

# PREPARED STATEMENT TO THE HOUSE SMALL BUSINESS COMMITTEE



## *High Cost of Healthcare for Small Business*

**March 5, 2003**

Honorable Chairman and Ranking Member:

Thank you for allowing National Small Business United to submit this written testimony to you regarding the high cost of healthcare for small businesses. On behalf of our more than 65,000 small businesses in all fifty states, as well as local, state and regional small business associations across the country, NSBU works with elected and administrative officials in Washington to improve the economic climate for small business growth and expansion.

Health care reform is extremely important to NSBU and its affiliates. In fact, health care reform is at the top of our priority issues for the 108<sup>th</sup> Congress and has been a priority issue for our organization for the last fifteen years. We are committed to working with the House Small Business Committee to see that this issue is addressed for small business.

### **I. How We Got Here**

There was a time, not so many years ago, when health care reform was clearly the number one small business issue. Costs were escalating at double digits every year, small business health policies faced close health underwriting, many employees were saddled with significant pre-existing condition exclusions, some small businesses couldn't find coverage at any price, and millions could not afford the prices they were charged. Layered on top of these problems, we were looking down the barrel of proposals for having universal coverage mandated on all employers. Our health care "system" was facing crisis.

But several key events interacted to relieve the pressure of those times, without resorting to a fundamental reform of the system. First, the states (and later the federal government) reformed the small group insurance market to make it more fair (though no less expensive). Second, managed health care began to kick-in, forcing cost discipline on providers and relieving the incessant upward push on premiums. Finally, Congress decisively defeated the employer mandates proposed by the Clinton Administration. The national upset over the issue helped pave the way for the Republicans to take over Congress.

But after several years of relative stability on the health care front, the patch-work of 1990s reforms have begun to fray and come apart. Small employers are once again facing enormous year-over-year premium increases, the cost, control, and quality improvement promises of managed care give every appearance of having run their course, and Congress is once again considering legislation that will make the situation far worse. To compound matters, the current recessionary environment is likely to further swell the ranks of the uninsured, which already number over 40 million.

In short, health care reform is once again the most pressing issue facing small business, and the most pressing domestic issue facing the nation. It is time to coalesce around a proactive agenda for reforming the health care system. These reforms should bring long-term stability, keep costs in check, be fair to all small businesses and their employees, and maintain the best health care in the world. Our national challenge is this: real solutions to these real problems will not always be easy, and they will not always be popular.

As we approach this challenge, however, let us keep in mind that every substantial reform that Congress has enacted on health care during the last decade has only driven up health care costs and insurance premiums. Medicare reforms, insurance market reforms, mental health parity revisions—all have responded to some real problem, but they have all piled on new costs or shifted costs to the private sector. And these changes have contributed significantly to health care coverage costs that have put insurance out of financial reach for tens of millions and threatened tens of millions more with loss of health care benefits.

## **II. Needed Small Business Reforms**

NSBU recommends that the states and Congress enact a series of health care reforms that could immediately reduce the health cost pressures that small firms and their employees face, improve health care access for individuals who would otherwise be uninsured, and increase the range of choices available to the underserved small business market.

**Pool Small Businesses Locally.** Encourage the development of local employer health care coalitions that would assist small employers in obtaining lower rates for coverage through group purchasing. Such coalitions would also assist small employers in learning about existing local health insurance plan options, how to be a wise health insurance purchaser, the issues of health care costs, health care quality and the availability of health care providers within their communities. Such local employer health care coalitions would continue to be subject to their respective state laws and therefore there would continue to be a level playing field for all employers providing insurance in the small employer market. Such local employer coalitions already exist, providing choice and savings for their members every day. Many of these organizations are part of NSBU.

**Fix the Medical Savings Account Law.** As currently structured, Medical Savings Accounts (MSAs) are confusing, restrictive, and largely unworkable for most Americans. Yet the promise of these plans is greater than ever. More and more health plans are moving toward higher deductibles, even though most out-of-pocket health care expenses do not qualify for any tax preference. MSAs respond to this unfairness in our tax policy, and they also generate a level of “consumer behavior” that can provide a significant component of an over-all market-based cost containment strategy. In addition, even in their limited use, MSAs have shown a powerful ability to cover the previously uninsured. About 40% of participants those who signed-up for MSAs during their first year were newly insured. To make them meaningfully effective for the future, though, we need the following changes:

- Allow both employers and employees to contribute to MSAs. Right now either may contribute, but not both. This restriction greatly inhibits the ability of individuals to collect sufficient funds into their MSA.
- Lower the minimum required deductible and out-of-pocket limits. Currently, participation in MSAs requires an insurance policy with a “deductible” amount of at least \$1,700 for individuals and \$3,350 for families. Lower minimum deductibles would make MSAs more attractive for many workers and ameliorate potential risk selection issues by making them more appealing to older and sicker individuals. Once individuals have a chance to “build up” their MSA funds, they will then be much more willing to have even higher deductibles.
- Remove the restriction that all family members who would be covered must be covered only by high deductible plans.
- Modify the current HMO Act to enable HMOs to offer high out-of-pocket plans. A large segment of the provider community is taken off the table by this provision and can make MSAs much less attractive.

