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S. HRG. 109–110

# SOLVING THE SMALL BUSINESS HEALTH CARE CRISIS: ALTERNATIVES FOR LOWERING COSTS AND COVERING THE UNINSURED

## HEARING

BEFORE THE

## COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP

## UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

APRIL 20, 2005

Printed for the use of the Committee on Small Business and Entrepreneurship

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# SOLVING THE SMALL BUSINESS HEALTH CARE CRISIS: ALTERNATIVES FOR LOWERING COSTS AND COVERING THE UNINSURED

COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

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OLYMPIA J. SNOWE, Maine, *Chair*
JOHN F. KERRY, Massachusetts, *Ranking Member*

CHRISTOPHER S. BOND, Missouri
CONRAD BURNS, Montana
GEORGE ALLEN, Virginia
NORMAN COLEMAN, Minnesota
JOHN THUNE, South Dakota
JOHN ISAKSON, Georgia
DAVID VITTER, Louisiana
MICHAEL ENZI, Wyoming
JOHN CORNYN, Texas

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TOM HARKIN, Iowa
JOSEPH I. LIEBERMAN, Connecticut
MARY LANDRIEU, Louisiana
MARIA CANTWELL, Washington
EVAN BAYH, Indiana
MARK PRYOR, Arkansas

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WESTON J. COULAM, *Staff Director*
NAOMI BAUM, *Democratic Staff Director*

# C O N T E N T S


Page

OPENING STATEMENTS

Snowe, The Honorable Olympia J., Chair, Committee on Small Business and Entrepreneurship, and a United States Senator from Maine ..... 1
Kerry, The Honorable John F., Ranking Member, and a United States Senator from Massachusetts ..... 4
Bond, The Honorable Christopher S., a United States Senator from Missouri . 7
Landrieu, The Honorable Mary L., a United States Senator from Louisiana .... 11
Burns, The Honorable Conrad R., a United States Senator from Montana ..... 14
Pryor, The Honorable Mark, a United States Senator from Arkansas ..... 18
Isakson, The Honorable Johnny, a United States Senator from Georgia ..... 21
Cornyn, The Honorable John, a United States Senator from Texas ..... 21
Thune, The Honorable John, a United States Senator from South Dakota ..... 22
Talent, The Honorable James M., a United States Senator from Missouri ..... 23
Lincoln, The Honorable Blanche, a United States Senator from Arkansas ..... 53

TESTIMONY

Chao, The Honorable Elaine L., Secretary, U.S. Department of Labor, Washington, DC ..... 30
Barreto, The Honorable Hector V., Administrator, U.S. Small Business Administration, Washington, DC ..... 47
Newman, Doug, Newman Concrete Services, Inc., Hallowell, Maine ..... 86
Mansell, Al, President, National Association of Realtors, Washington, DC ..... 98
Haynes, Tom, Executive Director, Coca-Cola Bottlers' Association, Atlanta, Georgia ..... 107
Nichols, Len, Director, Health Policy Program, the New America Foundation, Washington, DC ..... 116
Morrison, John, Montana State Auditor, Commissioner for Insurance and Securities, Helena, Montana, on behalf of the National Association of Insurance Commissioners ..... 127
Lindsay, William N., III, Past Chair, National Small Business Association, Denver, Colorado ..... 141

ALPHABETICAL LISTING AND APPENDIX MATERIAL SUBMITTED

Barreto, The Honorable Hector V.:
Testimony ..... 47
Prepared Statement ..... 49
Bond, The Honorable Christopher S.:
Prepared statement ..... 9
Burns, The Honorable Conrad R.:
Prepared statement ..... 16
Byrd, The Honorable Robert:
Prepared statement ..... 28
Chao, The Honorable Elaine L.:
Testimony ..... 30
Prepared statement ..... 32
Answers to Post-Hearing questions from Chair Snowe ..... 338
Answers to Post-Hearing questions from Senator Burns ..... 342

Page

Durbin, The Honorable Richard:
Prepared statement ..... 80
Kerry, The Honorable John F.:
Letter from Mila Kofman, Health Policy Institute, Georgetown University ..... 58
Haynes, Tom:
Testimony ..... 107
Prepared statement ..... 109
Landrieu, The Honorable Mary:
Prepared statement ..... 12
Lindsey, William N., III:
Testimony ..... 141
Prepared statement ..... 143
Answers to Post-Hearing Questions from Chair Snowe ..... 336
Answers to Post-Hearing Questions from Senator Burns ..... 337
Mansell, Al:
Testimony ..... 98
Prepared statement ..... 100
Morrison, John:
Testimony ..... 127
Prepared statement ..... 129
Answers to Post-Hearing Questions from Chair Snowe ..... 328
Answers to Post-Hearing Questions from Senator Burns ..... 330
Newman, Doug:
Testimony ..... 86
Prepared statement ..... 89
Nichols, Len:
Testimony ..... 116
Prepared statement ..... 119
Answers to Post-Hearing Questions from Chair Snowe ..... 332
Answers to Post-Hearing Questions from Senator Burns ..... 335
Pryor, The Honorable Mark:
Prepared statement ..... 19
Thune, The Honorable John:
Prepared statement ..... 326

COMMENTS FOR THE RECORD

Air Conditioning Contractors of America, prepared statement ..... 168
American Chiropractic Association on behalf of various health professional organizations, letter to Chair Snowe ..... 170
ASPPA, on behalf of SBCA, SBLC, ECFC, comments for the record and press release ..... 171
Associated Builders and Contractors, prepared statement and media advisory 180
Blunt, The Honorable Matt, Governor of the State of Missouri, letter to Senator Snowe ..... 187
Fiore, Paul, Service Station Dealers of America and Allied Trades, prepared statement ..... 188
Gay, John F., International Franchise Association, prepared statement ..... 191
Graham, John H., IV, American Society of Association Executives, letter with Comments for the Record ..... 196
Hill, Eleanor, King & Spaulding LLP, letters to Chair Snowe and Senator Kerry ..... 199
Johnson, Derrell E., American Council of Engineering Companies, prepared statement ..... 202

Page

Keffer, Jim, American Foundry Society, letter to Senator Snowe ..... 206
Keithly, Carter, President and CEO, Hearth, Patio & Barbecue Association, prepared statement ..... 207
Kerrigan, Karen, Small Business and Entrepreneurship Council, prepared statement ..... 210
MacDicken, Becky, Director of Government Affairs, The Tire Industry Association, prepared statements ..... 217
Matieu, Sandra J., Home Builders and Remodelers Association of Maine, letter to Senator Snowe ..... 222
Mental Health Liaison Group, letter to Congressman Hastert and Senator Frist ..... 224
National Association of Wholesaler-Distributors, prepared statement ..... 227
National Funeral Directors Association, prepared statement ..... 236
National Lumber and Building Material Dealers Association, prepared statement ..... 239
National Restaurant Association, letter to Chair Snowe ..... 241
Organizations and Public Officials Opposed to Federal AHP Legislation, list submitted for the record ..... 253
Perkins Restaurant and Bakery, letter to Chair Snowe ..... 242
Pound, William T., National Conference of State Legislatures, letter to Congressmen Boehner and Miller ..... 243
Printing Industries of America, Inc., prepared statement ..... 244
Warner, The Honorable Mark R., and Huckabee, The Honorable Mike, National Governors Association, letter to Senators Frist and Reid ..... 247
Ness, Debra, National Partnership for Women and Families, letters to Chair Snowe and Senator Kerry ..... 249
Professional Photographers of America, prepared statement ..... 280
Protect Your Healthcare, letter to Chair Snowe and Senator Kerry ..... 283
Rawlinson, David A., Textile Rental Services Association of America, letter to Senator Enzi ..... 286
Samuel, William, American Federation of Labor and Congress of Industrial Organizations, letter to Chair Snowe and Senator Kerry ..... 287
Schlicht, James, The American Diabetes Association, prepared statement ..... 289
Schmatz, Kathleen, President and CEO, Automotive Aftermarket Industry Association, letter to Chair Snowe ..... 292
Small Business Council of America, comments for the record ..... 173
Smith, Daniel E. and Selig, Wendy K.D., American Cancer Society, letter to Senator Kerry ..... 299
Stanton, Joseph M., National Association of Homebuilders, prepared statement ..... 301
Twarog, Daniel L., North American Die Casting Association, letter to Senator Snowe ..... 303
United States Chamber of Commerce, prepared statement ..... 304
Westerfield, Donald L., Ph.D., National Center for Policy Analysis, testimony submitted to HELP Committee ..... 309
Women Impacting Public Policy, prepared statement ..... 319

# SOLVING THE SMALL BUSINESS HEALTH CARE CRISIS: ALTERNATIVES FOR LOWERING COSTS AND COVERING THE UNINSURED

**WEDNESDAY, APRIL 20, 2005,**

UNITED STATES SENATE,
COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP,
*Washington, DC.*

The Committee met, pursuant to notice, at 10:04 a.m., in room 428–A, Russell Senate Office Building, the Honorable Olympia J. Snowe, Chair of the Committee, presiding.

Present: Senators Snowe, Bond, Burns, Thune, Isakson, Cornyn, Kerry, Landrieu, Pryor, Lincoln, and Talent.

## OPENING STATEMENT OF THE HONORABLE OLYMPIA J. SNOWE, CHAIR, SENATE COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP, AND A UNITED STATES SENATOR FROM MAINE

Chair SNOWE. The hearing will come to order. Good morning. I want to welcome everybody to today's hearing to focus on the health care crisis facing small businesses.

I want to most especially welcome Secretary Chao for being here today, for her long-standing championship of and advocacy for the creation of Association Health Plans to further the rights of hard-working Americans across this country. I also want to welcome Administrator Barreto, who is a former small business owner and knows all too well the difficulties of acquiring affordable health care for his employees. I want to thank you both for the leadership that you have given on behalf of this issue that is so central to the well-being of small businesses across this country.

Finally, I want to thank all the small business representatives who will testify on the serious challenges to reduce health care costs and expand coverage and also to hear opposing views on this subject, so hopefully we can clarify some of the issues here today.

As you may recall, we examined this issue 2 years ago during the very first hearing I conducted as Chair of this Committee, and regrettably, since then, the problem has only grown worse. Today, I want to probe deeper into solving this crisis and hopefully jump-start real action by Congress to enact solutions this year.

This hearing will focus on Association Health Plans, which I strongly believe can play a major role in addressing this country's health care crisis. Touted by President Bush as one of his major initiatives, supported by over 80 million Americans, AHPs will bring necessary reform to insurance markets that have long

trapped small businesses and their employees in a vicious cycle of escalating premium costs and fewer coverage options. AHPs are crucial to solving the small business health care crisis because they represent a fair, fiscally sound, and tested approach to reducing the ranks of the uninsured in this country at a nominal cost to the Federal Government.

Of the nearly 45 million uninsured Americans, 62 percent of the uninsured are either employed by small business or dependent on someone who is. If we want to get serious about helping the uninsured, which I certainly think is long overdue, we should start by focusing on small business.

*USA Today* recently identified health care insurance costs as the number one issue facing small business employers across the country, a fact confirmed in the National Federation of Independent Business's Small Business Economic Trends Monthly Report for March. Almost 30 percent of the small business owners surveyed responded that cost and availability of insurance was the single most important problem facing small businesses today. This was far and away their most pressing concern, and it is one that I have heard time and time again.

Indeed, these surveys and studies mirror what we already hear today from small business owners across the country. Today, we will hear from one of my constituents, Doug Newman, a concrete company owner from Hallowell, Maine, who has described premium increases of almost 65 percent since 2000.

The time has come for action, not words, to deliver small business owners relief from this crisis. AHPs accomplish this with a common sense approach that allows small employers to join together through bona fide associations to buy health care coverage. AHPs will level the playing field of employer health care coverage by giving participating small employers the advantages of Federal law currently enjoyed by large employers and unions.

AHPs have the strong support, as I mentioned, of President Bush, as he has said repeatedly in his State of the Union addresses. The Majority Leader, Senator Frist, has indicated he would like to see floor action on AHPs this year, and I certainly welcome and appreciate his support.

AHPs are supported by a coalition representing over 12 million employers and 80 million individuals, and significantly, for the first time ever, tomorrow in the HELP Committee, Chairman Enzi is hosting his first hearing on AHPs.

Moreover, as shown on Chart 1, a recent snapshot poll in *USA Today* asked 2,076 CEOs what changes to health care policies could be made that would have the greatest impact on your business? The number one response, at 56 percent, was consolidated group rates, pooling, just as recommended in the legislation that we have introduced with respect to Association Health Plans to help small businesses.

Today, I want to examine the truth and the realities involved with AHPs and to finally, once and for all, drive a stake into the myths that opponents have put forward about AHPs over the years. AHPs allow small businesses to pool their employees together to receive the same bulk purchasing and administrative efficiencies already enjoyed by large corporations and unions. It builds

on the success of ERISA's self-insurance plans, used by large employers, and the Taft-Hartley plans available to union employers, which currently provides health benefits for 78 million people, more than half of the people who receive health insurance from their employer.

Our aim is to inject competition in the marketplace and offer alternatives to small businesses trapped in the current system. Associations will be able to administer one national plan with lower administrative costs. And reducing costs for small businesses is why we are here today.

Studies by both the GAO and the Small Business Administration's Office of Advocacy concluded that small businesses currently absorb a greater portion of their plans' administrative costs, paying as much as 20 to 30 percent more in total premiums than larger health plans. As a result, small businesses receive less generous benefits than larger employers while paying the same level of premiums. On both counts, small businesses and their employees lose.

Now, here we have Chart 2. The Kaiser Family Foundation recently reported that between the spring of 2003 and the spring of 2004, health insurance premiums increased 11.2 percent. This marks the fourth consecutive year of increases. As you can see from this chart, health insurance premiums have seen annual increases since 2000 of 10.9 percent, 12.9 percent, and 13.9 percent, respectively, a growth that far outpaced inflation and erased wage gains.

AHP legislation will also provide a full range of benefits similar to what many States currently require. In many cases, large employers and unions, which are exempt from State benefit mandates, offer the most generous plans. Not surprisingly, many employees actually choose to stay in their jobs only to maintain that higher level of coverage. Like these larger plans, the bill's extensive new safeguards will ensure that health care coverage is available when employees need it as well as to prevent fraud.

Contrary to opponents of this legislation who claim it will lead to cherry-picking of only the young and the healthy, this legislation specifically requires that Association Plans must be open to all Association members, and each employer who participates in the plan must offer the plan to every eligible employee at the risk of fines and even imprisonment of up to 5 years.

Finally, critics claim that the Department of Labor could not handle its responsibilities under this legislation. Frankly, I cannot imagine an agency better prepared than the Labor Department, which currently oversees 300,000 similarly structured plans, and that is why I am delighted to have Secretary Chao here today to testify to this issue. We rarely hear complaints about these plans failing and leaving subscribers without coverage. AHPs would not add an unmanageable burden to the Department of Labor, and as the Secretary of Labor will testify, sufficient resources will be available to ensure that the Department fulfills its obligations.

AHP legislation is one excellent reform among myriad solutions to the health care crisis, but it is one that should be available to start making a difference immediately. This is not a radical new policy we are talking about here. We should also examine ways to use the tax code as a mechanism for increasing access to health care, and that is why I recently introduced legislation with Senator

Bond and Senator Bingaman to enable more small business owners to offer choice of cafeteria plans, to allow employees to purchase health insurance with tax-free dollars.

And with that in mind this morning, we will also review alternatives, including those put forth by the Administration. I know my colleagues have introduced various issues regarding refundable tax credits, expanded Health Savings Accounts, and so forth. I don't think all of these issues are mutually exclusive, but I think we should begin this process of starting to enact legislation. It is not without coincidence that 80-million-plus Americans support this legislation and 12 million employers. We all know that small business is a job generator in America and it is in our central and national interest to make sure that we preserve their economic well-being.

So with that, I will now turn to the Ranking Member, Senator Kerry, for any remarks he chooses to make.

**OPENING STATEMENT OF THE HONORABLE JOHN F. KERRY, A UNITED STATES SENATOR FROM MASSACHUSETTS**

Senator KERRY. Well, thank you very much. I appreciate the opportunity to share some thoughts and also to try to make the most of this Committee's opportunity here to really deal with this issue. I welcome our panels and all those of you who are interested in this subject.

Madam Chair, I thank you for bringing this Committee together to try to tackle this critical issue. I hope we will all make the most of it.

I want to thank you also for extending courtesies to our colleagues, Senators Lincoln and Senator Talent, to join us. They have been working on this on the side, and I think it is good when committees can allow that to happen.

We want to welcome all of the people here today who are going to testify on this. I want to thank State Auditor Morrison, who has joined us from Montana, and Bill Lindsay from Colorado, who is representing the National Small Business Association, and a special thanks to Len Nichols of the New America Foundation for agreeing to share his expert thoughts with us once again.

The Chair has properly underscored how important this issue is to all of us. Health insurance premiums, we will all agree—let us find the places we can agree first, obviously—we all agree that health insurance premiums are skyrocketing and they are squeezing our economy, squeezing businesses, squeezing individuals, and this is not new. This has been going on now for years, increasingly.

I think average premiums for most Americans are up something like $3,500. There is no family in America whose income has gone up anywhere commensurate to the rise of health care alone, before you even get to the rise of gasoline prices, education costs, and the other costs of the average American family.

The fact is that over the last 4 years, the average American family's income has gone down, and the wealthiest Americans have seen their income go up. The tax burden, when you add excise, property, sales, and all the other tax burdens, have gone up. So people are being squeezed and health insurance premiums are rising faster than wages. They have grown at double-digit increases

for the last 4 years. No salaries of the average American have grown at double-digits, let alone single-digits in many cases.

Since 2000, healthcare premiums for family coverage have increased 59 percent, compared with inflation at 9.7 percent, and wage growth at 12.4 percent. Small businesses have obviously been hit particularly hard. Some have reported their premiums increasing by more than 70 percent in one year alone. As a result, the number of small businesses in 2004 that offered health benefits to their workers is only 63 percent, which is down from 68 percent in 2001.

By contrast, 99 percent of businesses with 200 or more employees offer health benefits, though increasingly we see them moving from defined benefit to defined contribution, so there has been a transition even there. And if you talk to the auto manufacturers and others, they will tell you the greatest squeeze on competition today is the cost of health care at $1,200 to $1,700 per automobile.

Of the 45 million uninsured Americans, 60 percent, 27 million, are small business owners, their employees and their families, and that ought to be unacceptable in our country.

For nearly 2 years, I had the privilege of traveling across this great country of ours and speaking with Americans of every stripe, of every level of income, about this issue of health care. Time and again, the conversation became one of almost desperation. People really are not sure where to turn and how to control this. It is obvious to all of us that it is one of the most pressing issues. In fact, I think the Secretary of Health and Human Services and others answered at our Finance Committee hearing on Social Security that far more pressing than Social Security, in fact, are Medicare, Medicaid and health care.

Every time I would have the opportunity to talk about options, people's eyes lit up when I said to them, you know, we could have a program in America where small businesses and individual Americans have the right to buy into the same health care plan as Members of Congress give themselves, and I think many people in America like that idea and think it is very fair.

When I spoke to the self-employed and small business owners, it was good to be able to explain to them how we could not only allow them an access to a range of plan choices—we could offer them all kinds of plan choices, not just one, but several different plan choices—and you could offer them the same consumer protections that are offered to us and to those other Federal employees who take part in the Federal Employee Health Benefits Program. So you could give them affordable options and the same protections at the same time, and you could give them the Federal reinsurance plan that would reduce premiums for everyone in America.

You could make American businesses more competitive by reducing those premiums for everyone in America if we created a reinsurance pool to lower those premiums. And the minute you do that, you have a greater range of choices in the marketplace. All those who care about the marketplace, which we all do, the more choice you have, the more competition you have, the more you affect pricing, and we could do that with that kind of an insurance plan.

These ideas, I believe, are real solutions. They are not real because I proposed them. They are real because they work and they

are real because they have been tested and, in fact, a number of States are now moving on their own to embrace both reinsurance plans and other ways of lowering the cost of health care.

The relief is real. Independent academic analysis has found that health care proposals such as that one would cover 95 percent of all Americans, 99 percent of all children in America. We have 11 million children with no health insurance at all today. That is unacceptable. It would reduce health care premiums by at least 10 percent for every family in America.

Is there a cost to it? Sure, there is a cost to it. There is a cost to everything here, and we make our choices, one priority versus another. If your priority is to give people who earn more than $1 million $32 billion in tax relief next year, you can't do this. But if your priority is to lower the cost of health care for all Americans, you can.

The test is whether we are willing to give voice to our values and explain the choices to Americans and give them an important opportunity to have a choice during defining moments like these. So that is really what we are here to put to test.

Now, beginning today, this Committee has an opportunity to help lead the Senate. There is a difference of opinion. It is an honest difference of opinion and I really look forward to exploring it here. If somebody can prove to me that the things that a lot of experts say that are negative won't happen, terrific. But for the moment, we have strong evidence that Association Health Plans just don't live up to their billing.

We have expert testimony that suggests that they will cause premiums to rise for the vast majority of small businesses and their employees, that it will offer no help to many of the uninsured. It actually might even raise the uninsured rolls, according to some analyses, by an additional one million people, and in many cases will erode the benefits and consumer protections that are currently existing in the regulation of health insurance products and leave consumers at risk for unpaid claims as the result of plan failures, insolvency, or even fraud.

Now, I am not alone in believing this. That is why over 1,300 national and local organizations have spoken out against AHPs. It is nearly impossible to find an Attorney General, Governor, or insurance commissioner of either party—either party—that has not gone on record in opposition to these plans. Even our U.S. Secretary of Health and Human Services Mike Leavitt wrote a letter to Congress encouraging us to bypass this ill-conceived plan when he was Governor of Utah.

Now, if you truly want to solve the small business health care crisis, and if we really want to engage in a dialog of alternatives for lowering the costs and covering the uninsured, then I welcome a vigorous discussion about not only AHPs, but about all these other ideas that have been advanced. Let us not make this just a one-topic discussion. Let us not make this a one-plan possibility. Let us really examine, with the same kind of openness we approached the Bolton nomination yesterday, and talk about what the possibilities are. It is my hope that we can draft legislation—I am drafting some now—that would provide a more complete picture of how we can proceed to do this.

But the time to act is now. I hope we will find a real solution, and I welcome the testimony that we are about to hear and the effort to do that.

Chair SNOWE. Thank you, Senator Kerry.

Senator Bond, who was my predecessor as chair of this Committee and who began this effort, I welcome you, Senator Bond.

**OPENING STATEMENT OF THE HONORABLE CHRISTOPHER S. BOND, A UNITED STATES SENATOR FROM THE STATE OF MISSOURI**

Senator BOND. Thank you, Madam Chair. It is good to be back. I see a lot of friendly faces again.

We are talking about problems that are very important to small businesses across this country. When I first came on this Committee, small businesses were primarily concerned about excessive regulation and excessive taxation. I would like to think that this Committee, on a bipartisan basis, moved and moved effectively to deal with those problems, and we have made significant progress. We are delighted to have Administer Barreto here, who continues that fight.

But now, as I go around and I talk to small businesses, the one thing they tell me is they are concerned about the cost of health insurance premiums, and that is why we also are delighted to have Secretary Chao here, because I believe that she is going to be able in her testimony to debunk some of the myths that have been put forth about Association Health Plans.

There is no question that with approximately 45 million uninsured Americans, expanding access to quality, affordable health care must be a top priority for this Senate. Now, I was here back in 1993 and 1994 when they ran an idea for national health care up the flagpole. You know, they couldn't even get 50 people to salute that one, because when you looked at it and you found that raising taxes to put more burdens on small business, and supposedly to give them a break on their health insurance, was no solution whatsoever.

We know that the cost explosion the insurance companies are imposing on small businesses and how small business owners are finding it virtually impossible to provide the health care coverage that they, as well as other employees, need, we need to have better solutions.

One solution—and there is no easy, simple solution to this—but one solution has been to expand community health centers, and I have been proud to work on expanding community health centers, which do provide access on a very affordable basis to locally controlled primary health care entities. But we are now today going to talk about something that would give small businesses the opportunity to provide for themselves and their employees a solution to the health care cost problems that knocks 25 to 27 million small business owners and their dependents out of health insurance. Small businesses cannot compete with the kind of health care plans that corporations and unions provide for their employees.

Those people who get up on their high horses and say, well, the insurance regulators and the Attorneys General say they won't work. They are wrong. AHPs will work. Do you know why they

work? Because they provide a broad basis of employees, a large pool, not only that provides better management of risk, it provides administrative savings to the small businesses. We are talking about giving small businesses the same tools that large corporations and large unions have.

AHPs are not a new idea. They have been talked about and bandied about and compromised for almost a decade. During that period, what was once thought to be a manageable problem has become the crisis that we had today. Had we passed AHP legislation when it was first introduced, when people like my colleagues, Senator Talent and Senator Snowe, were first talking about it, we would not be seeing the problems we see today for small business.

Yes, as a former Governor, I want to see State solutions where they work. But when you have national small businesses competing with corporations that are national in scope in the insurance market which is national in scope, then we know we have to have a national solution.

The principle underpinning AHPs is simple, the same principle that makes it cheaper to buy your soda by the case instead of by individual cans. Bulk purchasing is why large companies and unions can get better rates for their employees than small businesses and it is about time that we bring Fortune 500-style health benefits to the Nation's main street small businesses and their employees.

I commend Senator Snowe for taking the lead and using this position to advance the number one health care priority. With the support of President Bush, the Department of Labor, Small Business Administration, and over 100 small business groups, I hope this bill will move quickly. For the sake of small businesses throughout the country, their employees, and their families, we must pass AHP legislation.

I thank Chair Snowe and Senator Talent for their leadership, dedication, and commitment on behalf of small business. I look forward to working with you, Madam Chair, to help pass Association Health Plans in this session of the Senate.

[The prepared statement of Senator Bond follows:]

Remarks
Senator Kit Bond
*Solving the Small Business Health Crisis: Alternatives for Lowering the Costs and Covering the Uninsured*
April 20, 2005

With approximately 45 million uninsured Americans, expanding access to quality, affordable health care must be a top priority for the Senate.

We hear about the cost explosion that insurance companies are imposing on small businesses and how small business owners are now finding it virtually impossible to provide the health insurance coverage that they, as well as their employees, need.

No one is harder hit by large premium increases than small businesses-- studies indicate more than 60 percent of these uninsured Americans either work for a small business or are dependent upon someone who does.

Today we are here to talk about a solution that can help millions of small business employees access the same type of health care that their counterparts in large corporations and unions already enjoy, through Association Health Plans (AHPs).

AHPs are not a new idea. They have been talked about, bandied about, argued about and compromised about for almost a decade.

And, during that period, what was once thought to be a manageable problem–became the crisis that we have today. Had we passed AHP legislation, we would not be seeing the problems we see today for small businesses.

The principle underpinning AHPs is simple. This is the same principle that makes it cheaper to buy your soda by the case instead of by individual cans. Bulk purchasing is why large companies and unions can get better rates for their employees than small businesses and it is about time that we bring Fortune 500 style health benefits to the nation's Main Street small businesses and their employees.

I commend Sen. Snowe for taking the lead on this critical issue and for using her position as chairwoman of the Small Business Committee to advance the number one health care priority of the small business community.

With the support of President Bush, the Department of Labor, the Small Business Administration, and a broad and diverse coalition of over 100 groups, I hope that this bill will move quickly.

For the sake of small businesses throughout this country, their employees, and their families we must pass AHP legislation. We must bring fortune 500 health care to small business.

I thank Senators Snowe and Talent for their leadership, dedication and commitment on behalf of small business and I look forward to working with them to pass Association Health Plans legislation in the Senate.

Chair SNOWE. Thank you, Senator Bond. I am looking forward to it, as well.

Senator Landrieu.

**OPENING STATEMENT OF THE HONORABLE MARY L. LANDRIEU, A UNITED STATES SENATOR FROM LOUISIANA**

Senator LANDRIEU. Thank you, Madam Chair. I know you are anxious to get to the panel, so I am going to submit my full statement for the record, but I just wanted to make a very brief opening comment thanking you for your hard work. This has been a very difficult issue that you and I have worked diligently over the last couple of years. I thank Senator Kerry for his leadership and work in reaching out to small businesses in our country.

I can only add this morning that the small businesses in our State are looking for relief. Ninety-seven percent of the people employed in my State are employed by businesses under 500 people. Health insurance prices are too high; are making them uncompetitive, and are losing jobs. So a solution needs to be found.

I think the solution, Madam Chair, that you have put forward has a great deal of merit. As you know, I have worked very closely with you as we have developed a lot of the ideas behind the bill. But I am still concerned about cherry-picking, that if not addressed completely in our effort could be the undoing of what we are actually trying to do and make the health crisis in our country worse instead of better.

In addition to cherry-picking, Madam Chair, there are a few other vulnerabilities I see in the plan that has been laid forward that I would like to pursue in the line of questioning.

Finally, I want to mention that the Durbin-Lincoln proposal called Small Employer Health Benefit Plan of 2005 is a different model, but I think it has a lot of promise. It tries to do and meet the same principles, giving options, more affordable options for small business.

While I would agree that the proposal before us should be given a lot of attention, there are perhaps other methods of getting to the same end, which is giving needed relief to small business. So I will look forward to this panel.

Thank you, Madam Chair.

[The prepared statement of Senator Landrieu follows:]

Statement of Senator Mary Landrieu
Committee on Small Business
April 20, 2005
9:30 a.m.

Madam Chair. I would like to begin my remarks this morning by thanking you for your outstanding leadership on this issue and other issues of importance to the small business community. Louisiana is a state that depends very heavily on the vitality of its small businesses. 97.4 percent of the businesses in Louisiana have less than 500 employees. In 2000, small businesses in our state employed 53.6 percent of Louisiana's 1,592,357 non-farm sector employees and contributed over 10 billion in income to our state's economy.

We are also a state that knows a lot about the looming crisis in health care. One in five non-elderly people in Louisiana are without health insurance. Fifty six percent of whom are full time, full year workers. Two hundred and thirty four thousand of these are children. As I am sure will be stated later by some of our panelists, the overwhelming number of those working without insurance are employed by a small firm. 1 in 4 uninsured workers in Louisiana are employed by a firm with less than 25 employees, which surprisingly, is less than the national average of 1 in 3.

Over the past several months I have had the opportunity to speak with members of the small business community and they have told me in no uncertain terms that the issue of health care is at the top their list of concerns. They have stressed to me time and time again that if we don't do something now to address this problem, we will be forced to address it in the future.

The concern over health care in America goes beyond the small business community. Literally every day, people from my state stop me in the street to share their growing concern with the rising cost and the lack of availability of high quality health care. Madam Chair, as you know, their concerns are well founded.

With the cost of health care increasing faster than inflation, an increasing number of employers are being forced to trim down or worse still, discontinue their coverage. Almost half of those uninsured in Louisiana make less than $20,000 a year. Without access to employer sponsored coverage or Medicaid, their only option is to purchase individual insurance, an option that is well above their means. Louisiana is the only state in the Union which offers a state sponsored Charity Hospital system, but even this system finds themselves buckling under the stress of rising costs and decreasing revenue.

The effects of this problem extend beyond the uninsured. The rising insurance rates and the related cost of care are due in large part to the fact that while these Americans may not have insurance they still need health care and are often using the most expensive routes to get it. Even in Congress we find ourselves confronted with questions on how to afford to afford to pay for programs such as Medicare and Medicaid which have become the critical safety net for so many in our Nation.

We cannot ignore this problem any longer. It is incumbent on us to come up with answers to these important questions. Solutions to the problems facing the small business community are an important part of that equation. I commend you Senator Snowe for introducing S. 406. As you know, I am very intrigued by the underlying principles espoused by this bill. It makes sense to me that we should be pursuing ways to allow small businesses to band together to enjoy greater bargaining power, economies of scale, administrative efficiencies, and the benefits of a uniform regulatory structure.

