



NEW AMERICA
FOUNDATION

Statement of Len M. Nichols
Director, Health Policy Program
New America Foundation

House Committee on Small Business
Making Health Care Reform Work for Small Business

September 18, 2008

New America Foundation
1630 Connecticut Avenue, NW
Washington, DC 20009

Introduction

Chairwoman Velázquez, Ranking Member Chabot, members of the Committee, thank you for inviting me here to testify today. My name is Len M. Nichols and I direct the Health Policy Program at the New America Foundation, a non-profit, non-partisan public policy research institute based in Washington, D.C., with offices in Sacramento, California. Our program seeks to nurture, advance, and protect a fact- and logic-based conversation about comprehensive health care reform. We remain open minded about the means, but not the goals: all Americans should have ensured access to high-quality, affordable health care that is delivered within a politically and economically sustainable system. I am happy to share ideas for your consideration today and hereafter with you or your staff.

I would like to begin by applauding the work of the Chairwoman Velázquez (D-NY) and her cosponsors, Representatives Fattah (D-PA), Graves (R-MO), Pitts (R-PA), and Sires (D-NJ) for their work on the CHOICE Act. First and foremost, CHOICE is bipartisan. This is exceedingly important in this sometimes extremely partisan time. Bipartisanship is likely the only way we will be able to move our nation's health care system forward; members of both parties must agree on the general direction policy is headed. Specifically, this legislation would enable small employers to achieve some of the advantages—economies of scale, administrative efficiencies, and large risk pools—that large group insurance offers, and would subsidize small firms that offer coverage. Congresswoman Velázquez and her cosponsors should be commended for their efforts.

I would also like to take this occasion to congratulate the bipartisan, bicameral cosponsors of the SHOP Act¹ who have also created a bill that would enable more small businesses to gain access to quality, affordable health coverage. It is inspiring to see such efforts in both houses of Congress focused on small employers and on our health system in general, especially given our failure as a nation to reform our health system in the early 1990s.² Those of you who have read my prior work and testimony know I believe strongly that comprehensive health care reform is neither possible nor sustainable without bipartisan support.³ The CHOICE and SHOP Acts add to a growing chorus that proves it is possible for us to move in this direction.

Overall Solution

In your invitation to testify you asked me to address a key question in the broader health reform conversation: how to make our health care system work for small businesses. This is clearly a critical question. More than 50 percent of uninsured workers are self-employed or work in a firm with fewer than 100 employees.⁴ My primary answer is that we can help small employers and their workers the same ways that we can help all Americans:

- 1) Create a marketplace that is accessible, competitive, and fair; and
- 2) Reform our delivery system to elicit far more clinical value for our health care dollar.

New Marketplace

The current small group and individual insurance markets do not work very well for many Americans. Therefore, the first step to creating a health system that works for small businesses and the nation is to create a marketplace that is accessible. This requires guaranteed issue, a requirement that insurers sell to all customers, regardless of health status. The Health Insurance Portability and Accountability Act (HIPAA) made this a requirement for small business insurance products nationwide. However, this is not the case in the non-group insurance market in a vast majority of states where lack of guaranteed issue in the individual market leaves many Americans—sole proprietors, self-employed, and workers whose employers do not offer coverage—unable to access insurance.

However, just requiring access to the insurance marketplace is not enough. The marketplace must also be fair and affordable, which means insurers should not charge premiums based on health status (though modified community rating by age has a number of advantages over pure community rating⁵), and there must be subsidies for individuals who cannot afford health insurance on their own.

In the context of small employers, it is worth describing briefly the tradeoffs between subsidizing firms versus workers. While encouraging employers to offer coverage by subsidizing them would surely lead to more insurance coverage than we observe today, a fair amount of research has concluded that it is more efficient, especially in terms of dollars per newly insured, to subsidize workers directly.⁶ Subsidizing employers without regard to income or wages will inevitably end up directing some portion of the limited subsidy resources to firms with higher wage workers. These types of firms (e.g. law or consulting firms), would likely offer generous coverage without new employer subsidies because many of them are already offering today. Subsidizing workers directly allows us to target those with lower incomes who are more likely to be uninsured because they cannot afford coverage, regardless of whether their firm offers health insurance or not. There are ways to target employer subsidies to be more efficient, and I would be glad to discuss some of those in the Q&A session and in follow-up meetings with your staffs if you would like.

