *STATEMENT OF MARK B. MCCLELLAN, M.D., MEMBER, COUNCIL OF ECONOMIC ADVISORS, WASHINGTON, D.C.*

Mr. Chairman, Ms. Rivers, and distinguished Members of the Subcommittee, I wish to thank you all on behalf of the Administration for your efforts to find bipartisan solutions to address the very closely related problems of the uninsured, and of rising health care costs.

The vast majority of the uninsured, as you know, come from families with at least one employed worker. And employers and workers everywhere are struggling with another year of rapidly rising health care costs.

As a result, this hearing on the problem of access to quality health care is especially timely and especially important. We very much appreciate your efforts to find common ground to provide relief for Americans who are uninsured, as well as those who are working and having more and more difficulty obtaining affordable health insurance.

The President has introduced a comprehensive set of proposals to ensure that all Americans have affordable health insurance coverage options with a particular emphasis on creating affordable options for the uninsured. All of these proposals are part of a broad vision for promoting health care quality and access for all Americans by developing flexible approaches to providing patient-centered health care coverage. Reflecting the urgency of the need for action, this vision involves strengthening every component of our health insurance system.

Many of these proposals such as new proposals to assist employees with high out-of-pocket costs, and our proposal for association health plans to help small businesses offer insurance are directed towards strengthening employer provided health insurance. In particular, the President

supports legislation that provides for the creation of association health plans or AHPs to enable small businesses to provide better and more affordable health insurance options for their employees, just like those that many large employers can offer.

Small businesses are far less likely than large businesses to offer health benefits. In 1999, less than half of the firms with fewer than 50 employees offered health insurance benefits, compared to 97 percent of larger firms. A major reason why smaller firms are less likely to offer health benefits is the fact that providing health benefits is more expensive on a per capita basis for small firms. In addition, some of the most rapid increases in health insurance premiums in the last few years have occurred for small businesses. AHPs will help solve the problems with access to coverage for millions of workers and small businesses.

Legislative proposals like H.R.1774, introduced by Representative Fletcher, with over 100 co-sponsors from both political parties, would allow large industry associations and other groups formed on the basis of factors other than expected health care costs to pool together to offer health insurance options.

Through the establishment of uniform federal standards for association health plans, small employers will be able to achieve greater purchasing power, administrative efficiencies, and flexibilities in benefit design, the same advantages that have long been available to large businesses and union plans.

Critics of AHP proposals argue that they will lead to fraud or failures, as that has occurred with some multiple employer welfare arrangements or MEWA plans. This is different. The AHP proposal is different. Through stringent regulatory requirements like those imposed by the Department of Labor on the plans of large employers and unions, and through much stronger solvency requirements, unprecedented federal consumer protections will be available for the AHP provided plans. There are more details on these provisions in my written testimony.

Another criticism of AHPs is that they will cater only to healthy enrollees, undermining the small group risk pools of each state. For many reasons, including bona fide association requirements, large size requirements for AHPs, and the strong regulatory sanctions I already mentioned, AHPs cannot simply choose to provide services to healthy, low-risk businesses. And a requirement of availability, regardless of the small business risk, is reinforced by prohibitions on selective marketing and enrollment.

Just as large employer health coverage and multiple employer union health coverage must be attractive to a broad spectrum of covered workers, AHPs will not be able to attract small businesses by catering only to their healthier workers. Rather, AHPs must offer and provide consistent services to a large spectrum of eligible small businesses regardless of their expected medical costs.

As you know, the President, like many distinguished Members of this Committee, also supports a range of other proposals to give employees better options including improved medical savings accounts and flexible spending account rollovers.

Recently, the IRS and the Department of Treasury announced new guidance that will make it much easier for employers like some of the firms that you heard from in a hearing several weeks ago to offer these kinds of benefits to allow employees to get better protection against their high out-of-pocket costs, and to rollover unused balances to subsequent years. I would be happy to elaborate on these provisions in my question and answer period.

And, finally, the Administration is pleased by the progress towards the introduction of health insurance tax credits in legislation this year. Both the House and Senate have passed them. We have some specific ideas on improving the kinds of health insurance credits that have made it through both Houses, particularly for those designed to help trade impacted workers. And I would be happy to talk about that as well.

So thank you again. I ask that the remainder of my written testimony be read into the record. And I would be very pleased to answer any questions you may have.

WRITTEN STATEMENT OF MARK B. MCCLELLAN, M.D., MEMBER, COUNCIL OF ECONOMIC ADVISORS, WASHINGTON, D.C. – SEE APPENDIX D

**Chairman Johnson**. Thank you. I appreciate you being here, and thank you for your comments.

Mr. Ballenger, do you care to question?

**Mr. Ballenger**. Thank you, Mr. Chairman.

I have a couple of questions. As an employer myself, I remember the good old days when we used to pay all of the health insurance costs for the worker and his family. As it got more and more expensive, sooner or later, the worker had to start paying more of the cost.

I wonder if there is a statistic that shows one family member insured, and other family members who are not insured, because the insured person cannot afford to cover the family? Is there such a statistic available?

**Dr. McClellan**. I don't know that figure off the top of my head. I suspect some of the other panelists might. I will try to get it to you. It is a number that we are concerned about as well and it has been rising because employers have found it more difficult to offer subsidized coverage to family members, as well as to the workers themselves.

And that is one reason for the need for policies like the one that I have discussed, to strengthen employer coverage, and also to provide affordable alternatives for people who are not offered employer coverage.

**Mr. Ballenger**. I wonder if you noticed in the previous discussion of the bills that in one a company's individual AHPs plans were involved in a competitive situation and in the other one, the

state studies this, and the state does that, and the state is in charge of this, and the state figures that. Pretty soon it sounded like the state was running an insurance company. Some states that I know couldn't run a one-car funeral procession very well.

**Dr. McClellan**. Sure.

**Mr. Ballenger**. Did you notice that in the testimony?

**Dr. McClellan**. We have noticed it in some of the testimony, Congressman. The Administration does believe that there are some things that states can do to help. And we have supported a number of states in expanding their Medicaid and SCHIP programs.

In many cases, by not trying to run the parade themselves, they have expanded those programs and provided more affordable coverage by contracting out to private insurers. And we want to encourage more of that.

But I think you hit on a very important point that individuals in this country deserve access to a range of health care choices. Private insurance choices that enable them to get the coverage they need in a way that keeps up with the rapid changes in medical technology, and in the way health care is delivered.

And that is why all of our proposals center on providing a broader range of affordable choices to patients, ways that let patients work together with doctors to get better coverage and better care.

**Mr. Ballenger**. Thank you, Mr. Chairman.

**Chairman Johnson**. Mr. Tierney, do you care to question?

**Mr. Tierney**. I would, thank you, Mr. Chairman.

Thank you for testifying today. When you are talking about the association health plans that the President supports, basically there is a concern that I have about small employers being able to band together.

Do you agree with that?

**Dr. McClellan**. They can band together under some circumstances and subject to state laws.

**Mr. Tierney**. So, basically, the only thing that the President's plan offers is he exempts them out of those state laws in some instances, right?

**Dr. McClellan**. And that is an important exemption available to large firms and to unions that cover multiple employers.

**Mr. Tierney**. But on your President's plan, what he would do is he would for insured plans eliminate all state authority to regulate any arrangement with respect to compliance with consumer issues, right?

**Dr. McClellan**. The President's plan would put in place for the association health plans the same regulatory structure run by the Department of Labor that has worked extremely well for large employer plans and union plans.

**Mr. Tierney**. My question was, what he would do is he would absolve or exempt them from having to comply with state consumer protection laws, right?

**Dr. McClellan**. Another option would be to use the federal regulatory system for consumer protection rather than a state system.

**Mr. Tierney**. I just wanted to see if I could get a straight and simple and very short answer.

**Dr. McClellan**. I will try to be very straight and simple.

**Mr. Tierney**. What about the exemptions?

**Chairman Johnson**. Mr. Tierney, let me just interject here a minute. Is that true?

**Dr. McClellan**. That is right.

**Chairman Johnson**. Thank you.

**Mr. Tierney**. Can I have my time back, or are we all done?

**Chairman Johnson**. You have it.

**Mr. Tierney**. Thank you. Remind me to interrupt you sometime to make a point.

The fact of the matter is that he exempts some from state regulation consumer protections and gives them alternatives but you take them out of the state realm.

**Dr. McClellan**. Federal consumer protections would apply. When it is a self-funded plan exempted from both solvency and consumer protections, you set up a separate structure for that, but the states would lose control over both of those things.

It also deals not only with solvency and consumer laws, but premium rating, limits on medical underwriting, and benefits. And the proposal would include specific federal standards for solvency, and underwriting requirements.

**Mr. Tierney**. So, essentially, we have a President of a party that always goes around claiming states' rights and state prerogatives telling us he wants to replace that with a federal program.

**Dr. McClellan**. Yes, sir.

**Mr. Tierney**. So that was my point. Thank you.

**Chairman Johnson**. Dr. McClellan, thanks again for being here.

You mentioned that some of the most rapid increases in health insurance premiums have occurred in small businesses. Can you account for that and tell me how AHPs might help that situation?

**Dr. McClellan**. There was a recent study done that tried to decompose cost increases in the last several years into different components. One component, rising malpractice liability costs is not something that this proposal would help with, but it is something that the President is very concerned about.

Things that this proposal could help address are the costs of compliance with state mandates. According to these estimates, something like 10 to 20 percent of cost increases could be addressed by providing the same kinds of exemptions from complex state mandates that are available to large firms. That is one important reason why large firms are able to offer health insurance that costs significantly less, and that the CBO and every other group that has studied this proposal clearly suggests would lead to lower costs here as well.

Another way that health care costs could be reduced is through lower administrative costs. Administrative costs for small firms which have to do with the individual underwriting, and the individual costs of enrolling their employees in a single plan are also quite high.

And finally, we think that an important source of savings for small businesses not available today is the opportunities for choice. By giving employees an opportunity to enroll in a plan that best meets their needs might involve some significant deductibles and the like, which we think would lead to savings as well.

Right now, small businesses can typically offer only one plan to all of their enrollees. So lower administrative costs, more flexibility to offer the kinds of benefits that employees want, and opportunities to offer choices are all ways in which the AHP proposal would lead to savings for small businesses, and they need them now.

**Chairman Johnson**. I believe the Administration also proposes a credit available to those who do not have employer-sponsored coverage. Studies that we have seen suggest that 13 million of the uninsured are in families where employer-sponsored coverage is turned down.

Is that a way to assist these workers in selecting employer-sponsored coverage?

**Dr. McClellan**. As I said at the outset we believe that the best way to help the uninsured, who comprise a very diverse population, is to strengthen all parts of our health care system. And that is why we support association health plans, medical savings accounts, flexible spending account

rollovers, and other steps to improve employer coverage.

**Chairman Johnson**. What about tax credits in particular?

**Dr. McClellan**. For those that aren't offered employer coverage, the President believes that a refundable tax credit is the quickest and most effective way to get assistance to them. Estimates by non-partisan, professional, Treasury Department staff state that something like 16 million people would benefit from our health insurance credit proposal.

And that includes over 6 million people who would otherwise be uninsured, and would also benefit a lot of the people, who today, because they work part-time, they work in agricultural industries, they work in the restaurant industry, and other businesses where health insurance just isn't available through the job. They would get help as well.

Also, Mr. Chairman, I direct your attention to a new study that came out today using actual data from individual insurance plans, which showed that for the amounts of the credits that we have proposed, there would in fact be affordable coverage available. The average person, based on actual data, not hypothetical cases, who was using our credit now, would be able to get a policy for something like $1,000 a year. These are good policies that people are buying now for health insurance. So we think this is an important element in our approach to improving health care costs.

**Chairman Johnson**. So what you are saying is there are about four plans out there, all of which are voluntary, and if they assume the tax credit role they can still stay under state control. Is that true?

**Dr. McClellan**. That is absolutely right, sir.

**Chairman Johnson**. Thank you very much.

Ms. Rivers, you may question.

**Ms. Rivers**. Thank you. During the time I have been in Congress these last eight years, there have been any number of proposals for new organizational ways of dealing with this problem; AHPs, MSAs, HRAs, any amalgamation of the alphabet you would like. And all of these seem to suggest that we would fragment the people who are purchasing insurance into these individual pools, or these smaller pools.

Is the best way to approach this problem to address smaller groups of people? You know, there are some people who are in AHPs, some people who are in employer-paid plans, and some who are in MSAs. Wouldn't it be smarter to go in the other direction to larger pools where most people share risks and costs, instead of by fewer with all of those different plans?

**Dr. McClellan**. Congresswoman, I would argue that our policies do allow for better risk pooling. With the association health plan for example, small businesses would be able to pool together into a large group to buy health insurance coverage.

**Ms. Rivers**. The real point I am making is that they are being argued concurrent with other proposals. So you may have some people who have not been able to be in an AHP before now, or something like that, who would choose it while others who work beside them would choose the MSA if they were in a better position financially.

So what I am asking you is to look all at once at all of the proposals that are out there, rather than bringing people into smaller risk pools or larger risk pools, which seems to be a trend toward fragmentation

**Dr. McClellan**. I think that our proposals do support better risk pooling. That is a very important goal of health insurance reforms, but they also support diversity and health insurance choices. We don't think that a one-size fits all plan is the right approach for American health care. People have different health care needs.

**Ms. Rivers**. Right now, is that a big problem we have, one size fits all? I mean, honestly, in this room, how many of us would have exactly the same coverage? The Members of Congress all would.

**Dr. McClellan**. Actually, I think the Members of Congress have several plans they can choose from ranging from a major medical type plan to a more comprehensive Blue Cross plan.

**Ms. Rivers**. I understand. But the point I am making is you said that the problem is one size fits all. And I am asking realistically whether that really is a problem in a nation of 280 million people that one size fits all is what is being promoted. I would think that probably everybody in this room has some sort of different kind of coverage than the person sitting next to them.

**Dr. McClellan**. And we certainly support the kinds of federal policies that would allow them to get the kinds of policies that they prefer.

**Ms. Rivers**. One of the things that I have heard argued before that I have never understood is health care being consumer-driven, and people making choices. Maybe since you are an economist you do this. But I have never encountered anyone who calls an array of doctors to find out what they charge in advance, what they are going to charge for a basic blood test, what they are going to charge for a urinalysis, and makes a determination on who to see based on that.

And I have never encountered anybody when they are sitting on the paper sheet with the little piece of cloth between them and the doctor, who said, “No, I don't want you to run that test because that might be costly.” As a matter of fact, what I see is patients who generally defer to the expertise of the doctor. So how do you see this consumer-driven system actually working in real life with real patients and real doctors?

**Dr. McClellan**. That is a very good question. Before coming into the Administration, I actually was an internist and saw a lot of patients, and got to experience first-hand some of the problems of what happens when patients and doctors working together don't get to make health care choices. That happens very often in Medicaid plans that keep costs down by restricting the types of

treatments that are covered, and the prices, and the access to physicians and specialists.

**Ms. Rivers**. That is not consumer-driven. You were talking about consumers making these kinds of choices.

**Dr. McClellan**. The best way I think for patients to make decisions is with support from their doctors, and with patients and doctors together thinking about both the costs and the benefits of the treatments they receive. And I think health plans in which government bureaucrats, or HMO bureaucrats, or others are making decisions for them by telling them what they can and can't get is the wrong way to go.

**Ms. Rivers**. The theory is lovely. I hear it all the time. But I am trying to understand, in practical application, where you see consumers changing their choices and bringing down the costs?

**Dr. McClellan**. Over the last 10 years we have seen patients moving from plans that are HMO style plans that were very popular in the early 1990s, towards plans that give them more choices of which doctors to see, and which treatments to get.

**Ms. Rivers**. That costs more money. The point that I am trying to get to is I want to see the reality of this proposal that somehow under a particular system consumers will now start shopping doctors for price, and will now start intervening to keep certain kinds of tests from being run because of costs. Because, frankly, that goes against everything I have seen in terms of how people behave about their health.

**Dr. McClellan**. As I understand, this Committee heard several weeks ago from a number of innovative new plans that encouraged patients to work with doctors to figure out how to treat their health.

**Ms. Rivers**. In theory. That is what they encourage in theory, but what I am looking for is real application.

**Dr. McClellan**. Well, I guess I would also point to the fact that many people, including many federal employees, have moved to plans that require them to pay something out-of-pocket when they go outside the network, and they often do. Sometimes they don't. Sometimes they get less costly care from a network provider, but often they don't. That is the kind of choice that patients should be able to make. And we want to encourage those kinds of options being available.

**Chairman Johnson**. Thank you, Ms. Rivers.

Mr. DeMint, do you care to question?

**Mr. DeMint**. Yes, I do. Thank you, Mr. Chairman.

Thank you, Dr. McClellan. And I appreciate your complete testimony very much. Actually, I think Ms. Rivers has put her finger on one of the biggest problems we have in health care today. That it is probably one of the few systems we have working where neither the

consumer nor the provider have a vested interest in the cost. Why should we ask for cost information if we are not paying for it? And that is one of the reasons why many agree, including me, that health care costs are going up so rapidly, since neither the patient nor the doctor nor hospital have a vested interest in the cost.

Some of the things that you have listed in your testimony are very exciting; including what the Treasury Department did two weeks ago to revise their regulations to clarify that employers can give employees' money to actually shop for their own health care. This is a situation that has not existed, which I think could demonstrate in general to a lot of us in America that if they kill the cost they can save what they don't spend, and there will be more downward pressure on costs.

I am also interested in your support for the improvement of flexible spending accounts that would allow employees to get more invested with pre-tax dollars. I think is very important. Is this an issue of an expansion of HRAs that Treasury has created in effect, as well as an expansion improvement of FSAs? Is this something the Administration is really going to get behind and promote to give us the leverage we need in Congress to push some of these ideas through?

**Dr. McClellan**. I think so. And our hope is that the clarification that the Treasury offered recently will provide some momentum for that. One reason, as I understand it, that the Treasury did announce this guidance when they did was they wanted to do it in time for employers that are formulating their health plan choices for next year right now to be able to take this into account.

And you all heard recently from some groups that are working with employers to offer these kinds of new benefits. Our hope is that we will see a number of employers now stepping forward. They have been telling us they want to have these kinds of flexible approaches to providing health care assistance.

We hope that is going to come to pass soon, and that it will provide more momentum for the kinds of legislative proposals that are really needed. The health account reimbursement clarification that the Treasury offered is a good first step, but it is not quite as flexible as flexible spending account rollovers would be, or as a true medical savings account that actually works would be.

So we think this is a step in the right direction, and we hope to work with you and other Members who have expressed concerns about these steps as well. One of the things that we will be continuing to work on is to clarify that in fact the kinds of reforms that we support in MSAs and FSAs will make them more attractive to people with significant health care expenses not less.

They will reduce and address the problems of so-called adverse selection that many critics of these proposals have made. And I think the kinds of plans that many companies are going to be implementing next year, as a result of the IRS guidance, will provide further evidence on that score.

**Mr. DeMint**. Excellent. Thank you very much.

**Chairman Johnson**. Thank you, Dr. McClellan. I appreciate your time and your testimony. You are working for a better America, and we all appreciate that. Your testimony has concluded and you may step down now. Thanks again for being here.

**Dr. McClellan**. Thank you all very much.

**Chairman Johnson**. I would ask our third and final panel of the day to come forward and take their seats please.

Our first witness on the third panel is Mr. Harry Kraemer. He is Chairman and CEO of Baxter International, Inc. Mr. Kraemer is here today on behalf of the Healthcare Leadership Council. Our second witness is Mr. Ron Pollack. Mr. Pollack is Executive Director of Families USA. And our final witness today is Mr. Joseph Rossmann. He is Vice President of Fringe Benefits for the Associated Builders and Contractors. Mr. Rossmann is testifying on behalf of the Association Health Plan Coalition.

Before the witnesses begin their testimony, I would like to remind Members we will ask questions after the complete panel has testified. In addition, Committee rule 2 imposes a five-minute limit on all questions. And I think after watching the previous panels, you all understand the green, yellow, and red lights down there.

Mr. Kraemer, you may begin your testimony now. Thank you very much.

## *STATEMENT OF HARRY M. JANSEN KRAEMER, JR., CHAIRMAN AND CHIEF EXECUTIVE OFFICER, BAXTER INTERNATIONAL, INC., DEERFIELD, IL, TESTIFYING ON BEHALF OF THE HEALTHCARE LEADERSHIP COUNCIL*

Thank you, Mr. Chairman and Members of the Subcommittee for inviting me here today. It is an honor to represent my fellow members of the Healthcare Leadership Council, as well as to share my own perspectives as Chief Executive Officer of Baxter International.

The Healthcare Leadership Council, or HLC, is a coalition of chief executives from America's leading health care companies and institutions, all of whom are committed to advancing a market-based health care system that values innovation and provides accessible, high quality care for all Americans.

