FULL COMMITTEE HEARING ON EXPANDING SMALL BUSINESS HEALTH INSURANCE COVERAGE USING THE PRIVATE REINSURANCE MARKET

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FULL COMITTEE HEARING ON EXPANDING SMALL BUSINESS HEALTH INSURANCE COVERAGE USING THE PRIVATE REINSURANCE MARKET

THURSDAY, MAY 24, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The Committee met, pursuant to call, at 10:00 a.m., in Room 2360 Rayburn House Office Building, Hon. Nydia Velázquez [Chairwoman of the Committee] presiding.

Present: Representatives Velázquez, Jefferson, Cuellar, Clarke, Ellsworth, Johnson, Sestak and Chabot.

OPENING STATEMENT OF CHAIRWOMAN VELÁZQUEZ

ChairwomanVELÁZQUEZ. Good morning. This hearing on expanding small business health insurance coverage using reinsurance in the private market is now called to order.

It is no secret that small employers are finding it difficult to purchase health insurance. However, what is less well known is that fewer carriers are offering coverage in the small group market.

In 2006, the Government Accountability Office reported that in a typical state the largest insurer controlled 43 percent of the market, up from 33 percent in 2002. In nine states, the largest carrier held more than 50 percent of the market. Consolidation in the insurance industry has made it difficult for smaller insurers to compete, and a number have dropped out altogether.

The lack of insurers helps explain why small employers can pay as much as 20 percent more than their corporate counterparts for the same health plan. Without competitive forces, insurance companies can dictate prices.

Today's hearing is the second in a series held by the Committee to address the issue of providing affordable health insurance for small businesses. This morning we will look at the state of the reinsurance market and whether there are ways to expand the use of reinsurance to provide more health insurance options for small employers.

Second, the Committee will consider whether it is feasible for small businesses to purchase reinsurance directly from a reinsurer. Typically, only insurance companies and large employers buy these policies to cover catastrophic claims. Small employers simply do not have the resources to purchase this type of policy on their own.

The issue is: what changes to our laws, if any, will make it possible for an entrepreneur to purchase such reinsurance coverage? I would like for witnesses to comment on whether collective arrangements would allow small employers to buy reinsurance.

Too often, we hear the excuse from insurance companies that they cannot offer small employers coverage or have to charge exorbitant prices due to the risk factor. If we can eliminate this argument, small businesses can start negotiating rather than simply accepting health insurance prices.

While this may seem like a unique approach, the depth of the problem requires us to look at all our options. If we fail to do anything, costs will continue to rise, more individuals will find themselves uninsured, and the growth of America's economy and small businesses will come to a halt.

We have with us a distinguished group of witnesses well equipped to help us understand the reinsurance market and whether it holds the key to expanding small business health insurance coverage. This Committee's goal is to ensure that health care reform does not occur without meaningful consideration of impact on this country's small businesses and the workers.

I am pleased that witnesses are here today to share their insights, and I look forward to today's testimony. I now recognize Ranking Member Chabot for his opening remarks.

OPENING STATEMENT OF MR. CHABOT

Mr.CHABOT. Thank you, Madam Chairwoman, and thank you for holding this hearing on expanding small business health insurance coverage.

At the center of our examination are the issues of cost and access. As we all know, purchasing health insurance is one of small business' most costly expenses. According to the National Federation of Independent Business, the NFIB, health care is the "most severe problem for small business owners"—greater than taxes, cash flow, or government regulations.

Small groups, including small businesses, usually pay more for similar or less coverage than large businesses. As a result, small businesses are less likely to offer health insurance than large firms. Not surprisingly, the principal reason given is that the small business could not afford the coverage.

Access to health insurance is also a challenge for small businesses. According to the Small Business Administration, employees with small firms are far less likely to have health insurance than those at larger ones. Ensuring that health care is affordable for small businesses is one of the most important issues Congress can address.

Our nation's small businesses drive the economy, and we need to do all that we can to help them stay competitive and encourage their growth. Association health plans, pool purchasing, and reinsurance have been mentioned as ways to help reduce the costs and increase access to health insurance for small businesses.

I am pleased that we will consider reinsurance during this hearing. Although I have reservations about the implications of a federal mandatory reinsurance program, I think reinsurance deserves further examination. I also believe that tax relief is not only an im-

portant way to reduce the overall tax burden, but to make health care more affordable for small businesses.

In previous Congresses, I have introduced the Health Care Affordability Act, which would allow every American to deduct 100 percent of the cost of their health insurance. I plan to introduce this bill or a similar bill in the near future.

Madam Chairwoman, I appreciate your holding this hearing. I look forward to hearing from our witnesses and to working with you on finding ways to make health care more affordable for small businesses and their employees, and I yield back the balance of my time.

ChairwomanVELÁZQUEZ. Thank you. I welcome all the witnesses. You will have five minutes to make your remarks.

Our first witness is Mr. Leonard Crouse. He is the Deputy Commissioner of Captive Insurance at the Vermont Department of Banking, Insurance, Securities & Health Care Administration. He has worked in the insurance regulation field for 35 years. Mr. Crouse has been the head of the Vermont Captive Insurance area for 16 years.

Welcome, sir.

STATEMENT OF MR. LEONARD D. CROUSE, CFE, DEPUTY COMMISSIONER, CAPTIVE INSURANCE DIVISION, VERMONT DEPARTMENT OF BANKING, INSURANCE, SECURITIES & HEALTH CARE ADMINISTRATION

Mr.CROUSE. Thank you, Madam Chair, and members of the Committee. I have been in insurance regulation for 35 years, the last 16, as the Chairman said, in Vermont. When I came to Vermont, we had 200 captive insurance companies. We just licensed our 800th captive insurance company last week.

It has been an industry that is referred to as the alternative insurance market. It has been around for a number of years. We passed our legislation in 1981. Many states have adopted regulations to form these type of insurance entities.

There are basically three types of captives when we talk about captives. We have a pure captive that insures only the corporation that owns it or that of its affiliates. And then, we have association captives made up of smaller groups that get together, pool their risks, whatever, and form. And then, we have what we call the risk retention groups. Those are the smaller groups that get together again, usually have similar business, similar type of exposure. They get together to form a risk retention group. We have 79 of those in Vermont currently.

If I could just refer back to the, oh, maybe four or five years ago, the medical malpractice crisis that was going on in this country and how the alternative market helped that market get over a major hump. Pennsylvania was a main state with major problems in medical malpractice. I believe we formed something like 39 captives that year, risk retention groups, put together by doctors, doctor groups, hospitals, universities with medical centers, and it really alleviated a serious problem. It was an alternative for many of these companies to go to.

Again, the reason was that costs were becoming too high in the traditional markets. Insurance was, in some cases, unavailable. So, again, it has been a great success in that industry.

Companies that do form captives, they generally realize lower costs, stable pricing, and the ability to receive a policy that meets its needs. Commercial premiums are based on the cost of claims, administrative costs, profit, and market competition. Companies forming captives feel that they can better estimate their own claim costs, lower administrative costs, and adjust the required profit to suit their needs.

Captives should not be subject to market conditions. Basically, a lot of people will form a captive, and what we call the hard market and the soft market occurs, a soft market being where insurance is readily available and a hard market when insurance costs go up and insurance is not readily available.

But when you form a captive, you stay in it for the long run, so you get over those humps that come and go, usually in the course of seven years, hard market/soft market, although recently those hard markets and soft markets have come a little bit more frequently.

We are a regulator in Vermont. I am a regulator, number one. It is important to regulate these entities. And anything that is done by your Committee or by the Federal Government that would be able to assist the small markets should be done in a regulated environment. Insurance is a regulated industry. It always has been; it always will be. And what we need in the smaller markets, we are having problems right now with risk retention groups.

It is a federal act. The Federal Risk Retention Act has been in effect since the early '80s when we passed our law. There is just not enough meat in the regulation and the requirements that are in that law. So if there is something that is passed, you have got to put a little more meat and a little more stiffness in there about the regulation and oversight of any type of program that is done.

We are working closely now with the NAIC, trying to bring the states together. There is about 15 active states in the risk retention group business. We are trying to bring them together and get some uniformity. There has to be uniformity in the oversight and regulation of any type of alternative program.

Basically, the GAO did a study, and it was completed two years ago. I believe it was the House Financial Services asked the GAO to do a report. It was a very successful report, and it would behoove you folks I believe to take a look at that and read it. It is excellent. There was a lot of good suggestions there on what they could do to improve the Risk Retention Act, and I think it would fit right into what you folks here are possibly thinking of doing.

I think the alternative market properly done for the small businesses and health care, something could be structured. I think a State like Vermont would be ready and willing to work with you folks to set something up, and I believe we are positioned to do so.

I will say this: Vermont has 28 people just in our alternative market division, which is the largest by far of any other state. We are the only state that has a dedicated department just for alternative markets and for risk retention groups, and what not.

So I just want to let you all know that we are readily available to answer any questions and work with you folks.

[The prepared statement of Mr. Crouse may be found on page 36 of the Appendix.]

ChairwomanVELÁZQUEZ. Thank you, Mr. Crouse.

Our next witness is Mr. Patrick Collins. He is the Vice President and Reinsurance Underwriter at Munich Re America HealthCare and is appearing on behalf of the American Academy of Actuaries. He is the Chairman of the Medical Reinsurance Workgroup and Vice Chairman of the Federal Health Committee. The American Academy of Actuaries represents over 15,000 members from all practice areas.

Welcome, sir.

STATEMENT OF MR. PATRICK L. COLLINS, MAAA, FSA, VICE PRESIDENT AND REINSURANCE UNDERWRITER, MUNICH RE AMERICA HEALTHCARE, PRINCETON, NEW JERSEY, ON BEHALF OF THE AMERICAN ACADEMY OF ACTUARIES

Mr.COLLINS. Thank you. Good morning, Madam Chairwoman Velázquez, Ranking Member Chabot, and members of the Committee. On behalf of the Academy of Actuaries, I thank you for the invitation to sit down with you today and discuss private reinsurance in the small business context. The Academy is a non-partisan public policy organization representing actuaries of all specialties in the United States.

We applaud your efforts to take on the difficult and complex health care cost problem. We are on an inevitable path to a collapse in the commercial medical insurance market. There is nothing that we can see on the horizon that will be able to stop it, and it is not a matter of if this will take place, but more of a matter of when and what form the market will look afterwards.

Small employers are on the front lines, bearing the brunt of these high health care costs, and it hurts, not just on a financial level but on a personal one. As you are aware, 80 percent of small employers have 10 or fewer employees, and the business owner tends to know each employee. In many cases, their relatives are family members.

The choices used to be which plan of benefits to buy or from which carrier, and now increasingly it is whether or not they can afford to buy anything at all. The burden imposed by these health costs on small business also hurts the very innovation and entrepreneurial activity that has been fueling the economic growth of this country, and for these reasons your efforts to address these items are to be commended.

The issue of how to address the high cost of health care benefits is indeed a complicated one, and solutions will most likely need multiple interlinking components that can't be solved with simple or quick fixes or sound bytes. And I understand you are considering reinsurance as part of the solution, and I hope that you found my written statement useful.

In addition to providing some background information on reinsurance, the statement is intended to provide you with a list of items to consider when designing a program. I would like to em-

phasize and highlight just a few of these points. I think it is important to understand the role that reinsurance plays.

In the private market, medical reinsurance reduces risk by providing financial protection. And by taking that risk, it reduces the required capital and increases the capacity by allowing the company to write larger programs. And it also provides the company with a source of intellectual capital and value added services.

What reinsurance does not do, however, is it does not reduce overall medical costs. It simply shifts costs from one entity to another. Nor does it render an uninsurable risk insurable. By simply shifting risk around does not change its underlying nature. While the commercial medical reinsurance market today is vibrant and fills a valuable market need, it is relatively small. It is used by small to mid-sized health insurers, and it is also used by small to mid-sized employers who self-fund their medical benefits.

Large health plans and large employers generally do not buy much reinsurance. For those who do buy reinsurance today, reinsurance tends to be very customized and tailored to the needs and goals of the organization. A standardized reinsurance program will tend to work well for some and not for others. And while it may work on average, it may not work very well for any one health plan or employer.

And of the issues outlined in my statement, I think the ones worth highlighting the most are, first, defining the objectives clearly. Understanding exactly what the program is trying to accomplish is important. Some objectives may tend to work against each other. For example, providing coverage to sicker people with higher health costs may work against an objective of lowering costs and premiums.

The second is: beware of unintended consequences. People in organizations, I think it will come to no surprise, will tend to act in their own best interest. One way that we use to flesh out these consequences is to look at the incentives. We first ask, what is the program incenting each party to do? And then, we ask if we are comfortable with those incentives.

Often programs are put into place with an assumption that everything else will remain the same. And often everything does not remain the same.

Before I close, I will leave you with one final thought. I was studying a condition recently called hormesis, and that is a condition where something in controlled doses is beneficial and good for you, but it is lethal in high doses. And the two most oft cited examples are water and oxygen.

And I suggest thinking about reinsurance in the same way. Using it wisely and judiciously and it will serve you well. Relying on it too heavily and it may cause more problems than it is worth.

Thank you for your time. I and the Academy are available to you as a resource to assist you in any way that we can. And I wish you all the best in your endeavors.

[The prepared statement of Mr. Collins may be found on page 40 of the Appendix.]

ChairwomanVELÁZQUEZ. Thank you. Thank you.

Our next witness is Mr. Steven Harter, owns and operates Select Risk Management Inc., and is the Past President of the National Association of Professional Insurance Agents. The National Association of Professional Insurance Agents represents member insurance agents and their employees who sell and service all various insurance products.

Welcome, sir.

STATEMENT OF MR. STEVEN J. HARTER, PAST PRESIDENT NAPIA, SELECT RISK MANAGEMENT INC., ON BEHALF OF THE NATIONAL ASSOCIATION OF PROFESSIONAL INSURANCE AGENTS (NAPIA)

Mr.HARTER. Thank you. Thank you, Madam Chairwoman, and members of the Committee. In 2002, I had the honor of serving as President of the National Association of Professional Insurance Agents. I continue to be involved with PIA and am the current President of the PIA trust, which is involved in health insurance products.

On behalf of PIA and its members, I would like to thank you for this opportunity to testify before the Committee.

PIA members are owner principals of their own independent agencies. We specialize in selling all sorts of insurance products, primarily to small and mid-sized businesses. Those products include automobile, home, business, including health insurance products. We are main street agents serving main street America.

PIA's experience and perspective in this area is both as purchasers as well as insurance experts. We also have to buy health insurance for our employees.

As I stated before, I do own and operate an insurance agency. In addition, until September of 2006, I owned another business. It was a social service agency providing supports to individuals with developmental disabilities. I employed approximately 120 people that we tried to provide health care for. In 2006, we merged with a large organization, largely because of the incredible cost of health insurance for my employees.