More than target efficiency, the main reason to consider subsidizing workers instead of employers is the direction our health economy is headed. Compared to our global competitors, the U.S. health care system is both far more expensive and more reliant upon employer contributions. This does not help our country's ability to create and hold high value added, middle-class jobs.⁷ Thus, policy changes that would increase, not decrease, reliance on employer financing should be weighed very carefully against feasible alternatives. If employers can remain American's primary source of health insurance only with greater and greater public subsidies over time, we might be wise to restructure insurance markets now in order to: 1) allow insurance markets to serve workers and families better and more efficiently, and 2) let most employers, especially smaller employers who face inherent diseconomies of scale in insurance provision, focus

on what they do best—creating jobs for Americans and generating products and services for the increasingly global marketplace.

Once insurance is accessible and affordable then there must also be a requirement that all individuals purchase health coverage. This protects against adverse selection (the tendency for high risk or sick people to buy insurance because they expect to need it, and for low risk or healthy people to remain uninsured) and enables insurers to compete based on price and value, not marketing and underwriting. Insurers competing in markets wherein individuals can remain uninsured will always seek to create value for the healthy by excluding the sick from their risk pools. The best way to transform insurers' business models into strategies that create value for everyone by improving enrollee health and convenience as much as possible is to re-organize their incentives. Purchase mandates, in addition to guaranteed issue and modified community rating, accomplish this goal by essentially making the risk pool the population and erasing the potential to earn high profits from excessive underwriting. If there is no financial incentive to underwrite aggressively, aggressive underwriting will disappear. The only way to make more money in an insurance environment where there is no incentive to underwrite is to demonstrate to more and more enrollees that you can improve their health efficiently in exchange for their premium dollar. These are exactly the market signals we need to send health insurers in the 21st century.

Both CHOICE and SHOP succeed in creating a marketplace that would work better than the status quo for American workers in small firms, regardless of whether they are sick or healthy. CHOICE would also create a new insurance company to spread the risks of those who enter the new marketplace. This could have advantages down the road. As we proceed toward more comprehensive reform, more people might be allowed to join in the new marketplace. This new “captive” insurer, for example, would never have had a culture of selecting risks and aggressive underwriting. Therefore, it could demonstrate the viability of a “new” kind of business model from its inception. Similar long run outcomes might be obtained just from melding the non-group, small group, and eventually the large group markets into one and using regulation to force existing private insurers to adopt the same kind of business model. However, the insurance model under the CHOICE Act might speed the transition along and therefore is worthy of serious consideration.

Delivery System Reform

No health reform proposal will be sustainable over time without serious efforts to improve the quality of patient care and get more value for our health care dollar. This will require a 21st century information infrastructure as well as more data about what works and does not work for whom in our health system. However and probably most importantly, we will never control health care costs unless we pay providers in a way that makes sense and introduce smart incentives to encourage patients to do the right thing. Comprehensive payment reform that uses health information technology and comparative quality information to align financial incentives with quality practice will save money and improve patient care.

Just because you are the Small Business Committee does not mean you must avoid considering key delivery system reform innovations. Indeed, the CHOICE Act requires employers to offer wellness programs in order to be eligible for the Small Business Choice Credit. As you clearly know, wellness and disease management programs have had very positive results for both large and small employers, and certainly for employees. This is one type of innovation that could help transform our health care delivery system and the health of our nation. Additional reforms you might consider include: incentives for enrollees to sign up with a qualified medical or health home and for providers to adopt electronic records and decision support tools.

Additional Issues to Consider

Anytime small business health care solutions are being discussed, a number of policy issues are brought to the forefront because they are either so important they should be considered or because they are particularly salient in health policy debates in general and should not be ignored. I will address three such policy questions during the remainder of my testimony:

- 1) If you create a new marketplace, should the old marketplace be allowed to continue?
- 2) Should you expand markets across state lines?
- 3) Who should be allowed to purchase insurance from the new marketplace?

