

## *CCBA's Background in the Health Care Benefits and Insurance Arenas*

CCBA is now in its 95<sup>th</sup> year of providing insurance services to independent Coca-Cola bottlers nationwide. Since its members range from large Fortune 200 companies to small local businesses with as few as 10 employees, it has decades of experience in dealing with the challenges faced by large and small businesses in obtaining high quality, affordable health care benefits for their employees.

For more than 30 years, CCBA has provided health care programs to its members. It is one of the few trade associations that still manages multistate, multiemployer health care programs. Until 2000, CCBA was able to provide a health care program for virtually all of its members, large and small. In 2000, CCBA was forced to disband its pooled risk program for members under 100 employees. It continues to manage a health care program for members with over 100 employees and delivers high quality benefits programs to those members at a cost that is approximately 15% below the average cost of small group coverage, based on widely accepted published sources.

CCBA has worked extensively with other trade associations and employer groups on health care solutions and has studied the experiences of those groups. It has also invested heavily in the analysis of alternatives for its members, working with most of the major carriers and with some of the most widely respected experts in the health care insurance and benefits field, including Mercer, Aon Consulting, the Groom Law Firm and many others. CCBA has also managed a broad-based, highly successful liability insurance program for its members, utilizing a group captive model to assume most of its members' liability risks, and thus has first hand knowledge of the sophisticated solutions that can be successfully employed to manage and reduce insurance risks and costs outside the health care arena.

CCBA's Executive Director, W. Thomas Haynes, has been invited to testify before Committees of the United States Congress on four separate occasions in the past five years. Two of those invitations came from the ranking Republican chair of the Committee in question and two came from the ranking Democratic chair of the Committee in question.

## *CCBA's Observations about the Health Care and Health Insurance Markets and the Critical Elements of Effective Health Care Reform*

1. The debate concerning our health care system and the challenges that we face in providing the appropriate level of care for our citizens often confuses two separate, but intertwined issues: (a) the health care system and (b) the health care insurance system. Both systems interact to influence both the quality and the cost of health care, but they involve two separate markets and two different sets of challenges. In CCBA's view, both the discussion of the challenge and the construction of a solution requires both an understanding of the underlying forces in both markets and a focus on the parts of the system that need the most urgent attention.

2. All of the published data demonstrates that, within the privately funded world of health care and health care insurance, health care insurance costs are rising much more rapidly than health care costs. The gap between the rate of increase in GDP and rate of increase in private sector health care costs is not as large as many may believe and was not widening prior to the recent recession. In other words, while revenues of health care providers are growing at a rate that exceeds GDP, the gap is not of crisis proportions. It could well be argued that increasing relative investment in the health care of our citizens is to be expected and is appropriate in any prosperous society and is not inherently problematic (just as increasing relative expenditures in information technology, like wider availability of personal computers, cell phones, wi-fi technology and other enablers of rapid communication is a major contributor to efficiency and quality of life).
3. In contrast, the statistics demonstrate that the rate of increase in the cost of health care *insurance* substantially outstrips GDP growth and does not appear to deliver the amount of societal benefit of increasing investment in health care services. What this means, as is well documented in every statistical study, is that an ever-shrinking part of our health care insurance dollars are actually reaching the hands of providers. That phenomenon is the trend that needs to be reversed through sound policy initiatives.
4. Moreover, the statistics reflecting that overall trend in non-provider insurance costs actually tend to understate the real scope of the core problem. Within the large business community, health care and health care insurance costs are trending upward at the same rate, largely because larger businesses employ self-funded solutions and use the insurance industry largely as a provider of claims processing and network management services, where the insurers compete vigorously on relatively narrow profit margins. In contrast, small businesses, which usually need to procure coverage in the small group market, are always facing double digit increases in premium costs, even when the underlying costs of medical services for their employees follow the mid- to high-single digit trend.
5. The sources of that burgeoning insurance cost are very complex, and include from (a) the high cost of compliance with inconsistent state regulation, (b) inadequate competition in some markets, (c) high marketing and administrative costs associated with pursuing the business of and managing large numbers of small employer groups, (d) state and local tax burdens and many other factors. While the insurance industry operates profitably in the small group market, it is unfair and inappropriate to see the high cost of small group insurance as a problem that can be solved through regulation and demonization of insurance carriers. Instead many of those costs are driven by regulatory and administrative complexity, and in particular by the fact that the structure and coverage mandates of regulated small group insurance lead to non-standardized policies and huge administrative burdens in managing and paying claims. In addition, because it is extremely difficult for small businesses to pool their development of health care solutions, few small employers utilize cost reduction strategies, such as risk retention,