For many years, I did provide full health insurance. I paid 100 percent of the premium. As the costs continue to rise, I raised deductibles, much like other small businesses do. At that point, the costs became too much, and I started having my employees contribute toward the cost of their insurance.

In the health care/social service industry, people are low paid. A lot of my people only make like $10 an hour. So an increase in cost to them was disastrous, and many of them dropped their coverage. On the last renewal, the cost for each employee was quoted at over $500 per month. I didn't have the money to do that.

I determined the amount that I could pay, searched the market to find some sort of product that would be better than nothing—and I think a lot of small business people do this every day—and what I wound up with was what is called a mini-med product that basically is a band-aid. It is not the answer to the problem. And I think you have other small businesses that are probably doing those same sorts of things. We are trying to work within the—in the system, but it is not being very successful.

Allowing cost considerations to limit access to care in this manner by employees of small businesses is not a solution. It is another indication that there is a broader problem. I feel the overwhelming driver of insurance costs is the high demand for medical services coupled with the skyrocketing costs of health care, including prescriptions. I am not telling you anything new.

Today, as a nation, we are healthier than we have ever been before. Part of the reason is the advance in medical treatment, which of course adds to the cost. I don't see that reinsurance will necessarily help curb costs. I see reinsurance as more of a vehicle for availability. I have always been able to find group insurance. I just can't afford it. I don't get the impression from my clients that they can't find the coverage. Most of the time there is a market somewhere, but people can't afford to pay the premium.

I think there are only three broad answers—either have the government pay for part of the cost, somehow limit the cost of services, or pass more of the costs to individuals. And more than likely, it is going to be some combination of all of the above.

All reinsurance does is redistribute the exposure to loss by the insurance company. It does not lower the total cost. Conceptually, the ability of insurance carriers to lower their overall exposure to loss through reinsurance could cause more carriers to compete in the marketplace. With more competition, costs could be lower. It is a concept that needs to be explored more, just as your Committee is doing.

As Congress moves forward in developing effective legislation, we would like to make the following recommendations. First of all, we need to consider affordability as a key to availability. Number two, we need to clearly outline administration of the program, preserving state regulation. We strongly believe that state coverage, mandates must remain. Establishing financial soundness standards, including a structure of operative principles, is critical. It is not merely enough to have funding.

We must learn from past mistakes. ERISA is an example. ERISA needs to be fixed before anything else is piled on top of it. We need to operate outside of that.

PIA strongly advises that legislation moving through Committee be available for public vetting, and that before the concepts are implemented they are subjected to economic and operative modeling.

In closing, let me emphasize that what we are really discussing here today is how we go about delivering more high-quality health care to people who cannot afford to bear the full brunt of the cost. People who choose to work for America's small businesses should not be less able to have quality health care than people who work for large concerns.

Aside from the issue of basic fairness, such a situation places small businesses at a competitive disadvantage in the marketplace. Reinsurance should be a part, but only one part, of a number of potential solutions that need to be accomplished to make health insurance available and affordable to small businesses.

Thank you.

[The prepared statement of Mr. Harter may be found on page 47 of the Appendix.]

ChairwomanVELÁZQUEZ. Thank you, Mr. Harter.

Our next witness is Ms. Janet Trautwein. She is the Executive Vice President and CEO of the National Association of Health Underwriters. The National Association of Health Underwriters is a trade association for health insurance agents and brokers, representing more than 20,000 health insurance producers nationally.

Welcome.

STATEMENT OF MS. JANET TRAUTWEIN, EXECUTIVE VICE PRESIDENT & CEO, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

Ms.TRAUTWEIN. Thank you, Madam Chairwoman. I think I just want to go ahead and move right into—not talk about the things that others have spoken about today.

I want to talk a little bit about reinsurance and why we are talking about reinsurance. You know, what is reinsurance for at the most basic level. One of the major cost drivers in health insurance today are the expenses by a few people who either have chronic or serious medical conditions. In fact, 20 percent of the people who have these conditions actually produce 80 percent of the expense in any plan, regardless of the size of the case.

And that is why reinsurance is used. Spreading the risk in plans, particularly small employer plans, is difficult for insurers to do that, and that is why many insurers do buy reinsurance. I find that people are surprised when insurance companies reinsure themselves. That seems, you know, at odds with what an insurance company would do. But this allows them to be more competitive.

And what do we mean by "being more competitive"? That means they are offering a lower cost. And if they can reinsure part of that risk, it helps them to offer a lower cost to more employers. That is what being competitive is all about.

And I want to emphasize one thing about reinsurance. When a company reinsures or even an employer, large or small, reinsures, they don't reinsure for losses that they expect—they price for those. They insure for losses that they don't expect, that would be out of the range of things that would normally happen.

There are two basic types of reinsurance. There are actually many types, so I am going to oversimplify this discussion for those of my fellow panelists that would say, "Well, it is really more complicated than that." It is, but I am going to—for purposes of our discussion today, I want to break it down into two types.

Reinsurance can be bought on individual losses, against losses by an individual within a group, and then it can also be purchased for the losses of a pool of individuals as a whole. And there are a lot of calculations that go into how much reinsurance you buy. One thing I want to point out is that the amount of coverage purchased is never an arbitrary amount today, and it never should be, because the ability to absorb risk is very, very different from one group to another.

And when I talk about a group, I don't mean one small employer. I mean for an insurer, their group of small employers, or their group of a particular market, and that is who they reinsure. If they were to buy too much reinsurance because it had to be purchased at an arbitrary amount, that would be a huge waste of money and

would cause prices to go up, not down. So you don't want to throw dollars away there.

I do want to point out that there is a cost for reinsurance. We have mentioned this before. It is factored back into the premiums that people pay. There is a premium that insurers or employers pay for reinsurance, and it does help them be more competitive, but it is not free. And that is just an important component to keep in mind, that it is a rearranging of things, and it can lower costs, but sometimes it is just spreading it out differently.

I want to point out that some states have tried to assist small employers already by developing small employer reinsurance pools. There are about 19 of these pools in existence so far today. They have been marginally successful, primarily for two reasons. One is that they are very small, and most of the large carriers do not participate.

The reason why they don't participate is because the pools are set up with an arbitrarily low attachment point for the reinsurance, which is—they feel is silly to reinsure at that level and would be a waste of the dollars that could go towards paying claims for their customers. And so the pools have almost today been set up to fail. That old NAIC model needs to be changed, so that they could work more effectively.

There have been some ideas circulated about federal subsidies for the reinsurance market, all different ways—federal subsidies, state subsidies, any sort of assistance. The reason why these have been kind of popular concepts is that they actually—a subsidy would actually take away part of the cost, as opposed to rearranging it, like I was talking about a few minutes ago.

So, for example, a subsidy could be constructed so that it would actually reduce the amount of a reinsurance cost or reduce the amount of a claims cost that normally would have been calculated into figuring how much to charge people for their coverage. So it should force costs down in the market, if it were done correctly.

In closing, I have just a couple of key principles that I would say that you should adhere to on any reinsurance proposal, no matter what it looks like. If you were going to set up a subsidy, or even a program, you need to make sure that you set it up across a market, and that you don't segment a market. And so what do I mean?

If you are going to set up a reinsurance program, then it is for the individual market or it is for the small employer market, but not a part of that market. Now, it can be broader than that, but you don't want it to be only for people who buy in this pool or only for people to do that. If it is for the small employer market, it is for the whole market. Otherwise, you are going to eliminate coverage that is already available to people. So no market segmentation, very important.

The other thing, as I mentioned before, this issue about not using arbitrary amounts, make it flexible, so that people buy coverage that would be in excess of claims that they already expect, and then they are not insuring—being forced to insure too low.

And those are my primary issues. I think there are a lot of creative things that could be done. It just needs to be done correctly, so that you are doing something good instead of doing something that backfires on you.

[The prepared statement of Ms. Trautwein may be found on page 50 of the Appendix.]

ChairwomanVELÁZQUEZ. Thank you.

Our last witness, but not least, is Mr. Edmund Haislmaier. He is a Senior Research Fellow at the Center for Health Policy Studies, which is part of The Heritage Foundation. Before coming to The Heritage Foundation, Mr. Haislmaier was the Director of Health Care Policy in the Corporate Strategic Planning and Policy Division of Pfizer.

Welcome.

STATEMENT OF MR. EDMUND HAISLMAIER, SENIOR RESEARCH FELLOW, THE HERITAGE FOUNDATION

Mr.HAISLMAIER. Thank you very much. The Committee has copies of my testimony. I won't go into that in great detail. I would like, Madam Chairman, to just echo a couple of comments that were made by the other witnesses, because I think they are very important ones, and they are comments that I made in my testimony.

First off is the observation by several of my fellow panelists here that what we are discussing is transferring costs or rearranging costs or shifting who bears some of the costs. We are not talking about reducing the underlying costs. It is possible in theory in some designs to marginally reduce the costs through better case management. But by and large, we are not here to talk—this sort of mechanism does not reduce cost. What it does is it more equitably distributes the cost.

Now, there is a value to more equitably distributing the cost, and so that is something worth pursuing. But let us make sure that we are not under any illusions that we are going to have reductions in the cost of health care as a result of this alone. That is a topic for another hearing, I am sure.

The other point that I would like to make here is that while, as my fellow panelists have explained, there is reinsurance in the current market, and particularly for smaller carriers and employers, and those are the ones who feel the need to get it, because they are the ones for whom one or two incidences might tip the balance.

It takes a lot for a large insurer in any line of insurance to have a situation where there is a sort of perfect storm of bad events that results in the inability to cover all the claims. The smaller you get, the more likely that is. And so the more likely they are to purchase reinsurance in any particular line.

Now, that does get to a related issue, which I won't get into now, but I find it extremely questionable whether we should continue to operate on the premise that employers in the small business sector should be the principal organizers of health care. This is a model that may work, and still in some respects does work quite well for large employers.

But I think it is quite clear that there are enormous problems when we try to pretend that a business of 10 is really sort of similar to General Motors or General Electric. It is not in this area, and I think we are putting too much of a burden on them, and I think we need to devise alternative methods for their workers to get cov-

erage. That is, again, a separate subject. I would be happy to talk about it if you would like.

The other point that I would like to make here is we very quickly get into something that is a related concept, but I think a more relevant concept and a slightly different concept, and that is whether or not government should organize risk transfer pools. That is not pure reinsurance, as it is commonly understood, and I address that in the testimony.

Rather, it is a way of dealing with selection issues to ensure that the distribution of the costs associated with a small portion of the population that has higher than average expenses, that it is evenly distributed. Again, there is value in doing that.

Right now, we have a situation in which it is almost hot potato. People are trying to avoid certain costs. Whether they are employers or insurers, everyone—I like to say it is—we see this in pharmaceutical pricing. It is sort of the reverse Lake Woebegone effect. As you recall, in Lake Woebegone all the kids were above average. Well, everybody wants to pay below average. The problem is that is not only economically impossible; it is mathematically impossible.

So what would a fairer system look like? It would be one in which I think everyone would pay an average appropriate cost based on the general population. And if there were disparities, they would be evened out through a risk transfer mechanism. So, for example, if on average say 10 percent of the population is diabetic, and one insurer gets—15 percent of its business is diabetics, and another gets 5, there would be a redistribution through some sort of pooling mechanism.

Now, states, as Ms. Trautwein pointed out, have done some of this in the small group market. They have done more in the individual market—and her organization has written extensively on that—in high-risk pools. Again, the cost does not go away. It is simply spread out evenly. It is simply transferred.

So what that leads to is another point that Ms. Trautwein made, which is that if you have any kind of mechanism like this, you want it to be as broad as possible to encompass as much as possible of the market to be as fair as possible, and also to be as—to minimize any kind of disruption.

Now, I happen to think that given the state's role in regulating insurance, in general, and some of the work that they have done there, that this is principally an activity that the states ought to pursue and experiment. Also, because markets are localized, both for health care services and for health insurance, the Federal Government may be able to help.

When the state tries to do this, it does run up against an obstacle that depending on the state, you know, upwards of a half of its population is beyond the reach of the state, because they are in self-insured ERISA plans. And so it is in that context that states look to use mechanisms other than passing back to carriers the cost, such as provider taxes or general revenues, to, again, make sure that the costs are being spread not just only on half the population but on all of the population.

That is an area that Congress ought to look at. Should ERISA be amended, for example, to allow states with a qualified risk

spreading mechanism to require ERISA plans to participate in it? I am sure that will be controversial. But if you look at the logic of trying to spread all the costs—to spread those costs across all of the participants, there is reason to consider that.

I will stop there. I would be happy to answer the Committee's questions, and thank you for the opportunity to testify.

[The prepared statement of Mr. Haislmaier may be found on page 56 of the Appendix.]

ChairwomanVELÁZQUEZ. Thank you very much, Mr. Haislmaier.

Mr. Crouse, I would like to address my first question to you. As you know, large employers' plans are sometimes underwritten by captive insurance companies formed, owned, and managed by the employer. And these arrangements allow for the employer to collect premiums, pay claims, while still managing the risk of running a plan. Can you give us a little more detail as to the nature of a captive insurance arrangement and why an employer will use such a structure?

Mr.CROUSE. Basically, we are talking about a pure now, something—a captive that is owned by a corporation that is writing business for themselves or their affiliated companies. The simplest answer to that would be insurance costs. You take worker's comp, you take general liability, some of the property casualty lines, a large corporation will be paying premium based on a national average. In other words, those rates are set by, you know, whomever.

That corporation may feel that their experience in worker's comp, their experience for general liability, is much better than that of the national average. So they will form a captive insurance company. They will pay them to set it up. It is capitalized, it is the actuarial work-up, the whole—everything involved. And what that does, it basically lowers the cost of the premium that they are being charged for, because their experience is better than the average.

And what they can do, then, is they get that money, they invest that money, you know, they collect their own premiums. Basically, it is their company, and they have got the investment income from that, the admin costs are less. There is just a lot of reasons why it makes sense for a large corporation.

And in the health care, most of our large corporations that are writing their post-retirement medical benefits, these large, large corporations are doing that. That is mostly on the pure side. But those are some of the reasons why corporations do form captive insurance companies. It is a better way to have their insurance programs directly in front of them. They are basing their insurance experience on themselves, as opposed to a national average.

ChairwomanVELÁZQUEZ. So do you believe that captives or some alternative options or version could successfully be used in the small group market to achieve the success experienced by large corporations?

Mr.CROUSE. Well, that is a difficult—Madam Chairman, that is a difficult question. We have had experience with small groups. We have small groups in transportation. We have small groups—you name it. I mean, medical groups, dental groups, small railroads. I

mean, there is a lot of small groups that have been successful in doing this business.

