# Statement of the U.S. Chamber of Commerce

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**ON:** **"AMERICA'S UNISURED: MYTHS, REALITIES AND SOLUTIONS"**

**TO:** **SENATE DEMOCRATIC POLICY COMMITTEE**

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The Chamber's mission is to advance human progress through an economic, political and social system based on individual freedom, incentive, initiative, opportunity and responsibility.

"America's Uninsured: Myths, Realities and Solutions"

TESTIMONY
of the
U.S. CHAMBER OF COMMERCE

by

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before the
Senate Democratic Policy Committee

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The U.S. Chamber of Commerce is pleased to testify at today's hearing on the issue of solutions to cover the uninsured. I am Kate Sullivan, the Chamber's director of health care policy, and I have been involved in health care policy for 18 years as a staff advisor in the U.S. House of Representatives, to a former state governor and in various capacities in the private sector. The U.S. Chamber of Commerce is the world's largest business federation representing employers of every size, sector and region, and has engaged for a number of years in advocating that all Americans have health coverage through an appropriate mix of market reforms, public financing and a meaningful safety net. Moreover, everyone in this country, whether privately covered, publicly subsidized or uninsured, has a right to expect that our health system has at its root the best possible quality with uncompromising standards of safety.

All Americans want to lower their health care costs and get better value for what they purchase. They also need to be able to make informed decisions about their health coverage choices and treatment options. Employers share these priorities, and as major purchasers in the overall health care marketplace, they act as a catalyst for this change.

## Health Care is a Public-Private Partnership

The Chamber believes that the appropriate role of government in health care is to facilitate affordable access to a system of private coverage to pay for health care providers operating in a private system in which decision-making is

made between patients and providers. In addition, government should ensure the overall safety of the system and facilitate the sharing of information about best practices and treatment outcomes. Government also has an historic and on-going role to ensure consumers' interests and fair treatment; to achieve proper market balance; and to enforce statutes combating fraud and abuse.

The nearly four decades old Medicare and Medicaid programs have also established a role for the federal (and state) government as a direct payer for designated populations. The Chamber does not believe these programs should be substantially expanded in their current format to cover more people, given limited public resources to pay for current services. Limited resources distributed to a larger group of people equates to a smaller payment to the providers caring for these populations. Inevitably, shortfalls are shifted to private payers; this trend must be reversed by fully funding the care for those now covered by Medicare and Medicaid.

## Principles to Expand Health Coverage

In considering proposals to reduce the number of uninsured, the Chamber urges policymakers to embrace certain principles:

- All Americans should have maximum flexibility to select a health plan design that meets their personal values and financial situation.
- Those who pay for health coverage on their own should have the same tax advantages as those who receive it through their employer.
- When health coverage is not affordable, financial assistance must be extended to those with the greatest need.
- Employers who voluntarily offer their workers health benefits must retain flexibility to determine eligibility and benefit offerings.
- Insurers should have incentives to take those with unknown health risks, and be protected from excessive loss when they do.

## "If you want health insurance, get a job."

Today's health system, apart from the government-run Medicare and Medicaid programs, is largely structured around voluntarily provided employment-based coverage – one that currently provides health coverage to

more than 175 million people (136 million of whom are covered by private employers). This made sense when workers spent decades with one large employer, but demographics, non-traditional work arrangements and the American spirit of entrepreneurship demand alternatives to this traditional system. Certainly, employers will continue to have an important role in our health system, and in fact have demanded many of the system efficiency and quality improvements now being implemented. The employment-based system must be reinforced and strengthened where possible for the sake of those millions of Americans who depend on it.

Historically, employers have been a relatively low-risk group to insure for health benefits. After all, employees were there first and foremost for the job, not the benefits. This is no longer true. Mass retailers, the hospitality industry and even health care systems, all of which offer more flexible scheduling because they operate around the clock, find that workers are taking jobs primarily for health benefits they cannot obtain on their own. In essence, these employers are being adversely selected against because the health benefits satisfy a specific need of the job applicant.