captive reinsurance, consumer driven benefit structures and other tactics used by large employers to reduce costs.

6. These costs drivers lead small employers that source health care benefits from the small group market to employ other tactics to manage costs. The only tactics available, however, involve reduction of coverage and shifts of costs to the employee. As a result of those forces, the percentage of the workforce that has access to what was once a standard health care benefit package has diminished considerably. Virtually all of that shrinkage, including the complete loss of workplace health care benefits (or the loss of dependent coverage) in many cases, has occurred in the small business workplace. Because, however, small businesses account for all of the employment growth in our economy, the combination of benefit reductions and increasing reliance on the small business community for available jobs has swollen the ranks of the uninsured and underinsured at an alarming rate.
7. Those forces have in turn increased public reliance on the public sector for health care benefits, since the availability of those benefits at work has contracted. The consequences have driven the need for SCHIP and its subsequent expansion and are also a major factor in the increase in Medicare and Medicaid costs. The budget issues now faced by the federal and state government in managing health care costs are a significant second order effect of the market forces at work in the small group/small business private sector market.
8. Relative to actual health care costs (i.e., provider costs), it is widely recognized that the single largest driver of those costs is ineffective management of chronic conditions like heart disease, diabetes, back and neck injuries and other similar conditions. It is also widely recognized that, at least in theory, huge strides could be made in managing those conditions through more effective disease management by the doctor and patient. Effective disease management, however, requires a level of day-to-day patient interaction that does not exist in the relationship between public sources of health care benefits and the beneficiaries, nor in all provider/patient relationships. The workplace is an ideal source of reinforcement for those programs. As noted in the August 12, 2009 column of Muhtar Kent, Chairman of the Board of The Coca-Cola Company in the Atlanta Constitution and Journal (republished on this web site), employers need to be key players in the solution to the nation's health care challenges. One of their key roles is to provide that reinforcement of the need for healthier lifestyles among our associates.

It is far more difficult for small employers to provide that reinforcement than larger employers because they often do not have the human resources staffs, nor all of the tools need to effectively promote disease management and health lifestyles solutions. Associations like CCBA provide a critical infrastructure to work with carriers to promote healthier behavior among employees of our smaller members.

9. Funding of health care reform costs is a very important topic, but must be considered in terms of both the amount of burden placed on the economy as well as the allocation of that burden. CCBA and the Coca-Cola system believe that it is entirely wrong to place that burden on a single product or industry (a soft drink tax), but it is also damaging to place that burden disproportionately on insurance companies, employers that provide jobs and benefits, beneficiaries of benefit programs, small entrepreneurs taxed as individual taxpayers or middle class Americans.

All Americans realize that the economy is in a fragile state, both in absolute terms and relative to other economies that compete with our own. The economy as a whole cannot withstand a major additional burden, irrespective of where the burden is initially directed, because any tax will generate ripples of adverse economic effects in the form of reduced employment, stagnant wages, cuts in discretionary spending or reduced entrepreneurial risk taking.

*CCBA's view of the implications of these 9 observations for the current health care debate:*

1. While both health care delivery and health insurance need to be addressed in health care reform, the more critical and effective initial focal point is health care insurance. Within that focus, the overwhelming need is for reforms in the small group market that will shrink the gap between insurance costs and provider costs. Absent real change in the insurance cost trend for small businesses, one of two things will happen: (a) small businesses will be forced to continue to reduce or eliminate coverage or (b) if small businesses choose (or are forced to) continue coverage, their benefit costs will soar and they will be forced to cut back elsewhere (i.e., jobs and wages).