- Remove the cap on the number of participants. Right now, only 750,000 individuals are allowed to participate in MSAs. With the other changes listed above, this cap would quickly be reached and MSAs would be unavailable to most small business employees.

Recently, the Administration highlighted Health Reimbursement Accounts (HRAs) which are similar to MSAs, but can only accept employer contributions, and employees cannot keep their excess funds. The objectives of MSAs could also be met by reforming the HRA structure: allowing employees to contribute, allowing employees to roll excess funds into retirement plans, and, most importantly, *allowing small business owners to participate*. Like so-called cafeteria plans, HRAs specifically exclude owners of non-C Corporations from participating. This is a major obstacle that must be overcome if small companies are ever to take advantage of the potential of these plans.

On the subject of cafeteria plans (Section 125 plans), it should be noted that reforms of these plans could also be an important factor in increasing the ability of small business employees to fund various kinds of unreimbursed care. Two major roadblocks are in the way. First, small business owners generally cannot participate in cafeteria plans. Second, these plans have annual “use-it-or-lose-it” provisions, which cause some to spend money that did not need to be spent, but cause many more to never contribute to the plan in the first place. Fixing these two mistakes would be a real benefit to small business employees struggling to meet their out-of-pocket medical bills.

**Create Health Insurance Tax Equity.** After sixteen years of struggle and unfairness, the dawning of 2003 has finally brought small business owners the ability to deduct all of their health insurance expenses against their income taxes. Great thanks is owed to the many members of this committee who labored to make this change a reality.

We are still only part way to real health insurance tax equity for small business. Except for business owners, workers are allowed to treat their contributions to health insurance premiums as “pre-tax.” This distinction means that those premium payments are subject neither to income taxes, nor to FICA taxes. While the owner of a non-C Corporation can now deduct the full premium against income taxes, that entire premium is paid after FICA taxes. Compounding matters, these business owners pay both halves of the FICA taxes on their own income for a total FICA tax burden of 15.3 percent.

Right here in Washington, D.C., the cost of a Blue Cross/Blue Shield family policy in a small group plan has topped \$12,000 per year. A business owner who makes \$60,000 and purchases this plan for his or her family pays \$2,000 in taxes on that policy. A worker who makes \$60,000 and has the same plan pays nothing in taxes on that

policy. By treating this business owner the same way that everyone else in this country is treated, we can give him or her a 15 percent discount on health insurance premiums—probably a greater savings for some than any other policy change we will discuss today.

**Reform the Medical Liability System.** The enormous costs of medical liability and the attending malpractice insurance premiums are a significant factor pushing health care costs higher and restricting choice and competition for consumers of health care. Triple digit increases in malpractice premiums over the last five years have been common in many states and specialties.

These costs have a distorting effect on the health care system by causing physicians to retire early, change their practices to serve lower-risk patients, move to states with reformed malpractice laws, and concentrate their practice in high-profit centers, making quality health in rural areas and smaller towns increasingly difficult to come by. All of these changes restrict competition and the ability of employers to negotiate lower reimbursement rates. But the most profound affect of the liability system is the “defensive medicine” that is practiced by many risk-averse providers. Unnecessary, purely defensive procedures, cost the health care system untold billions each year and drive up premiums for all of us.

**Protect the Small Employer Health Insurance Market from “Gamesmanship.”** The Health Insurance Portability and Accountability Act (HIPAA) of 1996 ensured that small groups could not be denied coverage by any insurer offering small group coverage in their state. The federal law, however, does not ensure that this coverage would be affordable, though states generally have implemented “rate bands” that provide some upper limit on rate increases for particular groups.