Proposals for the uninsured that focus primarily on job-based health coverage do a disservice to those whose primary need is health coverage, not a job. Mandates on employers will not help those who are retired, who wish to pursue careers in the arts or start their own businesses, who pursue higher education later in life or who wish to "chuck it all" and live a simpler life without being tied to a job. Mandates will reduce employees' wages and force those covered elsewhere to give up that coverage in order to ensure an employer satisfies "minimum participation" rules imposed by insurance carriers.

Certainly, even when employers offer coverage, the cost to participate is high and employees forego participation because they cannot afford it or they calculate that their health expenses are less than the cost of their portion of the premium. Specific solutions are on the table to remedy these situations. For the balance of the population, though, one should not be tied to a job because they need the health insurance, or be required to alter their health care arrangements each time they change jobs.

## Reducing Health Insurance Costs through Market Competition

The insurance market, particularly for small businesses, has largely stagnated over the last five years. Time and time again since the late 1990s,

small businesses have been forced to get a new health plan because their insurer has left the marketplace. Other employers have found that they have no other insurers in their area to call for a rate quote when their current plan premiums skyrocket. This lack of competition stems from state mandates on health plans, which have taken away health plans' ability to differentiate themselves in the marketplace and compete for customers by offering benefits tailored to meet their needs. When carriers leave the market, they leave employers with one less place to go with their business, and concentrate the market power of one or two dominant insurance companies. Two solutions, association health plans and health savings accounts, hold the promise of reviving the largely moribund but costly small business insurance market.

Association Health Plans

Nearly all large employers offer health coverage under ERISA, which generally preempts state insurance laws. Among the many benefits of ERISA is the ability to provide coverage uniformly to employees across state lines, which simplifies benefits administration and compensates employees equally. Large employers self-insure their health care costs, bypassing traditional insurance plans and the constraints imposed on them by the states. Small businesses, however, are unable to take on this kind of financial risk and must purchase insurance for their employees.

Complicating matters, more and more small businesses have employees in two or more states, and they must arrange health coverage for their employees in each of those states. Under legislation like S. 545, the "Small Business Health Care Fairness Act," small businesses could purchase coverage through associations and other organizations that meet federal requirements. No longer would small businesses be subject to state mandates and regulatory requirements that drive up costs, and small multi-state employers would enjoy a much simplified health care benefits program by being able to offer the same coverage to all their employees – just like larger businesses with whom they compete. Advantages of association health plans include:

- Greater stability in premium costs by sharing risk with other small businesses
- Reduced marketing, sales commission and administrative costs
- The ability to offer employees of small businesses a choice of health plans

- Simplified and uniform benefits administration for small businesses with employees in several states
- More market competition for small businesses' premium dollar
- Consumer protections under HIPAA to guard against adverse selection for healthier or sicker groups
- Federal solvency standards and regulatory oversight to prohibit illegal operations from scamming small businesses out of premium dollars

Legislation similar to S. 545 has passed the House of Representatives six times since it was first introduced ten years ago. It has no cost to the federal government, yet holds the promise of reducing and leveling small employers' insurance costs, revitalizing small businesses' insurance choices and offering employers the ability to retain and offer coverage that they otherwise could not.

Health Savings Accounts

HSAs were established in the Medicare prescription drug law and went into effect January 1, and will replace its more restrictive Archer MSA predecessor. While a number of larger employers have experimented with so-called "consumer-driven health plans" made possible by health reimbursement arrangements ("HRAs"), non-discrimination compensation testing largely prohibit these plan designs for some small businesses and partnership arrangements.

HSAs also offer a number of advantages for employees. Of primary benefit, the account is held exclusively by the taxpayer, rather than the employer. Employers may contribute to the HSA (as may the employee), easing concerns for younger or less affluent workers about funding their deductibles. As with other compensation requirements, employer contributions must be made fairly across the employee base, and HIPAA compliance will require that contributions not vary based on an employee's health status.

