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Chairman Harkin, Ranking Member Enzi, and Members of the Committee I am pleased to have the opportunity to appear before you today to discuss the important issue of health insurance costs and small businesses in America.

The Importance of Small Business

Small businesses and entrepreneurs are at the heart of the U.S. economy, although there is no single way to quantify their contribution. According the National Federation of Independent Businesses, there were almost 29 million federal income tax returns filed in 2004 with business income on them. Similarly, there were 16 million self-employed and working in their own businesses. 99 percent of employing businesses are "small" under prevailing definitions. 60 percent of all businesses that employ people other than the owners have 1 to 4 employees; another 20 percent have 5 to 9 employees; and yet another 10 percent have 10 to 19 employees. Businesses employing fewer than 100 people (excluding the self-employed who employ no one but themselves) constitute 96 percent of all employers

A large concern should be the impact of policy choices on individuals, as these are the nascent entrepreneurs that are our next business leaders. Roughly 10 percent of adults are interested in starting a business. My own research indicates that these entrepreneurs are sensitive to taxes and other aspects of the policy environment.

Finally, it is now well recognized that small business provides about 55 percent of all jobs in the private sector. Small business has created about two-thirds

of the net new jobs in the United States, where "net" means the number of jobs created minus the number of jobs lost. In the process, these businesses also produce about one-half of the private-sector GDP in the U.S.

Small Businesses and Health Insurance

Small businesses display a lesser ability to provide health insurance benefits for their workers (see table):

Percentage of Firms Offering Health Insurance Benefits
by Firm Size and Industry, 2008

	Percentage of Firms Offering Health Benefits (percent)
Firm Size	
3-9 workers	49
10-24 workers	78
25-49 workers	90
50-199 workers	94
200-999 workers	99
1,000-4,999 workers	100
5,000 or more workers	100
All Small Firms (3-199 workers)	62
All Large Firms (200 or more workers)	99
Industry	
Agriculture/Mining/Construction	67
Manufacturing	73
Transportation/Communications/Utilities	89
Wholesale	74
Retail	40
Finance	81
Service	58
State/Local Government	97
Health Care	71
All Firms	63

Source: Kaiser Family Foundation, *Employer Health Benefits* 2008; excerpted from Exhibit 2.3, p. 37.

For those who manage to provide benefits, however, the challenge is getting greater. Small businesses and entrepreneurs have faced rising costs of health insurance premiums in recent years, as evidenced by the table below.

Average Annual and Growth in Premiums for Covered Workers with Family Coverage, by Firm Size, 1999-2009		
	All Small Firms (3-199 Workers)	Percent Change
1999	$5,683	--
2000	$6,521	14.7%
2001	$6,959	6.7%
2002*	$7,781	11.8%
2003	$8,946	15.0%
2004	$9,737	8.8%
2005*	$10,587	8.7%
2006	$11,306	6.8%
2007	$11,835	4.7%
2008*	$12,091	2.2%
2009*	$12,696	5.0%
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009.		

These rising costs of insurance place pressure on firms to reduce costs in other areas of operations, reduce cash wages, and impede their ability to invest and expand.

The Desirability of Comprehensive Health Care Reform

These recent experiences in rising health insurance premiums highlight the need for effective reforms of U.S. health care. There are three major problems. First, health care costs too much. In 1970, national health expenditures were $1,300 per person and consumed 7 cents of every national dollar—7 percent of GDP. For the past three decades, health-care spending per person has grown roughly 2 percentage points faster every year than income per capita. That is, in the race between costs and resources, costs have been winning. The result is that health-care spending now exceeds 17 cents of every national dollar—and will rise to 20 percent by the end of next decade. Within the federal budget, the rising cost of Medicare and Medicaid threatens a tsunami of red ink in the decades to come.

A dominant characteristic of health care in the United States is its fragmentation and focus on acute-care episodes. This system feeds the growth in spending per capita above and beyond that due to the factors outlined above. The Medicare program itself is important in this regard. It has programs for "hospital" (Part A), for "doctors" (Part B), for "insurance companies" (Part C), and for "drug companies" (Part D). These compartmentalized programs are dedicated to ensuring that various providers receive their payments in a fee-for-service system. Doctors and hospitals are paid for services provided to patients; and the more they do, the more they are paid. This system is focused on payments to providers, not on the health of families. This system is not centered on quality of care and gives scant regard to coordinating the decisions of the various medical providers, and it does not reward appropriate preventive care. Importantly, because it is such a dominant payer, Medicare reimbursement policies drive many of the inefficient practices in American medicine.