The individual market, however, is generally free of the guaranteed issue requirements enacted by HIPAA. Only those who had other insurance within the previous six months would be free of exclusion. This difference in rules between the individual market and the small group market means that premiums for younger and healthier individuals are almost always lower in the individual market than in the small group market. The opposite is generally true for older and less healthy individuals: their premiums are less in the small group market than in the individual market. This dynamic understandably leads some employers to purchase less expensive individual coverage on behalf of their employees, when they can qualify for low rates. When significant illness occurs, the individual premium escalates sharply, and the business will often switch to a small group plan, where they must be accepted and where the premiums will be much lower.

While this entire process is perfectly rational from the employer's perspective, it forces small group premiums to be higher than they otherwise would be. We believe that premiums would be lower and overall access to health insurance higher if this practice were discouraged, perhaps through a surcharge when the business re-enters the small group market (much like the penalty for early withdrawal of IRAs). Another way would be to clarify that employer-paid premiums in the individual market are taxable to the employee.

**Help the Uninsured through Tax Credits and Current Programs.** Much of the question of adequate health insurance coverage is really a question of affordability. There is probably no more efficient way to provide public subsidies for health insurance than through a system of tax credits, scaled to income, and targeted at individuals, such as those proposals that the President has put on the table. Further expansions of Medicaid and SCHIP programs to serve uninsured populations should also be considered.

There is certainly the potential to provide tax credits to small employers, as well, but we should be aware that such action is a potentially slippery slope. Which businesses would we subsidize? Do we subsidize businesses that don't currently provide health insurance? Tell that to the business that has been providing coverage for years. Do we subsidize businesses with low average wages? Plenty of them are highly profitable. We do not close the door to the possibility that an appropriate mechanism could be established to help smaller companies, but the potential problems, distortions, and inequities in doing so are manifold.

### **III. What Not to Do**

Any new "improvement" to the private health insurance system that seeks to extend new benefits, provide new protections, or create new liabilities—no matter how well intentioned—should be carefully weighed against its cost. The worst case scenario is not no action, it is new federal action that increases expenses. All of these changes only pile more and more costs on a private system already tottering under the weight of its current load. We ask that the Committee members do all they can to educate themselves and their colleagues about this very complex situation.

There have also been calls from many of our brethren in the small business community to create a new form of federalized small business purchasing pools, run by associations. These Association Health Plans (AHPs) are a reaction to the very dire circumstances small businesses currently face in the health insurance arena: huge premium increases, a lack of control and clout, the costly tangle of state and federal regulations, and fewer funding, carrier, and plan selection options than their larger counterparts.

However, despite those good intentions, we are concerned that AHPs threaten to greatly worsen the market segmentation and risk-aversion that currently characterize the small group health insurance market, and which are at the root of the health care crisis uniquely faced by smaller firms. AHPs might be good for national small business associations (like NSBU) who want to run them, but NSBU believes they will not be good for the small business community at large, whose interests we are bound to represent.

**Bigger is Better?** One of the fundamental precepts that underpins the arguments of those advocating for AHPs is the idea that big pools will equal bargaining clout. In almost every market in the world, the larger the quantity you buy of something, the lower its per unit price will be. In the health insurance market, however, the make-up and location of that pool are both far more important factors in establishing a price than size alone.

A pool of 1,000 people with an average age of 40 could demand (and receive) a much better rate than a pool of 50,000 people with an average age of 55. Those are simply the actuarial facts of the matter. Moreover, when a plan is negotiating reimbursement with providers, a local hospital or physician will be driven by how many patients the plan will bring them. A local plan with a total of 100,000 lives will be able to drive a much better deal than a big national plan with 5 million lives, only 15,000 of which are local.

So, the risk profile of the group and their geographic concentration are the two most important factors in negotiating rates for small business health insurance. Unfortunately, AHPs would present us with problems on both fronts.

**Risk Selection.** The insurance industry competes based largely upon each company's ability to attract better (i.e. more profitable) risks. AHPs are likely to function in the same way. While AHPs could not exclude any specific qualified association member, risk selection is a much more subtle and powerful phenomenon than such blatant discrimination alone. In fact, such selection would be the crux of AHPs' competitive advantage.

By carefully designing benefit packages that will be relatively unattractive to older and less healthy populations, AHPs will be able to simultaneously attract a higher proportion of younger and healthier individuals in their pools, thereby driving down their expected claims costs and, thus, their premiums.

