"Regulations, Costs, and Uncertainty in Employer Provided Health Care"

House Committee on Education and the Workforce

Subcommittee on Health, Employer, Labor, and Pensions Subcommittee

Written Statement for the Record by

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Mr. Chairman and Members of the Committee:

Thank you for inviting Families USA to testify today at this very important hearing about health care reform, employers and consumers. Since 1982, Families USA has worked to promote high-quality, affordable health care for all Americans. We are pleased to be invited to testify about how the Affordable Care Act will offer concrete help to employers, their workers and their families. The strength of the U.S. labor market is inextricably linked to the scope and size of America's health care industry. According to the Bureau of Labor Statistics, more than 500,000 jobs have been created in the health care and social assistance sector since the passage of the Affordable Care Act. According to Bureau of Labor Statistics projections, nearly 4 million jobs will be added to the health care and social assistance sector between 2008 and 2018.

The Affordable Care Act Will Spur Job Growth

Our economy needs a jolt and policymakers should do as much as possible to encourage hiring and spur growth. When fully implemented, the Affordable Care Act will help promote economic growth by giving workers the freedom to move to new jobs at small firms and start-up companies without hinging their decision solely on the ability of the new employer to provide health care coverage to workers. In our current health care system, people with health conditions have a difficult time finding coverage in the individual market. Uncertainty about whether they'll be able to find affordable coverage leads many Americans to make decisions about which job to choose or whether to stay in a job based on whether the job provides health coverage. This phenomenon is known as "job lock."

Workers who have health problems are less likely to leave a job that offers health coverage. One study found that chronically ill workers who rely on their employers for health coverage are about 40 percent less likely to leave their job than chronically ill workers who do not rely on their employers for coverage. Another study found that workers with a history of health problems such as diabetes, cancer or heart disease, and those who have substantial medical bills, stay at their jobs significantly longer because of their job-based health coverage. And job lock has a particularly strong effect on workers who have family members with chronic illness. Research has shown that workers who rely on their employer to provide insurance for chronically ill family members stay in jobs they might otherwise leave. One study found that women with job-based coverage who have a chronically ill family member who depends on that coverage are 65 percent less likely to leave their job than women with job-based coverage who have a chronically ill family member who does *not* depend on that employer coverage.

The fear of going without health coverage discourages individuals from leaving their existing jobs and starting new businesses on their own, especially if they have pre-existing conditions or if they have a family member with a health condition. Productivity is hurt when the new ideas, new products and competitiveness that new businesses bring to the economy are lost. The Affordable Care Act will reduce the problem of job lock: individuals will no longer have to base their employment decisions on whether a job offers health coverage.

Employer-Based Health Coverage Declining Due to Rising Insurance Premiums

The number of Americans who receive their health insurance through their employer has dropped precipitously in recent years. In the year 2000, approximately two-thirds of the population (65.1 percent, or 181.9 million) had employer-based health coverage. Ten years later, in 2010, a little more than half of the population (169.3 million, or 55.3 percent) had coverage through their job or the job of a family member. Once implemented, the help provided by the Affordable Care Act to employers and consumers is likely to change this trend.

This trend is driven, in large part, by rising health insurance premiums. Between 2000 and 2010, premiums for job-based family coverage more than doubled, increasing from $6,348 to $13,770. These premiums continue to rise, growing to $15,073 by 2011. As premiums rise, it becomes more challenging for employers to offer quality, affordable health coverage to their workers, and employers are forced to make difficult decisions about such coverage.

Employers often respond first with efforts to control their health care costs without eliminating benefits entirely. Some employers attempt to control health care costs by "thinning" health benefits—offering plans with higher deductibles, copayments, and co-insurance, as well as plans that cover fewer benefits. Others cut costs by placing limits on which employees are eligible for coverage or by asking employees to pay more for coverage for spouses and children of employees (dependent coverage). In addition, many employers have stopped offering coverage to part-time, temporary, or seasonal workers.

The decline in employer-based coverage has been further exacerbated by the economic downturn that began in 2007. Millions of Americans lost their jobs during the recession and, for many, the loss of a job also meant the loss of health insurance coverage. And while the safety net of public health insurance programs, including Medicaid and the Children's Health Insurance Program (CHIP), provides coverage to some who lose their job-based coverage, current eligibility rules limit who qualifies for coverage based on income and family status. Because of these eligibility rules, Medicaid and CHIP act as a highly effective safety net for *children* during economic downturns but do not work nearly as well for *adults*.

Evidence of the critically important role that Medicaid and CHIP have played in protecting children can be seen in data from the Census Bureau. Between 2000 and 2010, enrollment in Medicaid and CHIP increased by 20.5 million, growing from 28.1 million to 48.6 million. More than half of this increase in enrollment was among children. Between 2000 and 2010, the number of children enrolled in Medicaid and CHIP rose from 14.9 million to 26.1 million, an increase of more than 11 million.

