EXAMINING INNOVATIVE HEALTH INSURANCE OPTIONS FOR WORKERS AND EMPLOYERS

HEARING

BEFORE THE

SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS

OF THE

COMMITTEE ON EDUCATION AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

June 24, 2004

Serial No. 108-66

Printed for the use of the Committee on Education and the Workforce

Available via the World Wide Web: http://www.access.gpo.gov/congress/house
or
Committee address: http://edworkforce.house.gov

U.S. GOVERNMENT PRINTING OFFICE

94-534 PDF WASHINGTON : 2004

For sale by the Superintendent of Documents, U.S. Government Printing Office
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C O N T E N T S

EXAMINING INNOVATIVE HEALTH INSURANCE OPTIONS FOR WORKERS AND EMPLOYERS

Thursday, June 24, 2004

U.S. House of Representatives

Subcommittee on Employer-Employee Relations

Committee on Education and the Workforce

Washington, DC

The Subcommittee met, pursuant to notice, at 10:04 a.m., in room 2181, Rayburn House Office Building, Hon. Sam Johnson [Chairman of the Subcommittee] presiding.

Present: Representatives Johnson, Tiberi, Wilson, Kline, Carter, Andrews, Payne, McCarthy, Kildee, Tierney, and McCollum.

Staff present: Kevin Frank, Professional Staff Member; Ed Gilroy, Director of Workforce Policy; Aron Griffin, Professional Staff Member; Richard Hoar, Staff Assistant; Molly Salmi, Deputy Director of Workforce Policy; Deborah L. Samantar, Committee Clerk/Intern Coordinator; Jody Calemine, Minority Counsel Employer-Employee Relations; Margo Hennigan, Minority Legislative Assistant/Labor; Marsha Renwanz, Minority Legislative Associate/ Labor; and Michele Varnhagen, Minority Labor Counsel/Coordinator.

Chairman JOHNSON. Good morning.

A quorum being present, the Subcommittee on Employer- Employee Relations of the Committee on Education and the Workforce will come to order.

We are holding a hearing today to hear testimony on examining innovative health insurance options for workers and employers. Under Committee Rule 12(b), opening statements are limited to the Chairman and Ranking Minority Member of the Subcommittee. Therefore, if other Members have statements, they will be included in the hearing record.

With that, I ask unanimous consent for the hearing record to remain open 14 days to allow Member statements and other extraneous material referenced during the hearing to be submitted into the official record.

Without objection, so ordered.

STATEMENT ON HON. SAM JOHNSON, CHAIRMAN, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

I want to extend a warm welcome to all of you and to the Ranking Member, Mr. Andrews, and my other colleagues who are present today.

With annual double-digit health care cost increases over the last few years, employers are faced with the question of how they will continue voluntarily providing the high level of quality benefits that they have in the past.

Essentially, they have three options: reduce benefits, ask employees to contribute more, or reexamine your whole workforce.

Many employers are redesigning their health plans and implementing new options to help employees become more savvy customers of health care. For example, the Wall Street Journal had an article yesterday which described what the Texas-based Whole Foods Market, Inc., was doing. In 2003, Whole Foods took a chance and implemented their own high-deductible plan combined with an account that the employer subsidized. By putting employees in the driver's seat when it came to their health care decisions, they hoped to lower costs.

The results of their decision was impressive. According to the article, overall medical claim costs fell 13 percent from the year before, and despite critics' conjecturing, one woman said that the plan certainly never stopped her from going to the doctor, "but it made me a more conscious spender."

At the end of 2003, $14 million carried over in employee accounts, which employees can use toward this year's medical expenses, and the benefits of a plan like this are not just cost-based. The number of Whole Foods employees with health insurance skyrocketed from 65 percent to 95 percent, and the employees are happy with their plans.

Last summer, the company gave their workers a choice between consumer-driven plans and one of the more traditional insurance arrangements. The high-deductible plan won out, with an overwhelming 83 percent of the vote. Many Members of Congress would do well to get that kind of confirmation.

The Whole Foods model is just one example of the innovative ways employers are continuing to offer benefits. In today's hearing, we will also explore two other options that were made available to employers in last year's Medicare Modernization Act. Employers now have the benefit of new health savings accounts. Individuals and employers may make annual contributions in these HSAs tax-free, and as long as the money is used for medical expenses, it can be withdrawn tax-free.

As a way of helping employers to continue offering high quality health benefits to their employees once they have retired, the recent Medicare prescription drug law also made a range of new options available to employers with respect to prescription drug benefits, and the options present a great opportunity to help ensure the viability of voluntarily sponsored health plans.

We look forward to hearing your testimony, and I thank all of you for coming.

I am going to yield now to the distinguished Ranking Minority Member of the Subcommittee, Mr. Andrews, for whatever statement you wish to make.

[The prepared statement of Chairman Johnson follows:]

Statement of Hon. Sam Johnson, Chairman, Subcommittee on Employer-Employee Relations, Committee on Education and the Workforce

Good morning. Let me extend a warm welcome to all of you, to the Ranking Member, Mr. Andrews, and to my other colleagues.

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The Whole Foods model is just one example of the innovative ways employers are continuing to offer sound benefits. In today's hearing we will also explore two other options that were made available to employers in last year's Medicare Modernization Act.

Employers now have the benefit of new health savings accounts (HSAs). Individuals and employers may make annual contributions in these HSAs tax-free. And, as long as the money is used for medical expenses, it may be withdrawn tax-free.

As a way of helping employers to continue offering high quality health benefits to their employees once they have retired, the recent Medicare prescription drug law also made a range of new options available to employers with respect to prescription drug benefits.

The options present a great opportunity to help ensure the viability of employer-sponsored health care. We look forward to hearing your testimony.

STATEMENT OF ROBERT E. ANDREWS, RANKING MEMBER, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

Mr. ANDREWS. Good morning. Thank you, Mr. Chairman, for your courtesy, and I appreciate the chance to hear from the witnesses this morning. Thank you for your time and your preparation.

In the last three-and-a-half years, over 4 million people have lost their health insurance. The number of people who are without health insurance has gone up from about 40 million to 44 million.

One of the driving factors in that is the wildly escalating cost of health insurance. There is not an employer with whom I have met in the last 5 years, frankly, that has not listed the skyrocketing

costs of health insurance at or near the top of his or her list of concerns. Without a doubt, the rising cost is a major contributor to the growing ranks of the uninsured. So, the focus on ways to reduce the cost of health insurance is a welcome focus.

It is a highly debatable area. I, frankly, am greatly skeptical that so-called consumer-driven models will reduce health care costs. Buying health care is not the same thing as buying an article of clothing or a piece of furniture. It is a very complex transaction, and I think that the presumption is that these choice models may deteriorate quality before they reduce cost, but that is why we have these hearings, so we can debate and hear the arguments for and against such models.

I would caution people, however, not to put too much credence in the theory that a modest cost reduction would radically reduce the number of uninsured people in the country, because it will not. A modest cost reduction is welcome and it is necessary, but it is wholly insufficient to deal with the vast majority of the 44 million uninsured Americans. If you look at American families that made less than $37,000 a year, half of them have been without health insurance in the last year.

Typically, the family that is without health insurance has a very low family income. The person who is working in that household is working for a thin margin industry at low wages with little or no health benefits. A significant drop in the price of health insurance is not going to reach most of those uninsured people. It is not.

The employer who is working on a very thin margin to begin with is not going to be motivated to provide health insurance to an employee if the price drops from $8,200 to $7,800 per family. He or she still cannot afford it.

The harsh reality here is, without significant public subsidies, there will not be a significant reduction in the number of uninsured people in the country. So I think that leads us to the discussions we are going to have on the floor today about the larger and global economic questions for the country. Are tax cuts the right policy or not? Is spending restraint the right policy or not? In what areas are these the right policies or not? Without a significant investment in subsidy to help uninsured people gain access to health care, it is not going to happen.

Now, that does not mean that we should not explore various tools at our disposal to reduce the price of health care, and I look at this morning's panel as an excellent opportunity for us to learn that.

There are many different approaches to this. Some I think will work and some will not, but I think it is very important that we approach this problem with a clear understanding that a family that is making 24 or $25,000 a year, that makes too much for Medicaid but not enough to pay for private health insurance, is not going to be helped very much by a stabilizing or modest reduction in prices of health care for employers. Some of those families will, in fact, get covered, but anyone who assumes that it is more than 15 or 20 percent of those families just is wrong. It is not.

So I think that not only do we need to focus on the issues of reducing cost, but we also need to focus on the budget priorities and policies of the country as to whether we are putting the money in the right place, and I will just conclude by saying I think we did

the right thing in 1997 with the creation of the State Children's Health Insurance Program, the SCHIP program.

There was more progress made in those few years when the funds were available for that program than any other time in the recent history of the country, because we put a significant amount of Federal resources into purchasing high-quality health insurance for children across the country.

That is what is going to make a dent. These other strategies are welcome and necessary, but they are not sufficient to address and solve the problem.

So I look forward to the testimony of the witnesses, and I look forward to the questions from the members of the Committee.

Thank you.

Chairman JOHNSON. Thank you, Mr. Andrews.

Let me introduce our witnesses now, and I want to thank you all for coming now, and I will again later.

The first witness is Mr. William Dennis, Jr. Mr. Dennis is a Senior Research Fellow at the National Federation of Independent Business. He has also served as President of the International Council for Small Business.

Second, Mr. Frank McArdle. Mr. McArdle is the manager of the Hewitt Associates Washington, DC Research Office. Prior to joining Hewitt, Mr. McArdle was Director of Education and Communications at the Employee Benefit Research Institute. Prior to assuming his position, he was a Professional Staff Member at the U.S. Senate.

You did not talk them into doing anything right over there, did you?

Mr. Ron Pollack is our third witness. Mr. Pollack is Executive Director of Families USA, a national organization for health care consumers. Mr. Pollack is also the founder and chair of the Health Assistance Partnership.

Finally, Mr. Rick Remmers. Mr. Remmers is the chief executive officer of Humana, Incorporated, Kentucky, Indiana, and Tennessee health plans. In this capacity, he is responsible for overall strategic direction and operational performance of a combined 500,000-member, $1 billion premium revenue commercial health plan operation.

Before the witnesses begin, I would like to remind the members that we will be asking questions after the entire panel has testified.

In addition, Committee rule 2 imposes a 5-minute limit on all questions, and the lights that you saw working down there are also 5-minute timer lights, and we would ask you if you could try to keep your comments within that limit. When you see the yellow light, you know you have got a minute left, and if you could shut it down pretty quick after the red one comes on, we would appreciate it.

You may begin your testimony, sir.

STATEMENT OF WILLIAM DENNIS, JR., SENIOR RESEARCH FELLOW, NATIONAL FEDERATION OF INDEPENDENT BUSINESS (NFIB), WASHINGTON, DC

Mr. DENNIS. Thank you, Mr. Chairman.

I would ask that my full statement be included in the record at this point.

What happens when small employers receive substantial increases in employee health insurance premiums? Well, the flip answer is they struggle a lot. Unfortunately, the real answer is they struggle a lot.

The easiest way to explain is to walk you through the process.

Once they receive a substantial increase, their first reaction is to shop for a better deal. Indeed, we now find 60 percent of small firms are shopping for a better deal every year. About half that number actually switch. Small firms are the most frequent shoppers, although they are the least frequent switchers. There are limits to what they can get in the market.

Some move to non-traditional forms of insurance. For example, 13 months ago, we found that about 5 percent of all small firms had an MSA. These firms employ 3.9 million employees, although obviously they all did not participate. Once they finish shopping and even if they get some price break, they still need to offset the rest. They have various options before them. I will mention three of the most important.

The first is to raise prices, in other words forward shift. The second is to back shift to employees. The third is to lower their own earnings.

Most would like to raise prices, but most also operate in highly competitive markets.

I would draw your attention to Exhibit 2. Exhibit 2 shows how unsuccessful small firms have been in passing on cost increases over the last decade. If you will note, the thin line represents those who would like to raise prices in the next 3 months; the heavy line indicates the number who were able to. You can see that the heavy line is around zero. Therefore, when they get—when small firms get premiums increases, substantial premium increases, they have a very difficult time forward shifting it.

The alternatives to back shift to employees in the form of fewer jobs, lower wages, fewer benefits, etcetera—economists argue that both theory and evidence show that most health insurance cost increases are back shifted over some period of time but not everything is back shifted and not everything is back shifted immediately.

For example, we can see 25 to 30 percent of all small firms raising cost shares, raising co-payments, raising deductibles. That is back shifting.

Actually, we are finding that relatively few drop insurance, per se. Now, that seemed kind of strange, because why would we have declining coverage? Well, we believe that an important reason for this is that new firms, of which there are 800,000 new employers every year, are reluctant to begin providing insurance.

The third thing that could be done is lower earnings. That is not viable over the longer term. No earnings, no business, no need for health insurance. Yet all costs cannot be back shifted, and we cannot forward shift, as you have seen.

So what is left? That is earnings, that is income, and most small firm owners are middle, upper middle-class folks. So what is the stopgap? Their income is stopgap until a transition can be made,

and those transitions are exacerbated by short notice of premium increases, unexpectedly large hikes, proportionally large hikes, payroll as a large portion of expenses, and a tough earnings environment, and that is what we have had, a tough earnings environment.

So what choices do they have? Well, there is no fixed strategy. It depends upon individual circumstances, but there is no reason to believe that back shifting will stop or decrease. We may be able to do a little more forward shifting. There has been some pricing power in the last couple of months, but I do not see Mr. Greenspan letting that go on for long, and they will continue to shop and look for better deals.

In conclusion, whatever one thinks of insurance companies, rates do reflect the price of health care. Curbing health care costs is an important target. How do we get there? Well, we get there best with individuals making choices about the health care rather than employers, through their insurers, or government making it for them.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Dennis follows:]

Statement of William Dennis, Jr., Senior Research Fellow, National Federation of Independent Business (NFIB), Washington, DC

Mr. Chairman, every measure of small business opinion of which I am aware conclusively shows that the primary concern of small employers is the cost of health insurance. This concern is not a recent phenomenon. But its intensity has grown remarkably in just the last four years. In the year 2000, the cost of health insurance headed a ranking of 75 possible small-business problems (Dennis, 2000). Forty-seven (47) percent of respondents to the survey from which that list was developed termed the cost of health insurance a critical problem. Within the last month, the NFIB Research Foundation published an up-dated list (Phillips). The cost of health insurance still headed the list, but by an even larger margin than in 2000. This spring the proportion terming the cost of health insurance a critical problem rose 19 percentage points to 66 percent. Clearly, the subcommittee is addressing a problem of enormous concern and interest to small employers.

I intend to focus the bulk of my remarks on small business responses to health insurance cost increases. The available data are not as extensive on this topic as desirable, but they lead us in important directions.

Health Insurance Cost Increases

The extraordinary run-up in health insurance costs over the last several years is well documented. Health insurance cost increases vastly outpaced increases in consumer prices or worker earnings over the last 15 years albeit with a brief respite in the mid-1990s. (Exhibit 1, drawn from the Kaiser Foundation/HRET annual survey, illustrates.) The practical effect of those differential increases is to leave those who pay the health insurance bill with substantially fewer resources to purchase other things, including non-covered health services.

Between 2002 and 2003, the cost of health insurance rose 13.9 percent, 15.5 percent for small employers (Kaiser Foundation/HRET). That means the average total cost of health insurance for a 10-employee firm (half individual coverage and half family coverage) rose on the order of $8,200. The $8,200 increase comes on top of a similar increase the prior year and an expected similar increase this year. Even deducting the typical employee cost share, the small-business owner would be looking at an increased bill for health insurance of about $20,000 over this three-year period. (If an employer in a 10 employee firm were to institute an average cost health plan with typical cost-sharing arrangements, the firm's share of the sticker shock would be $44,825.)[1]

Given the magnitude of these costs, the immediate question all owners providing employee health insurance must ask themselves is:

1. What are my alternatives? and
2. How do I pay for what coverage I provide?

The Alternatives

The first small employer reaction to a substantial increase in premiums is to start shopping for a new plan, new carrier or even a new insurance agent/broker. Kaiser/HRET reports that in 2003, 62 percent of those employing between 3 and 199 people shopped for a new health insurance plan; 33 percent switched. A switch estimate for the prior year was 27 percent (NSBP; *Business Insurance*). A point to note is that small employers are the most likely of any employer size to shop and the least to switch. The implication is that while shopping often, the available alternatives are not necessarily enticing. Still, about half of the shoppers seemed to find something better.

A second type of alternative is use of non-traditional insurance mechanisms. Within the last year, NFIB collected a modest amount of data on small business use of three variants - Flexible Spending Accounts, Medical Savings Accounts, and reimbursement for some or all of privately purchased health insurance (NSBP; *Health Insurance*). Exhibit 3 shows that about 13 months ago, an estimated 9 percent of small employers with between 1 and 249 employees offered a flexible spending account, 5 percent MSAs and 13 percent some type of reimbursement. Larger, small employers were more likely to offer each than smaller, small employers. This size distribution likely means that proportionally more small business employees are eligible for the benefits than firms offering them.

Sample sizes make estimation of covered employees perilous. However, a reasonable, but very rough, estimate of the number of people employed by businesses that host these alternative programs are 8.9 million for flexible spending accounts, 3.9 million for medical savings accounts, and 7.8 million for reimbursement. Not every employee in these firms participate. Further, there is some overlap among programs. The totals, therefore, cannot be added to obtain an estimate of total employees impacted. Still, the number of employees exposed to these alternative insurance mechanisms indicates that small employers are changing rapidly and exposing a broad and large range of employees to them.

The different frequency of use by firm size is not surprising. Larger, small firms typically have greater administrative sophistication and more established human resources policies than smaller, small firms. That reimbursement, the simplest of the three alternatives posed, is proportionally used more frequently than the other two forms is evidence of the size effect.

NFIB currently has a small Health Savings Account program (including conversions from MSAs) for its members that is in its infancy. The good news I am told by people in Nashville who run the program is that 94 percent renew and cost savings for equivalent policies are about half. The bad news is that distribution is a problem. Agents do not like to sell these products due to their relatively low commissions, so NFIB has just 3,000 lives covered to date. A new distribution system has been devised and will soon be implemented. The program's head expect the number of lives covered to rise exponentially.

Even if these options provide relief for small employers, many find it necessary to offset rising health insurance costs by other means.

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[1] All calculations made by the author using 2003 premium data collected by Kaiser/HRET.

The Limited Number of Potential Responses

The small employer, any employer for that matter, has a limited number of options from which to choose when facing cost increases for health insurance, energy, or even a government mandate. The most obvious is to pass-on cost increases in the form of higher selling prices. A second possibility is to reduce costs, such as cutting employee compensation or eliminating, postponing or trimming business investment. A third is to lower owner earnings. It is also feasible, at least theoretically, to increase sales (spread the cost increase over more units). Let us briefly review each in the context of health insurance.

Pass-On Costs (Raise Prices)

Raising prices seems to be the obvious solution for health insurance premium increases -- just let the customer pay the additional insurance cost a few pennies at a time. But if that were such an easy solution, business owners would be raising prices willy-nilly whether they received cost increases or not. Competition and the inflation environment affect the ability of any owner to raise prices. The more competitive the environment, the more difficult it is to raise prices. This is even more so when your cost increases are relatively greater than the competition's.

Small-business owners typically believe that they are in very competitive markets (NSBP: *Business Insurance*; NSBP: *Competition*). Moreover, the health insurance premium increases appear proportionally high for small compared to large firms, particularly when large firms are self-insured. (It should be noted that the cost comparisons between large and small are extraordinarily difficult to make given the internalization of many costs by large firms and the relative value of benefit packages offered.) However, premium increases are clearly proportionally high when firms compete against firms that do not offer employee health insurance. Since most without insurance are other small firms, and small firms are much more likely to be the primary competitor of other small firms (NSBP: *Competition*), the ability to raise prices is severely constrained.