Currently, the rates that can be charged in the small group market are regulated by the states. Most states have "rate bands" of varying degrees that define the window in which rates can fluctuate and on what basis they can fluctuate. Other states have a form of community rating in which rates are essentially the same for all participants. Fully insured AHPs would only be subject to the rate bands in their state of domicile and would use

those rules in all other states in which they operate. If an AHP were to sell into a community-rated state (such as Maine, to pick one at random) with varying rates, the consumer choices would be stark. The AHP rates for younger, healthier groups are likely to be significantly less than for other groups, while AHP rates for older, less healthy groups are likely to be higher than the average rate in a community-rated state. It is easy to see what will happen: younger, healthier groups will join AHPs, and the rest will not. Moreover, the out-of-state AHP is likely to be able to take into account all sorts of risk factors in setting their rates.

Since apportionment of health risk is ultimately a zero sum game, lower premiums for those participating in AHPs will mean higher premiums elsewhere. These increases will drive more healthy people away from the traditional pools and into AHPs. Those AHPs that attract significantly better risks can be highly profitable. But AHPs that refuse to engage in this sort of risk selection, as well as traditional plans that are forbidden by state law from doing so, will fall into what is known as a “death spiral,” where higher premiums chase away better risks, which leads to still higher premiums. The end result will be the destruction of the traditional insurance market for small firms and the displacement of millions of currently insured individuals.

Proponents of AHPs say that associations will act in their members’ best interests and avoid these practices. But, to serve their members and to attract new members, AHPs will want to keep premiums as low as possible. The most effective way for such a pool to achieve lower premiums is to attract better risks. To deny that such will occur is to deny the effect of market forces.

Two types of associations seem most likely to offer AHPs: national vertical trade associations (representing a specific industry, e.g. banking, restaurants) and national general small business groups (such as NSBU or NFIB). A vertical trade group that believes that its trade population is relatively young and healthy is likely to start an AHP, and expect it to be successful. Similarly, a vertical trade group that believes its trade population is relatively old and unhealthy is unlikely to be able to sustain an AHP. In other words, affected trade associations and their health insurer partners would behave predictably and according to their organizations’ financial interests. Risk selection would be part of AHPs from the very beginning. To believe otherwise is to refuse to acknowledge the way small group insurance markets function now, in spite of heavy state regulation. To disbelieve is literally “head-in-the-sand.”

It is also likely that there would be a number of national general small business AHPs. These associations would market nationally to potential members, largely on the basis of premium. Given that these groups would all have the same regulatory advantages, they would succeed or fail almost entirely on their ability to attract and maintain a healthier population.

**Cost and Access.** Proponents claim that AHPs will save their members significant amounts of money. In fact, a Congressional Budget Office (CBO) paper estimated that businesses switching from an existing state-regulated pool to an AHP would see their premiums decline by 13 percent, a fairly substantial savings. However, most (almost two-thirds) of those savings come from the risk selection described above. According to the CBO paper, AHPs would achieve cost savings by draining away healthier individuals from the state-regulated pools, thereby forcing premiums to go yet higher for the majority of the market. The CBO estimates costs will decline for the 20 percent of businesses that join AHPs, but will, therefore, go up for everyone else.

Proponents of AHPs hope that premium savings will cause new individuals to be insured. However, the CBO paper cited above clearly shows that the overwhelming number of participants in AHPs will be those who switched from a traditionally insured plan to an AHP. CBO believes that these switchers would outnumber the newly insured by nearly 14-to-1. We also must point out that the higher premiums for non-AHPs could lead to greater numbers of uninsured individuals, exactly the opposite of the outcome desired by proponents

**The AHP Forecast.** Despite the rosy picture painted by proponents of AHPs, we fear AHPs would only serve to dig the small business health market even deeper into a hole of adverse selection, further distorting an already perverted market. Those who have the least need for health care services will be able to buy health insurance cheaply (and insurers and AHPs will find this business very profitable). But those who are at greatest risk of illness will be least able to afford coverage, and insurers will be at ever-increasing pains not to sell coverage even to those who can scrape up a monthly premium payment that will soon surpass an average monthly mortgage payment.

AHPs may cause a number of currently uninsured Americans to get coverage. However, we believe that it will, over time, cause even more small business owners and employees to reduce and give up coverage due to cost increases.

If this hastened train-wreck is what occurs from AHPs, matters will not be politically or economically sustainable unless Congress embarks on exactly the kind of national mandate-setting and market regulation that all 50 states are struggling with right now (and which AHPs are a rebellion against). Some might think that would be a good thing, but one suspects that it would be very difficult to generate a majority for AHPs if it was understood this kind of additional federal intervention would be necessary in a few years.

We thank you for the opportunity to submit our remarks. NSBU welcomes any questions or comments you may have, please feel free to contact us at (202) 293-8830 or via e-mail at [mbrogan@nsbu.org](mailto:mbrogan@nsbu.org).