Let me begin, Mr. Chairman, by applauding you and your colleagues for the attention and energy you are devoting to our nation's uninsured. Like you, the members of the Healthcare Leadership Council are deeply concerned about this issue. We are concerned about the lives of 40 million people who lack health insurance. We are concerned about men, women, and children who are forced to receive their care in emergency rooms and acute care facilities, and who are suffering from avoidable illnesses and dying at too young an age. And we are also concerned about the

impact this issue has on the cost and accessibility of health care for all Americans, and the well being and productivity of our communities. In short, we believe the status quo is troubling and costly on many levels, and entirely unacceptable.

When the Healthcare Leadership Council took on this issue, we first asked the question, "Who are the uninsured?" The answers that came back from our research surprised us. Conventional wisdom about the uninsured labels people without health care as someone else, someone who doesn't have a job, someone living in extreme poverty, in short, someone people hear about, but don't really know. The truth, as I know you are now aware, is that we do know the uninsured. It may very well be your next-door neighbor, a cashier at the local market, or the person who runs our local day care center. We don't have to look far to find uninsured Americans.

It is impossible to put together a profile of a typical uninsured individual because this is a problem that crosses socioeconomic lines, but there are a few things we do know. Most uninsured Americans, 8 of every 10, live in a household in which there is at least one person currently working. We know that the smaller your workplace, the more likely you are to be uninsured.

Among businesses with fewer than 10 employees, one in every three workers is uninsured. Among those with 25 to 99 employees, it is one in every five. Many of these people are not eligible for programs like Medicaid or SCHIP. And even if they are eligible, large numbers of them are not applying for benefits.

If you are Hispanic, you have a 33 percent chance of being uninsured; if you are African-American, the likelihood is 20 percent; and if you are a young family, say between the ages of 18 and 24, most of these folks will be uninsured, and their offspring are among the 8.5 million children who do not have health coverage.

Knowing what we know about the uninsured, that the vast majority is in working households, and that the problem is focused to a large degree within small Main Street businesses, we can begin to structure workable solutions. The members of the Healthcare Leadership Council advocate a three-pronged approach to this problem:

First, use refundable tax incentives to encourage the purchase of insurance, including employer-covered insurance.

Second, improve our existing public programs like Medicaid and SCHIP so that they do a better job of enrolling those currently eligible. Also, Congress and the Administration should give states greater flexibility to use those program dollars to help low income workers afford private coverage.

And, third, provide a greater awareness among small business owners and low-income workers on the importance and availability of health coverage.

There is much we can do to increase health coverage among small businesses. Studies have shown that many small business owners do not know the cost of health insurance for their employees. Many, in fact, also don't know that health coverage is 100 percent tax deductible. The

Kaiser Family Foundation conducted a survey of small business owners who don't provide coverage for their employees, and asked those employers what they could afford and what they would be willing to pay for insurance. Remarkably, the price they listed was nearly adequate to purchase coverage. This tells us that we can reduce the number of uninsured Americans by providing small employers with credible, useful information on the cost, as well as the availability of health coverage.

Within HLC's Health Access America campaign, we have launched the Main Street Initiative to look at ways to increase the level of healthcare coverage among small business owners. We envision, for example, developing websites that would provide nationally publicized health insurance information for small employers. We foresee widely distributed regionally tailored materials giving costs and benefit comparisons of locally available health insurance products. There is much we can learn and model from the many successful local and regional programs around the country, programs in which employers, employees, and local governments collaborate to make coverage more accessible.

Once again, this Committee deserves appreciation for the work it is doing individually and collectively to help Americans without health insurance. The primary thought I want to leave with you today is that the health care industry stands enthusiastically ready to work with you to bring a healthier, fully insured America. Thank you very much.

WRITTEN STATEMENT OF HARRY M. JANSEN KRAEMER, JR., CHAIRMAN AND CHIEF EXECUTIVE OFFICER, BAXTER INTERNATIONAL, INC., DEERFIELD, IL, TESTIFYING ON BEHALF OF THE HEALTHCARE LEADERSHIP COUNCIL – SEE APPENDIX E

**Chairman Johnson**. Thank you, sir. I appreciate your testimony.

Mr. Pollack, you may begin your testimony now.

## *STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA, WASHINGTON, D.C.*

Thank you, Mr. Chairman, for inviting me to testify. Thank you for conducting this hearing.

As you said at the beginning of the hearing, there were 39 million Americans who were uninsured in the year 2000. By our estimate, another 2.2 million Americans lost health coverage as a result of losing jobs during the recession of 2001, leaving about 41 million Americans uninsured. That is more than the aggregate population of 23 states plus the District of Columbia. That is

extraordinary. So I think it makes a great deal of sense for us to focus on this issue.

And, clearly, I don't think progress is going to be made on this issue unless we try to find change that is done in a bipartisan manner, and find ways to combine public, as well as private sector approaches to expand coverage. Having said that, Families USA believes that certain approaches are far less effective than others, and that the public program approach building on Medicaid and SCHIP makes the most sense.

Let me focus on two of these issues that are private sector initiatives. The first is individual tax credits. There are two major problems with individual tax credit approaches currently being considered including the President's proposal that provides a $1,000 tax credit for individuals with incomes below $15,000, and families up to $2,000, that have incomes up to $25,000.

The first problem is that the size of the tax credit is much too small to make meaningful health coverage affordable. We, at Families USA, undertook a 50 state survey using e-health insurance to shop for the best insurance policies available for a healthy non-smoking 25-year-old woman and 55-year-old woman. Here is what we found. The average cost of the most popular FEHBP plan, the Blue Cross/Blue Shield Preferred Provider Organization Plan for a healthy non-smoking 55-year-old woman was $4,934. For a healthy non-smoking 25-year-old, it was $2,459.

Now if you take that amount of money that has to be spent over and above the tax credit for individuals with incomes below $15,000, what you will find is that it consumes a very high proportion of their resources. And for most people in that circumstance, it is like throwing a 10-foot rope to somebody in a 40-foot hole.

Let me tell you what we found specifically about policies for 55-year-old women. Among the 50 states, 47 out of 50 states did not have a single plan that was sold for $1,000, which is the size of the tax credit. Only three states did, Connecticut, Ohio, and Maryland. And for those states the deductibles in each of those plans was $5,000, in other words, one-third of the income of the target population. Clearly, that is unaffordable. For 25-year-old healthy, non-smoking women, there wasn't a single plan available in 19 states.

In the other states, the plans had high deductibles. Doctor visits were not covered in 18 states; prescription drugs were not covered in 19 states; maternity care for this very population was not available in 28 states. Mental health coverage was not covered in 22 states. In effect, these were Swiss cheese policies that had much more holes than they had cheese.

Our second concern is that this proposal is likely to jeopardize the coverage for people with health conditions. Because, clearly, what this is intended to do is to move people into the individual market and away from the employer market.

Clearly, people who have health conditions, or who have disabilities, are going to find that insurance companies do not want to sell to them. To the extent they do want to sell, they charge exorbitant premiums, and they don't make clean offers. So we think that the tax credit approach has severe limitations.

With respect to association health plans, Congressman Tierney raised questions earlier about some of the consumer protections. Let me raise one of those issues. In Rush Prudential HMO v. Moran, which was a recent Supreme Court case, it upheld the right of states to establish independent appeals rights. So if somebody feels they have been improperly denied or delayed care, states have established external independent appeals rights, so you can get a quick decision. So if you have been improperly denied care, you can get that care quickly. AHPs would be exempt from those laws, and they would join the approximately 60 million people who are currently exempt from these state regulations, and those folks would be left out in the cold. The response by Dr. McClellan was that we would leave this up to ERISA regulations. Unfortunately, ERISA regulations do not have external appeals rights.

I would be happy to go over other concerns about AHPs, but I see my time is up.

WRITTEN STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA, WASHINGTON, D.C. – SEE APPENDIX F

**Chairman Johnson**. Thank you Sir, we appreciate your testimony.

Mr. Rossmann, you may begin your testimony. I thank you for being here.

## *STATEMENT OF JOSEPH E. ROSSMANN, VICE PRESIDENT OF FRINGE BENEFITS, ASSOCIATED BUILDERS AND CONTRACTORS, ROSSLYN, VA, TESTIFYING ON BEHALF OF THE ASSOCIATION HEALTH PLAN COALITION*

Thank you. My name is Joe Rossmann. I am the Vice President of Fringe Benefits for Associated Builders and Contractors, ABC. I am testifying today on behalf of a coalition of organizations that support H.R.1774, the Small Business Health and Fairness Act of 2001.These organizations represent over 12 million small employers and 80 million workers.

The problem with small business workers not having access to affordable health benefits is reaching crisis proportions. To cite just one example, in Houston, Texas, Acoustical Concepts, an ABC member, was forced to accept a premium increase of 47 percent this year, even though they had no significant claims. Also, their insurance company informed them that in the next one to two years, they would only be offered catastrophic coverage.

Massive premium increases are typical of what businesses are facing throughout the nation today. And many employers are cutting benefits as a result. Currently, initiatives aimed at expanding access to affordable health care are not working. Our coalition strongly urges Congress to enact bipartisan association health plan legislation, and to help expand coverage to the

uninsured.

AHP legislation will empower small entrepreneurs with the same tools that large employers and unions use today to make coverage affordable with economies of scale and increased bargaining power, administrative savings from having one uniform set of rules, the option of self-funding, health plan design flexibility, and increased competition in health insurance markets.

We estimate that AHPs can reduce the cost of health insurance by 15 to 30 percent for small business workers. Association health plans have already proven that they can deliver such savings. For example, an association health plan sponsored by ABC had total expenses of $.13 1/2 on every premium dollar. This is in contrast to the small employers who can purchase the coverage directly from insurance companies and often pay total expenses of $.25 to $.35 on every premium dollar. Moreover, any profit generated by an AHP does not go to the stockholders and the insurance company, but rather stays in the plan for the benefit of participants keeping rates lower in the future.

Unfortunately, we had to discontinue the health insurance portion of our fully insured AHP a few years ago, when our insurance carrier informed us that they were terminating coverage. The problem is that it is just too costly and too complex for insurance companies to comply with the overlapping inconsistent and incompatible state laws. Thus, a badly needed source of dependable, quality health insurance coverage for small employers has been removed from the marketplace.

Workers in small businesses desperately need to have a new mechanism to group together to increase their bargaining clout and create more competition in the health insurance markets. This is true more so today because of the massive consolidations among insurance carriers, hospitals, and other providers. Recent mergers of health insurance companies have reduced competition, and likewise reduced choices for small employers.

I would like to address several of the issues that have been raised by the opponents of the AHP legislation. First, the opponents claim that AHPs will cherry pick the market and only benefit healthier groups. These assumptions under which the argument is made don't hold up under scrutiny. Under HIPAA, association health plans cannot exclude high-risk employers or individuals. They must accept all members of the association. Also, opponents' allegations about adverse selection rest on the mistaken assumption that AHPs will only offer bare bones benefit packages.

There is broad agreement that bare bones benefit plans have failed in the past due to the lack of demand. This is because small business workers want quality benefits like those enjoyed by workers in large companies. Also, small businesses must offer benefits comparable to those in large companies if they are going to attract and retain quality employees. AHPs will be able to offer Fortune 500 style benefit packages to small businesses by achieving the savings through economies of scale, greater bargaining power, and adding value for the members, not by cherry picking.

The other major criticism is the benefits offered by AHPs will not be secure. This ignores two important facts. First, association health plans under this legislation are fundamentally different from MEWA health plans. Second, it ignores the strong solvency standards and new

criminal and civil penalties for combating fraud, which are contained in this bill. These provisions go well beyond what is required in corporate union plans in order to make sure that benefits are secure in the future.

In conclusion, the 12 million employers and 80 million employees represented by our coalition urge Congress to enact H.R.1774. It is an essential component to any solution aimed at reducing the uninsured population.

Thank you again for this opportunity, Mr. Chairman.

WRITTEN STATEMENT OF JOSEPH E. ROSSMANN, VICE PRESIDENT OF FRINGE BENEFITS, ASSOCIATED BUILDERS AND CONTRACTORS, ROSSLYN, VA, TESTIFYING ON BEHALF OF THE ASSOCIATION HEALTH PLAN COALITION – SEE APPENDIX G

**Chairman Johnson**. Thank you, sir. I appreciate you being here. In your testimony you indicate mergers of health insurance companies that reduce competition and provide alternatives for small employers. I think you have been ahead of the curve with your organization. We appreciate it.

Mr. Tancredo, do you care to question?

**Mr. Tancredo**. Thanks. I have just a quick question, Mr. Chairman

In listening to this debate, in my own mind it boils down to a basic division of philosophy or ideas with regard to the government's role in this arena. And we really have devised a lot of ways to describe our position, vis-à-vis these plans. They are really based upon whether we believe down deep that any plan that is administered by, or has any participation by the private sector is either bad or good depending where you stand philosophically. Or on the other hand, whether we believe philosophically any plan that is essentially administered by a government agency has internal benefits that are worthy deliberation. That is really what we are talking about. Is the government better able to determine the kind of health care that all Americans should receive, thereby, eliminating this bizarre idea of individual choice or not? I am concerned about that. I don't believe that in the past it has ever shown its ability to actually provide a better kind of experience.

Mr. Rossmann, I am really interested in why your organization, and why people in private industry are not saying, "Let's have a full blown government health care plan that we no longer have to administer. It would have nothing to do with us. Let's just shove this whole thing on the Federal Government, and get out of the business essentially." I mean I have great concerns about what would happen, but I am more interested to know why it isn't a logical position for you to take.

**Mr. Rossmann**. I guess I would respond by saying that, our country was founded upon small business and small employers. And I think the private sector and competition goes a long way to make health insurance coverage, and any other commodity more efficient and better for employees,

and for individuals in this country.

So I am a firm believer in private enterprise, and a firm believer in competition. And the thing that concerns me is the fact that we have less and less competition in the health insurance market than we have ever seen before. And that is part of our problem. So I hope we can bring more competition back into the equation to help make coverage more affordable for small employers.

**Mr. Tancredo**. Thank you. I think it has certainly been a benefit to those of us who are Members of Congress, all federal employees that actually have plans that offer a wide variety of options. It is a great thing.

For the most part, I have noticed over the many years that I have actually been able to participate in a federal plan, before I was in Congress I was Regional Director of the U.S. Department of Education that my benefits actually improved over the years because I was able to select from a wide panoply of opportunities. And I wasn't trying to determine what the best procedure was for any particular condition. That wasn't the issue that I was trying to determine. I was trying to find, of course, the greatest scope of coverage for the least amount of money. I was looking for, how much out-of-pocket expenses there were going to be, and what the greatest scope of coverage would be.

And I think that has made the federal plan, very, very positive, and very good. It has improved all the time. And I have always been in a quandary in my own mind as to why we can't replicate that for millions of Americans through the AHP process that you are describing for instance.

**Mr. Pollack**. I don't think our choice is either/or. I don't think our choice is either 100 percent private sector, or 100 percent public sector. Those of us who get coverage through our employers, as I do, are satisfied with that coverage, and we want to see that strengthened.

There are a good number of populations, however, that do not enjoy the benefit of employer-provided coverage or other private sector coverage. The start of the Medicare program began because the private insurance industry failed and refused to provide health coverage for most of America's senior citizens. And we needed a public program to make sure that the most vulnerable senior citizens would get health coverage. They would not have received it otherwise.

Similarly, with Medicaid and SCHIP, there are low-income families and individuals who are not desirable from an insurance company standpoint, who would not get coverage without public insurance. So I don't think it is an either/or proposition.

**Mr. Tancredo**. Defending my time for just a second then. I certainly agree with you that there is a need for government participation in the process for the people that you have described. But when you start talking about Medicare, from my point of view anyway you have accurately described why we have a problem, because with Medicare you have the government making a determination as to what the costs are going to be, and what we are going to fund. And the whole range of decisions is made by a governmental agency.

We can change that, and we should, not by saying the government has no responsibility but by simply changing who makes the decisions for the "government to individual" process. And that's what I hope we can get to in this particular piece of legislation.

**Chairman Johnson**. The gentleman's time has expired. I might add, I am on Medicare, and I don't like it. I would like to have a private plan.

The gentleman from New Jersey, Mr. Payne, is recognized.

**Mr. Payne**. Thank you very much.

There are a lot of people that are under 65 that wish they had the Medicare plan that you have and don't like, because they don't have anything.

As a matter of fact, I think that with the inception of the HMOs 20 or 30 years ago, there were prognostications that they were a cure-all, and the answer was I believe that the early ones basically insured healthy people. In New Jersey, before they were popular or well known, HMOs were insuring healthy people, and therefore rates were low. Everybody was touting how great this new HMO business was. And there was a lot of whispering going around about them.

However, once you got in it, it was almost like an inverse chart. It wasn't designed that way, but it was just that the types of businesses participating had healthy people employed. Once we got into the whole mix that is when we found that it was not cracked up to be what the folks were talking about 25, 30 years ago.

Mr. Rossmann, in your statement, you stated that AHPs would increase bargaining power and limit cherry picking. But under proposed legislation, an AHP organization will be able to set prices for each individual company based on their individual worker's characteristics. Could you clarify that?

**Mr. Rossmann**. Yes, sir. In general, the association health plan would set its level of rates based upon the entire pool, if you will, or the community of the association. A firm can be rated to the same extent as under state law today, based on the demographics, location, ages, and health status of the people, but only at the same limits as various states today.

Did I make that clear, or did I confuse the issue?

**Mr. Payne**. Yes.

**Mr. Pollack**. Actually, I don't believe that the legislation reflects that. I think that there is no such limitation because state regulation is preempted as a result. And so, the rules that would prevent this kind of cherry picking through discriminatory premiums would not exist with respect to those AHPs. And so, you could have the cherry picking phenomenon as a result of those very different premiums.

**Mr. Rossmann**. I would respectfully disagree, and be glad to show it to you later if you would like. There is specific language for that. Also, the association health plans would not be cherry picking because they would not be developing a set of plans that were unique to a certain class of individuals within the association.

What bona fide associations are trying to do is to give coverage to all of their members. So they are not looking to pick a member here and a member there, or an employer here or there. They want to provide coverage for all of their members, and generate a risk pool based upon the demographics, and the risks, if you will, of that group.

**Mr. Pollack**. Let me give you a hypothetical situation that is not far-fetched.

You have an association of downtown, white-collar businesses that only applies to a certain geographical area of downtown. It excludes other parts of the metropolitan area. It does not include the low income, minority sections of town. You could create an association that could have another general purpose. And that association, in effect, would be cherry picking through its geographic location, in effect, redlining. And so, you would be able to exclude so-called undesirable risks through that kind of a process.

Obviously, that is not good for the remainder of workers. That might be very good for the white-collar, affluent, low cost workers. But for the remainder, who are going to wind up in a sicker pool, the costs for them are going to be considerably more expensive. So, in the totality, it is going to cause harm.

**Mr. Payne**. Right, that is what I was alluding to earlier when the HMOs, or they might have even been AHPs, started. They just occurred, as I indicated, in the healthier areas, where people who had something in common brought associations together. Maybe they all played golf every Saturday, or jogged every Monday, or consistently saw a doctor.

And so, I do believe that we have to be careful. Insurance in general is supposed to be pooling the risks. You take large numbers of people, whether it is Lloyds of London, or whether it is health insurance, and you see how many people there are, what you estimate the payments to be, and you spread the risks.

Cherry picking is against the whole basic concept on which insurance began. Back in 1875, Mr. John F. Dryden founded the Prudential Insurance Company, in Newark, New Jersey and the pooling idea treats everybody equally.

I will yield back the balance of my time.

**Chairman Johnson**. The gentleman's time has expired. We appreciate those comments, and I hope we get into that some more.

Mr. Wilson, do you care to question?

**Mr. Wilson**. Mr. Chairman, thank you very much.

Mr. Kraemer, we in South Carolina appreciate Baxter being a good corporate citizen. In fact, my oldest brother was a chemist for Baxter in King Street several years ago.

You mentioned that the Main Street Initiative might partner with local Chambers, development centers, and other business associations to provide information about insurance to small business owners. What kind of information do you see being provided? And how can government entities such as the Department of Labor or Small Business Administration (SBA) assist in the efforts?

**Mr. Kraemer**. Thanks for your question. I appreciate that. If you think about the discussion that we have had over the last hour-and-a-half, a lot of what needs to be done is to improve the level of education. The Healthcare Leadership Council believes that we should increase the amount of information and resources, through employer run plans, and government programs so that small businesses have a better understanding of what is going on.

I know a number of you have run small businesses. Some people depend on their local Chamber of Commerce, some people depend on their local accountant, and some people are more computer literate and access the web. But if we could provide information so that people could understand what is available, they could understand what the tax incentives really are. There is a very high percentage of individuals running businesses that aren't even aware that these types of premiums are tax deductible.