An inflationary environment also makes price increases more viable. Business owners are more likely to plan further increases after realizing prior increases (Dunkelberg, Scott, Dennis) and customers expect them even if they do not like them. But inflation has been under control for over 20 years, and with a few exceptions small-businesses have had virtually no pricing power. Exhibit 2 presents the net percent of NFIB members who plan to raise average-selling prices in the next three months and the net percent whom actually did. Since 1982, but particularly since 1992, substantially more planned to raise prices than eventually did (could). The era was low inflation. Compare that to the 1974 - 1982 period when the opposite transpired. Small business has obtained a little more pricing power over the last few months. But if Mr. Greenspan has his way, that will not continue.

Reduce Costs

Payroll costs constitute an important cost for smaller firms. It amounts to about 30 percent of total business expenses in the median firm (NSBP: *Adjusting to Cost Increases*). When health insurance costs rise, it is possible to offset them by reducing payroll costs through such actions as employee lay-offs or failure to fill vacant positions (job loss), smaller raises or wage cuts, or a benefit reduction such as foregoing a pension plan, a greater employee cost share for health insurance, and even the elimination of employee health insurance.

The most common response to health insurance cost increases is to shift at least a portion back to employees in the form of greater cost sharing, higher deductibles and/or higher co-pays. (Economists tend to agree that both theory and empirical evidence indicate that a large share of cost of health insurance is shifted back to employees, though there is little evidence on precisely how the process works (Blumberg)). Kaiser/HRET reported that in 2003, 27 percent of small employers increased their cost share (65 percent of employers with more than 200 employees did), 24 percent hiked their deductibles, and 26 percent raised the co-pay for an office visit. NFIB reported that of those who found health insurance costs rising faster than any other type of insurance, 27 percent raised the employee cost share and 31 percent increased deductibles the prior year (NSBP; *Business Insurance*).

One option small employers did not chose in response to health insurance price increases was to drop employee health insurance. Just 5 percent of those without employee health insurance said that they dropped the benefit in the last three years (NSBP: *Business Insurance*). These data argue that declining coverage is not so much a phenomenon of benefit elimination, as of new businesses less often or later in life offering the benefit. Small employers do not like to take things away from employees once given. That is why not only premium price, but premium price uncertainty, is such a frequently cited reason for not procuring employee health insurance (Fronstin and Helman, Kaiser/HRET, NSBP: *Health Insurance*).

The fact that health insurance is infrequently eliminated does not mean rising health insurance premiums do not result in reduced coverage (and lost jobs). Increased premiums have that effect (Morrisey). However, the route appears is more indirect than eliminated coverage.[2]

(The 5 percent figure over three years cited above is much smaller than the 21 percent figure (in 2002, 12 percent in 2000) over the prior five years reported by EBRI (Fronstin and Helman). Part of the difference can be explained by the population surveyed, up to 249 employees in one and up to 50 employees in the other. Another is the question wording, dropped health insurance coverage and offered plan in the past. These differences are important and need to be reviewed, but the former appears to be closer than the latter if for no other reason than the abruptness of the jump between 2000 and 2002.)

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[2]Owners of new firms appear increasingly reticent to offer health insurance. This push-back is significant because the business population constantly churns. About half of businesses die in the first five years and only one in ten reach 10 years old (Nucci). Every year about 800,000 new employers enter (about 5.8 million in the population) (SBA). If the owner of a new three employee firm chooses to pay a $10,000 health insurance premium, there is a strong likelihood the premium will be more the initial investment in the business (*Business Starts and Stops*).

Payroll is not the only important business cost. For example, physical facilities, i.e., the office, store, or plant, is another important cost that might be reduced. A large premium increase with more to follow might induce some owners to relocate to a less costly facility (though relocation costs may more than offset the savings realized for some period of time. In those circumstances, the change provides the business no immediate relief). Moreover, a central business strategy could be tied up in the location or appearance of a facility.

The difficulty with cutting other costs is the assumption that a business is currently wasting money and will stop it to pay for increased health insurance premiums. While priorities may dictate that other costs be scaled back to offset a premium increase, that trade-off goes to heart of production or sales. The most likely impact of such a move would fall on quality and service, and quality and service are the two basic strategies on which small businesses compete (NSBP: *Competition*).

Yet, another cost that could offset an increase in health insurance premiums is to eliminate, reduce or postpone business investment. This is the "eat the seed corn" strategy. Its effect is to impede growth or stimulate a downward spiral. Neither is good for the business, its employees, or the country. To the best of my knowledge, there is no data (except the little you will see later) that tells us the number of firms offsetting employee health insurance costs through smaller investment.

Lower Earnings

Lower earnings are not a viable option over the longer term. If earnings continue to absorb higher costs, earning gradually disappear. No earnings; no business; no need for employee health insurance!

But lower earnings often become a stopgap. While no one likes to take home less money this week than last, this year than last, small-business owners recognize that they do necessarily have a steady income. Their earnings fluctuate. But most small employers are middle-income people who cannot absorb another $5,000 or $10,000 year after year from their incomes to pay higher employee health insurance premiums.

In this regard, it is important to understand that a direct relationship exists between owner take-home and the provision of employee health insurance, establishment of an employee pension plan, and the average wage paid (Dennis, 1999). The more the owner takes home, the more likely the business is offer health insurance, pensions, and higher wages. The reverse is true as well. The corollary to this relationship is that the less profitable the business, the less likely it can use lower earnings to offset health insurance cost increases as even a stopgap measure.

Increase Sales

The idea of increasing sales to offset employee health insurance costs is to spread their cost over more units thereby minimizing the increase per unit of sales. But this option is not typically plausible because exercising it effectively assumes that the cost of increased sales is fixed rather than variable, and that the business is purposefully capping current sales. While theoretically possible, increasing sales is not a practical option in virtually any instance.

The Small Employer Choice

When presented these alternatives, what choices do small employers make? A sample of small-business owners was administered a series of hypothetical scenarios involving cost increases in 2001 (NSBP: *Adjusting to Cost Increases*). The question posed was how owners would handle cost increases under varying circumstances. The eight basic scenarios involved payroll cost increases and physical facility cost increases amounting to:

1. a 5 percent increase beginning in six months,
2. a 15 percent increase beginning in six months,
3. a 5 percent increase beginning next week, and
4. a 15 percent increase beginning next week.

Respondents chose the one action they were most likely to take from among: raising prices, cutting payroll costs, reducing earnings, or eliminating, postponing or delaying business investment.

The most appropriate scenario for present purposes, i.e., the closest to a substantial health insurance premium increase, is a 5 percent payroll hike beginning in six months. Under those circumstances 38 percent of small-business owners told interviewers that the most likely step they would take is to raise prices; 33 percent said that they would most likely cut earnings (which includes the volunteered response "do nothing"); 17 percent reported employees effectively would pay through lay-offs, not filling vacancies, the freezing or cutting of employee wages or benefits, etc.; and, 9 percent indicated that they would cut, eliminate or delay business investment (Exhibit 4). The remainder volunteered answers amounting to no more than one or two percentage points each, including cutting other business costs and increasing sales.

If owners were surprised by the magnitude of the payroll increase and had just one week to prepare for it, rather than the six months assumed above, about 10 percentage points more would reduce earnings and 12 percent less would force employees to absorb it. In other words, lower earnings would become the immediate cushion, though one can assume the shift back to employees over the longer term.

A five percent hike in payroll costs is more or less difficult to offset depending on payroll as a percent of total business expenses. Exhibit 4 presents the choices small employers would make under two scenarios with above and below median payroll, one with less lead time to implement and the other with more. The most important point in the exhibit is that when payrolls constitute a larger share of business expenses, owners are more likely to cut payroll costs. Similarly, when payrolls constitute a smaller share, they are more likely to absorb the cost through lower earnings.

Conclusion

Small business-owners struggle to pay the substantial increases in the employee health insurance premiums that now appear as regularly as the seasons. They have no single strategy to cope; they try to offset the increases as circumstances allow. Those circumstances include everything from the competitive environment (for sales and employees) to business earnings (profitability) to accurate forecasts of the next year's premium increase to expectations for the cost increases to be temporary or permanent. Too often, much of the initial cost is borne by the small employer. But that cannot continue and much is eventually shifted back to employees in one form or another. The most visible forms are greater cost-sharing, higher deductibles, larger co-pays and, possibly more stringent eligibility requirements. For the coming few months, it is likely that increases will more frequently be shifted forward to customers. Raising prices has limits, however, and cannot overtake back shifting as the primary offset vehicle.

It is important to recognize that whatever one thinks of insurance and/or insurance companies, insurance prices reflect the increased cost of health care. Therefore, it is critical that the rate of increase in health care costs be curbed. We need better value and better outcomes for the dollars we spend. But, health care is a scarce resource in the economic sense. The question is how are we going to ration that scarce resource and obtain the best outcomes possible. Are we going to ration it by having individuals make choices about health care use, or by insurance companies playing the "bad guy" by enforcing employer decisions, or by a government sponsored system like Canada that fails to provide adequate facilities and forces seriously ill patients to come to the United States for treatment.

Exhibit 1
Annual Health Insurances Premiums Compared to Other Indicators, 1988 - 2003

Year	Health Insur. Premiums	Overall Inflation	Workers' Earnings
1988	12.0%	3.9%	3.1%
1989	18.0	5.1	4.1
1990	14.0	4.7	3.7

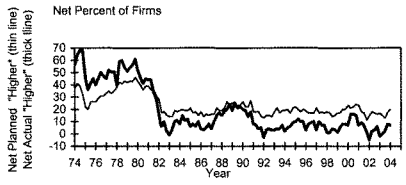
1993	8.5	3.2	2.5

1996	0.8	2.9	3.3

1999	5.3	2.3	3.5
2000	8.2	3.1	3.7
2001	10.9	3.3	4.1
2002	12.9	1.6	3.2
2003	13.9	2.2	3.1

Source: Kaiser/HRET

Exhibit 2
Planned and Actual Small Business Price Increases, 1974 – 2004



Source: Small Business Economic Trends

Exhibit 3
Use of Non-Traditional Health Insurance Mechanisms (Percent of Small Employer Population) by Employee Size of Firm

Non-Traditional Insurance Mechanisms	1 - 9 Employees	10 - 19 Employees	20 or More Employees	All Firms
Flexible Spending Accts.	6.5%	14.9%	24.1%	9.1%
Medical Savings Accts.	4.2%	5.6%	10.2%	5.0%
Reimbursement	11.4%	16.6%	17.5%	12.5%

Source: NSBP: *Health Insurance*

Exhibit 4
Responses to Hypothetical Five Percent Payroll Cost Increase Given Six Months and One Week Prior Knowledge by Firms with Above and Below Median Payroll Costs

a. Six Months Prior Knowledge

Response to Cost Increases	Below Median Payroll Costs	Above Median Payroll Costs	All Firms
Raise selling prices	40.3%	35.7%	37.8%
Reduce payroll costs	12.4	23.8	17.1
Cut business investment	6.0	8.4	7.2
Lower earnings	38.3	24.5	32.6
Other (including don't know)	3.0	7.6	5.3
Total	100.0%	100.0%	100.0%

b. One Week Prior Knowledge

Response to Cost Increases	Below Median Payroll Costs	Above Median Payroll Costs	All Firms
Raise selling prices	15.6%	20.0%	17.7%
Reduce payroll costs	12.1	17.1	13.3
Cut business investment	6.5	3.6	5.3
Lower earnings	61.3	51.4	56.4
Other (including don't know)	4.5	7.9	7.3
Total	100.0%	100.0%	100.0%

Source: NSBP: *Adjusting to Cost Increases*

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Chairman JOHNSON. Thank you, sir, and let me advise all of you, your full remarks will be entered into the record if you desire. So if you cannot get through them all, we will get them in the record for you and perhaps discuss them more in detail when the question period begins.

You may begin your testimony, sir.

STATEMENT OF FRANK McARDLE, MANAGER, WASHINGTON, DC RESEARCH OFFICE, HEWITT ASSOCIATES, WASHINGTON, DC

Mr. MCARDLE. Good morning, Mr. Chairman and Members of the Subcommittee.

Thank you for the invitation to appear before you this morning, and Mr. Chairman, I appreciate your condolences on my prior Senate staff experience.

My name is Frank McArdle, and I manage the Washington, DC, Research Office of Hewitt Associates. Hewitt is a global human resources outsourcing and consulting firm headquartered in Lincolnshire, Illinois. We have been in business since 1940, and we work with employers, employees, and retirees, literally millions of employees and retirees throughout the country.

In addition to that experience, I will also draw this morning from some surveys that we have conducted at Hewitt in conjunction with the Henry J. Kaiser Family Foundation, which are all available on the web-site, www.kff.org.

Today's hearing is focusing on new insurance options, and I would like to discuss some new options available to employers under the Medicare Prescription Drug Improvement and Modernization Act, which I will abbreviate as the MMA.

What I would like to do before I get into that, though, is describe four key pre-existing trends that were in force just prior to the enactment of the MMA, and one is employer plans were voluntarily providing very generous benefits to retirees, both pre–65 retirees and Medicare-eligible retirees, and these are highly valued.

Observation No. 2: Retiree health benefits were continuing to erode, as they had begun to do in the 1990's, early 1990's, and you have charts in my testimony that illustrate that.

Three, double-digit cost increases in the range of 13 to 14 percent were playing a major role in driving that erosion, and fourth, retiree health plans varied widely both within large, multi-state firms and across the country nationwide.

So, in light of these trends, the MMA seeks to encourage employers to continue providing retiree health coverage by offering incentives for employers to do so and, equally importantly, the flexibility for employers to choose among multiple options, because no single option would likely fit the situation of these complex entities.

There are basically three broad categories of options and then some additional ones. The three big ones are, option one, the plan sponsor provides retirees not enrolled in Part D—and that is important—qualified retiree prescription drug benefits that are at least equivalent actuarially to what Medicare will provide in 2006.

If the plan meets those requirements, then the plan is eligible for a payment from Medicare equal to 28 percent of the allowable costs for a drug for a retiree, between $250 and $5,000. So it is done on a per-retiree basis. It is not done on an aggregate basis.

This option is probably the least disruptive for all retirees, and it actually costs Medicare less to provide this 28-percent subsidy than it would cost Medicare to provide coverage to a similar retiree without employer coverage.

Option two, the plan sponsor can supplement or wrap around Medicare, generally using ways that are similar to what employers did in the past in terms of aligning with Medicare, but also, there is a new twist, and there are differences, because drug coverage is obviously very different than hospital care and physician services.

Then option three is an employer can become an employer-sponsored PDP or Medicare Advantage plan using a waiver authority that is provided for under the new law.

Beyond these three broad options, other possibilities exist for companies who may have the financial ability to do something but would choose a route that is better suited to their circumstances. At this stage, most large employers have yet to make the firm decisions as to which approach they will take, because it's still very early in the process and employers still lack certain piece of key information.

For example, there are unanswered questions that will be decided in forthcoming regulations at which CMS is busily and diligently at work, and in addition, employers will be looking to the marketplace to see how plans will respond to the prospect of becoming a stand-alone PDP or Medicare Advantage plan.

I can tell you that I think, at this point, that sponsors of large collectively bargained plans may be more inclined to choose a 28-percent subsidy while other sponsors may, instead, prefer to wrap around the new Medicare coverage.

Based upon CBO and Joint Tax estimates, these financial incentives for the 28-percent subsidy are very substantial, at $71 billion between 2006 and 2013 and nearly another $18 billion in related tax benefits.

In explaining these incentives, the Conference Report noted—and I quote—"Absent this assistance, many more retirees will lose their employer-sponsored coverage."

We agree with that conclusion, Mr. Chairman, and I thank you.

[The prepared statement of Mr. McArdle follows:]

Statement of Frank McArdle, Ph.D., Manager, Washington, DC Research Office, Hewitt Associates, Washington, DC

Mr. Chairman and Members of the Subcommittee, thank you for the invitation to appear before you today to discuss the employer-sponsored retiree health care options available under the Medicare Prescription Drug, Improvement, and Modernization Act (or MMA for short).

My name is Frank McArdle, and I manage the Washington, D.C. Research Office of Hewitt Associates. Hewitt is a global human resources outsourcing and consulting firm with operations in 38 countries. We are headquartered in Lincolnshire, IL, and we provide services to employers, employees, and retirees in the home states of all the Subcommittee members. In addition, Hewitt has significant operations at 27 offices in California, Connecticut, Florida, Georgia, Massachusetts, Minnesota, Missouri, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, and Texas.

As further background, Hewitt has worked in collaboration with The Henry J. Kaiser Family Foundation to conduct several detailed studies with respect to employer-provided retiree health benefits and their interaction with Medicare, all of which may be found at www.kff.org.

My task today is to describe the options available to employers under the MMA with respect to retiree health benefits. Before I do so, I would first like to place the MMA provisions in context relative to trends in the retiree health marketplace that preceded the new law.

Retiree Health Benefit Context Prior to the MMA

Retiree Health Benefits Have Been Eroding

As this Subcommittee well knows, over the past 15 years, there has been a well-documented decline in the prevalence of employers sponsoring retiree health care plans (Chart 1). Even so, among the largest companies, i.e., those with 1,000 or more employees, a majority still provide retiree health care coverage (Chart 2). Typically, though not universally, these plans offer generous health benefits that have greater value than the Medicare benefits package, and will also provide greater value in terms of prescription drug benefits than under Medicare Part D, which as you well know becomes effective on January 1, 2006.[i]

These benefits are highly valued by retirees, for the following reasons:

- More than 3 million pre-65 retirees, or nearly six in ten retirees age 55-64, have retiree health benefits through an employer plan, which bridges the gap in coverage until Medicare eligibility is available at age 65. Absent such coverage, pre-65 retirees would have great difficulty in finding and affording coverage in the individual insurance market.

- About 12 million seniors, one in three, have supplemental Medicare coverage from their employer and employer plans are the largest source of prescription drug coverage for Medicare beneficiaries.

Therefore, the impact of Medicare reform on retirees with employer coverage was a top concern for Members of Congress, employers and retirees themselves.

Rising Costs Are a Major Concern, Driving Changes in Plan Benefits

Employers have made significant changes to their retiree health programs over the past several years under pressure to balance rising health costs with the organization's business needs, other benefits costs, and global competition.

Despite employers' concerted efforts to rein in their retiree health costs in recent years, the total cost (employer and retiree share) continues to rise rapidly.

- Among the 408 large private sector firms surveyed in the KFF/Hewitt retiree health survey, which have about 8.3 million employees and 3.6 million retirees the total cost of providing retiree health coverage reached $18.1 billion in 2002. The same companies estimated the total cost would rise by an average 13.7%between 2002 and 2003, which, if realized, would result in a 2003 total cost of more than $20 billion.[ii] Some individual firms have total retiree health costs reaching or exceeding $1 billion.

- Among surveyed firms, retiree health costs represent more than a quarter of the total estimated cost of health coverage for active workers, retirees, and dependents. In addition, most of the large private companies offering retiree health plans tend to be more mature companies where there is already a ratio of only two workers per retiree, on average, which is what the worrisome average is projected to be for Social Security and the economy as a whole in about 25 years. Indeed, some of these companies have more retirees than active workers.