In regards to health care, it is going to be a little bit more complicated. Basically, what we have seen, what we have done with the small groups that have done—tried to accomplish some of these benefits in the health care field, a lot of these companies, they are small companies. And the other panelists here are talking about the large pool and everybody in the country. Well, I really can't sit here and tell you that is what our concept does.

Our concept would help individual small companies pool and get together and basically, you know, accomplish what they have to accomplish. But it is safety—it is a health program. A lot of these companies that come in, they must have a program that is designed to work with their employees, safety programs, health maintenance programs. And, basically, as you know, it is discriminatory to charge a certain group less than the average.

So what they do after the experience is all over and done with, those insurers get money back, and that is how our programs work. And they have to be put together by somebody. They just can't say, "I am going to do this." As someone talked about the agencies here, there has to be a large agent company, a large life agent or somebody, get together, get out there and try to bring these people together with the concept that this will work.

And then, the actuaries have to come into it. The most important part of any program is the feasibility study done by the actuarial community. It has to make sense. It has to be sound. So, yes, it works. But the captive business would not be in existence today if it wasn't for reinsurance markets. There is not a captive out there that doesn't utilize the reinsurance markets.

ChairwomanVELÁZQUEZ. Thank you.

Mr.CROUSE. Whether it be pure, small groups, whatever, associations.

ChairwomanVELÁZQUEZ. Thank you.

Mr. Collins, if a small business wants to reinsure its own catastrophic health risk, it can either purchase coverage to provide protection against individual claims or aggregate claims. Can you tell me at what point reinsurance coverage generally kicks in, or, rather, what is the average attachment point for the health reinsurance policy?

Mr.COLLINS. The average attachment point for the individual claim level starts out at a low point, relatively speaking, if the employer is very small. And as the employer gets larger, the attachment point rises. And the decision about whether the level that the employer decides to purchase is generally up to the employer based upon their risk tolerance and how much risk they feel like taking.

Generally speaking, I would say that they do not self-fund their plan and buy specific and aggregate stop loss, which is what you are referring to, if they have less than 50 employees. So it is generally not much of an issue for very small employers.

ChairwomanVELÁZQUEZ. Thank you.

Ms. Trautwein, one way to make reinsurance more available to small businesses will be to encourage formation of pool purchasing arrangements. In order for this to work, this task will likely fall on established business groups, such as trade associations rather

than individual business owners. Are there any dangers associated with this option? And what, if any, precautions should be taken?

Ms.TRAUTWEIN. Well, I think you would have to be very careful about on the trade association side making sure it is bona fide trade associations that were not what we would call "shelf associations," that they really have been in existence for some other purpose for a period of time. And then, you have to be careful when you are putting together a pool as to how you do it.

There are lots of different ways that you could use these ideas, and you could create a pool to do it, or you could do it without a pool, but you could do it with a pool, and it may not even be reinsurance in the way that any of us are thinking about it as the table.

It might just be super catastrophic coverage with a very, very high deductible, and then a company perhaps could purchase more of a mini-med type policy, like Mr. Harter was referring to, and then the super catastrophic coverage would pick up after that. That is kind of a—that is a sort of reinsurance coverage, too, but certainly associations and other groups—a lot of different kinds of groups could facilitate that type of thing, but we would want to be very careful so that the public was not misled.

The worst thing is for some small employer to think they are covered, and then when it comes time for their large claim it is not. So I would just say some very careful consideration of that language.

ChairwomanVELÁZQUEZ. Thank you.

Mr. Chabot.

Mr.CHABOT. Thank you, Madam Chair.

Let us see, Mr. Haislmaier, if I could begin with you. You mentioned I think in your comments that what we are really talking about here is not necessarily reducing the overall cost of the health insurance itself. It is sort of shifting who pays for it and—

Mr.HAISLMAIER. Yes, as did some of the other panelists, yes.

Mr.CHABOT. Right, right. Now, if you are looking at something that really does reduce the actual cost of the health care itself, would an example of that be something like if you are looking at maybe the high cost of medical malpractice insurance, and proliferation of lawsuits against doctors and things, and the resulting practice of defensive medicine, where a lot of expensive tests are ordered in order to protect somebody from being sued, perhaps more tests than are really warranted. Is that an example of where you actually could bring the cost down itself?

Mr.HAISLMAIER. In some cases, that might be. I mean, some states have had those problems more so than other states. Some states have done liability reform in that area. It is a piece of the issue. There are a lot of pieces that go into the cost of health care. There are enormous variations in practice patterns that are documented that have nothing to do with, really, you know, lawyers or anything like that.

There are regulatory costs and the insurance—you know, sometimes the benefit mandates. Again, those are usually small pieces, but you add these things up together, there is—in a number of states you have very uncompetitive provider markets in some

areas. You know, for example, in Massachusetts health reform, one of the things I always point out to people, you know, when they say, "Well, could we do that in another state?" and I say, "Well, we don't have this—we have got this problem that Massachusetts doesn't have."

And I said, "Yes, but you don't have their problem." And they said, "Well, what was that?" And I said, "Well, they have got the least competitive hospital system in the country." You know, so a large part of what they were doing in reforming their system was to focus on trying to create competition at the hospital level, which is not an issue, say, in California or Washington State.

So, yes, it is a piece of it. There are a number of different pieces. And I think, frankly, that would probably be another whole hearing.

Mr.CHABOT. Okay. Actually, we did have a hearing somewhat related to that, but let me ask a couple of the questions. And there are a number of people that addressed this, and I would like to hear you maybe elaborate a little bit on it. You talked about one possibility—I think you, Mr. Harter, especially mentioned this, and I think you did, Ms. Trautwein, as well, the possibility of a federal subsidy is part of the solution.

Now, as kind of a conservative member of Congress, there is a lot of us that think that when the Federal Government gets real involved, especially if it is—I mean, the money isn't ours to begin with. It is being taken from your employees and taxpayers, etcetera. So if we would fund something like that, it is not free money, obviously. It is something to be considered, that these are tax dollars and we would have to take them to give them out.

So what is your idea relative to that? And our concern that if we are using federal dollars, in essence we are just taking it from one group and then subsidizing this. And I think probably, Mr. Harter and Ms. Trautwein, and then Mr. Haislmaier, I would like to have your comment on that, too.

Mr.HARTER. My personal opinion is there is going to be—there is a lot of pain to be passed around in the health insurance issue. As I have said before, there are many, many components that go into the issue. I think federal subsidies is one solution to it. I think it is a very painful solution.

I think we have to really get down to the nuts and bolts of working the system. As people like at the table here, it is not the presidents of companies doing this. It is people who are in the working trenches with these products and with what can pull this together, I think is where the solution is going to come. A lot of agendas have to be set aside I think to have a successful outcome for this very, very complicated problem.

Mr.CHABOT. Ms. Trautwein?

Ms.TRAUTWEIN. Yes. And I have to tell you that I share some of your concern about even mentioning the words "federal subsidy." And the reason I do mention it, though, is I don't believe that it has to be complicated with lots of strings attached. We have watched the subsidies for the high-risk pools that came through, not huge amounts of money for the federal high-risk pool program.

And you know what they have done? It is a simple grant program. There is one person at CMS that administers that. One per-

son. And they look at these grants once per year. The grants go out to the state high-risk pools. They have not changed any of the way that they do business, other than the fact that the rates that they offer people are lower.

They are dealing with the sickest of the sick, and reinsurance also deals with the sickest of the sick, and that is why I have modified my own ideas about it a little bit, because when we look at what is an appropriate role of government, you know, my personal belief is that it is for people that need help the most. And I believe it is—really, really sick people do fall into that category, and they do impact the costs for everyone.

And so that is the reason why I have modified my own viewpoints about that more than I would have a few years ago, because I have seen that it actually has been beneficial in this other program, and I wonder if maybe it couldn't help this market, too.

Mr.CHABOT. Thank you.

Mr. Haislmaier?

Mr.HAISLMAIER. Yes. I come back to my comment that we are transferring these costs, we are not reducing them, and that is true if you have either a state or a federal taxpayer subsidy going into them. And, again, it is just a transfer to somebody.

Now, given that, does it make sense on occasion to do that? Well, let us walk through the scenario. Let us say a given state decides to have a system that says, "Look, we are going—10 percent of our state is, as Ms. Trautwein pointed out, the sickest group. We want to spread their excess costs evenly among the other 90 percent."

All right. At that point, you can say, "Well, we will pass it all back through the insurers, in which case it gets added to their premium." But what if we can't reach all of them that way? Well, then, maybe a tax mechanism, a taxpayer funding mechanism might be a way to do it.

At a national level, what Ms. Trautwein pointed out was really a demonstration project, a block grant, of a limited amount of money to help states set this up. At a national level, one could, in theory, say, "Well, all right. That is fine and good for each state to do it. But what if one state has a population that is sicker than the national average? Then, we are going to sort of rebalance."

We do that in Medicaid, in effect, when we say, "Well, some states have a much higher poor population than other states," and then so they get more money in Medicaid than other states. In theory, that would work.

The caveat that I have on all of this, whether you are doing it at the federal or state level, is if you do put public money in, make it—do not make it any kind of entitlement, do not make it attached to any kind of revenue source, it should be a very clear, very specified and capped amount going into that, because you do not want to create a situation where you then have a new game, which is let us tag the Federal Government or the state government, if it is the state, with these costs and let us shift more and more and more onto the taxpayer.

So you just have to be—I mean, it is possible to do it. A number of states fund their high-risk pools partly out of public money. Some states do not fund them out of public money at all. It is all passed back to the insurance carriers. So it is possible to do it, but

you have to be careful that you don't get a game of tag going where the taxpayer gets tagged as it for more and more and more.

Mr.CHABOT. Okay. Thank you.

Madam Chair, if I could just ask one quick final question.

ChairwomanVELÁZQUEZ. Sure.

Mr.CHABOT. Mr. Harter, you had mentioned when you had your insurance agency that the costs were getting very expensive. I think you said they were about $500 a month per employee at one point, and you got a mini-med plan. Could you just give us, very briefly, what sort of coverage your employees would get under mini-med, and about what it would cost a small business owner?

Mr.HARTER. We are speaking in Missouri. That is going to be probably less there than it might be in New Jersey or somewhere like that anyway. A mini-med basically provides specified coverage. It does pay some for doctor's visits. It will pay up to—I think mine is $90. There is a $30 co-pay, and then it will pay up to $90 for a certain number of visits per year.

It is very, very weak in the hospital side of it. Ms. Trautwein was mentioning I think the mini-med might be a good vehicle for some of the fundamental coverage, but somewhere you still need that major medical. I think this program pays $1,500 for a hospital visit. Well, a hospital—

Mr.CHABOT. But not over? There is not like a catastrophic?

Mr.HARTER. It is not.

Mr.CHABOT. Okay.

Mr.HARTER. It is not. You would have to somehow be able to put a catastrophic on top of one of these mini-med programs. The mini-med—we have a couple of versions of it that people can buy, but it is basically $150, $175 a month. So it is pretty affordable.

Mr.CHABOT. Now, that is for the—that is the total cost, including the employee and the employer?

Mr.HARTER. That is correct.

Mr.CHABOT. Yes. Okay. Versus, say, $500 or—

Mr.HARTER. Absolutely.

Mr.CHABOT. Okay. All right. Thank you very much, and I yield back, Madam Chair.

ChairwomanVELÁZQUEZ. Mr. Jefferson.

Mr.JEFFERSON. Thank you, Madam Chairlady.

I want to see if we can get back to what I think the Chairlady had in mind when she put this hearing together. That is this: that one of the reasons for high costs among small business—for small business employers and employees is a lack of competitive.

And the notion is that if competition is introduced into the small business market, costs will go down for insurance. This is borne out by the notion that in larger enterprises costs are lower, because there are larger pools and there is more competition and more people who want the business.

So it is not a matter of whether the cost is shifted around or not. It is a matter of whether the idea of reinsurance will mean there will be more people willing to come into a marketplace and compete for business.

Now, the notion here is not so much whether—as I saw it in the Hurricane Katrina context, it was this. The question was: who, amongst insurance companies, had to pay? And that was a big

question of risk, and not the questions underlining risk for the folks getting sick and all of that. It was a risk the insurance company had to pay, and whether somebody else would have to pay.

And we saw it in the case where those who didn't—who had help in that—for instance, call names, State Farm had most of its outfit reinsured. Therefore, it paid claims quickly and rapidly because it wasn't paying the whole thing. Whereas, I feel like Allstate that is invested in the market, playing the stock market, and had investment insurance, found itself in terrible trouble having to pay everything, and ended up threatening to go bankrupt, and all of that.

So the question I have is: do you think there is anything to the notion that reinsurance may help to introduce competition in the small business marketplace, and, by that fact, lead to some cost reductions on the part of those who compete? Because the notion is—and the American economy is the best competition, there is likely to be cost reduction. Does that make any sense to anybody out there?

Mr.CROUSE. Mr. Jefferson, it does make sense to me. There is usually a little bit of savings when you have large numbers, there is no question. And, again, getting back to what this Committee has addressed here is small business and small business owners as opposed to the national health problem, health care problem.

I do believe that reinsurance can help. I believe also that it is very, very important. There is a lot of costs involved when you have a small business and you pay that premium to the health insurer. The cost that they use to administer that, the admin cost, it gets quite expensive.

There are savings that small businesses can make. If they structure something put together with a group, a fairly large group, they can cut the costs of administration, they can cut some of these costs that are—you know, that go along with these normal policies with large life companies.

And as far as reinsurance goes, what you point out, Mr. Jefferson, is true. I mean, most companies do retrocede some of their risk. In the case that you said of Katrina, they spread their risk as well as the first risk. The second person spreads, the third person spreads. I mean, retrocessions are done all the time, and most reinsurance companies do that.

So I do believe that the numbers to me—if you get a pool big enough, and you can show that you can save some costs by doing something yourself—again, put together by someone that knows what they are doing. This takes a little bit of talent out there from various industries to put these together. It can be accomplished. It can be accomplished.

And then, you have a bargaining chip to go to these reinsurers—these insurers for your health care. They may look at your program and say, "That is a well-run program. There are some cost savings there. Maybe my rates won't be as bad." I have seen that.

Mr.HAISLMAIER. Yes, sir, if I could make a couple of comments. First off, the example you cited with your state being hit by two hurricanes actually back to back is a classic example of why a commercial and property insurer will buy reinsurance. It is for exactly that unlikely eventuality. And as you pointed out, State Farm, you know, came out okay because of that.

I want to make a couple of points here as we think about this. One of the big issues that folks focus on with small business is the size and the idea of aggregating them. I mean, association health plans, this is another aspect. And it is just very important to understand that in any risk pooling arrangement in health care or anything else, size is only part of the equation. The other two factors are randomness and stability.