HSAs will jump start the small group health insurance market in 2004. Many small businesses have already been forced to adopt higher deductible health plans as insurance costs nearly doubled over the last five years. Insurers specializing in these kinds of health plans will enter states where they had once done business and left, or will become new market alternatives to the one dominant insurance carrier serving the small group market. Traditional

insurers will also offer HSA products in an effort to retain small business customers. Small businesses desperately need this market competition for their substantial premium dollar.

HSAs also offer a pre-tax mechanism for paying for insurance when the account holder does not have workplace coverage, the first time the tax code has made this allowance. Premiums may be paid from HSA balances, though annual contributions are still restricted to the amount of the annual deductible. Therefore, greater tax code equity changes must still be made.

**Flexible Spending Account Changes Needed**

Long before HSAs came into being, many employees already had experience with health care flexible spending accounts ("FSAs"). These are accounts established under Section 125 flexible benefit plans to pay health care costs not covered by one's health plan, such as contact lenses, over-the-counter medications, dental care, co-payments and deductibles. However, employees must budget carefully: unspent funds at the end of the year are forfeited to the employer. Consequently, only 34 percent of eligible employees participate in their workplace FSA, and many under-budget their need.

FSAs will continue to be part of the mix of employee benefits even as HSAs are adopted. For those without an HSA, a major advantage of health care FSAs is that employees may access at the start of the year the entire amount they have budgeted for the year and then repay the funds with each paycheck. This feature is particularly valuable for those with more modest incomes as they won't have to break the family budget in order to meet a deductible at the start of the year.

The current "use it or lose it" rule has several ill effects on patient-consumer behavior. First, employees who find themselves with unspent balances as they approach the end of the plan year often embark on a spending spree for health care goods and services that they may not need just to avoid forfeiting their hard-earned money. Other employees budget too conservatively for their out-of-pocket expenses and end up paying more for those same costs than if they had paid them on a pre-tax basis through an FSA.

Employees should be able to carry over to the next year up to $500 of unspent funds or designate unspent funds to a qualified retirement savings plan, allowing them to reap the benefit of long-term growth and a more financially secure future. Employees should also be allowed to withdraw their

entire balance on an after-tax basis: It's their money, let them have it back! Moreover, because the employee receives the funds on an after-tax basis, this option is also less costly to the federal government to enact.

## Making Health Coverage Affordable: Targeted Tax Credits

Everyone who pays their own insurance premiums should be able do so on a tax-preferred basis. Currently, only those with employer-based health coverage have a significant tax advantage; the self-employed also enjoy a full tax deduction. Others may deduct the cost of their health insurance only to the extent costs exceed the 7.5 percent AGI threshold for itemized health deductions, offering little tax incentive or relief.

Many employees pay their portion of premiums on a pre-tax basis (including FICA and HI taxes) if they are covered under a Section 125 cafeteria plan. However, employees of small businesses that offer coverage under traditional Section 106 arrangements (largely due to non-discrimination compensation testing rules) pay premiums on an after-tax basis, forfeiting a significant savings in each paycheck. Small businesses tend to heavily subsidize the employee's share of premiums because insurance carriers require a significant percentage of employees to participate in the health plan in order to mitigate adverse selection. Consequently, employees who have dependent coverage pay a significant portion of the dependent premium themselves. The ability to pay this premium on a pre-tax basis will make those premiums more affordable.

Refundable tax credits for those with modest incomes will help many uninsured individuals obtain affordably priced basic health insurance. The Chamber supports the following principles for enactment of a tax credit:

- Tax credits should be income-related in order to avoid wholesale disruption of employer-based coverage. An employer will not drop its workplace health plan if only some employees are eligible for federal assistance.
- The value of a tax credit should be a sliding scale percentage of the premium for the covered individual. Health premiums vary widely based on geography, age and, of course, health status. Those with greater need should receive more assistance.

- Partial tax credits should also be made available for income-eligible workers who pay a substantial portion of premiums for themselves or dependents.
- The value of a tax credit should be advanced into workers' paychecks through W-4 withholding forms.
- A full tax deduction should remain an option for all taxpayers. As incomes change, the tax code should offer proper assistance and relief for those who obtain and retain coverage.