So if we can get that information to Chambers of Commerce, put it on the web, and make sure the local accountants are aware of it, we believe that just taking advantage of the programs that are available today could potentially take care of a portion of the uninsured who lack coverage simply because they lack correct information.

**Mr. Wilson**. Thank you very much.

Mr. Rossmann, in the district that I represent I am very fortunate that many of your ABC members are a vital part of our community, and particularly small businesses. And I appreciate your concern about the health care premium costs increasing for small businesses. Would you relay again with regard to AHPs how this would help small businesses reduce premiums?

**Mr. Rossmann**. It would basically give small businesses more choices through their association. An association could band together and go to an insurance company and negotiate rates and coverage on behalf of those small employers. Today's small employers are on an island all by themselves. And what they are essentially doing is going to large insurance carriers and just accepting the rates and coverage that are offered to them.

What associations can do, and what ABC has done for the past 40 years is to go out and negotiate with health insurance companies to provide packages of benefit programs and specific rates for those members. So it is mass purchasing power, if you will.

If I could backtrack, I would like to respond to Mr. Pollack's comment about "the association made up of white-collar individuals" in a specific zip code. The AHP legislation has specific provisions in it to recognize only bona fide associations that have been in existence for three years or more for purposes other than just providing insurance. They have to be legitimate associations like ABC.

In addition to that, the Certified Public Accountants Association in California did a study based on their health plan and compared it to the California small group market. And they found that even though they are a white-collar industry, their health plans were essentially very similar to what you would see in California's small group market. So I think that the idea that the white-collar is better than the blue-collar, or that there is some specific segment of the market that is better than another is somewhat of a misnomer.

**Mr. Pollack**. You know, I would like to just quickly respond. I didn't describe these as illegitimate associations. They are associations that could pick a very favorable constituency. But when you talk about saving money, where does that money get saved? It gets saved because it eliminates state regulation.

CBO informs us as to how that money would get saved. And CBO estimates that nearly two-thirds of the cost of savings from AHPs result from attracting healthier members from the pool of existing insured workers. So the point here is that while it is true that the AHPs may be able to have a cheaper product because they have a less risky population that is being insured, the remaining pools out there would then be robbed of having the ability to spread the risk more broadly to healthier populations, and would wind up spending more money. And, as a result, according to CBO, 80 percent of workers would be worse off under AHPs than if they did not exist.

**Mr. Rossmann**. If I might respond to that, Mr. Chairman, I would say the CBO Report had a couple of flaws in it, if you will. Number one, it didn't look specifically at association health plans. It looked at all types of pooling arrangements.

I can tell you from personal experience, the Associated Builders and Contractors plan had total expenses of $.13 1/2 cents on every dollar. If you go to the small employer market, expenses are
$.25 to $.35 cents on every dollar or premium. In addition to that, CBO made the assumption that the bare bones benefit plans cut the benefits, if you will, which is another mechanism in saving costs. I think our employers want quality benefits. Even small employers want quality benefits, so they can compete with large employers. So I feel that there were a couple of flaws in the CBO Report.

**Mr. Wilson**. Thank you, Mr. Chairman.

**Chairman Johnson**. Thank you. In grading America, we can have differences of opinion.

The gentleman from Massachusetts, Mr. Tierney?

**Mr. Tierney**. Thank you, Mr. Chairman. And thank all of you for your exchanges. I think they are helpful to a certain extent.

Mr. Kraemer talked about, the fact that he thought that education was an issue, and that with the proper amount of education he was confident that a number of small business employers would in fact buy coverage. They didn't realize there is a 100 percent tax deduction for one thing, or how accessible or affordable it could be.

So let me ask you, Mr. Pollack. Let's assume that small businesses really would pay the coverage. What if we were to mandate employer insurance coverage through employers, and that they pay a certain percentage of the premiums as an employer contribution with employees paying the balance. Then use SCHIP monies for people that may be at a lower income level to pay just the employee share of the insurance premium, or a pre-funded refundable tax credit to pay the difference on that. Would that make any impact on our coverage issues here?

**Mr. Pollack**. There is no question. I feel there are several parts to what you just asked.

**Mr. Tierney**. Is that right?

**Mr. Pollack**. Clearly, an employer mandate substantively would do a great deal to expand coverage, whether it is politically achievable is a very different matter. And, clearly, the business community would be strongly opposed to any kind of an employer mandate.

**Mr. Tierney**. Well, except that I gave information to Mr. Kraemer, who tells us that he believes that his group believes that small business employers made aware of certain factors would not object to it. Let's assume that.

**Mr. Pollack**. I actually assume that employers, particularly, large employers would embrace the employer mandate that was proposed and on the table in 1993/94. And we found that was not the case. I think it is a feasible method to expand coverage, although politically I think it is very difficult.

With respect to your other question, however, about subsidizing benefits through public programs, I think it is something well worth exploring with one major caveat, and that is that I would hate to have public programs subsidize coverage that is considerably lower in terms of what it covers than the requirements in some of the public programs, especially for low income people who need the coverage.

Let me give you an example. For children, one of the most important things to cover is a thing called EPSDT, Early Periodic Screening Diagnosis and Treatment. It provides preventive services. It diagnoses whether a child has got some kind of health problem, and then it treats them. Many plans do not provide that.

So I think that there are some possibilities along the direction that you suggested, but I would just caution to make sure that the public sector creates the same accountability, in terms of

what is covered through private plans, as it does through public plans.

**Mr. Tierney**. And I think the other thing that we haven't really discussed at any great length here today in all the plans is the cost issue, just the administrative costs because I know there were some shots taken at Medicare earlier.

But, frankly, I have to say that the costs for administration in Medicare is somewhere between $.03 and $.06 on the dollar. And it is about $.25 or $.26 cents on the dollar for the so-called private businesses of insurance, who do a miserable, absolutely abhorrent job of what they do. And for all of your laudatory comments about the marketplace and business being able to do it, they haven't done it in the health industry, and have done just a terrible, terrible job.

So I wonder if each of you would take a second at least to tell me what your thoughts are on how we would reduce the administrative costs of giving to the American people a healthcare system that had accessibility and comprehensive benefits.

I will start with you, Mr. Rossmann.

**Mr. Rossmann**. Thank you. I would go back to the example of ABC, and what we have done in the past.

Our total cost, which included ABC's administrative costs, delivering the product to the members, and also included the insurance company's costs, their risk charges, their claim payment costs, and all of those types of things was $.13 1/2 cents on the dollar. And I compare and contrast that to what you are saying today, that with the small employer market, the cost is $.25 to $.35 cents on the dollar.

**Mr. Tierney**. That is one. You cover one small segment of the market. That leaves a lot of other people covered otherwise. You know, I was really looking at the broad scope of our health care system what do we do to control costs?

**Mr. Rossmann**. I am sorry. I was specifically referencing association health plans.

**Mr. Tierney**. Right. So I have heard that. But now what about the rest of it?

**Mr. Rossmann**. The rest of the market? Well, I think we need to increase the competition, to a certain extent. You know the economies of scale go only so far I think, as far as insurance companies and administrative functions go. We talk about insurance carriers getting bigger and bigger and buying up other insurance companies under the perceived notion of economies of scale and I question that.

**Mr. Tierney**. Thank you. I am running out of time here, so I am going to move along.

**Mr. Pollack**. Let me give you one quick answer. We obviously just had a debate on the House floor, with respect to prescription drugs. It is the fastest rising cost in America's health care system. Here I think we could benefit from some significant competition.

Unfortunately, the brand name companies are preventing generic companies from coming to the market. They are suing them, thereby getting 30-month delays, in terms of generic drugs coming on the market. There are collusive practices where the brand name companies, after they have sued the generic companies, offer a deal of sometimes hundreds of millions of dollars, and in return the generic companies delay putting the generic drug on the market.

That failure to allow competition really hurts us all in the pocketbook. It fails to provide the kind of competition that can keep prices down. So that is one suggestion.

**Chairman Johnson**. Mr. Tierney, thank you. Your time has expired.

I think we will allow Mr. Tiberi to question if he so desires.

**Mr. Tiberi**. Thank you, Mr. Chairman.

Mr. Rossmann, you represent ABC. How many members are there?

**Mr. Rossmann**. There are 23,000 members.

**Mr. Tiberi**. What is the average size of a member group?

**Mr. Rossmann**. Our average size member group is probably about 15 to 20 employees. They are small employers. If you look at what we have under our insurance program, I would say the average size employer is about 15 employees.

**Mr. Tiberi**. And what type of work does the employer do, in terms of the 15 to 20 employees, white-collar or blue-collar? What is the mix?

**Mr. Rossmann**. Primarily, blue-collar, since our members are construction-related entities. And you would have craft employees involved, some administrative folks from the office, and probably the principal or the owner, and possibly the foreman too.

**Mr. Tiberi**. And your association supports association health plans?

**Mr. Rossmann**. Yes, sir.

**Mr. Tiberi**. I just wanted to get that clear.

Mr. Pollack, on page 13, in bold type you have, "AHPs leave many small employers behind with higher premiums." And next to you, you have a gentleman who represents small employers, mostly blue-collar employers, who are saying we want association health care plans.

Can you explain to us, why your statements conflict with a representative of small employers?

**Mr. Pollack**. It is not necessarily conflicting, but it does raise some serious issues for you as a legislator to consider. And that is I have no doubt that AHPs will reduce the costs for those employers who are in the AHPs. But if you take the discussion we had earlier, if what happens is that the companies that are part of the AHP have in them some of their least risky, in terms of health claims people in them, then what happens is the whole concept of an insurance pool really changes.

The purpose of an insurance pool is to spread the risk among high-risk people and low-risk people. When you and I buy homeowners insurance, or life insurance, I don't expect to die next year. I presume you don't either. I don't expect a fire in my house next year. I presume you don't either. But we are low risks, and as a result we can help subsidize through our being low risks, lower premiums for people who are going to have those problems.

To the extent that you take lower risk people out of the pool, and you leave in the pool only higher risk people, those people are left holding the bag because the cost per person for them is going to be considerably more expensive, and therefore their premiums are going to be higher. And for many of them it is going to become unaffordable.

**Mr. Tiberi**. I understand what you are saying, but the testimony that has been presented to us today states that not only is there a problem with the folks that you just talked about, but there is also a problem with employers not being able to afford health care coverage anymore. And we have small employers who are saying this would help them with that problem. And so, as legislators, sometimes it is better to take one bite of the apple than to try to swallow the entire apple.

What is your solution in terms of this particular issue of employers saying I can't afford to provide health care anymore, and thus my employees are going into that camp that you are talking about now?

**Mr. Pollack**. All right. First, we are not opposed at all. I thought I had made that clear in my written testimony, hopefully in my oral testimony. We are not opposed to employers banding together to get the benefits of banding together.

We are concerned about several things, which I think can be corrected, and I hope are corrected before we go forward with legislation. One is, I want to make sure that we minimize any opportunities for cherry picking. And I think there are some ways that we can achieve that.

Secondly, I want to make sure that plans, once they get established, do not have the kind of insolvency problems that MEWAs had years ago. I think any legislator who enacts AHPs, and then finds that you have those solvency problems is going to be sorely disappointed.

Groups like Families USA are not opposed to the concept. We are concerned about how it is being implemented. And we would very much be delighted to join with you and others to try to deal with some of these potential problems, so that we don't help some small businesses, and then harm a whole lot of others.

**Chairman Johnson**. Thank you. We are going to have to adjourn. We have about six-and-a-half minutes to make a vote.

I would like to ask Mr. Kraemer if you could answer a couple of questions in writing.

**Mr. Kraemer**. I'd be more than happy to.

**Chairman Johnson**. The first question is what are the advantages of covering the uninsured through employer programs versus SCHIP and Medicaid Programs? The second question is your testimony contained survey findings about small businesses that suggest many small business executives simply do not know the facts they need to know about the cost, and the administrative burden of insurance. And I would like to know why you think that is the case.

I appreciate all three of you being here, and thank you for your testimony. It was valuable to us. We certainly hope that you can come back sometime because I enjoyed the cross talk between the two of you.

Thank you for your testimony, and the Members for their participation. If there is no further business, the Subcommittee stands adjourned. Thank you.

Whereupon, at 3:50 p.m., the Subcommittee was adjourned.

***APPENDIX A - WRITTEN OPENING STATEMENT OF CHAIRMAN SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE***

**OPENING STATEMENT OF REP. SAM JOHNSON (R-TX)**

**CHAIRMAN, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS**

**Tuesday, July 9, 2002**

Today's hearing focuses on expanding access to health care for uninsured Americans.

On June 18th the subcommittee heard testimony about the rising cost of health care and how this impacts employers and employees.

In the last year alone, employers' health care benefit costs have increased by an average of thirteen percent.

This fact led the health economists at our last hearing to predict that a significant number of Americans would lose their health insurance if this alarming trend continues.

Because of the close relationship between health care costs and employers' ability to offer health insurance to employees, today's hearing will investigate how we can increase access to health care.

We will hear testimony painting a picture of the uninsured: who they are, where they work, and why they remain without health insurance.

Members of Congress, the administration and outside experts will highlight solutions for uninsured Americans -- solutions they believe will help put an end to this problem once and for all.

In the year 2000, 39 million Americans were uninsured. That means that one in seven Americans went without health insurance.

You might ask, just who are these uninsured?

Well they are working people who simply don't have access to insurance, or can't afford it.

Fifty percent of uninsured Americans work in small businesses. some of these people are offered insurance and turn it down because of the cost.

But many other employees in small businesses are not offered health insurance – leaving them without employer-sponsored coverage – our nation's primary form of insurance.

Why is this the case? one basic reason is affordability.

As we remember from our previous hearing, small businesses are subject to numerous state mandates, and often have access only to very expensive health coverage.

By contrast, their large business counterparts bargain for health care with the clout of a much bigger group.

Association Health Plans (AHP's) would solve these problems for small employers, letting them band together to bargain as a larger group, and giving them relief from costly state mandates.

Today we'll also hear about the congressional and white house support for these plans.

Additionally, we will hear testimony about other burdens that small employers face.

Many times these mom and pop shops simply don't have the time to investigate their health insurance options.

We'll hear about projects such as the "main street initiative" to help bridge this knowledge gap.

Over the years, congress has taken action to help the uninsured. for example, last year as a part of the patients' bill of rights, congress passed association health plans and medical savings accounts -- two measures that would greatly expand access to health coverage for uninsured Americans.

Unfortunately, these important initiatives that would reduce the number of uninsured have languished while the difficult political issues of the patients' bill of rights are debated.

Congress has also acted to provide health care assistance for dislocated workers.

This was done by way of tax credit provisions in the house passed economic stimulus package and the recently passed trade assistance act.

As the trade bill conference gets under way, debate will continue over the best way to provide health care assistance to workers who are in danger of losing their health insurance.

While congress debates these issues, 39 million Americans wait, wonder, and worry.... hoping that we will put aside our differences and offer them some help.

This subcommittee has jurisdiction over employer-sponsored health care coverage. the vast majority of Americans – 65 percent – have employment-based health insurance coverage.

Given this fact -- I would like to think that this subcommittee of all subcommittees COULD offer uninsured Americans some relief.

With that in mind, I look forward to working with my colleagues on the Subcommittee as we EXAMINE THIS ISSUE and potentially move forward with solutions to help these Americans.

Right now, I'd like to welcome all of our witnesses. We look forward to your testimony and THE

guidance it will offer us as we address the issue of the uninsured.

***APPENDIX B - WRITTEN STATEMENT OF CONGRESSMAN ERNIE FLETCHER, 6TH DISTRICT OF KENTUCKY, U.S. HOUSE OF REPRESENTATIVES***

**Testimony of Rep. Ernie Fletcher, M.D. (R-KY)**

**U.S. House of Representatives**

**July 9, 2002**

Thank you Chairman Boehner and Chairman Johnson and the all the Members of this Subcommittee, for inviting me here today to testify. As many of you know, I introduced H.R. 1774, the Small Business Health Fairness Act, on May 9, 2001.

Let me take a moment to note that there are 15 members on the full Committee that are cosponsors of H.R. 1774, including five members of the Employer-Employee Relations Subcommittee (Vice Chairman DeMint (R-SC), Rep. Donald Payne (D-NJ), Rep. Cass Ballenger (R-NC), Rep. Tom Tancredo (R-CO), and Rep. Joe Wilson (R-SC)). Also, 24 Members of the full Committee—including nine on the EER Subcommittee voted for the AHP amendment to the Patients Bill of Rights. As you know, this amendment passed the House (236-194 vote margin with 18 Democrats voting for it) and is included in the final House version of the bill. Thank you for your support.

America's growing healthcare dilemma calls for immediate Presidential and Congressional action. We must address the 40 million Americans that are currently without health insurance. The uninsured include some of the most vulnerable in our society--12 million children, 17 million low-income Americans, 7 million African-Americans, and 11 million Hispanics.

Those without health coverage confront barriers that discourage preventive care and delay disease diagnosis. They are more likely to be hospitalized for avoidable conditions. In fact, last year, nearly 40 percent of uninsured adults skipped recommended medical tests or treatment, and 20 percent did not get needed care for a serious problem. Consequently, studies reveal that morbidity and mortality rates among the uninsured are substantially higher than among those with health insurance.

As double-digit health premium increases and a weakened economy put more and more small business workers in jeopardy of losing their health benefits, we must turn our attention to the problem of the uninsured now. In light of the ongoing discussions between the President and the Senate regarding the Patients Bill of Rights, it is critical for Congress to take action on comprehensive small business health insurance reform. I feel strongly that this should include the enactment of the bipartisan Small Business Health Fairness Act of 2001 (H.R. 1774). Small firms deserve the opportunity to obtain high quality health insurance that is competitively priced. We need to bring Fortune 500 health benefits to the nation's Main Street small businesses and their employees.

I fear that the number of uninsured Americans will increase dramatically over the next few years, if we don't act now. Recently, the National Association for the Self-Employed (NASE) announced research findings about self-employed Americans and their attitudes towards Association Health Plans. NASE is the nation's leading voice for micro-businesses, four employees or less, and self-employed Americans. The NASE sponsored study profiles the dramatic challenges faced by the self-employed and micro-businesses in accessing affordable health insurance.

According to the recent NASE public opinion study:

> About three-fourths (75.1%) would be "very" or "somewhat likely" to participate in an Association Health Plan if it offered more choices in healthcare benefits for themselves and their employees.
>
> If the insurance through the Association Health Plan were less expensive, 78.0% said they would be "very" or "somewhat likely" to participate.
>
> If the Association Health Plan lessened paperwork and administrative burden, 72.7% said they would be "very" or "somewhat likely" to participate.

The Small Business Health Fairness Act creates new Association Health Plans (AHPs) for workers employed in small businesses and the self-employed. This bill will provide working families employed by small businesses, which make up 60 percent of the uninsured, with more health benefits and more health plan choices.

A recent GAO Report shows that the five largest insurance carriers combined have 75 percent or more of the market share in 19 of 34 states supplying information and more than 90 percent in seven of those states. Greater competition will benefit consumers by bringing premiums down and expanding access to coverage.

Lacking the bargaining power of large corporations, many of these businesses are priced out of the health insurance marketplace, reluctantly leaving their workers uncovered. AHPs address this problem by allowing small businesses to band together nationally into associations that can provide insurance to their members at lower cost.

Small businesses and the self-employed do not have the same advantages in the market place as do corporate and labor union health plans. In fact, small employers now pay 18 percent more for coverage than large employers. Moreover, corporate and union health plans operating under one set of rules across state lines are able to take advantage of the economies of scale.

As you may know, the three main arguments against AHPs are: 1) Adverse selection (cherry picking); 2) Inadequate solvency standards; and, 3) Inadequate oversight enforcement.

Let me address these myths regarding AHPs:

First, it is illegal for AHPs to deny coverage based on the health status of an individual employer or employee under HIPAA. "Cherry picking" is possible only when sick or high risk people who will generate significant claims can be denied coverage;

Secondly, the bill contains strict requirements under which only bona fide professional and trade associations, which exist for substantial purposes other than providing health insurance for at least three years, can sponsor an AHP. The bill strictly prohibits health plans that are set up only to offer health insurance or to accept only good risks;

Thirdly, to the extent that low and high risk industries can be identified, the bill only allows new self-funded AHPs in industries with average or above average risk profiles, thus preventing self-funded AHPs from forming in low risk industries;

Fourthly, opponents' allegations about adverse selection rest on the mistaken assumption that small businesses will only offer "bare bones" benefit packages through AHPs. However, small business owners and workers desire the same benefit packages as large business workers, and small businesses must offer comparable benefit options to attract and retain employees; and,

Fifthly, adverse selection that currently exists in state markets will be greatly reduced when younger, healthier workers employed in small businesses who are now uninsured are able to obtain coverage that is affordable.