And when you consider saying the difference between 1,000 small businesses of 10 employees each and one employer of 10,000, the difference is not in the size, it is in the randomness and the stability of those two pools. So when we look at why larger employers maybe come out with better rates than smaller businesses, a lot of that has to do with the uncertainties surrounding not the size but the randomness and stability, which gets me back to my point of risk transfer.

Now, to address your question, Congressman, about does this—is there ways to make—to increase competition, yes, there are. There has been limited success, as Ms. Trautwein pointed out—and she can speak to that—in trying to do precisely that in the small group reforms. A number of states—as she pointed out, 19 of them—said, "Well, we will set up a voluntary reinsurance mechanism in the small group market as part of our small group reforms."

And that was designed to encourage smaller carriers to come in and compete against the dominant incumbent carriers, by saying, well, you know, you don't have to have the same capitalization to go up against them, because you can offload some of the risk. Because of the voluntary nature of that, I think it has had limited success.

Now, the next question then becomes: well, do we move to an all market risk transfer mechanism? That was what I was getting at in my testimony. Do we say that, fine, anybody coming in here, we are going to level the playing field in a given state for any insurer coming in. And as part of that leveling, we are also going to have a risk transfer mechanism, so that any insurer, big or small, can pass claims into that.

Those claims get pooled together and then re-spread based on how many lives everybody is covering. And that way, if there is any disparities where one carrier, big or small, gets a larger than average share of sick people, that can be made up out of the carriers that don't. Those are the kinds of risk transfer mechanisms that we are looking at.

But, really, for that to work you have to have as much of the market as you possibly can. At a minimum, as Ms. Trautwein said, you don't want to subdivide an existing market. Ideally, you want to aggregate together markets—individual, small group, larger group, etcetera.

ChairwomanVELÁZQUEZ. Ms. Clarke.

Ms.CLARKE. Thank you very much, Madam Chairman.

And to our panelists, your testimony has been quite interesting and quite informative. You know, it is quite evident that fewer insurers are offering health insurance coverage to small businesses because of their unusually high health care expenses. This fact compels us to examine whether or not the expansion of the private

insurance market may be an approach that will lower health insurance costs and reduce health care premiums for small businesses, thereby making medical coverage more affordable.

I am intrigued by the notion that by developing small business coalitions—excuse me, small purchasing coalitions known as reinsurance pools—among health insurers, or small business employers, it will spread the insurance costs among everyone in the purchasing pool. More importantly, it will spread the risks more fairly, so that one catastrophically ill, sick employee out of work for an extended period of time will not cause a small business' health insurance rates to propel so high that it bankrupts them.

My question to the panelists is that I am trying to understand whether, in fact, there is a way that we can establish fairness and stability in the health reinsurance market that is private for small businesses when it is very probable that at any given time premiums can rise due to market volatility.

And, you know, whether small businesses in the long term greatly need—we know that small businesses in the long term greatly need insurance rates to be stable. What measures can be placed—can be put in place to ensure that these rates will be stable over time? If folks on the panel could sort of address those two issues. You know, I am trying to get to solutions here. We have come up with so many variables, I am just trying to find the common denominator. Maybe we can start with Mr. Crouse.

Mr.CROUSE. Well, you are answering a direct question. How can we reach a point where small businesses' costs are going to go down? Again, the only solution that I talked about, or that I thought, was that if small businesses get together and form cooperatives in a sense that there may be some more purchasing power. In other words, again, there may be better buying circumstances for these corporations—small businesses, rather.

Other than that, ma'am, I don't—it is a tough, tough call. I just don't know.

Ms.CLARKE. Do you think that will ensure these rates will be stable over time?

Mr.CROUSE. Again, they should be stable over time. If you look at happened in med mal right now—and med mal is tied into health care in a way. To go back to what people said about, you know, the tort reform, it is working in some states, it has helped states do that, if you look at the med malpractice—I mean, the industry right now, the rates are down. It is softening up in the med mal area. That all should go back into the costs of health care.

So I just feel that possibly—again, possibly, that if you do form cooperatives, but there has to be, you know, again, small businesses. We are not talking about the whole universe here in the country. I am talking about small businesses that want to get together and do it right and set it up and have the health program—you know, things that must be provided—that there can be benefits. It can be well structured within small businesses.

And I say small businesses—I say possibly even in associations, associations that we have that have up to 5,000 members. And they formed a small captive insurance company to do just that. It is put together by an insurance agency, a large TPA firm in the life business. It is being handled by them. It has worked. We have had

feasibility studies. We have had legal opinions on it. It is structured, and it is working fine.

So there is reinsurance involved at the high end. They fund it with trusts up to I think it is 125 percent of—you know, of the premium or what not. But it works. It works. There are ways to do this.

Ms.CLARKE. Thank you, Mr. Crouse. Let me try to get—I see Mr. Harter there chomping at the bit, and I am running out of time. But I appreciate your comments, Mr. Crouse. Thank you.

Mr.HARTER. I think we are talking about one aspect of it. I think the other end of it is the cost of the medical services is driving that. We have to respond to that, and I think that is a factor in that—in the unpredictability of the premium cost. It is all of it together. It is not just one factor.

Ms.CLARKE. Thank you.

Thank you, Madam Chair.

ChairwomanVELÁZQUEZ. Mr. Sestak.

Mr.SESTAK. Thank you.

Sir, may I follow up on a statement you made about ERISA?

Mr.HAISLMAIER. Certainly.

Mr.SESTAK. You also made the comment that the importance of any approach, if you want to distribute the risk, is the larger the market, the better it is. My understanding is ERISA, I mean, probably impacts, if I am wrong—and I am not sure of this fact, but over 50 percent of our employers in the state. Is that correct? Or 65 percent?

Mr.HAISLMAIER. It would depend on the state, but roughly.

Mr.SESTAK. So if you didn't want to go about this reinsurance and redistribution, you are not going to be able to do it unless you potentially change ERISA—do it as well until you change—

Mr.HAISLMAIER. You won't be able to do it as well. That is true. There are some work-arounds you can do, but they are not perfect.

Mr.SESTAK. I guess Maryland has, you know, had its effort at risk of fail.

Mr.HAISLMAIER. At the state, yes.

Mr.SESTAK. At the state. To pursue this reinsurance, I mean, you also made a statement that—to a comment about tort reform, something about it is a piece of it. Are we doing good by just focusing on the reinsurance? I mean, everybody has already asked a lot of questions in that area, so I won't. That piece—or do we really have to approach it more holistically to do—to really do it well?

And I ask that because somebody, as I walked in—I think it was you, Mr. Collins, is, you know, you can—by doing some good, you may impact something else that is not as—goes beyond here. Must we capture ERISA this?

Mr.HAISLMAIER. I don't think it is absolutely essential that you capture ERISA in this. I am simply pointing out that if you want to go beyond what states are capable of doing, this is an area that you would have to get into federal law. I can give you an example of, in states that I have worked in, where we have designed some of these proposals. And they haven't passed yet but, you know, there are various proposals on this—setting up a state—an all carrier risk transfer pool.

And you say, "Well, all carriers are members. They have to participate. By virtue of being a participant, they have a right to see, and they set their own rules as to what the attachment points and the risk corridors are." Now, at that point you are getting about half the market. And then, you say, "Well, can we do anything with this ERISA piece of it?"

Well, one of the creative things we did is we said, "Well, look, we can't as a state—as state can't require those employers to come in and play in that system." But what it could do is it could offer—it could say, "Look, you can voluntarily come in. Of course, you don't want them to come in, dump their risk, and leave."

So we set up what we call Lloyd's rules, which says that if you voluntarily come in, you have to stay and make payments on the assessments for three years after you voluntarily leave. That is how Lloyd's of London works with their syndicates. You can't just leave when the losses come.

So that is kind of a work-around on that. I think if you went that far, you would make huge progress.

Now, is there—to get to your second question, is there value in doing just this piece? And the answer I think is yes, and let me explain why. To the extent that you have some sort of a mechanism whereby the unpredictable disparities in where these high risks pop up and who gets, you know, a disproportionate share, to the extent that you have a mechanism that evens that out for everyone, what does that do? Well, it takes off the table that issue. Okay?

So it says that we can now focus on other things, like the underlying cost of care, and we have taken away the ability for people to, you know, do the easy route, which is, well, I will, you know, bring premiums down by not having sick people. So if you take that off the table, then you have improved the market, in my view, to the point where people now have to concentrate more—

Mr.SESTAK. But is there a transfer, then, between those who are bound by ERISA and those that aren't still? Since the state can only impact the insurers, can't impact the employers under ERISA.

Mr.HAISLMAIER. That is right, and that is why states have looked at several mechanisms—

Mr.SESTAK. In other words—

Mr.HAISLMAIER. —to subsidize that pool out of—

Mr.SESTAK. If you don't mind, just to make sure I have it—

Mr.HAISLMAIER. Sure.

Mr.SESTAK. —to do what you just said, which I agree with, you would have to have a mechanism such as you described—which state did you do that for?

Mr.HAISLMAIER. Well, we originally drafted it for D.C., and this will come back and probably be considered by the Council again this year, as part of—

Mr.SESTAK. You would also have to have that mechanism taking place.

Mr.HAISLMAIER. We have done that in Maryland, too.

Mr.SESTAK. You would also have to have that—a similar mechanism to what you described put into place in order to make sure that the distribution is fair throughout everyone. Is that correct?

Mr.HAISLMAIER. It helps to do that, yes. Now—

Mr.SESTAK. So you would need to do the reinsurance and this mechanism.

Mr.HAISLMAIER. Well, what I am saying is that this is different from classic reinsurance. Classic reinsurance is a carrier saying, "Look, under normal circumstances, I am going to have losses, and I can cover them." What happens if there is an abnormal loss? What if I am writing commercial and property insurance in the State of Louisiana and we get hit with two hurricanes back to back? I am not set up to deal with that.

So in classic reinsurance, that is what you are doing is you are buying against the very unlikely event. That is why, in the life and health area, you don't see a lot of it unless it is a small company. I mean, you know, a New York Life doesn't need to buy reinsurance against the unlikely event that half its policyholders die in a year and claim—and their life insurance is claimed against. That is just, you know, the—I mean, you never say never in insurance, but the likelihood of that happening is near zero.

So that—does that help?

Mr.SESTAK. Yes, that does. Thank you.

Thank you, Madam Chair.

ChairwomanVELÁZQUEZ. Mr. Ellsworth.

Mr.ELLSWORTH. Madam Chair, if it pleases the Chairlady, I would like to—Mr. Jefferson brought up a point during one of the questions. I would like to yield to him if that is agreeable.

ChairwomanVELÁZQUEZ. Sure.

Mr.JEFFERSON. Thank you for yielding. I thank the gentleman for yielding. I thank the Chair for indulging me.

First, I didn't know whether everyone had a chance to react to the question that I asked earlier. And I don't know whether there was someone left to react to it; my time had run considerably. If there wasn't, I have another thing I want to ask, but I want to make sure that everyone responded to it first of all.

[No response.]

I guess so. Let me get to the other one. There are two issues here. One is the issue of cost, and which we have talked about. The other is the issue of access, which is basic choice for people in the business. And so the second question is whether this idea of reinsurance, which we hope would bring folks to the marketplace, would give a greater panoply of choices for small business folks as opposed to the panoply of choices that only folks have in larger enterprises.

That is the second question, which I will just—and I will ask—the one that follows up, which I intend only for Mr. Haislmaier, I believe it is, the last one, which is, you talk about the different ways to set up the mechanisms for—that risk transfer mechanism set up, exclusionary, inclusionary, and so on.

And you prefer, at the end of the day—I think you do—the inclusionary design. And you say, but you must ensure there are sufficient incentives in that design to make it work across the board and be fair to everybody. So I want you, at the end of the day, to comment on the examples of what you mean by these incentives, to make an inclusionary plan work that at the end of the day might lower cost.

But the first issue is about the access issue, and the effect of reinsurance on that, because our notion here is that with reinsurance we bring more folks to the marketplace, and, therefore, create better access for a panoply of options for small business folks who may not have them now.

Ms.TRAUTWEIN. Can I start?

Mr.COLLINS. Before you do, what I was going to mention regarding cost and access is that those two things tend to compete with each other. And the one parallel that comes to mind is when they enacted rate reform for small business insurance plans throughout the states in various ways back in the '90s, prior to that health insurance companies could, if they chose to, raise rates on a particular group.

When rate reform was installed, it limited the ability, depending on the state, on the level of rate increases, and, therefore, promoted more rate stability at an employer level, and it increased access through guaranteed issue and in many cases a maximum rate that you could give to a particular group.

What it did, though, as the offsetting cost of putting into that type of benefit for the market is it raised the overall level of health insurance costs for the entire small employer market. So the ability to increase access may be a noble goal, but the experience is that increased access will generally result in higher costs. And as a policy decision, you will have to be able to balance those two.

Ms.TRAUTWEIN. That is exactly the point that I was going to make as well, that you have to be careful in access. Even if you are talking about just adding additional types of policy choices, human nature is that people gravitate toward the one they are going to use the most. And you know what happens if your—the one thing that you are going to use the most, that means that it will—the cost will be abnormally higher on a particular type of plan.

And we have seen this in purchasing pools across the country in the pools that are already there. Some certain plans end up dropping out because they are selected against. So I just wanted to—

Mr.JEFFERSON. Thank you.

Before my time goes, Mr. Haislmaier, could you—

Mr.HAISLMAIER. Yes. By inclusionary and exclusionary, as I said in the testimony, it refers to these risk transfer mechanisms. Essentially, an exclusionary mechanism is one where we say, "Well, we have identified somebody who is high risk. We are going to turn them down. We are not going to cover them. They can only go over there and get coverage, and we are going to subsidize the coverage over there." That is how the individual high-risk pool works.

Obviously, they lack choice when you do that. The inclusionary mechanism says, "Well, no, the insurers have to take all these folks. But if they have high claims"—

Mr.JEFFERSON. Where in the standards did you—

Mr.HAISLMAIER. The incentives I was referring to in the inclusionary model are this. In the exclusionary model, there is the ability of that pool, on the plus side, to manage those costs, because they got everybody together, and they are the only plan. In the inclusionary model, each of these people stays with their primary insurer. So the incentive—and this is what the carriers will be wor-

ried about—is to say, "Well, those primary insurers each have to have a continuing incent to manage those claims costs."

That is why when insurers look at doing this inclusionary model, they want to see things like risk corridors. In other words, you are still paying 20 cents of every dollar, so you still have to—you are only ceding 80 cents of the dollars about X. So you still have an incentive to manage, to just not say, "Well, okay, I am not paying anything anymore. I have given it to the pool. And the cost—you know, I don't care about the cost." That is the incentives I am referring to in the inclusionary model.

ChairwomanVELÁZQUEZ. Mr. Johnson.