- These costs have become a substantial concern, with 92% of surveyed companies reporting that their firm's CEO is very (64%) or somewhat (28%) concerned about retiree health care costs. Some companies are finding that more of their global competitors do not provide retiree health coverage, putting them at a competitive disadvantage. In addition, retiree health benefits are only part of the employer's total employee benefit spending. For example, among large employers in a proprietary Hewitt database, all of the large companies offering retiree health care plans also offer a defined benefit pension plan or a defined contribution retirement plan; 77% offer a defined benefit plan; 76% provide a defined benefit plan and a defined contribution retirement plan; and 98% provide a defined contribution retirement plan.

Retiree Health Plans Vary Significantly within Companies and across Firms
Retiree health benefits vary significantly both within large multi-state companies and across firms. Differences are commonplace between pre-65 retiree coverage and post-65 coverage, in part because pre-65 retirees are often offered the same coverage as active employees, whereas post-65 retiree health plans are structured to coordinate with Medicare. Differences in the number and types of plan options are commonplace, as are differences in premiums and cost-sharing. In fact, there are so many differences within companies that for the purpose of collecting detailed data without overburdening the survey respondent, our surveys typically request detailed data only for the plan with the largest number of enrolled retirees.

To sum up, on the eve of enactment of the MMA:

- Employer-sponsored retiree health plans were providing coverage that was more generous than Medicare benefits and of great value to millions of both pre-65 and Medicare-eligible retirees;
- Retiree health coverage was continuing to erode;
- Double-digit cost increases were playing a major role in driving that erosion; and
- Retiree health plans varied widely, both within individual companies and across firms nationwide.

Each of these factors influenced the provisions related to employer-provided retiree health plans under the MMA.

Medicare Prescription Drug, Improvement, and Modernization Act
As a way of encouraging employers to continue offering retiree health benefits, the MMA makes a range of new options available to employers. Reflecting the wide variations in plans and employer circumstances, this flexibility is intended to allow employers a choice among multiple options for supplementing Medicare benefits, which fall into three broad categories, as follows:

1) Offering prescription drug benefits that are at least actuarially equivalent to what Medicare will provide under Part D, and receiving a subsidy from Medicare to compensate for a portion of that employer cost for retirees not enrolled in Part D.
2) Supplementing Medicare Part D prescription drug benefits, using several approaches for coordinating with Medicare benefits.
3) Becoming an employer-sponsored Prescription Drug Plan (PDP) or Medicare Advantage (MA) plan.

Accepting the Subsidy for Offering Actuarially Equivalent Drug Benefits
This option is probably the one that has generated the most discussion. Employers who provide retiree health prescription drug benefits that are at least actuarially equivalent to what Medicare will provide under Medicare Part D may be eligible for a direct subsidy from Medicare.

- The retiree would not enroll in Part D and therefore no Part D premium would be required.
- The subsidy will be tax-free, and amounts to 28% of per retiree drug costs between $250 and $5,000 in 2006.

Note that this subsidy only partially compensates employers for providing prescription drug benefits that are at least as generous — if not more generous — than what Medicare would provide to a similarly situated retiree without employer coverage.[iii]

In sum, the subsidy offers partial compensation to the employer plan, saves money for Medicare, and avoids disruption by allowing retirees to stay in their current employer plan and receive prescription drug benefits that are at least as generous, if not more generous, than under Medicare.

Supplementing Medicare Part D Prescription Drug Benefits
Under this set of options, the retiree enrolls in Part D and the employer plan supplements the benefits provided through Medicare Part D. This supplementation can be accomplished in multiple ways. For example:

- Employers may supplement or "wrap around" a stand-alone PDP or a MA plan. This kind of coordination can be complicated if the employer's retirees are located throughout the country and enroll in dozens of different PDP or MA plans. It would be less complicated where an employer's retirees are concentrated in a few areas.
- To avoid administrative complexity, an employer may also contract with a PDP or a MA plan on behalf of its retirees and negotiate additional benefits for the retirees in the PDP or MA plan.

Becoming an Employer-Sponsored PDP or MA Plan
In addition, the law provides the Secretary with waiver authority under which an employer may become a PDP or a MA plan and accept payments from Medicare as other PDP or MA plans would. Under this scenario:

- The retiree would be enrolled in a PDP or MA plan offered only to members of an employer group.
- The employer would seek a waiver from HHS to limit enrollment or make other changes.

- Medicare would pay the employer-sponsored PDP or MA only for Medicare coverage (standard or actuarially equivalent plan design).

Other Possibilities
Employers that may not be able for whatever reasons to take advantage of one of the above options still have the opportunity to help retirees in other ways if they choose to. For example, the employer could make a contribution to assist retirees who are enrolled in Part D in one of several ways, including paying part of all of the Medicare Part D premium, or making a contribution available that the retiree can apply to the PDP or MA plan of the retiree's choice. An employer may also sponsor an HSA account to encourage employees in accumulating an account balance over their working careers that they can use at age 65 to pay Part D premiums or pay for other qualified health expenses.

Discussion
Choosing Among the Options
At this stage, most employers have not made firm decisions as to which course they will take. It is still relatively early in the process. The attractiveness of each of the above options will vary by company based on a number of considerations, including:

- The company's existing retiree health plans and the utilization of prescription drugs by Medicare-eligible retirees in those plans;

- How much flexibility the company has to make changes in its program; and

- The company's overall financial situation and competitive position.

Key Regulatory Decisions Pending
In addition, employers' final decisions about which options to use with respect to Medicare will hinge on pending regulations, and the answers to some key questions, such as:

- How and when employers will be paid if they choose to offer actuarially equivalent drug benefits and accept the 28% subsidy?

- How employers will be required to demonstrate actuarial equivalence?

- How administratively burdensome the data generation and other requirements will be for the employer who wants to accept the 28% subsidy?

- How administratively burdensome will it be for an employer plan to wrap around Medicare Part D coverage, in terms of formularies and other related issues?

- How the fallback plans will work in regions where there is not a sufficient choice of at least two plans, one of which may be a PDP and the other a MA plan?

The Centers for Medicare & Medicaid Services (CMS) has been hard at work in terms of drafting these forthcoming regulations under a tight deadline, and they are to be commended for those efforts, especially since CMS is being asked to make detailed interpretations without the benefit of much guidance from the statutory language.

However, until the proposed rules are issued, perhaps in late June or early July, a considerable amount of uncertainty will remain concerning the key questions of payment and administrative burden.

Employers will also be looking to gauge how the marketplace will respond in terms of the emergence of the PDP, MA plans, and fallback plans. Pending CMS regulations may also have an influence on how such plans respond.

In my opinion, both the Administration and the Congress have an important role to play in the development of these forthcoming regulations. The task is to ensure that the administrative requirements associated with the different employer options will not be so great as to frustrate congressional intent of encouraging employers to make use of these options and continue offering retiree health benefits.

Tracking Future Employer Reactions
As noted above, employer reactions to the new Medicare law are still being formulated. In the meantime, companies are trying to work through which of the options or which combination of options would best suit the needs of the organization and its retirees.

Reflecting the ongoing interest in this subject, the MMA has already mandated two General Accounting Office studies to examine trends in employment-based retiree health coverage, the options and incentives available under the MMA that may affect the provision of coverage, and how employers will be reacting to provisions of the MMA.

In attempting to sort out all these effects on retiree health plans, it will also be important, in my opinion, for policymakers to distinguish between continuation of trends that have already been firmly in place versus those that may be a new and direct response to the MMA. The KFF/Hewitt 2003 retiree health benefits survey is an excellent source of data, serving as a baseline of recent trends and future employer plans prior to enactment of the MMA. Of the many trends of interest, three are particularly noteworthy:

- Erosions in coverage were continuing on the eve of the MMA.
- 10% of surveyed employers said that they eliminated benefits for *future* retirees in the past year, these being mostly for new hires.
- Over the next three years, only 2% of employers said they are very or somewhat likely to terminate all subsidized health benefits for *current* retirees, whereas 20% said that they are very or somewhat likely to terminate subsidized benefits for *future* retirees.

Based upon Congressional Budget Office and Joint Committee on Taxation estimates,[iv] the 28% employer plan subsidies are projected at $71 billion between 2006 and 2013 along with a projected $17.8 billion in tax benefits over that same period.

In approving these subsidies, the conferees noted that: "Absent this assistance, many more retirees will lose their employer-sponsored coverage." We agree with that conclusion.

Thank you, Mr. Chairman. I will be pleased to respond to any questions that you and the other Subcommittee Members may have.

Chart 1

Trends in Employer Retiree Health Coverage

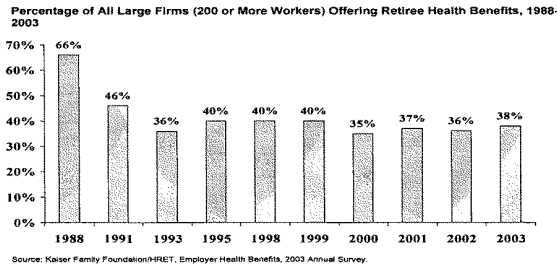
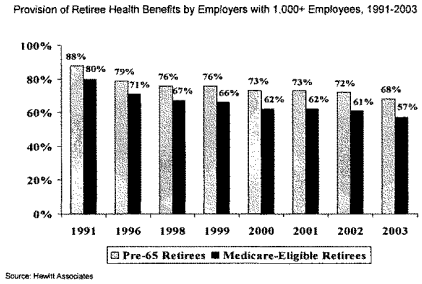


Chart 2

Retiree Health Trends 1991-2003



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[i] Frank B. McArdle, et al, "Large Firms' Retiree Health Benefits Before Medicare Reform: 2003 Survey Results," *Health Affairs* – Web Exclusive, January 14, 2004. http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.7v1

[ii] Frank McArdle, et al., *Retiree Benefits Now and in the Future: Findings from the Kaiser/Hewitt 2003 Survey on Retiree Health Benefits*, (Washington, Kaiser Family Foundation, 2004).

[iii] Assuming an employer group with average utilization, Hewitt estimates that the 28% subsidy would be $640 per retiree as opposed to a net Medicare cost that would otherwise be $1,210 (74.5% of total cost), assuming the same group goes to a PDP and reflecting their experience (adjusted for expected behavioral change going to Medicare benefit levels) and 10% administrative expense load.

[iv] Congressional Budget Office, letter to Sen. Don Nickles, November 20, 2003, Joint Committee on Taxation, "Estimated Revenue Effects of Certain Provisions Contained in the Conference Agreement for H.R. 1," November 21, 2003.

Chairman JOHNSON. Thank you, sir.
You may begin, sir.

STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA, WASHINGTON, DC

Mr. POLLACK. Mr. Chairman, thank you so much for inviting me. I am delighted to join you.

For three reasons, this is a very timely hearing. We issued—we at Families USA issued a report about 2 weeks ago that looks at the uninsured in a somewhat different way than we are normally used to doing.

The current population survey of the Census Bureau tells us there are 43.6 million people who are uninsured. Depending on your interpretation, that is either the number of people uninsured throughout the course of the year or a point-in-time estimate, but it does not tell you how many people are directly affected with being uninsured.

Our report, also based on Census Bureau data, shows that, over the course of the last 2 years, 81.8 million people, almost 82 million people were uninsured at some point over the last 2 years, 2002–2003.

That constitutes approximately one out of every three people under 65 years of age, and most of these people were uninsured for substantial periods of time. Over half were uninsured for more than 9 months, and the vast majority of these people are in working families. Four out of five are in working families.

Mr. Chairman, as you probably know, Texas ranks at the very top of the list that has a very high uninsured rate. In Texas, 43.4 percent of people under 65 years of age were uninsured at some point over the last 2 years.

Now, there are other reasons why this hearing is very timely. Obviously, there was a very important Supreme Court decision that was rendered which means that, for many people who have health coverage through their employer, even though they are covered, they may not get the care that they thought that they were supposed to get when they got coverage, and now it appears that there is not meaningful recourse to make sure that people actually get the care they thought they were supposed to get when they obtained insurance from an employer.

My hope is that we will work in a bipartisan fashion to enact a patient's bill of rights so that people who do have insurance actually get the care that they need.

Lastly, this is a very important and timely day for a hearing because later day, you may be voting on budget legislation that will establish entitlement caps that would cause severe harm to those people who are dependent on Medicaid.

If the legislation is adopted that establishes an entitlement cap, by the end of the 10-year period, 17 percent of those on Medicaid are projected to lose their coverage. As many as 8 million people whose lifeline is the Medicaid program would lose coverage.

So this is a very timely day for us to be having this hearing.

In my written testimony, I focus on three different aspects of proposal—I am not going to go into them in great detail—health savings accounts, tax credits to buy individual coverage, and associa-

tion health plans. We think, actually, that those approaches will do very little to provide health coverage for those people who do not have it today and, in some instances, may actually do harm.

Let me just mention that, with respect to health savings accounts, we think they are poorly targeted. They provide the greatest relief for people in the highest income brackets.

We do not believe it is going to achieve meaningful cost containment. It is more likely, ultimately, to cause adverse risk selection, and we believe that it will facilitate more cost shifting to workers who can ill afford it.

I think there are alternatives, and in the remaining time, I just want to suggest that one alternative that we should look at is reinsurance coverage, especially for small businesses, so that those small businesses who are having difficulties paying for the care of their workers have two things.

One is they get some relief, because by the provision of reinsurance, it would reduce the premiums, because for example, reinsurance that would provide protection for people with claims above $50,000—only one half of 1 percent actually encounter those kinds of costs, but they account for 20 percent of health care costs.

If we provided such reinsurance protection for employers, it would not only reduce their premiums, but it would provide greater predictability in terms of what those premiums would be in the future, and it could be a great help to small businesses.

Lastly, I would say, rather than establishing an arbitrary cap on public programs like Medicaid, I think we should be using those programs to expand coverage so that the arbitrariness that results in people getting coverage based on state of residence or their family's status is brought to an end and we can expand coverage substantially to working families in the process.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Pollack follows:]

Statement of Ron Pollack, Executive Director, Families USA, Washington, DC

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. Families USA strongly supports comprehensive, affordable health insurance for all residents of this nation.

One Out of Three Americans Without Health Insurance

Last week, Families USA released a new report that examined the number of Americans who experienced the physical and financial risk of being uninsured. We believe it is a shame and disgrace that in the two-year period 2002-2003, approximately 82 million people – *one out of three* Americans who are not eligible for Medicare – were uninsured for some period of time.[1] Contrary to popular perception, the overwhelming majority of people—more than four in five—who are without health insurance were connected to the workforce. Of these working uninsured, many—but certainly not all—are in low-wage jobs:

- Nearly two-thirds (60.9 percent) of individuals in families with incomes at or below 100 percent of the federal poverty threshold ($18,660 a year for a family of four in 2003) were uninsured at some point over the past two years.

- More than half (53.5 percent) of individuals in families with incomes between 100 and 200 percent of the federal poverty threshold (up to $37,320 a year for a family of four in 2003) were uninsured in that period.

- The likelihood of being uninsured decreases considerably as income increases. However, a quarter (25.2 percent) of working individuals and their families with incomes between 300 and 400 percent of the federal poverty threshold (from $55,980 to $74,640 a year for a family of four in 2003) were uninsured at some point over the past two years.

The growing number of Americans without health insurance is now a phenomenon that significantly affects middle class and working families. As a result, this problem is no longer simply an altruistic issue affecting the poor, but a matter of self-interest for almost everyone. Our new report describes the reasons why hard-working Americans are without health insurance coverage, and points out that any attempt to provide coverage to a significant number of uninsured individuals must address the problem of lower-wage workers who are not offered or cannot afford employer-based health insurance. Any solution must address the problem of insurance policies with deductibles and co-payments that are so high that the policy is unusable by lower-income individuals and families. For example, "consumer directed health care," with its high deductibles, is a cruel joke for those who today have trouble filling their gas tanks as they struggle to stay within very tight family budgets.

Further, solutions to the uninsured that build on the employer-based health insurance system also must address the gaps in health insurance coverage that occur with gaps in employment.

We all understand that going without health insurance can have terrible physical and financial consequences. Perhaps the most compelling statistic that drives this point home is from the Institute of Medicine: Every year about 18,000 Americans die prematurely and unnecessarily because they do not have health coverage.[2] That is about two deaths per hour. While we meet this morning, several of our fellow citizens are dying needlessly because they do not have health insurance. Millions more suffer from poorer health, lost income, bankruptcy, and stunted lifetime opportunities because they do not have coverage.

While not the topic of today's hearing, I also would like to point out that earlier this week the Supreme Court delivered some bad news for an estimated 131 million workers and their families that have employer-based coverage. In a unanimous decision, the Court ruled in *Aetna v. Davila* that patients cannot sue their managed care companies for damages in state court.[3] There is now no meaningful way for patients to hold their HMOs accountable for improper denials of care. As a result, there will be no economic deterrence to prevent HMOs from making wrongful decisions that cause significant harm to workers and their families. While these workers won't join the ranks of the uninsured, they may be considered "underinsured" or "incidentally uninsured" when they do not receive the vital health care that they need.

In response to this week's decision, we hope that Congress will reconsider passage of a strong patients' rights law. This Supreme Court decision provides new urgency to the passage of a strong federal Patients' Bill of Rights law, and I thank Representatives Andrews and Dingell, as well as other Members of Congress, for reintroducing a new version of the bill.

Medicare Modernization Act: A Missed Opportunity to Stabilize Retiree Health Benefits

The Medicare Modernization Act provides about $89 billion in subsidies to encourage public and private employers to continue to offer retiree prescription drug coverage. The subsidy is 28 percent of the cost between $250 and $5,000, provided the retiree plan has at least the actuarial value of the basic Medicare benefit. Despite this subsidy, the CBO predicts that about one in four (2.7 million beneficiaries) will see their current better-than-Medicare coverage reduced or eliminated in the coming years. This continuing deterioration of retiree coverage is one of the most controversial and disturbing features of the new law.

The wording of the law is not perfectly clear, but it appears that the subsidy will be paid even if an employer reduces the actuarial value of the plan to just above the actuarial value of the Medicare benefit. As employers start to do this, it will create great anger and fear among beneficiaries. The thought that companies will get billions in subsidies yet have reduced their retiree benefits will be another negative feature of the new legislation.

Congress and this Committee should provide early oversight of this issue to see what companies are planning to do and what can be done to prevent the loss of benefits by 2.7 million seniors and people with disabilities. In the meantime, we urge Congress, as soon as possible, to condition the subsidy on the maintenance of retiree prescription drug benefits at the level they were on, say, January 1, 2004. Only companies that continue to offer superior benefits should get the subsidy. It should also be made crystal clear that the subsidy applies to the employer's share of the program—not the beneficiaries. For employers to get a subsidy on the gross value of the benefit, while they are reducing their net expense by shifting costs onto individuals, would be considered an outrage by most Americans.

Employer-based Approaches to Expanding Health Insurance Coverage

While we all agree about the seriousness of the problem of the uninsured, we are struggling to find solutions that will allow us to move forward in the next few years with positive federal initiatives to expand health insurance coverage to uninsured Americans—and do so without undermining the existing employer-based coverage that the majority of us rely on. Unfortunately, three of the proposals that are seriously being considered by Congress do little to expand health insurance coverage to uninsured Americans and **threaten the stability of employer-based coverage**. I would like to comment on these proposals and urge Members of Congress to reconsider their merits:

- Health Savings Accounts
- Tax credits to buy insurance in the individual market
- Association Health Plans

By comparison, I also would like to share with you four alternative proposals for your consideration. Families USA has been promoting these proposals for several years as a positive agenda that will significantly reduce the number of uninsured in our nation without threatening the stability of existing employer-based coverage:

- Reinsurance assistance to small businesses
- Tax subsidies for unemployed workers to purchase COBRA or other group insurance coverage with consumer protections
- Tax credits for small businesses offering health insurance coverage to low-wage workers
- Public program safety net modernization

With respect to positive proposals, I also would like to acknowledge Representative Andrews' and Representative Payne's bill, "The Group Health Plan Coverage Expansion Act of 2003" (H.R. 2321), which would strengthen the employer-based system so that it better serves workers with serious illnesses by prohibiting group insurance plans from imposing lifetime limits on the value of benefits and prohibiting group health plans from charging workers more based on a pre-existing condition.