The Small Business Health Fairness Act of 2001 (SBHFA) (H.R. 1774/S. 858) contains tough new solvency provisions which will actually increase consumer protections for many small business workers. The Department of Labor's Inspector General has testified before Congress that the new enforcement tools for regulators contained in this legislation will help reduce health insurance fraud. The bill gives federal and state authorities new and better enforcement tools to ensure that coverage is secure and to prevent health insurance fraud:

AHPs must register with the state in which they are domiciled;

AHPs must abide by strict disclosure and actuarial reporting procedures; and,

The bill provides new criminal and civil penalties to combat fraud.

Allegations that health coverage obtained through AHPs will be anything less than secure ignore these strong protections contained in the bill. AHPs are fundamentally different from Multiple Employer Welfare Arrangements or MEWAs, which generally will not qualify as AHPs under the new certification process.

Creating new AHPs will help reduce the problem of fraud and abuse among health plans. H.R. 1774 establishes new AHPs with clear regulatory authority; whereas, many of the problems with MEWAs resulted from unclear regulatory authority and/or lax oversight by the states. With more choices provided to small businesses through AHPs operating with strong new solvency and certification standards, small businesses will have a secure alternative to MEWAs.

H.R. 1774 contains new solvency standards, which are equivalent or stronger than virtually all state insurance laws for association plans. The solvency standards include claims reserves, surplus capital reserves, stop-loss insurance, and back-up indemnification insurance to cover all claims in the event that a plan is terminated.

H.R. 1774 establishes new certification standards that do not duplicate current law under ERISA. This ensures that only bona fide trade and professional associations can sponsor AHPs which are in the best interests of the beneficiaries.

AHPs under H.R. 1774 are fundamentally different from MEWAs, which can be operated by anyone. The bill gives the Department of Labor (DOL) enhanced criminal and civil enforcement powers currently not available to regulators. New "cease and desist" authority will help stop health insurance fraud by terminating bogus small employer and union health plans.

Association Health Plans (AHPs) would be regulated in a manner similar to how single employer (corporate) and labor union pension and health plans are currently regulated. Thus, the bill does not require an entire new bureaucracy to ensure that AHPs are properly regulated.

> The DOL already regulates association-sponsored health plans for compliance with current federal laws governing group health plans. The SBHFA strengthens solvency standards and certification rules to plans operated by qualifying bona fide trade and professional associations.
>
> The DOL is devoted to identifying, investigating, and disbanding fraudulent MEWAs. This is the case for many state insurance departments as well. Since the bill provides new enforcement capabilities that will assist DOL and state insurance departments in identifying and shutting down fraudulent MEWAs and preventing new ones from getting started, resources can be redirected to the regulation of bona fide AHPs under new standards in the law.
>
> The bill provides that associations applying for certification as a federally-regulated AHP must pay a $5,000 filing fee, which will generate resources to enhance enforcement of the new law.
>
> The bill allows the Secretary of Labor to consult with the states in regulating AHPs and provides that new self-insured AHPs be subject to

> the assessment of state premium taxes or equivalent assessments, thus providing resources that can be used for regulatory responsibilities.
>
> The bill gives the DOL enhanced criminal and civil enforcement powers currently not available to stop health insurance fraud by terminating bogus small employer and union health plans. Illegitimate entities will become criminal enterprises, and the DOL will have new "cease and desist" authority to curtail such activities. The DOL Inspector General has testified that the bill's consumer protections are "important and necessary in stopping health insurance fraud."

Bona fide trade and professional associations can be trusted to operate health care plans in the same manner as labor unions and large corporations. If the labor unions are trusted to operate health care plans, trade and professional associations should be trusted, too. Long-standing organizations like the National Federation of Independent Business (NFIB), the U.S. Chamber of Commerce, Associated Builders and Contractors, etc., can be trusted with ERISA preemption similar to that extended to unions and corporations, particularly with the extensive new certification and solvency protections in the legislation.

H.R. 1774 preserves consumer protections enacted by state governments and expands opportunities for access to affordable health coverage.

Declining competition in the state small group markets is driving up premiums and adding to the ranks of the uninsured at record levels. The overwhelming trend in the state markets is less and less competition, which leads to fewer choices, smaller benefit packages, and rapidly escalating premiums for small business workers. H.R. 1774 can change this.

Association Health Plans (AHPs) would provide greater economies of scale to spread costs and risk, increase group bargaining power with large insurance companies, and reduce administrative costs for all members.

It is only fair that we should level the playing field and allow small businesses and the self-employed access to the same opportunities in health insurance coverage that large corporations and labor unions now enjoy. The Small Business Health Fairness Act would rectify this inequity by providing small businesses with similar opportunities to operate health plans under one uniform set of rules via bona fide trade and professional associations. This would provide workers with the benefits of greater economies of scale, more bargaining power with large insurance companies, reduced administrative costs, and greater benefit design flexibility. This bill will also inject competition into markets where it is severely lacking, thus further reducing premiums for workers. One independent study has concluded that AHPs could reduce premiums by up to 30 percent, and it is estimated that up to 8.5 million uninsured workers and employed by small businesses and their dependents would gain coverage if Congress enacts this legislation.

It is past time to pass the Patients Bill of Rights bill, including the Small Business Health Fairness Act, for the President's signature. The President, Vice President, and the Department of Labor have made AHP legislation a top priority within the Administration's health care and small business agendas. It is past time for Congress to make this important piece of legislation a priority. I urge Members of this important Committee to support action on Association Health Plans. It is important for the House to consider this bill, so that AHPs can be sent to the Senate and hopefully to the President's desk before the end of 2002.

Passage of any legislation, such as a Patients Bill of Rights or an uninsured package, will be a Pyrrhic victory if more Americans become uninsured due to the inevitable cost increases resulting from HMO reform, or if the package fails to address AHPs. We must properly address the health threat of rising cost and decreasing access, especially to the most vulnerable of Americans.

I can't put enough emphasis on the fact that delaying this issue continues to hurt the most vulnerable Americans. AHPs must become law this year. The most important patient protection is access to affordable health care coverage. As David Broder wrote recently, HMO reform alone "is likely to increase cost and could even aggravate the problem of wasteful expenditures for services of little or no health value by forcing HMO doctors to practice 'defensive medicine' to ward off lawsuits." We will do a terrible disservice to the American people by passing a bill designed to "protect" patients that ends up leaving millions of our fellow citizens "unprotected." We cannot be willing to hurt the most vulnerable - minorities and low-income folks - in America for the hope of a political victory.

***APPENDIX C - WRITTEN STATEMENT OF CONGRESSMAN JOHN F. TIERNEY, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE***

**Testimony of Rep. John F. Tierney (D-MA)**

**U.S. House of Representatives**

**July 9, 2002**

Mr. Chairman, and members of the Subcommittee, thank you for allowing me to testify before you today. As a co-chair of the House's Universal Health Care Task Force and as a member of this Subcommittee, I am pleased that we are taking the time to investigate the issue of expanding access to quality health care to all Americans.

In the last 10 months, our nation's attention has rightly been focused on homeland security. But we cannot ignore the most basic of security issues: our health. Defending our borders, making our skies safer and preventing biological terrorism will not be as meaningful if an increasing number of Americans lack basic health care coverage.

Throughout my time in the House, I have made expanding health care to all Americans one of my top priorities. For this reason, I am proud to be one of the 86 co-sponsors of H.Con.Res. 99, directing Congress to enact legislation by October 2004 that provides access to comprehensive health care for all Americans. The resolution also states that universal health care must remove financial barriers to needed care; must be comprehensive; must be fair and eliminate disparities based on age, income, race; must be affordable and of high quality; must have continuity; and maximize consumer choice.

We have set ourselves achievable goals. All we need is the will to get there. Unfortunately, as we know all too well, the devil is in the details. We need to work as a Congress to create a plan or plans that meet all of the criteria set out in H.Con.Res. 99. Until we reach that goal, we need to take the incremental steps needed to address the very real problem of inadequate health care facing a shamefully large number of Americans.

For this reason, I have introduced H.R. 1033, States' Right To Innovate in Health Care Act, which seeks to provide grants and flexibility through demonstration projects for states to provide universal, comprehensive, cost-effective systems of health care coverage, with simplified administration. We currently have 45 co-sponsors, many of whom are members of this Committee.

Under the bill, a state would be allowed to pool its own resources with any federal health care funding that it would otherwise receive. Federal laws or regulations that might prevent states from proceeding could be waived so long as all protections and

benefits currently enjoyed under federal programs in which the state participates would be maintained. States would be given one-time grants to cover the "start-up" costs of transitioning to their new programs.

The bill allows states to explore their innovative ideas. It may well be that rural areas prefer different solutions than urban areas, and the bill would let the states develop a system unique to their needs. From this we should get a model or models upon which others could base successful coverage plans.

Another step we can take is to ensure that retirees who have been promised health care by their former employers do not find those benefits subsequently reduced. That is why I have introduced H.R. 1322, the Emergency Retiree Health Benefits Protection Act. The bill's intent is to keep companies operating, earning and employing people, so it provides for exceptions if reinstating coverage would truly cause cancellation of current worker coverage or financial calamity for the business. For those who could perform, but need assistance, the bill would prevent companies from cutting or eliminating retiree health benefits and would restore benefits to retirees who have already lost coverage. The bill would also establish the Emergency Retiree Health Loan Guarantee Program and its Board. The Board would be authorized to guarantee loans provided by private banking and investment institutions to eligible plan sponsors to assist them in meeting obligations under the bill to restore benefits reduced after retirement. H.R. 1322 has 91 co-sponsors and counting.

At the same time, we should not be neglecting the health care needs of individuals who have lost their jobs and corresponding health insurance. Rep. Jim McDermott, who as a doctor knows first hand the challenges of providing medical care, has been a leader in the fight for universal health care. He has introduced H.R. 3341, the Putting Americans First Act, which would provide a 75 percent federal subsidy of COBRA premiums to those who lost their jobs after Sept. 11. Further, it gives the state the option to pay for the remaining 25 percent of the COBRA premium with Medicaid funds. H.R. 3341 also allows states to liberalize their Medicaid programs so those low-income individuals who lose jobs that did not provide health insurance would be covered by Medicaid. 201 Members of this House, including me, have signed a discharge petition to bring this bill to the floor. I am hopeful that we will soon be able to take that step.

But we know that the poor, unemployed and retired Americans are not the only people without proper health care. In too many cases, businesses are reluctant to provide their employees with health coverage because they are afraid of the cost. Some have tried to shift the burden to the employee through tax credits – a scheme that seems implausible for those who are already making a minimal amount. Even with a tax credit, poor families would likely have to spend half or more of their annual income to purchase health coverage. We do not have to accept that predicament. This nation is full of smart, innovative minds and entrepreneurs who could devise a unique way to address our needs. At the same time, businesses need to recognize that even under our current flawed health care system, providing health

coverage for employees means better workers, fewer sick days and ultimately, greater profits.

Many states have already used innovative ideas to provide coverage to families by imaginatively using available resources, including Medicaid and SCHIP, through extension of eligibility criteria. We need to have the will to help willing states help their residents, especially if we continue to delay action here in Washington. Health care coverage should not be the privilege it currently is. Health care should be a right. A person who becomes ill and who lacks health care is a person who is being denied the opportunity to live fully, freely and happily. We need to live up to the goals our founders set for us by assuring all Americans the right to good health and a long life.

***APPENDIX D - WRITTEN STATEMENT OF MARK B. MCCLELLAN, M.D., MEMBER, COUNCIL OF ECONOMIC ADVISORS, WASHINGTON, D.C.***

**Testimony of Dr. Mark McClellan**

**Member, Council of Economic Advisers**

**July 9, 2002**

Mr. Chairman, Mr. Ranking Member, and distinguished members of the Subcommittee, I wish to thank you on behalf of the Administration for your efforts to find bipartisan solutions to address the related problems of the uninsured and rising health care costs. Almost 40 million Americans are reported to go without health insurance coverage for an entire year, and as many as 20 million others are without health insurance coverage during some part of the year. The vast majority of the uninsured comes from families with at least one employed worker, and employers and workers everywhere are struggling with another year of rapidly-rising health care costs. As a result, this hearing on the problem of access to quality health care is particularly timely and important. We appreciate your effort to find common ground to provide relief for Americans who are uninsured, as well as those who are having more and more difficulty obtaining affordable health insurance.

The President has introduced a comprehensive set of proposals to ensure that all Americans have affordable health insurance coverage options, with a particular emphasis on creating affordable options for the uninsured. All of these proposals are part of a broad vision for promoting health care quality and access for all Americans, by developing flexible approaches to providing patient-centered health care coverage. Reflecting the urgency of the need for action, this vision involves strengthening every component of our health care system.

Many of these proposals, such as new proposals to assist employees with high out-of-pocket costs and our proposal for association health plans to help small businesses offer affordable health insurance options, are directed toward strengthening employer-provided health insurance. In addition, the President has proposed health insurance credits that will enable millions of workers who do not have access to good employer-provided coverage to obtain health insurance. Finally, the President has proposed substantial improvements in the health care safety net, reflecting his commitment to a major expansion of the successful community health center program. Other proposals in the President's budget will strengthen the ability of our entire private health care delivery system to provide high-quality, high-value care – so that the American health care system can drive dramatic improvements in the health of Americans even more effectively.

I will also devote part of this testimony to discussing recent legislative action on health insurance credits, as they comprise one of the most innovative policy approaches proposed in the President's budget this year. Health insurance credits use the infrastructure of the tax system to expand access to health insurance, by

giving individuals the help they need to get the coverage they prefer. As you know, both Democrats and Republicans have supported legislation to create health insurance credits, including many distinguished Members of this Committee and of the Senate. As a result, legislation that includes health insurance credits has passed both the House and Senate this year. We must seek to bridge remaining partisan divides to come to agreement on this key issue which enjoys such bipartisan support. This is possible, if we keep the focus on the goal we share: providing access to affordable health care coverage that meets the needs of eligible persons, at the lowest possible cost to the government.

The President's budget backs up his broad agenda for making health insurance more affordable with well over $100 billion in new funding. We hope that these specific proposals will provide a foundation for decisive action in Congress this year to address the serious problem of health care affordability and the uninsured.

**The Problem of the Uninsured**

In 2000, the most recent year for which complete statistics are available, 14 percent of Americans reported that they were uninsured for the entire year. Although many opportunities exist for the uninsured to get needed care, persons without health insurance are much more likely to go without effective health care, or they may rely on inefficient episodic care at hospital emergency rooms. As a result, our health system spends more than it should on complications of diseases that could have been prevented and on ways of delivering health care that too often do not serve patients well, and do not enable them to take control of their health.

The uninsured population does not consist primarily of the unemployed. In 1999, 80 percent of the uninsured population lived in families where the family head was employed. Moreover, workers in small businesses are much more likely to be uninsured. While 43 percent of the workforce is employed at firms with fewer than 100 employees, 57 percent of the working uninsured are self-employed or in firms with fewer than 100 employees. The reason so many uninsured workers are in small establishments are uninsured is partly due to the fact that small firms are less likely to offer health insurance. In 1999 only 47 percent of private-sector firms with fewer than 50 employees offered health benefits compared with 97 percent of private-sector firms with more than 50 employees.

Furthermore, the uninsured population does not consist primarily of the very poor. While 34 percent of the uninsured had incomes below the poverty line, a large fraction, 29 percent, had incomes between 100 and 200 percent of poverty. Nearly three-quarters of the uninsured below 200 percent of poverty are adults, many of whom do not live in households with children.

Insurance coverage differs significantly by race and ethnicity. In 1998-2000, 32 percent of Hispanics were uninsured, compared to almost 20 percent of blacks and Asians. In contrast, just 10 percent of non-Hispanic whites were uninsured.

Uninsured Americans are a diverse population with diverse preferences and health care needs, and the approaches available in the United States to provide good health insurance are also diverse. Thus, increasing health insurance coverage is best accomplished through a range of approaches. In all parts of our health care system, however, an important goal is to give all Americans the opportunity to choose the health insurance coverage that best meets their needs. The rapid pace of change in medical care means that coverage needs to be able to adapt to keep up. The policies we implement to help the uninsured should not only guarantee them access to up-to-date coverage today; they should ensure that Americans have access to coverage that can adapt to provide access to even more valuable treatments in the years ahead. The key to increasing health insurance coverage is addressing the problems that are making insurance less available, less efficient, and less affordable for many Americans, while encouraging flexibility and innovation in insurance coverage to keep with changes in medical care.

**Addressing the Key Problems Facing Health Insurance**

One major goal of health insurance is to allow individuals to join together to reduce their risk of high medical expenses by spreading that risk. Individuals trade the uncertainty of very unpredictable health care costs for the greater certainty of a known premium and protection from very high medical expenses. An important element of insurance is thus the "pooling" of risk – people sign up for insurance before they know how much they will spend on health care, and then the premiums of those who have low expenses help subsidize spending on those with high expenses.

A second major goal of health insurance is to make sure that Americans have access to the most innovative, high-value health care available. The American health care system leads the world in Nobel prizes and in the development of new drugs, devices, and other treatments to prevent and cure illnesses. To make sure these impressive medical breakthroughs translate into good care, health care coverage must be innovative as well. One needs look no further than the lack of prescription drug coverage in Medicare to understand the consequences of out-of-date health care coverage. In the years ahead, far more breakthroughs are possible – such as customized treatments based on a clear understanding of an individual's genetic makeup, and specialized "disease management" programs that rely on the Internet and other modern telecommunications technologies that allow patients with chronic illnesses not only to stay out of the hospital, but also out of the doctors office. Innovative health care coverage is essential for creating an environment for medical practice that encourages innovative treatments, value, and continuous improvement in health care.

Several problems can interfere with the ability of insurance markets to achieve these goals. A key problem is lack of choice and competition. As the President has said, our health care system works best when it supports patient-centered care: it should support the ability of patients to work with health care professionals to decide on the best possible treatments. To have control over their health care, Americans need

the opportunity to choose the health care coverage that is best for them. Without good choices, patients do not have the power to make sure that they are getting the best value from the health care system for their own needs. Instead, government or health plan bureaucrats effectively make decisions for them about what is covered, how their care is reimbursed, and how treatments are provided. In other countries, this has led to queues for treatments, poor quality, and lagging availability of innovative care. Our country has chosen another path: private sector health care based on trust in patients and their physicians. This path rewards innovation in delivering the best possible health care. But the tremendous potential of our health care system is threatened when patients do not have choices about their health care coverage. For this reason, the President strongly believes that we must take action to improve the health care coverage options available to Americans.

A second problem is adverse selection. If only individuals whose health insurance expenditures are likely to be high sign up for insurance, then the pooling of risk that is the key to insurance is undermined. Just as individuals with higher expenses want more insurance, insurance companies want customers with lower expenses, and may design their plans to appeal to those with low risk. Thus, health policies must be designed with the goal of limiting adverse selection problems. Too often, policies designed with the goal of making health insurance more affordable have had the effect of making it less so, contributing to the problem of uninsurance rather than solving it. For this reason, the President's policy proposals strengthen coverage options, rather than imposing new restrictions on them.

**Policies to Strengthen Employer-Provided Health Insurance and Make It More Affordable**

The President has proposed many steps to make better, more affordable coverage options available through employer-provided health insurance. The Administration appreciates the shared support for similar proposals by the Chairmen of the Committee and the Subcommittee, Representative DeMint, Representative Fletcher, and many other distinguished Republican and Democratic members.

The President has proposed to loosen the restrictions on Archer Medical Savings Accounts (MSAs) and Flexible Spending Arrangements (FSAs) to make such "health account" plans more attractive to employers, who otherwise might choose not to offer employee health insurance, perhaps fearing escalating medical costs. MSAs give individuals greater control over their health care spending, and make out-of-pocket spending on health care more affordable. A major trend in the last few years in private employer-provided insurance has been enrollment in "preferred provider organization" (PPO) and "point of service" (POS) plans that give employees more choices of providers and less HMO red tape to get the treatments they prefer. But these plans generally come with significant deductibles and out-of-pocket payments. Unfortunately, current tax law doesn't support this trend. In general, premium payments are excluded from tax, but out-of-pocket payments must be made out of after-tax earnings. This means that the premium expenses that are the main cost of HMO plans receive favorable tax treatment, but the higher out-

of-pocket payments that give PPO and POS plans their flexibility do not (unless the employer provides for a flexible spending account). In other words, some of the most popular employer health plans today get less favorable tax treatment.

The President has proposed to correct this inequity in employer coverage and provide better support for health insurance plans that allow greater employee choice, by allowing individuals to make pretax contributions to a health account that could be used with a much broader array of insurance plans available today. Under the proposal, all employees and individuals who purchase a health plan with a significant deductible (at least $1,000 for individuals and $2,000 for all other cases) would be eligible to contribute to an MSA up to the amount of the deductible. The plan would be allowed to cover basic care (i.e., preventive services) without counting against the deductible. With the health account, employees could make the out-of-pocket payments for health care with pretax dollars, making it easier for them to afford the payments that often go along with broad choice of providers and treatments.