Mr.JOHNSON. Thank you. And I apologize for coming in late. But I am having a problem just understanding how reinsurance will lower the cost of insurance for small businesses, or any business for that matter, other than to the insurance company that might purchase the reinsurance. It might add to their bottom line to have—like State Farm, but if a business or a person purchases reinsurance, how does that lower their cost of insurance?

Mr.COLLINS. If a plan is in place to, say, have a federal entity take all claims greater than a certain level, what will likely happen in a reasonably competitive market is that the premium rates will go down accordingly.

Mr.JOHNSON. If you have a federal entity—

Mr.COLLINS. That simply takes on all medical costs over a certain level, if there is competition of some kind in the market, what will happen to the premium rates is they will go down by roughly the same percentage. However, the point that was made before was—

Mr.JOHNSON. In other words, that is assuming that the Federal Government would become the reinsurer.

Mr.COLLINS. Correct. That is correct. And then, the same would apply if it transferred to some other entity, whether a private insurer or—so if somebody—the point that we were making earlier is the total costs aren't going down. And if that is what you are thinking of, I think you are exactly right. The responsibility for the total cost is still going to need to be borne by somebody, and it is simply being shifted.

Mr.JOHNSON. So reinsurance is really not—is there anyone who disagrees with that premise that reinsurance does not lower the cost of insurance for small businesses?

Ms.TRAUTWEIN. I just think I should add something there. To the extent that reinsurance allows more players in a market, so that you have the ability to spread risk more broadly, then for any given employer, you might—it might result in a lower cost. That doesn't mean that if you added all the people up together that you are really getting rid of the cost, but any certain employers might experience a lower cost if it results in an injection of more competition, and, thus, more ability to spread risk across a whole market. Then, it could help. I don't know if people disagree.

Mr.HAISLMAIER. I mean, again, this is—I mean, Ms. Trautwein's point is you bring more people in, you spread it across-again, you are just—you are transferring. And this is a good thing, and it can be beneficial in the market, and it can create a more competitive market, induce new entrants into the market in terms of players,

which then might later, through other mechanisms, bring down costs. But in and of itself, it is not going to bring—I would agree, it is not going to bring down costs of the underlying health system.

Mr.JOHNSON. So, basically, you are saying if there are more reinsurers that could potentially make more—create more competition, if you will, or create more opportunities for various insurers to get in the business, that would then insure the people and cause costs to go down as far as policies.

Mr.HAISLMAIER. The value—and I was trying to explain this to—and, unfortunately, the other Congressman has left. The value that I see in this is, to the extent that you theoretically have a system that fairly distributes the excess cost of the small number of people that are sick.

Then, you have a market in which it is not a winning strategy to base your business on avoiding sick people and only insuring healthy people. To win in that market, you have to come up with a different strategy. What is the different strategy? Do a better job of making sure that people get better quality care at a better price. That starts to maybe lower cost.

So what you have done is you have taken away something that might be an obstacle, but you haven't affirmatively lowered cost. That has to come later.

Mr.JOHNSON. It seems that there might be some—it might be a good thing for the Federal Government to step in and subsidize health care for high cost, individuals with medical needs of a high cost in other words, to kind of bridge the gap, take some of the strain off of the health insurance industry. Is that—would any disagree with that?

Mr.CROUSE. Catastrophic losses, large losses, on the high end, the Federal Government come in at the high end. Those lines that you—you know, those losses you can't basically afford.

The business I am in here, the alternative market, the small company, small company market, you have a company, a group of small businesses that get together and form a captive or a group. They will fund up to a certain level. They will put in X amount of dollars, the expected level. The actuarial will do a study. They will have expected losses are such, and they will fund to that.

And then, they go out and they buy reinsurance on top of that. Now, to me, if that reinsurer looks at that company, and it is well run, and the expected losses in the actuarial's workup, you know, it looks good, then the reinsurance costs will be less. But, again, it has be a well run captive company, a small group, that keeps their costs down, all actuarially determined on their loss experience.

So, you know, in that sense, I would say—and I don't know if the panel agrees—but wouldn't reinsurance be less at the higher end if you retain some risks yourselves and doing a good job with it? That is the alternative market that I am talking about, that Vermont—we are in here. And that is why, as I say, you get a group of companies together, similar business, similar exposure, and they want to form a large group. And if somebody can run this for them, including themselves, and make it work, there is savings there.

But, again, as someone else mentioned, you have to have a plan where you are going to have these people health plans. I mean, in other words, programs where they are going to stay healthy, they are going to follow certain criteria. That is why this wouldn't work—this concept did not work for the universe out there, but it does work for possibly some good small businesses that want to lower the cost of their health care.

Mr.HAISLMAIER. I would simply observe, Congressman, that what you are suggesting has been proposed, and, again, it is not reducing costs, it is simply shifting it to the federal taxpayer. So the cost reduction comes, as Mr. Crouse points out, if somebody somewhere in the system does a better job of providing quality care at a lower cost.

Now, one can make the argument that pooling people together who are sicker than average and managing them better, you know, is one way to go. So, for example, you know, specializing and treating cancer patients and getting a better result at a better price. Yes, that will bring down cost. But to simply transfer those costs to, say, a federal program or a state program is not in and of itself going to do that. Again, it is just transferring it to somebody else's pockets to pay for. So—

Mr.JOHNSON. Well, I am trying to find some way of mitigating the tension between insurers and health care providers. Insurers put pressure on the health care providers to cut as much—cut as many corners as possible to make—or to decrease the number of claims. In other words, you have a claim, so, therefore, let us make sure that the doctors do not—and health care providers do not embellish upon the claims. Let us cut those health care costs in that way, and I think insurance companies are in that kind of posture, a natural tension between the health care provider and the insurance company.

But then, the sick individual or the individual who needs the care perhaps may not get the kind of—or the extent of care that they may need, particularly when they are in bad shape. So the Federal Government may be stepping in to take over in that kind of a situation. I think it is something that we should definitely consider, and I know that there are those who are opposed to Federal Government becoming more involved in paying for health care. And there are some valid reasons for that.

Mr.CROUSE. Representative, you are correct. You take doctors that are adding all these tests on. Medical malpractice premiums for doctors are astronomical.

Mr.JOHNSON. And, certainly, there has been not one shred of evidence that when you go into a tort reform kind of posture and limit the amount of non-economic losses that can be recovered, that it actually translates into lowering of premiums for doctors.

Mr.CROUSE. Well, I guess my point was, most doctors now, they are going to send you for every possible test imaginable, just to protect themselves.

Mr.JOHNSON. Well, isn't, though, it a good idea for doctors to—and this gets into the tension with the insurance industry. Isn't it a good idea for the doctor to be able to, as a—as a scientist or a professional to be able to test as far as he or she thinks is prudent

for a particular individual without regard to whether or not they are going to be adequately reimbursed?

ChairwomanVELÁZQUEZ. Mr. Johnson, time has expired, but I will allow for the witness to answer your question.

Mr.JOHNSON. Thank you.

Mr.CROUSE. There is no question what is prudent. I guess what I am saying is I feel, and what I have read, and what not, and seen, that I just think there are too many of these, you know, additional tests being ordered by doctors. What is prudent is fine, and that is what a doctor should do to a certain point. But I think they get a little paranoid. I mean, the lawsuits that are out there, Representative, in this country, they are astronomical.

Mr.JOHNSON. I think that the more doctors could do to be careful about patient options, and to be careful about the kind of care that they give, the better off they are and the patients. And it is—

Mr.CROUSE. But that adds to that cost of health care, Representative.

Mr.JOHNSON. I understand. I understand. We have got to trust—who do we trust, though, the doctors, the insurance companies? Who should be in control of that? That is the real question.

Mr.CROUSE. You are exactly right.

Mr.JOHNSON. Thank you.

Mr.HAISLMAIER. I have an answer.

ChairwomanVELÁZQUEZ. Maybe you will answer now.

Mr.HAISLMAIER. Sorry. That is why I would favor a more consumer-driven system where instead of the business picking the plan, the individual is picking the plan, and the plan then works for the individual, because there is a lot of ways to raise costs and cut costs that have nothing to do, as you pointed out, with the quality and the benefit to the patient.

And it is only when the insurance plan works for the patient that it has the right incentives to balance these factors when dealing with the providers. That would be a much bigger reform in health care, and this would just simply be an ancillary piece to help make it work.

ChairwomanVELÁZQUEZ. Thank you.

Mr.HAISLMAIER. Thank you for indulging me.

ChairwomanVELÁZQUEZ. Mr. Collins, I would like to ask you, you know, sometimes lawmakers call for the Federal Government to intervene if an industry is encountering financial problems or regulatory issues. If there is any indication that the reinsurance industry is facing problems, or has a history of defaulting on its claims?

Mr.COLLINS. I don't think I would be prepared to comment on the reinsurance industry as a whole. I would say that in the medical reinsurance component there is none of that history that I have seen or experienced. It has been a fairly vibrant and active reinsurance marketplace.

ChairwomanVELÁZQUEZ. Any other of the witnesses? Ms. Trautwein?

Ms.TRAUTWEIN. I agree. Exactly. It is a pretty healthy market.

ChairwomanVELÁZQUEZ. Okay. Mr. Chabot.

Mr.CHABOT. Thank you, Madam Chair. I will be brief.

Just in the response to the gentleman from Georgia's comment about the "not a shred of evidence" that medical malpractice reform

has resulted in any doctors' premiums coming down. I think California is an example of a situation where the premiums on the doctors were skyrocketing, and they passed medical malpractice reform, pretty comprehensive out there, and I believe the premiums on the doctors came down substantially and—

ChairwomanVELÁZQUEZ. If the gentleman would yield?

Mr.CHABOT. I would be happy to yield.

ChairwomanVELÁZQUEZ. And I also know, if I am not mistaken, that the contrary is true in Texas where they passed liability reform. So in order to bring premiums down, it has to be coupled, liability plus insurance reform.

Mr.CHABOT. But anyway, so maybe there are shreds of evidence on both sides, depending on the particular state and how they dealt with it. But anyway, I just—I didn't want to let that go unresponded.

[Laughter.]

So I also, then, just wanted to conclude—and just—I said this in my opening statement and some of my questions. I have to say, I am very leery of federal subsidization for virtually anything, and not that it is never warranted, but I am always going to be very leery of it and hesitant to do it. And so, anyway, I just wanted to mention that in this case, although I certainly appreciate that point of view and would be willing to look into it.

But, finally, I just want to, once again, comment the Chairwoman for meeting her—what she said she was going to do. You know, she said at the beginning when she took over as Chair of this Committee that she was going to leave no stone unturned when it came to doing whatever we could to reduce health care costs to the small business community, and this is yet one again hearing where I think we are looking maybe to some degree at the minutia, but reinsurance is probably not a term that every American is familiar with.

But I believe those of us on the Committee that were here today are more familiar with it—you know, what it actually means and how it affects insurance and the ability to provide the health care to small businesses, and, most importantly, to their employees.

So I want to, again, compliment the Chairwoman for calling this hearing, and I want to thank the very informative panel here this morning for their testimony.

And I yield back.

ChairwomanVELÁZQUEZ. Thank you, Ranking Member.

And the truth of the matter is that this Committee has played an important role in addressing the issue of health care crisis in this country, especially when we know that a large number of the people that are uninsured in this country are either small businesses, their employees, and their relatives, and to look at solutions. This is a very complex issue. We will continue to hold hearings, to listen to everyone, to see if we can come up with maybe not the solution, but look at ways where we can bring premium costs down.

So I ask unanimous—I want to take the opportunity to thank the witnesses. This has been a very insightful hearing. I ask unanimous consent that members have five days to enter statements and supporting materials into the record. Without objection, so ordered.

This hearing is adjourned.
[Whereupon, at 11:44 a.m., the Committee was adjourned.]

STATEMENT
of the
Honorable Nydia M. Velázquez, Chairwoman
House Committee on Small Business
Hearing on Expanding Small Business Health Insurance Coverage Using the Private Reinsurance Market
May 24, 2007

This hearing on expanding small business health insurance coverage using reinsurance in the private market is now called to order.

It's no secret that small employers are finding it difficult to purchase health insurance. However, what is less well known is that fewer carriers are offering coverage in the small group market.

In 2006, the Government Accountability Office reported that in a typical state, the largest insurer controlled 43 percent of the market—up from 33 percent in 2002. In nine states, the largest carrier held more than 50 percent of the market.
Consolidation in the insurance industry has made it difficult for smaller insurers to compete and a number have dropped out altogether. The lack of insurers helps explain why small employers can pay as much as 20 percent more than their corporate counterparts for the same health plan. Without competitive forces, insurance companies can dictate prices.

Today's hearing is the second in a series held by the committee to address the issue of providing affordable health insurance for small businesses. This morning we will look at the state of the reinsurance market and whether there are ways to expand the use of reinsurance to provide more health insurance options for small employers.

Currently, reinsurance is used by insurers and businesses alike to retain risk, increase financial flexibility, and limit exposure to catastrophic costs. The question before this Committee is whether this model is a viable option to address one of the major cost drivers in the health care market, lack of competition.

First of all, I think it is important to examine whether more insurers could compete in the states if there were better access to reinsurance. Currently, many carriers are being locked out of the market by large insurance companies that are using near-monopolistic powers. I believe better access to reinsurance can get at this problem. Simple economics says that if more carriers are able to sell policies, increased competition could help bring down prices.

Second, the committee will consider whether it is feasible for small businesses to purchase reinsurance directly from a reinsurer. Typically, only insurance companies and large employers buy these policies to cover catastrophic claims. Small employers simply do not have the resources to purchase this type of policy on their own. The issue is what changes to our laws, if any, would make it possible for an entrepreneur to purchase such re-insurance coverage.

I would like for witnesses to comment on whether collective arrangements would allow small employers to buy reinsurance. Too often, we hear the excuse from insurance companies that they can't offer small employers coverage or have to charge exorbitant prices due to the risk factor. If we can eliminate this argument, small businesses can start negotiating rather than simply accepting health insurance prices.

While this may seem like a unique approach, the depth of the problem requires us to look at all our options. If we fail to do anything, costs will continue to rise, more individuals will find themselves uninsured, and the growth of America's economy and small businesses will come to a halt.

We have with us today a distinguished group of witnesses, well-equipped to help us understand the reinsurance market and whether it holds the key to expanding small business health insurance coverage.

This committee's goal is to ensure that health care reform does not occur without meaningful consideration of impact on this country's small business and the workers. I am pleased that witnesses are here today to share their insights and I look forward to today's testimony.

Opening Statement

Hearing Name	Expanding Small Business Health Insurance Coverage Using the Private Reinsurance Market
Committee	Full Committee
Date	5/24/2007

Opening Statement of Ranking Member Chabot

Madam Chairwoman, thank you for holding this hearing on expanding small business health insurance coverage.

At the center of our examination are the issues of cost and access. As we all know, purchasing health insurance is one of small businesses' most costly expenses. According to The National Federation of Independent Business (NFIB), health care is the "most severe problem for small business owners" – greater than taxes, cash flow or government regulations.