Before I present Families USA's perspectives on the HSAs, individual tax credits, and AHPs, I would like to briefly comment on the HR Policy Association's announcement last month that large employers plan to come together to offer health insurance to workers who do not currently have access to employer-based coverage.[4] The proposal targets part-time workers, contract workers, independent agents and consultants, pre-Medicare retirees, people who have exhausted COBRA, and students who are no longer eligible for their parents' coverage; pooling them together; and providing a range of coverage options for them at different prices.

We appreciate that large employers are taking steps to solve the problem of the uninsured and are willing to use their bargaining power to help individuals access health coverage. However, we are concerned that, even with negotiated prices, many working Americans will not be able to afford this coverage. Since more than 20 million of the people who were uninsured over the past two years are in low-income households – earning less than $18,660 a year for a family of four in 2003 -- premium costs of up to $2000 per year remain too high a price for them to pay.[5] We are also concerned that stripped-down benefits packages that might be offered to make premiums more affordable might not provide meaningful coverage for people who have or who may develop significant health care needs. What these packages will save workers in the front-end through lower premiums will cost them more later on through higher deductibles, copayments, and uncovered services. As well meaning as this proposal is, there is ample reason to doubt that this will be an effective response to workers without health coverage through their jobs, particularly lower-wage workers.

Approaches that Threaten the Stability of Employer-Based Coverage

Health Savings Accounts

HSAs were established by the new Medicare prescription drug law. Only individuals who enroll in high-deductible health insurance plans may establish these accounts. Not only are contributions to these accounts tax-deductible, but earnings on the money in the accounts accrue tax-free, and withdrawals are not taxed if they are used

for out-of-pocket medical expenses. The Administration's fiscal year 2005 budget more than doubled the previous ten-year cost estimates for the HSA provisions in the new Medicare law from $6.7 to $16 billion.

We believe that the HSAs will be harmful to the nation's employer-provided insurance system. Attached to this testimony is a health policy paper from Families USA on how these programs work, and why they are bad for American society as a whole.[6] Our analysis of HSAs finds that this approach: 1) does not effectively target resources to the uninsured Americans who most need help with the cost of health insurance; 2) does not impact the underlying cost of health care; 3) makes it easier for employers to shift costs to workers; and 4) has an enormous potential to dangerously undermine the core principle of risk sharing among individuals in employer-based health insurance.

HSAs Do Not Effectively Target Limited Federal Resources to the Uninsured

HSAs—an income tax deduction strategy—do little or nothing to help most uninsured people and fail to target resources to those Americans who most need help with health insurance costs. The large number of people living on incomes below 100 percent of poverty who have no health insurance also do not pay taxes and do not benefit from an income tax deduction. Likewise, for people living on incomes between 100 and 200 percent of poverty who have no health insurance (up to $37,320 for a family of four annually), the tax deduction offers very little help. They would receive *at most* a small tax deduction of ten percent, which does practically nothing to make health insurance affordable for their families.[7] A ten percent subsidy won't go far to help low-income workers and their families to find the "extra" cash needed to put into an HSA when they already struggle to make ends meet on very tight family budgets.[8]

HSAs Do Not Impact the Underlying Cost of Health Care

The majority of health care costs delivered in this country is not for elective care or care where choices of treatment or providers even come into play. In fact, 70 percent of all health care outlays are consumed by only ten percent of the population—the very sickest Americans.[9] To have any real impact on the vast majority of health care services, we need to control the cost of the largest and most expensive treatments for serious illness and disabilities. This kind of health care treatment is most often immediately needed, is physician-guided, and involves decisions that literally make the difference between life or death, sustained health or long-term disability or negative health consequences. When patients confront these "big ticket" health care decisions, they rely on their physicians' recommendations, go to the closest facility, and appropriately want the best care in accordance with scientific-based evidence. It is fallacious to talk about buying health care the same way we buy a toaster, a television, or even a car.

The health care expenditures that patient/consumers may be in a position to "shop" for—the spending represented by the dollars in a HSA—only have the potential to impact a very small percent of the total health care spending in the nation. At the same time, HSAs may present a "choice" to patient/consumers that could actually increase health care costs. Some of the health services that some people may "choose" to avoid in order to save the money in their HSAs are check-ups, diagnostic testing, and preventive care. In the long run, this behavior will increase the utilization of health care as conditions go untreated and escalate into more difficult and expensive serious illness.

HSAs Make It Easier to Shift Costs from Employers to Workers

While the impact of HSAs may not be felt immediately, over time HSAs create a structure that will make it easier for employers to shift more costs to their workers. Some proponents of HSAs argue that this is not the case because currently many employers are setting up alternative HSA plans that, on the surface, may look like a reasonable deal to all workers compared to the traditional plan offered by the employer. For example, while the deductible may rise from $300 to $800, the employer agrees to put $500 in the worker's HSA. The worker will then face the same window of $300 out-of-pocket costs before the traditional coverage kicks in as in the lower deductible plan. But what happens over time with this kind of HSA/high deductible plan structure?

There is no doubt that employers are moving toward these plans to save money. (And we do not argue that many employers are in desperate need of help with the cost of health insurance for their workers. We maintain that HSAs are the wrong way to help employers.) Premiums do go down as the size of the deductible grows, but it takes a significant jump in the deductible to bring down premiums. Thus, employers will want to move toward higher and higher deductible plans but they won't want to "make up the difference" in the growing deductible gap with HSA dollars. For example, in a year or two an employer will move to a plan with a deductible of $1,000, yet continue to only make a $500 contribution to the worker's HSA. The worker will then face an increase in out-of-pocket costs from $300 to $500.

HSAs Will Lead to Adverse Risk Selection

As you know, insurance is about spreading risk as broadly as possible. Again, 70 percent of all health care outlays are consumed by only ten percent of the population. Looking at health insurance claims, historically only five percent of the public has always used about 50 percent of the health care dollar.[10] None of us can predict with certainty who will end up in that five percent high cost group. The only way to make insurance affordable for

everyone, especially for those who are part of the five percent group with significant medical needs, is to spread the risk as broadly as possible. HSAs move insurance coverage away from risk sharing and toward risk segmentation.

Here is what happens if an employer offers workers a choice between a high-deductible health insurance plan with a tax-break versus a more traditional health insurance plan with reasonable deductibles and copayments. The HSA plans, with high deductibles, will likely siphon off healthier people who anticipate few medical treatment costs and hope to shelter more income from taxes in the account. The people who can't afford to put cash into HSAs will stay in insurance plans with a smaller deductible and lower copayments. So will people who have health problems and who expect to have health care expenses. As the traditional plans lose their healthier enrollees, they will be left with a higher proportion of unhealthy people. More unhealthy people will mean higher per capita costs, so premiums will have to be raised. The faster the premiums rise, the more healthy people with financial wherewithal will decide to opt into HSA plans. This continuing cycle of "cherry picking" healthy people will make the insurance we are used to — plans with smaller deductibles—extremely expensive for those who need them.[11]

The Administration's HSA Expansion Proposal – How to Spend $25 Billion to *Increase* the Number of Uninsured

The President's budget proposed an expansion of HSAs by allowing individuals to take another tax deduction for the cost of insurance *premiums* for the high-deductible plans linked to an HSA—*only* if these plans are bought in the private, individual market. This new deduction would cost the government an *additional* $25 billion over 10 years.

Again, this even larger drain of federal resources will not help the vast majority of uninsured Americans obtain health coverage. About 36 percent of uninsured Americans do not earn enough to pay taxes, so they would receive no benefit from this proposed tax deduction. Another 29 percent would be able to deduct, at most, ten percent of the cost of their premiums. Further, like the President's individual tax credit proposal, HSAs will hurt the nation's employer-based health insurance system. They will encourage healthier and wealthier workers to leave the traditional group market in favor of high-deductible plans. Those workers who stay in traditional plans will then face higher premiums. This proposal would only benefit high-income, healthy people, nearly all of whom already have access to health insurance.

Worse than not helping uninsured Americans, this proposal may **add to the number of uninsured**. An analysis by Jonathan Gruber, a highly regarded economist at MIT, estimates that nearly eight million people would use the proposed tax deduction—but only about 1.1 million of these people (13 percent) would have been previously uninsured. Further, Dr. Gruber finds that the HSA deduction would lead to some employers dropping existing employer-based coverage, or electing not to offer coverage, because their workers could use the tax deduction in the individual market. In total, Dr. Gruber estimates that employers would drop coverage for 2.1 million workers—**and 1.2 million of these workers would become uninsured**.[12]

Tax Credits to Buy Insurance in the Individual Market

This year, the President proposed tax credits to help people purchase health insurance in the individual market but did not provide funding for the proposal. If funded, the President's individual tax credits would cost an estimated $70 billion over ten years. Individuals with incomes under $15,000 could receive a maximum of a $1,000 tax credit annually towards the purchase of health insurance. Families with incomes below $25,000 would receive a $2,000 to $3,000 tax credit. The tax credit would gradually decline, ending for individuals with incomes of $30,000 and for families with incomes of $60,000. For people who do not owe taxes, the tax credit would be refundable. However, the individual market is not the answer for most uninsured people, and the size of the proposed credits is too small to help most of the uninsured, who are generally among the lowest income in our society. Further, the individual insurance market is deeply flawed: it will not help those who most need help with the high costs of health care.

The Administration claims that this tax credit will help 4.5 million low-income, uninsured people purchase insurance, but the tax credit is far too small to make this claim credible. Meaningful coverage would cost at least three times as much as the maximum value of the tax credit. The average annual cost of family health insurance provided by employers in 2003 was over $9,000 (and more than $3,300 for an individual).

The cost of comparable coverage in the individual, non-group health insurance market would be even higher, especially for older and sicker consumers—if that coverage were available to them at all. A recent Families USA investigation found that, in 48 states, there were no standard $1,000 policies available for a healthy, non-smoking 55-year-old woman. Even healthy, non-smoking 25-year-old women could not buy a $1,000 policy in 19 states.[13] Those plans that were available for less than $1,000 had high deductibles and very limited benefits. Services like prescription drugs, emergency services, inpatient hospital visits, and mental health were either severely restricted or not provided at all.

In addition, the individual health insurance market discriminates against individual consumers on the basis of health status. Sicker people can be rejected for coverage entirely. For example, a 2001 study by the Kaiser Family Foundation inquired about the availability of insurance for hypothetical consumers with varying health status in diverse insurance markets.[14] Applicants were rejected for coverage 37 percent of the time. The study also found that people with health problems who do find health insurance often face higher premiums, high deductibles, or

substantial exclusions on their policies. Moreover, someone who is healthy now and purchases an affordable individual policy could face unaffordable increases in premiums if he or she develops medical problems in the future.

Further, this proposal would undermine employer-provided health coverage, since the tax credits could not be used by employees seeking to pay for health coverage in the workplace. Employers will be tempted to drop health insurance for their employees, wrongly believing that workers could use tax credits to purchase coverage in the individual market. In addition, some young and healthy workers may voluntarily opt out of their employer-based coverage to use their tax credit in the individual market. The resulting pool of workers remaining in employer plans will be, on average, older and sicker, driving up the cost of the coverage. This "adverse selection" could cause even more young and healthy workers to depart, raising premiums even further. These rising costs could ultimately force employers to stop offering health insurance or to substantially increase the premiums employees must pay. Older and less healthy workers could lose their coverage and become uninsured.

Finally, individual tax credits are not a cost-effective approach to reducing the number of uninsured Americans. Two-thirds of the tax credits may go to people who already have health insurance.[15] Thus the number of uninsured Americans will not be significantly reduced.

Association Health Plans

We believe that the current Association Health Plan (AHP) proposal poses a serious threat to our existing employer-based health insurance system and violates the important principle: First, Do No Harm. AHPs, which allow small employers to band together to purchase health insurance outside of most state insurance laws, will weaken consumer protections and undermine the existing group market.

Proponents argue that AHPs are simply intended to allow small businesses to band together to purchase health coverage as a group and, therefore, to secure more favorable insurance premiums. Conceptually, such banding together makes good sense and, in fact, nothing in federal or state law prevents small businesses from coming together to purchase health insurance. However, recent proposals to foster AHPs, including legislation now pending in Congress (H.R 660), would exempt AHPs from state regulation—overriding rules that protect the financial solvency of the plans, that ensure that critical services are covered, and that prevent discrimination based on health status.

Instead, AHPs will be able to design their benefit packages to be attractive only to firms with healthy workers. They will also be able to target industries, sectors, and geographic regions with the healthiest employees and leave out small businesses with older or sicker workers—those who most need coverage. This ability to "cherry-pick" will drive up the cost of coverage for small businesses with less healthy workers, who will then be left in the insurance pool by themselves. This will drive up costs for the many employers who do not or cannot form or join a healthy AHP on their own. In fact, the Congressional Budget Office (CBO) has estimated that, under AHPs, 20 million employees of small employers, including dependents, would experience a premium rate *increase*.[16]

Approaches that Do Not Threaten Employer-Based Coverage

I would like to now briefly describe four proposals that Families USA believes will significantly reduce the number of uninsured in our nation **without threatening the stability of employer-based coverage.**

Reinsurance Assistance to Small Businesses

Four out of five people without health coverage today are in working families.[17] Typically the breadwinners in these families work in small businesses whose owners feel that health benefits are too expensive and volatile – and, therefore, they don't offer health benefits at all. Unless these small businesses receive effective and well-targeted support, it is unrealistic to expect that they will introduce health coverage for their employees

For small businesses, health costs are likely to be considerably more volatile than the costs experienced by large corporations. A serious illness for even one employee can result in very substantial premium increases for a small business, while larger businesses can absorb those unusual individual claims by spreading the cost risks over a much larger workforce. Therefore, this cost volatility is a significant obstacle for any small business.

To extend employer-provided health coverage, it would be reasonable to consider a federal back-up system that reinsures the relatively few, but costly, large claims incurred by insurers of small businesses, such as individual health expenses in excess of $50,000. Seventy percent of all health care outlays are consumed by only ten percent of the population.[18] High cost claims account for less than half of one percent of all health insurance claims but generate 20 percent of the nation's health care costs. Such a reinsurance system would not only reduce the volatility of future premium increases, but they would also decrease current premiums that small business owners incur—by at least ten percent.

Some have said that this reinsurance program will do nothing to control run-away medical inflation and simply shifts costs from the private sector to the federal government. Families USA maintains that this approach not only will decrease premiums for small businesses, but also can and should be designed to promote health care cost

containment. A reinsurance program could help control costs by tying participation in it to a requirement that the insurer participate in various "best practices." For example, an employer's ability to benefit from lower rates could be made contingent on participation in a plan that employed the latest medical information technology practices, electronic prescribing, electronic medical records, etc. Participation in wellness programs, chronic care, and disease management programs also could be a requirement for getting the subsidy. In this way, the program could lead the way in encouraging the adoption of true long-range cost containment strategies.

Tax Subsidies for Unemployed Workers to Purchase COBRA or Other Group Insurance Coverage with Consumer Protections

Certainly today's hearing underscores the many areas where there is little or no bipartisan agreement about how to reduce the number of uninsured Americans. However, one possible approach that should be part of the mix of solutions to reducing the number of uninsured seems to have generated across-the-aisle cooperation: the potential to help unemployed workers with a tax credit approach.[19] Since the 65 percent tax credit included in the Trade Adjustment Assistance Reform Act of 2002 (P.L. 107-210) was passed, a diverse group of organizations have worked together in an unprecedented effort to develop a workable infrastructure for administering the tax credit. Substantial progress has been made, with nearly 75 percent of those eligible for the tax credit now having a state-approved option for using this tax credit.[20]

By expanding the health coverage tax credit to the remainder of the unemployed, an estimated 4 million people, including dependents, could be kept off the uninsured rolls. Unfortunately, the size of the tax credit—65 percent of the cost of premiums—may not make it a viable solution for lower-income individuals and families. Families USA would recommend that for low-income unemployed people, the size of the subsidy be increased. In addition, the consumer protections in the original TAARA tax credit need to be strengthened so that older individuals and individuals in less-than-perfect health can use the credit. There must be guaranteed issue, no pre-existing condition exclusions, and plans must offer a community-rated premium without underwriting for health status, medical history, age, gender, and other factors.[21]

Tax Credit for Small Businesses Offering Health Insurance Coverage to Low-wage Workers

The percentage of small firms (3-199) workers) that offer health insurance has not changed in the last couple years—hovering at about 65 percent. For small businesses with low-wage workers (firms with 35 percent or more of the workers earning $20,000 a year or less), the offer rate drops to 54 percent. At the same time, the cost of coverage for small businesses has been rising at rates between 15 and 25 percent per year.

To expand the number of low-wage workers with access to employer-based health insurance coverage, Families USA has proposed a tax credit that would be effectively designed to target help to low-wage workers at small businesses. This approach efficiently uses federal resources to decrease the number of uninsured workers who most need help while supporting the stability of employer-based health insurance coverage for those workers who now have it.

Public Program Safety Net Modernization

Medicaid and the State Children's Health Insurance Program (SCHIP) are the most important safety-net health programs in America today. Medicaid, by far the program with the largest enrollment, serves approximately 51 million lower-income people,[22] most of whom would be uninsured but for Medicaid. The program, however, does not reach many millions of others who are uninsured and no less needy – typically low-wage workers and the dependents of those workers. This is because Medicaid's current structure creates eligibility standards that resemble a crazy-quilt.

Eligibility for Medicaid varies substantially from one state to another. Medicaid eligibility also *differs quite radically based on family status*. In nearly four out of five states, for example, *a child* is eligible for public health coverage (through either Medicaid or SCHIP) if that child's family income is below 200 percent of the federal poverty level.[23] *For parents*, however, the eligibility standards are very different and considerably lower than they are for children: In 36 states, parents with incomes below poverty (below $15,260 for a family of three) cannot qualify for public health insurance. A parent in a family of three working full time all year at the minimum wage ($5.15 an hour) would earn too much to qualify for Medicaid in half the states, even though the family's annual income would only be about $10,700—well below the poverty level. Thus, parents of children eligible for Medicaid or SCHIP are often ineligible for public health coverage. In fact, seven out of ten low-income, uninsured parents do not qualify for Medicaid.[24]

For *adults who are not parents* – individuals living alone or childless couples – the federal safety net is almost all holes and no webbing. In 42 states, childless adults can literally be penniless and still fail to qualify for Medicaid or any other public health coverage. Thus, contrary to public belief, there are many millions of low-income people – usually low-paid workers in jobs that provide no health care coverage – who are ineligible for safety-net health coverage.

This arbitrary eligibility system needs to be modernized. Eligibility for Medicaid should be made more uniform and should no longer be predicated on family status. Everyone with family income below a specified level –

such as 200 percent of the federal poverty level – should be eligible for public health coverage, irrespective of his or her state of residence or family status, especially if he or she cannot obtain health coverage in the workplace. An incremental step towards this goal would be to provide health coverage to low-income parents of children eligible for SCHIP or Medicaid coverage.[25] It would enable approximately 7 million currently uninsured parents to gain public health coverage, *and* – in so doing – would improve children's enrollment in such coverage by allowing them to sign up for health coverage as a family unit.