The proposal would also make improved MSAs available to all employees, and would not discriminate, as current law does, on the basis of how many employees their employer has. The substantial reduction in the deductible, and the enhanced opportunity to use pre-tax dollars to pay out-of-pocket health care costs, add significantly to the actuarial value of MSA plans and will encourage less healthy individuals to participate. Indeed, such a plan is likely to compare favorably for many people with substantial health care needs to low-copay plans typically offered by employers today, which often include significant provider network restrictions and other restrictions on the utilization of certain costly medical treatments. Thus, the improved health account plans are unlikely to lead to the enrollment of much healthier individuals than in the other health plan options that an employer offers. The improved health account arrangement would be made a permanent program in law, providing much stronger incentives for insurers, financial organizations, and others to spend the start-up money and effort to create MSA products and integrate them effectively with the other health plan options they offer.

The President also supports improvements in Flexible Spending Arrangements (FSAs) to make them work more effectively as health accounts. As you know, FSAs are tax-free accounts that many employers have set up to help give employees more control over their medical expenses as well as better protection against out-of-pocket spending. However, FSAs are subject to an end-of-the-year "use it or lose it" requirement that limits their value for protecting against unexpected out-of-pocket medical expenses. Like many members of this Committee, the President proposes to expand FSAs to encourage employers and employees to increase their use of these accounts. Under the proposal, employees could roll over as much as $500 in unspent health care contributions to an FSA for use in the following year or to their 401(k) plan for retirement income or health expenses at older ages.

Recently, the Department of the Treasury issued new guidance on the tax treatment of health reimbursement arrangements (HRAs). In an HRA, an employer provides a

health benefit that includes health insurance coverage and also an account that employees can use to reimburse their out-of-pocket medical costs. It differs from an FSA in that it is an employer commitment of funding, rather than an actual account controlled by the employee and funded by salary reduction. It is also not subject to the same restrictions as FSAs and MSAs, such as funding by salary reduction and a minimum deductible level for the accompanying health plan. The Treasury guidance clarifies that HRAs that meet certain requirements are not taxable. This guidance is consistent with the goals of our legislative proposals: to make it easier for employers to adopt health plans with patient-directed features, giving employees have more choice and greater control over their health care coverage.

The primary requirements for an HRA are that (1) the plan must be funded solely the employer and cannot be funded by salary reduction, and (2) the plan may only provide benefits for substantiated medical expenses. If the plan provides for payments or other benefits irrespective of medical expenses, all amounts paid by the plan become taxable, including prior medical reimbursements.

Under this guidance HRAs can allow the carryover of unused amounts to later years (i.e., the "use-it-or-lose-it rule" does not apply), allowing employees to get both favorable tax treatment of out-of-pocket expenses and far better opportunities to build up balances for major health care expenses. In addition, these HRAs can be used toward the purchase of health insurance, can be continued by former employees (including retirees), and can be used in conjunction with FSAs.

At a recent hearing of this Committee, members heard testimony from health plans and companies who have had considerable success with HRA-style plans. The Treasury clarification will make it possible for employers to adopt such plans with confidence about their tax treatment, giving employees a new option for reducing their out-of-pocket expenses and getting the kind of health care they prefer.

Together, these proposals provide an additional $15 billion primarily in support of employer provided insurance, in addition to the current tax expenditure for employer-provided health insurance, projected to be well over $100 billion in 2003.

**Association Health Plans to Help Small Businesses Provide Health Insurance**

The President supports legislation that provides for the creation of association health plans (AHPs) to enable small businesses to provide better and more affordable health insurance options for their employees – like those that many large employers can offer. Small businesses are far less likely than larger businesses to offer health benefits: in 1999 only 47 percent of firms with fewer than 50 employees offered health benefits compared with 97 percent of larger firms. A major reason why small firms are less likely to offer health benefits to their workers than are larger firms is the fact that providing health benefits is more expensive on a per capita basis for small firms. In addition, some of the most rapid increases in health insurance premiums in the last few years have occurred in small businesses.

AHPs will help solve the problems with access to coverage for millions of workers in small businesses. Legislative proposals like H.R. 1774, introduced by Rep. Fletcher with over one hundred cosponsors from both political parties, would allow large industry associations and other groups formed on the basis of factors other than expected health care costs to pool together to offer health insurance options. Through the establishment of uniform federal standards for association health plans (AHPs), small employers will be able to achieve greater purchasing power, administrative efficiencies, and flexibility in benefit design – the same advantages long available to large businesses.

Critics of AHP proposals will lead to fraud and outright failures, as has occurred with some multiple employer welfare arrangements (MEWAs). There are several elements of this criticism, all of which are addressed by provisions in recent AHP proposals. One criticism is that regulation by the Department of Labor (DOL) will not be an effective alternative to state regulation, and that AHPs will create the same risks for consumers posed by MEWAs when they were exempt from state law. But regulation of AHPs will build on the successful Employee Retirement Income Security Act (ERISA) framework that has allowed hundreds of thousands of employers to voluntarily provide affordable health care to employees for more than a quarter of a century. In fact, ERISA plans cover nearly half of all Americans. ERISA governs not only large individual firms; it also governs multiple-employer union health plans. The existing ERISA regulatory structure in the DOL's Pension and Welfare Benefits Administration has been highly effective in preventing and in providing cost-effective health benefits, for workers in large firms and unions. The Department is confident that it can take on these regulatory responsibilities, just as it has effectively implemented significant new responsibilities for regulating employer-provided health coverage as a result of the Health Insurance Portability and Accountability Act, the Newborn's and Mother's Health Protection Act, the Womens' Health and Cancer Rights Act, and other legislation.

Also unlike MEWAs, AHPs can only be offered by bona fide organizations that have been in existence for at least three years as an association; they cannot be formed just to provide health insurance in a way that undercuts the state-regulated health insurance market. And in contrast to MEWAs, in which an entity might start offering questionable benefits and then claim that it was a group health plan governed by DOL to hold state regulators at bay, there will be no confusion over regulatory jurisdiction. AHPs can only exist and offer insurance coverage upon affirmative certification by DOL.

AHPs must also meet much more stringent design and offering requirements. These requirements include strong solvency standards, with stop-loss and indemnification insurance (similar to widely-offered reinsurance products). The requirements also include a substantial minimum size. AHP managers also face strengthened sanctions, including criminal penalties, for violations of AHP standards. No such Federal consumer protections have ever existed for MEWA participants.

Another criticism is that AHPs will cater only to healthy enrollees, undermining the small-group risk pools of each state. For all the reasons mentioned above – including bona fide association requirements, large size requirements, and strong sanctions – AHPs cannot simply choose to provide services to "healthy," low-risk businesses. And the requirement of availability regardless of a small business's risk is reinforced by prohibitions on selective marketing and enrollment. Just as large employer health coverage and multiple-employer union health coverage must be attractive to a broad spectrum of covered workers, AHPs will not be able to attract small businesses by catering only to their healthier workers. Rather, AHPs must offer and provide consistent services to a large spectrum of eligible small businesses regardless of their expected medical costs.

By lowering the cost of providing health benefits, AHPs will encourage and enable more small businesses to offer health benefits. According to a variety of analyses, the result will be a significant increase in the number of small firm employees and dependents with health insurance coverage. Agricultural workers and service industry workers, for example, would benefit from the reduced cost and increase portability of health plans offered by their employers through their employers' trade associations. AHPs will also help workers at small businesses that currently offer health benefits, by providing lower-cost options and a broader range of health insurance choices for these workers as well. And AHPs will achieve these improvements in affordability and coverage without new taxes or costly federal mandates. Most importantly, they would put the nation on its way to closing the gap in health care coverage for small businesses by giving millions of small business workers, their spouses, and their children access to more affordable coverage and real choices in how they receive their coverage. The Administration hopes to work with members of both parties to resolve remaining concerns about AHP legislation, so that many more Americans can have affordable coverage options, not just select employees of large firms and union members.

**Health Insurance Credits for Americans Who Do Not Have Employer-Provided Coverage**

Current law provides a number of tax incentives for individuals to obtain health insurance coverage. Employer-provided health insurance and reimbursements for medical care are generally excluded from gross income for income tax purposes and from wages for employment tax purposes. Active employees participating in a cafeteria plan may pay their employee share of premiums and other medical care expenses on the same pre-tax basis. In addition, for self-employed individuals who are not eligible for subsidized employer coverage, 70 percent of health insurance premiums are deductible for 2002, and 100 percent are deductible for 2003 and thereafter.

However, as noted above, millions of Americans still are without health insurance coverage. The refundable health insurance credit proposed in the President's Budget is designed to provide these incentives to assist uninsured individuals in purchasing health insurance.

The President has proposed a health insurance credit that is refundable, so even those without income tax liability can receive the benefit of the credit. In fact, the largest subsidies will be targeted to low-income families, and only individuals who are not covered by public or employer-based health insurance will be eligible for credit. Therefore, the credit will be of most help to individuals who are most likely to be uninsured—childless adults who are generally not eligible for public insurance and persons in families with incomes too high to participate in public insurance programs and too low to find affordable coverage options in the private market. The credit will help families who prefer the innovation and flexibility of private insurance options to public insurance, and will enable families to obtain coverage for the entire family from the same providers.

The President's proposed credit is also designed to be available at the time the individual purchases health insurance. That is, people eligible for the credit can receive it in advance, before filing their tax returns, to reduce their monthly checks for insurance premium payments. In addition, because the advance credit is based on income from the previous year, the credit is "non-reconcilable." Earning more income in the current year does not reduce the value of the credit, and no end-of-year reconciliation is necessary. Taxpayers who did not claim the advance credit would be eligible to claim the credit at the end of the year when filing their tax return. Eligible health insurance plans would be required to meet minimum coverage standards, including coverage for high medical expenses.

The credit would provide a subsidy of up to 90 percent of a capped amount of health insurance premiums. The maximum credit would be $1,000 per adult and $500 per child for up to two children, so that the maximum credit per family is $3,000. The maximum subsidy percentage of 90 percent would apply for low-income taxpayers and would be phased down at higher incomes.

The credit would be used for qualifying health insurance purchased in the non-group market. In addition, qualifying health insurance could also be purchased through private purchasing groups, state-sponsored insurance purchasing pools and state high-risk pools. At state option, effective after December 31, 2003, the tax credit would be allowed for certain individuals not otherwise eligible for public health insurance programs to purchase insurance from private plans that already participate in State sponsored purchasing groups, such as Medicaid, SCHIP, or state government employee programs.

States could, under limited circumstances, provide an additional contribution to individuals who claim the credit in connection with purchases of private insurance through Medicaid, SCHIP, or other state-sponsored purchasing groups. The maximum additional state contribution would be $2,000 per adult for up to two adults for individuals with incomes up to 133 percent of poverty. The maximum state contribution would phase down ratably reaching $500 per adult at 200 percent of poverty. Individuals with income above 200 percent of poverty would not be eligible for a state contribution. States would not be allowed to provide any other explicit or implicit cross subsidies.

This proposal contains a number of new, important, and innovative features. First, the credit amount varies with family size and composition, reflecting the impact of these factors in the non-group market. For example, two adults face higher premiums, and will receive a larger credit, than a single adult. Likewise, families with children face higher premiums, and will receive a larger credit, than families without children. Second, the credit is "advanceable," and eligibility for the advance credit is based on the individual's prior year's tax return. This design guarantees certainty of the amount of the credit and makes it available at the time individuals purchase health insurance. They do not have to wait until they file their tax returns after the year is over. Third, the proposal allows the credit to be used toward private insurance purchased through private purchasing groups, state-sponsored insurance purchasing pools and state high-risk pools. This provision will increase coverage options, achieve economies of scale, and encourage risk pooling in the non-employer market.

In designing a policy to expand health insurance coverage to the uninsured, one concern is that the policy not inadvertently decrease the health insurance options available to those presently insured. Some have suggested that if the purchase of health insurance outside of the employer market became sufficiently attractive, employers might stop providing health insurance coverage to their workers, potentially resulting in a net decrease in health insurance coverage among the population. Based on these concerns, the Administration's proposal has been carefully designed to minimize "crowdout" of subsidized employer coverage, and thus will expand coverage substantially.

Several elements of the credit design contribute to this desirable result. Most importantly, low-income individuals and families, who are least likely to have employer-based health insurance, will receive the largest incentives under this proposal. In addition, the health credit subsidy rate decreases with income, requiring larger individual contributions for any given policy and making it a less attractive alternative to the employer-provided insurance at higher income levels. The health credit is further limited by a cap on the amount of premium eligible for subsidy. Although the subsidy rate and the cap on the eligible premium are generally adequate for making good health insurance affordable, they are less generous than the subsidies provided in most employer plans for most persons.

The credit is also designed to target individuals who are most likely to be uninsured during at least some part of the year. Approximately six million such individuals are expected to gain additional coverage as a result of the credit. Most of these individuals are not offered employer-based insurance over the course of their uninsured spells. The credit will provide a strong new incentive for these persons to find coverage in the individual market. It will also allow many families that are already purchasing coverage in the individual insurance market, and receiving very little government assistance in doing so, to obtain better coverage at a lower out-of-pocket cost.

The credit will significantly increase participation and quality of coverage in non-

group health insurance markets. These improvements will not come at the expense of employer group markets. Those low-income Americans who are eligible for the largest credit are less likely to have employer-sponsored health insurance. Around 80 percent of uninsured workers are not offered health insurance by their employers. Only 36 percent of people under age 65 with income below 200 percent of the federal poverty line have employer-sponsored health insurance, while 81 percent of those above do. Furthermore, the generosity of employer-sponsored insurance is determined by the tax benefits for the group of employees, not the attractiveness for low-income employees only. Tax benefits for employer coverage will remain large for the middle- and higher-income workers that make up most of the employees of most firms that offer generous employer-sponsored plans. Those workers' incomes are too high for them to get more attractive benefits from the proposed health credit. Thus, employer-provided coverage will remain more attractive for firms that offer generous coverage today. That is, the phase-out and cap on the credit ensure that employers will continue to offer insurance and that employees will continue to enroll. The proposed credit will simply eliminate an inequity in the current system that disadvantages workers without employer coverage, helping them to purchase the coverage that meets their needs.

Recent research also suggests that the credit would provide good, affordable health insurance options for the vast majority of individuals who are eligible for the credit. This is the subject of a detailed state-by-state analysis by the Council of Economic Advisers, which finds that for lower-income Americans, the proposed health insurance credit generally covers more than half of the premium the purchaser would face, and would almost always covers more than a third. This study is available on the CEA website. A recent study by the health insurance distributor eHealthInsurance found that three-quarters of premiums for individual health insurance plans that it sold were less than $2,000 and three-quarters of family premiums were less than $5,000, with the average cost for a family policy under $3,000. These findings were confirmed in another recent study by the Council on Affordable Health Insurance.

The credit would make health insurance affordable not just for the healthy or the young. Some recent reports on hypothetical insurance purchasers, for example a report sponsored by the Kaiser Family Foundation, claimed that those with chronic health conditions were unable to obtain reasonably-priced comprehensive health insurance in the non-group market. But as reported by the National Association of Health Underwriters, a close examination of the survey results reported in the study reveals that virtually all of the hypothetical applicants were able to obtain at least one good policy in every area of the country that was surveyed. The one applicant who generally could not get an insurance offer (a person who was HIV positive) could still obtain subsidized insurance through high-risk pools available in 30 states. Earlier this year, the House of Representatives passed legislation that would provide additional Federal subsidies for high-risk pools, to help ensure that affordable coverage would be available in all states for persons with preexisting conditions. Adequately-funded high risk pools are a proven approach to help make sure that all persons in a state can get good coverage. Indeed, states like New Hampshire that

previously tried and failed to provide affordable coverage by imposing strict rating restrictions are now turning to high risk pools. The total health care expenses faced by individuals with preexisting conditions are generally much higher in the states that rely on community rating and guaranteed issue compared to states with working high-risk pools.

Another effective approach to further ensure that affordable coverage options are available to all eligible lower-income persons involves state-sponsored purchasing groups. Many states have set up purchasing groups that allow SCHIP-eligible families to choose among private insurance plans, and all states offer a range of private insurance choices to their employees through purchasing groups. The President's proposal permits at state option certain low-income individuals to purchase private insurance through such state-sponsored health insurance purchasing groups.

We believe that the availability and certainty of the advance credit will make it extremely attractive to Americans who do not have employer-subsidized insurance, making it more effective in expanding health insurance coverage. The credit induces persons currently experiencing spells without insurance to buy cost-effective protection, limiting the cost per covered person. According to estimates by the Treasury Department's nonpartisan professional staff, the credit would be taken up by approximately 17 million Americans. This includes a net total of 6 million Americans who would otherwise have been uninsured for some or all of the year. It also includes over 8 million Americans who previously were purchasing non-employer coverage and who now would be able to afford better insurance. And the comprehensive Treasury analysis shows that only 15 percent of those taking up the credit are persons who otherwise would have purchased employer coverage, well under two percent of those currently covered by employer insurance.

This crowdout rate compares favorably to alternative proposals for providing health insurance coverage for Americans who do not have access to employer-subsidized insurance. Any proposal that expands alternatives to employer coverage, including expansions of Medicaid or SCHIP eligibility, also risks crowdout. For example in research published in 1996 in *the Quarterly Journal of Economics*, a prominent economic journal, by Professors David Cutler and Jonathan Gruber showed that 50 to 75 percent of the "new" coverage resulting from Medicaid expansions in the early 1990s was actually crowdout of employer coverage. While some reports suggest less substantial crowdout, a recent comprehensive review of the many studies of Medicaid expansions concluded that 20 percent or more of the coverage expansions were actually the replacement of employer coverage with Medicaid. Moreover, these studies were primarily focused on low-income Medicaid expansions involving children (up to 133 percent of poverty). The studies have generally concluded that Medicaid expansions involving families at higher income levels would cause even more crowdout.

A final strength of the President's proposal is that it provides assistance to a broad range of individuals who currently receive no assistance with health care costs. The

credit is available to persons who do not get employer subsidies for health insurance for a variety of reasons, whether due to job loss, employment in a firm that does not offer health insurance, or any other cause.

**Recent Progress on Health Insurance Credits**

This year, both the House and Senate have passed more narrowly targeted health insurance credits for individual workers. This legislation is important progress toward making affordable coverage more widely available. Early this year, the House passed a health insurance credit for displaced workers that had been proposed by a bipartisan group of Senate Centrists. Recently, both the House and Senate have passed health insurance credits for workers eligible for Trade Adjustment Assistance and (in the House) certain retirees who have lost their employer-provided retirement benefits. Because these credits only provide assistance for those who are not currently working, they will only help a fraction of the lower- and middle-income Americans who do not have access to affordable employer-provided health insurance coverage. Such credits may also provide a disincentive to return to work, especially if it is as generous or more generous than the health insurance assistance that many employers are able to provide.

Unfortunately, the health insurance credit in the Senate-passed trade legislation includes other features that will delay and prevent it from providing timely and effective assistance for the trade-impacted workers it is intended to cover. The credit can only be used to continue certain kinds of existing coverage (COBRA and non-group coverage purchased for at least six months prior to job loss). But almost half of TAA workers may be unable to continue their existing coverage, and the Senate bill only allows them to use the credit to buy coverage through new purchasing arrangements that states are required to create. The credit cannot be used for any other private health insurance coverage that might be preferred by many workers who want affordable coverage while they are between jobs.

Instead of building on existing laws that Congress has crafted to encourage health insurance portability and availability, and on existing state pools to assist low-income workers, the Senate bill mandates a variety of new conditions that are met by no state pools in existence today. Further, the mandates that the plans offered by the states must be guaranteed issue and must not exceed the cost of health insurance for "similar" individuals will generally be impossible for states to fulfill without additional subsidies. Moreover, in the vast majority of states, the TAA population is not large enough to support actuarially stable purchasing pools. As a result, if enacted, it is likely that many workers will not be able to use the credit. The bill also requires struggling employers to re-open COBRA enrollment many months after the COBRA enrollment period required under current law. This employer mandate will be costly for employers to administer and will increase the adverse selection in employer health insurance pools, undermining employer-provided health insurance coverage.

Because of these inefficient features, the Senate-passed credit will be much more

costly per worker covered than a better-designed credit with more of the features proposed by the President. If these features are not modified, many TAA-eligible workers may get no assistance at all. The Administration hopes to work with the House and Senate to address these concerns and implement an effective tax credit.

**Improved Health Care Options in Medicaid and the State Children's Health Insurance Program**

The President is also committed to improving the opportunities for Americans with modest means to get mainstream health insurance coverage through the Medicaid and SCHIP programs. This requires reducing the burdens associated with Medicaid laws and administrative guidelines that historically have hampered the ability of states to expand coverage and to adopt cost-effective private sector innovations in providing coverage.