Consequences of Multiple Marketplaces

As stated above, in order to address the small business health care crisis we must first create a marketplace that is accessible, fair, and affordable. The creation of a new marketplace, however, requires an answer to the question: What do you do with the old one? Ideally, the new marketplace would become the *only* small group (and possibly individual) market to protect against any risk of adverse selection over time and create the largest risk pool possible. Should you decide to leave both markets in place, however, the rules and requirements must be the same so that the healthy and sick have an equal likelihood of choosing to buy insurance through one market or the other. If the rules are not the same, then the healthy would always be attracted by lower premiums to the more heavily underwritten market. This will leave the other pool full of high risk, high cost customers, who will be hard for insurers to serve alone.

Now, making subsidies available only in the new market with the more stringent regulations will compensate for any inherent underwriting disadvantage, but a simpler strategy of making the new market work better is to make the new market the only market. If you believe the rules of the CHOICE Act's purchasing pool—guaranteed issue and strict community rating—are the right rules for small employers and their employees, why not make them the law of the land? Under this scenario your subsidies will actually go farther toward covering more Americans because they will not be diluted by higher premiums as a result of lower quality risk pools in the new marketplace.

Selling Insurance across State Lines

Several previous and current proposals purporting to help small businesses would allow groups to purchase insurance across state lines. While this sounds inherently appealing to anyone in favor of market competition, this approach has a number of risks that stem from the intrinsically problematic nature of insurer competition when insurers are governed by different regulations. In the small group market case (unlike the non-group market case), these risks are mitigated somewhat by HIPAA, which requires insurers in every state to offer all products on a guaranteed issue basis to all small employers. Still, across-state-line competition would make it very difficult for insurers in states which require certain benefits (i.e. maternity care) to be covered to compete on price with insurers from states without a maternity benefit mandate. The logical and practical extension of this would be very few if any benefit mandates could survive in the long run. In effect, selling across state lines would reduce every state's insurance market rules to those that are operable in the least restrictive state in the country. Thus, "across state lines" is in essence a federal law that would undermine the insurance laws of all but one state (the state with the fewest regulations).

The fundamental problem with "across state lines" is that buying health insurance is not like buying a car where you can add air conditioning or a high-end stereo system as a matter of on-the-spot consumer preference and differential willingness to pay. Health risks are *probabilities*. Very few people know the odds of getting cancer or conceiving a child. Therefore, if benefit packages were allowed to vary infinitely and carve out expensive conditions or treatments that "many will not need," many people would be effectively uncovered for what they may need the most. Policies that were more comprehensive in this environment would end up costing high health risks—or regular people who want what we consider to be standard insurance protection today—quite a bit because risk pools would become increasingly segmented over time.

Market Eligibility

If you take the first step by creating a new insurance marketplace for small firms, who should be allowed to buy health coverage in it? In the context of proposals aimed at small employers this question usually focuses on whether or not to permit the self-employed or "business groups of one" to buy coverage in the new pool. Prohibiting the self-employed from accessing the new market could inadvertently stifle entrepreneurship by encouraging "job lock" or staying in a job as an employee in order to maintain health benefits. On the other hand, there is a selection risk associated with allowing the self-employed to enter the pool initially, especially if the non-group market is allowed to remain as it is at present. In that case, since guaranteed issue is the law in the small group market but typically not in the non-group market, the self-employed who would fare well in a heavily underwritten market will purchase in the non-group market and only those with significant health risks will purchase in the guaranteed issue small group market. If pooled with *all* small groups, the impact on average premiums in the small group market might not be very great, but in most markets insurers are allowed (and therefore do) segment their pricing by business size classes. In this case, as in Colorado in the mid-

1990s, passage of a business group of one rule can lead to very rapid increases in premiums for the 1–5 employee size class.