It is hardly surprising that a medical system focused on paying for acute-care episodes has spawned a reward to the innovation, adoption, diffusion, and utilization of new technologies for these episodes. Because the system is not oriented toward quality outcomes—particularly, paying for quality outcomes—a key feature of rising health-care spending is that it has not generated improved outcomes: the U.S. spends a greater fraction of its income on health care but does not have comparably superior longevity or health quality. The trends are most pronounced in Medicare, but the same broad characteristics prevail for the private system serving those younger than sixty-five. Also, in both cases (but again larger for Medicare) in the United States, there are large regional differences in spending that do not lead to apparent differences in the quality of outcomes.

Second, because health care is becoming more expensive, the cost of health insurance is skyrocketing. Over the last decade, insurance costs have increased by 120 percent—three times the growth of inflation and four times the growth of wages. With higher costs has come reduced insurance coverage. It is important to

solve the first problem—rising costs—before committing to large-scale coverage expansions. Dealing with the problems in the wrong order will be prohibitively expensive and will likely cause the reform effort to unwind.

Finally, health insurance and health-care systems underperform. A job loss typically also means loss of health insurance; workers would be better served by more portable options. Insurance companies would have better incentives if faced with life-cycle costs for a policyholder. Similarly, high spending has not yielded comparably high outcomes for infant mortality, longevity, or treatment of chronic disease. The delivery system can be greatly improved.

Senate Legislation and Health Care Reform

It is useful to examine proposed legislation before the Senate in light of the need for reform. Unfortunately, I believe that the existing efforts fall far short of what is needed and, in some instances, take unfortunate steps in the wrong direction.

Proposals to date do not "bend the cost curve". The most important first steps in health care reform are delivery system reforms that maintain or improve quality *and* reduce the pace at which health care spending grows. Rapid health care spending growth is the root cause of rising insurance costs. Rapid health care spending growth is a key part of the dangerous U.S. fiscal outlook. The existing proposals do not address this problem. Indeed, to the extent that they impact cost growth, they make the problem worse.

House legislation put forth earlier this year created a new health entitlement spending program that the Congressional Budget Office projected would grow 8 percent annually for the foreseeable future. CBO Director Douglas Elmendorf responded directly and negatively to questions about whether it (or HELP Committee legislation) would "bend the cost curve." Similarly, Health and Human Services Actuary Richard Foster concluded that the legislation would *raise* national

health expenditures – exactly the opposite of the desired result. In sum, creating a new entitlement spending program that grows at 8 percent annually is not bending the cost curve.

The Senate Finance Committee legislation creates a new health entitlement spending program that grows at 8 percent annually for the foreseeable future. It, also, does not bend the cost curve.

Proposals endanger the budget and risk broader economic stress. The Federal budget has entered dangerous territory. Under the Administration's proposals (as analyzed by the CBO), debt relative to GDP will rise from roughly 40 percent in 2008 to over 80 percent in 2019; at which time it will be spiraling north. Deficits will not fall below 4 percent of GDP during the next ten years. In 2019, the Federal government will borrowing roughly $1 trillion dollars with nearly $800 billion necessary merely to pay interest on previous borrowing.

This outlook in not merely the residue of the financial crisis and recession, which have demanded tremendous resources in the near term. Instead, they reflect conscious policy choices that persist long after the financial crisis is assumed to be resolved and the economy restored to health.

International financial markets have long been presented with a U.S. fiscal picture that does not add up over the long term. Successive versions of the CBO's *Long-Term Budget Outlook* volume have documented the basic facts: spending that is on track to consume an ever-larger share of GDP and tax revenues that could never grow to match. These most recent policy decisions simply accelerate dramatically the underlying problems.

Analysts have long worried about the potential fallout of this budgetary outlook. At what point do rating agencies downgrade the United States. When do lenders price additional risk and charge higher interest rates to federal borrowing.

How quickly will international investors flee the dollar for a new reserve currency? If so, how will the resulting higher interest rates, diminished dollar, higher inflation, and economic distress manifest itself?

To date, one explanation of why these events have yet to transpire is that the same financial market analysts who understand the weak state of the U.S. books also believe that they will be rectified before serious distress arrives. Put bluntly, the U.S. is relying on the faith of others in its ability to undertake serious budgetary reforms.

A large new spending program that grows at 8 percent a year – faster than the economy will growth; faster than tax revenues will grow – is a dramatic statement to financial markets that the Federal government does not understand that it must get its fiscal house in order. It is a statement that it is content to make things *worse*. It would be a risky move at a dangerous time.

Small businesses are a powerful economic force in the U.S.. However, they would find themselves swimming against even greater tides of higher borrowing costs, rising prices, and an economic slump. As in the current recession, many would be unable to hire, forced to lay off workers, or even shutter their operations. I believe it is a disservice to this important piece of the fabric of our economy to pursue legislation that puts their foundations at risk.