Thus, the concept of an employer mandate is incomplete and inappropriate if it does nothing more than address one of those two options (reduction or elimination of benefits) and does nothing to deal with the fundamental problem that has brought employers to the Hobson's choice of reduced benefits or reduced employment and wages.

2. Reduction of administrative and risk transfer costs associated with insurance markets, through facilitation of pooling by small groups, as well as formation of cooperatives and group captives, should not result in fundamental changes in the quality of health care and will enhance the quality of health care insurance options. In contrast, strategies that depend on reduction of provider costs carry that enormous risk of adversely affecting health care quality and health care outcomes. Thus, focus on reforms that will reduce insurance costs, rather than reforms that are aimed at provider decisions and their cost implications, is not only more effective, but it is less risky.

Health care is fundamentally different from most products. Consumers understand and will make difficult decisions concerning tradeoffs between costs and quality/features when they purchase homes, cars, televisions and auto insurance because they understand that their means may not allow them to choose higher quality/higher cost options. But when it comes to their health or their family's health they will (and should) rebel at those choices.

Much of the divisive rhetoric over the current proposals before Congress is driven by the degree to which efforts to adopt policies that reduce provider costs carry obvious risks of adversely affecting health care quality and outcomes. A solution that relies on a well-designed and well-staffed federal government agency to influence those decisions is necessarily going to be viewed as inferior to decisions made by doctors and patients. And the public is understandably skeptical about the quality of the government bureaucracy that is supposed to be entrusted with those decisions, even if it were willing to empower government with those intensely personal and complex decisions.

3. None of the bills before the Congress contains a well-designed solution to the small group market crisis. The small business tax credit contained in the legislation is only available to low wage employers providing a handful of jobs. Paradoxically, those bills phase out the tax credit for employers that pay more attractive wages or add to their headcount, well below the point at which those employers are large enough or wealthy enough to provide Fortune 500 benefits at the dramatically elevated costs paid by smaller employers.

The premise of the pending bills appears to be that a government option, combined with an on-line exchange, is the right path to create the competition necessary to drive down the small group market cost disparity. Some form of incremental competition is better than none, but the problem is that there are no proven models where a government managed and sponsored competitor has ever created a fully competitive private market where one did not exist before. Indeed, state government pools have been developed in several places, without any proven impact on the small group cost disparity.

Beyond that gap, the forces that create that cost disparity go considerably beyond local competition in the small group market. Health care is inherently complex and is made more so by state regulation of pricing, benefits, coverage rules, claims management and numerous other features. Unlike other forms of insurance, health insurance is not easily standardized, particularly given state regulation that requires both coverage and claims management variations. The resulting product is so complex that almost all small and medium businesses rely on brokers to shop for alternatives and explain their choices. Placing all of those choices on a national exchange will make the work of brokers somewhat easier, but will still leave employers with a matrix of complex choices and with very high administrative expenses.

What is really needed is reform that will empower employers to adopt the solutions that allow them to pursue the type of innovative solutions that have driven cost containment for larger employers, including risk retention, multistate uniformity in plan design and group purchasing of administrative and network management services. Bipartisan solutions that will contribute toward that goal, including the Small Business CHOICE Act and the SHOP Act, both of which include Democratic and Republican leaders as cosponsors, need to be the centerpiece of effective health care reform.

4. Beyond that need for small group reform, it is also critical that Congress do nothing to increase the current cost of health care insurance, particularly relative to the health care services that are covered by that insurance. The current bills before Congress create a number of coverage and other mandates that reduce employer and employee choice relative to the type of coverage that they can pay for and still receive credit for providing qualified health care benefits. They also mandate insurance coverage for various types of extraordinary costs that often are not covered by most current benefit packages. Paradoxically, they prohibit insurers from providing lower pricing to small employers that present relatively more attractive risks because their employees are healthier than average. Finally, they create a set of new government agencies, with new regulatory powers, that will have the authority to set pricing and rates and remake the rules associated with health care benefits and health care insurance markets.