What it is not so clear to me is under what structure should these small businesses be banding together. While I see the benefits offered by a system built on the trade and professional associations, I also see some potential dangers. It is my hope that we can use this time here today to explore these issues and work creatively and collectively to overcome them.

Let me raise a few of my particular concerns regarding S. 406. In Louisiana, State insurance laws are specifically designed to protect the insured from abuse and rate hikes and to ensure that necessary benefits, such as mental health care and mammography services, are available. The approach taken by current legislation would exempt these plans from some of the most important requirements of state law. I understand that large corporations and union plans function under these same exemptions and often offer more rich benefit plans than those that are state regulated, but I would suggest to this committee that we must bear in mind that associations are not large companies or unions. We cannot just assume that given the same rights and freedoms, these entities will act in the same fashion.

I am also concerned about the solvency and liability of these plans should they go out of business. Recent media coverage reveals that the failure of three similar health benefit plans for small employers. These plans left 65,000 participants with $30 million in unpaid medical bills. More than 15,000 doctors and hospitals were left without unpaid medical claims. I understand that this legislation provides protection for up to $2,000,000 but realistically, in this market, that would not be enough to cover more than two or three serious claims.

Finally, I am concerned about what the introduction of these plans would mean for the small group market as a whole. Albeit, this market has its share of problems, but since CBO estimates that two-thirds of the cost savings would result from attracting healthier members from the pool of existing workers, it occurs to me that could result in a huge imbalance in the current market. In fact, CBO estimated that while 4.6 percent employees and dependents of small employers would experience a rate reduction, 20 million might experience a small increase in rates under AHP's. In addition, 10,000 of the sickest individuals could lose coverage all together. I, for one, do not want to solve one problem by creating another.

I am glad to have Senators Lincoln and Kerry with us today as I know that each of them has put forward alternative solutions to this very pressing problem. I look forward to hearing from them and our other panelists as we strive to put forward a plan that will reverse the trend in small business health care. In closing, let me just say that I think that there are answers to be had here. I am confident that, working together, we can produce legislation that provides much needed relief.

Chair SNOWE. Thank you.

An important Member of this Committee, Senator Burns.

**OPENING STATEMENT OF THE HONORABLE CONRAD R. BURNS, A UNITED STATES SENATOR FROM THE STATE OF MONTANA**

Senator BURNS. Thank you, Madam Chair, and I welcome my good friend from Montana this morning. I am looking forward to his testimony. I have a prepared statement. I would just like to make a couple of points, though.

I think ever since I have been on this Committee, going way back to when Senator Bumpers was Chairman way back in the 1990s, we were talking about health care, and we are still talking about it today. Senator Pryor, you have big shoes to fill on this Committee. And we accomplished a lot of things during that Committee, so you have got big shoes.

But this issue comes up, and as you get comments from your State here in Washington and when you are back in the State and you have conversations, no matter what the event is, it seems like it goes from conversational chatter to screaming about doing something about the affordability and the accessibility to health care. And, of course, insurance premiums always come up in the series. So I held a series of roundtables in the State on this and asked what the possible solutions were.

I was a small businessman. It wasn't planned to be that way, but that is the way it was. That was a long time ago, and even back then, we bought insurance for our employees, but Phyllis and I chose not to buy any on ourselves. So even back then, the concern of cost was very real.

It is tremendous—the reason for the cost in health care, we have made tremendous technological advances and we all share in those costs and they come at a price.

Now, I know there has been a lot of discussion on AHPs. It has been very contentious to some folks. And, of course, I have always had some reservation about it. I want to make sure I want to know what the role of the Federal Government should be. Should we be making decisions here in Washington, DC for people in Montana? I don't know. We pass a lot of legislation that one size fits all, and sometimes it doesn't and so we have some problems with that.

With that said, I firmly believe that perfection should not be the enemy of the good. When health care costs spiral out of control, as they have done in these recent years, the American public needs relief, and one way to address this issue is through Congressional action. It may be the only action that we have to take.

I know this. The Chair of this Committee, ever since I have been in the Senate and ever since she has been here, has worked tirelessly in health care issues and I applaud her for her work, and I plan on working with her. I am not a co-sponsor yet of this piece of legislation, but I think maybe it is narrowing down. We are coming to the choke point where we may have to act. And, just like I said, I have reservations about that, but nonetheless, small business cries out right now. Their ability to expand, provide jobs and economic growth is being stifled by this issue of high costs of health care premiums and accessibility to those plans.

I look forward to the testimony. Madam Chair, congratulations for taking this on. It is a monumental task, but I believe that you are up for it and I thank you.

Chair SNOWE. Thank you.

Senator BURNS. I will make my formal statement a part of the record.

[The prepared statement of Senator Burns follows:]

Senator Conrad Burns
Opening Statement
"Solving the Small Business Health Crisis: Alternatives for Lowering the Costs and Covering the Uninsured"
April 20, 2005

I want to thank everyone for being here this morning. The idea of Association Health Plans (AHPs) has been around for quite some time. As a member of the Senate Small Business Committee, we have looked at this idea many times in the past, as health care access and affordability has become more critical for small business owners and the self-employed. Over the years, I have seen health care issues be the burning issue of the day. I hear from my constituents back here in Washington and at home, in Montana. iIn any meeting or event, this issue goes from conversational chatter to all out screaming from the small business community – it cries out asking us to do something – anything – in an effort to bring health care within reach. As a result, a few months ago, I held a series of roundtables around the state, with small business owners, to discuss health care issues. I always ask what they see as a possible solution.

My wife Phyllis and I know this access and affordability issue all too well. We were small business owners – and this was a while ago folks – we went without insurance, so we could provide coverage for our employees. Even back then, health coverage was too expensive to afford.

Tremendous advances in technology have provided us with the ability to live longer and healthier than ever before. These advances, however, have come at a great cost – a cost which we all bear. Those costs really hits home for those operating a commercial enterprise on narrow margins with only a few employees. This is why we're here today: to address this issue and look at options that may lead to possible solutions. AHPs may prove to be the right option. They may be our only option.

I want to again highlight how important this issue is for many of Montana's small businesses. I can't tell you the number of times an employer has requested some relief so that he or she may be able to offer health insurance to employees. It is a burdensome cost that continues to escalate.

Now I know that the discussion of Association Health Plans has been a contentious one to some folks. Before we proceed with legislation, I want to be sure this is the correct role for the federal government and that concerns are addressed in this underlying piece of legislation.

With that said, I firmly believe that the perfect should not be the enemy of the good. When healthcare costs spiral out of control as they have been in recent years, the American public needs relief, and one way to address the issue is through congressional action. I know people across the nation are asking for us to take action.

S. 406, as introduced during the 109th Congress by the Chair of this Committee, would allow employers to joining together to purchase healthcare coverage. While I remain sensitive to experience some states have had in the past with AHPs, my foremost concern is addressing the needs of Montanans, particularly those who are uninsured. I am not a co-sponsor yet and let the record show that the Chairman has worked tirelessly in this area of health care dealing with the costs and the accessibility. I applaud her in her work and plan to work with her.

I look forward to working with all of my colleagues to find a long-term solution to addressing the rising costs of health care and its impact on small businesses. Thank you all for coming today.

Chair SNOWE. Thank you very much, Senator Burns. I appreciate your willingness to work through some of these issues and for your comments and perspective on this important issue for small businesses. Thank you.

Senator Pryor.

**OPENING STATEMENT OF THE HONORABLE MARK PRYOR, A UNITED STATES SENATOR FROM THE STATE OF ARKANSAS**

Senator PRYOR. Thank you, Madam Chair. I have a statement for the record and I don't want to take any more of the Committee's time. Thank you.

[The prepared statement of Senator Pryor follows:]

**Senator Mark Pryor**
**Committee on Small Business and Entrepreneurship**
**Solving the Small Business Health Care Crisis:**
**Alternatives for Lowering the Costs and Covering the Uninsured**

- I applaud Chairman Snowe for holding this important hearing today. I also thank Senator Kerry.

- I don't believe there is any more important of a hearing we could have than the subject of today's hearing.

- Almost 45 million Americans lack health insurance. In Arkansas, over 450,000 people go without health insurance, almost one in five Arkansans.

- Today's hearing is about a very real problem. It is a problem in need of a real solution.

- I want to also thank Senators Lincoln and Durbin for their leadership and their sincere efforts to address this problem and for being here today. I also thank Senator Talent for participating in this hearing.

- I am a cosponsor of Senator Durbin's and Lincoln's bill to create a Small Employers Health Benefits Program.

- I believe that the cost of health insurance is unreasonably high, that small-employers need more affordable alternatives and better choices, and that there are serious problems in maintaining continuity of coverage.

- While I agree with the supporters of AHPs that the are serious problems that must be addressed, I am also concerned that it will be counter productive to have a solution that likely will create more problems than it solves.

- I believe we must address this problem in a way that does not cause health insurance rates to go up for many employers and that does not remove state protections without ensuring that reasonable protections are left in place with a strong enforcement mechanism ensuring patients are not left without a safety net.

- Again, thank you Senator Snowe for holding this important hearing.

Chair SNOWE. It will be incorporated in the record, without objection.

Senator Isakson, welcome.

**OPENING STATEMENT OF HON. JOHNNY ISAKSON, A UNITED STATES SENATOR FROM THE STATE OF GEORGIA**

Senator ISAKSON. Thank you very much, Madam Chair. I, too, will be brief, but I do want to tell you where I am coming from.

Prior to my election to the U.S. Congress in 1999, I ran a residential real estate brokerage company. It had 200 employees and 900 independent contractors. The employees, I could provide with group medical insurance by virtue of ERISA. They paid part, I paid part as the operator of the company.

But to the 800 to 900 independent contractors, by law, I could not provide them with benefits because of the IRS test on independent contractors, which so many small businesses deal with in construction and real estate and consulting and education and so many other areas. Of those 900 people that worked for me and produced the sales that produced the revenue that paid the taxes in support of this country, many were second or third career, single, divorced, or widowed women or individual single men who could not literally at that time—and this was 6 years ago—buy competitively in the marketplace health insurance. I tried as hard as I could without violating the IRS code to direct them wherever I could to be able to buy insurance, which was generally terribly excessive if even accessible.

So one of the reasons I am so proud of your effort and that of Senator Talent is that you are filling probably the largest—or attempting to fill probably the largest single void that exists out there in small business, which is part of the most productive part of our economy. We have a crisis and these individuals have a crisis. Your Association Health Plan approach is a way to help fill that void and give them accessibility and some semblance of affordability by being able to pool together that, quite frankly for those individuals is just almost not available today, and I want to thank you and Senator Talent for your effort.

Chair SNOWE. Thank you very much, Senator Isakson, for offering that view and insight into your experience. I appreciate that.

Senator Cornyn, thank you.

**OPENING STATEMENT OF THE HONORABLE JOHN CORNYN, A UNITED STATES SENATOR FROM TEXAS**

Senator CORNYN. Thank you, Chair Snowe. It is good to be a new Member of this Committee. You and I have worked together as fellow members of our party's task force on the health care costs and the uninsured, and I think we all recognize that there is no more pressing issue confronting America today than dealing with health care issues—cost, access, and all the issues that follow from them.

I support the goals of Association Health Plans, trying to make health insurance more affordable and more accessible. I also support other approaches that are designed to get us to those ultimate goals, such as market reforms and State mandates on health insurance coverage which make it unaffordable to many individuals. I think we made some good headway in 2003 with the Medicare

Modernization Act when we created Health Savings Accounts, and I think they offer a lot of potential for individuals and employers to increase access and to manage health care costs. It is going to require some additional transparency by health care providers so consumers can actually make good choices and compare prices in a way that I think has great promise to bring costs down and increase access to health care.

I, along with Senator Bond, agree that FQHCs, Federally Qualified Health Centers, are an important part of the solution.

Another area that we have failed to act on in the Senate is medical liability reform and the defensive medicine that is attendant to our current medical liability crisis in the country, driving up costs in a way that prevent access to good quality care. In my own State, 100 out of our 254 counties could not offer an obstetrician, for example, to a woman who wanted to deliver a baby before we passed medical liability reform on the State level. And in high-risk medical specialties like neurosurgery and emergency room medicine, it was simply impossible to recruit qualified physicians to come work in those counties because of the medical liability situation.

I hope to help contribute to this debate, because I think it is one of the most compelling issues confronting our country today. Our ability to compete and the ability of small employers, as has already been noted, to create jobs for the American people is dependent on our ability to provide employees with affordable, quality healthcare.

Thank you for convening this hearing, and I look forward to working with you and the other Committee Members.

Chair SNOWE. Thank you. We have a great line-up of newly elected Members on this Committee with Senator Isakson, Senator Cornyn, and Senator Thune. Thank you.

## OPENING STATEMENT OF THE HONORABLE JOHN THUNE, A UNITED STATES SENATOR FROM THE STATE OF SOUTH DAKOTA

Senator THUNE. Thank you, Madam Chair and Senator Kerry, for holding this important hearing. I also want to thank Secretary Chao and Administrator Barreto for being here, as well as the other panelists we are going to hear from.

This is an incredibly important issue to the economy. It is clearly the one that I think, as you travel across the country and in my State of South Dakota, hear as much about if not more than anything else, maybe with the exception now being the cost of energy. But the cost of health care is enormously important, and again, it is, of the 45 million people who aren't covered in this country, half of them work for, or their family members do, for small businesses.

I think the thing that gets missed in this debate is the people who work for larger companies, for big businesses, they have the benefit of economies of scale and that is not something that small businesses can benefit from. What I think this proposal simply tries to do is provide that group purchasing power, those economies of scale that are available to larger businesses to help drive down costs for small businesses.

We have got 88,000 uninsured people in South Dakota. We have got 71,000 small businesses. Almost every business in South Dakota is, by definition, a small business. And so this is really an issue crying out for a solution. There have been a lot of—this issue has been kicking around for a long time. Jim Talent chaired the Small Business Committee in the House. I was a Member of that Committee. We voted this out of the House I think on more than one occasion when I was a Member of the House, 5-, 6-, 7-, 8-years ago, and we still haven't seen any final action on this, and furthermore, any effort, I think, on the Senate to get it on the floor for a vote.

But in any case, it is time for this hearing. It is time for this issue to be addressed, and frankly, I am hopeful that we will be able to make progress on meaningful solutions to the cost of health care in this country. And whether or not you like Association Health Plans as a solution, I think it is an issue that has been debated and discussed around here. It is one that clearly has, I think, tremendous potential to help lower costs by giving small businesses access to group purchasing.

I would certainly hope that this Committee could work constructively to get a bill out of here and to have a debate on the floor and then hopefully to do something that, in my view, at least would give small businesses out there another option. This is, with the appropriate safeguards for solvency and with the issues that have been addressed, I think, in this legislation with regard to giving our small businesses more choices, it is an approach whose time has come.

So thank you, Madam Chair, for conducting the hearing. I look forward to hearing from the witnesses.

Chair SNOWE. Thank you, Senator Thune.

Senator Talent, who is not a Member of this Committee, but we welcome him because he chaired the Small Business Committee in the House previously and was a leader and continues to be a leader on this subject and certainly has a very important point of view. So Senator Talent, thank you.

**STATEMENT OF THE HONORABLE JAMES M. TALENT, A UNITED STATES SENATOR FROM THE STATE OF MISSOURI**

Senator TALENT. I thank you, Madam Chair, and I want to thank the Ranking Member also, both for holding this hearing, for your leadership, for allowing me to come here and make a brief statement, and I understand that Senator Durbin and Senator Lincoln are going to do the same thing. I have chaired a Committee and I know that sometimes you feel like the Members not on a Committee who have an interest in the hearing are trying to hijack the Committee, and I think you have got a useful compromise, just allowing us to come and make a few statements.

I do feel strongly about this because it is so important, and we all know that. I guess that is one thing we agree on, Senator Kerry. In fact, I think we probably agree on a lot of things.

All the Association Health Plan idea does is allow small employers to do what large employers have been doing for many, many years. That is really all it does. And if you think about it, everybody in the United States, or virtually everybody who has health

insurance, and there are a lot of people, unfortunately, who don't, but just about everybody who does has it as part of a big pool, a big national pool. In some cases it is private, like the big Fortune 500 companies or the labor union plans. It may be public, you know, Medicare and Medicaid, retired Federal employees, current Federal employees. They are all part of a big pool because there are economies of scale to insuring large pools. I mean, it is a matter of common sense. It costs less from an overhead and administrative standpoint to insure a pool of 300,000 people than it does a pool of 30 people, much less three people.

I don't understand why small businesspeople shouldn't have the same opportunity. When we came up with this idea, and the Chair has been working on it for a long time, too, one of the things I liked about it is I thought it ought to be attractive to everybody. It is fully within the philosophical mainstream of both parties and it really was in the House. We put this bill out of our Committee with strong support by Members on both sides of the aisle and it has passed in the House on strong bipartisan votes on a number of occasions.

It empowers the little guy—I mean, if you want to think about it this way, it empowers the little guy and gal against the big insurance companies that currently dominate this market. It is a lot like the co-ops that grew out of the agricultural movements in the populus parts of the country. It just empowers people to do something on their own to reduce costs for themselves.

It has a big advantage in these days of big deficits. It doesn't cost anything, if you read about a cost to associations and health plans, other than the money the Secretary of Labor may need to hire a few more people to regulate it, which is a very small amount of money. The only other cost that anybody will ever posit for this is the cost that happens when employers who haven't been insuring people in the past buy health insurance for them, because then money that they had been paying in wages, which are taxable, goes to a fringe benefit, which is not taxable. So the cost is the Government loses revenue because people get health insurance. That is a cost I don't mind. That means the number of uninsured are going down in the country. That is the only cost to Association Health Plans.

One of the reasons I thought it wouldn't be so controversial is there is really no down side to it. We set them up. If we are wrong and people don't want them, they just won't buy them. We are not saying to insurance companies, you can't offer people insurance on a small group basis. Go ahead and do it. States can regulate that just like they are doing now.

We are saying small business people ought to have another option, and I think they will use that option, and let me just say, the argument that is offered, and I have people come up to me with this argument that we shouldn't do this because only the employers who have healthy people will want to go into the Association Health Plan, that the employers who have sick people won't be able to go into the Association Health Plans. Madam Chair, as you know, that is not allowed under the bill. The bill requires that these associations—it is must offer, must carry.

It is not possible. Think about how this will work. My brother has a small restaurant. If this were allowed, he might join the restaurant association to get the health insurance. They don't know about his employees. His employees could change overnight. How are they going to exclude people because they have sick employees working for them?

In fact, I think the opposite is true. It is precisely the employer who has the sickest workforce who is the most desperately looking for an alternative. Now, they are going to go into these Association Health Plans so fast, if you blink, you are going to miss them. And I may just say, it is ironic when people raise that argument, Madam Chair, because we all know, because we all deal with constituents, it is the insurance companies now who are cherry-picking. They are the ones who are canceling insurance because somebody files a claim. They are the ones who are jacking up rates because somebody files a claim. It happens every day. It won't happen with Association Health Plans.

Just very briefly—I am not going to punish you for your hospitality by going on forever, Madam Chair——

[Laughter.]

Senator TALENT [continuing.] It has been raised that it won't be regulated by the States. We have talked about this. These are national pools. Believe me, I will say this to the State regulators, if there were some way to have national pools regulated by the States, I would do it. Just to get you on board, I would do it, but you can't. You can't have 50 different sets of regulations for national pools. That is why we don't allow it for big companies, for labor union plans, because you can't—you just physically can't do it.

I supported this, and originally we passed it—you remember, Madam Chair—as part of a patients' bill of rights, which was fine with me. I begged for people to pass it with this as part of it and it got held up in the Senate.

Finally, I just want to say one other thing, Madam Chair, and there are lots of ideas out there and I am certainly very open to them. What I hope we don't do is let Association Health Plans get sucked into the polarizing ideological battles about the direction of health care. One of the things I like about Association Health Plans, it is not a global change in the direction of our health care policy. You may have one side that wants a national single-payer system or a government-run system. You have another side that really would like to eliminate the employer-based system and pass all the tax deductions down to individuals and have them go out and buy their own health insurance, and those are two very respected points of view. I don't begrudge anybody for having that point of view.

But one of the genius of this is, it is not a revolutionary change on an ideological level in health care. It is a perfection of the employer-based system. It is a practical solution to the practical problems people confront, and I think that is what the American people want us to do. I don't think they are going to let us go into some whole new world for health care, but I do think they want us to help them help themselves where we can.

That is what this is all about, and I am just grateful to you. Every time I hear you talk about this, Madam Chair, I become encouraged because I think you have really got the idea behind it. Thank you for letting me trespass and the time. I appreciate it.

Chair SNOWE. I appreciate that. Thank you very much.

Senator KERRY. Madam Chair.

Chair SNOWE. Yes.

Senator KERRY. Just before we go to this, I just want to say to Senator Talent, first of all, I want to assure him and the other Members of the Committee, and I hope we can work in the way that this Committee has normally worked, that there is no ideological predetermination on this side as to how we do this, number one.

Number two, the split is not between a quote: Federalized, Government-paid, one-size-fits-all versus AHPs—that is not at all what we are talking about and I want to make that clear. The alternative I am talking about, among many alternatives, incidentally, is a completely market-based, not-Government-paid-for plan, but incentivized system where people choose to get in it or don't choose to get in it. And I think it is very important that we approach this with a view to trying to find the most effective means of doing it.

In fairness, however, when the Senator says this is so simple, and all we are trying to do is allow people to do this banding together, it is not that simple. I am for people banding together. I am for economies of scale. Yes, it is important that people be able to come in and find those market-based economies of scale. The problem is that that is not all that it does. The fact is that you are allowed to band together today under the law. Nothing stops you from banding together today under the law. The question is, in what form.

And when you say, must carry, must offer, the fact is that that is only if you are a member of the association. Who gets into the association? They have the power to say you don't join our association. And that is where some—so there are issues here.

I want to work in good faith with the Senator. I want to work to try to get rid of those, and if we do, we ought to be able to find a common ground here where we can help deal with the problem of small business. But we can't be false in the packaging and say this is all it does or this is as simple as it is when there are serious issues of enforcement and structure and defining who gets what coverage and how is it enforced and so forth.

Chair SNOWE. I just want to make a point on that. But under this Association Health Plan, they have to offer it to all their members, so there is no exclusivity——

Senator KERRY. But who gets to be a member?

Chair SNOWE. Well——

Senator KERRY. That is a major issue. You can cherry-pick in who becomes your members. Sure, you can.

Chair SNOWE. To all of its membership. You can't.

Senator KERRY. You can not let somebody be a member, so we will get at it.

Chair SNOWE. OK. We will.

Senator TALENT. I thank you again, and I thank Senator Kerry.

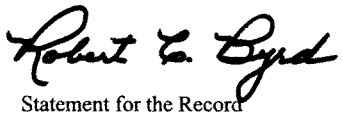
Chair SNOWE. We will look at legislative language.

[Laughter.]

Chair SNOWE. Thank you.

And before I begin, I am pleased to submit for the record a statement by Senator Byrd, who is a co-sponsor of this legislation, and so I ask unanimous consent that this statement be included in the record. Without objection, it is so ordered. We are delighted to have Senator Byrd as a co-sponsor.

[The prepared statement of Senator Byrd follows:]



Statement for the Record
Senate Committee on Small Business and Entrepreneurship
Senator Robert C. Byrd
April 20, 2005

**Health Care for America's Small Businesses**

I want to thank Senator Snowe, Senator Kerry, and the other members of the Small Business Committee for allowing me to address you today with regard to the health care crisis facing small businesses in my state of West Virginia and throughout the nation.

At a time when health care costs are skyrocketing, the number of individuals with access to medical insurance is dwindling. The harsh reality is that 45 million Americans have no health care coverage, including 275,000 West Virginians. For these people, health conditions go undiagnosed, illnesses go untreated, and critical medicines are not made available. These individuals go through life hoping and praying that they do not get sick or face a catastrophic medical problem.

Nowhere are the shortfalls in our health care system more apparent than in America's small businesses. The mom and pop shops that support our communities across the country have increasingly become the face of the uninsured. In fact, those working in small business, and their dependents, now represent the majority of the country's uninsured.

Many small business owners and their employees lack health insurance, not because they do not want it or that they are trying to cut corners, but because they simply cannot afford the soaring premiums. While the cost of providing employee health benefits is rising for all employers, small business owners are bearing an even greater burden. Small business owners have little buying power and few affordable options when it comes to purchasing health insurance for themselves and their workers. They are forced to pay more for policies that offer less. This lack of competition in the small group health insurance market is contributing to double-digit rate increases in health care costs for many small businesses.

Exorbitant health care costs also serve as a barrier to job creation, forcing many small businesses to rely on part-time or temporary employees or to limp along without needed help. And surging health insurance costs act as a hidden tax on American businesses. In the interest of improving our economy and ensuring that adequate health care is available to those in the small business community, this situation must be remedied. However, finding a way to address this problem confronting small businesses and our health care system is not simple.

I have cosponsored the Small Business Health Fairness Act, along with Senator Snowe, Senator Talent, and others, which would open the door to health insurance for more small businesses. It would give more Americans access to affordable, good quality medical coverage. This legislation would allow small businesses to band together through a trade association to purchase health insurance. These partnerships would allow for the establishment of small business health plans. By joining together, small businesses would enjoy greater bargaining power, less financial risk, and lower administrative costs.

The Small Business Health Fairness Act would help more workers afford health care benefits, regardless of whether they work for a large international company or for a small hardware store. A worker at a local pizza place in West Virginia should have the same choice of health benefits as someone who works for a large Fortune 500 company.

This legislation is only one step that can be taken to make health care coverage available to more Americans. It will not provide a miracle cure for the crisis of spiraling health care costs in America. It is not the be-all, end-all solution. But the establishment of small business health plans would help to move toward a goal we all share, namely, to have as few uninsured Americans as possible.

Health care should not be a matter of partisan politics. Rather, it is a basic quality of life issue. We must reach across party lines and work together to reverse the trend of rising numbers of uninsured Americans. Helping small employers to provide health benefits for their workers and their families is a smart first step.

Chair SNOWE. So now it is your turn. We have a great team of leaders in support of Association Health Plans and hopefully we can talk about some of the issues that have been raised here today. They are both extremely knowledgeable and have been champions and advocates, and so Secretary Chao, let us begin. Thank you for being here. Thank you for your patience. Thank you both.

**STATEMENT OF HON. ELAINE L. CHAO, SECRETARY, U.S. DEPARTMENT OF LABOR**

Secretary CHAO. Thank you, Madam Chair, and also Senator Kerry, for the opportunity to be here to discuss Association Health Plans. It has been very, very helpful for me and my staff to listen to the opening statements.

Association Health Plans are indeed a key component of the President's plan to make quality affordable health care benefits available to all Americans and I really want to commend your leadership on the health care needs of small business workers and their families. President Bush strongly supports S. 406, the Small Business Health Fairness Act, and I look forward to continuing to work with this Committee as the Senate considers this much-needed legislation.

Madam Chair, I do have a much longer statement which I will submit for the record, and if I could, I will just summarize the key points.

Today, as we have heard, there are about 45 million Americans who lack health care insurance. Clearly, all of us care about how to solve the plight of these Americans. Sixty percent of the workers are employed by small businesses and their families, and small businesses, as we have heard, are only half as likely to offer health benefits as large businesses, due in part to the high cost that they face. A small business pays about 20 to 30 percent higher premiums than large organizations or labor unions.

The Small Business Health Fairness Act, S. 406, addresses this problem by providing a level playing field for small businesses by allowing them to join together through their trade or professional associations. Small business owners and their employees will be able to access the same economies of scale, negotiating clout, administrative efficiencies, and uniform regulations enjoyed by big businesses and labor unions. AHPs will provide small businesses with new health care coverage options and foster competition in the small group insurance marketplace.

This bill will also reduce the vulnerability of small businesses to health insurance scams by providing secure, affordable, quality health benefits. Before an AHP can offer health benefits to a single worker, the Department of Labor will have to certify that this organization meets the tough standards in this legislation.

Small business employers obtaining insurance through AHPs will also enjoy significant premium reductions. According to CBO, the average savings will be about 13 to 25 percent. Even more significantly, CBO estimates that about two million additional Americans who are currently uninsured will be able to get coverage through AHPs.

The Department of Labor's role is one that we are very serious about. The Department of Labor has extensive experience in regu-

lating group health insurance and also in combatting insurance fraud. The Department of Labor currently administers ERISA. This Act covers approximately 2.5 million private employer-based, job-based health plans covering 135 million workers, retirees, and their families. Of these, about 300,000 plans are self-insured plans, which means that they are exclusively regulated by the Department of Labor. These plans that the Department of Labor exclusively cover regulates about 78 million people.

ERISA has both civil and criminal enforcement authority to protect the benefits of workers in these plans, and in 2004, the Department reported about $3.1 billion in monetary recoveries from our enforcement efforts on behalf of employee benefit health plans. We have also had 121 criminal indictments. So our enforcement effort is strong and robust.

In addition, we have a nationwide network of benefits advisors who answered roughly 160,000 inquiries from workers last year, nearly 60 percent of which concern health plans.

Because of our responsibilities under the current law, the Department already performs many of the functions necessary to administer Association Health Plans and I am confident that we can and will protect the workers who are participating in Association Health Plans just as we currently protect the millions of workers in other kinds of group health plans in large business and organized labor plans. The Department will allocate the resources necessary to carry out the certification and oversight responsibilities of Association Health Plans, and we will do so with effective, efficient, and timely regulation and enforcement.

So in conclusion, AHPs will reduce the health coverage barriers facing many small businesses. This bill will give them the tools to pool risk, enjoy administrative savings on behalf of their workers, and participation in nationwide health plans, and I ask that the Senate take a serious look at the Association Health Plan legislation and give this much, much needed relief to small businesses. Thank you.

[The prepared statement of Secretary Chao follows:]

**TESTIMONY OF ELAINE L. CHAO**
**SECRETARY OF LABOR**
**BEFORE THE COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP**
**UNITED STATES SENATE**

April 20, 2005

**Introductory Remarks**

Good morning Chairwoman Snowe, Ranking Member Kerry, and members of the Committee. Thank you for inviting me to discuss Association Health Plans (AHPs) - a key component of the President's efforts to make quality, affordable health benefits available to all Americans. I applaud your leadership, Sen. Snowe, for focusing on the health care needs of small business employers and their employees by championing AHP legislation in the Senate. I support S. 406, the Small Business Health Fairness Act, and I look forward to continuing to work with you as the Senate considers this much-needed legislation.

Approximately 45 million Americans lack health insurance, and approximately 84 percent of the uninsured are in families headed by workers - with most working at firms with fewer than 100 employees. In fact, small firm workers and their families comprise more than 60 percent of the working uninsured.[1] To increase health insurance coverage, the President has proposed a comprehensive reform agenda that includes tax credits for the purchase of individual coverage, policies that encourage increased use of health savings accounts (HSAs), medical malpractice reform, and AHPs sponsored by trade and professional associations, as well as civic, religious and other community groups.

**The Uninsured and Small Businesses**

Although most working Americans receive health insurance from their employers, small firms with fewer than 100 employees find it particularly difficult to offer benefits. Just 46 percent of these small businesses offer insurance, compared to 98 percent of larger firms with more than 100 employees. The difficulties that small businesses face in trying to offer quality, affordable health insurance account for a significant part of America's uninsured.