As a first step, the Administration introduced the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative in August 2001. The HIFA demonstration initiative encourages States to develop comprehensive insurance coverage for individuals with incomes up to twice the Federal poverty level using Medicaid and SCHIP funds. It gives States the flexibility to increase health insurance coverage through support of private group health coverage and simplifies the waiver application process. Arizona and California received the first HIFA demonstrations in December 2001 and January 2002, respectively. These SCHIP expansions provide coverage for parents up to 200% of the poverty line. The Administration intends to continue to build on the HIFA demonstration initiative in FY 2003. States will be encouraged to use their program resources to extend coverage to more of their neediest residents and reduce the number of people without health insurance coverage.

In his 2003 budget, the President also proposed to strengthen SCHIP by making available to states unused SCHIP funds that otherwise would return to the federal treasury at the end of this year and next year. The SCHIP law requires states that did not use their full SCHIP allotment during the previous three years to return the unused funds, making additional enhanced-match funds available to every state. Coupled with the flexibility provided under HIFA to expand coverage for both children and adults with incomes under 200 percent of poverty, the availability of more enhanced-match funds would give every state a greater opportunity to increase coverage for the uninsured. However, essentially all states are facing budget shortfalls this year and are struggling to maintain their existing Medicaid and SCHIP coverage in the face of rapidly-rising costs. Thus, the President's strategy for reducing the number of uninsured does not depend only on Medicaid expansions; instead, the President has proposed a range of new directions for providing affordable health care coverage that do not require rapidly-rising funding commitments by states.

The President's budget also provides $350 million in FY 2003 to continue funding Medicaid for families in transition from welfare to work. This coverage helps to

ensure that work pays for families by preventing them from losing their health coverage when they start jobs.

**Improved Health Care Safety Net**

Community Health Centers (CHCs) are a critical part of the health care safety net, delivering primary and preventive health services to 11 million patients who are either uninsured or have inadequate coverage. The President's budget includes $1.5 billion for CHCs, a $114 million increase that would continue toward the Administration's long-term objective of adding 1,200 new and expanded health center sites over five years and serve an additional 6.1 million patients. The increase for fiscal year 2003 would support 170 new and expanded health centers, and provide services to a million additional patients.

The President has also proposed addressing the problem of access to health professionals that exists in many parts of the country by expanding the National Health Service Corps. Since 1970, over 20,000 doctors, nurses, dentists, midwives, and mental health clinicians have been placed in medically underserved communities through the National Health Service Corps (NHSC). The President's budget includes $191.5 million -- a $44 million increase -- to strengthen the NHSC. With the increased funding, the NHSC will provide scholarships or loan assistance to about 1,800 professionals practicing in underserved areas - an increase of over 460 participants.

**Conclusion**

The absence of health insurance coverage for some 40 million or more Americans, and the increasing health care costs faced by all Americans, is a problem calling for immediate solutions. The President has proposed a comprehensive package of solutions, including proposals to provide more affordable health insurance options for employers, proposals with bipartisan support to provide health insurance credits for persons who do not have employer-provided coverage, and proposals to strengthen the Medicaid and S-CHIP programs. The President's budget also provides a stronger safety net for Americans without adequate coverage. Together, these proposals will provide health security and additional health insurance coverage for many millions of Americans, while preserving the best features of our highly innovative health care system. The Administration will continue to work closely with Congress, on a bipartisan basis, to fulfill the President's vision for affordable, patient-centered, 21st-century health care for all Americans. I will now be happy to answer any questions you may have.

***APPENDIX E - WRITTEN STATEMENT OF HARRY M. JANSEN KRAEMER, JR., CHAIRMAN AND CHIEF EXECUTIVE OFFICER, BAXTER INTERNATIONAL, INC., DEERFIELD, IL, TESTIFYING ON BEHALF OF THE HEALTHCARE LEADERSHIP COUNCIL***

**Testimony of Mr. Harry M. J. Kraemer, Jr.**

**Chairman & CEO, Baxter International, Inc.**
**and member of the Healthcare Leadership Council**

**July 9, 2002**

Mr. Chairman and members of the subcommittee, I am Harry Kraemer, President and CEO of Baxter International, a global medical products and services company with a mission of developing critical therapies for people with life-threatening conditions. I am also chairman of the Healthcare Leadership Council's Executive Task Force on the Uninsured. On behalf of the members of the HLC, I would like to thank you for focusing today's hearing and your attentions on the vitally important issue of uninsured Americans.

The members of the Healthcare Leadership Council are committed to advocating a successful combination of solutions to solve this national crisis. We have both experience and ideas concerning reaching out to individuals and small businesses to begin reducing the number of uninsured Americans. And, through our grassroots initiatives, we are gaining additional insights in how to attack the educational and administrative barriers that stand in the way of broader health coverage for working families. I welcome and appreciate the opportunity to discuss the HLC's views and initiatives on this issue.

This subcommittee has an important role in addressing this national crisis. As I will discuss in my testimony, a large number of the uninsured in this country are workers in small businesses, and our efforts to address this problem must be focused accordingly. Our experience with the nation's public insurance programs B Medicaid, S-CHIP and the Qualified Medicare Beneficiaries' program B has taught us that simply making assistance available or providing financial subsidies does not, in itself, solve the problem. It is essential that funding efforts go hand in hand with complementary education and outreach efforts to maximize and ensure the effectiveness of any federal solutions for the uninsured.

Today, I want to discuss both the policy approaches that we believe will be most effective in helping working Americans gain greater access to health coverage, as well as the necessary outreach initiatives that must take place in order to achieve real progress on reducing the number of uninsured in our country.

***About the Healthcare Leadership Council***

Mr. Chairman, the health care industry is, I am pleased to tell you, actively engaged in the mission of finding solutions to the problem of the uninsured. The Healthcare

Leadership Council (HLC) is a coalition of chief executives of the nation's leading health care companies and institutions, representing all sectors of American health care. Our members are committed to advancing a market-based health care system that values innovation and that provides accessible, high-quality care for all Americans.

Last year, the members of the HLC launched a national campaign called ***Health Access America***. Our mission is to raise national awareness of the uninsured problem, and to advance solutions that will put health coverage within the reach of uninsured Americans. I speak for all of my fellow members and health industry CEOs in saying that we believe strongly that all persons should have access to today's modern medical miracles and life-enhancing technologies and treatments.

The health consequences experienced by those without health insurance are well documented. People without coverage tend to get sick more often because they do not receive the preventive and diagnostic care that so many of us take for granted. They miss more time on the job. They are absent from school more frequently and statistics recently released in an Institute of Medicine study tell us they will die too early.

This is a major social problem, and it is also an economic one. When a large percentage of our population is uninsured, our productivity suffers and our health providers are confronted with a tremendous economic strain caused by uncompensated care. Hospitals alone are absorbing over $19 billion per year in care provided to those who do not have adequate coverage.

It is critical to point out that there is no single answer, no one policy solution that will address the needs of more than 40 million uninsured Americans. Taking on this issue requires flexibility and a mix of targeted public and private solutions.

The HLC supports a three-pronged approach to reduce the number of uninsured Americans: (1) refundable tax incentives to encourage the purchase of insurance, including employer-offered coverage; (2) improvements to the current Medicaid program and S-CHIP, including improved outreach to enroll those currently eligible and the flexibility to use program dollars to expand private coverage; and (3) increased efforts to facilitate awareness of the importance and availability of health insurance, especially among the nation=s small businesses.

We are focused intensely on this issue, and on making progress toward solutions. Under the auspices of our Health Access America campaign, we are spotlighting local and regional programs throughout the country that are developing successful, innovative approaches to help provide coverage. We are using our HLC Web page (www.hlc.org) to provide uninsured Americans with one-click access to information about coverage and safety net programs in their states. We are conducting research studies on the most effective ways to address this crisis. And we are talking to people who don't have health coverage, listening to their stories and sharing them with a wider, national audience to broaden awareness of the

personal pain and the cost to society that will continue to be felt if we don't solve this problem.

In my testimony, I would like to share with you some of what we have learned, through our research, about the characteristics of the uninsured, and then discuss how we are using that knowledge. Of particular relevance to this hearing, I would like to discuss the very important objective of providing information to small businesses and working families on the value and accessibility of health insurance coverage. Finally, I would like to submit our views regarding two of the important components of expanding health coverage access B providing tax incentives to working Americans, and improving Medicaid and the State Children's Health Insurance Program.

***Characteristics of the Uninsured***

HLC has undertaken several research projects that are helping us to better understand the characteristics of the uninsured and potential solutions to the significant challenges before us. I would like to share a few of our most important observations:

Four out of every five uninsured persons are in families with at least one employed family member. This is critically important, because it alters long-held preconceptions about the uninsured and helps shape our policy approaches to address this problem. This is the dominant picture of the uninsured B hard-working people who are not offered or cannot afford health insurance. Of the 33 million uninsured in working families, 13 million are in families where an offer of insurance from an employer is turned down, usually because the family cannot afford it. Twenty million of the uninsured in working households are not offered employer insurance.

The cost of insurance, not surprisingly, is the most significant barrier to insurance enrollment for low-income workers and their dependents. This is in part because their share of premiums consumes a higher percentage of their income than is the case for workers with higher incomes. Also, workers in middle and upper-income brackets tend to work for employers who subsidize a larger portion of their health insurance premiums, whereas low-wage firms offer a smaller subsidy to their employees.

In all of our research, the single most important point that cannot be ignored is that the uninsured issue is a workplace issue, with millions of wage-earning households representing the lion's share of the uninsured population. It then stands to reason that our most effective solutions must be found within the existing private employer-based health care system. We believe strongly that the focus of our energies must be directed where it is needed most B toward the nation's small, Main Street businesses.

***Targeting Small Business: The Need for Intensive Outreach***

HLC's overarching belief is that consumers should have a variety of health coverage choices B in both the group and non-group markets. However, it cannot be overlooked that our current employer-based coverage system is serving the nation well, and has the potential to be our most effective and expedient tool for substantially minimizing our national uninsured crisis. Employers now insure over 64 percent B or about 177 million Americans. Not only are employers uniquely effective in pooling varied risks, but they also are a driving force in negotiating fair prices and quality improvement.

According to our research, more than 80 percent of the uninsured, or about 33 million uninsured individuals, are in families with at least one active worker. And most of these uninsured workers are employed by small businesses. At companies with fewer than 10 employees, about 33 percent of workers are uninsured; with 25 to 99 employees the figure is about 21 percent. In firms with 500 to 999 employees, only about 11 percent are uninsured.

As I mentioned previously, the primary barrier to health coverage for the uninsured is financing B for individuals and small businesses. However, there is growing evidence that the complexity of the small group insurance market and a basic lack of awareness about the value and cost of health insurance also act as significant barriers preventing small businesses from providing health insurance. Recent research, illustrated by the following examples, underscores this fact:

> In an April 2002 survey by the Kaiser Family Foundation, over one third of small businesses not offering coverage said that Aadministrative hassle@ was a very important reason. The same survey found that about one third of small business executives in companies not offering coverage admitted that they do not know how much health insurance costs. Many small business executives in these firms greatly overestimated the average cost of insurance premiums. They also provided estimates of what they believed they and their employees could contribute to insurance premiums. These amounts ($110 per month from the employer and $89 per month from the employee) were very nearly adequate to purchase a health insurance policy.
>
> This correlates with a 1999 California Health Institute survey, in which many individuals who cited expense as the reason for not purchasing insurance actually agreed that it was affordable once they were informed of the true cost of various policies. More than likely, there are similar misconceptions among small business owners.
>
> A California Health Foundation survey published in March of this year, concluded that the group of surveyed small businesses not offering coverage were a promising target for outreach and education activities regarding marketplace characteristics, including information about market protections, options, and tax deductibility of insurance

premiums.

A 2000 focus group of the California Health Care Foundation found that a lack of unbiased, easily understood information on health insurance was a major barrier in acquiring coverage. Many small business owners do not fully understand the health insurance market and are skeptical of information from insurance companies, the focus group report stated. This lack of credible information could be leading to inaction on the part of employers.

An EBRI 2000 Small Employer Health Benefits Survey found that many small employers make decisions about whether to offer health benefits to their workers without being fully aware of the tax advantages that can make this benefit more affordable. This survey found that 57 percent of small employers do not know that health insurance premiums are 100 percent tax deductible. The survey also found that small employers are largely unaware of the laws that nearly all states and the federal government have enacted to make health insurance more accessible and more affordable for many small employers. For example, the survey showed that 65 percent of the nation's small employers are unaware that there are limits on what insurers can charge employers with sick workers compared with employers that have healthier workers.

Two local programs (Access Health, Muskegan County, Michigan, and the Small Business Health Insurance Demonstration of New York) dedicated to helping small businesses obtain health insurance have cited marketing failures as the major barriers to enrolling businesses in these subsidized programs.

This information clearly indicates that lack of information is a significant factor in our nation's struggle to reduce the number of uninsured. While efforts to address the major financial barriers to health coverage must await legislative action, HLC and other private and public organizations can take action now to help break down the education and complexity barrier.

***HLC Main Street Initiative***

HLC has begun to develop regional initiatives targeted directly and specifically toward small businesses. Our goal is to help these businesses navigate the complexities of their local health insurance market in hopes that more, if not all, will purchase coverage.

For this Main Street Initiative, we are conducting an initial analysis of various small group markets. This analysis includes:

Examining state small market insurance laws and other major factors

that result in state and regional variations of small business insurance rates;

Analyzing within various regions the characteristics of small businesses that provide health insurance coverage for their workers as well as businesses which do not;

Interviewing major small group market insurance companies to assess and understand their marketing efforts, and to analyze varying levels of marketing successes and failures;

Investigating potential information outlets used by small businesses in a region. Those outlets could include Small Business Development Centers, chambers of commerce, county tax offices, accounting firms, local business associations and university offices;

Conducting a health insurance survey of small businesses in selected regions to determine the baseline of knowledge about B and opinions on B employer health insurance.

The information from each regional analysis will be used to design a set of outreach efforts for the region. These efforts will be aimed at increasing health insurance coverage among employees of small businesses. Components of this initiative may include:

Partnerships with local small business development centers, chambers of commerce and other business association affiliates to provide model curriculums for use in small business training sessions.

Regional websites specifically dedicated to health insurance information for small businesses. Working on a national basis to publicize the site to small businesses and to include links to the site on hundreds of other web pages frequently accessed by small businesses.

A coordinated effort to get small businesses which provide insurance to their employees to consult with small businesses not offering health insurance within the same region. With the understanding that a larger pool of small businesses may help to sustain insurance rates and preserve the small group insurance market in their area, small businesses offering insurance can be motivated to participate in this effort.

A widely distributed standard brochure or pamphlet for small businesses containing essential information about health insurance and available health coverage programs, developed on a state by state basis.

Comparative options menus of locally available health insurance

products. Comparative information would include average premium costs, benefits, and enrollment details. Making such comparative information widely available may also encourage more competitive pricing of insurance products in some areas.

Mr. Chairman, this is clearly an area in which the public and private sectors can work together to achieve considerable progress. Evidence has shown that greater access to information about health coverage can lead to more small employers providing that coverage and more working men and women electing to receive it. Those of us who are large employers can and must join with the public sector in making this education and outreach happen.

In fact, on a regional basis, we're already seeing the results of what can be gained when creative, innovative initiatives are allowed to flourish. Specific examples are cited below.

***Facilitating Awareness and Solutions***

Through our extensive grassroots program, the HLC is developing programs B in conjunction with community leaders B to provide local health briefings and forums, local media events, and awards presentations to model programs on the uninsured.

Our work in highlighting model programs throughout the country that promote health coverage and access has been particularly valuable. We spotlight these programs with the HLC Honor Roll for Coverage award. In 2000, we presented awards to the Wayne County, Michigan HealthChoice program as well as the FOCUS program in San Diego. Both of these programs provide subsidies to help small businesses and their employees afford health insurance. In 2001, we recognized Virginia's exemplary waiver program that allows S-CHIP funds to be used to help expand employer health coverage, and South Carolina's Commun-I-Care program, which provides health care services and products to individuals who are not eligible for public assistance or employer-based insurance.

In August, HLC will present its Honor Roll Award to a new program in Sacramento County, California, called SACAdvantage. Modeled after the San Diego FOCUS program, SACAdvantage will work with small employers to increase access to coverage for their employees.

Since the launch of Health Access America, HLC's grassroots operation has been working in local communities with members of Congress and others to identify potential outreach opportunities with small business. One such partnership is with Congressman Adam Smith's small business advisory council. HLC hosted a forum with this group of business owners on July 2nd in Tacoma, Washington, to focus on ways to access health coverage.

We believe these and similar state and local programs, small business and association purchasing pools, and other creative ways to encourage health care

coverage merit national attention. There are a number of different causes that lead to millions of people being without health insurance, and each of these local programs has analyzed the unique needs and potential solutions for their uninsured populations.

These initiatives are not only providing coverage for a growing number of individuals, families and small businesses, but they are providing us with a critical road map leading toward workable solutions that may encourage small employers and individuals to participate in coverage programs. For example, Wayne County's HealthChoice program found that it was difficult to entice businesses to participate in providing health insurance as long as subsidies to those businesses were less than one-third of their insurance premium costs. The premium formula that eventually made the program a success was one-third paid by the employer, one-third paid by the employee, and one-third subsidized by the county government.

In addition, these small employers received the benefit of the pooling arrangement created by the county, which offered a negotiated price as well as a subsidy. This mirrors some of the advantages enjoyed by large employers and other types of purchasing pool arrangements.

Also in effort to increase awareness about the importance of health care coverage, HLC has worked with Congresswoman Heather Wilson and Congressman Dennis Moore to pass H.Con.R. 271, *The Importance of Health Care Coverage Month,* and secured bipartisan cosponsors for that resolution. Concurrently, our grassroots organization is coordinating events around the country with cosponsors of the resolution to help educate individuals and small business of the importance and availability of health care coverage. A similar resolution has been introduced in the Senate with bipartisan cosponsors, including Senator Susan Collins and Senator Ron Wyden.

While these regional efforts are vitally important, it is also critical that we establish sound national policies to make private health coverage more accessible for working families and to improve the effectiveness of the dollars currently devoted to federal programs like Medicaid and S-CHIP.

***Targeted, Refundable Tax Incentives***

Having established that the majority of the uninsured live within working, low-wage households, it is a logical conclusion that a pre-funded, refundable tax credit to lower income workers B for use toward group or individual insurance B could help to reduce the number of uninsured. Health coverage tax credits have the potential for providing consumers with a great amount of flexibility for choosing health coverage options that best suit their needs. They also can act as a stimulus to create new and wider coverage choices in the marketplace.

This approach is not without its critics. There are some who believe, and have stated, that a tax credit would not be sufficient for helping individuals purchase

insurance from their employers or from the individual market. These critics liken tax credits to using a short rope to rescue someone in a deep hole. That analogy, however, misstates the current problem. Millions of uninsured workers are not at the bottom of that so-called deep hole, but are instead in a position of needing limited help to make health coverage feasible. We prefer to think of tax credits as a bridge to span the gap between the price of coverage and what the worker and/or employer are able to contribute.

The HLC believes tax credits should be refundable for persons with little or no tax liability, and they should be paid in advance so that individuals with limited or no savings can take advantage of them to pay monthly premiums before the end of the tax year. Risk adjusting tax credits for those with chronic diseases and other health conditions, as well as facilitating the development of state high risk pools toward which credits can be applied, can also help to ensure that the majority of the uninsured are served by this approach.

Refundable tax credits would be of tremendous value to low-income working families. The current tax exclusion for health insurance has less value for low-income workers than for their better-paid counterparts. For families with income levels between 200 to 300 percent of the federal poverty level ($35,000 to $53,000 for a family of four), the existing tax exclusion for employer-paid health insurance is worth only about $661. For families between 300 and 400 percent of poverty, the exclusion has a value of about $801.

While we are pleased to see proposals moving forward to use tax credits to address the needs of individuals who do not have an offer of employer insurance, it is our hope that these proposals will be expanded to include others in the workplace who face health coverage challenges. The HLC's strong advocacy for tax incentives to subsidize the purchase of employer-offered insurance stems from the compelling fact that over 80 percent of the uninsured are connected to the workforce. The combination of a refundable tax subsidy, the often lower cost of group health insurance and the natural outreach opportunities within an employment setting creates the most promising environment for increasing coverage for families and individuals.

***Improving Medicaid and S-CHIP***

Medicaid and S-CHIP have proven extremely valuable for providing health care to very low income populations, and must play a role in the package of solutions that will reduce America's uninsured population.

However, evidence suggests that we are reaching the limits of effectiveness in reducing the number of uninsured through these programs, as they currently function. Only about half of the individuals currently eligible for Medicaid and S-CHIP actually participate in the programs, suggesting that eligibility alone B without considerable investment to remove existing barriers to participation B does not and will not efficiently increase the number of people receiving coverage.

A number of reasons have been cited for low participation in these programs, including the fact that participation rates in means-tested public insurance programs decline as incomes rise. A large number of those electing not to participate are families with higher income levels who were offered public insurance upon the inception of S-CHIP.