This problem could be mitigated if the small group and individual markets were combined with one set of guaranteed issue plus modified community rating rules for all people. Under this scenario, employer groups would not be rated separately as employer groups and all people the same age would be charged the same premium by each insurer. Employers could contribute whatever they and workers negotiate in that regard. In the long run, large firms could also be allowed to enter the marketplace. This would lead to the kind of efficient and powerful insurance marketplace that a number of health proposals have envisioned recently: Insurance marketplaces that can be catalytic in bringing about the delivery system reforms we need to sustain comprehensive health reform.⁸

Conclusion

Small employers will always hold a large stake in conversations about health care reform because no single group is more important to the American economy and society. Small group insurance markets have been the focus of repeated policy interventions since the late 1980s. Small employers have long suffered from high administrative loads (and therefore high premiums), little effective competition (and therefore rapidly rising premiums), and increasingly intense competition from large domestic firms and foreign competitors. Thus, it is clear that health reforms focused on increasing access to quality, affordable health coverage for small businesses could serve as an important and catalytic step for changes nationwide. As you contemplate how best to design a marketplace for small employers, I encourage you to take care to build a marketplace with rules and institutions that would welcome more and more Americans into the new risk pool over time. This eventual marketplace could prove to be an essential part of a more value-oriented health system that would better serve small employers and all Americans.

Notes

¹ Sen. Richard Durbin (D-IL), Sen. Jeff Bingaman (D-NM), Sen. Christopher Bond (R-MO), Sen. Robert Casey (D-PA), Sen. Norm Coleman (R-MN), Sen. Susan Collins (R-ME), Sen. Amy Klobuchar (D-MN), Sen. Herbert Kohl (D-WI), Sen. Joseph Lieberman (I-CT), Sen. Blanche Lincoln (D-AR), Sen. Mark Pryor (D-AR), Sen. Ken Salazar (D-CO), Sen. Olympia Snowe (R-ME), and Sen. Arlen Specter (R-PA). Rep. Ronald Kind, (D-WI), Rep. Thomas Allen (D-ME), Rep. Jason Altmire (D-PA), Rep. John Barrow (D-GA), Rep. Roscoe Bartlett (R-MD), Rep. Shelley Berkley (D-NV), Rep. Bruce Braley (D-IA), Rep. Lois Capps (D-CA), Rep. Russ Carnahan (D-MO), Rep. André Carson (D-IN), Rep. Donald Cazayoux (D-LA), Rep. Travis Childers (D-MS), Rep. Steve Cohen (D-TN), Rep. Jerry Costello (D-IL), Rep. Joe Courtney (D-CT), Rep. Joseph Crowley (D-NY), Rep. Diana DeGette (D-CO), Rep. Charles Dent (R-PA), Rep. Joe Donnelly (D-IN), Rep. Brad Ellsworth (D-IN), Rep. Rahm Emanuel (D-IL), Rep. Jo Ann Emerson (R-MO), Rep. Philip English (R-PA), Rep. Bill Foster (D-IL), Rep. Jim Gerlach (R-PA), Rep. Gabrielle Giffords (D-AZ), Rep. Kay Granger (R-TX), Rep. Paul Hodes (D-NH), Rep. Jesse Jackson (D-IL), Rep. Steve Kagen (D-WI), Rep. Daniel Lipinski (D-IL), Rep. Tim Mahoney (D-FL), Rep. Donald Manzullo (R-IL), Rep. Patrick Murphy (D-PA), Rep. Tim Murphy (R-PA), Rep. Joseph Pitts (R-PA), Rep. James Ramstad (R-MN), Rep. Mike Ross (D-AR), Rep. Allyson Schwartz (D-PA), Rep. Christopher Shays (R-CT), Rep. Carol Shea-Porter (D-NH), Rep. Albio Sires (D-NJ), Rep. Zachary Space (D-OH), Rep. Peter Welch (D-VT), Rep. Charles Wilson (D-OH), Rep. Frank Wolf (R-VA), Rep. Bill Young (R-FL), Rep. Christopher Carney (D-PA), Rep. Michael Michaud (D-ME), Rep. Robert Wexler (D-FL), and Rep. Kirsten E. Gillibrand (D-NY).