Each of those reforms is based on the legitimate needs of some beneficiaries, some providers and some employers. In combination, however, a new regime of rate and benefit regulations carries enormous risks of increasing private sector costs, eliminating cost saving options and innovation and driving additional unpredictability in assessing likely health care costs.

CCBA's experience in insurance markets is that the enemy of affordability is unpredictability. Any "reform" which reduces predictability, including elimination of lifetime and annual maximums, mandated coverage of less predictable and manageable risks, prohibitions of risk based underwriting and the like is certain to increase unpredictability and cost. Conversely, reforms which reduce unpredictability, such as malpractice caps, flexible risk-based underwriting and sensible coverage limits (subject to a public safety net) are likely to reduce insurance costs, without necessarily imposing any hardship on plan beneficiaries.

5. Ultimately, a key element in effective management of health care outcomes and costs is alignment of the incentives necessary to improve the actual health of as many Americans as possible. All of the literature identifies the potential risks associated with third party payer systems (users of health care services do not directly pay for them and thus do not see the cost of behavior that drives up expenses) and systems that pay for services rather than outcomes

(providers are incentivized to support decisions that drive additional services). At the same time, the solution that would solve those perverse incentives (users of health care services would pay all of the costs) is simply not feasible. The next best solution is to place both the tools and the incentives in the hands of trusted advocates that are committed to the health of the users of health care services, yet have the resources to manage extraordinary cost events. The locus of that solution is the employer and empowerment of employers to work with their associates in their mutual interest must be the central tenet of effective reform.

No one should view a public sector role in that process as inherently threatening. A system which encourages employers to provide meaningful coverage and which helps make that coverage affordable would make an enormous contribution to our country's future. A system which encourages Americans to plan for health care challenges before they face them is entirely appropriate.

However, complex regulatory schemes and new federal agencies which seek to manage and limit alternatives for delivering cost-effective health care to everyone in all circumstances will inevitably drive an enormous set of unintended consequences that may place us even further from the goal of the world's finest, yet most cost-effective health care system. There is simply too much to preserve in our current system to perform radical surgery on its fundamental foundation, particularly without real world experience with the many unintended consequences.

6. CCBA is in the process of designing its own health care program within the current regulatory and market structure. Its work to date demonstrates that it can deliver expanded benefits to many of its smaller members for the same or very similar cost, while containing any future expansion of the gap between health care costs and health care insurance costs and improving the effectiveness of disease management programs that may in the long term improve the health of our members' employees. A modest level of government support for the solution that it is developing, in the form of a bill like the Small Business CHOICE Act (HR 6582), could spark an outbreak of similar market-based innovation and reverse the trend of reduced private sector coverage and increase reliance on public sector "safety net" programs. CCBA and other similar organizations are committed to and capable of helping the small business community with those solutions, with limited federal investment and minimal changes in the current regulatory system.
7. Nothing good, however, will come of a continuing series of political maneuverings that are driven by the hope of achieving political gain from demonizing well-intended participants in the debate or from characterizing positions taken in complex policy debates as indicia of cynical plans to extract political or economic gain from outcomes that are detrimental to the public

interest. There are serious and consequential differences between the solutions advocated by those that are participating in the debate, but questioning their motives accomplishes very little in finding a solution which advances America's long term interests.

8. Perhaps the most salient piece of advice for lawmakers wrestling with health care reform was attributed, appropriately enough to Hippocrates of Kos nearly 2500 years ago. Loosely translated, his advice was "above all, do no harm" and it is embodied in the oath of nearly all medical practitioners. By starting with that premise and focusing on those parts of the system that need to be changed and can be changed with the least risk to the parts that work, Congress can find the path to a better health care system.