End Notes

[1] Kathleen Stoll and Kim Jones, *One in Three: Non-Elderly Americans Without Health Insurance, 2002-2003* (Washington: Families USA, June 2004). Of these 81.8 million uninsured individuals, **two-thirds (65.3 percent) were uninsured for six months or more**.
[2] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (Washington: National Academies Press, 2003), p. 107.
[3] Aetna v. Davila, Cigna v. Calad, 542 U.S. ___ (2004). Available online at (http://www.supremecourtus.gov/opinions/03slipopinion.html).
[4] Prepared Remarks, Health Care Policy Roundtable Press Conference (Washington: Leadership Action Plan on the Uninsured, May 10, 2004).
[5] Kathleen Stoll and Kim Jones, *One in Three: Non-Elderly Americans Without Health Insurance* (Washington: Families USA, June 2004).
[6] Families USA, *Tax-Free Savings Accounts for Medical Expenses: A Tax Cut Masquerading as Help to the Uninsured* (Washington: Families USA, July 22, 2003); Kathleen Stoll and Kim Jones, *One in Three: Non-Elderly Americans Without Health Insurance, 2002-2003* (Washington: Families USA, June 2004).
[7] *Ibid*, p. 2.
[8] A 2003 Congressional Budget Office analysis found that only six percent of workers with incomes below $20,000 made any contribution to a 401(k) retirement plan, and only 27 percent of those in the $20,000-$40,000 range did.
[9] Karen Davis and Cathy Schoen, "Creating Consensus on Coverage Choices," *Health Affairs*, Web Exclusive (April 23, 2003) p. W3 – W206. Available at content.healthaffairs.org/cgi/content/full/hlthstaff.w3.199v1/DCI
[10] Marc L. Berk and Alan C. Monheit, "The Concentration of Health Care Expenditures, Revisited," *Health Affairs*, 20, No. 2 (March/April, 2001): p.12.
[11] For additional discussion of HSAs and increased cost-shifting and how it leads to adverse risk selection, see Kathleen Stoll, *What's Wrong with Tax-Free Savings Accounts for Health Care* (Washington: Families USA, November 20, 2003).
[12] Edwin Park and Robert Greenstein, *Proposal for New HSA Tax Deduction Found Likely to Increase the Ranks of the Uninsured* (Washington: The Center on Budget and Policy Priorities, May 10, 2004).
[13] Kathleen Stoll and Erica Molliver, *A 10-Foot Rope for a 40-Foot Hole: Tax Credits for the Uninsured, 2002 Update* (Washington: Families USA, May 2002).
[14] Karen Pollitz, Richard Sorian, and Kathy Thomas, *How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (Washington: The Henry J. Kaiser Family Foundation, June 2001).
[15] Jonathan Gruber and Larry Levitt, "Tax Subsidies for Health Insurance: Costs and Benefits," *Health Affairs*, 19, No. 1 (January/February, 2000): 72-85.
[16] Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts* (Washington: CBO, January 2000).
[17] Kathleen Stoll and Kim Jones, *One in Three: Non-Elderly Americans Without Health Insurance, 2002-2003* (Washington: Families USA, June 2004), p. 5.
[18] Karen Davis and Cathy Schoen, "Creating Consensus on Coverage Choices," *Health Affairs*, Web Exclusive (April 23, 2003), p. W3-206, available at content.healthaffairs.org/cgi/content/full/hlthaff.w3.199v1/DC1.
[19] Sonya Schwartz, *A Shelter in the Storm: How A Subsidy Could Help Unemployed Workers Get Health Insurance* (Washington: Families USA, October 2003).
[20] Stan Dorn, *Health Coverage Tax Credits Under the Trade Act of 2004* (New York: Commonwealth Fund, April 2004).
[21] For more detailed discussions of a possible TAARA tax credit expansion, see Sonya Schwartz and Adele Bruce, *The Trade Act Health Insurance Subsidy: An Update from the States* (Washington: Families USA, December 2003); Sonya Schwartz and Marc Steinberg, *A Shelter in the Storm: How a Subsidy Could Help Unemployed Workers Get Health Insurance* (Washington: Families USA, October 2003).
[22] John Holahan and Brian Bruen, *Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002?* (Washington: Kaiser Commission on Medicaid and the Uninsured, September 2003), p. 4.
[23] Donna Cohen Ross and Laura Cox, *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge* (Washington: Kaiser Commission on Medicaid and the Uninsured, July 2003), p. 2.
[24] Marc Steinberg, *Working without a Net: The Health Care Safety Net Still Leaves Millions of Low-Income Workers Uninsured* (Washington: Families USA, April 2004).
[25] The FamilyCare Act of 2001, 107th Congress, S. 1244, H.R. 2630.

Chairman JOHNSON. Thank you.
Mr. Remmers, you may begin.

STATEMENT OF RICK REMMERS, CHIEF EXECUTIVE OFFICER, HUMANA, INC.– KENTUCKY, LOUISVILLE, KY

Mr. REMMERS. Chairman Johnson, Ranking Member Andrews, and distinguished Members of the Subcommittee, my name is Rick Remmers. I am Chief Executive Officer of Humana's operations in Kentucky, Indiana, and Tennessee.

Humana is one of the nation's largest health benefit companies. We provide health benefits to approximately 7 million Americans.

I am also testifying today on behalf of America's Health Insurance Plans, AHIP. AHIP is a national trade association representing approximately 1,300 private sector companies providing

health insurance coverage to more than 200 million Americans. Its members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

I appreciate having this opportunity to testify about health insurance options for American workers and their employers. I will begin by reviewing the innovative strategies health insurers are developing to help employers and workers receive the greatest possible value for their health care dollars.

Next, I will highlight initiatives AHIP's board of directors have endorsed in an effort to make health coverage more affordable for small employers and their employees. I will conclude by identifying steps Congress and the Administration can take to make health savings accounts and flexible spending accounts more workable and attractive options for patients.

To reduce health care costs, Humana and other health insurance plans are developing innovative solutions in two broad areas. First, we are offering consumer choice products to give workers new options for exercising greater control over their health care decisions. Second, we are advancing disease management, wellness, and pay for performance initiatives to improve patient care and help workers stay healthy.

Patient choice products are available in the marketplace today in at least three basic designs: low-premium health plans offered in combination with a health savings account, health reimbursement arrangement, or flexible spending accounts; two, products that allow employees to build their own plans after employers have chosen a core level of benefits; and three, products designed around tiered networks of providers.

At Humana, we have designed product offerings known as Smart Suite and Smart Select that combine some of these features. Our Smart Select product is available to self-funded employers of 300 or more workers. Employers are allowed to choose from a variety of plans, some of which include a health reimbursement arrangement and flexible spending account.

Smart Suite and Smart Select also include web-based tools that are both sophisticated and user friendly. Employees can use these tools to compare cost and benefits, estimate their total health care spending, and customize their health plan by selecting varying levels of co-payments, co-insurance, and premium costs, and prescription drug options.

This approach allows employers to maintain a single insurance pool with a single insurance carrier and, at the same time, give employees the ability to choose health plans based on their own evaluation of their health care needs, preferences, and values.

Smart Suite and Smart Select have demonstrated that consumer choice offerings reduce medical costs in total. Humana has seen single-digit annual medical cost increases in Smart Suite compared to medical cost increases approaching 17 percent on traditional offerings.

Humana has offered Smart Select to our own associates over the last 2 years and has experienced an average medical cost trend under 5 percent without shifting a larger portion of the cost to the associates.

In fact, Humana's workers' overall contribution rate actually, on average, decreased from 21 percent of the total premium to 19 percent in the first year.

Medical cost savings are the result of utilization reductions in hospital in-patient and out-patient services. Preventative services and routine physician services actually increased by 14 percent, indicating that associates and their dependents are not avoiding care but are more cost-conscious about the choices of benefits, services, and providers.

Our experience with these products has recently led us to offer a new enhancement, Smart Assurance. Many Americans are worried about future increases in the cost of health care. Smart Assurance is the nation's first enhancement to a consumer choice product that gives workers the ability to ensure that their costs rise at a predictable single-digit rate of no more than 9.9 percent.

Quality improvement is another important area where health plans and insurers are working to provide greater value to employers and their workers.

My written testimony explains the steps the private sector is taking to promote evidence-based medicine, disease management programs, predictive modeling programs, wellness and prevention programs and incentives to reward quality.

Humana uses a technique known as predictive modeling to help employers understand the dynamics of their work forces and identify at-risk and chronically ill persons. We then work with employers to tailor the types of disease management programs that should be implemented for their employees. These disease management programs improve health care quality by focusing on the comprehensive care of patients over time rather than their individual episode of care.

I also want to briefly focus on small employers and the challenges they face in offering affordable coverage to their employees. We know that small employers are much less likely than large firms to provide health care coverage for their employees.

Almost all employers offer health insurance coverage. However, among employers with fewer than 50 employees, only 80 percent offer coverage; among employers with fewer than 10, only 55 percent offer health insurance coverage. Affordability is the most important reason that many small employers do not offer coverage. To address this concern, I urge the Subcommittee to consider policy proposals endorsed in March of this year by the board of directors of America's Health Insurance Plans, AHIP. These proposals would directly address the problem of affordability through a program of tax credits for small employers and individuals. My written testimony outlines additional details on these proposals.

Implementation of these tax credits would make health coverage more affordable for workers and increase the number of small employers who offer coverage.

Lastly, I want to discuss ways Congress and the Administration can make health savings accounts and flexible spending accounts more workable and attractive in the marketplace.

First, on behalf of both Humana and AHIP, I want to thank Chairman Johnson and many other Subcommittee Members who helped to win Congressional approval of health savings accounts.

I also want to emphasize our enthusiastic support for bipartisan legislation recently approved by the House which would allow up to $500 in unused FSA funds to roll over from 1 year to the next. These are valuable options for health care consumers.

I have a number of other ideas that we can address during the questioning.

Thank you.

[The prepared statement of Mr. Remmers follows:]

Statement of Rick Remmers, Chief Executive Officer, Humana, Inc. – Kentucky, Louisville, KY

I. Introduction

Good morning, Mr. Chairman and members of the subcommittee. I am Rick Remmers, Chief Executive Officer of Humana-Kentucky/Indiana/Tennessee. I am here today to testify on behalf of America's Health Insurance Plans (AHIP). AHIP is the largest health trade association in the country, representing over 1,300 companies that provide health benefits to over 200 million Americans. I appreciate the opportunity to provide information to the subcommittee on the new products and services that health insurance plans have developed to meet the needs of employers.

I will focus my remarks on the following four areas:

- Trends in the employer group market
- Innovative health insurance plan strategies to assist workers in using their premium dollars
- The special needs of small employers
- Regulatory challenges to meeting employers' needs

II. Trends in the Employer Group Market

More than 161 million Americans receive private health care coverage through the workplace. Despite rising health care costs, the overwhelming majority of employers continue to offer coverage: in 2003, the offer rate ranged from 65% of smaller firms with 3 to 199 workers to 98% of larger firms with more than 200 workers. Employers paid an average of $2,900 a year for single coverage (84% of total premiums) and $6,700 for family coverage (73% of total premiums). The percentage of premium paid by employers has been steady since 2000, rarely varying by more than one or two percentage points from one year to the next.[1]

Though workers have experienced a rise in deductibles and copayments – for example, the average annual in-network deductible for a worker in a Preferred Provider Organization (PPO) plan rose from $251 in 2002 to $275 in 2003[2] – most have experienced no other types of reduction in their benefit packages. Most employer-sponsored health plans continue to offer their workers generous benefits, including comprehensive coverage for prescription drugs and preventive services. Moreover, the percentage of workers with a choice of health plans has remained relatively stable, at 62%.[3]

Nonetheless, employers and workers rightly remained concerned over cost trends. In a recent survey of employers, 25% said they expected to increase employee contributions, and 23% said they would pass on more costs by making changes to the health plans they offer their workers.[4]

These are short-term strategies. Employers and workers need additional solutions that will help them control their health care costs. Health insurance plans are developing additional solutions through:

- Consumer choice products—to give workers options for using their purchasing clout in the marketplace.
- Disease management, wellness and education programs, and pay-for-performance—to give workers with chronic conditions more services, and opportunities to stay healthy, and to align reimbursement with providers' performance, higher quality, and ultimately more cost-effective, health care.
- Information transparency—ensuring that consumers have cost and quality tools that will help them make choices that are right for them and for their loved ones. These tools allow consumers to compare providers on price and performance.

III. Responding to Employers' Needs with Consumer Choice Products

Health insurance plans have developed a spectrum of "consumer choice" products that give workers the incentives and the tools to become better consumers of health care. By giving workers more control over funds allocated for their health benefits, workers will be more engaged in how they spend their money. This is especially true once a worker becomes more educated about the actual cost of health services.

Consumer choice products are available in at least three basic designs:

- Products designed around tax-advantaged spending accounts – such as Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs), or Flexible Spending Arrangements (FSAs) – and a low premium (high deductible) health plan.
- Products designed around tiered networks of providers.
- Products designed around structured choice, where workers "build their own" plans after their employer has chosen a core set or level of benefits.

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[1] Kaiser Family Foundation/Health Research and Educational Trust. (2003). *Employer health benefits: 2003 annual survey.*
[2] *Ibid.*
[3] *Ibid.*
[4] Gunsauley, C. (2003, December) Employers stay committed as costs soar. *Employee Benefit News.*

Tax-Advantaged Spending Accounts

An example of a product designed around a spending account is the "Liberty plan" offered by Tufts Health Plan, in alliance with Destiny Health. At the heart of the Liberty plan is the Personal Medical Fund™ (PMF), an interest-earning fund to which the employer credits a fixed amount of money for the individual to spend each year on health care expenses that are subject to an annual deductible. The PMF could easily be a Health Reimbursement Arrangement or a Health Savings Account: an HRA is an employer-funded account that reimburses workers for qualified medical care expenses; an HSA is a tax-exempt trust or custodial account with a financial institution that can be funded by the employer, the worker, or both.

If eligible health care expenses are more than the amount in the PMF, then the member pays additional health care expenses within the remaining deductible. Comprehensive coverage takes care of eligible expenses above the plan's deductible. Comprehensive coverage also covers drugs for chronic illness.

Complementing the Personal Medical Fund is the "Vitality Program" of rewards for healthy behaviors. Consumers are able to earn points – the equivalent of frequent flier miles – for making healthy choices. For many people, this might include joining a health club. For others, it might include losing weight or giving up smoking. For diabetics, it might be getting regular eye exams.

A 2002 survey by Destiny Health offers an early peek into the potential of consumer choice products like the Liberty plan:

- 41% of enrollees took a more active role in well-being and physical activity
- 37% improved their preventive healthcare regimen
- 16% reduced their number of doctor visits
- 12% negotiated costs with their doctor before receiving care

These changes in patients' behavior could result in big long-term changes in cost trends. More important, it demonstrates the power of informed consumers to make healthy choices.

Tiered Networks

One example of a product designed around a "tiered" network is Aetna's "Aexcel" network of specialist physicians. Based on an analysis of clinical measures of effectiveness (such as hospital readmission rates over a 30-day period and reduced rates of unexpected complications by hospitalized patients) and use of health care resources, Aetna identifies best-performing specialists (cardiologists, cardiothoracic surgeons, gastroenterologists, general surgeons, obstetrician-gynecologists and orthopedic specialists), and places them in a new, discrete network.

Employers have the option of directing their workers to use only Aexcel physicians for the six specialties. Or employers can offer Aexcel to workers along with Aetna's broader network of specialists. If both networks are offered to a workforce, employees choosing Aexcel physicians receive a reduction in copayments or coinsurance, or a reduction in deductibles. The Aexcel network is currently available in the three markets of Dallas/Fort Worth, North Florida and Seattle/Western Washington. Aetna intends to expand this product into additional service areas and specialties throughout the next two years.

"Build-Your-Own" Plans

Two examples of the build-your-own approach are offered by Highmark Blue Cross Blue Shield and Anthem Blue Cross Blue Shield.

Highmark's BlueChoice program features interactive selection tools that allow members to indicate general preferences and receive a list of plans ranked by how well they meet those preferences. Employers choose a central benefit plan and funding level. For workers, additional plan options allow them to choose from up to 200 additional options. These interactive selection tools ensure that each worker has a health plan tailored to his or her personal situation.

Anthem ByDesign permits employers to select a core level of benefits, and workers can opt to upgrade benefits for additional cost. Employers may choose from PPO health, dental, vision, prescription, life and disability benefits. This plan gives workers more control of their choices so that they can tailor family or personal health care strategies, and become more vested in their healthcare decisions.

Multiple Design Features

As health insurance plans and employers gain experience with consumer choice plans, the pace of product innovations will increase. A number of health insurance plans – including many of those previously discussed – combine multiple design elements. For example, Humana's SmartSelect product, available to self-funded groups of 300 or more workers, allows employers to choose from a variety of PPO plans, some of which include a Health Reimbursement Arrangement (HRA). Using sophisticated but user-friendly web-based tools, workers compare costs and benefits, estimate their total health care spending, and customize their plan by selecting varying levels of copayments, coinsurance and premium costs, as well as prescription benefit options. By offering workers choices in a suite of benefit options from the same carrier, employers can maintain the integrity of their insurance pool to protect the coverage of both the sick and the well, the young and the aged. This suite of choices allows workers a chance to select a plan based on their own evaluation of their health care and financial needs.

Humana's SmartSuite plans allow workers to choose from pre-packaged plan designs including HMOs, PPOs and plans with a spending account. A comprehensive education program is wrapped around these Humana products that provide the worker with education and support on a year round basis helping them become engaged health care consumers.

Experience shows that products such as these appeal to workers across a wide range of incomes. One Humana customer, an employer of 700 people with average compensation in the "high $30s, low $40s" and 15% to 20% of workers with average compensation in the "low $20s," reports that "even our workers who have more modest incomes are able to budget their finances and afford coverage through these mechanisms."[5] In addition, these plans have wide employer appeal as Humana clients on average have consistently experienced single digit increases. Moreover, employers can actually limit their exposure year over year through rate cap guarantees. For example, Humana's SmartAssurance program limits the maximum second year employer rate increase to 9.9%.

IV. **Responding to Employers' Needs with Programs to Improve Quality**

Recent major studies show that people in all parts of the United States, even in areas with outstanding medical institutions, are at significant risk of receiving poor health care. Across a wide range of communities, people received only 50% to 60% of treatments that have been determined to be the "best practices" for addressing their medical conditions. For example, less than one-quarter of diabetics had their average blood sugar levels measured regularly, and only 45% of heart attack patients received beta blockers and only 61% received aspirin. These findings are consistent with substantial research over the past several decades – including continuing research by Dr. John Wennberg and others at Dartmouth – on regional variations in care that have found shortfalls in the quality of health care delivered to Americans.[6]

Clearly, millions of Americans who have health care coverage through the workplace are not receiving care that is consistent with the highest level of objective scientific evidence. While the overuse, underuse and misuse of health care services have been well documented, the significant efficiencies that would result to the entire health care system have not been as well recognized:

- 30% of all direct health care expenditures are the result of poor quality and its indirect costs (e.g., reduced productivity due to absenteeism) cost a combined total of between $525 and $630 billion annually.[7]

AHIP member companies support the improvement of health care quality through the use of evidence-based medicine as the standard for health care. We support advancing health care quality and transparency to improve outcomes, eliminate errors, reduce costs, and help consumers to make informed health care choices. We should seek to control costs by informing consumers, promoting safe and effective care, offering payment incentives that reward quality, enacting sensible liability reforms, and enhancing benefits that emphasize health and wellness programs. These initiatives are happening today. They empower consumers and represent our best opportunity to ensure choice and quality while controlling costs.