We know that small employers want to offer health insurance to their workers and their families. Among 600 small businesses responding to a survey, less than one-third currently offer insurance, but about three-fourths said they would be "very" or "somewhat likely" to participate in an AHP that offered lower prices, more choices, or less paperwork. [2] Further, small business employees value health insurance. According to a recent survey, health insurance was ranked as "very important" by 89 percent of small business employees.[3]

AHPs are a central component of the President's overall plan for expanding access to health care. Your legislation, Sen. Snowe, is aimed squarely at the gap in coverage among small businesses, and to understand why your bill will have such a significant impact on reducing the uninsured, it's important to understand the barriers that prevent many small employers from offering coverage today.

**Small Firms Face Numerous Barriers to Coverage**

Cost is clearly the biggest barrier for small employers wishing to provide health benefits. For a variety of reasons, insurers typically charge small firms more per employee than large firms for comparable coverage. Small company premiums are 20 percent to 30 percent higher than those of large self-insured companies

with similar claims per covered employee.[4] Cost drivers include small businesses' higher fees for administration, insurance company marketing, and underwriting expenses, as well as adverse selection, and state regulatory burdens. Further, small firms that are able to offer coverage, are likely to offer less generous benefits and more of their premiums are consumed by administrative costs. In addition, vulnerability to insurance fraud leaves many small firms unsure about where to go for affordable, reliable coverage.

Small employers' costs are rising more rapidly than those of larger employers. Total costs per employee increased by 13.6 percent at firms with 3 to 24 employees in 2004, compared with 11.6 percent at the largest firms.[5] Employees in small businesses bear the brunt of these cost increases, according to a survey by the Blue Cross Blue Shield Association (BCBSA), the Employee Benefit Research Institute (EBRI), and the Consumer Health Education Council. Of the small businesses that changed their health benefits, 65 percent increased workers' copayments and deductibles, 30 percent raised the percentage of premiums paid by employees, and 29 percent cut back on the package of benefits offered.[6]

**Employer Expenses:** When a small firm decides to offer health insurance, it must undertake numerous administrative tasks, including identifying available insurance policies; comparing their prices, benefit packages and other features; assembling plan descriptions, enrollment materials and other forms; and educating and enrolling its workforce. Small firms must pay for these activities with typically fewer resources than large firms, and the cost of these activities for each covered employee is higher.

**Insurance Company Expenses:** According to the Government Accountability Office[7], insurers incur higher costs when providing health care coverage to small employers than to large employers. Insurers must market and distribute their

policies to a very large number of unconnected employers. They typically must compensate agents for each small policy sold or renewed. Some costs, such as the cost of collecting detailed medical histories for purposes of medical underwriting, are layered on each time an employer changes insurers - and smaller employers generally tend to change insurers more frequently.

**Underwriting and Adverse Selection:** Under current law, many small employers face higher premium costs based on insurers' underwriting practices. In underwriting an insurance policy, the insurer estimates its cost to insure the employer's workforce, by looking at the group's demographics, past claims experience, and/or health status and other factors. Small groups have few participants among whom to spread the risk, and, as a result, a few unhealthy workers or dependents will skew the claims experience and may force the employer to pay much higher premiums.

Faced with high premiums and limited budgets, small employers often share more of the costs with their employees than larger employers. In the worst-case scenario, healthy workers will balk at higher costs and may not accept the offer to purchase insurance, either obtaining private individual coverage or joining and increasing the ranks of the uninsured. When healthy workers give up health insurance, sponsored by a small employer, only higher-risk individuals remain, leading to a predictable spiral of ever-increasing premiums and declining coverage as the insured group becomes less and less healthy. The small-group market is particularly vulnerable to this situation.

**State Regulatory Burdens:** Some state laws further impede small employer coverage. Because some states have been very aggressive in regulating small-group markets, many insurance carriers have withdrawn from those markets, leaving employers with little choice in plan design or cost options. Five or fewer insurers control at least three-quarters of the small-group market in most states.

In some states, insurance for certain small firms is available only through a state-operated risk pool or from one insurance carrier.[8]

Additionally, small employers are sensitive to the cost of state benefit mandates (such as requiring coverage for hair transplants, or treatment provided by acupuncturists) that drive up the cost of the small group coverage. Such mandates are responsible for one of every five small employer decisions not to offer coverage.[9] Another study reported that mandates raise premiums by four to 13 percent, and that up to one-quarter of uninsured Americans lack insurance because of state mandates.[10]

**Vulnerability to Fraud:** Small employers and their employees are often victims of fraudulent schemes that promise low-cost health coverage. Many of these arrangements are multiple employer welfare arrangements (MEWAs). MEWAs are arrangements that provide health benefits to employees of two or more unrelated employers who are not parties to collective bargaining agreements. MEWAs are subject to a complex mix of state and federal laws and regulations. Unfortunately, unscrupulous promoters have exploited MEWAs' complex regulatory and oversight structure to operate Ponzi schemes that collect premiums but intentionally default on benefit obligations.

Any small businessperson who has been harmed by fraud will be wary of buying coverage again. And all small businesses are vulnerable to such schemes because the marketing can be persuasive and the price is often "too good to be true." Because of this, any new legislation aimed at expanding access to affordable health coverage must protect against this type of abuse and provide assurances to small businesses that the product is legitimate.

**AHPs Address These Barriers to Coverage**

Association Health Plans will have the effect of reducing these barriers to coverage. Small businesses would enjoy greater bargaining power, economies of scale, administrative efficiencies, and the benefits of a uniform regulatory structure. Federal certification demonstrating that legitimate and financially sound sponsors operate AHPs would provide small businesses with the assurance that the Department of Labor has determined that the organization offering coverage is not a "fly-by-night" operation, reducing the vulnerability of small businesses to fraud by providing secure, high quality, and affordable health benefits.

The AHP legislation provides a level playing field for small business by allowing small employers to join together through *bona fide* associations to purchase or provide health insurance coverage for their employees. Through the power of group purchasing, Sen. Snowe's legislation would give small firms many of the economic and legal advantages currently enjoyed by large companies and labor unions. The Administration also believes that quality affordable insurance could be expanded to many more Americans by further adopting the President's proposal to expand AHPs to civic and community groups. This would allow private, non-profit, multi-State entities outside the workplace, as well as small businesses, to offer affordable health coverage to their members and dependents.

**Bargaining Power and Economies of Scale:** By grouping small employers, as well as civic and community organizations, together to purchase coverage, AHPs will be able to act more like large employers and offer lower cost coverage to employers, employees and their families. If the AHP chooses to purchase insurance, it will be in a better position to negotiate with insurers regarding the terms and costs of coverage than a small employer acting individually. AHPs

will also enjoy economies of scale in the administration of plans. They will give insurers a vehicle to market and distribute policies to many small employers at once. By offering a well-selected and stable choice of policies to members, AHPs can help slow small employers' otherwise costly movements from one insurer to another.

**Streamlined Regulation:** AHPs will allow small businesses to enjoy the benefits of a more uniform regulatory system. For AHPs that offer fully insured coverage, state laws will govern the solvency requirements and other consumer protections, just as the states regulate insurance policies issued to group health plans today. However, insured AHPs will be able to offer a uniform benefits package nationwide, making it possible for employees to receive the same benefits regardless of where they live.

AHPs that offer self-insured coverage will be subject to a single, effective, national certification, solvency and oversight process that will be administered by the Department of Labor. Strict standards would be met to ensure solvency and protect consumers.

**Pooling Risk:** AHPs will help ensure small employers are not denied insurance coverage or priced out of the market due to the health of their employees. As a member of a *bona fide* association, even an employer with high claims experience would be offered the same coverage options as those offered to other employers within the AHP. Large AHPs can spread the risk of insuring unhealthy groups or individuals among a larger population of health risks.

**Broader Choice of Coverage:** Associations will be able to fashion coverage that best meets their members' needs, even choosing to offer more than one plan. By

offering broader choices, AHPs will encourage healthy small business members to purchase coverage and pay into the premium pool.

**AHPs Will Reduce Costs and Cover the Uninsured**

**Cost Savings and Increased Coverage:** Small businesses obtaining insurance through AHPs could lower premiums. According to the Congressional Budget Office (CBO),[11] the average savings would be 13 percent, and could be as much as 25 percent per employer. CBO further estimates that, because insurance will be more affordable, more small firms will be able to provide coverage to their employees and families. Even firms that already offer coverage could obtain lower-cost coverage through AHPs. According to CBO, as many as 2 million American workers and their families who are currently uninsured could obtain health benefits through AHPs.

**Wide Availability and Greater Access:** Numerous small business groups are eager to offer coverage and look forward to enactment of AHP legislation, including organizations such as the National Federation of Independent Business, United States Hispanic Chamber of Commerce, the American Farm Bureau Federation, and dozens of groups representing small businesses and professionals. The Small Business Survival Committee (SBSC), representing nearly 100 existing associations and employer groups, believes that coverage will increase dramatically. According to the SBSC, "AHPs will empower America's small employers with the tools needed to harness their entrepreneurial spirit and skills in providing working families with more health benefits, and more health plan choices, at affordable prices."

**Ensuring AHPs Keep Their Promises: Strong DOL Oversight**

The Department of Labor has extensive experience in regulating group health insurance and in combating insurance fraud. The Department of Labor currently administers Employee Retirement Income Security Act (ERISA) protections covering approximately 2.5 million private, job-based health plans and 135 million workers, retirees and their families. Of these, 300,000 plans covering 78 million individuals are self-insured, and therefore subject exclusively to DOL oversight. In addition, self-insured multiemployer plans (established and operated jointly by a union and two or more employers) are overseen exclusively by DOL. These plans cover more than 5 million participants, not counting their covered dependents.

Your legislation, Sen. Snowe, gives the Department new, but not unfamiliar, responsibilities with respect to Association Health Plans. I am confident that we can and will protect the workers in an AHP just as we currently protect the millions of workers in other kinds of group health plans. Rest assured, I will allocate the resources necessary to effectively carry out our AHP certification and oversight responsibilities with effective, efficient and timely regulation and enforcement. I am confident of our ability to administer the AHP program successfully.

**Certification and Oversight:** To ensure that unscrupulous promoters would not operate AHPs, only *bona fide* trade or industry associations that have been in operation for more than three years for purposes other than providing health benefits are allowed to sponsor an AHP. The Department will examine AHP sponsors and certify them only if they meet this standard, as well as applicable solvency and membership requirements.

Whether AHPs are self-funded or fully insured, the AHP may not offer benefits to a single worker until the Department of Labor certifies that the AHP complies with the strong protections in the law. And I can assure you, we will not issue such a certification until we are satisfied that the AHP will comply with the law and our regulations.

**Safeguards Against Insolvency:** The states will regulate the solvency of insurers selling insurance to an AHP, just as they currently do for group health plans. Thus, workers in a fully insured AHP will be guaranteed that the current protections against insolvency apply to their plans as well.

For self-funded AHPs, the bill establishes new, strict solvency requirements in Federal law. An AHP that offers self-insured coverage will be required to establish premium rates that are adequate to cover claims and to maintain adequate reserves, as determined by a qualified actuary. Self-insured AHPs will also be required to keep additional reserves on hand to cover unexpected losses, and to purchase both specific and aggregate stop loss insurance to cover unusually large claims. AHPs will be required to purchase indemnification insurance to ensure that claims are paid in the event of plan termination. Self-insured AHPs must pay annual fees to a fund administered by the Department that is used to ensure that indemnification policies remain in force for terminating plans.

Further, the legislation provides regulatory authority to the Department of Labor to expand upon these requirements to ensure that workers' health benefits provided through an AHP are secure.

**Insurance Market Safeguards:** AHP legislation includes provisions to ensure that AHPs result in stable, reliable markets for health insurance. Spreading risk

and costs across a large group of individuals is fundamental to effective health insurance. In the past, small group markets have sometimes been vulnerable to practices, such as adverse selection or "cherry picking," that segregate good risks from bad. Such practices can make insurance unaffordable or unavailable for small firms when employees or their families become seriously ill. To prevent cherry-picking, AHPs and participating employers will not be allowed to direct their higher-cost employees to the individual insurance market based on health status. AHPs must offer all available health policy options to all of the membership's employers and individuals. The proposed legislation also limits AHPs' ability to vary the premiums for their participating employers, including a general prohibition on rating based on health status.

**ERISA, HIPAA and Other Laws:** Like other group health plans, AHPs will be subject to the fiduciary requirements of ERISA, which set high standards of behavior for health plan sponsors. In particular, the Health Insurance Portability and Accountability Act (HIPAA) would apply to AHPs. Under HIPAA, group health plans are subject to portability, pre-existing condition, nondiscrimination, special enrollment, and renewability provisions. These provisions also will limit the opportunity for cherry-picking. Other federal health insurance requirements that provide consumer protections, such as COBRA, DOL's claims regulation, the Mental Health Parity Act, the Women's Health and Cancer Rights Act, and the Newborn's and Mother's Health Protection Act would apply to AHPs.

**Strong DOL Enforcement and Education:** The Department takes health care fraud very seriously, and pursues an active strategy of enforcement and education to combat it. We devote significant resources to enforcement efforts, and we have been effective in closing down fraudulent health plans and in recovering money for their victims. We also work to educate small employers,

alerting them to ways they can protect themselves and their employees from fraudulent health insurance schemes.

- **Enforcement:** The Department places a heavy emphasis on enforcing existing health laws and on working with state insurance departments and the National Association of Insurance Commissioners (NAIC) to protect workers and their families. In particular, EBSA is actively investigating and litigating issues connected with some MEWAs. The Department's primary goals are to shut down such scam artists quickly, to appoint independent plan fiduciaries in order to protect plan assets, and to recover money for victimized workers.

  To combat MEWA fraud and corruption, EBSA has implemented a two-pronged approach using both its civil and criminal enforcement authorities. Due to our enforcement efforts, more than $7 million was recovered in FY 2004 alone for innocent victims to assist them with unpaid medical bills. Most of the criminal MEWA investigations have been jointly conducted with other agencies including the Department's Office of the Inspector General, the FBI and the United States Postal Inspection Service. As of March 31, 2005, EBSA was pursuing 120 civil and 46 criminal investigations related to MEWA health fraud. From March 1, 2004, to the present, EBSA's criminal investigations into MEWA fraud have led to the indictment of 25 individuals in 8 cases.

  Examples demonstrating the level of fraud perpetrated by unscrupulous MEWA operators are numerous. In one recent prosecution, the Department obtained court orders to shut down an abusive MEWA called Employers Mutual, LLC, sixteen related entities, and the individuals who operate them. Employers Mutual offered health benefits in all fifty states

and the District of Columbia, with over 22,000 individuals enrolled in its plans. After collecting over $14 million in employer premiums, Employers Mutual paid less than $3 million in claims. Nearly fifty percent of the contributions were diverted to the personal accounts of the principals and to pay administrative expenses. Through our timely enforcement actions, an independent fiduciary was appointed and the court approved an orderly method of resolving unpaid medical providers' claims in order to protect the plan participants from being pursued by the health providers. In addition to this civil action, EBSA's criminal investigation of Employers Mutual led to the indictment of three individuals. The indictment alleges that the defendants committed fraud by, among other things, misappropriating premiums, including $1 million in payments to two fictitious vendors set up for the benefit of the defendants, and not paying most of the claims.

- **Education and Outreach:** Through our outreach, education and assistance programs, EBSA has made educating small employers a top priority. The Department provides guidance to small employers on how they can avoid purchasing health coverage from fraudulent MEWA operators. EBSA's website lists a series of anti-fraud publications, including *How to Protect Your Employees When Purchasing Health Insurance*. These tips, designed for small employers, offer important warning signs to consider when purchasing health coverage. Checking simple information can alert small employers to fraudulent schemes. The Department worked with dozens of small business groups to disseminate these tips to their members. I encourage interested small employers and employees to visit the EBSA website at www.dol.gov/ebsa/ or call EBSA's toll-free hotline at 1-866-444-EBSA (1-866-444-3272) for further information about protecting themselves against fraud.

Other materials published on the Department's website include a publication explaining current federal and state regulation of MEWAs, and guidance on what to do when health coverage offered by a MEWA is lost. EBSA has also issued numerous advisory opinions to assist state prosecutors and regulators in the enforcement of state insurance laws against MEWAs.

**Conclusion**

Thank you for the opportunity to testify today. Small business employers and employees are in critical need of new ways to increase health insurance coverage, and the Association Health Plan legislation pending before the Senate is a central part of a solution to this problem. President Bush strongly supports Association Health Plans for small businesses through trade and professional associations, as well as for other members of civic, religious and community based groups. I look forward to working with the members of Congress and this Committee to help pass and administer legislation that expands health insurance coverage for working Americans.

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[1] Department of Labor estimates of working families' health insurance status, based on the Census Bureau's annual March Current Population Survey.

[2] National Association for the Self Employed.

[3] Transamerica Center for Retirement Studies.

[4] Actuarial Research Corporation.

[5] Kaiser Family Foundation Employer Health Benefits 2004 Annual Survey.

[6] The 2002 Small Employer Health Benefits Survey.

[7] U.S. Government Accountability Office, *Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage*, GAO-02-8; and *Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market*, GAO-02-536R.

[8] U.S. Government Accountability Office, Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage, GAO-02-8; and Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market, GAO-02-536R.

[9] Gail A. Jensen and Jon Gabel, "State Mandated Benefits and the Small Firm's Decision to Offer Insurance," Journal of Regulatory Economics; 4:379-404 (1992).

[10] Gail A. Jensen and Michael A. Morrisey, Mandated Benefit Laws and Employer-Sponsored Health Insurance (Washington, D.C.: HIAA, 1999).

[11] Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage through Association Health Plans and Healthmarts*, January 2000.

Chair SNOWE. Thank you, Secretary Chao.
Administrator Barreto.

**STATEMENT OF HON. HECTOR V. BARRETO, ADMINISTRATOR, U.S. SMALL BUSINESS ADMINISTRATION**

Mr. BARRETO. Good morning, Chair Snowe, Ranking Member Kerry, and distinguished Members of the Committee. Thank you for inviting me here to discuss with you a solution to the current health care crisis facing America's small businesses.

I also want to thank you, Senator Snowe, for championing AHP legislation in the Senate. I echo Secretary Chao in supporting S. 406, the Small Business Health Fairness Act, and I look forward to continuing to work with you as the Senate considers this much needed legislation.

The biggest concern for small business owners is their inability to access quality, affordable health care. As Administrator of the SBA, I see this every day as I travel throughout the country. Regardless of the discussion topic, small business owners inevitably focus the conversation on health care. They ask me what we in Washington can do to make health care more affordable for them, and I hear from them time and time again that their inability to access affordable quality health care is their biggest concern.

Although businesses large and small have experienced rises in health insurance premiums disproportionate to inflation, the smallest businesses have been particularly hard hit. In 2004, premiums for companies with 3 to 24 employees grew 13.6 percent. I think this was also illustrated in the chart that Senator Snowe shared with us at the beginning of her presentation.

The administrative cost involved with insuring employees of small businesses pose a major stumbling block. In 2003, SBA's Office of Advocacy examined 19 health care plans in two States. It determined that administrative expenses for insurers of small group health plans range from 33 to 37 percent of their claims, versus 5 to 11 percent for larger self-insured plans. That is a difference of 22 to 33 percent between large businesses and small businesses, and that was one of the problems that has already been discussed and talked about.

Many small business owners have been forced to stop offering insurance coverage altogether. According to the 2004 Kaiser Family Survey, and I believe Senator Snowe talked about this, as well, the smallest firms are the least likely to offer health insurance. Only 52 percent of firms between 3 and 9 workers offer coverage, compared to 74 percent of firms with 10 to 24 workers, and 87 percent of the firms with 25 to 49 workers.

When small companies do offer health benefits, the prospect of picking between plans is a pipe dream and employees only hope they can afford the higher premiums they face simply for working at a small business. All in all, it is a terrible way to treat people who are keeping our economy afloat.

Given the staggering costs facing small businesses, their employees are far less likely to have health coverage. The Department of Labor estimates show that people and families headed by self-employed and small firm workers make up 50 percent of all uninsured Americans.

The President wants all Americans to have access to high-quality affordable health care. This is why the President supports lowering the barriers on Association Health Plans. Flourishing AHPs will expand access to health benefits to millions of uninsured Americans. Since small employers are forced to seek health insurance for their workers as separate entities, it is more expensive and often impossible for these firms to purchase insurance coverage. AHPs would allow small businesses to pool their resources together across State lines, affording them the benefits of uniform Federal regulation, greater economies of scale, and flexibility to design coverage options that large firms and labor unions currently enjoy.

Today, small businesses that choose to pool their resources under current law must instead cope with the requirements of 50 different State insurance regulators and State mandates rendering AHPs in their current State cost prohibitive. Legislation to enhance AHPs would have allowed small businesses participating in AHPs to save an average of somewhere between 9 to 25 percent of the cost of their health insurance premiums. This is according to a study by the Congressional Budget Office. Three-hundred-and-thirty-thousand people without health insurance would have been covered had Congress passed that legislation.

Lowering the cost of health insurance will also provide small businesses with better opportunities to recruit and retain the employees they need to grow and prosper. The availability and quality of health care benefits is often a deal breaker for Americans seeking employment. Strengthening AHPs will even the playing field for small businesses by allowing them to offer health benefit plans similar to those that are offered by their larger competitors.

I again want to thank Secretary Chao for the leadership that she and the Department of Labor have shown on AHPs. Her commitment to helping small business owners overcome their biggest hurdle has been admirable. I hope that Secretary Chao and I, on behalf of President Bush, can work closely with you and all the Senators this year so that small businesses and the 57 million Americans who work for them can receive access to better, more affordable health care through the strengthening of AHPs.

Until we come up with an affordable solution that crosses State lines, I don't think that we can solve this problem for small businesses, but we need to act now. Continuing to do nothing to address this crisis is unacceptable for millions of small business owners struggling to make ends meet in the face of ever-increasing costs.

Thank you, Chair Snowe, for the opportunity to speak to you today and the Committee about this very important topic. I now look forward to answering your questions.

[The prepared statement of Mr. Barreto follows:]

**Statement of Hector V. Barreto**
**Administrator**
**U.S. Small Business Administration**
**Helping Small Businesses Provide Lower Health Coverage and Lower Costs**
**Senate Committee on Small Business and Entrepreneurship**
**April 20, 2005**

Good morning, Chair Snowe, Ranking Member Kerry and distinguished Members of the Committee. Thank you for inviting me to discuss with you how to provide greater access to affordable, quality health care to small businesses.

For many small business owners, this is the most important issue they face. The problem of access to affordable health insurance has grown in recent years. Without prompt action, this crisis will only become more acute. According to a recent survey (February 2005) of small business owners by the National Federation of Independent Business (NFIB), the cost and availability of affordable insurance continues to be the biggest problem facing small businesses. Small business owners cite insurance cost (27%) more than they do even taxes (15%) or poor sales (9%) as the chief impediment to their success.

I personally experienced this crunch prior to becoming Administrator of the U.S. Small Business Administration (SBA) in 2001. Working for a small business, then as a small business employer and finally as the head of an association, I saw first-hand just how difficult it is for small businesses - - the businesses which are the backbone of our Nation's economy - - to secure the health care their employees want and need.

Running a small business, I witnessed how running your own health plan is costly, not only in terms of the administrative costs involved - - costs that these small businesses often cannot pass on to consumers - - but also because of the time spent dealing with the problems employees often faced when making claims. Employees of small businesses often speak with their boss directly when these problems arise, since the boss is in most cases the "human resources" office of a small business. For the owner, this drains time away from other activities vital to running to his or her business.

Later, as the head of an association, insurance companies constantly told me that they could not provide coverage to our members because, despite having thousands of members, we were simply not big enough. Our pool of employers was too small.

As Administrator of the SBA, I have had a chance to visit with small business owners throughout the country. No matter the topic of these discussions, small business owners inevitably ask me at these gatherings what we in Washington can do to make health care more affordable for them. They tell me time and time again that their inability to find access to affordable, quality health care is their biggest concern.

The problem of providing access to affordable health insurance often forces small business owners into a cycle of delivering increasingly bad news to their employees. Small business owners first have to inform their employees that their premiums will go up yet again for the upcoming year. Soon, that will not be all - - despite the increased premiums, choices will be more limited, as employers will have to move employees to a less generous health plan. Finally, in a number of cases, even that does not end the cycle. In those situations, small business owners are forced to tell their employees that providing any health insurance is beyond their economic means – all coverage will be eliminated. The result is that employees of these companies have to find their own coverage.

Studies bear witness to the truth of these anecdotes. Although businesses large and small have experienced rises in health insurance premiums disproportionate to inflation, small businesses have been particularly hard-hit. For instance, while premiums for the largest companies (5,000+ employees) grew by 11.6% in 2004, premiums for companies with 3-24 employees grew by 13.6% in the same time period. Even before these increases, small businesses were already struggling to keep health care affordable for their employees.

Small businesses also face much higher administrative costs. A report released by SBA's Office of Advocacy in 2003 examined 19 health care plans in two states and determined that administrative expenses for insurers of small group health plans ranged from 33% to 37% of claims versus 5% to 11% for larger companies' self-insured plans. Additionally, the report revealed that sales, underwriting and operating expenses were all higher for small group health plans studied as opposed to those designed for their larger counterparts.

This lack of readily available affordable health insurance has even forced many small business owners to stop offering insurance coverage altogether. According to the 2004 Kaiser Survey, The smallest firms are least likely to offer health insurance. Only 52% of firms with 3-9 workers offer coverage, compared to 74% of firms with 10-24 workers and 87% of firms with 25-49 workers.

As identified in a 2002 Department of Labor report, this disparity is even greater for small low-wage firms, defined as firms at which more than 50 percent of all employees earn less than $9.50 an hour. Only 34% of all low-wage small firms offer health benefits, as opposed to 95% of all low-wage large firms.

The employees of small businesses are consequently far less likely to be covered on the job. Department of Labor (DOL) estimates show that people in families headed by self-employed and small firm workers make up 50% of all uninsured Americans.

When small companies do offer health benefits, they typically offer a narrower range of options than do larger companies. According to the Kaiser Family Foundation

Employer Health Benefits Annual Survey, in 2004 86% of small firms that provide health benefits only offer one plan to their workers, with the primary reason cited for offering just one option being that the companies receive better deals from insurers by requiring all or most employees to join the same plan.

Given these staggering costs faced by all small businesses, President Bush has placed making health care for small businesses more affordable at the top of his Small Business Agenda.

The President wants to make it easier for small business owners to pool together to offer their employees the same sort of affordable health coverage options that many large corporations and labor unions can currently offer their employees and members. To do so requires reducing the administrative costs small businesses face in providing health care to their employees. This is why the President supports lowering the barriers current law imposes on Association Health Plans (AHPs). Allowing AHPs to flourish will expand access to health benefits to millions of uninsured Americans while providing more choices to small businesses that currently only have limited choices.

Enhancing AHPs will level the playing field for small businesses. They will enable small businesses to pool their resources together across state lines to access the same discounts from higher-volume purchasing and the same flexibility to design coverage options that large firms and labor unions currently enjoy.

Small employers are forced to seek health insurance for their workers as separate entities, making it more expensive or even impossible for these firms to purchase insurance coverage. AHPs would allow these small businesses to join together, affording them the benefits of uniform federal regulation and greater economies of scale enjoyed by large employers.

Without strengthening AHPs, small businesses will not have this opportunity. Those that choose to pool their resources under current law must instead continue to cope with the requirements of 50 different state insurance regulators and state mandates that can often prove to be very costly to the point where forming AHPs is almost always cost-prohibitive.

The President's plan to strengthen AHPs would make the option of pooling together with other small businesses and within associations to purchase health insurance much more cost-effective. Participants in a panel organized by the Tomás Rivera Policy Institute (TRPI) in the wake of its report recommended such a solution for Hispanic-owned businesses due in part to these cost efficiencies. This plan will allow small businesses to have access to the same quality of health care across state lines.

Legislation introduced in the 107th Congress which would have enhanced AHPs would have allowed small businesses participating in AHPs to save, on average, somewhere between 9% to 25% of the cost of their health care premiums, according to a study by the Congressional Budget Office (CBO). With the cost to small businesses

of providing insurance decreasing so dramatically, the CBO study indicated that 330,000 people without health insurance would have been covered had Congress passed that legislation.

Lowering the costs of health insurance will also provide small businesses with better opportunities to recruit and retain the employees they need to grow and prosper. The availability and quality of health care benefits is often a deal-breaker for employees seeking places of employment. Strengthening AHPs will even the playing field for small businesses by allowing them to offer health benefit plans similar to those offered by their larger competitors.

As President Bush said last March at the Women's Entrepreneurship Summit, "I strongly support Association Health Plans. That means that small businesses will be able to pool together and spread their risk across a large employee base. It makes no sense, no sense in America, to isolate small businesses as little health care islands unto themselves. We must have Association Health Plans."

Once Congress passes legislation enhancing AHPs, SBA will seek to connect small business owners with the best solutions for providing health insurance to their employees, while DOL will implement the necessary programmatic structure. I want to thank Secretary Chao for the leadership she and DOL have shown on AHPs. Her commitment to helping small business owners overcome their biggest hurdle has been admirable. Small business owners struggling to make ends meet in the face of these ever-increasing costs are appreciative of your efforts.

I hope that Secretary Chao and I, on behalf of President Bush, can work closely with you and all Senators this year so that small businesses, and the 57 million Americans who work for them, can receive access to better, more affordable health care coverage through the strengthening of AHPs. Until we come up with an affordable solution that crosses state lines, I do not think we can solve this problem for small businesses. The time to act is now. Continuing to do nothing to address this crisis is unacceptable for millions of small business owners.

Thank you, Chair Snowe, for the opportunity to speak to you today about this very important topic. I now look forward to answering your questions.

Chair SNOWE. Thank you, Administrator Barreto.

Before I begin, Senator Lincoln, welcome. You are not a Member of the Committee, but we welcome you and your contribution. Thank you for being here. Do you want to make a statement? You are welcome to if you—go right ahead.

**STATEMENT OF THE HONORABLE BLANCHE LINCOLN, A UNITED STATES SENATOR FROM THE STATE OF ARKANSAS**

Senator LINCOLN. I want to thank you, Madam Chair, for the opportunity to be here and your graciousness in allowing me to come and be a part of your conversation.

I have a special interest in this issue, as do you. I know how hard you worked for the solutions that we need to find here, and with the small business health care crisis that exists in our State and in your State, which have very similar demographics, it is undoubtedly our number one issue in Arkansas when I am traveling through the State and hearing from people.

I am very pleased with your intent on looking at what the solutions can be for this problem. I am looking forward to working with you, and I will reserve my time to be able to ask a few questions. Thank you, Madam Chair.

Chair SNOWE. Thank you, Senator Lincoln. Thank you for being here.

Let us begin, because obviously, we hear a number of concerns, the ones that have been repeated over time. I would like to systematically address them.

I will begin with you, Secretary Chao, because we have heard, well, it is going to eliminate consumer protections under this legislation and this approach because the Department of Labor will not be able to provide the oversight for these Association Health Plans. It won't have the repeated circumstances of the MEWAs, the multiple-employer arrangements that subjected a lot of small businesses to fraud.

We have established entirely different conditions in this legislation. It is a bona fide organization. They cannot discriminate against any of their members. They have to offer it to all of their members. They have to have been in existence for 3 years for other purposes other than health insurance. We provide reserves, solvency requirements, stop loss, notification, resources. In fact, CBO underscores what needs to be done in making sure the Department of Labor has at least 150 people to oversee this, and I would like your comments on it.

But I would like to hear from you this morning, Secretary Chao, what has been your experience as Secretary of Labor with respect to providing oversight in this instance compared to the instances for corporations and unions, because obviously we don't hear the similar complaints. I don't hear any frustrations, concerns about the fact that corporations or unions are offering less generous plans, that they are cherry-picking, they are subjecting their members, employees, to discriminatory behavior. So we don't hear the same complaints and concerns about these plans that insure 78 million Americans, and yet what we are now hearing is that all of these complaints are going to be waged against small businesses if

we allow them to engage in Association Health Plans on a national basis.