Small groups (including small businesses) usually pay more for similar or less coverage than large businesses. As a result, small businesses are less likely to offer health insurance than large firms. Not surprisingly, the principal reason given is that the small business could not afford the coverage.

Access to health insurance is also a challenge for small businesses. According to the Small Business Administration (SBA), employees with small firms are far less likely to have health insurance than those at larger ones.

Ensuring that health care is affordable for small businesses is one of the most important issues Congress can address. Our nation's small businesses drive the economy, and we need to do all that we can to help them stay competitive and encourage their growth.

Association health plans, pool purchasing and reinsurance have been mentioned as ways to help reduce the cost and increase access to health insurance for small businesses. I am pleased that we will consider reinsurance during this hearing. Although I have reservations about the implications of a federal mandatory reinsurance program, I think reinsurance deserves further examination.

I also believe that tax relief is an important way to reduce the overall tax burden and to make healthcare more affordable for small businesses. In previous Congresses, I introduced the *Health Care Affordability Act,* which would allow every American to deduct 100 percent of the cost of their health insurance. I plan to introduce this bill (or a similar bill) in the near future.

Madam Chairwoman, I appreciate your holding this hearing. I look forward to hearing from our witnesses, and to working with you on finding ways to make health care more affordable for small businesses and their employees.

I yield back the balance of my time.

Statement of Rep. Jason Altmire
Committee on Small Business Hearing
"Expanding Small Business Health Insurance Coverage Using the Private Reinsurance Market"
May 24, 2007

Thank you, Madam Chairwoman. I appreciate your commitment to exploring innovative ways to address rising health care costs. Prohibitive health care costs threaten small businesses and entrepreneurs more than any other problem they face.

Helping entrepreneurs manage health care costs is one of the greatest challenges this Committee will address. It is also one of the most important things we can do for the long term growth of the American small business economy.

The reinsurance market may be an attractive option for helping to control costs and allow small businesses to offer affordable coverage. I look forward to hearing our witnesses' views on this possibility and working with the Committee to provide real relief to small businesses.

Again, thank you, Chairwoman Velazquez, for holding this hearing today. I yield back the balance of my time.

# # #

Statement for the Hearing "Expanding Small Business Health Insurance Coverage Using the Private Reinsurance Market"

May 24, 2007

Submitted to the
Committee on Small Business
United States House of Representatives

By

Leonard D. Crouse, CFE
Deputy Commissioner of Captive Insurance
Vermont Department of Banking, Insurance, Securities and Health Care Administration
Montpelier, Vermont

Chairwoman and Members of the Committee:

Good Morning, I'm Leonard Crouse the Deputy Commissioner of Captive Insurance for the State of Vermont. I've been in insurance regulation for 35 years, first with the Massachusetts Department for 19 years now 16 years as head of the Vermont captive insurance area.

When I came to Vermont in 1992, the state had fewer than 200 captive insurers. We've grown. Vermont passed its captive enabling legislation in 1981 and we have since licensed over 800 captive insurers, with approximately 565 currently active. Captive insurers licensed in Vermont wrote premium of $11.5 billion during 2006 and maintained assets of $103 billion.

Captive insurance is a highly specialized form of self-insurance. A captive is a licensed, regulated insurance company formed to insure the risks of its owners. There are currently over 5,000 captives licensed worldwide.

Captive insurers provide an alternative to the commercial insurance market. Captives are generally formed when commercial coverage is not available, or not available at a reasonable price. Captives are formed when the commercial premium is too high in relation to the claims experience, or the when the commercial premium is artificially raised and lowered each year by market swings.

A. The Benefits of Captive Insurance

Companies forming captive insurers generally realize lower costs, stable pricing and the ability to receive a policy that meets its needs.

Commercial premiums are based on the cost of claims, administrative costs, profit, and market competition. Companies forming captives feel they can better estimate their own claims costs, lower administrative costs and adjust the required profit to suit their needs.

Captives should not be subject to market conditions. Captive owners should realize the captive is theirs and will benefit them in the long run. Commercial insurers may under price policies in one year then swing in the opposite direction the next. A good captive will adequately price its coverage each year maintaining stable pricing.

Profits generated by a captive belong to its owners. These profits can be used for dividends or to provide the surplus to expand coverage.

B. Regulation

Captives are licensed in a single state, or country. Approximately thirty states have captive enabling laws and approximately 1,000 captives have been formed and domiciled in the U.S. These captives are regulated primarily by one domicile regulator, which keeps regulatory compliance simple and reduces administrative costs. Most domiciles require annual or quarterly reporting, annual independent audits, independent actuarial studies and periodic state examinations.

C. Captive Insurance as Solutions

Captives are small and nimble and can react quicker than the commercial market to fill sudden needs. An example is the medical malpractice problem in the beginning of this decade. For whatever reason, and all sides have a reason, commercial insurers pulled out of the med mal market and those that remained increased the price. Some hospitals and groups of physicians with a very low loss history were paying premium on par with hospitals and physicians with a high loss history.

These "good" hospitals quickly realized they had to find a better answer than stay in the commercial market. They took their money out of the commercial market and formed captive insurers. They engaged actuaries to predict their future losses; hired loss prevention specialists to keep their claims low, and now are in charge of their own destiny. As long as they can keep losses within a predictable range, their premiums should now be predictable from year to year.

Today, Vermont has approximately 90 captives providing medical malpractice coverage with premiums around $1.5 billion.

Vermont recently licensed a captive to insure liability risks of short-line railroads. These small companies had banded together for many years to purchase coverage from the commercial market. However, being the only group in the country and so specialized, the commercial market was indifferent to the group. They frequently were forced to change carriers. The captive insurer will put and end to the changes, allowing the members to own an insurance company that understands their risks.

Captives are also being used in other new areas such as employee benefits and terrorism, and possibly pensions.

Captives started out writing very predictable lines of coverage, workers comp, general liability, and professional liability with captives retaining a low amount of risk. Over the years as the industry became more sophisticated and more comfortable with captives, other lines were added such as property, earthquake, asbestos, various forms of bonds, Directors and Officers coverage and many other lines.

D. Captives and Health Insurance

Vermont has licensed almost 20 captives that provide health care. Very large corporations formed most but three have recently formed for smaller groups of employers. These three captive insurers have used different forms of captives but have commonalities:

1. The employer remains responsible for the actuarially expected claim volume,
2. The captive provides for a buffer layer above the expected amount,
3. The captive provides for, and then reinsurers the catastrophic layer to the commercial market.

Using these formations as a guide, the employer pays for the expected claims but pools the risk above this layer, sharing with other employers. These captives save money for their members by requiring participation in wellness programs, lowering administrative costs, and pricing with lower profit in mind.

Use of health care in captives is still in its infancy. I think this is for a few reasons:

1. Captives are known mainly among Risk Managers and not Human Resource Managers. Since the Risk Managers deals with mainly property & casualty risks and not employee benefits, captives have been used mainly for property & casualty risks,

2. Most of the risk insured with captives today, are the captive owners own risk. If something negative happens to the captive, it is the owner that is harmed. By including health care for employees in a captive, the actual employees could be

harmed. However, there are things that can be done to help ensure the claims get paid,

3. Most small businesses are unfamiliar with captive insurance and could not meet the funding required to form a captive alone. Outside effort would be needed to gather a group of small business together to plan and establish a captive program.

Conclusion

Captive insurers have helped many companies take control of claim costs, save money and stabilize their insurance budgets. Captive insurers are just beginning to help in the health care arena.

Thank you for the opportunity to discuss Vermont's experience and the captive insurance industry.

AMERICAN ACADEMY *of* ACTUARIES

Committee on Small Business
U.S. House of Representatives

Hearing on
Increasing Competition, Reducing Costs, and Expanding Small Business Health Insurance Coverage Using the Private Reinsurance Market

May 24, 2007

Statement of
Patrick L. Collins, MAAA, FSA
Chairperson, Medical Reinsurance Work Group
Vice Chairperson, Committee on Federal Health
American Academy of Actuaries

The American Academy of Actuaries is a national organization formed in 1965 to bring together, in a single entity, actuaries of all specializations within the United States. A major purpose of the Academy is to act as a public information organization for the profession. Academy committees, task forces and work groups regularly prepare testimony and provide information to Congress and senior federal policy-makers, comment on proposed federal and state regulations, and work closely with the National Association of Insurance Commissioners and state officials on issues related to insurance, pensions and other forms of risk financing. The Academy establishes qualification standards for the actuarial profession in the United States and supports two independent boards. The Actuarial Standards Board promulgates standards of practice for the profession, and the Actuarial Board for Counseling and Discipline helps to ensure high standards of professional conduct are met. The Academy also supports the Joint Committee for the Code of Professional Conduct, which develops standards of conduct for the U.S. actuarial profession.

Thank you Madame Chair, Ranking Member Chabot, and distinguished committee members, for inviting me to testify on the current medical reinsurance market, under what conditions reinsurance might provide for the expansion of small business health insurance coverage, how businesses utilize reinsurance to manage their risk, and alternative reinsurance arrangements employers use to control catastrophic health care costs.

My name is Patrick Collins, and I serve as the chairperson of the American Academy of Actuaries' Medical Reinsurance Work Group and vice chairperson of the Academy's Federal Health Committee. The Academy is the non-partisan, public policy organization representing actuaries of all specialties in the United States.

On behalf of the Academy's Reinsurance Work Group, my testimony will first provide a brief description of medical reinsurance in order to introduce basic terminology and provide a framework of reference when discussing reinsurance proposals. And then, it will outline the issues recommended for policymakers to consider when designing and implementing a reinsurance program.

Medical Reinsurance

Simply put, reinsurance is insurance for insurance companies. It is a mechanism whereby one party transfers a portion of its insurance risk to another party. The insurer, or the entity that is transferring or ceding the risk, is called the "ceding" company. The reinsurer, or the entity that assumes the risk, is called the "assuming" company. To make this transfer occur, both parties (typically an insurer and reinsurer) enter into a reinsurance contract.

Under a reinsurance contract, the assuming company agrees to reimburse the ceding company for losses, typically referred to as "reinsurance claims." In medical reinsurance, losses may fall into one of three categories:

- Claims: These are medical claims incurred and paid by the ceding company under the insurance polices that are reinsured.
- Claim adjustment expenses: These are expenses that are incurred by the ceding company to help reduce overall medical claims. For example, a ceding company may agree to contract with an outside party to negotiate a lower price on a claim. The outside party requires a fee for its services, which would be considered a claim adjustment expense.
- Extra contractual obligations: These are court-ordered judgments against the ceding company.

The reinsurance agreement should clearly spell out the term of the reinsurance agreement from the date of inception to the date of termination. Losses occurring during this reinsurance agreement term will then be reimbursed by the reinsurer. Ceding companies pay premiums to the reinsurer, which include provisions to cover reinsurance losses, expenses, and risk margin.

Compared to the health insurance market as a whole, the commercial medical reinsurance market is very small. Reinsurance is typically purchased by small to mid-sized insurers who are primarily looking for

ways in which to manage their risks. A similar coverage, called "stop-loss" insurance, is purchased by small to mid-sized self-funded employer plans for similar reasons. The largest entities that assume medical risk today, whether large health plans or large employers, do not currently purchase any type of protection against large medical claims.

Why do entities buy reinsurance?
There are a number of reasons why an insurance company may want to buy reinsurance, and I address some of those briefly later in this testimony. However, the overriding consideration is that this transaction (similar to an insurance transaction) protects the purchaser from unforeseen events. Financial success in the insurance business requires much more than being able to understand and manage statistical risk. There are numerous other business risks to consider. In addition to helping with statistical risk, a reinsurer can be a type of business partner or consultant, providing additional services and insights to help insurers better understand and manage their business:

- Financial protection: Reinsurance can help insurance companies control their exposure to losses. Whether these losses are on one individual, a series of individuals, or an aggregate block of business, companies may wish to limit their exposure and thereby stabilize their earnings.

- Increased capacity: A smaller insurance company may not wish to or be able to absorb large-dollar individual risks. By purchasing reinsurance, a company may be able to offer individual limits in amounts similar to their larger competitors. By passing losses (and therefore risk) to another entity, the insurer may be able to reduce the amount of surplus that is required to allocate to that particular line of business. Reducing required surplus will enable an insurer to improve its overall balance sheet position and may free up capital to allocate surplus to other lines of business or for other investments.

- Expertise and services: Reinsurers also offer resources to help insurers manage their business. By taking advantage of these resources, insurers may be able to obtain a more competitive position in the marketplace. These resources include, but are not limited to, expertise or services regarding: product design and development, market research, claims services, care management services, underwriting, pricing, rate development and management, reserve valuation and financial management, compliance services, and distribution design and management.

Reinsurance and stop-loss insurance for self- insured plans
To this point, the discussion of reinsurance has been limited to a traditional reinsurance agreement between an insurance company and a reinsurer. In the employer group benefit market, there is a similar structure known as stop-loss insurance. While this is not technically reinsurance, stop-loss insurance is similar in many ways to specific and aggregate excess-of-loss reinsurance.

As an alternative to purchasing a fully insured product, an employer may choose to set up a group benefit plan for its employees. An employer has a number of advantages when taking this approach, including financial flexibility and the ability to custom design plans to the needs of its employees. Sometimes, this plan is referred to as a "self-funded" or a "self-insured" plan because the employer (instead of the insurance company) is responsible for paying the benefits to the employees.

Many employers who offer a self-funded medical benefit plan to their employees, particularly small to mid-sized employers, choose to buy an insurance policy that provides stop-loss insurance protection against individual or aggregate claims. There are two common forms of stop-loss insurance, which are analogous to excess-loss reinsurance. Specific stop-loss insurance provides protection against individual claims above a pre-determined specified amount called the specific deductible. Aggregate stop-loss insurance provides protection against claims exceeding a total amount of claims going over a pre-defined threshold – i.e., the attachment point. A common aggregate stop-loss attachment point is 125 percent of expected claims in a given time period.

In a stop-loss insurance context, the employer plan acts as the insurance company and the stop-loss insurance company acts as a reinsurer. The employer plan effectively cedes certain losses to the stop-loss insurer.

Considerations for Designing and Implementing a Successful Medical Reinsurance Program

Whether a medical reinsurance program would meet its goals depends on various factors, including the specific design features and claim management provisions. The following are common considerations that need to be addressed when designing and implementing a reinsurance program, regardless of the source (e.g., government-sponsored or a private-market arrangement).

What are the objectives of the medical reinsurance program?
Developing clear objectives for a medical reinsurance program is an important step toward designing a program that has a high probability of achieving these objectives while minimizing the change of unforeseen or unintended consequences. Developing clear objectives will also help to design effective tools to measure whether these goals have been met.