Health insurance plans have developed a spectrum of programs that give physicians and patients the information, tools, and incentives to enhance the quality of care:

- Evidence-based medicine (EBM)
- Disease management (DM) programs
- Predictive modeling programs
- Wellness and prevention programs
- Quality recognition and incentives to reward quality

Evidence-Based Medicine

In *Crossing the Quality Chasm*, the Institute of Medicine defines the practice of evidence-based medicine as the integration of best research evidence with clinical expertise and patient values. Patient care can be enhanced through a national commitment to evidence-based medicine and transparency in the health care system. It is important that scientific research, best practices, and consumer information be applied in everyday medical practice and health care decision-making. Total health costs due to preventable adverse events (medical errors resulting in injury) are estimated to be in the range of $8.5-$14.5 billion.[8] At the low end, elimination of $8.5 billion in medical errors would be enough for employers to insure almost 2.5 million additional Americans with quality coverage. Instead, those funds are wasted on unnecessary care.

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[5] Patrick B. McGinnis, Chairman and CEO, Trover Solutions Inc., Louisville, KY.

[6] J.E. Wennberg and M.M. Cooper, *The Dartmouth Atlas of Health Care in the United States* (Chicago, 1999); Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the Twenty-first Century* (Washington: National Academies Press, 2001); E. McGlynn, S. Asch, J. Adams, J. Keesey, J. Hicks, A. Cristofaro, E. Kerr, "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*, 348, no. 26 (2003): 2635-2645; E. Kerr, E. McGlynn, J. Adams, J. Keesey, and S. Asch, "Profiling the Quality of Care in Twelve Communities: Results From The CQI Study," *Health Affairs*, 233, no. 3, May-June, 2004: 247-256.

[7] *Reducing the Costs of Poor-Quality Health Care*, Midwest Business Group on Health in collaboration with the Juran Institute, Inc., and The Severyn Group, Inc. 2003.

[8] IOM, *To Err is Human*, 1999, Executive Summary, p. 1.

AHIP members are currently working with a number of medical specialty societies to develop tools to implement these principles. We believe in promoting comparative effectiveness research and the development of a national repository to identify and make public practices that translate evidence into practice.

Disease Management

Disease management (DM) programs are available to employers across the full range of product platforms, from HMOs to PPOs to newer consumer choice products. Using a variety of approaches – among them patient education materials, information on self-care management, telephone-based nurse case management and home visits – disease management programs help patients take responsibility for their own care, while working with physicians to ensure patients receive recommended care.

Virtually all health plans have implemented disease management programs. Ninety-nine percent of health plan enrollees are offered a DM or chronic care program for diabetes; 93% are offered DM or chronic care program for congestive heart failure; and 82% are offered a program for asthma.[9] These are conditions for which proactive and timely intervention may result in delayed progression of the disease, better health outcomes, and lower overall costs.

A study of the disease management programs offered by 10 AHIP member health plans and insurers released in November 2003[10] found:

- *Asthma DM programs reduce total health care costs and show a strong return on investment.* One evaluation compared the cost of care for people with asthma with costs for the rest of the health plan population. In the year before the DM program was implemented (1996), the cost of care for people with asthma was 2.4 times that of the rest of the plan population. This number declined to 2.1 in 2001. The difference in pharmacy costs for patients with and without asthma declined from 4.5 times that of the rest of the plan population in 1996 to 3.6 in 2001. Another evaluation of a health plan's asthma program found that for every dollar spent on the program, the savings ranged from $1.25 to $1.40.

- *DM programs for congestive heart failure reduce ER visits and inpatient admissions by one-third.* A DM program for commercial and Medicare patients with congestive heart failure reduced emergency room visits and inpatient admissions by 33 percent. Given the high costs associated with emergency room visits, this finding has significant cost saving implications.

- *DM programs for lower back pain provide a strong return on investment.* A DM program for commercial HMO and commercial self-insured plan members with lower back pain found that for every dollar spent on the program, costs were reduced between $1.30 and $1.50.

- *Diabetes DM programs reduce per-member, per-month costs, inpatient days, inpatient costs, and total costs.* One health plan that implemented a DM program for Medicare and commercial members with diabetes found that total per-member, per-month costs for diabetes patients enrolled in the program were 33 percent less than costs in a control group. Another plan found that its diabetes DM program for commercial HMO members and employer self-insured plans reduced total inpatient costs by 14.4 percent; reduced inpatient days by 6.9 percent; and reduced total costs by 6.4 percent during a one-year period. The plan estimated that for every dollar spent on the program, it saved between $1.75 and $2.00.

- *DM programs for multiple chronic conditions provide a major return on investment.* Health plans' DM programs often address multiple chronic conditions, including diabetes, coronary artery disease, asthma, and congestive heart failure. An evaluation of a plan with a multi-condition DM program for its Medicare, Medicaid, and commercial members found that for every dollar spent, it saved $2.94. Preliminary analysis of the program also found a net savings of $.90 per-member, per-month. A similar program that another health plan established for commercial HMO and employer-self insured members found that the program saved between $2.25 and $2.50 for every dollar spent.

An example that illustrates how disease management can be integrated into a consumer choice plan is offered by Lumenos. Employers who contract with Lumenos encourage at-risk patients to enroll in DM programs by adding $50 to $100 to their health reimbursement account (HRA) if they agree to take a health risk assessment. Then, at the worker's request, the results are sent to a personal health coach who helps the member manage his or her health more effectively.

How well are such DM programs working? DM's success in promoting safe and effective care and improving health outcomes is well-documented by successes such as Geisinger Health Plans' 20 percent reduction in claims costs for patients in a diabetes DM program.[11] DM's success in saving employers money is evidenced by the findings of an AHIP study. The results of this study indicate that patient outcomes improved for enrollees in DM programs. Additionally, these individuals had fewer hospital admissions, fewer emergency room visits, and lower health care costs. These evaluations suggest that the real savings for consumers, health insurers and plans, purchasers and consumers are in the range of 5% to 33%.[12]

Predictive Modeling

An actuarial rule-of-thumb is that 5% of workers generate more than 50% of a health plan's costs. Predictive modeling is a technique that health insurers and plans may use to identify at-risk and chronically ill patients. These programs help patients uncover inconsistencies in care, identify potential health risks and focus on best practices for their care. Through analysis of

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[9] American Association of Health Plans (2002). 2002 Annual Survey of Health Plans. Publication pending.
[10] American Association of Health Plans/Health Insurance Association of America, *The Costs Savings of Disease Management Programs: Report on a Study of Health Plans*, (November 2003).
[11] Ibid.; J. Sidorov et al, "Does Diabetes Disease Management Save Money and Improve Outcome?" Diabetes Care 25 (2002):684-689.
[12] Ibid.

demographic, medical, laboratory, and pharmacy data, predictive modeling can identify high-risk patients and identify individuals at future risk, before the onset of an adverse condition. Patients benefit and health care costs can be reduced.

For example, Blue Cross Blue Shield of Michigan incorporates predictive modeling into its disease management programs, focusing on identifying candidates most likely to respond to interventions. Humana uses predictive modeling to advise employers on the types of disease management programs that would offer the greatest benefit to their workers. Workers benefit from coverage that meets their needs and tools that allow them to take charge of their own care needs and remain productive members of the workforce. Employers also may benefit from reduced costs and improved employee satisfaction.

Wellness and Prevention Programs

Wellness programs offer another effective strategy for increasing employee awareness of health concerns, preventing illness and disability, and increasing productivity. Examples of such programs to empower consumers include:

- PacifiCare offers employers a new free-of-charge voluntary program, *HealthCredits*. It rewards members who participate in nutrition, exercise and life-skills management programs with points, which translate into rewards, discounts on health-related items and even enhanced benefits or lower health insurance premiums and copayments. *HealthCredits* can serve as a motivational tool for workers who have the opportunity to see their health insurance and premiums decrease through more active participation in their healthcare.

- United Healthcare offers an interactive website for health plan members to: 1) order prescription drugs and over-the-counter medications online, ask a pharmacist questions about medications, and identify adverse drug interactions; 2) access clinical and other information about specified health conditions; and 3) set up a "my health" account, which tracks medical and medication history and provides tools to promote wellness, prevention, and prescription drug compliance.

Quality Recognition and Incentives to Reward Quality

AHIP member companies have been leaders in the movement of realigning payments to providers with the delivery of safe and effective, high-quality care: an approach known as pay-for-performance. Through a variety of programs, health insurance plans are identifying and rewarding high performing physicians, medical groups and hospitals, and giving consumers incentives to these providers.

- CIGNA HealthCare recognizes participating physicians and hospitals who have met certain quality criteria in its online *Provider Excellence Recognition Directory.* Physicians are recognized for being certified by the National Committee for Quality Assurance (NCQA) for providing high quality diabetes or heart/stroke care. Hospitals are highlighted for meeting the Leapfrog Group's three patient safety standards (e.g., Computer Physician Order Entry systems, Intensive Care Unit Physician Staffing, and Evidence-based Hospital Referrals). Such recognition provides consumers with valuable information about providers and allows them to make informed choices of physicians and hospitals.

- Anthem Blue Cross and Blue Shield is one of the first health benefits companies to collaborate with hospitals on an extensive hospital quality program that includes increased reimbursement based in part on quality measures. The program has been successful in improving the quality of care and outcomes at participating hospitals for all patients, not just Anthem members.

  Anthem's Hospital Quality Program began in Ohio in 1992 with the quality reimbursement component added in 2002. The program evaluates quality of care provided in its network hospitals based on quality indicators (such as care provided for coronary services, obstetrics, breast cancer, asthma, joint replacement surgery, emergency departments, patient safety and accreditation status). Since its inception, this program has made statistically significant improvements in the care delivered to Anthem members in areas such as neonatal mortality rates, the use of beta blockers after heart attacks, and patient safety. Hospitals convene and share best practices. This Midwest program has been extended across all Anthem regions. These programs incorporate a payment system to recognize and reward physicians and hospitals for improved health care quality, patient safety and clinical results, such as reduced infections or medical errors. The programs measure a broad set of metrics that are based on best practices and developed in collaboration with participating hospitals and specialty medical societies.

- Empire Blue Cross Blue Shield is working with several of its large employer customers – IBM, PepsiCo, Xerox, and Verizon – to provide bonuses to hospitals that implement two of the Leapfrog Group standards: Computer Physician Order Entry (CPOE) and Intensive Care Unit (ICU) staffing. As of December 31, 2002, 53 hospitals in the plan's service area had completed the voluntary Leapfrog Group hospital survey and self-certified the status of CPOE and ICU staffing at their facilities. Bonuses were paid under the program to 29 hospitals during 2002.

- Harvard Pilgrim Health Care has a Provider Network Quality Incentive Program which includes support for medical directors and clinical practices, a Quality Grant Program and an Honor Roll program that publicly recognizes outstanding physicians. Another component of the Provider Network Incentive Program is a *Rewards for Excellence* program that recognizes and rewards the exemplary performance that local quality efforts achieve. Harvard Pilgrim has identified a subset of key HEDIS performance measures where effective clinical interventions have been identified and/or where current levels of performance – nationally, regionally, and within Harvard Pilgrim – are less than clinically optimal. Harvard Pilgrim offers its providers financial rewards for achieving excellent levels of performance in the defined target areas. In 2003, Harvard Pilgrim rewarded 55 out of 66 eligible practices.

- In California, the Integrated Healthcare Association, including health plans and insurers, physician groups, and health care systems, is implementing a state-wide *Pay for Performance* initiative. Participating health insurance plans include Aetna, Blue Cross of California, Blue Shield of California, CIGNA HealthCare of California, Inc., Health Net, and PacifiCare Health Systems. A common set of performance measures will evaluate physician groups in six clinical areas, patient

satisfaction, and information technology investment (e.g., electronic medical records or computerized physician order entry of medications) and financial incentives will subsequently be awarded based on the physician groups' performance. A public scorecard will be available in September 2004 and initial payouts are expected in June 2005.

V. Recognizing the Special Needs of Small Employers

No discussion of employers' needs is complete without considering the special needs of small employers. Small businesses with fewer than 50 workers – three-fourths of all U.S. private establishments, employing nearly one-third of the private sector workforce – are much less likely than large firms to provide health coverage for their workers. Almost all larger employers offer health insurance coverage – more than 95% in 2003. But only 80% of employers with fewer than 50 workers offer coverage. And among the smallest of small employers, those with fewer than 10 workers, only 55% offer health insurance coverage.

Affordability is the most important reason for small employers not to offer coverage. For small employers that did offer coverage in 2003, the average amount spent on single premiums was approximately $3,000 a year; on family premiums, approximately $8,500 a year.

- In 2002, nearly 80 percent of employers not offering health benefits reported that a major or minor reason for not offering them was that their business could not afford to offer such benefits, up from 69 percent in 2000.

- In addition, 68 percent reported that revenue is too uncertain to commit to offering a health benefits plan, up from 56 percent in 2000.

- Complementing the problem of affordability is the relatively low wage structure of small businesses. For example, average hourly earnings for businesses with fewer than 100 workers are only 62% of the average hourly earnings for businesses with 2,500 workers or more.

In response, health insurance plans have developed products that are specifically tailored to the needs of small business. For example, Blue Cross of California (Wellpoint) sells FlexScape, a product for firms with two to 50 workers that offers an array of PPO and HMO options. Depending on price, benefits vary from basic catastrophic to comprehensive packages with a range of deductibles and coinsurance levels. First available in April 2001, FlexScape now has more than 800,000 enrollees.

When the state of Florida passed a law loosening restrictions on what insurers can charge for co-pays, deductibles and other out-of-pocket expenses, Blue Cross Blue Shield of Florida made four types of plans available to employers with 50 workers or less. These BlueCare plans have higher costs for consumers when they seek service, but the premiums are about 10% to 20% less than the lowest cost plan available.

The opportunity for consumer choice products and HSAs is especially promising in the small group market. Though only 3% of firms with 1,000 or fewer workers offered a consumer choice health plan in 2002, the number is sure to rise as health insurance plans introduce new products. When HSAs became effective on January 1, 2004, companies that had previously offered Medical Savings Accounts – among them Blue Cross Blue Shield of Minnesota and Assurant Health (previously known as Fortis Health), and UnitedHealth (through its Golden Rule division) – immediately began offering HSAs to small groups. Other companies, such as American Medical Security Group and HealthPartners, immediately began designing HSA-compatible products for availability later in the year.

However, health insurance plans can not, on their own, solve the problem of affordability for small employers. Therefore, as Congress crafts legislation aimed at improving access to health care coverage for small employers and their workers, we urge you to consider the policy proposals recently issued by AHIP's Board of Directors. These proposals would directly address the problem of affordability through a program of individual and employer tax credits.

Tax Credits for Individuals

Roughly 15 million uninsured individuals and families—about 34% of the uninsured overall—with incomes ranging from 150% to 300% of poverty lack health care coverage and are not eligible for public programs. About 50% of these individuals work for small businesses that employ fewer than 100 workers.

To improve affordability, AHIP believes the federal government should provide an advanceable, refundable tax credit that allows for variations in such factors as family size and age. Federal funding for this tax credit could be established through annual allotments, just as funding is currently set for SCHIP.

For eligible individuals with access to employer-subsidized coverage, the credit could be used to subsidize the cost of the employee contribution. Not only would this initiative make coverage more affordable for workers, it would also increase the number of small employers offering coverage. Employers would see tax credits as a way to reduce the price of insurance for workers, which would induce some employers, especially small employers with high concentrations of low-wage workers who are eligible for the credit, to start to offer coverage.

Tax Credits for Employers

To enhance the effectiveness of individual tax credits, the federal government should also aim targeted tax relief at small employers with total gross receipts below a certain level (e.g., $100,000). Such employers who buy coverage for their workers should receive a tax credit to offset a part of the employer's premium contribution for workers earning between 150% and 300% of poverty. Credits would be determined on a sliding scale based on the number of workers: the very smallest businesses, those with fewer than 10 workers, would receive the largest credit because those businesses have the lowest offer rate. Federal funding for this tax credit could be established through annual allotments, just as funding is currently set for SCHIP.

VI. Regulatory Challenges to Meeting Employers' Needs

On a variety of fronts, health insurance plans are working hard to give employers a range of new health care choices. Unfortunately, many states have over the years created a regulatory environment that slows health insurance plans' efforts. It is an environment that fails to serve consumers and employers by simply layering regulatory requirement over regulatory requirement. The result:

- Lack of uniformity of laws, regulations and interpretations from state to state.
- Dual—and frequently inconsistent—regulation by state and federal regulators.
- Absence of regulatory coordination from state to state.

We would like to provide the committee with some examples of how the lack of uniformity in the insurance regulatory system is affecting the development of Health Savings Account (HSA) products.

First-Dollar Benefit Mandates

Under the statutory language authorizing HSAs, the low premium health plans that accompany HSAs cannot provide first-dollar coverage, *except* for preventive care. Recent guidance from the Treasury Department defines preventive care as including:

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals.
- Routine prenatal and well-child care.
- Child and adult immunizations.
- Tobacco cessation programs.
- Obesity weight-loss programs.
- Screening services.

However, some states have first-dollar coverage mandates for benefits that may not fit the definition of preventive services. For example, New Jersey requires that hospital service corporations, health service corporations and group health insurers cover screening by blood lead measurement for children and *any necessary medical follow-up and treatment* for lead poisoned children, without application of a deductible. Pennsylvania requires that all health policies cover medical foods for the treatment of certain nutritional and metabolic diseases that require careful dietary supervision (e.g. phenylketonuria) without application of a deductible. And in North Dakota, group health plans must cover the first five hours of mental health services without application of a deductible.

Speed-to-Market Approval Times

Every state requires that health insurance plans make form or rate filings before selling a new product in the individual or small group markets. The faster states approve those filings, the faster the speed-to-market of new products for consumers and employers.

Some health insurance plans were immediately ready on January 1, 2004 to sell low premium health plans to accompany HSAs because those companies already had received state approval to sell low premium health plan policies. Other health insurance plans, however, had to file new policy forms in various states. AHIP has conducted a survey to ascertain how quickly states are approving new forms.

As of May 13, 2004, health insurance plans responding to the survey reported filing 136 policy forms for individual and group low premium health plans in 31 states. In 15 of those 31 states, two or more health insurance plans filed forms.

- Eighty-three forms have been approved, generally within 40 days or less.
- However, 53 forms remain pending, some for more than 100 days.

In the 15 states where two or more health insurance plans filed forms: two states approved all forms in 20 days or less (SC, VA); six states approved all forms in 40 days or less (AL, AZ, IL, NE, OH, OK); and the remaining seven states approved some forms, but left other forms pending.

Illinois and Indiana offer a good example of the lack of uniformity in the state approval process for low premium health plans. As of May 6, four companies have filed policy forms to sell low premium health plans to small groups in Illinois: one was approved in six days, the others were all approved in 36 days or less. The same four companies filed policy forms for low premium health plans in Indiana: one was approved in 75 days, and the other three are still pending, the longest for 80 days.

Status of Company Filings for Low Premium Health Plans
in Illinois and Indiana as of May 6, 2004

Company	Illinois	Indiana
A	Approved in 6 days	Approved in 75 days
B	Approved in 36 days	Pending for 32 days
C	Approved in 14 days	Pending for 80 days
D	Approved in 30 days	Pending for 70 days

As these examples show, under the insurance regulatory system as it exists today, it is virtually impossible to craft a compliance system that works across state lines. It is extremely difficult for health insurance plans to standardize and streamline their operational systems if those systems need to be re-calibrated for each state in which they do business. Health insurance plans have no choice but to pass on these costs to consumers and employers.

VII. Conclusion

America's Health Insurance Plans and its member companies are committed to developing consumer choice products, such as Health Savings Accounts, that give employers and their workers new and innovative health benefit options. However, it is important that policymakers take into consideration the compliance obligations imposed on health plans and insurers by federal and state laws. We have identified several areas where Congress and the federal government can take action to expand HSA opportunities for employers and consumers.