Faced with the loss of job-based health coverage, those who don't qualify for public health coverage must make a tough decision: Those who are eligible for COBRA continuation coverage under federal law (or "mini-COBRA" continuation coverage under state law) may be able to keep their job-based health coverage. Those who do not qualify for COBRA may be able to purchase coverage on their own through the individual market. However, COBRA premiums are often unaffordable, and the cost of individual market coverage is often prohibitive, as well. In addition, in most states, insurers are currently free to deny coverage or charge people more in premiums based upon their age, health status, and even gender. As a result, many who lose their job-based coverage remain uninsured.

Accordingly, the number and percentage of uninsured Americans has risen substantially in the last decade. Between 2000 and 2010, the number of uninsured grew by 13.3 million, rising from 36.6 million to 49.9 million. During this same period, the proportion of the population who went without health insurance grew by 3.2 percentage points.

The Affordable Care Act will help cut the cost of health care and lower costs for employers and consumers in three ways: First, the law will make insurance companies more accountable, giving states and the federal government more tools to hold down the cost of insurance premiums. Second, the Affordable Care Act contains a range of tools to control ever-escalating health care costs that will improve quality and make care more efficient. Third, the Affordable Care Act will provide concrete help to employers, in the form of tax credits and new regulated marketplaces to purchase insurance, and help to health care consumers, in the form of premium subsidies and out-of-pocket spending caps.

The Affordable Care Act Will Make Insurance Companies More Accountable

The Affordable Care Act includes critical protections to hold insurance companies accountable for consumers' and businesses' premium dollars. The medical loss ratio (MLR) standards in the law ensure that a reasonable share of premiums go toward medical care and quality improvement, instead of marketing, administration, and excessive profits. This measure to cut out wasteful spending is particularly important for small businesses and individuals who buy coverage on their own, since they do not have sufficient negotiating power with major insurance companies to ensure fair premiums.

Without the Affordable Care Act, insurers could continue to raise rates for consumers regardless of how little they spend on medical care. Under the new law, if a company spends less than a set share of premiums delivering care, it will owe rebates to enrollees. Starting in 2012, up to 9 million Americans could be eligible for rebates worth up to $1.4 billion. These rebates will average an estimated $164 a year per person.

The MLR requirements are already helping families. For example, effective last month, 15,000 Aetna enrollees in Connecticut's individual market received a 10 percent decrease in their premiums due to the Affordable Care Act's MLR requirements. Aetna implemented this change because its MLR in Connecticut was just 54.3 percent in 2010, far below the 80 percent standard

that individual and small group market insurers must meet under the Affordable Care Act. (This standard is set at 85 percent for large group carriers).

Connecticut is not the only state where carriers have demonstrated unacceptably low MLRs in recent years. A quarter of the 16 plans listed in Minnesota's individual market reported MLRs of less than 60 percent for 2010, with one company reporting a MLR of only 41 percent. That means, for every $10 this company collected in premiums, just a little over $4 was spent on medical care. For 2009, Anthem Health Plans of New Hampshire reported a MLR of just 63 percent in the individual market and Anthem Health Plans of Virginia reported a small group MLR of 67 percent. (Note that before the implementation of a national MLR standard, states may have used different methods for calculating carriers' MLRs. The state figures cited here may not include quality improvement as a medical expense.)

The rate review provisions are also essential to holding insurers accountable and keeping premiums reasonable for consumers. Carriers cannot increase rates by 10 percent or more without providing justification. The law also makes information on rate increases more transparent, including through a new section on HHS' healthcare.gov website that gives the public to access rate justification information for any rate increase of 10 percent or more.

Further, the rate review funding has already had a significant impact on affordability. For example, when Regence BlueCross BlueShield of Oregon proposed a 22.1 percent rate increase for individual enrollees in the spring of 2011, the state used grant funding from the Affordable Care Act to hold its first public rate hearing in 20 years and to scrutinize the underlying assumptions and calculations used by the insurer to formulate its proposed increase. As a result, the state determined the 22.1 percent proposed rate increase was unjustified and approved only half of the proposed increase (12.8 percent). In Connecticut, a 19.9 percent Anthem BlueCross BlueShield proposed rate increase in the individual market was denied outright, due to rate review at the end of 2010. Last month, the state's insurance department found another of the company's proposed rate increases unjustified and is granting only a 3.9 percent increase for the plan's rates, instead of the 12.9 percent hike the company sought to impose. The rate review provisions, along with MLR requirements, are holding insurers accountable for how they spend consumers' dollars and keeping premium increases in check.

The Affordable Care Act Will Help Slow the Growth of Health Care Costs

In addition to holding insurance companies accountable, the Affordable Care Act authorizes multiple initiatives and demonstration projects designed to improve quality and reduce the rise in health care costs. The law seeks to reduce costs through a range of solutions focused on doctors, hospitals, insurance companies, employers, and patients.

Unlike other approaches to reducing health care costs, these provisions do not resort to simply reducing payments for health care services or shifting costs to consumers through higher deductibles and copayments. Rather, the aim of these provisions is to provide higher-quality care more efficiently and with less waste. These provisions fall into the following categories:

Provisions designed to test ways that doctors and hospitals can better coordinate care, especially for people with chronic health problems: The current fragmented nature of our health care system leads, for example, to the unnecessary duplication of tests and procedures. Through better care coordination, much of the excess costs can be prevented.