Some of the objectives of reinsurance would include, but are not limited to:

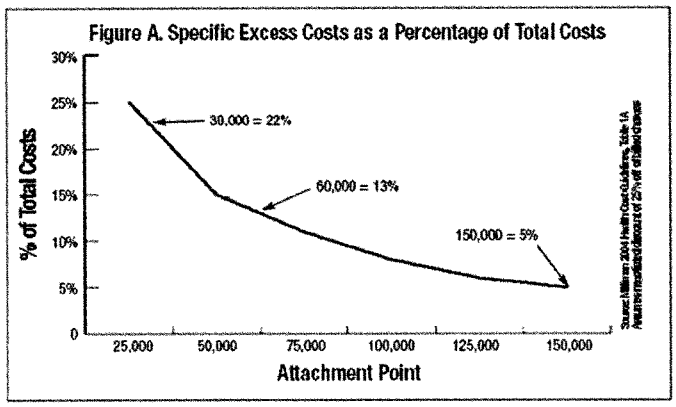
- Lower premiums: By reimbursing plans for high claims, a primary goal of the program is for health plans to pass along this cost reduction to policyholders in the form of reduced premiums. Some refer to this reduced premium as a "savings" to policyholders even though there may be no net reduction in overall health care expenditures.

- Increasing Competition: By absorbing large individual losses, it is hoped that the reinsurance program would promote more premium stability due to less dramatic premium increases from year to year. Reducing risk and improving stability, could also increase competition and innovation in medical insurance.

- Expanding Health Coverage: As a result of lower and more stable premiums, it is hoped that coverage will become more affordable to both employers and individuals, thereby expanding small business health coverage and reducing the number of uninsured.

What is the impact on cost?
The extent to which reinsurance can reduce a plan's costs depends, in part, on the reinsurance attachment point. The lower the attachment point, the higher the potential savings. Figure A presents an example of how excess claim costs as a share of total claim costs (i.e., the share of claims that would be

covered by reinsurance) vary by attachment point. In this example, an attachment point of $150,000 would reduce a plan's claim costs by 5 percent. Looked at another way, an attachment point of $150,000 would imply that the reinsurer would be responsible for 5 percent of claim costs.



Lowering the attachment point to $60,000 would increase a plan's savings (or the reinsurer's costs) to 13 percent of the plan's claim costs. Lowering the attachment point to $30,000 would further increase a plan's savings (or the reinsurer's costs) to 22 percent. Note, however, that this is just one example of how reinsurance costs would vary by attachment point. Although other data sources would likely reveal similar patterns, the specific savings at different attachment points could vary significantly using different data.

Reducing claim costs would, in turn, reduce premiums, although the costs of administering reinsurance would lessen these savings. A reinsurance program would result in a one-time premium savings only. Transferring losses from a health plan or insurer to the government would not reduce overall health cost trends unless measures are taken to encourage plans to further manage costs. The existence of reinsurance programs could provide an incentive for insurers to reduce cost controls for large claims. Therefore, policy-makers should consider the impact of a reinsurance program on total health care expenditures. Would the incentives intended through such a proposed reinsurance program lead to decreased cost management? If overall expenditures were to increase as a result of the reinsurance program, the premium savings would be reduced.

Will the attachment point be increased over time, and if so how?
The cost of a reinsurance program would increase at a rate faster than underlying medical trend due to the leveraging effect of a fixed attachment point. That is, costs of the program would increase not only because underlying medical costs would increase, but also because more claims would exceed the attachment point. Over time, this leveraging effect would increase the costs of the program substantially, and therefore, the costs to a reinsurer would also increase. An option to mitigate this effect would be to

increase the attachment point annually by: the increase in the Medical Consumer Price Index; the increase in health spending; or some other measure of health cost increases.

How would moral hazard be minimized?
If reimbursement is based on actual amounts paid by insurers and self-funded plans, the payers probably would alter certain behaviors (e.g., provider contracts, cost-saving measures) as they will no longer be responsible for the catastrophic costs associated with individuals or groups covered by reinsurance. Options to mitigate this effect (known as "moral hazard"), to varying degrees, include:

- Reimbursing payers based on reinsurer-defined nominal costs per service (e.g., Medicare fee-for-service payable amount)
- Requiring coinsurance amount from payers, thereby keeping a portion of the catastrophic claims as the payers' responsibility
- Reimbursing payers based on a risk adjuster or other predictive model (e.g., the CMS-HCC (Hierarchical Condition Category)
- Requiring payers to have in place cost-containment measures, such as disease management, in order to participate in the pool.

Would participation in the reinsurance program be voluntary or mandatory?
A program could be voluntary or mandatory. If the program was made voluntary, it would need to be determined what stratum the decision would be made on. There are several choices:

- Insurer stratum: Under this option, insurers who opt to participate in the reinsurance program would be required to do so for all of their health plans, not just select groups.
- Employer group stratum: Under this option, insurers could determine to enroll employer group plans on a case-by-case basis, enrolling some groups, but not others.
- Individual employee stratum: Under this option, insurers could determine to enroll particular employees (and any dependents) on a case-by-case basis, enrolling some employees, but not others.
- Individual insured stratum: Under this option, insurers could determine to enroll particular insureds on a case-by-case basis. This differs from the employee level above, because the insurer could choose to reinsure only a dependent, but not the employee.

If participation in the program was mandatory, it could apply to:

- All health plans
- All self-insured health plans
- All health plans, excluding those that are self-insured
- All health plans with less than some fixed number of members
- Some other subset of health plans

What types of services are eligible for reimbursement?
Different insurance plans will have different benefit packages, covering different services. In addition, some benefit packages will be more generous than others. As a result, it is important to define what services are eligible for reimbursement under the reinsurance program. Options include:

- Medicare/CMS reimbursement policy
- Reimbursement based on the underlying insurance plan

How should the accumulation point be defined?
Most reinsurance arrangements are based on one year's claims, but it must be determined how this is defined. Options include:

- Reimbursing payers on a "paid-claims" basis, that is, based on all claims pad by the insurer during the year
- Reimbursing payers on an "incurred-claims" basis, that is, all claims for services received by the insured (and thus incurred by the payer) during the year

How would geographic cost factors be addressed?
If a reinsurance program is created at the federal level, geographic cost differentials may result in different subsidies for different geographic areas of the country. Because health care costs are high in some parts of the country, due to both cost per unit differences and utilization differences, a fixed attachment point could result in insurers in low-cost areas subsidizing insurers in high-cost areas. Ways to mitigate this potential problem include:

- Adjusting the "national-average" attachment point based on Medicare geographic cost factors
- To the extent that the program is financed by assessing participating insurers, calculating the assessment on a statewide or regional basis, rather than across the entire federal program

What issues should be taken into account for a reinsurance program at the state level, the federal level, or for a program that has both state and federal elements?
Issues that would need to be considered include the interplay of state regulations and ERISA with the reinsurance program, how current state high-risk pools and other state reinsurance programs would be impacted, issues unique to multi-state employers, and the desirability of uniform benefits and procedures.

What other considerations should be addressed?

- How would the reinsurance program be administered? Through a government agency? Through the states? Through private reinsurers? Through a partnership or combination of public and private entities?
- Would premiums from insurers and self-funded plans be required for participation in the reinsurance program? If so, how should these premiums be determined?

Conclusion

Designing a reinsurance program that attempts to reduce health care premiums, increase competition, and expand small business health insurance coverage is a worthwhile goal. Though reinsurance does not reduce overall health costs by itself, a reinsurance program that addresses the issues described above could help meet these goals if it is designed properly and incentives for all parties involved are properly aligned.

Thank you for your time and consideration, and I welcome the opportunity to answer any questions or assist you as you move forward with your consideration of this important matter.

Testimony of Steve Harter
Past President, National Association of Professional Insurance Agents
Before the House Small Business Committee
Thursday, May 24, 10:00 AM
2360 Rayburn House Office Building
"Expanding Small Business Health Insurance Coverage Using the Private Reinsurance Market"

Thank you, Madam Chairwoman and members of the Committee.

My name is Steve Harter. I am an independent insurance agent and I own my own insurance agency, Select Risk Management, in Ava, Missouri.

In 2002, I had the honor of serving as president of the National Association of Professional Insurance Agents. I continue to be involved with PIA as the current President of the PIA Trust.

On behalf of PIA and its members, I would like to thank you for this opportunity to testify before the committee.

PIA is a national trade association that was founded in 1931, which represents member insurance agents and their employees who sell and service all kinds of insurance, but specialize in coverage of automobiles, homes and businesses.

Like me, PIA members are the owner/principals of their independent insurance agencies.

PIA agencies provide their individual clients with personal lines insurance (such as homeowners and auto). In addition, they provide small-to-mid-sized commercial business clients with property and casualty and many PIA agencies offer life and health along with property and casualty products.

PIA's experience and perspective in this area is both as purchasers and insurance experts.

I own and operate an insurance agency. In addition, I did own, until September 1, 2006 a Social Service agency providing supports to individuals with developmental disabilities. On that date, that company merged with a larger organization. One of the reasons was the incredible cost of health insurance for my employees.

Several years ago, I provided full health insurance to all my full time employees. I paid 100% of the premium. As the cost continued to rise, I raised deductibles. Eventually, I had to require employees to pay for part of the coverage. Wages paid for Social Service employees are not high. Most receive less than $10 per hour. Even a small cost pass-through forced several to drop their coverage.

On my last renewal, the cost for each employee was quoted at over $500 per month. At that point, I determined an amount I could pay, then searched the marketplace to find

some sort of product that would be better than nothing. I now have a product that is referred to as a "mini-med" policy. It is not a comprehensive medical product at all. It will pay certain specified amounts, very limited, for specified illnesses. Even at that, the small cost sharing with the employees prevents most of them from participating.

Allowing cost considerations to limit access to care in this manner by employees of small businesses is not a solution, it's another indication that there is a broader problem.

I feel the overwhelming driver of insurance cost is the high demand for medical services coupled with the skyrocketing costs of health care, including prescriptions. I am not ancient, but thinking back to when my children were young, we did not seek medical attention nearly as often as my grandchildren are accessing healthcare services today. But this is a good thing. Today as a nation, we are healthier than ever before. Part of the reason is the advances in medical treatment, which of course add to the cost.

I do not see that reinsurance will necessarily help curb costs. I see reinsurance as more of a vehicle for availability. I have always been able to find group health insurance, just not able to afford it. I don't get the impression from my clients that they cannot find coverage.

I think there are only three broad answers—either have the government pay part of the cost, somehow limit the cost of services, or pass more of the cost to individuals (or some combination thereof.) All reinsurance does is redistribute the cost.

What drives availability among employers is cost. However one way to lower costs is to pool employers in a way that may give them some level of more direct control over the cost of the insurance coverage. The question is, how to do this.

Beginning in the late 1970's, PIA established a Trust for our insured beneficiaries. Savings that developed as a result of aggregating our health insurance policyholders in this structure were brought back into the Trust, and then used for the program to offer benefits to all covered PIA members and their covered employees. At its peak, 90%+ of PIA members and their employees were covered by this program.

Unfortunately, today there is no available private national health insurance program to fit into such a structure. As a result, we have lost the ability to use this as a strategy to recapture savings from good years and reinvest them into this program to keep costs lower in other years. We are also unable to negotiate better coverage for our members by negotiating on a national basis.

As Congress moves forward in developing effective legislation, we would like to make the following recommendations:

1. Consider affordability as the key to availability.

2. Clearly outline administration of the program, preserving state regulation.

PIA members have been adamant supporters of state-based regulation of insurance since our creation in 1931.

PIA believes state coverage mandates must remain.

3. Establishing financial soundness standards including a structure of operative disciplines is critical. It is not enough to merely have funding.

4. Learn from past mistakes. PIA continues to have reservations about Association Health Plan (AHP) proposals that too closely and fully build their structure adhering to ERISA, without including the lessons learned from all the adverse and unintended consequences that continue under it. ERISA needs to be fixed before anything else is piled on top of it.

5. PIA strongly advises that legislation moving through Committee be available for public vetting – and that before the concepts are implemented, they are subjected to economic and operative modeling. Through this modeling process, the Committee can better identify the hidden details that are always present – and how the structure might act in different markets.

6. Have a consistent definition of what constitutes a small business for purposes of potential legislation. For example, we suggest 200 or fewer full-time, year round employees or 500 or less including full-time, part-time and/or seasonal workers.

In closing, let me emphasize that what we are really discussing here today is how to go about delivering more high-quality health care to people who cannot afford to bear the full brunt of the cost. People who choose to work for America's small businesses should not be less able to have quality health care than people who work for larger concerns. Aside from the issue of basic fairness, such a situation places small businesses at a competitive disadvantage in the marketplace.

All of us must work together to craft solutions that will expand access to quality, affordable health care to America's small businesses and the people they employ.

Thank you very much for the opportunity to share PIA's perspective on this important issue. PIA members are "Local Agents Serving Main Street America." And for that reason, we look forward to continuing to work with the committee to find effective solutions to the health insurance problems facing Main Street America's small businesses.

Statement for the

United States House of Representatives
Small Business Committee

May 24, 2007 Hearing On:

"Expanding Small Business Health Insurance
Coverage Using the
Private Reinsurance Market"

Submitted by

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National Association of Health Underwriters

America's Benefits Specialists

The National Association of Health Underwriters (NAHU) is a trade association for health insurance agents and brokers, representing more than 20,000 health insurance producers nationally. Our members help millions of Americans find affordable health insurance every day and assist them in making that coverage work in the best possible way. We have thousands of members all across the country who specialize in the sale of small employer health plans, and many function as an extended Human Resources department for their clients. We are pleased to be here today to discuss how creative uses of reinsurance could decrease the cost of health insurance in the small employer health insurance market and make coverage more affordable for more small employers.

Numerous studies of health insurance claims indicate that a small number of insured individuals with serious and/or chronic conditions are responsible for the majority of health care expenses on which health insurance companies pay claims. Spreading the potential risk of these individuals is difficult in every insurance market, which is why private reinsurance coverage is already broadly used and why there are insurers that specialize in this type of product. It is often surprising for people when they learn that even insurance companies buy reinsurance. They do this to provide additional stability for their clients, by protecting them against large rate fluctuations that can occur when losses that are greater than anticipated. It is those unexpected losses that are the problem, much more than those that are expected, and this is why insurers may buy additional reinsurance. This is also the reason that self-funded employers purchase reinsurance coverage, often called "stop-loss".

Although there are many different types of reinsurance, there are two main categories or types of coverage for health insurance purposes. First, reinsurance can be purchased either to protect against excessive claims by an individual, or second, against losses from an aggregate pool of insured people or businesses, such as an employer group or an insurer's pool of small employer health insurance policies, or both. It is very important to those who purchase reinsurance that they purchase the right amount of coverage. Too much reinsurance is a waste of dollars, and causes rates to be higher. Too little can cause huge rate fluctuations when a number of large claims occur in a given year.