## Making Health Coverage Available: Risk Pools and Reinsurance

The insurance market also needs relief from those with very high health care costs. Too often, individuals are denied health coverage because of an on-going or past medical condition. Under many risk pool arrangements, these individuals are shifted into much more expensive health coverage, sometimes excluding coverage for a period of time for the very condition that caused them to end up in the more expensive risk pool in the first place. Often risk pools rely in part on state financing (along with enrollee premiums), which in recent budget cycles has been insufficient to meet greater demand and higher costs, leading to temporary caps in enrollment.

While risk pools serve to make coverage more affordable for those without serious medical conditions, a few states have experimented with other ways to guard against high premium increases when people do incur significant medical costs and to encourage insurers to accept those with greater medical risks. Publicly financed reinsurance pools exist to provide stop-loss coverage above a certain dollar threshold, in exchange for covering those with both known and unanticipated health risks. Reinsurance pools are used in both the small group and individual insurance markets, and they should be actively promoted for expansion in order to encourage more mainstream health insurance options for those with preexisting medical conditions and extraordinary health costs.

## Reducing Health Care Costs through Better Information

Information is an important component to reducing costs and ensuring good outcomes – whether that information is about provider performance, best treatment options, available health plan choices or ways to improve one's own personal health. Components of better information to improve quality and lower costs include:

- Sharing information about provider performance
- Developing evidence-based protocols to reduce practice variation
- Eliminating medical errors through greater use of technology-based information systems
- Steering patients to providers dedicated to quality improvement and best practices
- Disclosing the cost of items and services so patients can, when appropriate, compare prices relative to benefit

There is growing consensus among a broad array of federal and state, business and union, employer and consumer stakeholders around the importance of public reporting of health care quality and efficiency measures, including those that measure clinical outcomes, the patient's perception of care and relative efficiency. Valid, reliable, comparable and salient quality and efficiency measures have been shown to provide a potent stimulus for clinicians and providers to improve the quality and cost effectiveness of the care they provide. Employers spend more than $400 billion annually on workplace health care benefits and therefore have a vested interest in ensuring the highest quality and most cost-effective care possible for their employees, retirees and their dependents.

Consequently, the Chamber has endorsed "The Quality Initiative," a voluntary reporting system of hospitals in 10 standardized protocols relating to three diagnoses. More protocols have been identified for future reporting. Medicare will soon begin paying an enhanced inflation adjustment to hospitals that report this information. Voluntary public reporting will give employers and consumers needed information about the quality and efficiency performance of the health care system and help them to make more informed decisions about their care, and health plan designs will encourage those informed choices.

Further research into clinical treatment protocols will enhance patient care, reduce practice variation and health care disparities, and improve patient outcome. This research should be supported in the public and private sectors, its results widely disseminated, and the ensuing protocols incorporated into reimbursement systems. Providers should be rewarded for being efficient and treating patients successfully the first time; the current system pays to correct each medical complication, side effect and even error. Employers do not wish to spend their health care dollars in such haphazard fashion, and some are

revising their payment systems to promote efficient care. Medicare is also experimenting with such an approach, and we encourage these developments.

Similarly, employers have demanded greater use of technology based systems for patient care, resulting in more electronic records and prescription ordering, minimizing the chance of handwriting errors and speeding information retrieval in easily sorted formats.

**Lower Costs through Personal Responsibility**

Finally, just as society has a responsibility to ensure that no fellow human being lacks basic or necessary medical care, so do members of this nation have personal responsibility to ensure they are not an undue burden to others. We have an obligation to one another to take care of ourselves by engaging in good health habits, as well as by obtaining health coverage to ensure timely treatment and to protect against catastrophic financial harm.

Health coverage helps ensure access to care when it is needed, and offers economic security for working families. The private market can work with the proper incentives and oversight from government. Tax incentives, market stimulation, financial guarantees and better information all have their place alongside traditional government programs for select populations and a strong safety net.