This pattern of lower participation among higher income persons is also evident in other government health care subsidy programs, including the Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) programs. Forty-five percent of QMBs who have incomes at or below 100 percent of poverty do not participate in the QMB program. Among SLMBs, who have slightly higher incomes than QMBs at 100 to 120 percent of poverty, 84 percent of those eligible fail to participate. Obviously, substantial outreach is necessary to overcome barriers to participation, such as the stigma many associate with public programs.

Any discussion of expanding S-CHIP or Medicaid eligibility must also take into consideration the deteriorating fiscal health of many of our states. Medicaid and S-CHIP account for the largest line item in most state budgets. And, unlike the federal government, virtually all of the states do not have the option of deficit spending, meaning that budget cuts will have to occur. The National Conference of State Legislature's annual Health Priorities Survey for 2002 found that 28 states will consider cutting Medicaid benefit packages this year. Several governors have stated publicly that Medicaid spending is one of the greatest problems they face.

This challenging environment requires innovative approaches. For example, using S-CHIP funds to supplement employer premium contributions is a logical way to stretch scarce health care dollars. Virginia's FAMIS program, is one of the first programs in the nation to combine its S-CHIP funding with employer-offered coverage. This program is now enrolling thousands of uninsured children into their parents' health plans in the work place.

This idea should be examined closely by other states as well as the Federal government. Many eligible individuals in the higher income categories of Medicaid and S-CHIP, as well as income categories under consideration for Medicaid and S-CHIP expansions, are connected to the workforce through at least one family member. Therefore, solutions involving ways to supplement employer insurance may be highly effective in increasing coverage rates for these populations, providing coverage without the stigma of government dependence. There are steps that must be taken, though, to make this approach work better. There are administrative complexities within the Medicaid and S-CHIP programs that discourage states from opting to coordinate with employer health plans. HHS currently does not have the authority to eliminate all of these barriers.

***Conclusion***

Mr. Chairman, the Healthcare Leadership Council commends you and your

colleagues for your ongoing work to find solutions to this nation's most pressing health care issue. We firmly believe that the nation's uninsured problem is not an insolvable one. Through tax incentives, through improvements in our public programs and through intensive outreach and education to small businesses and working families, we can help more Americans achieve the key to longer, healthier lives that comes with having health coverage.

***APPENDIX F - WRITTEN STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA, WASHINGTON, D.C.***

**Testimony of Mr. Ronald F. Pollack**

**Executive Director, Families USA**

**July 9, 2002**

Mr. Chairman and Members of the Committee:

Thank you for inviting me to testify today. Families USA is the national organization for health care consumers. Our mission is to ensure that all Americans have access to high-quality, affordable health care.

In my testimony today I will begin by identifying the primary target population for the first steps that should be taken to expand health coverage for the uninsured. After that, I will turn to an examination of the merits of several proposed solutions designed to reach that population.

In doing so, I will first present the reasons why Families USA has determined that expansion of public programs—Medicaid and the State Children's Health Insurance Program (SCHIP)—is a better strategy than individual tax credits for decreasing the number of low-wage workers and their families without health insurance coverage. While individual tax credits may help some families cope with high health insurance premiums, the proposals before Congress do not provide a sufficient subsidy to allow low-wage workers and their families to purchase insurance, and will discriminate against workers who need health care the most.

Second, in recognition of the jurisdiction of this Committee, I would like to present the reasons why Families USA and other consumer groups oppose the current Association Health Plan (AHP) proposal (H.R. 2563). After extended and careful consideration, we find that the current AHP proposal poses a serious threat to our existing employer-based health insurance system and violates the important principle: do no harm.

**The Target: Uninsured Low-Income Workers and Their Families**

The uninsured are predominantly low-income working families: over half (58 percent) of the uninsured who are poor have at least one family member who works full- or part-time outside the home. Eighty-five percent of the uninsured who are near-poor (below 200 percent of the federal poverty level or an annual income of a little more than $3o,000 for a family of three) come from families with at least one full-time worker.

As you know from previous hearings, more than 60 percent of the U.S. population

receives employer-based health insurance coverage. However, there are working Americans that fall through the cracks in employer-based health insurance—especially low-wage workers, part-time workers, and workers in personal services. In fact, eight out of ten of the uninsured are in working families. Most of these uninsured workers (70 percent) do not have an *offer* of employer-based coverage. This is especially true for low-wage workers. Nine out of 10 workers whose wages are $15 an hour or more are *offered* coverage by their employer, but only half of those whose wages are $7 an hour or less are *offered* coverage.

Most workers participate in employer health plans when offered, but for low-wage workers affordability is an issue. For workers with an offer of coverage and whose family income is below the poverty line, 19 percent are uninsured (compared to 2 percent for workers with an offer and incomes above 300 percent of the poverty line). As you heard at this Subcommittee's hearing on June 18th, the situation will only worsen for low-wage workers as employers pass on higher premiums and higher out-of-pocket costs to their employees.

Medicaid and SCHIP fill in only portions of the gaps left by employer-based coverage. While Medicaid reaches many people who need basic health care, millions of low-wage workers and their families are left behind. Today, more than four out of five low-income, uninsured adults are ineligible for Medicaid or other public health coverage. An analysis by Families USA of Census Bureau data show that, nationally, an estimated 81 percent of low-wage, uninsured adults—more than 13 million people—have incomes that are considered "too high" to qualify for Medicaid coverage in their state.

The holes in the Medicaid safety net are readily apparent. In 42 states, non-parent adults (childless couples or single adults) are ineligible for Medicaid—even if they are penniless—unless they are severely disabled. For parents, the Medicaid eligibility levels are very low—below $15,000 in annual income for a family of three in almost three-quarters (37) of the states.

As I will describe, Families USA had determined that the best approach to help low-income people without health insurance is to build on the Medicaid and SCHIP programs, thereby fixing the holes in our already existing health care safety net.

**Weighing Medicaid Expansion versus Individual Tax Credits**

Families USA has identified two over-riding principles that guide us as we evaluate proposals to reduce the number of uninsured Americans. First, to be effective, any proposal directed at low-wage people and families must realistically make coverage affordable in light of their low-income status. Second, the proposal should extend help equally to all low-income uninsured regardless of health status.

These two principles clearly lead us to support Medicaid- and SCHIP-type expansions over individual tax credits. In a nutshell, federal dollars spent on Medicaid- and SCHIP-type expansions, unlike individual tax credits, provide a

realistic subsidy for the cost of meaningful coverage. Further, unlike individual tax credits, Medicaid does not reject sick people or charge sick people very high premiums.

**Principle #1:**

***Unlike pending tax credit proposals, Medicaid provides a realistic subsidy for the cost of meaningful coverage.***

Medicaid provides coverage for virtually the *full* cost of meaningful insurance that is precisely targeted to persons and families with limited incomes. By way of contrast, the size of currently proposed tax credits—even for young healthy non-smokers—buys inadequate coverage that often does not cover critical services and has high out-of-pocket deductibles and copayments that low-income people can't afford.

Research shows that those with low and modest incomes are unlikely to take advantage of subsidies that fall short of the costs of insurance and are unlikely to use care if they face large out-of-pocket costs. Current individual tax credit proposals would force low-income people to pay from 20 to 50 percent of their annual incomes on top of the tax credit value for decent health insurance coverage. Not many low-wage working families can afford to do this.

President Bush has proposed a $1,000 individual tax credit. In a recent report, Families USA looked at the annual premium for a standard plan that is comparable to typical employer-based coverage and to the most popular plan in the Federal Employee Health Benefits Plan (FEHBP) program. The average annual premium for a standard health plan was $4,934 for a healthy, non-smoking 55-year-old woman and $2,459 for a healthy, non-smoking 25-year-old woman.

Our recent report also found that no $1,000 policies were available to healthy, non-smoking 55-year-old women in 47 states. Even healthy, non-smoking 25-year-old women could not buy $1,000 policy in 19 states.

When $1,000 plans were available, they had limited coverage with high deductibles and out-of-pocket costs. Benefits—such as prescription drugs, emergency services, inpatient hospital services, and mental health—were not covered in some states and very limited in others. The plans that were available to 25-year-old women did not cover doctors' visits in 18 states and prescription drugs in 19 states. In the three states that did offer $1,000 plans to healthy, non-smoking 55-year-old women, the annual deductibles were $5,000.

**Principle #2:**

***Unlike individual tax credit approaches that push people into the individual market, Medicaid does not reject sick people or charge sick people high premiums.***

Government insurance programs do not underwrite on the basis of risk. Medicaid provides all eligible people with the same covered benefits and with the same protections against high out-of-pocket costs. The tax credit proposal, however, would result in discriminatory harm to people with health conditions or disabilities. This is because the tax credit approach pushes people into the individual market, and people with health conditions or disabilities face discriminatory denials of coverage or unaffordable high premiums from insurance companies. Although the value of the proposed individual tax credit would remain fixed, private health insurance premiums, copayments and other out-of-pocket costs are significantly higher for sick people, older people, and other people at risk of needing health care. Thus, the tax credit leaves the very people who most need health insurance with the highest out-of-pocket costs. And for some sick people, no individual health insurance would be available at any price.

A study by the Kaiser Family Foundation documents what happens to people in less-than-perfect health in the private individual insurance market. The study had hypothetical consumers with varying health problems apply for coverage in diverse insurance markets: the applicants were rejected for coverage 37 percent of the time. The Maryland Insurance Administration found health insurance applicant rejection rates comparable to those found in the Kaiser study: one Maryland plan rejected 32 percent of the 18,000 people who applied for individual coverage in 1998.

For the hypothetical consumers in the Kaiser study who were offered coverage, only 10 percent of the offers were "clean"—that is, the plans were offered at the standard premium, with no limitations on covered benefits. The rest of the offers had significant limitations on benefits. For example, Frank, a 62-year-old retired salesman who smokes, is overweight, and has high blood pressure, was rejected on 55 percent of his applications and received only two clean offers. Three of the 27 offers he received included riders excluding coverage of his entire circulatory system.

People in less-than-perfect health also faced higher premiums for coverage. For example, one national carrier in the Kaiser study offered the same policy to Alice (a 24-year-old with hay fever) in Corning, Iowa for $1,471 per year and to Frank (a 62-year-old overweight smoker with high blood pressure) in Miami for just over $30,000 per year—more than a 20-fold difference in price. Thus, an individual tax credit would provide greatly varying levels of help based *not on need*, but rather on age, gender, health status, place of residence, occupation, and many other factors used to price or underwrite individual policies.

By way of contrast, Medicaid cannot discriminate by turning away sick or older people (or any other higher-risk people). Further, Medicaid provides reasonable limits on how much low-income people can be charged for health services regardless of their health status, age or other risk factors. Only public sector programs like Medicaid truly guarantee the availability of medically necessary care to people with serious health conditions and protects them from the high cost of their care.

**Next Steps to Improve Medicaid and Cover More Low-Income Working Families**

The holes in the Medicaid safety net leave a large number of low-income adults without health coverage. In effect, these programs divide low-income populations into three groups—children, parents of children, and childless adults—and treat each group very differently. This categorization and differential treatment is an unfortunate vestige of the 16th-century Elizabethan Poor Laws that formed the basis of our nation's welfare system and, starting in 1965, the Medicaid program as well.

Children, who in recent years have aroused the greatest political sympathy, are accorded better coverage than the two adult groups. Most states now consider children eligible for public-sector coverage if they live in families with incomes below 200 percent of the federal poverty level ($30,040 for a family of three).

Low-income parents receive considerably less coverage protection than their children do. States have near-total discretion to establish the Medicaid income eligibility standards for parents—and most states have established standards that are very low. In more than half (26) of the states, a parent in a three-person family working at the minimum wage ($5.15 per hour) is considered to have "too much income" to qualify for Medicaid if that parent works full time. As a result, there are 6.5 million low-income uninsured parents and approximately two-thirds of them—4.3 million—are ineligible for Medicaid coverage.

Single adults or childless couples—even if they have no income at all—are excluded from Medicaid coverage in 42 of the 50 states. But even in the states that provide some coverage, the income eligibility standards are meager: in five of the eight states, income eligibility standards are below $9,000 of annual income. As a result, among the 9.8 million low-income, non-parent adults who are uninsured today, approximately 91 percent—or more than 8.9 million people—are ineligible for Medicaid or Medicaid-like coverage.

It is time for the Medicaid program to be modernized. And it is time to recognize that work does not always move a family out of poverty. As first steps, we have three recommended improvements to the Medicaid and SCHIP programs.

First, we recommend that the historical ties to categories of eligibility be undone once and for all. States should be allowed to cover low-income adults—regardless of their parental status—without a waiver of federal law.

Second, to encourage states in these tough fiscal times to provide expanded health insurance coverage to parents of children eligible for Medicaid and SCHIP, we recommend that states be given an enhanced matching rate for parents. Ideally, parents should be served by the same program—Medicaid or SCHIP—that serves the children. Thus, this enhanced matching rate would be provided both through the Medicaid program and through additional funding in the SCHIP allotments.

Third, states must be given the flexibility to cover legal immigrant children, parents, and pregnant women in their Medicaid and SCHIP programs. Without preventive and basic care, uninsured parents' and children's minor health problems can become life-threatening and require treatment in hospital emergency rooms—and *then* Medicaid covers the more expensive care required. Likewise, without access to prenatal care, pregnant legal immigrant women are four times more likely to deliver low-birth weight infants and seven times more likely to deliver premature infants than women with prenatal care. These infants, born citizens, *then* qualify for Medicaid and SCHIP to cover the expensive complications created by the lack of prenatal care. Thus, the prohibition against Medicaid and SCHIP coverage of legal immigrant parents, children and pregnant women is penny-wise and pound-foolish.

**Additional Help to the Recently Unemployed: COBRA Subsidy**

In addition to building on the existing Medicaid and SCHIP programs, Families USA supports a COBRA subsidy to help recently unemployed families afford the cost of continuing their employer-based coverage.

Certainly, for many recently unemployed families, the cost of COBRA coverage is a very real barrier. Newly unemployed workers must pay 102 percent of the employer's cost—the full premium, including the portion that the employer previously paid, plus a 2 percent administrative fee. It is estimated that only one out of five unemployed workers who are eligible for COBRA coverage took advantage of the opportunity. A major reason for the low COBRA take-up rate is the high cost of premiums for employer-based coverage. The 2001 cost of COBRA continuation coverage through the average employer plan was $7,194 for family coverage and $2,705 for a single worker.

A COBRA subsidy allows people to retain their group health insurance coverage rather than face the severe limitations of the individual market—especially important for any person who is not young or who is in less-than-perfect health. From an employer's standpoint, however, the high cost of COBRA coverage creates a problem of adverse risk selection—sicker and older former employees are more likely to stay in the employer's insurance pool and healthier and younger former employees move into the individual market. This segmentation of the insurance pool drives up the cost of employer-based health insurance coverage. By subsidizing COBRA premiums, this problem is greatly ameliorated because young and healthy former employees will find the cost of subsidized COBRA coverage to compare favorably to the cost of unsubsidized coverage in the individual market.

However, if unemployed workers are given the "choice" to go into the individual market with their subsidy, the problem of adverse risk selection will be *worse* for employers. As I have already described, older workers and workers with any kind of health conditions will not be able to find coverage (or it will be significantly more expensive and less comprehensive) in the individual market and will remain in the employer insurance pool. These workers don't really have a "choice" to buy coverage in the individual market. However, younger and healthier workers, who

are often willing to settle for less coverage to save money, will remain likely to purchase coverage in the individual market because they won't forfeit their subsidy. As this adverse risk selection continues, premiums also will continue to rise as employer plans do not gain any ability to cross-subsidize premiums among *all* former workers.

Some laid-off workers are not eligible for federal COBRA continuation coverage even though their employer provided health insurance benefits: workers who had jobs in firms with fewer than 20 employees. However, 38 states have enacted COBRA-like laws that supplement the federal law and help workers laid off from firms with fewer than 20 employees. Thus, it is very important that a subsidy be available for the purchase of continuation coverage guaranteed by *both* federal *and state* laws. The combination of both federal and supplemental state laws provides continuation coverage to almost three-quarters of laid-off workers.

**Why Families USA Opposes Current AHP Proposals**

The current Association Health Plans (AHPs) legislative proposal (H.R. 2563) is intended to help smaller employers and self-employed individuals come together to purchase health insurance coverage at lower cost. While the concept sounds reasonable—allowing small employers to come together to achieve cost-savings through greater bargaining clout and efficiencies of scale—the current legislation has the potential to cause significant harm to the existing small employer insurance market.

In fact, small employers can come together under existing law to purchase health insurance. Nothing in current federal or state law *prohibits* small employers from forming associations. In fact, one in four of all private employers and one in three of all small employers (nine or fewer employees) purchase insurance through group purchasing arrangements.

Generally, any time more than one small employer comes together it is considered a Multiple Employer Welfare Arrangement (MEWA) under ERISA law and must comply with certain DoL registration requirements and basic fiduciary duties. In addition, both fully-insured and self-insured MEWAs also are under state regulation. MEWAs must comply with state laws, including: solvency standards to protect against plan financial failures and state consumer protection laws, as well as rating, underwriting laws, and benefits mandates that protect against adverse risk selection and segmentation in the small group market.

If small employers currently are able to band together to purchase health insurance, then what does AHP legislation accomplish? The key change is that AHPs will be able to operate outside of state insurance laws.

The proposed federal AHP legislation would federalize the regulation of Association Health Plans by eliminating state authority to regulate these arrangements. H.R. 2563 would create two types of AHPs. For *insured* AHPs, the

insurance company would be required to comply with state laws regarding solvency requirements in the state where it is licensed, as under current law. However, the *plans* offered by insurance companies to AHP members would have to comply with the state consumer protection laws in *only one state* in which the plan is offered—even if it is offered in more than one state. Currently plans must comply with the laws in *each* state where the plan is offered. Logically, insurance companies would select states with the fewest consumer protections. Further, insured AHPs would *not* have to comply with state rating laws, limits on medical underwriting, and benefits mandates.

Even more problematic, *self-funded* AHPs would be exempt from *all* state laws and oversight—including solvency requirements and all consumer protections as well as premium rating laws, limits on medical underwriting and benefits mandates.

After careful consideration, Families USA does not find evidence that exempting AHPs from state regulation will improve the situation for small employers. Rather, we find that the current AHP proposal would not lower average premiums for small employers but would actually *increase* premiums for many small employers. In fact, costs for some employers that now offer health insurance benefits would increase so significantly that they would be forced to drop coverage. In addition, an exemption from state oversight will place consumers at a great risk for enrollment in insolvent plans—whether the financial failure is due to deliberate fraud or poor management.

**AHPs: Leave Many Small Employers Behind with Higher Premiums**

States enact premium rating and underwriting laws to actually require insurers to "pool" all their small employers in setting premiums. With exemptions from these state laws, AHPs will divide small employers into high-cost and low-cost groups ("segment the market"). AHPs will be able to skim low-risk employers (employers with a young, healthy workforce) from the existing state-regulated small group market by attracting them with cheaper premiums. At the same time, high-risk employers will be left behind with much *higher* premiums because they will no longer have the benefit of cross-subsidization of costs between high- and low-risk employers. The capacity of AHPs to significantly lower premiums is very much dependent on their ability to successfully "cherry-pick" healthy members—to "rob Peter to pay Paul." *In fact, the CBO estimates that nearly two-thirds of the cost savings from AHPs would result from attracting healthier members from the pool of existing insured workers.* Without state limits, many small employers with sicker or older workers will simply be driven out of the small group health insurance market by higher premiums. The CBO estimates that 80 percent of workers would be worse off under AHPs: 20 million employees and dependents of small employers would experience a rate *increase*.

Proponents of AHPs also argue that small employers should be able to offer less generous benefits packages in order to bring down the cost of coverage. And, indeed, dropping state mandated benefits would be a major method that AHPs could use to reduce costs. The CBO estimated that one-third of cost savings in AHPs

would come from eliminating state benefits mandates. However, the issue goes beyond simply weighing the social and political merits of guaranteeing certain benefits against the cost of those benefits. It is not simply a question of "some coverage is better than no coverage" for workers. It is critical to examine how exempting AHPs from state benefit mandates again will allow AHPs to cherry-pick healthy people and segment the small employer insurance pool.

An exemption from key benefit mandates would allow AHPs to offer benefit packages that save money by excluding prescription drugs, mental health services, and maternity coverage, for example. But these cheaper, less comprehensive packages will attract healthy people with lower premiums because they feel confident that they won't need the missing benefits. But this financial calculation also makes the AHP plan coverage less attractive for individuals who know that they will need these benefits—older workers, women, disabled and chronically ill individuals. Thus, the AHP can manipulate the benefits package to attract people who are young and healthy, and to discourage other people. Once again, this "adverse risk selection" ultimately leads to increased costs for the small employers and workers who are left behind to insure through the traditional, non-AHP market.