So would you begin, Secretary Chao, and tell us, first of all, why don't we hear similar complaints about corporations and unions? Why doesn't it occur under those circumstances? And if it doesn't, then why are there concerns expressed about Association Health Plans for small businesses and why is there this disparate approach to these entities?

Secretary CHAO. Well, you are absolutely right. The Department of Labor currently oversees about 2.5 million private job-based health care plans, and again, that covers 135 million people. About 300,000 plans are regulated exclusively by the Department of Labor, and most of that is with large businesses that are self-insured, and a lot of labor union organizations, that are again self-insured. We also have a nationwide network of benefits advisors. We field about 160,000 inquiries a year. Over 60 percent of those are health care inquiries.

So we feel very confident in our ability to regulate under the new AHP bill, should it be passed, the responsibilities and the authorities it would give to us.

On the issue of State protections, as you well know, in S. 406, there will be consumer protection provisions that will still be regulated by individual States. Those will still remain.

And in terms of concerns about health fraud, your bill would strengthen protections against unscrupulous health plan organizations, because the Department of Labor will be responsible for regulating whether an AHP can come into existence or not, and the bill has very strong consumer protection provisions at both the State and Federal level, as well as solvency requirements at the State and Federal level.

Chair SNOWE. Administrator Barreto, would you answer this question, as well, because it is mystifying to me. We have an explicit prohibition in this legislation against cherry-picking. We have language in here that does not condition membership, such as dues, payments, coverage, on the basis of health status-related factors with respect to the employees of its members or affiliated members or dependents. It does not condition such dues or payments on the basis of group health plan participation. It would be subject to the HIPAA requirements, some preexisting status. And the fact is, it is probably far superior in a lot of respects.

So can you address the issue of cherry-picking, because again, we are talking about a dual standard here. One, corporations and unions. We don't hear those complaints. No one is saying, let us put them back in the State pool. We are not hearing that. We are seeing, keep small businesses in the State pool and we will leave them victims to the problems dealing with health insurance today, which essentially is leaving small businesses and their employees and their families uninsured or paying escalating prices beyond comprehension. Frankly, from all my small business owners in Maine, it is devastating. Maybe they get catastrophic coverage.

Can you address this issue, because somehow, we have to get to the core of it. Obviously, none of us want to support adverse selection and cherry-picking, so if it is not happening with corporations and unions, why would it happen under this circumstance? Is there

something we are missing here? I mean, I just really want to know because I can't—we have been discussing this for several years now and I have yet to understand how it would come about in this instance but it hasn't come about with corporations and unions.

Mr. BARRETO. It is a great point. If what we mean by cherry-picking is that we are going to pick winners and losers, we are going to choose which small businesses get health care and what small businesses don't get health care, I think Senator Talent brought up a great point and I think what he is saying is that is happening right now.

You know, there was a time—I remember when I was in California leading a business association, there were 20 major insurance companies offering health care coverage to small businesses, and there were a lot of smaller players that were actually from outside of California that were offering it, as well. Today, small businesses are lucky if they have four or five choices. Oftentimes, those insurance plans are almost exactly alike. There is not a lot of difference between these insurance plans. Oftentimes, the premiums are exactly alike.

Sometimes, insurance companies decide to quote on a piece of business, on a small business. Some years, they don't decide, and they don't tell you why. Some years, they raise your insurance premiums whether you use the insurance coverage or not. That is why small businesses are screaming. They are saying, this problem gets worse every single year. It doesn't matter if I use it or not. I know I am going to get a double-digit increase.

Also, the things that small businesses can't control, they can't control what is inside their insurance plan because of the State mandates. They can't control the administrative cost of those plans, which keep going up higher and higher. They can't control the cost of small prescription drug benefits. They can't control the cost that doctors have to pay for malpractice insurance, which drives their insurance premiums up and sometimes drives them out of the market, as well.

So the things that are keeping small businesses from participating. The cherry-picking that is happening and the reason there are 45 million uninsured Americans, the reason the 60 percent of people that don't have health insurance work for a small business. I mean is occurring right now, and I think what Senator Talent was alluding to and you have alluded to, as well, is that what we need to do is provide small businesses with more access, more choice, more control, and that is what we believe Association Health Plans will do.

Chair SNOWE. But I am trying to understand the difference between why it works well for corporations and unions, and we don't hear similar concerns or complaints or saying let us go back to the old way, and the Department of Labor is doing a very effective, efficient job, has historically, and Secretary Chao has spoken to it, about providing the aggressive oversight that is necessary, so we don't hear those complaints.

I don't understand why it would be different for small businesses, and I think that that is really the challenge here, is to overcome that, because clearly, it seems to me, we ought to be able to draft legislation in a way that addresses these concerns and satisfy

the issues that have been raised. They are legitimate concerns. We think we have addressed them. I keep adding more criteria and standards and insurances to guard against any ability for these associations to be other than bona fide organizations for the purposes in which they are intended and to offer this benefit to their members.

Mr. BARRETO. You are hitting a very important point, Senator Snowe. You know, when a large corporation has 100,000 employees, or when the Federal Government has a million employees, or when a union has tens of thousands of members, they have got power. They have got clout. And if they don't like what is happening in their insurance plan, they can move it, and there is a lot more choice for them. They have a lot more control.

And some of these companies or organizations get so big that they decide to self-insure themselves and the insurance company is really just administering the claims. So there are options for them.

Small businesses don't have those options. Small businesses have take it or leave it. Here is the shelf plan. Here is what it costs if we offer it to you this year, and if not, you are out of luck, and that is the big problem and that is what we believe Association Health Plans can go a long way to solving.

Chair SNOWE. Senator Kerry.

Senator KERRY. I hate to say it, but I think there is a lot of wishful thinking and we need to explore this. I have said to the Chair, I really want to work with her closely and see if we can patch some of these holes, but I think we have got to be honest about some of the holes and not just gloss over them.

To that end, let me ask you, Secretary Chao, States currently have protection mechanisms in place that limit how much and how often premiums can increase. There is a right to an external review of denied medical claims and direct access to emergency care or specialty care or consumer marketing protections. All of these rights currently exist.

The public needs to know that these rights only exist at the State level. There are no Federal premium protections, no Federal patient protections. And as you read S. 406 and H.R. 525, these comprehensive protections will be eliminated.

Now, let me just focus on one of these rights of the many, protections for patients when an insurance company denies their medical claim. Right now, 44 States require insurers to provide an external review for enrollees. A centerpiece of the AHP is to exempt insurance plans from State protections. So if AHPs were enacted, would patients have the right to an external review, external review when an insurer denies a medical claim? Can you show me how that right is guaranteed and enforced?

Secretary CHAO. Well, first of all, Senator, you are only talking about the fully-insured, which is only half of the——

Senator KERRY. Well, I am talking about people.

Secretary CHAO. No, if I——

Senator KERRY. It doesn't matter whether it is half or——

Secretary CHAO. It makes a difference, because if it is a fully-insured AHP, it is largely regulated by the State. If it is a self-funded plan, which many large companies, and many large labor unions have, it is regulated by the Department of Labor.

Senator KERRY. I understand that.

Secretary CHAO. So there are two different plans here and the AHP proposal does not take away the external review State consumer protections at all.

Senator KERRY. Every interpretation of it says it does.

Secretary CHAO. Self-funded plans already——

Senator KERRY. So you would be willing to write into it—we can patch that hole, in other words. You are willing to guarantee that those rights of external review will be afforded, is that what I hear?

Secretary CHAO. We are willing to address what concerns you have, but there is a big difference between—right now, there is a whole group of organizations, companies, labor union plans which are not regulated by the States already——

Senator KERRY. I completely understand that. I understand that.

Secretary CHAO. So let us keep that in mind——

Senator KERRY. We will get to some of that——

Secretary CHAO [continuing]. ——because there is an inequity here, an unfairness that the AHP proposal is trying to address.

Senator KERRY. Well, it doesn't create a fairness if it takes away rights that people currently have and need. Now, let me speak to that for a minute. There is a letter from Professor Mila Kofman at Georgetown University at the Health Policy Institute. I would like to ask that it be put into the record.

Chair SNOWE. Without objection, so ordered.

[The information of Senator Kerry follows:]

GEORGETOWN UNIVERSITY

Health Policy Institute

April 20, 2005

**VIA: FACSIMILE**

The Honorable Chairwoman Olympia J. Snowe
The Honorable Ranking Member John F. Kerry
Small Business & Entrepreneurship Committee
United States Senate
Russell Senate Office Building, Room 428A
Washington, DC 20510

Dear Chairwoman Snowe and Ranking Member Kerry:

I write to submit comments for the record of the "Solving the Small Business Health Care Crisis: Alternatives for Lowering the Costs and Covering the Uninsured" hearing that the Small Business and Entrepreneurship Committee will be having on April 20, 2005. As an academic researcher who has studied consumers' experiences with association coverage under current law and a former federal regulator at the U.S. Department of Labor, I wanted to offer some insights into the problems that small businesses and their workers are now facing.

As a way of background, researchers at Georgetown University's Health Policy Institute conduct a range of studies on the uninsured problem. We are focusing on private market obstacles that prevent consumers from buying health insurance for themselves and their families. We also are looking at reasons why people lose their private health insurance coverage. In my research, I have extensively studied the regulation of small business health insurance and more recently the problem of phony health insurance sold through phony and legitimate associations. In fact, my report on phony insurance was the first to document the third cycle of insurance scams -- how promoters of phony insurance use associations as a primary way to sell phony insurance and to defraud America's small businesses and their workers. I am the principal researcher and author of several studies on association coverage, how states regulate such coverage, how states regulate self-insured associations, and how federal proposals might impact

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consumer protections.[1]

Before joining the faculty at Georgetown University, I was a federal regulator at the U.S. Department of Labor, where I worked on federal legislation affecting association health plans in addition to regulating such arrangements. Prior to joining the U.S. Department of Labor, I was Counsel for Health Policy and Regulation at the Institute for Health Policy Solutions, a non-profit, non-partisan firm, assisting small businesses in establishing health insurance purchasing coalitions. My knowledge, therefore, is both practical and academic.

First, I want to thank you for your leadership in investigating the crisis with health insurance for small businesses and self-employed people. In your deliberations, I urge you to consider the reasons that make health coverage expensive and to work toward making coverage more affordable, accessible, and secure for all businesses and workers. My comments below reflect what I have learned through the years of studying associations, the small group market, and regulation.

The cost of health insurance has increased in the double-digits. Some of the biggest cost drivers have been the increased cost of prescription drugs, higher provider costs, and an increase in use of services. Provider costs have increased due to mergers among hospitals and new hospital construction and expansions. Additionally, Americans use more health care services. There are 125 million people with chronic conditions; people live longer; and, an aging population requires additional medical services. Another factor driving up prices is the cost of the uninsured. The cost shifting for uncompensated care is a factor in how much insured people pay for their health insurance. Last year the cost of providing care to uninsured people was $124.5 billion ($40.7 billion or 33% was uncompensated, payment for the rest was paid for out-of-pocket and by private insurance – if available part of the time – and public insurance/spending). These cost drivers have affected everyone -- even employers who self-insure their health benefits (exempt from state regulation).

The proposal -- S. 406, to establish federally licensed association health plans (AHPs) that are exempt from state consumer protection and regulation -- would not address the reasons why health coverage is expensive and thus would not achieve its goal of addressing the uninsured problem or making health coverage more affordable for all small businesses. Instead, the proposal would have many unintended consequences that would adversely affect millions of people who rely on private health insurance to finance their medical care and for financial security.

The proposal would allow AHPs to offer less expensive coverage. However, such savings would be achieved from attracting more favorable risks and stripping away state-based consumer protections. State-based standards include rules to ensure that insurance companies are financially stable to pay claims, requirements to provide access to care for people with medical conditions, rules to protect people from being targeted for premium increases if they get sick, and standards for minimum benefits including maternity coverage, diabetes, cancer screening, and other key consumer protections. Such requirements

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[1] Some of my published reports include: *Multiple Employer Arrangements: Another Piece of a Puzzle, Analysis of Form M-1 Filings*, Journal of Insurance Regulation 63 (Dec 2004); *Federal Association Health Plans – Will This Proposal Remedy the Health Insurance Crisis?* 5 Policy, Politics & Nursing Practice 167 (Aug. 2004) (co-authored with Karl Polzer); *MEWAs: The Threat of Plan Insolvency and Other Challenges* (Commonwealth Fund March 2004); Opinions Commentary, *Disassociate from this plan*, Modern Healthcare, Feb. 2004 (invited guest column with Karl Polzer); *What Would Association Health Plans Mean for California?: Full Report* (California HealthCare Foundation Jan. 2004); *Issue Brief: Health Insurance Scams: How Government Is Responding and What Further Steps Are Necessary* (Commonwealth Fund Aug. 2003); *Proliferation of Phony Health Insurance: States and the Federal Government Respond* (BNA Plus Fall 2003); *Insurance Markets: Group Purchasing Arrangements: Implications of MEWAs* (California HealthCare Foundation July 2003); *Issue Brief: Group Purchasing Arrangements: Issues for States* (State Coverage Initiatives, Vol. IV, No. 3 April 2003); *Health Insurance Scams Promoted Through Associations: A Primer*, The Insurance Receiver, Vol. 11, No. 3 Sept. 2002. My research also includes several papers due to be published later this year on how states regulate associations.

add costs to coverage, but without such state based consumer protections, plans may not provide such needed benefits. Absent requirements to do so, plans may not provide access to emergency services, well baby care, care for handicapped adult children, and independent review of benefit denial decisions. AHP coverage would be less expensive because AHPs would not have to provide these important benefits.

Cost savings would also come from AHPs' ability to cherry-pick the market by designing and pricing coverage to attract businesses with young and healthy people. The trade off would be that businesses with older and sicker workers would have to pay more and some will be forced out of the private market. In a 2004 report analyzing the potential impact of AHPs on California's private market, my co-author and I concluded that in addition to a loss of consumer protections, this legislation would significantly disrupt state-regulated small group insurance markets, in which small businesses that need comprehensive coverage would be more likely to remain.[2] When healthy people leave the state market, coverage will become more expensive for everyone left. A companion study by the Urban Institute estimated that prices would increase by approximately 5% in the rest of the state's small-group market as a result of AHPs (in addition to premium increases from rising healthcare costs, even after groups with older and sicker workers would drop out of the market).[3] We concluded that AHPs would also affect availability of private insurance for people not covered by AHPs. Because for-profit insurance companies cannot stay in business insuring only the sick, there may be fewer choices for small businesses and people in the selection of companies and products available.

In addition to an adverse impact on private health insurance, under the federal legislation, many consumers would face greater financial exposure when an AHP becomes insolvent. Since 2000, association insolvencies have left more than 66,000 workers and their families and thousands of participating employers responsible for $48 million in medical bills that should have been covered by the AHPs.[4] The federal proposal would make things worse by replacing state solvency standards with less stringent federal standards and regulation. AHPs have a long history of financial instability. The U.S. Department of Labor (DOL), which would regulate AHPs, has no experience in regulating the solvency of health plans. Inadequate standards and an inexperienced regulator would mean that participating small businesses may be stuck with unpaid medical bills when an AHP becomes bankrupt.

Finally, the AHP bill would increase opportunities for health insurance scams, which have been on the rise since 2000.[5] Health insurance scams promoted through associations have left over 200,000 policyholders with over $252 million in unpaid medical bills between 2000 and 2002. The bill would put the U.S. Department of Labor in charge of an area that is currently regulated by both the federal government and states. And by putting DOL in charge, it would prohibit states from helping consumers.

DOL's record on shutting down scams is weak especially compared to states. During the recent cycle of scams, while states have shut down 41 arrangements, DOL was able to shut down 3 (GAO 2004). The bill would not give DOL new enforcement tools, the type of administrative authority that states have to shut down scams quickly. It can take DOL two years to shut down an arrangement compared to quick actions by states -- weeks in some cases and months in most cases.[6] Time is critical because operators of

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[2] Mila Kofman and Karl Polzer, *What Would Association Health Plans Mean for California?: Full Report*, California HealthCare Foundation, January 2004.

[3] Linda Blumberg and Yu-Chu Shen's, *The Effects of Introducing Federally Licensed Association Health Plans in California: A Quantitative Analysis*, California HealthCare Foundation, January 2004.

[4] Mila Kofman, Kevin Lucia, and Eliza Bangit, *Self-Insured MEWAs: Insolvency and Other Challenges, Lessons from California, Michigan, and Oklahoma*, Commonwealth Fund, Spring 2004.

[5] U.S. General Accounting Office, Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entities Selling Coverage, GAO-04-312 (Feb. 2004); Mila Kofman, Kevin Lucia, and Eliza Bangit, *Health Insurance Scams: How Government is Responding and What Further Steps are Needed*, The Commonwealth Fund (August 2003) (available at www.cmwf.org).

[6] Mila Kofman, Kevin Lucia, and Eliza Bangit, Proliferation of Phony Health Insurance: States and the Federal Government Respond, BNA Plus (2003).

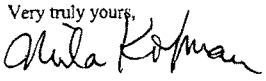
scams move, hide, or spend assets quickly. DOL cannot adequately protect consumers. Preempting states from investigating health insurance scams and shutting down phony companies would adversely affect small businesses and their workers.[7]

Additionally, the AHP bill would create new preemption ambiguities in ERISA. It is like turning back the clock to pre-1983. In the early 1980s, Congress stepped in to fix the problem of rampant fraud and insolvencies of multiple employer arrangements when DOL was the only regulator and not able to effectively regulate. Congress clarified ERISA to say that both states and DOL have authority to regulate multiple employer arrangements. Although there is still some ambiguity of which promoters of phony health plans take advantage, the amendment to ERISA in the early 1980s worked to better protect consumers with both states and the federal government having oversight. This bill would turn back the clock and preempt states once again. The new ambiguity in ERISA will give criminals the excuse they need to once again claim exemption from state oversight even when they are not licensed as AHPs. Additionally, due to the new preemption standard in the legislation, states would be powerless to stop phony insurance companies from selling coverage to licensed AHPs. The AHP bill would make things worse for consumers who now more than ever need state insurance department intervention and quick state action to shut down scams.

In conclusion, despite its objectives, it is unlikely that the AHP bill would be able to increase the overall number of insured. In fact, a number of studies, including two by the Congressional Budget Office, have found that few would be newly insured while millions would face premium increases because of the legislation.[8] It is unlikely that the AHP bill would be able to stem runaway healthcare costs and help all small businesses—including those that happen to have less-than-healthy employees—find affordable and stable sources of coverage. While it is clear that small businesses face problems in finding affordable health insurance, the AHP legislation does not provide long-term or even short term solutions to those problems. Many employers and workers lack the financial resources to buy coverage. In order to expand coverage, it is likely that policymakers will have to address the reasons for expensive health coverage and address the reasons why people are uninsured (65% are below 200% of federal poverty level). Financial assistance and access to adequate and stable coverage is what America's businesses and workers need. The AHP legislation would not and could not accomplish this. And, its unintended consequences (insolvency and fraud) may be devastating for many small businesses.

Thank you for your consideration of this important issue. Please do not hesitate to contact me if I can be of assistance to you or your staff as you consider appropriate policy solutions to the problems facing small businesses and their workers and families.

Very truly yours,



Mila Kofman, J.D.
Assistant Research Professor

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[7] There is evidence that DOL does not have sufficient resources to oversee their current responsibilities. See discussion of their lack of enforcement of standards that requires multiple employer arrangements to register with DOL. Mila Kofman, Eliza Bangit, and Kevin Lucia, *Multiple Employer Arrangements: Another Piece of a Puzzle, Analysis of Form M-1 Filings*, Journal of Insurance Regulation 63 (Dec 2004).

[8] *Increasing Small-Firm Health Insurance Coverage through Association Health Plans and Healthmarts*, Congressional Budget Office (Jan. 2000) (available at http://www.cbo.gov); Congressional Budget Office, letter to the Honorable George Miller, Senior Democratic Member, Committee on Education and the Workforce, U.S. House of Representatives, June 18, 2003 (available at www.cbo.gov); Congressional Budget Office Cost Estimate: H.R. 660: Small Business Health Fairness Act of 2003 (as passed by the House on June 19, 2003), July 11, 2003 (available at www.cbo.gov).

Senator KERRY. Let me just read from one component of it. There are a lot of issues raised in it. But she writes to the Committee—she incidentally addresses it to you, also, Madam Chair. She says, "In addition to an adverse impact on private health insurance under the Federal legislation, many consumers would face greater financial exposure when an AHP becomes insolvent. Since 2000, association insolvencies have left more than 66,000 workers and their families and thousands of participating employers responsible for $48 million in medical bills that should have been covered by the AHPs. The Federal proposal would make things worse by replacing State solvency standards with less-stringent Federal standards and regulation. AHPs have a long history of financial instability. The U.S. Department of Labor, which would regulate AHPs, has no experience in regulating the solvency of health plans. Inadequate standards and an inexperienced regulator would mean that participating small businesses may be stuck with unpaid medical bills when an AHP becomes bankrupt." Could you address that?

Secretary CHAO. I certainly can. There is an assumption that somehow a self-funded plan offers less generous benefits, but in reality, the record shows that self-funded plans, which are not regulated by the States, in fact, offer as good or better health plans, in part because their cost is so much lower. So with lower costs, they are able to offer more benefits.

Senator KERRY. But that is not my question. That is not even what we are talking about.

Secretary CHAO. Yes, we are. We are, because we are talking about solvency and we are talking about plans and our ability to administer these. The solvency requirements put into AHPs will, in fact, strengthen the ability of the department to protect these plans, because right now, there are no Federal regulations on certification or solvency, and with AHPs, there will be. So that will be an added——

Senator KERRY. You are saying to this Committee that in this legislation as written, the Federal solvency standards are, in fact, stronger than State standards? That is your testimony?

Secretary CHAO. There will be——

Senator KERRY. No, my question is, are you saying that they are stronger now, because that is not the reading of——

Secretary CHAO. It varies from State to State, obviously——

Senator KERRY. Correct, and there is no Federal——

Secretary CHAO [continuing]. And overall, the new protections put into the AHPs will require the Department of Labor to certify the solvencies of new self-funded AHPs that are being set up.

Senator KERRY. According to what standards?

Secretary CHAO. The AHP legislation sets up a revenue pool that will provide a reservoir of indemnification insurance to AHPs. AHPs will not be offered except——

Senator KERRY. Don't you think, Madam Secretary, that it is important for us to guarantee that there are strong solvency standards, Federal standards, with respect to who may be left holding the bag?

Secretary CHAO. Oh, absolutely, and I think the Federal——

Senator KERRY. And if they are not there and it is not adequate, that is another hole we ought to plug, is that correct?

Secretary CHAO. I think the Federal provisions for solvency under the AHP legislation will be quite strong.

Senator KERRY. Well, quite strong may not be as strong as current State standards.

Let me go to the second paragraph of what she said, another paragraph.

Secretary CHAO. May I just address that, please?

Senator KERRY. Sure.

Secretary CHAO. A fully-insured AHP will be subject to the solvency requirements of State law. There is no change from that, from current law. A self-funded AHP is both accountable under ERISA and subject to these new solvency rules. Self-insured plans must make, under the legislation, detailed solvency requirements, including actuarially determined reserves sufficient to meet claims, additional cash reserves of up to $2 million, specific and aggregate stop loss insurance to protect against unexpectedly high claims, indemnification insurance to insure that a terminating plan pays all of its remaining claims, payment of an annual fee to a fund controlled by the Department of Labor to pay indemnity insurance premiums, and the regulations will allow the Secretary to increase these requirements, as necessary.

Senator KERRY. So you are in agreement with me that if there is any discrepancy here with respect to State standards versus Federal, we ought to guarantee that we have the strong solvency standards that are in here?

Secretary CHAO. That is the goal, yes, but you also have to have balance. The overall goal is to be able to provide more insurance on a nationwide basis, and if you are just going to graft whatever is the State requirement onto the national Federal regulations, that really wouldn't work, either.

Senator KERRY. She goes on to say, "Finally, the AHP bill would increase opportunities for health insurance scams, which have been on the rise since 2000. Health insurance scams promoted through associations have left over 200,000 policy holders with over $252 million in unpaid medical bills between 2000 and 2002. The bill would put the U.S. Department of Labor in charge of an area that is currently regulated by both the Federal Government and States, and by putting DOL in charge, it would prohibit States from helping consumers." Can you address that?

Secretary CHAO. Yes, I can. First of all, we are very concerned, as everyone here is, about these scams. And, in fact, the best way to fight these scams is to certify that these organizations are able to offer health insurance. That is an added new protection which is now in the Association Health Plans legislation.

In terms of the question as to Federal regulations, I wonder who the writer thinks is regulating these health plans now? It is the Department of Labor. So it is an incremental change for us in terms of additional regulations. We already regulate over 300—actually, over 2.5 million health care plans, 300,000 of which are solely within the Department of Labor's jurisdiction. And we have an effective team of investigators and benefit advisors. So I think that this is, again, an incremental increase as most of the regulatory authorities we already have and we already exercise.

Senator KERRY. I have a lot of questions. I know others have questions, too. I want to perhaps come back to them, but can I just ask you, at a hearing before the Health and Labor Committee in 1997, the then-Assistant Secretary of Labor in the Clinton Administration said that DOL did not have the resources to regulate AHPs. She said then, and I quote her, "Based on our investigative experience, we could review each pension plan once in 170 years, and if you include health plans, once in 300 years. An infrastructure adequate to handle the new responsibilities replicating the functions of 50 State insurance commissioners simply doesn't exist."

What has changed, and there is nothing in the budget that I have seen that shows an increase sufficient to be able to meet what a lot of people fear is just an already overburdened Department?

Secretary CHAO. Well, I can't speak for the witness who spoke at that time, but our responsibilities have not changed, and our staff has significantly increased.

Senator KERRY. Well, the GAO, the CBO have all said that there is not an adequate capacity. I mean, this is not new. In fact, in 2002, the GAO report said that it would take DOL's current investigative staff 90 years to do a baseline assessment of non-compliance for pension plans alone. That is 2002. That is the GAO report. What has changed? I mean, this is a continuum——

Secretary CHAO. I think citing those numbers is very misleading. The real issue is, are we able to do the job, and the answer is, I feel very confident that we can do the job.

The CBO report said that DOL needed approximately an additional $55 million and 150 employees over the next 5 years to regulate AHPs. That is a very doable number. We have a budget of $60 billion, with $11.5 billion discretionary. Most recently, we implemented the Energy Workers' Compensation System under which we hired 300 people within about a 6-month period, as required by the statute. We have also given $60 million in additional resources.

Now, it is very difficult to predict exactly how much money or how much staff is necessary, but Association Health Plans are a Presidential priority and we will certainly make sure that the resources are there to carry out any of the incremental authorities that may be required.

Senator KERRY. Well, Madam Secretary, I respect what you are saying, but I have to tell you, my experience in 22 years here has shown no matter what the Administration is, that when you Federalize these responsibilities, you are often way behind in terms of the staffing and adequacy of the capacity for oversight. And there is a reason the Attorneys General across the country and insurance commissioners and others are deeply concerned about the enforcement mechanism here, and I don't think we should kid anybody here that the resources are suddenly going to come pouring in. I would like to believe it, but it is just very difficult to assume when we see the difficulties already in exposing scams and in doing a lot of the oversight that ought to be done, but I will come back. I will let other colleagues——

Chair SNOWE. Thank you, Senator Kerry.

Just a point on that, because the CBO did estimate last month in its analysis that it would require 150 workers regarding the im-

plementation of these provisions, and obviously, the various estimates through 2010 and the costs.

On the issue of fully-insured versus self-insured, I think it is an important clarification. We certainly could look at the solvency questions again in this legislation to address some of the issues you are raising, Senator Kerry. But it is my understanding on the fully-insured that it will continue to be subject to State solvency requirements and the State laws, and in fact, you will have the certification ability to determine whether or not the AHPs are meeting those standards within each State.

With respect to the self-insured AHPs, again, ERISA has no solvency standards for these entities, but we have set forth solvency requirement standards in this legislation, in many cases will be much stronger than what exists for the self-insured for corporations and unions, and so——

Senator KERRY. Well, I respect that, but here is the problem. Look, I am not an expert, but I have to listen to experts. We all do. And the National Association of Insurance Commissioners has characterized the solvency standards in the bills as, quote, "woefully inadequate." They stated that the bill's $2 million cap on reserves would, quote, "result in disaster for consumers." Now, that is the warning to us. The American Academy of Actuaries concluded that the standards included in the bill would, quote, "contribute to AHP insolvencies, resulting in consumers and providers being responsible for unpaid claims." So I am just listening to the experts tell us—woefully inadequate, not able to do it, and we will hear from other people over the course of time.

But let me ask you, what steps could we take to guarantee and really assure that workers are not going to be left with unpaid claims? It seems to me we ought to be able to plug that hole, also, with language.

Chair SNOWE. And the reason for the cap, and I would be interested in hearing your point of view on this, but on the cap and what they are in the $2 million, we saw that the members were not unnecessarily paying higher-price premiums, that they are keeping larger and larger reserves for other purposes or just, you know, so that the premiums become punishing for no good reason. That was the reason. But, you know——

Secretary CHAO. But that is our responsibility.

Chair SNOWE. That is right.

Secretary CHAO. That is the responsibility of the Department of Labor, to protect workers and their health plans, and if there are unpaid claims, that is our responsibility to pursue them——

Senator KERRY. What does that mean, you are going to pursue them?

Secretary CHAO [continuing]. To pursue them and to get it back. And last year, we recovered $3.1 billion in employee benefit plan claims for consumers.

Senator KERRY. We can get into the scam part of it. I wanted to cede to another Senator, and I will do it——

Secretary CHAO. And the scam part——

Senator KERRY [continuing]. But the scam record is not great. There are a lot of people left holding the bag, and we will go into that a little later.

Secretary CHAO. That is why additional regulations are required and that is where the Association Health Plan legislation with its certification provisions, will help to ensure that credible organizations are indeed offering these kinds of benefits.

Chair SNOWE. In fact, we strengthen them in this legislation——

Secretary CHAO. Yes.

Chair SNOWE [continuing]. With respect to these issues, but I would be glad to hear more.

Senator KERRY. Maybe we can strengthen them even more.

Chair SNOWE. Absolutely.

Senator Burns.

Senator BURNS. I am sitting here listening to this whole thing and you asked about all the questions that I wanted to ask this morning with regard to this. I hope we are recording this over here, this little debate going on.

I would ask one question, I guess, and maybe it is for the next panel. You almost, if you are the regulator, you have almost got to have the capability of being the underwriter, it seems to me. Do you have that capability in the Department of Labor?

Secretary CHAO. To the extent that underwriting includes actuarial determinations, that is a part, as I mentioned, that we will have to——

Senator BURNS. Yes. In other words, you have got to make the decision that this is sound and it is safe, and how closely will you look at the required coverages and demands that are set in each State?

Secretary CHAO. Well, we will look at the solvency to ensure that these are financially sturdy organizations that are ready to provide this kind of benefit, and there will be, again, a setting up of insurance, of a reservoir, a pool of assets that will act as a backstop to shore up Association Health Plans for any unforseen circumstances. So this is an added layer of protection. But again, fully-insured plans will still have State-by-State solvency rules, so that will remain.

Senator BURNS. OK. That is all the questions I had. I just wanted to kind of go one step beyond yours, so thank you.

Chair SNOWE. Thank you very much, Senator Burns.

Senator Lincoln.

Senator LINCOLN. Again, I would like to compliment Senator Snowe. She is a real problem solver and I always liked working with her, so I am looking forward to coming together to solve this problem on behalf of the uninsured, and particularly our small businesses.