The current proposals will raise costs for the majority of Americans who have insurance. As noted earlier, if anything these proposals bend the cost curve the wrong direction. Since health care spending is the ultimate driver of health insurance costs, this is a step in the wrong direction for those who have insurance. In addition, some specific policies will directly raise the cost of insurance.

Fees. A notable feature of the America's Healthy Future Act is a total of $13 billion in annual fees on health insurance companies ($6.7 billion), medical device manufacturers ($4 billion) and pharmaceutical companies ($2.3 billion). In

substance, these fees are the economic equivalent of a excise taxes whose burden will be shifted forward onto consumers. Due to the non-deductibility of these fees, the impact will be magnified, with the end result being $200 billion of higher premium costs over the next 10 years.

To see this, begin with the annual fee that applies to any U.S. health insurance provider. The aggregate annual fee for all U.S. health insurance providers is $6.7 billion, with the total fee is apportioned among the providers based on relative market share. The fees would not be deductible for income tax purposes and would take effect in calendar year 2010.

The fee is tantamount to an excise tax on health insurance. For any company, as it sells more insurance policies it will incur a greater market share, and thus a greater share of the $6.7 billion. That is, with each policy sold, the total tax liability rises; precisely the structure of an excise tax. As such, it is important to understand the difference between the statutory incidence of the excise tax – the legal responsibility to remit the tax to the Treasury – and the economic incidence – the loss in real income as a result of the tax.

Insurance companies will have to send in the tax payments, so the statutory incidence is obvious. However, a basic lesson of tax policy is that people pay taxes; firms do not. Accordingly, the economic burden of the $6.7 billion tax must be borne by individuals. Which individuals bear the economic cost?

The imposition of a tax will upset the cost structure of the insurance companies, raising costs per policy and reducing net income (or exacerbating losses). Some might argue that the firms will "eat the tax" – that is simply accept the reduction in net income. For a short time, this may well be the case. Unfortunately, to make no changes whatsoever is tantamount to promising shareholders a permanently lower (risk-adjusted) rate of return. Because insurance companies compete for investor dollars in competitive, global capital markets, they will be

unable to both offer a permanently lower return and raise the equity capital necessary to service their policyholders.

Interestingly, a similar logic applies to not-for-profit insurers, who rely on retaining earnings as reserves to augment their capital base. Bearing the burden of the tax means lower access to these reserves and diminished capital.

Accordingly, firms will seek to restructure in an attempt to restore profitability, with the main opportunity lying in the area of labor compensation costs. To the extent possible, firms will either reduce compensation growth, squeeze labor expansion plans (or even lay off workers), or both. Again, however, insurance firms will find their responses constrained by the realities of the market environment. Cutting back compensation is an invitation for the best-skilled workers to depart the insurance industry. Layoffs and labor squeezes make it difficult to attract the inputs to firm growth.

In short, there are sharp limits on the ability of firms to shift the effective burden of excise taxes onto either shareholders (capital) or employees (labor). Moreover, their ability to do so diminishes over time as capital and labor seek out better market opportunities.

The Congressional Budget Office and Joint Committee on Taxation revenue estimating conventions recognize these economic realities. Specifically, they apply a 25 percent "offset" to the estimated gross receipts of any excise tax. In terms of the discussion above, the convention recognizes the incentives to attempt to shift some of the burden of the tax in the form of lower dividends, capital gains, and wages. To the extent this happens, receipts of income-based taxes will fall; hence the need for an offset to the gross receipts of the excise tax.

There are three additional points about the 25 percent offset. First, while it recognizes the economic incentives to shift the burden of excise taxes, it is only a

rough approximation to the case-by-case reality. Depending on the nature of the market setting, more or less of the tax may be shifted to taxable wages or profits and those resources may be taxed at either higher or lower rates.

The more important aspect of the offset is that it is not 100 percent. That is, the non-partisan consensus-based revenue estimators have concluded that the vast majority of the burden of excise taxes will not be borne by shareholders or workers. Who, then, bears the burden? Consumers.

If competitive conditions make it impossible for insurers to absorb the economic burden of the tax, they will have no choice but to build the new, higher costs into the pricing structure of policies. In this way, the economic burden of the tax is shifted to the purchasers of health insurance. In particular, the more competitive are markets for equity capital and hired labor, the greater the fraction of the burden that will be borne by consumers.

This phenomenon leads to the third aspect of the 25 percent offset. If health insurance is more costly, firms will be forced to offset this higher cost by lowering the other aspects of compensation – namely cash wages. Lower cash wages throughout the economy are an important burden to workers, and provide a second avenue for reduced personal income tax receipts.