Provisions that promote preventive services so costly complications can be avoided: The Affordable Care Act eliminates deductibles and copayments for preventive services in Medicare and private coverage. Preventive services include tests such as mammograms, Pap tests, colorectal cancer and diabetes screenings, autism screenings for children, as well as wellness check-ups and immunizations. If problems are identified early, and treated before they become serious, dollars can be saved.

Provisions that promote the sharing of unbiased information about which medical treatments work and which do not: Every day, new drugs and treatments are identified; they may be life-saving breakthroughs or they may have little benefit to patients. But busy doctors struggle to stay abreast of new developments. The law creates a new independent, nonprofit entity charged researching what drugs and treatments work best, so doctors have the information they need to provide the best possible care to patients.

Provisions that promote real competition among health insurance companies in more transparent insurance marketplaces: The Affordable Care Act will help people shop for the best health care plan for the price, and it will promote competition among different health care plans. Beginning in 2014, the establishment of state exchanges will provide regulated marketplaces where small businesses, the self-employed and eligible consumers can choose from a range of health insurance plans. In the new exchanges, insurance companies will have to clearly explain what care is covered and at what cost.

The Affordable Care Act Will Help Employers and Workers with the Cost of Health Care

Along with slowing the growth of health care costs and holding insurance companies accountable, the Affordable Care Act will provide much-needed financial relief to millions of small businesses, families, and large employers.

While small businesses are the backbone of America's economy, our health care system has been failing them. The current system makes it difficult, if not impossible, for small business owners to provide their workers with quality, affordable coverage. The Affordable Care Act provides small businesses with fewer than 25 workers and average wages of less than $50,000 with a tax credit for employee coverage. More than **80 percent** of all American small businesses (those with up to 25 workers) were eligible for this tax credit in 2010.

Other provisions of the Affordable Care Act will also provide critical assistance to small businesses struggling to afford health coverage. For example, the SHOP exchanges will create a new competitive marketplace where small employers and their workers will be able to see transparent information about health plans on a user-friendly website. In the SHOP, employers and workers will be able to choose from a variety of plans that meet strong quality standards so that they know they're getting good value for their money. In addition, new consumer protections, such as those that prohibit insurers from imposing lifetime or annual dollars caps on how much they'll pay for enrollees' care, will ensure that the coverage that small employers buy actually works for them and their workers when illness strikes.

Lower- and middle-income individuals and families will get help with the cost of care in two ways: 1) a new tax credit to assist with the cost of health insurance premiums; and 2) protections on how much they spend on out-of-pocket costs.

The new premium tax credits will help both insured individuals who struggle to pay rising premiums and uninsured individuals who need help to be able to purchase coverage. Generally, the premium tax credits will be available to individuals and families who have incomes between 133 and 400 percent of poverty (between about $30,000 and $90,000 for a family of four in 2011). The credits can be used to purchase insurance in the new health insurance exchanges. People who have an offer of health coverage from their employer may be eligible for a premium tax credit if their employer's plan would be unaffordable for them.

Approximately 28.6 million Americans will be eligible for the tax credits in 2014; more than half (52 percent) are currently insured.

The Affordable Care Act will also protect how much consumers must spend out of pocket each year on health insurance deductibles and copayments for covered benefits. It is estimated that the number of people who are "underinsured," that is, who have high medical costs as a share of their income, will be cut by 70 percent due to this provision in the Affordable Care Act. Too many lower- and middle-class families are only one health crisis away from financial devastation. For example, the average hospital charge nationally for a stay associated with a heart attack is nearly $63,000, and for people with inadequate coverage, their share of these costs can quickly drive them into bankruptcy. The law will mean that insurance coverage actually covers the medical bills. A family of three with an income between 100 and 200 percent of poverty (or about $18,500 and $37,000) would not have to pay more than $3,967 out of pocket for their care in one year. Moreover, the law will provide some additional cost-sharing subsidies for low-income families who purchase insurance in the new exchanges.

The Affordable Care Act Does Not Shift Costs to Consumers

Many of the deficit reduction proposals under discussion this year in Congress do nothing to address the underlying causes in the rise in health care costs. Instead, many deficit plans merely shift the burden of health care costs from the federal government either to states, or to consumers, or to both. For example, cutting federal Medicaid spending – either through a block grant or reduced funding for states – would ultimately increase the number of uninsured Americans. That would raise health care costs for the rest of us. Family coverage costs an extra $1,000 or more a year, on average, to pay for health care costs for the uninsured. A growth in the uninsured results in an increase in the "hidden health care tax" for those who have insurance, because health care providers must pass along the costs of caring for the uninsured. Repealing the tax credits in the Affordable Care Act would effectively increase taxes on middle class families and leave them with no assistance to purchase health insurance. If the tax credits were repealed, the increased tax burden on these families would total $777 billion between 2012 and 2021. The Affordable Care Act is designed to slow the growth in health care costs while providing concrete assistance to businesses and families to pay for the cost of insurance.