Our States are very, very similar, and truly, our small businesses, particularly in my State, are our largest employers. Unfortunately, because they are less likely to be able to afford health insurance, they are also the bigger component of the problem of the uninsured. These people are working hard and we want to be able to try to provide them as much as we possibly can in the way of health insurance, not only for the benefit of them and their families, but also for the fact that it helps us better manage the cost of health care overall. So again, Senator Snowe, I am pleased by your hard work on this issue and look forward to working with you.

I guess my frustration has been that it seems like we always try to reinvent the wheel, and to me, there is no real need to reinvent the wheel. As I found myself traveling across my State and listening to people talk about my insurance plan, and I realized that the Federal Employees' Health Benefits Plan has been doing a pretty decent job for the last 40 years in allowing us to pool all the Federal employees, those that are the young, fearless single staffers that we all have who know no danger, to the families like myself, as well as the Park Ranger in the remotest parts of Montana, to be able to pool all of those different individuals and to increase their choice and hopefully, as we have been over the years, decrease the cost.

So looking at that and trying to work from something that exists, I have been trying to come up with one of these solutions, as well.

The FEHBP, which I have just described, our program, in my opinion, does not promote Government-run health care, but harnesses the power of market competition to bring down health costs and uses a proven Government negotiator.

So I think as we look at all of the different options that are out there for small businesses, I hope we will bring the best of all these worlds together.

Madam Secretary, we are pleased you are here, and certainly your wealth of knowledge and what you already do in helping to regulate and maintain insured individuals is critically important. When you talk about the solvency, that is a critical part of what we have to do, and I guess some of the concerns stem from the stipulations or the parameters that would probably need to be around this reservoir of resources that you mention, and I guess also the idea that the solvency—well, I guess the basis is whether or not under the AHPs that they have to be licensed in the States where they operate, and I don't believe the AHP requires that.

Secretary CHAO. The proposal is——

Senator LINCOLN. Both the national and the State plans.

Secretary CHAO. The proposal for the AHPs is to certify them. The whole purpose is to enable organizations to come together to pool their resources across State lines.

Senator LINCOLN. Right.

Secretary CHAO. So there will be these increased solvency requirements——

Senator LINCOLN. But would the AHP——

Secretary CHAO [continuing]. At the Federal level which had not been there before.

Senator LINCOLN. Right. Would the AHP plans, would they have to offer to every member in every area of the country? Would that be required of them?

Secretary CHAO. They cannot discriminate against any member in a group.

Senator LINCOLN. So they would be mandated to offer their plan in every area of the country?

Secretary CHAO. There is a difference between—I think there is a basic difference as we talk. When we talk about AHPs, I think the intent is we are removing a barrier. We are creating a level playing field.

Senator LINCOLN. It is a simple question. Are they required to be licensed in the States that they operate, and are they going to be required to offer to every member in every area of the country?

Secretary CHAO. They cannot discriminate against any member who wants to access those plans.

Senator LINCOLN. So you are saying they have to offer their plan to every member——

Secretary CHAO. Well, not to somebody who doesn't want it.

Senator LINCOLN [continuing]. In every area of the country?

Secretary CHAO. If it is someone who wants it, yes.

Senator LINCOLN. Every area in the country.

Secretary CHAO. Perhaps someone doesn't want it. Then they don't have to have it.

Senator LINCOLN. But, I mean, it needs to be offered in all those areas.

Secretary CHAO. All the Federal health protections would apply.

Senator LINCOLN. And the licensure in each State, is that going to be—are they going to be required to be licensed in the States where they operate?

Secretary CHAO. I don't think so.

Senator LINCOLN. Or serve?

Secretary CHAO. Fully-insured AHPs have got to file in each State, because again, they are the ones that are regulated by the States.

Senator LINCOLN. The national plans don't.

Secretary CHAO. The self-insured currently are not registered in each State.

Senator LINCOLN. Well, that is one of the things—in the Federal plan, they do. Both the State and the national plans have to be licensed in the States that they offer, and I think some of that has to do with some of the consumer protections that we talked about.

Secretary CHAO. Yes. We talked about the State consumer protections, which will still remain with AHPs, as will the solvency requirements.

Senator LINCOLN. But if it is a national plan and they are not licensed in that State, they are not subjected to that, is that correct?

Secretary CHAO. The State consumer protections apply to fully-insured AHPs across wherever they operate, across all States. The State solvency requirements and consumer protection requirements remain. That is my understanding.

Senator KERRY. By virtue of what——

Senator LINCOLN. Without licensure, I don't think that is the—but that is something we should——

Senator KERRY. We will work it out.

Secretary CHAO. Well, maybe we should discuss it.

Senator LINCOLN. Absolutely. That is something we should talk about.

Secretary CHAO. My understanding is that all the State consumer protection and solvency requirements apply to fully-insured AHPs.

Senator LINCOLN. In terms of the solvency issue, the Department of Labor ensures the solvency at the beginning of the AHP. What is the process with which you maintain the integrity of that sol-

vency? I mean, are there audits? The current law is that you audit every 3 to 5 years their annual financial exams. There are quarterly financial exams that allow for the compliance of solvency. Is any of that——

Secretary CHAO. I would imagine there will be annual reviews as to the quality of the portfolio by the Department of Labor.

Senator LINCOLN. Is that written into the law?

Secretary CHAO. That, I am not sure of.

Senator LINCOLN. I think that would be something that would provide assurances of knowing how the upkeep of the solvency is going to be guaranteed for these plans and not just the initial solvency. Obviously, when you from the Department of Labor would initiate an AHP, you are going to ensure its solvency from the beginning. But we as we are quickly finding out from Social Security and everything else, unless that continued solvency is monitored.

Secretary CHAO. We regularly monitor and regulate health plans now, so we wouldn't just look at it in the beginning and then neglect it. It is an ongoing responsibility to monitor these, and also to pursue malfeasant actors in providing these plans.

Senator LINCOLN. Well, I am not saying you don't have the capability.

Secretary CHAO. Right.

Senator LINCOLN. I am just asking, is that required in the law for you to do that? I am not saying that you don't have the capability or that you don't do it in what you do now.

Secretary CHAO. What I am saying, whatever is within the Department's practice of monitoring these plans. But, of course, I will be more than glad to talk about that with you because we have a plan for monitoring that.

Senator LINCOLN. Well, I think what is important is that it is written into the law of how the AHPs are governed, is that you not only have the capability but you are given the requirement and the authority to do that. So I think that is what the concerns may be in terms of the solvency oversight, is to make sure that those things are written into the law and required not just of you, which you may already be capable of, and it sounds like you are from what you already do, but that it is required of the AHPs in their practice and it is required of you as a statutory requirement of how they are going to be monitored, which gives people greater assurance, I think.

And I think one of the concerns particularly about the solvency and the regulatory aspect is that it doesn't require the Department to regulate that particular plan in that State. It can regulate it by any State standards, not just the State that it is practiced in. And I may be incorrect in interpreting it that way, but I think that would be something that would be very important to look into, that you don't just use one State's law to regulate all of the AHPs in other States but that they are using the current law of the current State that they are actually practicing in, which is important, I think, for the people in those States.

I know I have used an awful lot of my time, Madam Chair. Just I guess one of the last things is to Mr. Barreto. I guess if you could help us understand, because truly, our small businesses are our number one employers and we want to give them every benefit pos-

sible to access the health care market. What would the legislation do in addressing the rising costs of health care other than pooling individuals? We know that that is going to be an important part, and CBO, I believe, has given us some studies on what the small group market does, but are there other things that we need to do? I am not so sure that that is enough.

Mr. BARRETO. Well, it is not enough.

Senator LINCOLN. I believe that tax credits are very important.

Mr. BARRETO. It is not enough, but that is not all that it does. Not only does it provide small businesses more choices, because they will be part of a bigger pool which will attract more insurance companies interested in providing them insurance, but when you are not subject to the State mandate, you also have much more leverage to negotiate the benefits that you want.

You know, there are a lot of small businesses in your State. They have to buy the insurance plan that is mandated inside that State. In other words, if there was another plan in another State, let us say in an adjoining State, let us say Texas, if they wanted to buy the plan there, they couldn't. Maybe they like the Texas plan better because there are more benefits that they like in that plan. They wouldn't have that choice.

Also, when you start getting these larger pools, you are able to do a lot about the administrative cost. That is a huge cost of health insurance premiums. We have already talked about how larger pools, Federal employees, unions, large corporations, their administrative costs are half of what they are for small businesses. So for a small business, it is really the best of all worlds. They are part of a bigger pool. They have more buying power. They are going to pay less administrative costs. They have more flexibility to get the benefits that they want, not the benefits that they are told that they have to buy. So for them, this is a huge win.

Senator LINCOLN. We provide all that through the Federal employees' plan, too, that template we are using.

Mr. BARRETO. Yes.

Senator LINCOLN. But I guess my question to you is, is that enough? I mean, do you not think that small businesses need an extra help in paying——

Mr. BARRETO. Well, if they could save 25 percent on their insurance premium, and that is what is estimated as the potential, they could save 25 percent off their bottom line.

Senator LINCOLN. Is that enough of an incentive to get them into the marketplace?

Mr. BARRETO. That is huge. That is big. There are a lot of small businesses that aren't hiring people right now because they say, look, I need more employees, but I can't afford the health insurance premium so I am not going to hire anybody. There are small businesses that go out of business because they have a huge claim that comes in to them and they don't have the money to pay the claim because they can't afford the insurance.

Senator LINCOLN. So you don't think there need to be any other sweeteners to help get our small businesses into the marketplace?

Mr. BARRETO. I think that this is a good first step. This doesn't solve the health care crisis. The health care crisis is very complex. There are a lot of things that drive up health care costs. But what

this does, it provides them access that they don't have. It provides them purchasing power that they don't have.

Senator LINCOLN. Do the low-income workers, I mean, without any kind of an incentive for their employer, is it going to be financially feasible without tax incentives for our——

Mr. BARRETO. A lot of those small businesses say to us, look, we think that our employees are the most important thing that we have and we don't think that this is just an employee benefit per se. We think that these employees have a right to have these insurance benefits. But we can't afford it.

Senator LINCOLN. You think it is going to fly on its own without the extra incentives that we need?

Mr. BARRETO. I think that this goes a long way to getting a lot more people insured that don't have insurance right now.

Senator LINCOLN. Thank you, Madam Chair.

Mr. BARRETO. And we do need to work on those other things. I think that is important. I think tax credits and other incentives are great. But if we can tackle this, the big problem that they have is that they don't have access. The big problem that they have is they don't have choice, they don't have control, and they don't have what large corporations and unions have, and that is what we want to provide small businesses. Small businesses are the only group that don't have this. Everybody else has it. Government employees like me have it. You know, if you are a member of a union, if you work for a large corporation you do. But if you work for a small business, you don't have it, and not just in your State, in all 50 States. That is why it is such a big problem.

Senator LINCOLN. I do think they need a little more incentive, but thanks, Madam Chair.

Chair SNOWE. Thank you, Senator Lincoln.

You know, it is interesting, the CBO report. Looking at the CBO report from last month, it said that the effects of the bill on Medicaid would result in estimated savings to States of $18 million over the 2006 to 2010 period, and $60 million over the 2006 to 2015 period. It also would increase their net revenues, too, over the long term.

I think the point of it is it could have an important impact on some of the programs in the State, especially on Medicaid, in reducing the number of uninsured. I mean, whether it is going to be 600,000 or eight million, depending on the various estimates, the point is it is reducing it and it is offering an option. I think that is what we have to look at in terms of this issue.

Plus, it doesn't cost any significant amount of money to the Federal Government. I mean, that is the other thing. It is a nominal cost to the Government, and that is why it becomes a very attractive option, in addition to the other issues that have been raised, if we could address some of these issues and working with Senator Kerry and all of you, because I think it could go a long ways toward helping give the States an option they otherwise do not have.

Senator Kerry, do you have any other questions before we move on to the second panel?

Senator KERRY. I do, Madam Chair. I am sorry about that, but I do, a few.

Chair SNOWE. OK. We have got five others on the second panel. I know the Administrator has to leave in a few minutes.

Senator KERRY. I know we do, but let me come back to what the Administrator was just talking about with Senator Lincoln, and I want to thank Senator Lincoln for her work on this. She has been doing a terrific job in thinking about it and coming up with some solutions.

Mr. Barreto, what you have chosen to do—first of all, you just said this does not fix the health care crisis. I suppose an obvious question is, why aren't you proposing something that fixes the health care crisis?

Mr. BARRETO. Well, I think this is part of starting to fix the health care crisis, especially for small businesses. You know, small businesses, they don't complain about the health care system in America. They complain that they don't have access to it. They complain that they don't have choice and they complain that they can't afford it. So that goes a long way. But we are also doing other things, too. We are trying to do something about the frivolous lawsuits and the cost of prescription drugs and trying to provide more incentives to small business, as well, with Health Savings Accounts and other incentives that small business can take advantage of.

Senator KERRY. Well, in my judgment, there is a more effective way to try to do it. Madam Chair, what we are really talking about here is the choice of incentive. Right now, small business can pool. When you say they can pool, they don't. They can't pool because in many cases, they don't want to be subject to the State regulations because it is costly. It is a cost issue and a regulatory issue, right? And they can't afford it.

Mr. BARRETO. Right.

Senator KERRY. OK. Your choice is to let them out from under the State regulation, which a lot of people believe winds up creating—sure, they will get access to something, but what is that something? Is it adequate? Is it going to protect people? Is it going to provide them the coverage they have today?

Let me give you an example. You exempt them from State law, and that means there is no requirement for mammography screenings. There is no requirement for prenatal or maternity care or well baby care, well child care, or diabetes supplies and education, or cancer screenings and mental health services because AHPs are exempted from all those requirements.

Mr. BARRETO. But they could buy it if they wanted it. If they want that, they can negotiate with an insurance carrier to have that.

Senator KERRY. But the whole issue here is what is going to be available and what is the quality going to be? Can they buy into something? Yes, they may be able to buy into something. But why should they be granted an exemption from those services which States have decided are really critical to the quality of care that is being provided in that State?

Mr. BARRETO. Because not every small business wants to buy it. Not every small business feels that they need—I mean, some of these things are just like a long menu that keeps gets adding onto which keeps rising the cost of health insurance. Let us say that, for example, there are some benefits on there that really don't

apply to the small business's workforce. In other words, they don't need it. Let us say there were a lot of benefits there that are very important to women, but you have a small business that just has men inside of it. Maybe they wouldn't need all those benefits, and vice versa. Maybe there are benefits that favor men in a business that is run by all women. I mean, there are a lot of different choices.

Here is the thing, is this is voluntary. If a small business likes the plan that they have, they don't have to change. Nothing has to change for them. They can stay exactly where they are at right now. But what we are talking about is this huge pool, millions of small businesses that have no choice, and what we are saying to them is we would like to offer them another option.

And as Senator Talent said, if they don't work, they won't buy these plans. They won't go into these plans. And so for us, we think that this is, again, a step in the right direction to solve what they believe is one of their most critical problems—lack of options, lack of competition, and price.

Senator KERRY. Yes, but to some degree the question is whether or not you want to try to establish a standard, which is what we have been fighting about for years, as to what might or might not be available at what kind of price.

I mean, under this approach, no one disputes that an AHP can't deny coverage to somebody. I don't dispute that.

Mr. BARRETO. Senator, when you say the AHP cannot deny coverage, that is right. If they are a member of that——

Senator KERRY. I am not disputing that. They can't discriminate.

Mr. BARRETO. Right.

Senator KERRY. That is not the question. At least as it is written, they can't.

Mr. BARRETO. Right.

Senator KERRY. But here is the problem. The premium that can be charged has no limit whatsoever. There is no regulation whatsoever with respect to a premium that can be charged. And an AHP could structure itself—I mean, according to good business practice, you could say, well, we want to attract a certain kind of client, and they could structure themselves as an association and only let people in who meet their particular structural requirements. They could do that.

Mr. BARRETO. They probably wouldn't do that.

Senator KERRY. Why not? Why not if a best business practice was to find those kind of people because that is the way you make the most money and have the least sickness?

Mr. BARRETO. First of all, most of the organizations that are going to offer this are going to be Chambers of Commerce and business associations, organizations that specialize in meeting the needs of small businesses, and there is no organization that I have ever met in my life that wants less members. They want more members. And so I don't see them excluding people. But let us just say that they did——

Senator KERRY. They want the right kind of client that meets their business profile.

Mr. BARRETO. Most—if it is a trade association, obviously, it is going to be anybody inside of that trade. If it is a Chamber of Com-

merce, it can be almost any kind of a business. But here is the thing. Most small business owners, I mean, the ones that are successful and are networking, belong to two or three organizations. They don't belong to just one organization. So if the organization that they belong to is not providing what they want, they are either going to get it from one of the other organizations that they join, or also competition is going to spring forward. There is going to be an organization out there, a Chamber of Commerce that gets it, does it right, and everybody else is going to flock to them.

That is the reason that every major business organization in the United States—you know, we talked about experts. The experts on small business are the Chambers of Commerce, the NFIB and the Retailers Association. All of them have endorsed AHPs, and they didn't do it spontaneously. They have been studying this issue for 10 years and they are desperately seeking this option. That is why there is so much passion around this issue. Every major business organization in the United States has endorsed AHPs, and they understand what is at stake here. They have looked at this issue and that is why they want it.

Senator KERRY. Well, there are loads and loads of Chambers of Commerce who do not support it.

Mr. BARRETO. Some of them don't, and there are some Chambers of Commerce——

Senator KERRY. A whole bunch of them don't.

Mr. BARRETO. There are some Chambers of Commerce——

Senator KERRY. I have got a list of them right here, and there are a whole bunch of Farm Bureaus that don't like it and small business associations who don't like it——

Mr. BARRETO. I have met with some of them, and some of them already have a good health insurance benefit for their members and they don't want to change anything. They are happy with the status quo. And I say to them, you know what? If you are happy with your health insurance benefits, you should stay with them. But we have got to do something about 99 percent of the other small businesses that don't have it.

Senator KERRY. Why do you think that so many consumer groups across the country are opposed to this? I mean, a great number of groups that represent the people who hopefully will get coverage or have coverage, are opposed to this?

Mr. BARRETO. I think once you educate and inform people, they are going to like the choice.

Senator KERRY. Do you think they are all ill-informed? Is that it?

Mr. BARRETO. I am not saying they are all ill-informed, but some of them may not need this kind of health insurance benefit. But for millions of small businesses who have nothing else, have no other option.

Senator KERRY. You don't think that they are concerned about the rights of people, about people being able to be protected against——

Mr. BARRETO. If they like their system that they have now, they can stay in it. Nobody is telling anybody that they have to change. What we are saying is that we want to give these small businesses who are screaming for relief another option, and they want this option. You know, we have already talked about it. We have made

some significant progress. This has passed already several times on a bipartisan basis in the House of Representatives and this is the last place that we have to make progress. We have to make progress in the Senate and make sure that people are informed and educated about what the stakes are.

Senator KERRY. Can I ask you what insurance you have?

Mr. BARRETO. I have Blue Cross-Blue Shield.

Senator KERRY. Through the Federal Government?

Mr. BARRETO. Through the Federal Government.

Senator KERRY. And Madam Secretary?

Secretary CHAO. Same.

Senator KERRY. Good plan?

Mr. BARRETO. It has worked pretty well for us.

Senator KERRY. Any reason it shouldn't be available to all Americans?

Mr. BARRETO. Well, I think Blue Cross-Blue Shield does make their insurance available.

Senator KERRY. No, the Federal Employees Health Benefits Program, FEHB.

Mr. BARRETO. You are talking about a totally different thing there. Obviously, part of our insurance premium is paid by the Federal Government. Obviously, we are part of a pool of millions of people, which gives us better benefits and better costs. Those are the same kinds of things we want to give to small businesses.

Senator KERRY. But if we could, which we could, why shouldn't we make it possible for all small businesses to buy into the same plan as we do?

Secretary CHAO. I think you would have to set up a whole new program. What we are talking about here is tearing down barriers and allowing small businesses to come together and pool risks so they can decrease their costs——

Senator KERRY. Well, we are talking about making the market more competitive.

Secretary CHAO [continuing]. So they can offer more health care to their workers.

Senator KERRY. Wouldn't it be a nice market offering to say to people that you could buy into the same program that we do?

Mr. BARRETO. I think that there is a concern with a lot of small business. Any time that you talk about something being part of the Government, a Government plan, when you talk about adding maybe $70 billion——

Senator KERRY. Blue Cross isn't a Government plan. Blue Cross is a private plan.

Mr. BARRETO. But it would be in the context of——

Senator KERRY. You have Blue Cross, don't you?

Mr. BARRETO. I do.

Senator KERRY. You have Blue Cross, Madam Secretary? It is not a Government plan.

Mr. BARRETO. We buy it as a Federal employee.

Senator KERRY. Yes, but why not let other people buy in as whatever kind of employees they are?

Mr. BARRETO. Well, I mean, a lot of it would depend on what the cost would be. Would they receive the same benefits we do, because part of our insurance is paid for by the Federal Government.

Senator KERRY. Correct, and what we would do is provide a 50 percent tax credit to small businesses to be able to buy in, so they could afford it.

Secretary CHAO. I think the particular bill you are referring to that was just offered also by Senator Lincoln.

Senator KERRY. That is a slightly different plan, but it is modeled on the same concept.

Secretary CHAO. That bill will cost $18 billion from mandatory appropriations over the next 4 years.

Senator KERRY. Yes, I don't support their bill because I think it doesn't bring in enough people, but there is a way to bring in more people.

Secretary CHAO. The total cost to the Federal Government for AHPs would be approximately $100 million over the next 5 years. So again, I think the approach is quite sound. It would enable us to cover more people and it would, again, tear down barriers that currently exist and prevent a level playing field. And the AHP legislation does not establish a new and more expensive Federal program legislation.

Senator KERRY. So it is a matter of choice of expense, is that it?

Mr. BARRETO. Well, I think there are other things, too.

Secretary CHAO. It is a matter of choice and helping people. What I am concerned about are workers who are working for small companies who do not have health care insurance——

Senator KERRY. No, I know, but if you could provide health insurance——

Secretary CHAO. [continuing.] ——and they cannot have it because of these artificial barriers that are preventing their companies and their employers from coming together, sharing in the pooling of the risk, which is commonly available to large corporations and labor unions. Because small businesses currently cannot do that, and therefore, they cannot offer that benefit to their workers.

Senator KERRY. Well, let me just point out, because I have heard so many times here that this is going to be trying to make small business exactly like big business and we are going to give them the level playing field. It is not the same playing field, and it is not making them the same, because small employers are going to pay premiums to the AHPs just like insurance and they are going to trust that the AHP is going to be there to pay for them down the road. In contrast, large employers in America who self-fund are at risk for their employees. These folks won't be, which is why the solvency issue is so critical. So it is not the same playing field.

Secretary CHAO. Well, self-insured plans under current law are not under State jurisdictions, either. There is a big difference.

Senator KERRY. Well, I realize that, but it is the question of what is the bottom line here with respect to the person signing up.

And the second thing I want to say is that you have to make a fundamental decision in public life about what you think the standard is you are trying to make available to people. We in the Congress have decided that somehow we get this terrific plan, but Americans shouldn't be able to buy into it. I don't think that is right. I think Americans ought to be able to buy into it. Now, if they can buy into it, so much the better for them. And if we were to give them an economic incentive to empower them to buy into

it and lower the premiums, you could, in fact, have 95 percent of all Americans covered.

So when you say we are not solving the whole problem, you are making a choice not to solve it because you think tax cuts are more important.

Mr. BARRETO. I think what we are trying to do is respond to the different parts of it. I am not sure that you can solve it in just one-size-fits-all. I think that you have got to solve these different moving parts that we talked about. What we are dealing with right here is one——

Senator KERRY. But you can provide a comprehensive plan, Mr. Barreto—I know it because a lot of people have done it through the years—where you help deal with the cost side of it, you help deal with—I mean, I know what the Administration is doing. I think they put up $50 million nationally to try to deal with technology in hospitals and in the health care industry. Fifty-million dollars is laughed at in State after State. It doesn't even take care of one State's challenge.

So it is really a choice of where you want to put your money, and we disagree on that. But I think there is a better solution and there is a better way to provide more affordable health care, which is better health care to more people under better standards than we are choosing to do, and that is an important debate to have and that is an important role for us to play here. Is there a better way to do this?

Now, we are not in charge of the Congress or the White House, I understand that. So, therefore, we are going to have to try to find a way to stop-gap this. What I want to do is not do harm, and what I want to do is try to find a way to get as many businesses into this as possible under the fairest mechanism possible. So I hope we can stop-gap some of these holes on solvency, on coverage, on rights and so forth, and I want to work with the Chair to do that. But we ought to be honest in our appraisal of where some of those issues may exist. It just happens in the writing of law that sometimes there are holes and misinterpretations.

Mr. BARRETO. I agree with you wholeheartedly, Senator Kerry, and I think what small businesses are saying is, please send help as soon as possible. We can't discuss this and debate this for another 10 years. Some of us won't be in business any longer if we keep getting double-digit increases in our health insurance.

So again, and I think some of the other Senators mentioned this, we should be talking about all of these options, and this is, I think, something that is going to be with us for a long, long time. But if we could do something like AHPs and do it this year, you could provide relief to millions of small businesses while we are working on some of those other issues that affect their health care costs and access.

Senator KERRY. I just want to listen carefully to the experts who tell me there may be more people uninsured and there may be more problems with people scammed and there may be less delivery of adequate health care. Now, if I hear people saying that to me, I am going to stop and examine it pretty carefully.

Chair SNOWE. Thank you. Thank you, Senator Kerry. No, I appreciate your comments and hopefully we can work through these

issues. I think this was valuable, to have this discussion on the specifics of the legislation, because it gets us beyond. I hope we can create a building block and step forward. These issues, as I said earlier, aren't mutually exclusive. There are a variety of initiatives.

Let me just make several points. Obviously, Association Health Plans are optional and they are voluntary. They can't be created—well, you could State-by-State, but we are going to hear in a subsequent panel an individual talk about the fact they weren't able to, because it is not efficient to create an AHP or a statewide pool for small businesses in every State or a variety of States. I mean, it just makes it almost impossible from a regulatory standpoint, and ultimately they closed down their Association Health Plans because you couldn't transcend State boundaries. That is one of the issues.

The other issue is corporations and unions. We cite that for a good reason. First of all, it is interesting to note, as I said earlier in my statement, that they offer the more generous and most generous plans, and they are exempted from State mandates in that they don't have to comply with State mandates. It is suggesting that if you don't have State mandates, you are never going to get the best benefits. That is not necessarily true. State benefits and State mandates are important. Obviously, it sets a threshold establishing what we think is important.

On the other hand, it doesn't mean to say small businesses and their employees aren't interested in those benefits and they have to be mandated in order to get them. The whole purpose is to make small business competitive with corporations and larger businesses that offer this as a benefit.

Having good health insurance is an important benefit to attracting good employees, and that is the other thing, is to level the playing field for small businesses so that they can stay on par in competing for the good employees with corporations who can offer this generous health care package. If you don't have that in today's world, that can be first and foremost as to whether or not an employee or potential employee is going to make the decision, and so that is another tool that we can give small business that they otherwise do not have.

Now, my small businesses have, what do they have, catastrophic at best. I mean, they are paying $5,000 to $6,000 minimum a year just to get the catastrophic coverage because it is the bare bones. So what is the option here, is to give them something, the ability—and these packages will be designed to attract the maximum number of participants in a plan, not the least number.

Now, we all want to avoid any issue regarding the race to the bottom or the lowest common denominator, but I think that the best instincts ultimately will prevail for very good reason, and we have the oversight mechanisms in here to do it.

And so I hope that we can look at these issues in that sense. And might I also add, on the legislation that was suggested here by Senator Durbin, Senator Lincoln, and others, they also preempt State benefit mandates. So under their plan, the Federal Government would make those decisions about what would be incorporated and they would be bypassing State mandates, as well. We all are seeing why those State mandates are there. They are important. We are not saying we are trying to get out from under them.

That is not the point of this. The point of this is desperation. That is it. It is desperation. I mean, small businesses are desperate. They are in a crisis and we have got to help them.

Let us just take one step forward, one step forward that won't cost anywhere from $18 to $70 billion that they are suggesting. I would like it. I mean, there are very good options. But we have got to do something, and in this era of——

Senator KERRY. Would you like it more than a tax cut? No.

[Laughter.]

Chair SNOWE. Well, I have also had issues on that, too. In any event, I think that is the point. I think we can. I think that is the point here. I think that there are ways of reaching some conclusion, and there are other issues that you are suggesting. I think we can get there on some of these things. I just hope it won't be a barrier that we can't—you know, we ought to be able to do something.

Senator KERRY. Madam Chair, can I ask that Senator Durbin's statement be made part of the record?

Chair SNOWE. Yes. Without objection, so ordered.

[The prepared statement of Senator Durbin follows:]

**STATEMENT OF SENATOR RICHARD J. DURBIN**

Small Business Health Insurance Hearing
Senate Small Business Committee
Opening Statement
April 19, 2005

Everywhere I go in Illinois, the number-one concern I hear from business owners – large and small – is about the high cost of health care.

No matter how hard they work, or what kinds of innovations they come up, they tell me they just can't get ahead. They can't hire new workers or purchase new equipment because whatever profits they make are immediately consumed by skyrocketing health care costs.

Mercer Consulting is a respected human resources consulting group. Every year, it conducts a survey of American business leaders. Last year -- for the first time ever -- business owners listed the high cost of workers' health care – not taxes – as their biggest concern. Two-thirds of the business owners surveyed said they shop for new health plans every year to try to save money.

Small businesses are especially hard hit because they don't have the negotiating power of large businesses. The limited number of

people small businesses employ hinders their ability to command discounts, or find much choice in the insurance marketplace.

We all agree that small businesses need relief from the pressure of double-digit annual health insurance premium increases.

I believe we agree on some fundamental principles:

1) We should make premiums more affordable by giving small businesses a way to pool their purchasing power;

2) We should encourage competition among health plans on the basis of quality, efficiency and value; and

3) We should help reduce the administrative and transaction costs in the small group market.

Unfortunately, insurance is an extremely complicated field and it is the details that will make or break the effectiveness of a new insurance framework.

In my opinion, there are some key details that need to be addressed in a small business insurance proposal.

**Adequate Oversight**

There must be quality oversight. Without adequate regulation, insurance products would not be reliable.

Congress preempted state insurance regulation and oversight for Multiple Employer Welfare Arrangements, which are plans sponsored by a group or association for multiple employers.

This preemption led to a rash of health insurance scams and bankruptcies by operators of MEWAs, including MEWAs sponsored by associations. Thousands of people were left without insurance and millions of dollars in unpaid claims.

Congress repealed the exemption in 1982.

**Minimum Benefits**

Health insurance is not much use if you can't get the benefits you need. States have worked hard to ensure that adequate benefits are included in insurance packages, so people with diabetes are assured access to diebetic supplies.

In our drive to bring down the cost of health insurance, we cannot ignore the importance of benefit mandates. We should look at reducing the underlying costs of health care rather than simply excluding important benefits.

One of my concerns with the Association Health Plan legislation is that none of the benefit mandates currently written in state law will apply to AHP insurance.

**SEHBP**

Senator Blanche Lincoln and I have introduced a bill that we believe achieves the twin goals of lowering cost while maintaining adequate oversight and benefits.

The Small Employers Health Benefits Plan is modeled after the successful federal employees plan. SEHBP would allow small businesses to band together nationwide and choose from plans that would bid to offer coverage in the pool.

This year, 249 different insurance plans will offer coverage in the FEHBP pool. Imagine if small businesses could have access to

those kinds of choices.

Plans participating in SEHBP would be subject to strict regulatory and solvency standards, and would be audited annually by the Office of Personnel Management.