The amount of coverage purchased is related to claims expected by the pooled group, even when buying coverage for individuals. For example, an insurer who sells policies to small employers can anticipate the amount of expected claims in a given year from its pool of small employer policies. The insurer may decide to buy reinsurance coverage for individuals within those groups who have claims above a certain level, which is likely to

be a percentage of expected claims for the whole pool of individuals they have. Larger employer groups who self-insure use a similar calculation when they are deciding how much reinsurance to buy against losses by individuals in their group. It is very important to note that for a very large employer or an insurer with a large block of a particular type of business, the calculation for an individual reinsurance level may be so high that they decide not to purchase coverage and self-insure against individual losses. This is one reason why reinsurance should not be for an arbitrary amount but rather directly related to the ability to spread risk and absorb losses.

Reinsuring coverage for a group's losses in aggregate, in other words, heavy utilization by many members of the group, is a similar calculation. Again, the "group" for an insurer is likely to be the block of a particular kind of business, for example, the insurer's block of small employer policies. Again, expected claims are calculated and reinsurance coverage for losses in the event there are many claims within this block of business in a given year may be purchased. Again, large insurers or large employers will not need the same level of protection as that of smaller insurers or smaller self-funded employers because of their greater ability to spread risk and absorb losses.

It is important to note that reinsurance doesn't offer full protection against rising costs due to excessive claims expenses. The reason for this is that there is a cost to provide reinsurance (a premium) and if there are claims on the reinsurance, this cost will increase at a higher rate than it normally would. Regardless of whether or not there are claims, the cost of reinsurance is a cost of doing business and is factored back into the premium policyholders pay for their coverage.

Insurance carriers who operate in the small employer health insurance market currently pool similar small employers together in each of the states where they do business. Although they may be allowed some limited initial pricing flexibility based on underwriting of each small employer, and even though they are pooling many small employers together, it is often difficult to adequately spread the risk for individuals with significant health problems. The result is higher claims for the whole "pool" of small employers, which in turn results in higher premiums for all small employers.

It should be noted for comparison purposes that in the individual health insurance market in the majority of states, insurance carriers can underwrite based on health status, and can decline to issue coverage on the sickest of individuals. This keeps rates affordable in the individual market, absent other regulations that impact premiums. Those who are turned down for coverage can obtain coverage in a state high-risk pool in thirty-two states, and most other states have some other mechanism to guarantee coverage to those with significant health conditions. A key element of these mechanisms is that the sickest individuals are pooled separately from those that are healthy.[1]

HIPAA does not allow this type of high-risk pool arrangement in the small employer market, even though the small employer market shares many of the characteristics of the

[1] States that guarantee issue all individual health insurance policies do not pool sick individuals apart from those who are healthy, but prices are significantly higher for all individuals in those states.

individual market. HIPAA does not allow individuals to be excluded from a group, or rated separately based on their individual health status. For this reason, each small employer's claims, including the claims from high-risk individuals, are included when calculating the total claims expense incurred for the whole "pool" of small employer business. This claims cost is the largest component of small employer health insurance premiums.

Some states have tried to assist with the cost of reinsurance especially for smaller insurance carriers by forming state reinsurance pools for insurers in the small employer health insurance market. These pools are not purchasing pools, but rather financial pools set up at the state level strictly to handle the financial side of insuring high-risk individuals. Small employers purchase coverage through carriers as they normally do, but when a carrier initially underwrites a case, they purchase extra reinsurance coverage on the unhealthiest risks from a state reinsurance pool. This is transparent to the covered individual, who continues to receive benefits exactly the same as all other members of the employer group. If claims on the individual exceed a certain level, the reinsurance pool reimburses the carrier for their losses above that level. The carriers continue to retain a small part of the risk at that point, to ensure that incentives to control claims cost are retained.

Today there are nineteen active reinsurance pools, and another eleven pools that are either inactive or in the proposal stage. Reinsurance pools are currently funded by premiums paid by participating carriers. Up until this time, reinsurance pool success has been marginal in terms of its ability to produce cost savings in a given state market, primarily due to the size of current pools. The main reason for this is that the pools are largely voluntary and small with only a few participants to share in the cost of the reinsurance.

Many large carriers have decided not to participate in the pools, because they felt they were large enough to absorb more risk, or because they had already developed their own source of internal or external reinsurance. Their feeling was that they had no need to pay premiums to a reinsurance pool. So, some, but not all, carriers in a market participate in the current state reinsurance pools. As a result, savings have been less than they would have been in a larger pool, and the cost of reinsurance passed back to consumers has been greater than it would have been with more participation by more and larger carriers with more risks to reinsure.

Part of the reason why the current structure of the state reinsurance pools is unattractive to carriers is the arbitrary nature of the pools. They follow an older NAIC model that uses a very low stop-loss level considered ridiculous by many larger carriers. They have no need to incur the cost of reinsurance at the level, and they have wisely chosen not to do so. So, for these pools to ever be truly successful, some significant changes would be needed.

One idea that has been circulated is for the federal government to subsidize reinsurance in some way. If done correctly, this could remove reduce the cost of coverage currently

paid by employers and their employees today by taking away part of the dollars paid in claims that are normally factored into calculation of the health insurance premium. The amount of savings would depend on the amount of subsidy provided, but any reduction is more than they now are receiving. Although this reduction could be structured many ways, it is simple math that if you take away part of the total number used to calculate a premium, the total premium will be less. That means a lower cost to small employers, a reduction in the employee's share of the cost of coverage, and hopefully more employers that would be able to offer coverage to their employees.

It is important to note that if reinsurance were subsidized in the health insurance market, some important principles should be followed. Since there is a vibrant reinsurance market already in existence, it is not necessary for federal or state governments to become reinsurers. In fact, it is very important that in trying to provide assistance, federal and state governments do not harm the market that already exists or impose demands on plans that would ultimately increase rather than decrease costs. The simplest approach would be a simple federal grant program similar to the current program for subsidies to state high risk pools. The purpose of such a plan would be to remove cost for high cost cases from the system through reimbursing some of the of an employer or insurer's reinsurance premiums if they incur losses significantly above those they would already expect to incur. Some important principles to ensure such a grant program would work effectively within the current insurance market structure would be:

- Reinsurance subsidies would need to be available across a market and must not segment markets. For example, if it were decided to provide reinsurance subsidies for the small employer market, those subsidies would need to be available for every insurer in that market, not simply to insurers that offer coverage in a particular purchasing pool.
- Reinsurance subsidies should not be arbitrary. One of the reasons for the lack of success in small employer reinsurance pools that exist in states today is that the level of coverage is at an arbitrary level which is too low to be attractive to the large insurers that would make the pools more effective.[2]
- Reinsurance subsidies should be based on losses significantly in excess of those already expected

If done correctly, providing some help with the cost of reinsurance would seem an appropriate role for the government, and one that is consistent with other roles appropriately taken on by government. It would mean that the federal government would be subsidizing the cost of coverage for those who are sick. It would not create a new government-run bureaucracy, but merely provide financial assistance on behalf of those who most need help. The government would subsidize reinsurance premiums, but not

[2] A large employer or large insurer does not buy reinsurance today at the same level as does a smaller insurer or employer, and subsidies should reflect that dynamic. For example, if a self-funded employer were purchasing reinsurance against individual losses, a $50,000 level would probably be selected only if expected claims were $500,000 for that year. This would represent a fairly small employer and would be a ridiculously low level for a large insurer or employer.

become the reinsurer itself. It would bolster the private system, and make coverage more affordable for all small employers.

I appreciate the opportunity to be here today and would be happy to answer any questions now or as they may occur in the days ahead. Should you wish to reach me later, you can contact me at (703) 276-3800 or jtrautwein@nahu.org or our vice president of congressional affairs, John Greene, at (703)-276-3807 or jgreene@nahu.org.

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CONGRESSIONAL TESTIMONY

Risk Transfer Mechanisms in Health Insurance Markets

Testimony before
Committee on Small Business
United States House of Representatives

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My name is Edmund F. Haislmaier. I am Senior Research Fellow in the Center for Health Policy Studies at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

In addressing this somewhat arcane subject, it is helpful if we start with a common understanding of the concepts and terminology involved. This hearing is on the use of reinsurance in the small business health insurance market. But in reality, we are here to examine the related, though different, concept of market-wide risk-transfer and risk-pooling arrangements

In the classic definition, reinsurance can be thought of as an insurance company buying insurance for itself against a portion of the collective risk it has acquired from its own policyholders. In most cases, the primary insurer is buying protection against the unlikely, but theoretically possible, eventuality that some rare set of circumstances might produce losses that the primary insurer is unable to fund on its own. That is why reinsurance is a more common practice in certain lines of insurance, such as property and casualty. For example, one can envision the rare, but not unheard of, coincidence of multiple natural disasters occurring within weeks or months of each other and creating substantial losses among a large share of a property insurer's policyholders. It is that kind of 'perfect storm' of large losses happening all at once, that induces insurers to buy reinsurance on the commercial market.

However, those kinds of circumstances, and the consequent need for reinsurance against them, are not really issues in other lines of insurance, such as life or health, except maybe for very small carriers. While one can never say "never" in insurance, the risk that, say, half the policyholders of a large life insurance company will all die in the same year is virtually zero. Similarly, there is virtually zero risk that two-thirds of the policyholders of a large health insurance company will all need major operations and hospitalization in the same year.

So, when people talk about reinsurance in the context of health insurance, they really mean insurance against a different kind of potential risk faced by health insurers. Specifically, the risk in question can best be described as 'selection risk.' In other words, the risk that the insure will inadvertently acquire a larger than average share of costly individuals in its book of business.

In the current individual and small group markets, the insurers' first line of defense against selection risk is the practice of underwriting. Through underwriting the insurers seek to determine the risk profile of individuals or groups before issuing coverage, and then responds either by denying coverage altogether, or by limiting coverage for pre-existing medical conditions, or by charging poorer risk individuals or groups higher premiums.

In the group market, particularly the small group market, insurers also use 'minimum participation' requirements as another tool to guard against selection risk. The insurer will not issue group coverage to an employer unless the employer ensures that a minimum share of its workers (usually 75 or 80 percent) participate in the coverage. That way, the insurer limits the possibility that only poorer risk employees will take up the offered coverage.

While these practices help protect health insurers against selection risks, they also create problems for individuals and employer groups, particularly small employers.

First, they can make health insurance unaffordable, or even unavailable, for poorer risk individuals.

Second, they make it more difficult for insured individuals who develop a medical condition to retain coverage, as those individuals must now be careful that any change in their employment doesn't result in the next insurer to denying or limiting their coverage.

Third, they create obstacles to employers offering group coverage to their workers. In particular smaller employers often find it difficult to induce enough of their employees to take up coverage and thus meet the insurer's minimum participation requirement for covering the whole group.

It is these problems that various health insurance risk transfer concepts are designed to address.

Health insurance risk transfer mechanisms essentially fall into one of two basic categories -- what I will call 'exclusionary' and 'inclusionary.' The 'exclusionary' mechanisms are ones that segregate poorer risk individuals into separate pools and subsidize them separately from the better risk population. The 'inclusionary' mechanisms are ones that retain poorer risk individuals in the same pool with the better risk insured individuals but seek to redistribute and/or subsidize their higher claims costs.

The most common exclusionary mechanism is the state high-risk pool for the individual market. Individuals who have been refused coverage in the individual market due to their poor health status may apply for coverage through the state high-risk pool. The coverage carries higher premiums (up to 150 percent of standard rates) but the premiums charged are still insufficient to cover the claims cost of high-risk pool enrollees. States make up the difference using a combination of assessments on private insurers and public subsidies.

Inclusionary risk transfer mechanisms operate on essentially the same principle, but with the difference that higher cost individuals are not given separate coverage. Instead, some portion of the claims associated with those individuals is pool and then redistributed evenly among carriers in the market. Public subsidies to offset some of those claims costs may also be part of the design as well. Several states currently use this kind of mechanism in their small group markets.

There are a number of considerations that need to be taken into account in designing and implementing a health insurance risk transfer mechanism:

1) Under an inclusionary design the risk transfer mechanism is opaque to the insured -- meaning that the individual is not aware that a portion of his claims are being ceded to the pool. In contrast, under an exclusionary design, the insured is given separate primary coverage. Thus, individuals lose choice of coverage in a health insurance market with an exclusionary risk transfer mechanism, but can retain choice of coverage in a market complemented by an inclusionary risk transfer mechanism.

2) Under an exclusionary design, it is possible to contract with an entity to 'case manage' the care of pool enrollees. In theory, this could result in aggregate claims costs for a pool of high cost individuals that is somewhat lower than what they would otherwise incur if they were remained covered in the general of the market. However, the extent of any such theoretical savings is heavily dependent on the validity of the assumption that the pool will do a better job of case management than existing carriers in the market.

3) In contrast, any inclusionary design must ensure that sufficient incentives remain for the primary insurers to effectively manage claims costs, as the pool will not be performing that function. Setting the rules of the pool such that the primary insurer ceding claims to the pool must retain a portion of those claims can do that. Typically, the pool will only accept ceded claims above a certain threshold (called the 'attachment point'), and above that attachment point the ceding carrier also remains responsible for paying a portion of the claims (called a 'risk corridor').

4) Beyond the limited, and speculative, ability of an exclusionary pool design to achieve some reduction in aggregate claims through better case management, risk transfer mechanisms only shift or redistribute costs among funding sources.

5) As a corollary, government subsidies for health insurance transfer pools, whether direct or indirect, do not reduce costs -- they simply shift costs on to taxpayers.

6) The broader the redistribution of costs under a risk transfer mechanism (regardless of design) the less burdensome it will be and the fewer distortions it will create in the market.

Given these considerations, I would advise policymakers to adopt the inclusionary design for health insurance risk transfer pools. That design has the advantage of allowing individuals to retain choice of coverage. It also facilitates creating a single pooling mechanism across all market segments -- individual, small group and large group. With respect to financing, the losses of the risk transfer pool should be apportioned among all

carriers in the market on a per-covered life basis. While it is possible to provide public subsidies to offset some of those costs, any such funding should be fixed and limited, in order to prevent unintentionally creating incentives for carriers to try to transfer more of their risks onto taxpayers.

I would also caution policymakers to keep in mind the limitations of risk transfer mechanisms. They can compensate for the risk selection effects that occur in the market by more fairly and evenly distributing the cost burden associated with the relatively small share of high-risk individuals. What they can't do, at least to any significant degree, is to reduce those cost.

Policymakers need to understand that risk transfer pools, like traditional reinsurance, are only tools for redistributing risks and cost. They should be under no illusion that any of these mechanisms will -- in and of itself -- limit or reduce health system costs or improve the quality of care. Other tools are needed for those tasks.

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