- *Coordination of HSAs with FSAs and HRAs* —The Treasury Department has released guidance limiting the coordination of HSAs with employer-sponsored flexible spending arrangements (FSAs) and Health Reimbursement Arrangements (HRAs). Legislation should give individuals the ability to choose between using their FSA, HRA or HSA to pay for qualified medical expenses.

- *Allowing Roll-Over of FSA Funds*—We strongly support legislation to allow the roll-over of up to $500 in unused FSA funds each year – or the transfer of that money into the individual's HSA – to deal with the problems of the current "use it or lose it" rule for such arrangements.

- *Using HSAs to Pay Health Premiums for Early Retirees*—"Early retirees" are penalized because they cannot use their HSAs to pay for health insurance coverage, including employer-provided retiree coverage. Legislation should allow HSA funds to pay the cost of health insurance coverage for individuals who retire before age 65.

- *Using HSAs to Pay for Medicare Supplement Coverage*—Individuals age 65 and older may use HSA funds to pay the cost of Medicare-related coverage – except for Medicare Supplement premiums. Legislation should allow the use of funds from the account to pay for Medicare Supplement premiums.

- *Allowing Funding of HSAs after Age 65*—Individuals who are Medicare-eligible may no longer fund an HSA, although they can use the money in the account for qualified medical expenses. Legislation could allow individuals to put money into an HSA after age 65.

Finally, we are most appreciative of the commitment that Chairman Oxley and Chairman Baker of the House Committee on Financial Services have shown to advancing a reliable, uniform system of regulation for insurers, and we have been talking with them about our members' priorities. As the experience with HSAs indicates, one of the top issues meriting regulatory consideration is speed-to-market.

These strategies will help America's health insurance plans transform coverage and care options tomorrow in ways that will streamline and strengthen the employer-based system, rather than merely burdening it with added complexity and costs.

Thank you Chairman Johnson, and other members of the subcommittee, for the opportunity to appear before you today.

Chairman JOHNSON. Thank you, sir. We appreciate the testimony of all of you, and your remarks will be entered into the record.

You know, Mr. Dennis, it sounded to me like you think small business guys are having a hard time, and I know they are. Do you anticipate employers not having the competitive competition between each other in order to provide health care to obtain good employees? Is that fading from our system, or are the prices just running them out of business?

Mr. DENNIS. Well, there is a certain element—there is a proportion of businesses that are vigorously competing for employees and for very high quality employees, and they need to provide health care, there's no ifs, ands, or buts about it, and they frequently provide very, very good benefits.

There is another side, though, where that is not the case at all, and they are struggling to meet payroll. They are in highly competitive markets, very frequently. They are not taking much out.

In fact, there is a direct relationship, quite frankly, between the amount of money a business owner takes out of the business, whether or not they provide health care, whether or not they provide pensions, and the wages they provide. I mean there is a direct relationship there.

So, there are—you have almost a situation where you have some that are vigorously competing, using health care and using all types of benefits, and you have others that are not.

Chairman JOHNSON. Thank you.

Well, I know, when I was running a business, it was tough finding health care, and you have really got to search around for it, and sometimes you don't get the best stuff.

Mr. McArdle, on page 5 of your testimony, you mention one option employers may take advantage of when providing retiree prescription drugs, supplementing or wrapping around a stand-alone prescription drug plan.

Could you tell me how that option might work for an employer?

Mr. MCARDLE. That is an excellent question, Mr. Chairman.

There are various ways of doing that. One way might be—and that is why I said in my opening remarks that the employers are looking to see what happens in the marketplace, who is standing up to do PDP plans or Medicare Advantage plans, but one option would be to contract—for the employer to contract with a Medicare Advantage plan or a PDP plan for their retirees to get coverage through that plan and the employer would pay an additional premium to provide more generous benefits than what's in the standard plan. For that purpose, it would really be an advantage.

Most of the employers offering retiree health are large multistate employers, and so, they have retirees all over, and if they had to coordinate with 50 or—who knows?—75 different PDPs, the coordination problem could be quite severe.

So, for that purpose, having an opportunity for a national PDP plan or a national Medicare Advantage plan would be a big boon, because then the employers could be able to service all their retirees and do it in a way that is administratively feasible.

Chairman JOHNSON. Thank you.

You know, Mr. Pollack made the statement that—it is all doom and gloom according to him, and you know, some of the statistics that we have seen indicate that HSA applicants, for example, did not have any prior coverage, which means some of them are getting insurance that did not have it, and some of them are older than those purchasing traditional insurance, and quite a few of them are buying policies who make less than $50,000 or even down to less than $25,000 a year.

So I am not sure that your statement that we are only helping the wealthy is a true statement, and I would be interested in your response to that remark and where you got your statistics from.

You know, since I have been up here in the Congress—when I first got here, we started with 15 million people uninsured. Then it went to 18. Then it went to 21. Then 35. Now 40 and now 41 and now 45, maybe 48, and gosh, you are talking about 85 million. Come on. Where are you getting those statistics from?

Mr. POLLACK. Well, if—so, you want me to focus on the 82 million number? I am happy to do that.

Chairman JOHNSON. Sure.

Mr. POLLACK. The 82 million figure also is derived through Census Bureau data, and there is no actual contradiction between the 43.6 million figure that is most commonly cited and the 81.1 million that we cite in our report. They actually depict two different things.

The 43.6 million figure, which comes from the current population survey, comes from a question that essentially asks were you uninsured throughout the course of the year? Most policy analysts actually interpret that question differently. Most policy analysts interpret the 43.6 million as being a point-in-time figure, how many people were uninsured at the time the survey was taken.

The 82 million figure comes from trying to look at how many people over a period of time—in this instance, 2 years—were uninsured at some point in that 2-year period. As you know, some people are uninsured and then they regain insurance. Others, at the time a survey may be taken, have insurance, but later on, they lose that insurance, and so this depicts how many people over the course of the last 2 years, 2002–2003, were uninsured at some point, and of course, that number is considerably larger.

The two numbers do not contradict one another, they depict something very different; and I would suggest that the 82 million figure is a very useful way of analyzing how many people are directly impacted by the lack or loss of health coverage.

Chairman JOHNSON. Well, our CBO estimates 20 million uninsured in any given time.

Mr. POLLACK. That is a different—again, we are depicting different numbers.

Chairman JOHNSON. Well, that is why you cannot use numbers like that. I do not think they are realistic.

Mr. POLLACK. Well, I think it is very useful to have a base of information about how many people are truly affected. The Census Bureau data that I cited, both in terms of the 43.6 million and the 82 million, are not contradictory with one another. They give you different pictures of this problem.

Chairman JOHNSON. Maybe they tell you how many babies are born a day.

Mr. POLLACK. I am sorry?

Chairman JOHNSON. Maybe they tell you how many babies are born a day, because they are not insured. Our time is up. We will get back to that issue.

Mr. Andrews, you are recognized for questions.

Mr. ANDREWS. Thank you, Mr. Chairman.

I would suggest that we could easily settle this dispute about numbers if we adopted a national policy and made the number zero, which is what it ought to be. If we had a policy that invested the right number of resources into health care for people, it would be zero. We would not have to worry about this.

I wanted to ask Mr. Remmers and Mr. Dennis a question about reducing costs by more competition. In the market that I represent, two insurers have 82 percent of the covered lives, there is very little competition, and I think that is common in markets throughout the country.

What would you think about a proposal that would create a Federal charter for health insurance underwriters that would say that if you met a fixed standard of fiduciary responsibility and a fixed level of consumer protection, benefit protection, if you met these standards, that you would be able to write insurance in any of the 50 states and compete on a national basis?

Do you think that would induce competition that would lower costs for health insurance buyers, Mr. Remmers?

Mr. REMMERS. Congressman Andrews, if you could clarify one more time—you gave several criteria before you finished the question. What were the criteria again?

Mr. ANDREWS. The criteria are that there would be fiduciary standards that would ensure that the company would be solvent, and there would be consumer protection standards so that certain benefits would be mandated and covered, similar to state mandate benefits. There would be one set of mandates for the whole country. Do you think that would lower costs or not?

Mr. REMMERS. Probably have to get back for the record on that; I do not have the information at my fingertips. But my first reflection on this is that it probably would not, that competition is driven through normal competitive alignment of are you committed to a marketplace, do you have the network-based contracts, do you have the things that are, frankly, very important in order to provide a competitive offering in a given state.

Mr. ANDREWS. Isn't it, in part, driven now by the fact that, in fact, as a practical matter, you have to be licensed by each state that you operate in, so the regulatory barriers to market entry are very significant? If you knock down those regulatory barriers, wouldn't you have more competitors in the marketplace?

Mr. REMMERS. I think that would be helpful. I think there are regulatory barriers, and they do vary by state. In Kentucky, where I reside, I think our state legislature has recognized that and had worked to try to soften some of the barriers to entry and encourage competition to come back in.

Having said that, we have very actively six or seven offerings in most areas of the state for competitive offerings rather than just a presence.

Mr. ANDREWS. Does any one insurer have more than 40 percent of the market share where you live?

Mr. REMMERS. No, not where I live, in Louisville, Kentucky, no.

Mr. ANDREWS. That is unusual.

Mr. Dennis, what do you think?

Mr. DENNIS. Yes, I would agree, and in fact, associated health plans are kind of a parallel to what you are talking about. There

are some differences, but clearly the idea of this relatively uniform regulatory set is to cut entry barriers and to eliminate overlap, duplication, so on and so forth. So, yes.

Mr. ANDREWS. Well, of course, a lot of us think associated health plans create an un-level playing field, because they create one set of rules for one competitor and another set for another, but that is an argument for a different day.

Mr. DENNIS. Yes.

Mr. ANDREWS. Mr. Pollack, I wanted to ask you a question. Your idea about providing tax credits to small businesses to help them purchase insurance for their employees, I think, is the only viable strategy out there. As I said earlier, I think subsidies for people who cannot afford insurance are necessary, and I think an employer-based system works. I do not think it is a wheel that needs to be reinvented.

What do you do about the problem of increasing the number of uninsured because you are subsidizing those who do not provide coverage? What do you do in a situation where one service station owner goes the extra mile and insures his or her employees, but the guy down the street does not? Do you offer the tax credit to both service station employers, or do you only do the one who does not offer coverage, and how do we reconcile that problem?

Mr. POLLACK. I think that is a very tough issue, because on the one hand, you want to use your tax dollars as prudently as possible and achieve policy results. On the other hand, you do not want to penalize somebody who's done the right thing in the first place.

Mr. ANDREWS. Right.

Mr. POLLACK. So I think there has got to be a very careful balance.

I think we send the wrong signal when those people who have done something voluntarily then get disadvantaged in terms of the tax benefits that are offered.

Mr. ANDREWS. It is a hard problem.

Mr. POLLACK. I do not think you can simply provide that tax benefit to those people who had not provided it in the past and now provide it and do not provide assistance to those who——

Mr. ANDREWS. I think Mr. Dennis had a—one comment he made earlier suggests where you might break that gradation. There is a cleft in the marketplace, there is a cleavage in the marketplace between employers who are competing for employees who demand health insurance and cannot get them without it and employers that are not in that marketplace, and I think that is probably the way you have to do this, and you have to extend the tax credit to some of the employers in that marketplace where employers—employees do not have the market power to demand health care.

You have got to extend it to them, which means that these all cost more than you and I would think they would originally, because it has to cover not only employers who are employing uninsured people but employers who are employing insured people but competing with people who do not insure, if you follow me.

It is a very tough problem.

Mr. POLLACK. I think it is. I mean, it creates a cost inefficiency, but you have to balance it with equity and fairness.

Mr. ANDREWS. Thank you very much.

Chairman JOHNSON. Thank you, Mr. Andrews.

Mr. Carter, do you care to question?

Mr. CARTER. Thank you, Mr. Chairman.

First, let me apologize for being late. We had a markup down the hall I had to be at.

A question was asked just a minute ago—and I took it as a two-part question—and one of the things was mandated coverage. Mr. Remmers, I think my colleague down here mentioned two parts, and one part you addressed. The other was mandated coverage, like many of the states have mandated coverage that they require of anyone who offers policies. I have heard testimony that mandated coverage actually drives the cost up, rather than down, and having policies that offer marketplace-driven coverage is a more economical method. Do you have a comment on that?

Mr. REMMERS. I would agree with you. From Humana's perspective, our experience is you get into various forms of mandates, whether it is at the benefit level or at the coverage level, as you mentioned, I think it is going to be difficult for employers to assume.

That is why we favor strongly the marketplace approach of offering innovation, which I referenced some and go into further detail on or off the record, offering innovation in the marketplace to allow the voluntary system to continue but provide some of the gaps, solutions, which I think is what Congressman Andrews was referencing with various types of public—both financing support and program support, which are badly needed in certain areas of the market.

Mr. CARTER. I understood the other part he was addressing.

Mr. Dennis, in your opinion, proposals to make it easier for patients to sue employers—would that have any help to small business, the way you look at it?

Mr. DENNIS. I am sorry. I did not hear the question.

Mr. CARTER. There are proposals to make it easier for patients to sue their employers in state courts. Do you see that as any help at all to these small businesses that are trying to offer health insurance coverage?

Mr. DENNIS. No, sir. No, sir.

I would like to go back to the prior question, too, about mandates. I mean I think the empirical evidence suggests that they add considerable cost, and it ought to be taken in that light.

Mr. CARTER. Well, it seems to me—for instance, there was a time in my life when my wife and I needed to have maternity benefits in our family, and in fact, I had four children and never had a policy that had them, on four children, just bad luck, but now I really do not care anything about that, and so, to me, policies that—the more you can offer a marketplace solution where you could tailor the policy to fit your individual needs, the better you are served by the coverage that you receive, and so, I agree with that.

What significant steps can Congress take that will make it easier for small employers to offer health insurance benefits that you see?

Mr. DENNIS. There are really a series of them. We think, certainly, the HSA program that's now on the books is definitely a step in the right direction; association health plans, definitely a

step in the right direction. We ought to be looking at some medical malpractice sorts of reforms, steps in the right direction.

One of the things that I think is quite clear is that there is no magic bullet.

I do not see one magic bullet either holding down health care costs or making sure that we cover a lot more people than are currently covered. It is important, though—and a major target is that we curb the rising cost of health care, because that does have impacts on all kinds of coverage issues. We know that there is an elasticity in health care, that when it gets higher, fewer people get it. So, we need to really look at those things.

Mr. CARTER. Thank you.

Thank you, Mr. Chairman.

Chairman JOHNSON. Thank you, Mr. Carter.

Mr. Tierney, do you care to question?

Mr. TIERNEY. I do.

Chairman JOHNSON. You are recognized.

Mr. TIERNEY. Thank you, Mr. Chairman.

Mr. Pollack, I would like to cover some ground that I think you mentioned in your testimony, and that is the prospect of reinsurance, and I would like to—my understanding is you're talking about reinsurance through a premium rebate pool and that you would reimburse the employee health plans for 75 percent of the cost for catastrophic cases over $50,000.

Would you expand on that a little bit, how that would work, and what the benefits of that would be?

Mr. POLLACK. Well, I think this is a very practical step that would be of real help to small businesses. For small businesses, they not only have to worry about the general cost increases, but they also have to worry about the unpredictability of those costs, and for a small business, if they have just one employee who has a major catastrophic illness, this could devastate a small business and certainly would significantly increase their premiums in future years.

So the idea is to provide help to small businesses to improve the predictability of their costs and to help reduce premiums somewhat, and the way this would work is that, for the very, very small number of individuals who have really catastrophic expenses, say expenses in excess of $50,000—and that only constitutes about one-half of 1 percent of all people who have health coverage, but yet, it accounts for about 20 percent of total cost.

This would mean that a small business would understand that there would, in a sense, be some significant cap in their liability, and it would mean that they would much better predictability in the future, so that I think this is a very practical step that is worth looking into. There are some difficult issues, I think, that need to be worked out in terms of how this gets implemented, but I think the concept makes abundant sense and hopefully will be welcomed by the small business community.

Mr. TIERNEY. Thank you.

Mr. Dennis, let me ask you—some people have proposed allowing small businesses to join insurance pools, like the Federal Employee Health Benefit plan. In fact, I know Stu Butler, over at the Herit-

age Foundation, seemed to have sort of endorsed this concept lately.

What do you think? Would you think that the government-sponsored insurance pools would allow small businesses to benefit from this? Would that be a helpful prospect?

Mr. DENNIS. I am not sure. Clearly, there are some conceptual pros to it.

I notice that Stuart has just changed his mind, for what that's worth, has come up with a separate proposal, but the idea of having a very large pool operating in which these individual employers can operate in and around, or whatever you want to call it, is very, very attractive. That is one of the reasons we have supported HSAs, for example—not HSAs—AHPs, is the whole idea that, you know, we are going to have a larger pool, we are going to have better bargaining power, and so on and so forth, and so, in that sense, it is very positive.

I do not think that we have, as an organization, have taken any position on the Federal plan itself, though.

Mr. TIERNEY. Mr. Pollack, do you have an opinion on the benefit of that type of a process, allowing employers to buy into the Federal employee health benefit plan, helping them with the affordability, hopefully, and the administration of their plans?

Mr. POLLACK. Yes, I do. I think it would make a great deal of sense, and I am not sure whether it would be the precise same plan as the Federal employees, but it could be some kind of a parallel plan, and my hope is that through economies of scale, that employers would be able to achieve some significant savings in the process.

Mr. TIERNEY. Thank you.

I yield back, Mr. Chairman.

Chairman JOHNSON. Thank you, sir.

Mr. Kline, do you care to question?

Mr. KLINE. Yes. Thank you, Mr. Chairman.

Chairman JOHNSON. You are recognized.

Mr. KLINE. I want to thank the panel for being here. This is a subject that has been driving us all crazy for years now, but the last two or 3 years, it has just been remarkable how I travel around my district in Minnesota and talk to employees and employers, and both sides always, invariably, talk about the cost of health insurance. It is frequently the No. 1 issue to the businesses that I am visiting. Sometimes it is the No. 1 expense, but it is always very, very high. So I very much appreciate your being here today, and I certainly want to thank the Chairman for holding this hearing.

Mr. Dennis, a couple of minutes ago, you said HSAs and corrected yourself to say AHPs, but both are possibilities. HSAs are, in fact, now in law, and I have been surprised, as I have traveled around to talk to these same business owners, that they do not know what HSAs are, and so, my first question to you is, since you are representing a very large organization, what is the discussion to educate employers about the potential for HSAs?

Mr. DENNIS. Well, that's a major thrust that we are going to be undertaking, in fact have begun to undertake, but more than that, I think one of the major issues involved is that is how do we get

the word out through the normal market process, through the insurance industry, if you will?

We have had a very small MSA program before AHAs came along, and it was reasonably well—well, the renewal rate was very high—94, 95 percent—savings were quite substantial, but the problem was we had an issue of marketing, and that is what the issue is right now, because the incentives for those to market it, for the agents, if you will, are not there, and what we have to do is find a way to make sure that the agents involved in this have incentives, and we have got some plans on the drawing board right now, hopefully, to do that, because if you have got active sales forces out there doing it, that is the best publicity, in effect, there is.

Mr. KLINE. Well, exactly, and we had a meeting here a month or so ago—we had a number of representatives from the insurers and were talking about how well received they were and talking about, frankly, their efforts to inform the public about HSAs, and yet, I have yet to go to one of these companies—and I visit two or three a week every week when I am back in the district—who knew about them and anymore than the most rudimentary notion of how they might work. So, I would encourage you and your organization to talk about it as much as you can, and then, as you say, the industry is going to have to do that, as well.