Statewide plans in SEHBP will be required to offer state-mandated benefits and OPM would develop a comprehensive national benefit package.

Finally, small employers would receive an annual tax credit to defray part of the employer contribution for low-income workers.

Senator Lincoln and I believe SEHBP is a common sense approach to lowering health insurance costs for small businesses while affording them adequate consumer protections and I hope the Committee will consider the bill.

Senator KERRY. Just kind of quickly, and we are going to end up, but I want to find a solution. I ran a small business. I had about 35-, 40 part-time employees. I would have loved to have given health care, but I couldn't even consider it. I understand it, but I also understand that there is a reason many of these protections are standard, and that is the history of this. We all understand it. There are costs and ways to reduce those costs.

I hope we can come up with a way to bridge these differences, and I think we probably can if we work in good faith at it and there isn't just sort of an ideological quest here. If we really want to try to find a way to help small business, hopefully, we can do it in a fair-minded manner.

Chair SNOWE. Thank you.

Mr. BARRETO. Thank you very much, Senator.

Chair SNOWE. Thank you, and thank you for your patience. Thank you for your contributions and your leadership. Again, thank you very much.

The next panel, who have been more than patient. We have tested your endurance today. Sorry. But you see that it is obviously a very important issue to all of us and I think it was a very constructive discussion here this morning, and so I appreciate your willingness to be patient.

Our second panel this morning represents the small business community, obviously different associations and State governments here, and so we appreciate your all being here today.

First of all, I would like to introduce Doug Newman, President and owner of Newman Concrete Services located in Hallowell, Maine. Mr. Newman is an active member of the Associated Builders and Contractors, served as the board representative for ABC's Maine Small Business for Responsible Health Care Reform Task Force.

Also testifying is Mr. Al Mansell, a Realtor from Salt Lake City, Utah, and current President of the National Association of Realtors, the Nation's largest professional association, representing two million members involved in all aspects of the residential and commercial real estate industry.

Testifying also is Mr. Tom Haynes, the Executive Director of the Coca-Cola Bottlers' Association. The Coca-Cola Bottlers' Association not only represents the interests of Coca-Cola Bottlers in dealing with the Government and the company, but also manages numerous employee benefits, purchasing, and insurance programs for these bottlers.

Also, Len Nichols, who directs the Health Policy Program at the New America Foundation, which aims to expand health insurance coverage to all Americans while reigning in costs and improving efficiency of the overall health care system.

I want to also welcome John Morrison, Montana State Auditor and Commissioner for Insurance and Securities. Mr. Morrison is representing the National Association of Insurance Commissioners today.

Finally, I welcome Mr. Lindsay, who currently oversees the Employee Benefits Group at Lockton Companies of Colorado, one of the largest insurance brokerage firms in the country. We appreciate your being here, too, and we thank you for being here. We

welcome your testimony as former Chair of the National Small Business Association, which is the Nation's oldest non-partisan small business advocacy group, reaching more than 150,000 nationwide. Thank you.

So, Doug, we will begin with you.

**STATEMENT OF DOUG NEWMAN, OWNER, NEWMAN CONCRETE SERVICES, INC., HALLOWELL, MAINE**

Mr. NEWMAN. Good morning, Senator Snowe, Senator Kerry. Thank you very much for having me here today to discuss this important issue of vital importance to small businesses. I would also like to take the opportunity——

Chair SNOWE. Sorry to interrupt, but hopefully, you can summarize your statements within 5 minutes and we will submit your entire statement for the record. Thank you.

Mr. NEWMAN. I will be brief. I would also like to take a moment and thank Senator Snowe for her strong leadership on behalf of small businesses back in Maine. We are very proud to have you up here fighting for us.

My name is Doug Newman. I own a company called Newman Concrete Services located in Hallowell, Maine. We employ 50 men and women on some of the largest construction projects in Maine. Of the many challenges I faced starting my business 10 years ago, health insurance is at the top of the list.

Looking ahead, what we find discouraging is we don't see anything on the horizon that appears ready and willing and able to address the situation. Association Health Plans, we think, is a legislation that could provide some immediate relief.

I started my business in 1996, after working in the construction industry since getting out of college. Within a few years, we had grown to over $3 million in sales and had over 50 employees. Like most people who started a small business, I wasn't really prepared for the obstacles I was going to face. I am very proud of what we accomplished, but if you asked me if I would do it all over again, I am not sure I could say with all honesty that I would.

Of all those risks and difficulties, health insurance has been one of the most troubling. I learned early on that providing health insurance to my employees is a vital part of having a business. But more importantly than that, like most small businesses, I think it is the right thing to do. You feel a very strong moral obligation to your employees. We are small businesses. I have less than 50 of them. When the car breaks down, when the family problems arise, when things aren't going well at home, I know about it. These people, I deal with every day. We don't have 2,000 or 3,000 employees. I have a very small number of them.

When we were able to finally purchase health insurance 2 or 3 years after we started, it was a real milestone in my business. I thought my business had finally arrived. We were now a solid, legitimate business. We were providing health insurance to our employees. Some of my proudest moments as a business owner has been when people that work for me came to me and they were secure enough in the business, they were secure enough in the pay and benefits that they started families, they bought homes. That, to me, was when a business really arrives, when you have employ-

ees who work for you that feel confident enough in what you are doing to do that.

What I didn't know, and what I am learning every day, is just how difficult it is to maintain that. And even as I face the challenges of rising health insurance costs, my employees face the same thing.

In my State, the economy has been slow the last few years. The price I charge for my projects that I get isn't going up any. Wages isn't going up any. Unfortunately, everything else is.

Of my 50 employees, about half are covered by an HMO offered through Anthem Blue Cross-Blue Shield. Employees and their families are eligible after 6 months to join the plan. I pay 70 percent of the individual premium and I pay 50 percent of the family cost. It is offered through a flex benefits account, which allows the deduction to be made before taxes.

Despite difficult financial times in recent years, reducing my employees' share, or increasing my employees' share just hasn't been an option. They can't afford it. So as a result, the company has absorbed in the last 4 or 5 years some pretty large increases. I can't afford to ask my employees to pay more and I can't afford to lose my good employees.

We have cut costs and downsized what we can, but there is an inevitable day of reckoning coming if we continue to face the same unsustainable health insurance costs year in and year out. We are just going to reach a point where we just can't keep going. We are literally being put in a situation where we can't charge more, we can't make more, and the costs are coming up to a point where the company is just simply not going to be profitable.

In the last 4 years, since 2000, health insurance premiums for an individual has risen from $42 a week to $70 a week. Family coverage went from $123 a week to $211 a week, represents about a 70 percent increase in just the last 4 years. All-told, my company contributes right now well over $50,000 a year in health insurance premiums. Unfortunately, this is often the difference between making money and losing money, and the last few years, it has put me on the wrong side of that line.

Every year when renewals come, we are very fortunate—very fortunate—to get two quotes. In Maine, there are only three companies that are even writing insurance, and we have a relatively weak market up there. If I have two insurance quotes to choose from, I consider myself lucky. They are both basically the same exact plan and the difference in cost generally isn't that much.

One thing is inescapable. If we don't do something very shortly to provide access to lower health insurance for small businesses, they are just going to be forced to drop it. Health insurance ceased to be affordable a long time ago. Right now, it is affecting our ability to be profitable and to grow, and in the near future, it is going to become simply impossible.

In Maine, we have had a shift of over 10 percent from private insurance to Medicaid. In the last 4 or 5 years, the number of uninsured in Maine has remained pretty constant. We have had a shift from 10 percent of the population enrolled in Medicaid to now 20 percent of the population is enrolled in Medicaid. No change in the uninsured, just a shift from people paying private insurance to our

Medicaid system, and anybody that has paid any attention to our budget up there, they will see what kind of havoc that is causing.

It is for all these reasons that I support S. 406, the Small Business Health Fairness Act. There is no doubt in my mind that within a very short period of time, the bargaining power, the lower administrative costs, the freedom from very high costs associated with mandates would lower my insurance and provide a break that if we don't get, I don't know where we are going to go.

Another issue is just one of basic fairness. We compete against companies every day that have been around a long time, have a much better balance sheet than we do, and are financially able to self-insure. They are able to create plans that meet their needs at a significantly lower cost to me. It seems ironic to me that in a country where the vast number of people are employed by small business, we afford big businesses and labor unions the kind of benefits that we don't make available to small businesses.

The more technical issues have been discussed at great length, so I will stop there and I would look forward to answering any questions that you might have.

[The prepared statement of Mr. Newman follows:]

TESTIMONY BEFORE THE UNITED STATES CONGRESS
ON BEHALF OF THE

# NATIONAL FEDERATION OF INDEPENDENT BUSINESS

NFIB
The Voice of Small Business®

*Testimony of*

Doug Newman

*before the*

Senate Committee on Small Business and Entrepreneurship

*on the date of*

April 20, 2005, at 10:00 a.m.

*on the subject of*

"Solving the Small Business Health Care Crisis: Alternatives for Lowering Costs and Covering the Uninsured"

Testimony of

F. Douglas Newman

Newman Concrete Services, Inc.

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Good morning Ms. Chairwoman and Members of the Committee. On behalf of the 600,000 members of the National Federation of Independent Business (NFIB), and the 23,000 member companies of Associated Builders and Contractors (ABC), I want to thank you for inviting me to speak with you about the health care crisis facing small businesses all over the United States. I would also like to extend a special thank you to Chairwoman Snowe for the strong support you have given small businesses and their employees back in Maine.

My name is Doug Newman, and I own Newman Concrete Services Inc., a concrete construction company based in Hallowell, Maine. We employ 50 hardworking men and women on some of the largest construction projects throughout the State. Of the many challenges I have faced as a small business owner, providing health insurance to my employees has proven to be among the most difficult. Looking ahead, I see the crisis worsening and not much relief on the horizon.

Finding solutions that provide affordable, accessible health insurance is critical for small businesses and, just as importantly, their employees. 45 million Americans are uninsured, and nearly 63 percent of those are employed by small businesses with fewer than 100 employees. Rapidly rising costs and limited choices keep small businesses from providing insurance and will force even more to drop the coverage they currently provide. I believe Association Health Plans (AHPs) offer exactly the kind of immediate relief from rapidly rising health insurance costs small businesses need.

After working in the construction industry for many years, working my way up from laborer to vice president of one of Maine's largest firms, I started my own construction company in 1996. Within a few years, Newman Concrete Services grew to over $3.5 million in sales and 50 employees. Like most people who start a small business, I was unprepared for the obstacles I would face in starting a company from scratch. I am proud of what my employees and I have accomplished and the company we have built. That said, if you asked me whether I'd do it all over again, I don't know if I could say that I would. The risks and difficulties seem to outweigh the benefits. Trying to maintain health insurance for my employees is at the top of the list.

Like many entrepreneurs, I learned early on that quality employees are vital to a business's success. I compete for the best employees and have to offer health insurance to attract and keep good workers. I believe I share something else with many other business owners, a strong belief that offering health insurance to my employees is the right thing to do. We worked hard to get to a point where we could provide health insurance and view it as a milestone in our company's development. Some of my employees have purchased their first homes and started families now that they have health insurance coverage. Little did I know just how difficult it would be to keep.

As my business struggles to pay rising health insurance premiums, my employees face the same challenge. Just as I cannot raise prices in the current economy to keep up with rising health insurance costs, wages are not keeping up either. Many of my employees are young and most never made it to college. At the entry level, some laborer's wages barely cover basic living expenses for a young family, leaving little room for rising costs like health insurance.

Of my 50 employees, about half are covered under the Health Maintenance Organization Plan (HMO) I offer to my employees through Anthem/Blue Cross Blue Shield. Employees and their families are eligible to participate after six months on the job. I pay over 70% of the employee's premium and 50% of the premium cost for their family. Despite difficult financial times in recent years, reducing the company's share is not an option. My employees simply cannot afford to pay more, and I cannot afford to lose good workers to my competitors. We have cut costs and downsized where we can, but - with limited options - I am forced to stand by as my company slowly slips closer and closer to an inevitable day of reckoning.

I'm not alone in this. Through my involvement with other small businesses in groups like NFIB and ABC, I've met dozens and dozens of others with similar stories. The rising cost of health insurance has overtaken workers' compensation insurance costs, high taxes, onerous regulation and a weak economy as the greatest concern of most small business owners I talk to.

One thing most everyone agrees on is that help is urgently needed. What many find discouraging is not only the lack of hopeful developments on the horizon, but the fact that many State legislatures are making things worse. In addition to expanding Medicaid eligibility without providing a means to pay for it, State legislatures are passing unaffordable mandates and burdensome regulations, which drive the cost of health insurance higher and higher.

Health insurance premiums have increased dramatically in the past four years. In 2000, health insurance for an individual cost about $42 dollars per week. In 2004, the same coverage cost over $70 dollars per week for the same employee. Family coverage was $123 per week in 2000, but by 2004 it had risen to $211. This amounts to an increase of almost 70% in the last four years. All told, my company contributes over $50,000 a year for health insurance for my employees and their families. Unfortunately this is often the difference between a small business like mine making money or losing money.

Every year at renewal time, I wonder whether we will be able to offer health insurance another year. We consider ourselves lucky if we get quotes from two carriers, as Maine has only three insurance companies writing a significant number of policies. It seems likely that the rising cost of health care, Maine's aging population and increasing regulation will result in fewer choices in the future.

One reality is inescapable. If health care reforms are not enacted soon to provide relief to small businesses like mine and their employees, there will come a day, soon, when we will be unable to make the numbers work. Health insurance ceased being affordable a long time ago. The cost already affects our ability to grow and make a profit. In the near future, it will simply be impossible to afford. When small businesses like mine can no longer provide insurance, the cost to society will be great. State Medicaid systems, already in crisis, will be overloaded, and the rolls of the uninsured will swell uncontrollably.

For all these reasons, I support S. 406, the Small Business Health Fairness Act of 2005 sponsored by Chairwoman Olympia Snowe - the legislation endorsed by NFIB and ABC that would create Association Health Plans (AHPs). These plans would allow small business owners to band together across state lines to purchase health insurance as part of a larger group, thus ensuring greater bargaining power, lower administrative costs and freedom from the costs of complying with 50 different sets of state insurance mandates.

Extending ERISA preemption of costly and burdensome state mandates currently available for larger self-insured plans to bona fide AHPs will make creative, innovative and cost-effective health benefit plans available to small businesses. In addition, AHPs will decrease administrative expenses and thus provide additional benefit to small businesses providing health insurance. A recent actuarial study released by the U.S. Small Business Administration shows that administrative expenses for health insurance plans that cover small businesses range from 33 to 37 percent of claims as opposed to just 5 to 11 percent of large companies' self insured plans. Before costs associated with overlapping and incompatible State regulation forced ABC to drop it's nationally operated health plan after 40 successful years, the plan incurred total administrative expenses of just 13.5%. It stands to reason that AHPs could result in a 15-20% savings for small businesses from administrative cost decreases alone.

Another benefit to AHPs is that any profit margin generated by an AHP is retained by the plan to the benefit of policyholders rather than being paid out to stockholders. This is a benefit that small businesses who can't qualify for a self-insured plan currently don't have.

Fortune 500 companies and labor unions already enjoy these benefits. Association Health Plans will level the playing field – giving small employers the same privileges as their counterparts in labor and big business. Cost savings and the ability to tailor plans like big business and unions do today is what small business needs to compete and prosper.

Association Health Plans will restore competition by bringing new players into the market. ABC, NFIB and others will compete for my business resulting in lower costs and choices I don't currently have. The affordability and flexibility of AHPs will help reverse the decline in private insurance by offering affordable insurance to the small businesses that provide the jobs to so many who are currently uninsured. Working families will be the beneficiaries.

AHPs will benefit small businesses in every part of the economy including the construction industry. Construction represents close to 12% of the Gross National Product and is the nation's second largest employer with over 7 million workers. An industry of small businesses, 94% of construction companies are privately held. A vital resource for economic growth and the source of lucrative entry-level employment, the construction industry needs to recruit almost 300,000 new workers a year. The ability to offer affordable health insurance is vital to this effort.

There are no other solutions currently on the table that can match AHPs for immediate and positive impact. Association Health Plans are not the only solution to our health care crisis, but they are an essential component to the solution.

Ms. Chairwoman, thank you for allowing me to share my experience with you and the Members of the Committee. I appreciate your support and leadership on Association Health Plans. I urge every member of the committee to support this vital piece of legislation. Small businesses and their employees are looking to you for help, and I know you will respond. Millions of hard working Americans have waited a long time for relief and will be grateful for your action on this issue. Thank you again for your time. I am happy to answer any questions the Committee may have.

# CORE VALUES

## We believe deeply that:

Small business is essential to America.

Free enterprise is essential to the start-up and expansion of small business.

Small business is threatened by government intervention.

An informed, educated, concerned, and involved public is the ultimate safeguard for small business.

Members determine the public policy positions of the organization.

Our employees and members, collectively and individually, determine the success of the NFIB's endeavors, and each person has a valued contribution to make.

Honesty, integrity, and respect for human and spiritual values are important in all aspects of life, and are essential to a sustaining work environment.

**NFIB**

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Chair SNOWE. Thank you very much, Doug.
Mr. Mansell.

**STATEMENT OF AL MANSELL, PRESIDENT, NATIONAL ASSOCIATION OF REALTORS, WASHINGTON, DC**

Mr. MANSELL. Thank you very much, Madam Chair Snowe and Ranking Member Kerry and the only Member of the Committee left, Senator Burns.

[Laughter.]

Senator BURNS. We have a lot of things to do.

[Laughter.]

Mr. MANSELL. You are a patient man.

[Laughter.]

We appreciate the opportunity to be able to come and speak to the Committee today. I do, and particularly on behalf of the National Association of Realtors. We do not have 2,000 members, though, Madam Chair. I will tell you, we only have 1.2 million.

Chair SNOWE. Oh, did I say 2,000? I thought I said two million.

Mr. MANSELL. You said two million, yes.

Chair SNOWE. Oh, thank you.

Mr. MANSELL. I like the growth, but it was a little more than we actually have, so I just wanted to set that record straight. But we are the largest trade association in the United States and we appreciate the opportunity to come and speak today on the Small Business Health Fairness Act. We applaud you for your willingness to sponsor this legislation and work it through the Congress.

Our members are very interested in S. 406, and unlike many other pieces of legislation that we work on, this happens to be a very personal issue for them. Of our 1.2 million members, 28 percent, or 330,000 of those members are uninsured. This is about double the percentage uninsured as compared with the general U.S. population.

Real estate firms are the prototypical small business. Most of our firms, or the average firm, have only five or fewer employees or independent contractor agents. These are truly small businesses, and like most small businesses of any sort, they have a number of issues with insurance. One is our salespeople who are not employees of our firms, are rather self-employed, independent contractors. This makes it much more difficult for realty firm owners to provide insurance to them. As Senator Isakson mentioned to you earlier, because of the Internal Revenue laws, we can't do that.

In a survey we did of our members, we found that 74 percent of the uninsured Realtors said the reason they are uninsured is the cost of coverage. Only 7 percent cited pre-existing conditions. We are nervous that we are going to have an increase even in the 28 percent that are now uninsured because we have an additional 5 percent of our members who are actually on COBRA. So those opportunities are going to run out for them.

Our numbers of uninsured members have doubled over the past 7 years. The numbers in 1996 were 13 percent, or roughly 90,000 members. At the end of 2004, 300,000 members, or 28 percent, were uninsured. This is something that we really feel strongly about, that we need to be able to draw our ability to negotiate a good deal as a large association and offer this benefit to our mem-

bers and help them to find affordable coverage in the health care arena.

The most often asked question when members call in to our Information Central, which is kind of a hotline for our members, is, "What can NAR offer me in the way of affordable health care insurance?" And the answer we have to give is, "Very little," because we do not have the ability to form an Association Health Care Plan. We very much would like to do that and be on a par with large employers and unions who can do that all over the Nation. We believe if we were able to do that, we would be able to really help with the uninsured problem facing our members and of the Nation as a whole.

We have, as an association, done some survey work of the public and small business owners. I would like to share what we found. We found that 87 percent of the small business owners favor the concept of S. 406. We found that 77 percent of small business owners say they likely would participate in an AHP program. Eighty-nine percent of voters favored the concept. And even when we presented the opponents' arguments against small business health plans, 81 percent of small business owners still favored it and 88 percent of the national voters favor it.

This is an across-the-board, non-partisan issue as far as we can tell. This is something the public wants, and I can tell you for our own folks, this is something they want. Certainly, our association has people from all over the country and every party, and we want to help them do that.

We know it isn't a fix to everything. We know it isn't the silver bullet that is going to fix the world for us. But we think it is a viable option that will at least assist us in helping serve our members better. We want to work with you to be able to come up with solutions to some of the problems that have been brought up, some of the concerns, and get through those and get this piece of legislation passed this year, because we believe that it will, in fact, help our membership and reduce the number of uninsured in this country and we will work with you to accomplish that.

Thank you very much.

[The prepared statement of Mr. Mansell follows:]

**Al Mansell**
**President**
**NATIONAL ASSOCIATION OF REALTORS®**

**Statement Of**
**The NATIONAL ASSOCIATION of REALTORS®**
**Before The United States Senate**
**Committee on Small Business and Entrepreneurship**
**Regarding**
**The Health Insurance Challenges Facing Small Businesses**
**&**
**The Small Business Health Fairness Act of 2005**
**April 20, 2005**

Chairwoman Snowe, Ranking Member Kerry and members of the Committee, my name is Al Mansell and I am the president of the NATIONAL ASSOCIATION OF REALTORS® (NAR). I would like to commend the committee for holding this hearing and appreciate the opportunity to share NAR's thoughts regarding the health insurance challenges facing small businesses and the S. 406, Small Business Health Fairness Act of 2005.

First let me say that the NATIONAL ASSOCIATION OF REALTORS® strongly supports S. 406. I want to thank the Chair and each of her fellow cosponsors of the Small Business Health Fairness Act for the leadership they have shown by introducing the Act this Congress. I especially appreciate their recognition of the vitally important role that professional trade organizations can play in increasing the array of health insurance coverage options available to their memberships. NAR's leadership and staff are committed to working with Congress to advance this bill.

NAR is the nation's largest professional trade association with over 1.2 million members who belong to over 1500 REALTOR® associations and boards at the state and local levels. NAR membership includes brokers, salespeople, property managers, appraisers and counselors as well as others engaged in every aspect of the real estate industry.

Unlike other pieces of legislation that NAR's members support because the bills enhance the ability of Americans to own property and/or advance our members' business interests, our interest in S. 406 is a very personal one. Let me explain why this is so.

Today 28 percent of REALTORS® - more than one in four of the nation's 1.2 million REALTORS® - do not have health insurance coverage. For comparison purposes, the percent of the U.S. population without health insurance coverage was estimated to be

15.6 percent in 2003. The percentage of uninsured REALTORS® is almost double that of the nation as a whole.

It's not surprising then that the number one question asked by members who call NAR's Information Central call center is "What can NAR offer me as a member in the way of affordable health insurance coverage?"

Right now, unfortunately, the answer to that question is that we can offer them very little more than what they can find for themselves in the individual market.

As you can imagine, that answer isn't very satisfactory to the typical caller. Their immediate response is "Why can't an organization the size of the NAR offer its members the kind of quality health insurance plans that my neighbor's or sister's corporate employer or trade union offers them? With a million-plus members, NAR should be able to provide its members with access to a comparable group health insurance plan!"

The fact is that the complexity and administrative burden of offering a program that meets the requirements of the fifty states and four territories within which NAR's members reside makes it impossible to do so – even with a million-plus members. We now work with one of the largest third party administrators of association insurance programs to provide our members with access to a large number of fine companies. Even making use of a national broker, we find the premiums offered our members are not what we believe we would be able to offer if we were able to negotiate on behalf of the membership and offer a single, uniform national health insurance program.

It is for this reason that NAR strongly supports the Small Business Health Fairness Act. We believe that the small business health plan construct creates a vehicle that will allow NAR to offer members an affordable alternative source of health insurance coverage. The ability to offer a uniform national insurance program will allow NAR to effectively use the bargaining power and administrative efficiencies that having a large membership creates. We are committed to using that expertise to negotiate for and provide the type of affordable coverage package that Americans have come to expect and deserve. NAR has already demonstrated its ability to deliver a wide array of lower cost services and goods to our members. We firmly believe that NAR can do so in this arena also.

## The REALTOR® Health Insurance Profile

While the current number of members uninsured just cited is problematic, we are equally troubled by what we have found to be (1) the reasons for the lack of coverage, (2) the types of coverage enjoyed by those who have insurance and (3) what we believe will be the future percentage of uninsured REALTORS® if nothing is done.

**Reasons for Lack of Coverage.** In order to determine our members' current health insurance coverage and concerns, NAR surveyed a random and representative sample of its members. As indicated earlier, 28 percent or roughly 336,000 REALTORS® have no

health insurance coverage. When asked why they were uninsured, the overwhelming majority (84 percent) surveyed indicated that cost was the primary reason.

Knowing the structure of the real estate sales industry, it is not unexpected that real estate professionals would be very sensitive to premium costs. Like all self-employed and commission-based workers, real estate licensees have no employer who contributes to the cost of health insurance, no guaranteed monthly income and significant monthly business expenses that continue even in those months when there is no sale, and therefore, no income. These factors, together with the fact that in many states independent contractors do not have access to less expensive small group plans, can make it difficult for real estate licensees to afford monthly premiums that can reach over $1000 per couple or family.

I would note that only seven percent of all respondents indicated that they did not have coverage because they had been denied coverage due to a pre-existing condition that made them ineligible.

**Sources of Coverage Concerns.** We are concerned that this high percentage of uninsured is likely to grow in future years. Our concern stems from the typical sources of insurance coverage among those who are insured and what we know to be likely future trends in each of these insurance market segments.

Among those who have health insurance coverage, REALTORS® are most likely to obtain their coverage from their spouse's employer (25 percent). We expect this source of coverage to decline in future surveys as more and more employers reconsider whether to continue to offer insurance coverage to employee's spouses and dependents. As employers face the steady rise in the cost of providing health insurance coverage, we anticipate that more will drop extended coverage to employees' families.

Group coverage does provide coverage for 23 percent of the membership. In the past, this type of coverage was typically held by an agent who was engaged in real estate as a second career and had health insurance as part of their retiree benefits. Today, however, outside of a few states that require insurers to group the self-employed with other small businesses, group coverage is more likely to be held by either a new agent who continues to work two jobs as they transition from a prior career or an established agent who takes a second job simply because that job provides the agent with health insurance benefits.

We believe that future surveys will show that those who hold group coverage will decline in number. Those in real estate as a second career will likely not have health benefits from an earlier job as retiree insurance benefits become a thing of the past for a new generation of workers. Working two jobs is stressful for any period of time. Eventually, decisions have to be made as to which job offers the worker the mix of fulfillment and benefits that are essential to a healthy like. For those who cannot do without health insurance coverage, real estate is likely not to be the final choice if current conditions continue.

Five percent of NAR's members today have coverage through COBRA (Consolidated Omnibus Budget Reconciliation Act) which gives workers and their families who lose their health benefits the right to continued coverage for limited periods of time under certain circumstances. Given the rapid growth in the number of new agents who have moved in recent months into the real estate sales industry, it is not surprising to us that COBRA coverage would be a source for a significant numbers of new agents. However, these members will eventually have to find alternative coverage or go without insurance.

Most indicative of the changes that have occurred in the eight years since NAR last surveyed the member's health insurance coverages is a final statistic. Today 18 percent of REALTORS® with insurance obtain coverage through individual policies. This category was not even included in our earlier 1996 health insurance member survey – so insignificant was this source of insurance coverage.

Individual coverage is also the most problematic and unaffordable coverage option according to our members. One agent recently commented to our CEO that he had been told that his family insurance premium was going to increase forty percent this next year despite having had no changes in health status that would seem to warrant such an increase. If past annual premium increases continue into the future, I would expect to see more of our members who are dependent upon individual policies move from the insured category to the uninsured category in any future surveys we may do.

**A Growing Number of Uninsured REALTORS®.** We expect the number of uninsured members to continue to grow for the simple reason that our survey results indicate that this has been the trend. In the past seven years, for example, the number of uninsured NAR members has doubled, going from approximately 13% of the membership in 1996 to 28% in 2004. For the reasons cited earlier – lapsing COBRA coverage, changing employer insurance benefit policies, sensitivity to costs – we are most concerned that our now high percentage of uninsured members will grow larger over time as the cost of health insurance increases.

## REALTORS®, Small Business Owners and Public Support for SBHPs

Madam Chair, even though I well understand the factors that currently limit the ability of NAR to provide members with coverage and can explain to my members these regulatory barriers, it is very difficult to explain to the membership why their trade organization isn't allowed to use its collective bargaining expertise to provide a national, uniform health insurance plan in the same manner that large employers or trade unions are able to use their collective size to negotiate a quality, uniform national health plan for their employees or union members regardless of where they live.

Americans believe in equal treatment and "playing fair". The current system that allows unions or large firms to offer a health insurance program unhampered by the need to comply with 50 sets of state mandates and regulations – while their trade organization can't offer them the same type of program - just isn't viewed as fair or right.

As it turns out, our member's perception isn't that much different from the general public's view of the matter either. In March, we undertook a major survey of REALTORS® and the general public, including small business owners and male and female voters. NAR commissioned a series of focus groups and two national surveys by a nationally respected independent polling firm.

In voter focus groups, for example, we found that many people were surprised that a national trade organization like the NAR couldn't offer their members a uniform, national insurance program. They knew that large firms and unions were able to do so but were surprised to find out that large corporations and unions were subject to one set of rules and small businesses and the self employed were subject to a second, more restrictive set of rules.

The general public also perceives a disparity in the current system and believes that small businesses should be able to ban together through their trade organizations to obtain access to a single, uniform program unhampered by differing sets of rules and regulations.

Our survey found that the American public and small business owners share NAR's members support for the small business health plans (SBHPs), sometimes referred to as association health plans, authorized by S. 406.

The first survey included a representative sample of 800 registered voters; a second poll surveyed a national sample of small business owners of firms with fewer than 50 employees and/or those who were self-employed. In these telephone interviews, the individual was asked about their general views on the state of health insurance and their own level of satisfaction with the current system. The concept of small business health plans was also explained and discussed. The individual was then asked if this concept was something that they would favor or oppose. The arguments in favor and those against SBHPs were also shared with the individual and their level of support or opposition again solicited.

Not surprisingly, we found that across all groups, cost is a major health care concern. For consumers, costs are impacting their personal budget through higher premiums, co-pays and drug prices. For some, a decision to take one job over another or to take a job over being self-employed was driven by the need to have affordable health insurance benefits. Small business owners indicated that they are having significant difficulties affording employee health coverage. Additionally, these same owners indicated that they may not be able to continue to offer coverage and recognize that their inability to provide benefits comparable to those offered by larger firms is affecting their ability to attract and retain skilled workers.

When the survey work turned to the concept of allowing the creation of small business health plans, both voters and small business owners were very supportive. When small business health plans are described to voters, 89% favored the concept; even after

arguments in opposition were shared and explained, 88% continued to support the concept. Among small business owners, 87% favored the concept initially and 81% continued to support the concept even after a discussion of arguments in opposition.

Also, of interest, the results show that support for the small business health plans crosses party lines with almost equal percentages of Republicans, Democrats and Independents supporting the concept.

When asked if they would be likely to participate in a plan like this if available, 77% of small business owners said they would be likely to participate in a plan like this, including 41% who indicated that they would be very likely to do so.

It is clear, however, that small business owners are very aware of the need to choose a quality health plan for their workers so as to continue to attract quality workers. In this way, small business owners and the trade organizations that represent them are in step with each other.