It is critical to understand that state rating laws, underwriting laws, and benefit and provider mandate laws are all designed to make coverage affordable and accessible for *all* small employers and their employees. We are willing to work with proponents of AHPs to design structures that would address some of the cost concerns of small employers. For example, a productive discussion might examine what benefits mandates are critical to prevent adverse risk selection and market segmentation. And there are some promising ideas about how small employers might be helped with the cost of insurance through a small employer tax credit. *But we are opposed to any design or structure that will lower the cost of premiums for a few lucky healthy workers at the cost of the majority of workers that are in less-than-perfect health.*

**AHPs: Solvency Protections and Active Oversight Essential**

In addition to our concerns about market segmentation, we are extremely concerned about protecting consumers from plan failures that leave consumers with unpaid medical claims. For self-funded AHPs, the proposed (H.R. 2563) would preempt states from continuing their traditional role of regulating such matters as solvency and consumer protections and place self-funded AHPs under the jurisdiction of the U.S. Department of Labor (DoL).

Proponents of AHPs argue that their proposal would allow pools of small employers to operate under the same rules as large self-funded employers that are governed by ERISA. While this may sound reasonable at first glance, a large self-funded employer is a very different entity from an AHP. When a large employer self-funds, the large employer has considerable assets, revenue flow and resources to handle fluctuations in the number of claims. Further, large employers tend to be more stable entities and to have a more stable workforce so that the level of claims is

predictable.

An AHP is only a shell or skeletal structure created by an association of small employers and comprised of a board of directors. The assets of the small employers who are members are available to pay medical claims if the small employers sign a promissory note to put up their business assets against future unpaid claims. However, this places employers at very serious risk of financial ruin and bankruptcy. This is because it will be very hard to predict the claims that an AHP will experience: the average small employer's workforce is much less stable—the mix of healthy, sick, young, and old is changing—and small firms are more likely to come and go. If the actual claims level exceeds what was predicted, small employers have very little cash flow or liquid assets to make up the shortfall. Thus, a self-funded AHP must operate more like an insurance company to adequately protect its members—it must offer protection against unpredicted claims fluctuations—than is true of a self-funded large employer. These new "AHP insurance companies" for small employers would be created without any of the state laws and oversight that govern the solvency of other insurance companies. The only solvency protections that will exist are those that are required by the proposed AHP legislation.

While proponents of AHPs maintain that H.R. 2564 "fixed" the solvency protection problems of past AHP proposals, we find that *the solvency requirements for self-funded AHPs are clearly not adequate.* Without elaborating on the details, provisions in the bill regarding minimum surplus, minimum reserve, and individual and aggregate stop-loss insurance must be enhanced to protect workers. Even if these solvency requirements were appropriately strengthened, in order to provide workers in AHPs real protection, the federal government must establish a true guarantee fund sufficient in size to pay the unpaid claims of insured workers. The so-called "guarantee fund" in the AHP bill only pays the premiums for stop-loss and "indemnification insurance." A true guarantee fund will require significant federal funding support from general revenues; fees or assessments from AHPs will not be adequate to create this guarantee fund.

In addition to the cost of a federal guarantee fund, we should not underestimate the cost to provide the Department of Labor with the enforcement tools, staff, and resources necessary to oversee these many new "AHP insurance companies" removed from state jurisdiction. The AHP proposal would, in effect, re-create a national insurance department to replicate the function of 50 state insurance departments. The DoL has testified that they lack the funding and manpower to take on this enormous responsibility and estimate that they could review each AHP only once every 300 years. A recent GAO report found that it would take DoL's current investigative staff 90 years to do a baseline assessment of noncompliance for pension plans alone.

Are opponents of AHP legislation over-reacting to the potential for fraud, abuse and insolvency? History and recent events would indicate not.

In 1974, Multiple Employer Welfare Arrangements were exempted from state regulation and placed under the authority of the Department of Labor. The members of this Committee are aware of the disastrous results: MEWA failures in the four years from 1988 to 1991 left at least 398,000 consumers with over $123 million in unpaid claims, according to a 1992 General Accounting Office report. Through hearings and review of the situation, Congress decided that MEWA regulation had to be returned to the states. We do not want to repeat this mistake by leaving AHPs exempt from state solvency and consumer protection laws.

The regulation of MEWAs or association-type health plans for small employers is an enormous task. Recent media reports have documented the failure of self-funded association-type health plans for small employers over the last six months. These failures have hurt more than 50,000 workers and their families by leaving them with millions of dollars in unpaid medical bills. By contrast, that is more than twice the number of people hurt by the ENRON benefits plan failure. State and federal regulators indicate that in the last two years, the number and magnitude of association health plans' abuses have grown and that such "illegal operations are rapidly growing and spreading around the country." While some of the failed health plans were clearly fraudulent criminal schemes, others were sponsored by business groups that likely could have obtained certification as AHPs under the proposed legislation.

AHPs would also be exempt from state consumer protection laws that ensure that HMOs and other insurers do not wrongfully deny health care. The recent Supreme Court decision in *Rush Prudential HMO, Inc. v. Moran* provided a victory for patients by upholding the Illinois external appeal process that gives patients a right to have impartial health experts review the denial. This right would be meaningless for any worker receiving health coverage through an AHP. Nothing in the AHP legislation would replace that right to a fair and independent review that consumer advocates, policymakers and regulators in 42 states have deemed to be essential to balance the power between consumers and health insurers.

States have passed many other health insurance consumer protection laws that would be immediately wiped out for any worker covered under an AHP. These laws protect access to specialists, continuity of care, the autonomy of the patient-physician relationship, the right to emergency care, the right to full and fair disclosure of information about coverage, and the availability and timeliness of internal appeals of denials of treatment, to name just a few key protections. The policy decisions and best judgment of 50 state legislative bodies—reflecting the experiences and problems of people in their states as well as the political weighing of the costs and benefits of these protections—would be usurped.

In closing, we share the concern of proponents of AHP about the growing number of uninsured and, in particular, share the recognition that the rising cost of health insurance is a major barrier to small employers who want to offer coverage to their workers. We are ready and willing to work with Congress to help craft solutions to help more small employers provide health insurance coverage. But we must be sure

that what we design does not deliver more harm than help to workers and owners of small firms.

***APPENDIX G - WRITTEN STATEMENT OF JOSEPH E. ROSSMANN, VICE PRESIDENT OF FRINGE BENEFITS, ASSOCIATED BUILDERS AND CONTRACTORS, ROSSLYN, VA, TESTIFYING ON BEHALF OF THE ASSOCIATION HEALTH PLAN COALITION***

**Testimony of Mr. Joseph E. Rossmann**

**Vice President of Fringe Benefits, Associated Builders and Contractors**

**On behalf of the Association Health Plan Coalition**

**July 9, 2002**

***Introduction***

Mr. Chairman, Ranking Member Andrews and members of the Subcommittee, thank you for holding this hearing to review efforts to expand access to quality health benefits and the problem of the uninsured.

My name is Joseph E. Rossmann, and I am Vice President of Fringe Benefits for Associated Builders and Contractors (ABC), a national trade association representing over 23,000 contractors, subcontractors and suppliers through a network of 81 chapters. I am testifying before you today on behalf of the Association Health Plan (AHP) Coalition, which consists of over 85 national and regional organizations that support H.R. 1774, the Small Business Health Fairness Act of 2001. The AHP Coalition represents over 12 million employers and over 80 million small business workers throughout America. I also am secretary and past president of The Association Healthcare Coalition, which consists of bona fide trade and professional associations that currently operate association-sponsored health plans, or have done so in the past.

Mr. Chairman, today's hearing is extremely timely. The problem of small business workers not having access to affordable health benefits is reaching epidemic proportions across the nation. Since over 60 percent of all uninsured Americans are employed in a small business, or are dependents thereof, the current trend of skyrocketing premium increases threatens to greatly expand the number of uninsured Americans, which now stands at approximately 40 million. To give you some idea of the problems that small business workers face, attached are three pages of "small business health insurance horror stories" compiled this month from ABC members across the country. For example, in Houston, Texas, Acoustical Concepts, Inc. was forced to accept a premium increase of 47% this year, even though they had no significant claims. Moreover, their insurance company, Blue Cross/Blue Shield, has informed them that in 1-2 years, the 87 employees at this company will be offered only catastrophic coverage.

Indeed, massive premium increases of 40 percent, 50 percent and higher, and/or benefit reductions, are typical of what small businesses throughout the nation are experiencing today. Clearly, current initiatives aimed at expanding access to

affordable health care are not working. As such, Congress must take action to address this critical issue this year to prevent thousands of small business workers from losing their health benefits, and to expand coverage to millions of uninsured Americans.

Our coalition strongly urges Congress to enact the Small Business Health Fairness Act (H.R. 1774), bipartisan "AHP" legislation sponsored by Reps. Ernie Fletcher (R-KY) and Cal Dooley (D-CA), which is essential to addressing this acute problem. We commend the House for approving similar legislation as an amendment to the Patients' Bill of Rights (PBOR) last year. However, regardless of the fate of the PBOR legislation, Congress should approve the AHP bill this year to expand access to health benefits for small businesses and the self-employed.

***The Need for Association Health Plans***

H.R. 1774 is essential to the goal of providing Fortune 500-style health benefits to working families employed in small businesses. Through this legislation, AHPs will empower our nation's entrepreneurs with the same tools that large employers and unions use to make health coverage affordable for working families. These tools are:

- economies of scale and increased bargaining power for small employers;
- administrative savings from having one uniform set of rules;
- the option of self-funding health benefits;
- health benefit design flexibility;
- increased competition in health insurance markets.

AHPs can reduce health insurance costs by 15 – 30 percent by allowing small businesses to join together nationwide to obtain the same economies of scale, bargaining clout, and administrative efficiencies now available to employees in large employer and union health plans. New coverage options will promote greater competition and more choices in health insurance markets. In order to make sure benefits for small business workers are secure, the legislation also contains tough new solvency standards that are as stringent as most similar state laws.

H.R. 1774 is the ONLY proposal which will put small business workers on a level playing field with employees in large corporations or union health plans. Right now, small business workers are second-class citizens when it comes to health benefits. On average, workers in firms with less than 10 employees pay 17% more for a given health benefit than workers employed in a large company. This is because small businesses don't have access to the type of economies of scale, bargaining power and administrative savings that corporate and union plans now have. The AHP legislation will rectify this inequity by leveling the playing field between workers in small and large businesses.

We estimate that AHPs, with the benefits of H.R. 1774, can reduce the cost of health benefits by 15 –30 percent for small business workers. We know this because

association plans have already proven they can deliver savings compared with the cost of small employers purchasing directly from an insurance company. For example, the AHP sponsored by ABC for more than 40 years, which operated nationally, had total administrative expenses of 13 ½ cents (13.5 percent) for every dollar of premium. These costs included all marketing, administration, insurance company risk, claim payment expenses and state premium taxes. Alternatively, small employers who purchase coverage directly from an insurance company can experience total expenses of 25 to 35 cents (25 – 35 percent) for every dollar of premium. Moreover, any profit generated by an AHP in a given year does not go to the stockholders of the insurance company, but rather stays in the plan and inures to the benefit of participants by keeping costs lower in the future.

The ABC plan was founded in 1957 by five contractors who could not buy group health insurance for their employees in the open market due to their small size. Through an AHP, our plan offered HMOs, PPOs, and traditional health insurance plans including both in-network and out-of-network benefits. All of ABC's plans provided wellness benefits with coverage for physicals and annual check ups. The plan operated in full compliance with the Employee Retirement Income Security Act (ERISA) of 1974, the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, and the Health Insurance Portability and Accountability Act (HIPPA) of 1996. Complying with the federal HIPPA legislation requires AHPs to provide open access to all members and provide credit for prior coverage.

Unfortunately, we had to discontinue the health insurance portion of our fully insured AHP a few years ago when our insurance carrier informed us that they were terminating our coverage. This happened to many other association plans as well. The problem is that it is just too costly for insurance companies to comply with overlapping, inconsistent and often incompatible state laws. Thus, a badly-needed source of dependable, quality health insurance coverage for small employers, designed to give them economies of scale and greater bargaining power with insurance companies, has been effectively removed from the market.

The inability of states to provide a regulatory environment in which national associations can serve as a source of affordable health benefits for small business workers is a real tragedy. Bona fide trade associations have an established infrastructure that allows them to communicate with members more effectively because of their pre-established relationships. This unique structure allows associations to add value to their members and workers that other organizations or purchasing pools cannot duplicate. AHPs are capable of offering valuable options by providing additional benefits over and above what many insurance companies provide today. Associations can successfully tailor the products and services specifically for the needs of their members.

An important component of an AHP is that it is guided by employer members who serve as trustees. As participants in the program, they act in the best interest of their fellow members and their employees. Participation of the board of trustees is a key ingredient in aggregating the voice of employers to negotiate price and coverage

with insurance carriers and medical providers.

Workers in small businesses desperately need a viable mechanism to group together to increase their bargaining clout and create more competition in health insurance markets. This is true more so today than ever before due to the huge wave of consolidation among health insurance companies and hospitals. Recent mergers of health insurance companies have reduced competition and alternatives for small employers who seek access to quality and affordable health insurance. In fact, a survey of state insurance commissioners conducted by the General Accounting Office (GAO) at the request of Senator Kit Bond (R-MO) found disturbing levels of concentration on the small group health insurance markets, with market shares of nearly 90 percent among the five largest companies in 7 states.

Today, there is a great need to bring more competition back into the system rather than continually reducing it. By providing more options and choices for small employers, the AHP legislation will inject greater competition in health insurance markets, thus bringing down premiums and expanding health plan benefits and plan options to more small business workers and their families.

***Rebuttal of Criticism of AHP Legislation***

I would like to address criticisms of H.R. 1774 that have been raised by large insurance companies and state insurance commissioners, who have a vested interested in maintaining the status quo. First, opponents claim that AHPs will "cherry pick" the market and only benefit healthier groups of people. But the assumptions under which this argument is made do not hold up to scrutiny.

AHP legislation will **not** result in cherry picking for the following reasons:

> It is illegal for AHPs to deny coverage to any eligible participants based on the health status of an individual employer or employee under HIPAA, and the AHP bill maintains this. Thus, it will not be possible for AHPs to "cherry pick" because sick or high-risk groups or individuals cannot be denied coverage;
>
> The bill contains strict requirements under which only **bona fide** professional and trade associations can sponsor an AHP. These organizations must be established for purposes **other than** providing health insurance for at least three years. Thus, an AHP **cannot** "select a population that is healthier than those in state regulated pools." The bill strictly prohibits "sham association plans" set up by insurance companies in the past as a front group aimed at cherry picking the market;
>
> Opponents' allegations about adverse selection rest on the

**mistaken assumption** that small businesses will offer only "bare bones" benefit packages through AHPs. There is broad agreement that "bare bones" plans, wherever they have been tried, have failed due to lack of demand. This is because small business workers want Fortune-500 style benefits like those enjoyed by workers in large companies. Also, small businesses **must** offer benefit options comparable to those offered by large companies if they are going to attract and retain quality employees;

Adverse selection that **currently exists** in state markets will be greatly reduced when younger, healthier workers employed in small businesses who are now uninsured are able to obtain coverage that is affordable;

The bill gives small businesses the ability to offer the **same** type of benefit packages now available to health plans established by large corporations and labor unions;

Non-profit associations exist to serve their members. If they attempt to exclude members to avoid higher risks, or do not offer attractive benefit options, their mission is fundamentally compromised and they will not be able to compete in the marketplace;

Bona fide associations will be able to offer Fortune 500-style benefit packages to small business workers by achieving savings through economies of scale, greater bargaining power, administrative efficiencies and adding value for their members.

The other major criticism is that benefits offered by AHPs will not be secure. This ignores two facts: First, that AHPs under this legislation are fundamentally different from MEWA health plans which operate under state laws; and second, it ignores the strong new solvency standards required for AHPs under the bill, which will increase consumer protections for many small business workers. The bill requires the following solvency provisions for self-funded AHPs:

- claims reserves certified by a qualified actuary;
- minimum surplus requirements;
- both specific and aggregate stop-loss insurance;
- indemnification insurance to ensure that all claims are paid;
- AHPs must register with the state in which they are domiciled;
- AHPs must abide by strict disclosure and actuarial reporting procedures; and,
- The bill provides new criminal and civil penalties to combat fraud.

Indeed, a former Inspector General at the Department of Labor has testified before

Congress that the new enforcement tools for regulators contained in this legislation will help reduce health insurance fraud. Thus, allegations that health coverage obtained through AHPs will not be secure ignore these strong protections contained in the bill. I would like to summarize our response to this question with a quote from Secretary of Labor Elaine Chao on this topic:

> "I know that many of you are concern that the creation of Association Health Plans – something the President strongly supports – will lead to abuses similar to what we have seen with some MEWAs. I want to reassure you that the Association Health Plan provisions included in the version of the Patients' Bill of Rights passed by the House has strong provisions to protect against abuse. Additionally, the bill protects against adverse risk selection and includes safeguards to prevent destabilization of the private market."

***Conclusion***

The 12 million employers and more than 80 million employees represented in the AHP Coalition strongly urge Congress to enact H.R. 1774 this year. This legislation will expand Fortune 500-style health benefits to workers employed in small businesses and the self-employed. AHPs are important for many working families employed in small businesses that otherwise could not afford coverage. As such, AHPs are an essential component of any solution aimed at reducing the uninsured population in our nation.

***APPENDIX H – SUBMITTED FOR THE RECORD, HARRY M.J. KRAEMER, JR., CHAIRMAN AND CEO, BAXTER INTERNATIONAL, INC., DEERFIELD, IL, TESTIFYING ON BEHALF OF THE HEALTHCARE LEADERSHIP COUNCIL, ANSWERS TO QUESTIONS RAISED BY CHAIRMAN SAM JOHNSON, JULY 25, 2002***


**Committee on Education and the Workforce**
**Subcommittee on Employer-Employee Relations**

**Hearing**
**Expanding Access to Quality Health Care: Solutions for Uninsured Americans**
**July 9, 2002**

**Answers to Questions Raised**

**Mr. Harry M. J. Kraemer, Jr., Chairman and CEO, Baxter International, Inc., on behalf of the Healthcare Leadership Council**

* * * * *

**Q1: What are the advantages of covering the uninsured through employer programs versus the S-CHIP and Medicaid programs?**

HLC believes the S-CHIP and Medicaid programs are very valuable for their intended purposes for low-income families. However, evidence suggests that we are reaching the limits of effectiveness in reducing the number of uninsured through the S-CHIP and Medicaid programs. Only about half of individuals currently eligible for Medicaid and S-CHIP actually participate. A number of reasons have been cited for low participation rates, including the fact that participation rates of means-tested public insurance programs decline as incomes rise. A large number of those not participating in these programs are those with incomes too high for Medicaid eligibility, but low enough to qualify for S-CHIP. Therefore, expanding Medicaid or S-CHIP up the income ladder would most likely meet the same non-participation fate. Families with incomes just above the poverty level are often working full time and are more reluctant to receive their health care through a public program. Therefore, solutions involving employer insurance may be more effective in increasing coverage rates for these populations.

In addition, many of the working poor often do not know how or where to sign up for Medicaid or S-CHIP. There are natural outreach opportunities within an employment setting not found in the Medicaid and S-CHIP programs that can better assist in getting people enrolled.

A number of surveys, including one by the Commonwealth Fund, have shown that people prefer receiving coverage through their employer, rather than public programs, if they have that choice.

**Q2: Your testimony contained survey findings about small businesses that suggest many small business executives simply do not know the facts they need to know about the cost, and the administrative burden of insurance. And I would like to know why you think this is the case.**

There are hundreds of thousands of small business owners who are passionate about starting their own businesses and passionate about providing for their families. This passion does not necessarily equate to spending hours on end studying employer tax law, or searching for employee benefits information. Most small business owners are so focused on their actual trade and getting their businesses off the ground, they don't have the time or financial resources to research this type of information. That's why organizations like HLC, and public entities like this Committee, can and should help contribute to the knowledge base of the small business community by reaching out with literature, websites, and various media to help inform these businesses.

At HLC we are thinking hard about how we can interface with small businesses and we are willing to go door-to-door, if that is what it is going to take. Small businesses typically receive information through their accountants, their chambers of commerce, community associations, even through town meetings with their Congressmen. Each community has various information outlets, requiring tailored education initiatives.

Perhaps the federal government could create a small grants program specifically for community entities, like chambers of commerce, to provide information on health insurance to the small businesses they serve. In addition, I assume the SBA and the Small Business Development Center Association maintain a rich database of small businesses across the country. Direct mailings to these businesses specifically about the importance of health insurance, including resource information, may be effective for this purpose. I must warn, however, that some demonstration projects have shown that it is important to reduce the perception of government interference in this task, so I recommend that you take this into consideration in designing such a program.

07.25.2002

***Table of Indexes***