This line of reasoning is sometimes met with skepticism, and countered with the notion that consumers will simply be unwilling to accept a higher price. Evidence suggests that this is not true, but suppose the counter-argument is taken at face value. To the extent that firms accept a lower rate of return, they will be unable to attract capital. Similarly, to the extent they reduce employment in response to the tax (or cut wages and lose skilled employees to better opportunities), they will again suffer in their ability raise their scale of operations. In short, for firms that attempt to adjust entirely on the cost side will be unable to maintain their operations at a competitive level, and will lose market share or even

depart the industry entirely. For health insurance markets as a whole, this reduces competition. The bottom line for consumers is the same: higher prices.

The argument thus far suggests that $1 of fees would show up as $1 of higher health insurance premiums. Unfortunately, the Senate has chosen to make the fees non-deductible for purposes of computing income taxes.

This non-standard tax treatment matters a lot. If a firm passes along $1 in higher prices and cannot deduct the cost (fee), it will pay another $0.35 in taxes. Accordingly the impact on the firm is $0.65 in net revenue minus the $1 fee. Bottom line: a loss of $0.35. (The problem gets worse when you consider that the $1 of additional premium is also subject to premium taxes and in some cases a state income tax.)

To break even, the firm will have to raise prices by $1/(1-0.35) or $1.54. If it does this, the after-tax revenue is the full $1 needed to offset the fee. This has dramatic implications for the overall impact of $6.7 billion in health insurance company fees. Instead of imposing a burden of $67 billion in higher premiums over the next decade, the impact will likely be over $100 billion in additional costs on holders of insurance policies.

In sum, the health insurance fee will likely quickly and nearly completed be incorporated into higher insurance premiums at a greater than dollar-for-dollar rate. The same considerations apply to fees on pharmaceutical companies and medical device manufacturer. The economic impact of these fees are similar in character; the fees will likely result in higher costs for these products and services, which will in turn have to be covered by higher health insurance premiums.

These fees mean that American families, workers and small businesses will pay as much as $200b in higher premium costs for their existing health insurance policies. My personal estimate is that roughly 90 percent of this burden will be

borne by those making under $200,000 per year – including small businesses and entrepreneurs.

Taxes. The Senate Finance Committee legislation also imposes a 40 percent excise tax on issuers of "Cadillac" plans (over $21,000 for a family; $8,000 for an individual). As with the fees discussed above, this tax will surely be passed to holders of insurance adding an additional $200 billion in premium costs over the next decade. Again, a fraction over 80 percent will be borne by those making less than $200,000.

It should be noted that this excise tax represents the notable feature of the proposed legislation that could contribute to bending the cost curve. I am among those who have argued that capping the open-ended tax subsidy to health insurance is a sensible part of comprehensive reform. Unfortunately, the inclusion of this provision appears to be a case of "too-little, too-late." The cost curve has not been bent and the resulting higher premiums will not be offset by a generally improved health care cost climate.

Insurance Market Reform. Finally, proposed legislation would include insurance market reforms – guaranteed issues, community rating/rating bands, restrictions on rating factors – that would raise insurance premiums on average.

I believe it is non-controversial that the combination of guaranteed issue and community rating would raise average premiums. Guaranteed issue invites the most costly of the uninsured to get insurance and community rating ensures that they will be charged less than their share of the increased costs. The remainder of the insurance pool – existing policyholders – must bear the additional cost. This is straightforward.

What apparently *has* been controversial is that insurance companies have been the carriers of this message. I urge Members to look past the industry's

obvious self interest and recognize that there are now a handful of increasingly detailed and careful studies documenting the forces for higher premiums – often double-digit percentage rises in costs. In addition, it is useful to note that non-partisan analysts such as the CBO, JCT, CMS, and NAIC have recognized these forces, even if they have not yet done a comparable analysis of the impact on premiums.

A second issue in this area is the role of mandates. For some, a mandate "solves" the problem with these insurance reforms by forcing healthier, low-costs individuals into the insurance pool, where they would pay far more than their share of the health care costs.

While opinions vary, I believe this is a mistake. Forcing individuals to participate in a system that is already broken and will be getting more expensive is not reform. Guaranteeing insurance companies additional business without commensurate efforts on their part in the areas of pricing, quality of service, and product innovation is at odds with the basic recipe for economic success. I would urge Congress to instead undertake genuine, effective reforms that address the cost of care. These reforms would translate into lower insurance costs and greater take-up of insurance in the United States.

Thank you. I look forward to answering any questions you may have.