NAR's leadership, for example, is very aware that if we are able to provide a small business health plan to our members it will need to be the very best program possible. We're a volunteer organization. Our members can decide not to join just as easily as they join. We can't afford to alienate our members by providing them with a second class, stripped–down coverage plan. That would just not be in the best interests of our members nor of the Association itself.

I can tell you that when this legislation is adopted, the NATIONAL ASSOCIATION of REALTORS® will be one of the first to be actively involved in discussions with the nation's insurers to work out a quality health insurance coverage package that we can work together to provide REALTORS® nationwide.

**Conclusion**

Finally, I would like to close by saying that we know that this bill is not the silver bullet that will solve the nation's health insurance problems. We do believe, however, that it is an approach that can provide a viable alternative source of health insurance coverage for a significant component of the nation's uninsured small businesses and our own self-employed, independent contractor members.

The debate over the concept has been ongoing for some time now. We've all heard the arguments for why this should or shouldn't be done. As one company analyst put it, "We've had dueling Myths and Fact papers circulating for some time."

I believe that it is now time for all parties – supporters and opponents – to sit down together and figure out how to address the issues that are contentious. If there are concerns that the bill's solvency provisions are too lax, then let's talk about what a more acceptable level of reserves would be. If there is confusion over the degree of oversight

that the Department of Labor and the state insurance commissioners would have over self-insured versus fully insured small business health plans, let's clarify. If the definition of what it takes to be "bona-fide" professional or trade association eligible to offer a small business health plan - especially a self-insured plan - is too open-ended, let's discuss how that definition could be modified to avoid the problems that some contend will exist.

It's simply time to stop the broadsides and begin a constructive discussion. My members and those who belong to the nation's other trade organizations need someone negotiating with insurers on their behalf. They need alternative sources of health insurance coverage now. They can't wait for yet another session of Congress to come and go without action.

I want to thank you for giving me the opportunity to share with you our thoughts. I'll be happy to take any questions that you might have.

Chair SNOWE. Thank you.
Mr. Haynes.

**STATEMENT OF TOM HAYNES, EXECUTIVE DIRECTOR, COCA-COLA BOTTLERS' ASSOCIATION, ATLANTA, GEORGIA**

Mr. HAYNES. Thank you, Chair Snowe and Ranking Member Kerry, for inviting us here to this hearing and for holding this hearing and for your focus and your work on trying to help the small business community with their concerns, particularly this pressing concern on health care.

I am here both on behalf of the Coca-Cola Bottlers' Association, which, as Chair Snowe said, represents all the Coca-Cola bottlers in the United States, but also on behalf of a coalition of trade associations, all of whom believe that this is the single most important thing we can do to help our members provide more affordable health care to their employees.

I think our experiences should be very helpful to the Committee in understanding the realities of what we are living with and understanding that some of the concerns expressed about AHPs are not borne out by the real world experience of trade associations.

As Senator Kerry pointed out, it is possible to do this today. We do have an Association Health Plan, but there is one fundamental problem. It only works for the big businesses in our association, not for the small businesses.

Five years ago, the plan that we had for small bottlers, bottlers with less than 50 employees, was disbanded because we couldn't find a carrier in the country to work with who would help us put this plan together and keep it together. So the bottlers that were part of our plan were left to whatever alternatives they had, and I think many of them found those alternatives very unattractive.

Now, the plan we have does not, again, reflect what we hear about AHPs from the critics. Our administrative costs are quite manageable. They are in the 7 percent range. We desperately want to expand this program and to improve this program, but primarily to expand this program to include the small businesses that bottle and distribute Coca-Cola in the United States. If we could do it, it would make a huge difference for them and their employees.

We have talked to some of the bottlers who used to be in our small business plan, our small bottler plan, and they fall into two categories. One is bottlers that have found their health insurance costs rising very substantially and simply have not been able to continue to do what they were doing before. So they increased deductibles, they reduced coverages. The costs go up to employees. Employees opt out of those programs. And what we have found with some of the bottlers that once were in our program is that they have gone from having 100 percent of their workforce insured to having less than 50 percent of their workforce insured, and I know that for all the Members of the Committee is the kind of situation that you do not want to see happen, increasing the rolls of uninsured because of the cost of insurance to small business.

The second thing that we see is people who are continuing to stick with it, absorb the increases, and simply change the rest of their business, recognizing that health care is going to make other things less possible. An example that we have looked at actually

happens to be a foundation that manages scholarships provided to 250 students every year throughout the country, college scholarships. This foundation, which has a staff of seven, was once in our small bottlers pool and their costs, their expenses were comparable to those for big bottlers, big businesses within our association.

Since they were forced out of our plan by these market forces and really fundamentally by the impact of trying to comply with State mandates, their costs have gone up materially. Today, they pay about 60 percent more than a bottler that operates in the same State and in neighboring States. They pay more than the bottler that pays the most in our program, which is at least partially experience-related, and it is fully-insured.

Even for the bigger bottlers that are still part of our program, and there are about—I think we have 13 in that program out of a possibility of 77—with AHP legislation, we would have lots of opportunities in the marketplace to improve their coverages to make them more affordable.

I think the other fundamental thing, I think we are very typical of a lot of associations. We don't exist to write health insurance. We do a lot of things for our bottlers. Every bottler in the country is a member of our association. Most of them have been so for 90 years. So there is no possibility we would discriminate in terms of membership. And even if we were inclined to, our relationship with our members is multi-faceted and to think that we would make a decision about our relationship with one of our members based purely upon some prediction as to the healthiness of their workforce as part of our program, I just don't think it is realistic and I don't think it is realistic for many of the other associations who would try to write these plans.

So that is, in a nutshell—there is a lot more detail in my statement, but I look forward to answering your questions and I thank you.

[The prepared statement of Mr. Haynes follows:]

**Statement of W. Thomas Haynes**

**Executive Director, The Coca-Cola Bottlers' Association**

**Senate Committee on Small Business & Entrepreneurship**

**"Solving the Small Business Health Care Crisis: Alternatives for Lowering Costs and Covering the Uninsured"**

**April 20, 2005**

Thank you, Chairman Snowe, for the opportunity to testify before the Senate Committee on Small Business & Entrepreneurship to discuss policy solutions aimed at providing small businesses and their employees with access to affordable health insurance. I am appearing today as Executive Director of the Coca-Cola Bottlers' Association (CCBA), which represents 77 bottlers and 87,000 employees in all 50 states. I also am appearing as President of The Association Healthcare Coalition (TAHC), a coalition of trade and professional associations that have decades of experience in operating Association Health Plans (AHPs).

The CCBA and TAHC strongly support S. 406, the Small Business Health Fairness Act, which would strengthen and expand the ability of bona fide associations to deliver affordable health care benefits to small businesses through the sponsorship of AHPs. We view S. 406 as a critical component of any federal policy changes aimed at expanding access to affordable health coverage for small businesses and reducing the nation's uninsured population, and we urge Congress to enact the legislation in 2005. I want to especially commend Chairwoman Snowe and the other cosponsors of S. 406 for their leadership on this legislation. We also want to commend President Bush and Secretary of Labor Chao for their leadership on behalf of the AHP legislation.

S. 406 is vital to the ability of small and medium-sized businesses across the nation to obtain access to affordable health insurance. Today, I would like to discuss our experience at the CCBA with an Association Health Plan in order to illustrate how S. 406 can expand access to affordable health benefits to small employers, and how workers in small businesses are put at a great disadvantage to their counterparts working for large employers in today's markets. CCBA's experience represents a living example of the disparities created by the current system.

**Coca-Cola Bottlers' Association AHP**

For 90 years, the CCBA has sponsored programs for our member bottlers. For most of that period, medical and other benefit programs have been one of our core offerings. We have historically administered two separate AHP plans: a fully-pooled program for small bottlers with under 100 employees; and another experience rated program for those bottlers with over 100 employees.

Until recently, CCBA's AHP was able to significantly reduce the cost of insurance by combining over 60 small employers who participated in our fully pooled program with administrative costs of approximately 7%. This fully-pooled program for small employers (under 100 employees) was disbanded at the end of 2000 due to the overwhelming complexity of state small group reform laws and regulations. These well-meaning but counterproductive laws eliminated virtually all insurance companies from participating in multi-state arrangements due to their reluctance to navigate the myriad individual state premium and coverage requirements for small employers. Since then, health insurance premiums for our smaller member bottlers have increased from 20% to 25% annually. Further, their plan offerings have increasingly utilized higher copays, higher deductibles and higher annual out-of-pocket maximums. These changes have greatly reduced the employees' participation rates, effectively pricing 50% of the employees out of insurance and increasing the number of uninsured employees. Additionally, for many of those that remain insured, their quality of care has been negatively affected by changing insurance carriers annually, thereby forcing changes in covered providers associated with their new insurance carriers.

While CCBA was forced to disband our AHP for small employers, we have been able to continue operating the AHP for the benefit of our larger employer members (Coca-Cola bottlers with more than 100 employees). While our small employer members have incurred **20% to 25% annual** premium increases, our large employer members have been able to continue benefiting from the cost-saving efficiencies of participation in the CCBA AHP, with average annual premium increases of only **9%**. Our large employer AHP program also provides stability of plan design offerings and long term carrier contracting that enables access to a consistent provider panel enabling fewer provider – patient disruptions.

This situation clearly illustrates the severe disadvantage that small employers face relative to large employers in obtaining affordable health insurance coverage. It should be noted that while we can and do continue to operate a multi-state AHP plan for large employers, this program will also benefit from S. 406. This proposal will enable more insurance companies to enter into a market where there are few options available today. Under today's regulatory environment, our large employer multi-state AHP program must be fully-insured. Given the ability to self-fund our program, as would be provided under S. 406, we would be able to provide custom PPO network solutions for specific non-participating large employers in geographic areas where our current insurance carrier is reluctant to pursue expanding their network. Our large employer AHP has the potential to expand from its current enrollment of 6,000 employees to upwards of 15,000 employees if we are allowed the same options as corporations and unions utilize today. Growth of this AHP program will enable us to have greater leverage in negotiating long- term, cost-stabilizing contracts with available vendors.

The CCBA now delivers high quality, affordable health care benefits to its large employer members through an Association Health Plan. There is no good reason why a bona fide association like CCBA, which has vast experience in providing employee benefit plans for 90 years, should not be allowed to offer similar health benefits to small and large employers under the same uniform federal regulations under which corporate and union plans now operate.

With the passage of S. 406, the CCBA will again be able to provide health care benefits to over 60 small Coca-Cola bottlers through the AHP in which our large employers now participate. This would provide more affordable health benefits to thousands of workers! Moreover, without this legislation, our small bottlers will be forced to continue shifting costs to their employees, and even more may be forced to drop coverage altogether! Clearly Congress can not continue to allow this intolerable situation to continue!

Beyond the critical needs of our smaller bottlers and their employees for more affordable healthcare options, I want to emphasize that this issue is not just a dollars and cents issue, but a survival issue for small soft drink bottlers. Two decades ago, there were thousands of soft drink bottlers spread across the country. In part because of the effects of changes in operating efficiencies in soft drink production, but also because of the higher fixed costs of operating a small business, including benefits administration, ninety percent of those bottlers have disappeared through acquisitions by their larger, more efficient, brethren. CCBA's job is to do our best to allow the 75 non-public independent owners of Coca-Cola bottling operations to remain in business if they choose. The owners of those businesses, mostly fourth and fifth generation Coca-Cola families in places like Farmington, Maine, Deming, New Mexico, Pottsville, Pennsylvania, or Sitka and Kechikan, Alaska, and other communities look to us to help give them that option. For the most part, we have solved many of the operational challenges that caused many of their brethren to sell their business. Our biggest remaining challenge is to solve the problems associated with the disadvantages that they face in being small in providing competitive employee benefits, including health care. To solve that problem, we need Congress to enact S. 406 into law.

**The Role of Associations in Health Care Benefits**

Bona fide trade and professional associations are established and run by their employer members and exist for the sole purpose of serving the needs of their members and members' employees. Bona fide associations, including national, regional and state-based associations, have been a vital source of health coverage for millions of American workers employed in small businesses for decades. Many associations have been sponsoring health plans for over 50 years. It is critical to note that bona fide associations are organized for purposes *other than* selling health insurance, a critical distinction in the debate over the proper role of associations in providing health benefits to employers and workers.

Associations are uniquely structured to be part of our healthcare delivery system. Because they are established to represent their members in other areas, they possess the infrastructure, administrative mechanisms, and experience needed to unify employers and employees into effective consumers of health services. By serving this need for small employers, associations add value to our health care system as a whole, as well as to their members.

Associations are able to purchase affordable health coverage for pools of small employers because they offer health plans that are specifically designed to meet the needs of their membership. Associations have traditionally offered a wide variety of approved health plans and managed care arrangements, both fully insured and self-funded. Health plans sponsored by bona fide associations have an outstanding track record in providing high quality health coverage to small businesses and their workers.

AHPs have already demonstrated the ability to provide savings in health insurance costs for small employers. Because they already exist for other purposes, associations are able to sponsor health plans with administrative costs that are substantially lower than similar costs charged by insurance companies when selling directly to a small employer. As indicated previously, our AHP at CCBA has administrative costs of approximately 7%. In contrast, a small employer on its own is likely to pay administrative costs of anywhere from 17% to 30% or even higher when purchasing coverage in the existing small group marketplace. The ability of AHPs to deliver health benefits with low administrative costs is extremely important to providing small employers with access to affordable health care benefits.

Unfortunately, the ability of associations to serve small businesses and their workers with affordable health benefits has severely declined in recent years. As inconsistent government mandates and regulations continue to proliferate at both the federal and state level, it is becoming more and more difficult for associations to provide affordable health benefits to their members. The regulation of AHPs on an inefficient, state-by-state basis thus jeopardizes the ability of AHPs to continue providing dependable and affordable health coverage to small businesses. In fact, many associations have had to close down their health plans because health insurance companies cannot afford the cost of compliance in multiple states. This has severely reduced the availability of AHPs for small businesses.

**The Small Business Health Fairness Act**

S. 406 will allow associations to utilize the tools which corporate and union plans now use to keep health coverage affordable. In contrast to the regulation of AHPs on an inefficient state-by-state basis, large corporate and union health plans are exempt from state insurance regulations and mandates. It is time that Congress provided workers in small businesses with similar opportunities as are now afforded to their counterparts in large corporations and unions in the delivery of health benefits. By allowing AHPs sponsored by bona fide associations to operate under a uniform regulatory structure like corporate and union health plans, small business workers will receive the benefits of economies of scale, greater bargaining power, regulatory uniformity, and the flexibility to design benefit options that meet working families' needs.

The AHP legislation is the *only* policy option that levels the playing field between small businesses and large corporations in offering affordable health benefits. In order for small employers to be able to compete successfully in the marketplace for quality workers, it is vital that they have access to similar health benefit options now available to large corporations.

Another important component of S. 406 is that it will foster greater competition in health insurance markets. Over the past decade, many insurance carriers have left many of the state

small group insurance markets, and small employers have fewer choices of insurance carriers and fewer health plan choices. By facilitating the ability of associations to sponsor AHPs, S. 406 will provide small employers with more health plan options. This will ultimately bring about greater long-term price stability and reverse the current trends of skyrocketing health insurance premiums, declining benefits and fewer choices for small employers.

**Response to Critics of S. 406**

Finally, I would like to respond to some of the criticisms that have been made by opponents of S. 406, and will do so in detail below. But first let me assure you that it is in the interest of bona fide associations for Congress to approve legislation that 1) benefits workers of all types, including healthy and high risk individuals and groups; 2) has strong solvency protections; and 3) has strong oversight by the U.S. Department of Labor. We believe S. 406 can be positive for all small employers and their workers, bona fide associations, and the insurance industry working together in a partnership to expand access to affordable health benefits, and we have always been willing to work with members of Congress and other parties in "good faith" efforts to achieve this objective. Regrettably, we have not seen real efforts from other parties to have such a dialogue to move the bill forward. However, we today renew our invitation for other parties to step forward and work with us *in good faith* to improve the legislation rather than merely attempting to block it.

Opponents have suggested that the bill will harm some small business workers by driving up their premiums and would do little to reduce the number of uninsured Americans. Opponents often cite a study done by the Congressional Budget Office in 2000 when making such allegations.

However, the CBO study had several fundamental flaws. First, it *assumed* that AHPs cannot deliver health benefits to employers with substantially lower administrative costs than insurance companies selling to small employers directly. CBO based its incorrect assumption on a review of *one* study which found that *all types* of group purchasing arrangements considered collectively have not been effective in making health coverage affordable for small businesses. This study concluded:

> Pooled purchasing does have a positive effect on employers' provision of choice and information, but the effect fell far short of our expectations. This may be because we *combined all of the different forms of pooling....* Our evidence is far from definitive, however.... Clearly, there is a need for more research beyond what this first descriptive study can do (emphasis added).

CBO never looked specifically at AHPs! As indicated previously, CCBA's AHP has administrative costs of about 7%, compared with similar administrative costs (including insurance company profits) of 17-30% or higher for insurance companies selling directly to small employers. Many other AHPs have proven that they can provide substantial savings to small employers of all types. I am aware that the primary author of the CBO study basically admitted to Senator Talent, then Chairman of the House Small Business Committee, at a public hearing, that CBO did not look specifically at AHPs in making its assumptions.

After making the above-discussed incorrect assumption, CBO then *assumed* that AHPs will try to compete by offering scaled-down benefit packages in order to target low-risk employers or industries. This ignores the reality that small businesses must compete against large businesses for employees, and therefore must offer competitive benefit packages. It also incorrectly assumes that small business workers want benefit packages that are inferior to those offered by the state-regulated market and large businesses.

In reality, AHPs will be able to compete with insurance companies in offering comparable benefit packages for less cost through savings achieved from reducing administrative costs through operating efficiencies, as the CCBA and other associations have already proven can be done.

In contrast to the CBO study, an independent study done by the Consad Research Corporation for the National Federation of Independent Business in 1998 estimated that between 2 million and 8.5 million currently uninsured individuals will receive health insurance if AHP legislation similar to S. 406 is enacted.

Critics of S. 406 have also argued that, by providing AHPs with an exemption from state benefit mandates similar to that now utilized by corporate and union health plans, AHPs will reduce the amount of benefits currently available to small business workers. However, millions of small employers across the nation support S. 406 because it will *increase* affordable health care benefits to all small business workers. As CCBA and other associations have proven, AHPs can deliver health care benefits to small business workers who participate in an AHP for substantially less in administrative costs than small businesses purchasing coverage directly from insurance companies. Money saved from having lower administrative costs can be used to purchase more health care benefits (e.g., well child care, cancer screenings, etc.). Small employers want the same type of health benefit options now available to large corporations and will purchase more benefits for their workers if they can have access to plans with low administrative costs.

Currently, many small business workers, if they have access to health coverage at all, only have access to one health plan option. AHPs also will provide employers and workers with substantially more choices in health plan options from which to choose to best meet their needs.

Some critics have stated that the preemption of state insurance laws will enable AHPs to "cherry pick" healthy workers or groups. Again, because AHPs have shown they can deliver health care benefits with low administrative costs, AHPs will be able to provide affordable benefits to workers of all health types if given the proper set of tools. We believe S. 406 prevents AHPs from being able to exclude any individuals or employer groups based on health status. Further, S. 406 does not preempt state rating laws for fully-insured AHPs, and self-funded plans cannot charge higher rates for sicker individuals or groups within the plan, except to the extent already allowed under the relevant state rating law for an employer located in a given state. However, we would welcome the opportunity to work with Congress to consider additional provisions aimed at ensuring that AHPs serve small businesses of all types.

I would also note that the allegations made by opponents about adverse selection rest on the mistaken assumption that AHPs will offer primarily "bare bones" benefit packages to small employers. There is broad agreement that "bare bones" plans, where they have been tried, have failed due to lack of demand. This is because small business workers want Fortune-500 style benefits like those enjoyed by workers in large companies. Also, small businesses must offer benefit options like those offered by large companies if they are going to attract and retain quality employees.

In addition, adverse selection that currently exists in the balkanized state insurance markets will be reduced when younger, healthier workers who now choose to remain uninsured because of the high cost of coverage are able to obtain coverage that is affordable and are brought back into the insurance system through expanded AHPs.

Finally, some critics have stated that AHPs would not receive adequate federal oversight. However, AHPs would be regulated in a manner similar to how existing corporate and union health plans are regulated by the Department of Labor (DOL). The AHP bill extends additional solvency standards and certification rules to plans operated by qualifying bona fide trade and professional associations. In addition, the bill gives DOL enhanced criminal and civil enforcement powers currently not available to regulators, and thus it will help stop health fraud by assisting DOL in the termination of fraudulent health plans. We appreciate Secretary of Labor Chao's testimony indicating that DOL has the expertise to properly regulate AHPs and will make sure that resources are made available for this purpose.

**Conclusion**

S. 406 represents a market-oriented solution to the problem of declining access to affordable health benefits for our nation's small employers. CCBA and TAHC strongly urge Congress to expand access to affordable health insurance for working families by enacting this legislation. The time for elimination of the health insurance "double standard" for small businesses is long past due!

Again, we commend Chairwoman Snowe for her leadership on S. 406, and look forward to working with all members of the committee to see that this legislation is enacted by the 109th Congress. Thank you for this opportunity to discuss Association Health Plans.

Chair SNOWE. Thank you.
Mr. Nichols.

**STATEMENT OF LEN NICHOLS, DIRECTOR, HEALTH POLICY PROGRAM, THE NEW AMERICA FOUNDATION, WASHINGTON, DC**

Mr. NICHOLS. Madam Chair, Senator Kerry, Senator Burns, it is a high honor, indeed, to have been invited back to testify before this Committee on this topic because I know how dedicated you all are to improving health insurance coverage options for small business owners, their workers, and their families.

My name is Len Nichols and I am the Director of the Health Policy Program at the New America Foundation—Senator, I have moved in the last 2 weeks—a non-profit, non-partisan public policy institute dedicated to finding practical solutions to our Nation's most pressing problems. Our focus today is on enabling more small employers to offer health insurance to their workers by being, and I quote, more like large firms.

The primary reason for this huge discrepancy in offer rates by firm size, which are documented in my written testimony, is that large firms achieve economies of scale, as we talked about earlier today. These economies of scale come from three sources. I am going to focus on one, the one most relevant to our discussion, risk pool size and stability. Simply put, the larger the risk pool, the lower the variance of expected medical claims costs. The statistical law of large numbers is a good friend to large pools.

It is possible for insurers to create a large stable pool out of many small employers, but in real life, for various reasons, premium variance is higher for small firms than for large. So my testimony will address the pros and cons of alternative ways to enable small firms to be more like large firms in purchasing health insurance.

Currently, there are two broad approaches on the table, Association Health Plans and subsidized participation in broader purchasing pools. Simply put, AHPs are one step forward, but I fear they are two steps backward at the same time. And while the best alternative is perhaps two small steps forward, it is, in my view, well past time for small steps only. You have heard the urgency described.

Association Health Plans would make insurance cheaper by exempting members' self-insured plans from State regulations, including benefit mandates, solvency standards, State taxes, and the rest. These exemptions would lower premiums a bit, but the largest gain to the AHP members would more likely come from scale economies and from favorable risk selection vis-a-vis the rest of the market as a whole, not necessarily within an association.

Firms with low-risk workers, whoever they were, young and healthy, will find the self-insured AHP product exempted from benefit mandates that are most attractive, and as these firms leave the currently fully-insured market pools, those pools would necessarily deteriorate. The only empirical question is how much premiums would rise for those who weren't able to get into the self-insured AHPs, and that is really what the ying-yang in this debate is all about.

You know, we have been talking about this for quite some time. I think I have been testifying on it for at least 9 years. I think you all have been talking about it for longer. And I have often asked myself, why is it that proponents are so intent on creating a separate market for some small firms, but not for others, and I really can only think of two reasons.

Some proponents, I think, really sincerely want to help firms and they know their firms and they know that those firms are relatively low-risk and that would work. They could band together and be similar. And they either don't know about other firms in the market or just don't worry about firms that may have different risk profiles.

Other proponents perhaps hope to administer self-insured AHPs and use the market opportunity as a way to finance other objectives of the organization. These are fine reasons to seek legislation, but they are not compelling public policy rationales, certainly not for a Committee as dedicated to the well-being of the entire small business sector as this one.

A better way to continue your historic mission is to encourage all small firms to act like large businesses by banding together in a truly large and powerful purchasing pool.

Now, some State benefit mandates, at least in my experience, may indeed merit repeal on the arguments, on the real analysis you can do. If so, then Congress should override them for all small firms in all States, not just for those who happen to belong already or come to qualify for an association.

So if AHPs aren't the best way to go, how should Congress react? Creating a single large purchasing pool, either in each State or in a locale within a State, would indeed lower premiums, but subsidies, of course they are expensive, but they would entice even more entry and help stabilize the risk pool, as well.

Who should be subsidized in this way? A lot of researchers asked this question and we have pretty much concluded the most efficient subsidies are those that are linked to low-income workers directly. So if the policy objective is to subsidize firms that don't offer today, then linking firm-level tax credits to worker wages would be far more efficient than subsidizing firms regardless of worker wages and incomes, as implicitly AHPs would.

The SEHBP bill co-sponsored by Senators Durbin and Lincoln links employer subsidies to worker wages and provides larger tax credits the greater the employer's share. This extra price reduction means that that approach would likely increase coverage on net more than AHP legislation, but neither approach is powerful enough to solve the uninsured crisis which you all have articulated so well.

In fact, recent work I have completed with the support of the California Health Care Foundation makes clear that the greatest risk to our health system's future is this: an increasing fraction of our workforce cannot afford health care as we know it. Premiums are growing faster than wages. A worker with median wages in 2003 had the same purchasing power vis-a-vis health insurance as a worker at the 25th percentile wage 5 years ago.

This rapid decline in purchasing power is surely responsible for the decline in take-up and in overall ESI coverage we observed re-

cently, and this fact helps remind us of the three interrelated problems of our impressive, but flawed, health care system: low clinical value per dollar, highly uneven quality of care, and inequitable access to that care.

To avoid more uninsured, higher costs, and even more stress on small business owners, I think we have to tackle these problems simultaneously through comprehensive reforms. Support for what I will call an adult conversation about health policy alternatives is actually growing around the country, a conversation we postponed far too long. The fact that more workers cannot afford private health insurance each year, as has been testified to today, has been noticed in every community around our country.

Details are better left for another day, but the principal and central elements of a far better health care system are emerging. The guiding principle is universal coverage in exchange for universal responsibility. Key elements of this center on an individual mandate to purchase private health insurance with continued employer and increased social responsibility for financing support. There must also be effective cost growth control so that the public subsidy guarantee and continued employer participation will indeed be sustainable.

Now, while we muster the courage for this larger task, perhaps our most important next step is to acknowledge as a Nation that access to health care is fundamentally a moral issue. The Institute of Medicine has clearly interpreted the research literature to tell us that some of the consequences of lack of insurance are thousands of premature deaths every year. This should be just as unacceptable to us as are deaths from smoking, drunk driving, medical errors, or acts of terrorism here and abroad.

Over 5,000 years of various scriptural traditions call upon us all to clearly pursue justice and enhance the life chances of all our fellow human beings. Once we agree to stop accepting the morally unacceptable, then maybe we will be ready to talk about how, rather than whether, to inprove our entire health care system, being ever mindful of the essential role small employers will always have in our economy and our health insurance opportunities.

Thank you very much.

[The prepared statement of Mr. Nichols follows:]

Challenges Facing Small Employers in Purchasing Health Insurance
A Statement of
Len M. Nichols, Ph.D.
Director, Health Policy Program
New America Foundation
Before the
Senate Committee on Small Business and Entreprenuership
April 20, 2005

My name is Len M. Nichols and I am the Director of the Health Policy Program at the New America Foundation, a non-profit, non-partisan public policy institute dedicated to finding practical solutions to our nation's most important problems. The range of our programs, research, and policy proposals can be found at www.newamerica.net.

Our health care system as a whole suffers from three inter-related problems: (1) low clinical value per dollar spent, (2) highly uneven quality, and (3) inequitable access to effective care. The first two problems have become so severe that many say ensuring equitable access is now beyond the reach of our political will. And so, the number and percent uninsured continues to rise, as does the share of our nation's income devoted to health spending.

Our three major health problems exacerbate each other. Poor quality coupled with large amounts of ineffective care increase costs. Even the sub-standard care received by the uninsured raises costs for health providers, the privately insured, and taxpayers alike. High cost relative to income is the single more important reason people are uninsured in the first place. And as long as 60+ million people spend time uninsured in any two-year period and outside any information system's ability to monitor their health status, health service, and pharmaceutical use, universal application of evidence-based medicine and efficient health care delivery systems will remain beyond our reach. Thus the policy stalemate continues. Our health system's problems simply cannot be solved piecemeal or in isolation; we must summon the courage to pursue comprehensive solutions. I'll return to this larger reality before closing.

The main focus for today is on a central piece of the uninsured problem: enabling more small businesses to offer health insurance to their workers. It is a high honor indeed to be invited back to testify before this Committee on this topic,[1] because I know how committed are the Chair, the Ranking Member, and all members of the committee as well as today's guest members (Senator Durbin and Senator Lincoln) to improving insurance coverage options for small business owners, their workers and their families.

As an economist, I have studied the decisions of employers, and specifically small employers, to offer health insurance or not, as well as the general workings of small group insurance markets for the past 12 years. My research ranges from statistical analyses with nationally representative survey data gathered from employers to interviews with small employers, large employers, small business coalitions, insurers,

[1] My previous testimony to this committee was delivered on February 5, 2003.

insurance brokers, actuaries, state regulators, purchasing cooperatives, state legislators, and site visit research in conjunction with the Center for Studying Health System Change.

According to the most recent data from AHRQ, 44% of small establishments (those with fewer than 50 workers) offer health insurance, and 64 % of workers are in small establishments in firms that offer health insurance. This contrasts with 97% of large (not small) establishments and 98% of workers in large establishments.[2] The primary reason for this huge disparity in offer rates by firm size is well known in the research literature and in this Committee: large firms can provide health insurance to their workers far more efficiently than small firms can due to economies of scale.

These economies of scale emanate from 3 sources: purchasing and administration economies within the firm, selling economies of the insurer, and risk pool stability.

Purchasing and administration scale economies arise because the large firm can spread the fixed costs of a benefits manager or department over many workers, so the per worker cost of this crucial information gathering, processing, and dissemination function is small. Small firms cannot afford a benefits manager or department, so these tasks typically fall to the already overburdened small business owner. Health insurance is a very complicated product to research and purchase, thus the amount of effort a small business owner must invest, per worker, is relatively high. This time and information processing effort represents too high an opportunity cost for many small business owners, for their time must often be devoted to even more pressing matters related to small business survival.

Selling costs of the insurer are also largely fixed in that they do not vary with the number of employees. Since presentation and preparation time is virtually identical for small and large firms, making a sale to a firm with 10,000 workers costs less per worker than making a sale to a firm with 10 employees. These selling costs must be recouped in the premium, as must agent/broker commission rates, which are also higher for small groups, else no one would ever bother selling (insurance?).

Finally, the larger the risk pool, the lower the variance of expected medical claims costs. The statistical law of large numbers is a good friend of large groups. It is theoretically possible for insurers to "make" a large group out of many small employers and for that risk pool to be stable over time, but in practice small firms are formed and go bankrupt, as well as drop and add coverage even if continuously in business, at much higher rates than large firms, so that no pool formed exclusively among small groups can be as stable as a large firm or state employee pool. In practice as well, at least above a certain minimum size, most insurers price their products with two components, one based on the firm's own claims experience and one based on the pooled group's own experience, so that even a one-time shock to one employee's health costs – a single heart attack and attendant surgery or cancer therapy – can significantly affect a small firm's premium for

[2] Nationally representative MEPS-IC data, AHRQ, calendar year 2002, www.meps.ahrq.gov.

years, even relative to premiums of otherwise similar small groups. This is why premium variance is higher for small firms than for large.[3]

These economies of scale lead to far lower premiums per dollar of actuarial value in their benefit packages for large firms when compared to small firms, and that plus the observed higher variance in premiums makes small firms naturally want to become "more like large firms" in the ways they purchase health insurance. This policy desire to enable small firms to purchase health insurance more efficiently is why we are here today. My testimony will address the pros and cons of alternative ways to facilitate this.