² As in: “Healthy Americans Act,” S. 334, 110th Cong., 2007–2008. These efforts are spearheaded by: Sen. Ron Wyden (D-OR), Sen. Robert Bennett (R-UT), Sen. Lamar Alexander (R-TN), Sen. Maria Cantwell (D-WA), Sen. Thomas Carper (D-DE), Sen. Norm Coleman (R-MN), Sen. Bob Corker (R-TN), Sen. Michael Crapo (R-ID), Sen. Charles Grassley (R-IA), Sen. Judd Gregg (R-NH), Sen. Daniel Inouye (D-HI), Sen. Mary Landrieu (D-LA), Sen. Joseph Lieberman (I-CT), Sen. Bill Nelson (D-FL), Sen. Gordon Smith (R-OR), Sen. Debbie Ann Stabenow (D-MI). As in: “Healthy Americans Act,” HR. 6444, 110th Cong., 2007–2008, Rep. Debbie Wasserman Schultz (D-FL), Rep. Brian Baird (D-WA), Rep. Earl Blumenauer (D-OR), Rep. Jim Cooper (D-TN), Rep. Artur Davis (D-AL), Rep. Norman Dicks (D-WA), Rep. Jo Ann Emerson (R-MO), Rep. Philip English (R-PA), Rep. Anna Eshoo (D-CA), Rep. Jane Harman (D-CA), Rep. Alcee Hastings (D-FL), Rep. Rubén Hinojosa (D-TX), Rep. Darlene Hooley (D-OR), Rep. Daniel Lipinski (D-IL), Rep. Carolyn McCarthy (D-NY), Rep. Kendrick Meek (D-FL), Rep. James Moran (D-VA), Rep. Ileana Ros-Lehtinen (R-FL), Rep. Victor Snyder (D-AR), Rep. Niki Tsongas (D-MA), Rep. Peter Welch (D-VT), Rep. David Wu (D-OR). As in: “American Health Benefits Program Act of 2008,” HR. 5348, 110th Cong., 2007–2008, Rep. Jim Langevin (D-RI) and Rep. Christopher Shays (R-CT).

³ For Len M. Nichols testimony, see: http://www.newamerica.net/files/archive/Doc_File_2330_1.pdf; http://www.newamerica.net/files/archive/Doc_File_3018_1.pdf; <http://www.newamerica.net/files/Nichols%20Testimony%20-%20Senate%20Budget%20June%2026%202007%20Final.pdf>

⁴ Sarah Axeen & Elizabeth Carpenter, “Who are the Uninsured?” *New America Foundation*, (December 2007).

⁵ Age rating allows premiums to be as low as possible for young customers, which helps bring healthy enrollees into the risk pool. In addition, young people are more likely to be low-income. In a world with income-based subsidies, older, low wage workers are also protected.

⁶ Ferry, Danielle, Sherry Glied, Bowen Garrett, and Len M. Nichols, “Health Insurance Expansions of Working Families: A Comparison of Targeting Strategies,” *Health Affairs* 21, no. 4 (July/August 2002).

⁷ Len M. Nichols & Sarah Axeen, “Employer Health Costs in a Global Economy: A Competitive Disadvantage for U.S. Firms,” *New America Foundation*, (May 2008).

⁸ For examples of proposals that would, see: Len M. Nichols, “A Sustainable Health System for All Americans,” *New America Foundation*, July 2007; ERISA Industry Committee, “A New Benefit Platform for Life Security,” May 2007; Committee for Economic Development, “Quality Affordable Health Care for

All,” *Research and Policy Committee of the Committee for Economic Development*, 2007; Senator Ron Wyden, “Healthy Americans Act,” *S. 334*, 110th Cong., 2007–2008; Representative Debbie Wasserman-Schultz, “Healthy Americans Act,” *HR. 6444*, 110th Cong., 2007–2008; Representatives Jim Langevin & Christopher Shays, “American Health Benefits Program Act,” *H.R. 5348*, 110th Cong., 2007–2008.