Mr. Remmers, on page 3 of your testimony, if I have got the right note here, you talk about information transparency and other quality tools. How will the average consumer be able to access these tools, and what benefits will they gain?

Mr. REMMERS. There's a variety of work taking place in the transparency area today, and it is all predicated on, if you believe in the patient as an active consumer and having the right to know information regarding cost and quality, which we do stand for at Humana, you have to put information in a way that they can, one, get to it, and two, understand it.

Sometimes it is easier to give an example, and I can give one in my own life that is personal. When I was asked to be put on a cholesterol-lowering medication about 2 years ago, for the most part it was a bunch of Latin to me, the various options, as they are to most people. My internist suggested—and I will refrain from using the drug name here for a moment—drug A, which in my benefit plan would have cost me $50 a month. It was, in fact, a benefit plan that I chose. No one chose it for me. So for $50 a month or $600 a year, I could have this drug that I needed to have, that in fact would benefit me in out-years, not near term.

I went to the drug store, got it, and was shocked at the $50.

Having said that, Humana contacted me in about 24 hours, in my case through the web, because that is how I asked to be contacted, through e-mail, but we can do it through phone, which most people have access to, or regular mail. In my case, it came through an e-mail that gave me an alert. I signed on a private web-site, secured just to me, not to my spouse or anyone else, for privacy reasons, and I saw, as I clicked onto my e-mail, an alert message, a little red flag flicking, which all 3 million of our commercially insured people have access to this, it said if you would like some helpful information regarding the opportunity to lower your prescription costs, click here.

I did so and found a row of alternative drugs, in this case one that would cost me 25 a month or, in effect, save me $300 a year.

I, in turn, took the initiative—Humana did not require me to do it, I did not have to ask permission to do it, so there was choice in play here—I chose to call the internist back and discuss it with her, which, frankly, was a little bit startling to her office, if I have to be candid. They were not used to this kind of engagement——

Mr. KLINE. I can imagine.

Mr. REMMERS.—which we are going to see more and more as people get more and more in tune with having access to information and having the ability to control their own decisions.

She was thrilled. She said, "I am in the habit of prescribing drug A, but for $300 a year less, I would absolutely suggest drug B."

That has been 2 years, and I am fine.

So that is maybe a specific example of the way that we are—and by the way, I could see the actual retail cost of the drug, I could see our Humana cost for the drug, and what my cost share piece of it was, or any other drug that you want to see on our web-site.

Mr. ANDREWS. Will the gentleman yield for a second?

Mr. KLINE. Certainly, glad to yield.

Mr. ANDREWS. Who was it that made the judgment that the other drugs on that list were the equivalent of drug A that you bought? Who made that decision?

Mr. REMMERS. We have a group of people that are physicians and pharmacists that stratify the whole PDR. So this is not that 50 percent of the drugs are available across the list.

In my case, in my benefit plan, there are four tiers that this group decides, for both cost and clinical efficaciousness reasons, reside in one of these four tiers, and this is not administrators; it's pharmacists and physicians.

Mr. ANDREWS. Thank you.

Thank you for yielding.

Mr. KLINE. I see my time has expired, so I yield back.

Chairman JOHNSON. Thank you, Mr. Kline.

Is that a generic drug?

Mr. REMMERS. Neither of these are.

Chairman JOHNSON. OK. Thank you very much.

Ms. McCarthy, you are recognized.

Mrs. MCCARTHY. Thank you, Mr. Chairman, and I probably know what the first choice of the drug was. Most likely, it was Lipitor, because I started off with it—oh, gosh—too long ago, but I have slowly seen it go from $20 a month up to the $50 a month, and people should have more choices, or at least the information.

What I will say—and I am going to probably come in a different way—I happen to believe, because you went on your medication, I went on mine, that some of the best practices that are agreed upon are disease management or wellness programs. That is not what we do enough in this country. Unfortunately, we still look at medicine during the crisis center instead of the prevention that we're looking at.

So I do not know why we do not have a standard part in almost every health insurance plan. Some do, and I know they do, and those are the ones I look for.

I am lucky. I work here. I have the doctors here that have me on a computer and say, hey, you have to go for your test, you have to have this done next month, so they keep track to keep me healthy, which hopefully, in the end, when I am in my 80's, is going to pay off, but I guess my question is—and I also—when we were talking earlier—and I am sorry if I am talking funny, I had a little teeth work done this morning.

Many of us are also onto a bill, legislation that is here on the House, which we cannot seem to get a hearing on, to give small businesses a tax credit for the health care costs on top of the already existing full tax deductibility, and I guess my question would be how big would a tax credit have to be in order to make a difference for the small businesses to be able to cover, certainly, their low-wage workers?

I mean, how do you figure that out?

Mr. DENNIS. There are elasticities that economists have developed over the years. They are very crude at this time. This goes all the way back to some of the early Rand studies in the 1980's or late '70's, where they know that certain—you know, you add a certain price, lower a certain price, you get more, you get less people that will be covered.

I do not know if anything has been done specifically dealing with smaller firms, however, on that score.

I have no idea what those numbers would be, and clearly, the higher, the more you would include, and the lower, the less you would include, if that is what you determine would be good policy, but I do not know of any number and I do not know of anybody who does have a number for you.

Mrs. MCCARTHY. On the cost-effectiveness, just going back, because we had—it came through this Committee going back where we had the AHPs passed for small businesses. I fought against that, and basically, it goes back to my original part on the wellness.

My state of New York and many other states throughout this country, through the attorney generals, through legislation, realized that wellness, yearly physicals, mammograms were important so we could prevent or, if we found a disease, get it early, and yet, the bill that was passed through here on the House side would have done away with all of that.

You know, when I try to talk to my small business people, I want you to have insurance, I want you to be able to cover your employees, but we have to somehow find a way—forget about the politics—on what is good health care practice, because in the end, in the end, we will end up saving so much more money.

Diabetes—perfect example—people that do not take care of themselves end up in a dialysis center, which is costing us so much money, or lose a leg or their eyesight, come off the workforce.

It is complicated. I think everybody here cares very much that people have insurance, but we seem to—cannot find an answer.

Mr. DENNIS. One of the situations is that, with the constant—with constant price increases, smaller firms are constantly shopping, and when they are constantly shopping, it is very difficult to develop relationships with insurers and insurance products and that sort of thing where you might institute a wellness program for

three or 4 years or something like that, if you are constantly going back and forth, and that is one of the really difficult problems created by this environment of rapidly rising prices, and that is small business owners have to look for new things, they just cannot take those, and as long as we do it, it is going to—as long as we have to keep shopping, it is going to work against precisely those relationships which will give you what you are looking for.

Mrs. MCCARTHY. Mr. Pollack?

Mr. POLLACK. I think the issue of AHPs that I find even more troubling relates to the potential for market segmentation and dividing those who are healthier, younger, from those who are sicker and older.

I do not worry so much about this with a group like NFIB or the Chamber of Commerce, which has members—they are not—these members have joined those organizations for other reasons other than becoming a member of an association health plan, but for others who really would be encouraged to create these association health plans and for whom market segmentation could potentially be very easy and whom I try to encourage those businesses that have a healthier, younger workforce to join and to discourage the older, sicker ones from joining, I think for those who are left in the traditional pools, it means the costs for them are going to increase, and CBO tells us it would increase, I think, for approximately 20 million people who would be left in these traditional pools.

Mrs. MCCARTHY. Thank you.

I see my time is up.

Thank you, Mr. Chairman.

Chairman JOHNSON. Thank you. I appreciate your questions.

You know, AHPs are part of large organizations like the Chamber, for example, which you say would be OK, and I think there is a requirement for any organization to be in effect for at least 3 years before they can start an AHP program, under the law, if it's ever passed, and so, I think that maybe we are talking about something that will not ever happen, but can I just ask—your large companies who have health insurance do provide wellness programs, do they not?

Mr. REMMERS. Yes, sir.

Mr. Chairman, in part, it is the definition of a wellness program, and I would say not just large but small and medium-size employers—the vast majority of our health plans that we at Humana sell to customers and administer for them do include preventative services, mammograms, physicals, things such as that; other kinds of wellness and lifestyle programs along the lines of fitness and that sort of thing, no.

Most of that, as Denny mentioned down the row, generally aren't offered by a vast majority of employers, and the reason is their health benefits costs are costing them too much and they cannot invest the additional amount, which is one of the reasons that giving more options and more choice and more innovation in the marketplace is extremely important, because as people decide to possibly consider a lower-premium plan, if that's right for them—if it's right for them in accordance with their needs, their values, their ability to do that, that is an attractive offer, and in turn, there may be more money freed up to invest in other fairly more traditional

wellness programs, but preventative services, yes, including in the lower-premium plans like HRAs and HSAs.

Chairman JOHNSON. Disease management, if you will.

Mr. REMMERS. Disease management applies to all of our 3 million people that we administer or insure unless a large self-funded employer specifically requests not to, but beyond that, all of our insured business, it does.

Chairman JOHNSON. Thank you, sir.

Mr. Wilson, do you care to question?

Mr. WILSON. Yes, Mr. Chairman. Thank you, and I would like to thank all of you for coming this morning, and Mr. Dennis, thank you very much for your past presidency of the International Council for Small Business.

I also very much appreciate your service with NFIB. I served for a number of years in the State Senate and worked very closely with the executive director, Michael Fields, in South Carolina, and NFIB is a real world advocate for small business, and in our state, which is not unusual, 99 percent of the businesses are small businesses, 85 percent of the employment are small businesses, and so, we really appreciate your input, and today, in your testimony, you noted that small employers have a limited number of options from which to choose when facing the cost increases. They can pass on the cost increases to consumers, reduce employee compensation, or limit business investment or owner earnings.

How feasible are any of these options for the small employer?

Mr. DENNIS. None of them are very attractive. I mentioned that it is very difficult to pass on cost increases right now, particularly in this low inflation environment. Most of it ends up getting passed back to employees, but small employers do not like to do that. I mean somehow it is the idea that, you know, we are having a good time when we do that sort of thing.

Employees do not like it, we do not like to do it to employees, and so, that is not—that is what happens, eventually, but that is not a very positive thing, and if you take it out of your investments, business investments, you are eating your seed corn, in effect, you cannot operate that way, and if you take it out of your own earnings, well, a middle-class person cannot take a lot of money out of their earnings as a stop gap, even as a temporary measure. The alternatives are not very attractive, let me put it that way, none of them.

Mr. WILSON. I do appreciate NFIB trying to get the word out to businesses as to what is the best approach.

Mr. DENNIS. Thank you.

Mr. WILSON. Also in terms of your opinion, what regulatory burdens do you foresee in creating and offering consumer-driven health plans, and how can Congress best address them?

Mr. DENNIS. Regulatory burdens.

Well, there is a potential range of mischief, but I think one has to look at it not so much about where the problems are but where you want to go, and is something necessary?

I mean if you want to offer certain options, is there—is it necessary that you put a certain requirement on the—on that option?

Within reason, I would generally say stay as flexible as possible, but there are clearly some things, in terms of various types of dis-

crimination and things like that, that you want to, you know, fence off.

So I'm not sure that I can answer your question very well without a little bit more—in a more specific context, unless I have a more specific context, but generally, flexible is the watch word.

Mr. WILSON. Excellent.

Mr. Remmers, I really appreciated—I, 2 years ago, too, started on the cholesterol-lowering pharmaceutical, and I am really grateful for the effect and very pleased about the advance, and I appreciated your recounting how you looked into lowering the cost, and in fact, you mentioned in your testimony that many insurers and employers are providing education to consumers.

Can you relate efforts to, again, educate consumers as well as you did on the internet?

Mr. REMMERS. I will be glad to. I will give you another specific example. Maybe it is a bit more tangible. I would love a shot at your previous question for 30 seconds, as well.

Mr. WILSON. You can come back and get that one, too.

Mr. REMMERS. OK.

A large health system in Louisville, just as an example—I will not reference their name, but they are a large employer, multiple hospitals, health system—went into a patient choice, consumer-driven, however you choose to reference it, which really meant they gave a choice, a range of choices of health options for people to consider—in their case, six.

They have about 8,500 people enrolled in their plan, meaning employees, workers, and in turn, about roughly 14,000 people when you include family members and such. One of the things they were concerned about was how do you—how do we communicate with and educate a workforce while in health care, for the most part, although you have a wide diversity of workers in that sort of environment, not just nurses and doctors and such.

So we have tools that we deployed. We happen to call them Plan Professor. We did it, in their case, on both paper and through the web. We also asked them to come on and consider how they would choose one of the six plans that would most meet their needs, again, from a leaner benefit offering to a very rich benefit. What might meet my needs may not meet your needs.

We had a tool—we have a tool called the Plan Wizard that helped them select the plan that would best meet their needs, again, or preferences, and that was both on-line and on paper. In fact, the irony of this is that the leadership of that organization was doubtful that, of their 8,500 people, many would have access to the web or know how to use it. So we gave them a voluntary option of enrolling in these plans, which meant, when you enrolled in these plans, you both got the benefit of the education—you had to read through things to learn how to become a more active health care consumer in both choosing your plan and using your plan, so is this plan best for me, and how do I make certain decisions like a drug choice, as I use the health system.

They could either go through the phone to do that, through a voice-activated type of technology, which again, most people have the phone, or they could voluntarily go on-line, through the web,

and go through the enrollment, where they got introduced to all these guidance tools, if you will.

In fact, they felt that less than 30 percent of their people would go on-line to do this, because they would not have access or would not know how to use it.

Now, through multiple support systems that we offered them, 84 percent of their people went on-line to both enroll and use these other tools. To me, that is a terrific success story. It is one story, but I think it gets at some of your question.

Mr. WILSON. Yes.

Mr. REMMERS. Your previous question on what regulatory hurdles are there——

Mr. WILSON. Right.

Mr. REMMERS.—here are several, but there are many more we could talk about for the record.

One, in regard to the HSAs, health savings accounts, the health care reimbursement arrangements, and FSAs, flexible spending accounts, there are rules—the Treasury Department gave some relief this week, but—that limit the coordination of these three things, and these are how people can begin to think about how they plan for their health care financing out in the future in a tax advantaged way.

Secondly, the President's final legislation to allow unspent funds in these flexible spending accounts, which now you cannot roll over from year to year, so very few employers, small or large, take advantage of that, or their workers, frankly—they ought to be able to carry those over from year to year.

There is a proposal working its way through now to allow $500 of unused money—allow HSA funds to be used to pay the health insurance premiums of individuals who retire before they are age 65, speaking to the retirement dilemma, allow those monies to be used for that. Again, it is a way to plan for your retirement in a tax advantaged way.

Fourth, allow HSA funds to be used to pay Medi-gap premiums, again, so if you are over 65 and retired, you would have these funds available to help you do that. And last, allow consumers to continue to contribute to an HSA after age 65, again for tax purposes and planning.

The HSAs are good news for consumers, but the lack of uniformity in state insurance regulations are a barrier to us getting them out in the market and having understanding and acceptance in the marketplace.

I will not bore you with what all of those are, but they have to do with other kinds of mandated benefits and such that counteract with the HSAs in a negative way regarding deductibles and such, and that needs to be worked through.

Mr. WILSON. Well, thank you, and in particular, I appreciate you bringing up about the HSAs, because I believe they can be very helpful, but we do need, certainly, to fine tune, and I know that I was hopeful that they would be very flexible, and—but thank you all for your participation, and Mr. Chairman, thank you for your leadership in trying to assist small businesses address the problem of health care cost.

Chairman JOHNSON. Thank you.

The gentleman's time has expired.

Actually, HSAs are in 49 states, as we speak.

Mr. Holt, you are recognized for 5 minutes.

Mr. HOLT. Thank you, Mr. Chairman, and I thank the witnesses for your good presentations.

Let me understand better the effects of risk pooling. Obviously, in some general sense, it makes sense. Is there a well-understood industry-wide formula for the function for decreasing rates with increasing pool, and does it vary greatly from company to company?

In other words, if—what we are trying to get at is, if we are trying to find mechanisms to increase pools, association health plans or whatever, do we really know what we will get, and you know, maybe Mr. McArdle, maybe you have thoughts on that?

Mr. MCARDLE. Yes, sir. I think it would—pooling, conceptually, I think would be very helpful. I mean you have issues about what is the experience of the pool and, you know, the companies and the employees that are in the pool, but I think the pool is also maybe helpful in making larger group sort of possibilities available.

Mr. HOLT. Apart from questions of skimming and segmentation and so forth, is the function well understood, you know, the lower rates?

I mean can we say it will be 10-percent lower if you have 50 percent more members in the pool?

Mr. MCARDLE. I think you can say generally yes, that the larger the pool, the larger the risk is.

Mr. HOLT. In general, I understand. Is the function well understood, and is there a great deal of variation?

Mr. MCARDLE. Well, I think it would depend a lot on how you design it.

There can be variation, absolutely, but you know, I think, again, the advantage is—I mean you have to look at what the experience has been of individuals and whether they have been subject to underwriting before and whether they would no longer be subject to underwriting, whether they would have guaranteed access, for example, under the pool, which they might not have outside the pool.

So it can be beneficial in a number of ways, and you know, let's say, because there is no underwriting, that it jumps up a percentage point or two, on average, just hypothetically. Then it would still be a great advantage for the employees who would be in that pool.

Mr. HOLT. Mr. Dennis, both on that question and another question—really, why are businesses not pooling more? I mean, there is nothing under law that prevents them from doing it. Why do we need to provide them more incentives to do it? Why do we need to excuse them from various state law to prompt them to do it?

Mr. DENNIS. Let me start with the first question first, if I might, and that is yes, as a general rule, this is understood, the whole idea, because the difference between pooling costs and the price of the insurance that comes out of it—and I think that that may be an issue that is causing some confusion or something of that nature.

In other words, we basically know and understand what the costs are given the larger pools, as you increase the pool. We do not nec-

essarily know what the price is, because price is based on other things besides the actual loss.

Why are we not already doing it? Well, I can give you one example, and that is, several years ago, we tried as an organization to do it, and we just ran into state law after state law after state law being contradictory, and it was just—it became impossible for us to do anything like that, and this goes back several years, and we just had to give up the whole effort.

Mr. HOLT. Why is it not happening more, say, within a state's, say, chamber of commerce or some intra-state organization?

Mr. DENNIS. Frequently what has happened is that the pool has not been large enough. They have not been able to sell and get enough people.

Mr. HOLT. We have millions of workers in New Jersey.

Mr. DENNIS. Yes, but a lot of them already have something, you know, already have health insurance somewhere, they are happy with it for some reason or another, and there has not been able to get a critical mass together to do it. Why more effort has not been put into it, I do not know.

Mr. HOLT. I am sure that small businesses would like to be relieved somewhat of the burden. They want to provide good insurance for their employees.

I guess a question is do they care whether that burden is shifted to the government or shifted to the employee? Do they care for any reasons other than kind of ideological reasons? Let us consider, say, catastrophic insurance.

Mr. DENNIS. Well, as a general rule, without a specific type, they do not want it shifted to the government, partially for ideological, partially because it is going to be higher taxes for them, assuming that is where the money is going to come from and we do not borrow it all, but you know, it is higher taxes.

So I would assume that probably the cost shift would be the preferred strategy, but you know, that would be pure speculation on my part.

Mr. HOLT. Well, I see my time has expired and the Chairman is eager to move on.

Thank you.

Chairman JOHNSON. Thank you, Mr. Holt.

I appreciate the testimony that you all have provided today, and obviously we still have some problems in the health care business and need to address them, and we appreciate your input, and I hope you all will stay in touch with both Mr. Andrews and myself.

I think this was a good hearing, and if there is no further business, the Committee stands adjourned.

Thank you.

[Whereupon, at 11:32 a.m., the Subcommittee was adjourned.]

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