Currently there are two broad approaches to this worthwhile policy goal on the table: association health plans and subsidized participation in broader purchasing pools.

Association health plans would pursue the goal of more affordable insurance for small firms primarily by exempting the self-insured plans that could be marketed to members of the association from various state regulations: benefit mandates, solvency standards, state taxes, and premium rating restrictions. These exemptions alone would lower premiums a few percentage points, as CBO and others have previously indicated,[4] but the largest gains to AHP members would more likely come from some degree of scale economies discussed above and especially from the favorable selection of health risks.

AHPs would create a kind of safe harbor from existing state insurance market laws, and as such would create a different kind of market for members than would be available to non-member small firms, and even to member firms who might initially prefer to purchase fully insured plans within the AHP. Firms with low-risk workers – young and healthy – will find the self-insured AHP product most attractive because it has no benefit mandates and no premium variance restrictions. As these firms leave the currently fully-insured market and risk pools, those risk pools would necessarily deteriorate in terms of average health risk. The only empirical question is how much premiums would rise for all but those in the self-insured AHP. Most analytic estimates are that the premium increase will not be too large, but that depends on how large the self-insured AHP grows and who exactly is able to enroll.

At this point a key policy analysis question must be asked: why would the proponents of AHPs want to create a separate market for some small firms and not others, especially when all credible analyses of this kind of legislation have always found that premiums within the self-insured AHP will be lower for low-risk firms but higher for everywhere else in each state's small group market? I have tried to answer this question for years

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[3] David M. Cutler, "Market Failure in Small Group Health Insurance," NBER working paper, October 1994; Stephen H. Long and M. Susan Marquis, "Stability and Variation in Employment-Based Health Insurance Coverage, 1993-97." *Health Affairs* v. 18 # 6 (Nov-Dec 1999). Cutler, NBER Working Paper, ...

[4] Congressional Budget Office. "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts," January 2000; Linda J. Blumberg, Len M. Nichols, and David Liska, *Choosing Employment-Based Health Insurance Arrangements: An Application of the Health Insurance Reform Simulation Model.* Final Report 0657-001-00, Department of Labor, Pension and Welfare Benefits Administration, March 1999.

now and only two rationales have come to mind. One, the proponents want to enable firms with low-risks to band together and act more like large firms when purchasing health insurance, and they simply do not worry about the fact they will harm – to an unknown and potentially large degree – the small group market as a whole. Two, at least some of the proponents may hope to enter the business of administering self-insured AHP plans or creating AHPs in general, for they see this created market opportunity as a way to fund other objectives they may have as organizations.

Both of these are perfectly normal reasons to seek specific, self-interested legislation, but they are hardly compelling public policy rationales for the nation as a whole, and certainly not for a committee as dedicated to the health of the overall small business sector as this one has always been and, I trust, remains. Indeed, it is fairly easy to see how to be true to that longstanding commitment to all small businesses in this case: enable or encourage *all* of them to act like large businesses by banding together in a truly large and powerful purchasing pool.

By having one pool within a state or perhaps multiple pools within distinct locales (since all health care and health insurance markets are ultimately local) that were open to all small businesses in particular areas, and with consistent insurance market regulations in and outside the pools, you would avoid the risk segmentation problems that self-insured AHP products invite. A majority in both houses of Congress may well think that some state legislation, e.g., some benefit mandates, are unwise public policy, because they impose more costs on all than the benefit to the few may appear to be worth. If that is the judgment of Congress, then you already clearly have the authority to repeal or override the unworthy mandates for all small firms, not just for those who happen to belong already or come to qualify for associations with the power to exclude those they do not want in their risk pool.[5] The research literature is very clear, by the way, that benefit mandates are not nearly as costly as their opponents seem to think,[6] but the larger point is that repealing them for some and not all firms is arguably discriminatory and certainly destabilizing for small group risk pools that are already fragile enough as it is.

Stability of the commercial and fully-insured risk pool would be threatened by regulation-exempt AHP products because initially the low-risk groups would leave to join the AHP. But if an individual firm's workers became less healthy over time, underwriting abilities preserved within the AHP would lead to higher premiums, until it might be well-advised to re-enter the commercial and regulated small group insurance market. HIPAA's guaranteed issue provisions and existing state insurance market regulations on premium variance restriction would force the insurers to accept this now higher risk group at a pooled premium rate, lower than its expected cost. Thus the commercial pool would lose healthy groups over time and then see the return of groups as their own experience deteriorated within the AHP. This is not a dynamic picture for a happy market equilibrium.

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[5] Nichols, Len M. and Linda J. Blumberg, "The Health Insurance Portability and Accountability Act: A New Kind of Federalism?" *Health Affairs*,(May-June 1998).
[6] www.doi.tx.st.gov; CBO and Blumberg et al, op cit.

There are other dangers with AHPs related to their removal from oversight by experienced state insurance regulators, but other testimony before this Committee two years ago, from Sandy Praeger, Insurance Commissioner in Kansas and then representing the NAIC, made all the relevant points so there is no need to repeat them here.[7]

So if AHPs are not the best way to go, what sort of encouragement should legislation give to the formation of other "large firm-like" pools among small firms? Many states already have legislation for enabling purchasing pools, but few work as well as they could because states put tighter insurance market rules on competition within the pool than without. This ultimately had the effect of rendering the pools more attractive to unfavorable risks, and that, along with early but lingering attempts to limit agent/broker commissions on purchasing pool products has stymied their growth. So lesson number one, learn from those lessons: have the same insurance market rules inside the pool as outside, and make sure agents and brokers are at least indifferent between selling inside or outside the pool. Industry insiders will tell you that small group health insurance is a product that is sold and not bought, by which I mean the purchaser must be talked into it. It is not worth expending the considerable and necessary persuasive and educational effort for a sub-standard commission.

Second, while forming the purchasing pool alone could lower administrative loads and premiums for all small firms that join, subsidies would clearly entice more entry and may help stabilize the risk pool as well. Who should be subsidized? The research literature is fairly clear that the most efficient use of new subsidy dollars, whether through tax credits or direct subsidies of some kind, is to link the subsidy to low-income workers as directly as possible.[8] Subsidizing small firms in general, as AHPs could be interpreted as doing by exempting qualified firms from state regulations and enticing favorable risk selection, is likely to "waste" subsidy dollars on higher-income workers and firms that are likely to be offering anyway and to continue offering after new laws are passed. Indeed, all analytic studies of AHPs concluded that the vast majority of likely participants are already insured.

Likewise, subsidizing low-wage workers, as opposed to low-income workers, risks wasting subsidy dollars on some low-wage workers who are married to higher-wage workers and who therefore have substantial family income. The tradeoff is that it is difficult, if not impossible, for firms to learn about or verify family income, so administrative costs might outweigh the inefficiently expended subsidy dollars.

One step toward efficient subsidies would be to offer a tax-credit to low-income workers for the purchase of group health insurance, and then eligibility for the tax-break and any necessary reconciliation would be between the IRS and the worker's family.

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[7] Statement of Sandy Praeger, Senate Small Business and Entrepreneurship Committee, February 5, 2003.
[8] Ferry, Danielle, Sherry Glied, Bowen Garrett, and Len M. Nichols, "Health Insurance Expansions of Working Families: A Comparison of Targeting Strategies," *Health Affairs* v. 21 # 4 (July/August 2002); Bowen Garrett, Len M. Nichols, and Emily K. Greenman, "Workers without health insurance: Who are they and how can policy reach them?" WKKellogg Foundation Community Voices report, August 2001.

If the policy objective is to subsidize firms, however, then linking firm level tax credits to worker wages is a kind of second best solution, far more efficient than just subsidizing firms regardless of worker wages and incomes. The SEHBP bill co-sponsored by Senators Durbin and Lincoln does just this, and provides for greater tax credits the more the employer pays toward the premium. Much research concludes that the single most important factor affecting worker take-up is the out-of-pocket premium facing the worker and her family.[9] Since tax credits to either workers or firms effectively lower the price of the premium by the credit, and since the credits proposed by Senators Durbin and Lincoln are likely to yield subsidies in the 10-50% range on top of scale economies from forming a pool, the SEHBP bill would likely increase coverage more than AHP legislation, but neither approach is going to solve the uninsured crisis facing our country, let us be clear.

In fact, recent work I have completed with the support of the California HealthCare Foundation makes clear that the fundamental health system problem we face today is that an increasing fraction of our workforce cannot afford health insurance, as we know it.

Table 1 illustrates this sad fact by reporting the ratio of family premiums to wages at different points in the wage distribution. The total family premium cost (on an hourly basis), as a percentage of wages at the 25th percentile of private sector workers' wages, rose from 33.2% to 47.1% between 1998 and 2003. Even for median wages, the family premium rises from 22.4% to 32.6%. Note then the median worker in 2003 is about where the 25th percentile worker was, in terms of health insurance purchasing power, in 1998. This illustrates how an increasing fraction of our workforce cannot afford health insurance, as we know it, for in 5 years the median worker fell to the 25th percentile worker's level of purchasing power. The average wage is higher than the median wage – earned by the person in the precise middle of the wage distribution – due to rock stars and professional athletes. A worker earning the average wage would still have had to devote 25.7% of wages to buy a family health insurance policy in 2003, and that is up from 17.9% only five years prior. This rapid decline in the power to purchase health insurance out of worker wages – either through the firm implicitly or as out-of-pocket payments -- is surely responsible for the decline in take-up and in overall ESI coverage that we have observed in recent years.

Table 1. Hourly cost of family health insurance as a percent of various hourly wage levels

| | 1998 | 2001 | 2003 |
|---|---|---|---|
| | | | |
| 25th percentile wage | 33.2% | 38.7% | 47.1% |
| Median wage | 22.4% | 27.6% | 32.6% |
| Mean wage | 17.9% | 21.9% | 25.7% |
| | | | |

Source: Total – employer plus employee share -- Premiums from KFF annual surveys, various years, converted to hourly amount by dividing by 2080 = 52*40. National wages from the National Compensation Surveys, Bureau of Labor Statistics, corresponding years.

[9]Blumberg, Linda J., Len M. Nichols, and Jessica S. Banthin, "Worker Decisions to Purchase Health Insurance," *International Journal of Health Care Finance and Economics* V. 1 Number ¾, September/December 2001.

Premiums as a fraction of the median wages of specific occupations, shown in Table 2, may illustrate the distributional nature of the affordability problem even more clearly. In California and in the nation as a whole, half of physicians would have to spend less than 7% of their wages to buy a family health insurance policy, whereas half of all cooks would have to spend more than 50% of their wages to do the same. It is hard to imagine employers of workers making in the $8-10 range being willing to pay 45-50% more than that for health insurance in addition, or those workers being willing to trade half their earnings for health insurance as we know it. Therefore far bolder solutions than either AHPs or SEHBPs are required.

Table 2. Family health insurance premium costs as a fraction of median wages, 2002.

| | US | | CA | |
|---|---|---|---|---|
| | Median hourly wage | Family premium / median wage | Median hourly wage | Family premium / median wage |
| Physician | $60.10 | 7.3% | $62.21* | 7.5% |
| History professor | $27.63 | 15.8% | $31.74 | 14.6% |
| Licensed practical nurse | $16.18 | 26.9% | $18.31 | 25.3% |
| Secretary | $15.00 | 29.1% | $14.55 | 31.9% |
| Bank teller | $ 9.93 | 43.9% | $10.34 | 44.9% |
| Carpenter | $18.00 | 24.2% | $20.49 | 22.6% |
| Cook | $ 8.75 | 49.8% | $ 9.68 | 47.9% |

Source: National and California premiums from the MEPS-IC. National and California wages from the US Bureau of Labor Statistics. *US physician data are for general internists. The median wage for that specialty was not reported for California, so the roughly comparable 25th percentile of psychiatrist wages was used instead.

I will close my written testimony with a reminder about the three inter-related problems of our impressive but flawed health care system: low clinical value per dollar, highly uneven quality of care, and inequitable access to care. To avoid ever-increasing uninsured rates, and we know that a disproportionate share of the uninsured are connected to the workforce of small firms, you on this Committee and we as a nation must tackle all three problems simultaneously in a comprehensive reform. Our political system may not be ready for this conversation just yet, but support for responsible policy debate is growing around the country.[10] The fundamental dynamic of an increasing percentage of our workforce being unable to afford health insurance as we know has been noticed all over our country.

Although certain details of a comprehensive solution have yet to be addressed, the principle and central elements of a feasible path to a far better health care system are increasingly clear. The guiding principle is universal coverage in exchange for universal

[10] Nichols, Len M. et al, "Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning in 12 Communities," *Health Affairs* (March-June 2004).

responsibility.[11] The elements center on an individual mandate to purchase private insurance coverage with continued employer and increased social responsibility for financing the subsidies that will make the mandate feasible. There must also be effective cost-containment mechanisms that will substantially lower the rate of health care cost growth, so that the public subsidy guarantee and continued employer participation will be politically feasible. There are promising experiments around the country but assembling these initiatives into a cohesive cost-containment strategy is a task not yet completed, and it is one my New America colleagues and I will undertake in the next two years.

In the meantime however, perhaps our most important next step is to begin to acknowledge as a nation that access to health care is fundamentally a moral issue: the Institute of Medicine has clearly interpreted the research literature to tell us that one of the consequences of lack of insurance is thousands of premature deaths every year.[12] This should be just as unacceptable to us as deaths from smoking, drunk driving, medical errors, and acts of terrorism here and abroad. Over five thousand years of various scriptural traditions call upon us all quite clearly to pursue justice and enhance the life chances of all our fellow human beings. Once we agree to stop accepting the morally unacceptable, then maybe we will be ready to talk about how, rather than whether, to reform our entire health care system, being ever mindful of the essential role small employers will always have in our economy and our health insurance opportunities.

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[11] Calabrese, Michael and Laurie Rubiner, "Universal Coverage, Universal Responsibility: A Roadmap to Make Coverage Affordable for All Americans," http://www.newamerica.net/Download_Docs/pdfs/Pub_File_1443_1.pdf

[12] *Hidden Costs, Value Lost: Uninsurance in America.* Institute of Medicine, 2003.

Chair SNOWE. Thank you, Mr. Nichols.
Mr. Morrison.

**STATEMENT OF JOHN MORRISON, MONTANA STATE AUDITOR, COMMISSIONER FOR INSURANCE AND SECURITIES, HELENA, MONTANA, ON BEHALF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS**

Mr. MORRISON. Thank you, Madam Chair, Ranking Member Kerry, Senator Burns. My name is John Morrison. I am the elected Montana State Auditor and Commissioner of Insurance and Securities. I am testifying today on behalf of the National Association of Insurance Commissioners.

The NAIC represents the chief insurance regulators of the 50 States, the District of Columbia, and the five U.S. Territories. I chair the NAIC's Health Insurance and Managed Care Committee. The insurance regulators are devoted to protecting consumers, and it is with this goal in mind that I comment today generally on the small business health care crisis, and in particular on the proposal to create association health plans.

Providing affordable health coverage to small businesses is critically important in many ways. The statistics cited here today show the urgency of the problem. The numbers are even greater in Montana. In our State, 1-in-5 Montanans have no health insurance, and over half of them—over half of them—work for a small business with fewer than ten employees. What we do as policymakers and regulators impacts the health of these employees and their families, the stability of the health insurance market, and the vitality of the small business community. I am pleased to offer the full support of the NAIC in developing legislation that will reach these goals.

States have acted aggressively over the past 15 years to stabilize and improve the small group market. States have required insurers to pool all of their small group risk by imposing rating bands to further spread the risk of small, unhealthy businesses across a larger population. States have created purchasing pools and allowed associations to provide State-regulated insurance products to their members.

In Montana, we just enacted a plan that I proposed to give substantial tax credits and purchasing pool access to several thousand small businesses to make health insurance more affordable. Our proposal is supported by the Montana Chamber of Commerce, NFIB, and over 40 major organizations representing labor, education, public health, providers, seniors, and others. The Montana Chamber of Commerce has its own insured association plan, Chamber Choices. The Flathead County Business and Industry Association has its own insured association plan, the FBIA plan.

The Federal Government and the States must work closely with these broad coalitions to implement reforms that truly make insurance more affordable to small businesses. Rehashing strategies that have failed, such as AHPs, is not a step forward. It is time to move forward to find effective solutions.

In their search for effective solutions, the Nation's insurance regulators have identified seven basic principles by which Federal health insurance reform legislation can be analyzed. These prin-

ciples are intended to keep the focus on the needs of consumers and the true causes of the current crisis.

One, the rights of all consumers must be protected. States have patient protections, solvency standards, fraud prevention programs, and oversight mechanisms in place to protect consumers. These standards should not be preempted.

Two, do not damage existing State reforms that are working. Small group purchasing pools, high risk pools, and other reforms increase availability and affordability of health insurance. Federal reforms must not erode these successful efforts.

Three, consumer education must be provided. The Federal Government must coordinate with State consumer education programs to ensure consumers are able to make informed choices.

Four, rising health care costs must be addressed. There are multiple drivers of health care costs and they, in turn, are driving up the cost of health insurance. Effective policy must include provisions to address cost drivers and control rising health care costs.

Five, do not make cost shifting worse. Low reimbursement payments have shifted costs to the private sector. Unfunded Federal mandates have shifted costs to State governments. The cost of providing care to the uninsured is also shifted, driving up rates for insured consumers. Federal health insurance legislation must address cost shifting.

Six, the position of less healthy individuals must be protected. New designs must not shift more costs to the sicker patient or discourage appropriate care.

Finally, seven, public policymakers should not allow the creation of insurance companies that do not have appropriate oversight. To allow them to be formed outside the existing regulatory structure will create an unlevel playing field that is unfair to existing insurers and eventually harmful to consumers.

States continue to experiment with reinsurance, tax credits, subsidies, basic health plans for small businesses, regional pooling, and programs to promote healthier lifestyles and manage diseases. As always, States are the laboratories for innovative ideas. The NAIC this year—this year—will examine these State initiatives to find successful trends that can be followed by the States.

Still, the impact of the Federal Government on health care policy is tremendous and America's State insurance regulators look forward to working with you toward real progress on this issue for small businesses and their employees everywhere.

[The prepared statement of Mr. Morrison follows:]

# TESTIMONY

# OF THE

# NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

**BEFORE THE**

**SENATE COMMITTEE ON**

**SMALL BUSINESS COMMITTEE AND ENTREPRENEURSHIP**

on

**Solving the Small Business Health Care Crisis:**

**Alternatives for Lowering the Costs and Covering the Uninsured**

**Presented by:**

**The Honorable John Morrison**
**Montana State Auditor**
**Commissioner for Insurance and Securities**

April 20, 2005

**Introduction**

Good morning Madam Chairwoman. My name is John Morrison and I am testifying today on behalf of the National Association of Insurance Commissioners (NAIC). The NAIC represents the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. The primary objective of insurance regulators is to protect consumers and it is with this goal in mind that I comment today generally on the small business healthcare crisis, and in particular the proposal to create Association Health Plans (AHPs).

To begin I will emphasize the commissioners' recognition of how important it is to ensure affordable, available health coverage for small businesses and offer the full support of the NAIC in developing legislation that will reach these goals. States have acted aggressively over the past fifteen years to stabilize and improve the small group market. States have required insurers to pool all of their small group risk by imposing rating bands or limitations, to further spread the risk of smaller, unhealthier businesses across a larger population. Many states have created purchasing pools and allowed associations to provide licensed, state-regulated insurance products to their members.

States continue to experiment with reinsurance, tax credits, subsidies, basic health plans for small businesses, and programs to promote healthier lifestyles and manage diseases. As always, states are the laboratories for innovative ideas. It is critical that the federal government and the states work closely with healthcare providers, insurers and consumers to implement true reforms that will curb spending and make insurance more affordable to small businesses. Rehashing strategies that have failed, such as Association Health Plans, is not a step forward. It's time to move on to find effective solutions.

**NAIC's Principles for Federal Reform**

In their search for effective solutions, the nation's insurance regulators have identified seven basic principles by which federal health insurance reform legislation can be analyzed. These principles are intended to keep the focus on the needs of consumers and the true causes of the current crisis. These principles are:

**Principle 1: The rights of all consumers must be protected.** States already have patient protections, solvency standards, fraud prevention programs, and oversight mechanisms in place to protect consumers; unless new federal standards equal or exceed existing state standards and enforcement they should not be preempted. Any new insurance arrangement purporting to increase the number of people with health insurance will be a failure if the insurance arrangement is not solvent and cannot pay the claims of those who have placed their trust in it. Further, all new proposals must preserve access to sufficient grievance and appeals procedures, and also assure that benefits and provider networks are adequate. Consumers must always be protected from fraud and misinformation.

**Principle 2: Existing state reforms and assistance programs must be supported, not degraded.** As you know, states have already enacted small group purchasing pools, high-risk pools, and other reforms to increase the availability and affordability of health insurance. Federal reforms must not erode these successful efforts by permitting good risk to be siphoned off through manipulation of benefit design or eligibility for benefit provisions.

**Principle 3: Adequate consumer education must be provided.** Federal reform will be complicated, creating new insurance choices for many Americans. The federal government must coordinate with existing state consumer education programs to ensure consumers are able to make informed choices.

**Principle 4: The overarching issue of rising healthcare costs must be addressed.** Federal efforts to increase access to insurance will not be successful over time unless the overriding issue of rapidly rising healthcare costs is also addressed. Insurance is a mechanism for paying for health care and has had only limited success in controlling costs, but insurance is not the cause of those skyrocketing costs. There are multiple drivers of healthcare costs, and they in turn are driving up the cost of health insurance. To bring long-term stability to the healthcare system efforts must include provisions to address cost drivers and control rising healthcare costs.

**Principle 5. Current cost shifting must not be exacerbated.** Inadequate reimbursement payments have led to cost shifting to the private sector. Unfunded federal mandates to states have shifted costs onto state governments. The cost of providing care to the uninsured is also shifted, driving up rates for insurance consumers. These actions have resulted in higher overall costs and decreased access for many consumers. Federal health insurance reform legislation must address cost shifting.

**Principle 6: The position of less healthy individuals must be protected.** Both state and the federal governments have begun the process of reforming tax structure and other financial policies to encourage individuals to be more responsible consumers of health care. Emerging industry trends reflect developments in benefit and plan designs that create incentives for responsible consumer behavior in health care purchasing decisions. Public policy decisions must assure that new designs do not shift costs to such an extent that insurance no longer offers meaningful protection to the sick or discourage appropriate care. Federal legislation should encourage appropriate usage of the health care system without inappropriately withholding needed health care services to the sicker patient.

**Principle 7: Public policymakers should be wary of allowing the creation of insurance companies without appropriate oversight.** Remember, legislation that allows alternative risk-bearing arrangements must acknowledge that it is allowing the creation of new insurance companies. A mere change in the name of the arrangement does not transform its essential insurance nature and function – the acceptance and spreading of risk. To allow such new insurance companies to be formed outside the existing regulatory structure will create an unlevel playing field that is unfair to existing insurers and potentially harmful to consumers. To do so without providing adequate additional federal resources to ensure sufficient oversight of new entities will be disastrous.

**AHP Legislation Violates NAIC Principles**

The AHP legislation that has been once again introduced in the House and the Senate violates almost all of the principles outlined above and, therefore, the NAIC must remain steadfast in its objections to the AHP bills. Specifically, the legislation would:

**1. Undermine State Reforms**

Before state small group market reforms were implemented, the small group market was fragmented into various pools based on risk. If a small employer had healthy employees in a relatively safe working environment the employer could easily find coverage at a good rate. However, if one of the employees became sick, the employer would be shifted to a higher risk pool and often priced out of coverage. Those who started with sicker or higher risk employees were often priced out of the market from the beginning.

State small group market reforms forced insurers to treat all small employers as part of a single pool and allow only modest, and in some states no, variations in premiums based on

risk. This spreading of risk has brought some fairness to the market. Although the proponents claim AHPs are a vehicle for allowing small businesses to pool together, they would actually reduce the amount of pooling in the small group market. In fact, it is not pooling but "cherry picking" that would enable AHPs to offer lower-cost coverage in some cases. Such savings would come at the expense of all others in the small group market who are not part of AHPs. The AHP legislation in Congress would undermine state reforms and once again fragment the market.

While the AHP bill does make some effort to reduce "cherry picking" the NAIC believes the provisions will be ineffective in stopping risk selection. Under the current bill, AHPs can still "cherry-pick" using four very basic methods:

a) Membership – S. 545 permits associations to offer coverage only to their members, allowing plans to seek memberships with better risk;
b) Rating – S. 545 eliminates state rating limits for most plans, allowing them to charge far more for higher risk persons, forcing them out of the pool;
c) Service area – S. 545 eliminates state service area and network requirements, allowing plans to "redline" and avoid more costly areas;
d) Benefit design – S. 545 eliminates all state benefit mandates, allowing plans to cut prices by denying consumers costlier treatments, driving employers whose workers need these treatments into the regulated market while siphoning off employers with healthier workforces.

If no cherry picking were possible, AHPs would attract a risk pool that, on average, was the same as the current small group market – which would take away a major advantage of forming AHPs. Assertions by proponents of this measure that this issue has been addressed are incorrect.

**2. Lead to Increased Plan Failures and Fraud Due to Inadequate Oversight**

Proponents of the AHP legislation claim that the Department of Labor has sufficient resources to oversee the new plans and insolvencies and fraud will be prevented. This simply is not the case. The Department of Labor has neither the resources nor the expertise to

regulate insurance products. The states have invested more than 125 years in regulating the insurance industry. State insurance departments nationwide employ over 10,000 highly skilled people. The combined budgets of state insurance departments total more than $700 million. The AHP bill provides no new resources for regulating these plans.

While the NAIC acknowledges state regulation may cost slightly more initially, those costs are offset by the protections provided to our consumers. Insurance is a complicated business, involving billions of dollars, with ample opportunity for unscrupulous or financially unsophisticated entities to harm millions of consumers. Unless oversight is diligent, consumers will be harmed.

This is not just speculation, but fact borne of years of experience with Multiple Employer Welfare Arrangements (MEWAs), multi-state association plans, out-of-state trusts, and other schemes to avoid or limit state regulation. Within the last year, 16 states have shut down 48 AHP-like plans that had been operating illegally in those states, many through bona fide associations. Association plans in several states have gone bankrupt because they did not have the same regulatory oversight as state-regulated plans, leaving millions of dollars in provider bills unpaid and consumers liable for their payment.

Each time oversight has been limited the result has been the same – increased fraud, increased plan failures, decreased coverage for consumers, and piles of unpaid claims. Specifically, the NAIC believes the following issues must be addressed:

**a. Solvency Standards Must Be Increased**

While the solvency standards in the AHP legislation have been increased over the years, they are still woefully inadequate. The capital reserve requirement for any and all AHPs is capped at $2 million -- no matter the size of the plan. States require the capital surpluses to grow as the plan grows, with no cap or a far higher cap than

that in the federal legislation. If a nationwide AHP were offered to a large association, a capital surplus of merely $2 million would result in disaster.

**b. AHP Finances Must Receive Greater Oversight**

Even if the solvency standards are increased, oversight is almost nonexistent in the bill. Under the bill the AHP would work with an actuary chosen by the association to set the reserve levels with little or no government oversight to ensure the levels are sufficient or maintained. Also, the AHP is required to "self-report" any financial problems. As we have seen over the past few years, relying on a company-picked accountant or actuary to alert the government to any problems can have dire consequences for consumers who expect to have protection under their health plan.

State regulators comb over financial reports and continually check investment ratings to ensure that any potential problems are identified and rectified quickly. AHP plans must be held to the same standard.

Simply limiting participation in AHPs to "bona fide trade and professional associations" and providing limited Department of Labor oversight of self-reported problems will not prevent fraud and mismanagement. Strict oversight is required and this will only occur if all health plans delivered through associations are licensed and regulated at the state level.

**3. Eliminate Important Consumer Protections**

Included in the current AHP legislative proposals is the broad preemption of consumer protection laws. AHP proponents argue that state mandated benefit laws must be preempted so that AHPs do not have to provide coverage for expensive benefits. However, states have a multi-faceted regulatory structure in place for insurers. Not only are mandated benefit laws

preempted, but other laws protecting patient rights and ensuring the integrity of the insurers are preempted as well. Here is a small sample of preempted consumer protections:

- Internal and external appeals processes.
- Investment regulations to ensure that carriers only make solid investments instead of taking on risky investments such as junk bonds.
- Unfair claims settlement practices laws.
- Advertising regulation to prevent misleading or fraudulent claims.
- Policy form reviews to prevent unfair or misleading language.
- Rate reviews. Insurance departments may review rates to make sure the premiums charged are fair and reasonable in relation to the benefits received.
- Background review of officers.
- Network requirements including provider credentialing and network adequacy, to ensure that plans offer a provider network that is capable of delivering covered services.
- Utilization review requirements to ensure that plans have acceptable processes and standards in place to determine medical necessity and to make coverage determinations.

While some of these protections may be offered by AHPs as a service to their association members, there would be no requirement that they do so, and no entity to complain to if a patient's rights are violated by the plan. State insurance regulators act on hundreds of thousands of consumer complaints every year and work hard to protect the rights of patients. AHP participants deserve access to the same protections and complaint process.

**4. Cut Funds to State High-Risk Pools and Guaranty Funds**

While the latest version of the AHP legislation allows states to impose premium taxes on AHP plans – to the extent they are imposed on other insurance plans – it preempts other state assessments. States use health insurance assessments to fund such important entities as

high-risk pools (which provide coverage to the uninsurable) and guaranty funds (which help cover claims if a plan is insolvent.) Such programs are vital to the stability of the small group and individual markets and to the protection of consumers – they must not be undercut by federal preemption.

**Alternatives for Real Reform**

If this hearing is truly about alternatives to our healthcare needs, then it is time to look at alternatives. As you know, states have been the laboratories for innovative ideas in this arena for some time. In Montana, the legislature is considering a proposal in which tax credits will be offered to small businesses that are currently providing health insurance to their employees, *and* premium incentive/assistance payments will be available to small businesses currently without coverage. National health policy experts have helped create a plan to combine the premium payments for small businesses that cannot afford coverage with a purchasing pool. The pool will increase the purchasing power of the premium payments by negotiating lower-priced health plans through group purchasing. These proposals are funded by an increase in the tobacco tax that was passed by over 60% of the voters of Montana in a ballot initiative last November.

- Sixty percent of the available revenue appropriated through this legislation will be available for businesses without coverage. The Premium Payments will be split between the employer and employee share of the monthly premium. The Premium Incentive Payment will be applied to the employer portion and the Premium Assistance Payment will be applied to the employee portion.
- Small businesses will be eligible for monthly premium payments on a first come, first served basis until available funding is allocated for the year. Businesses will

apply to register for eligibility to receive the payments. To use the payments, the small business must join the pool, or a qualified small group association health plan. Revenue available for small businesses eligible for association health plans will be capped to ensure that the pool attracts enough members to lower the price of coverage through economies of scale for administrative costs, negotiating for health coverage, and by preventing adverse selection.

- Small businesses with coverage (40% of credits) may apply for eligibility for a tax credit that is refundable to small business owners. After eligibility is determined, credits will be distributed on a first come first served basis. Coverage for this group will continue to be purchased in the existing market. Businesses would receive the credit when they file their tax returns.
- The amount of the refundable tax credit will be $100 or $125 per employee per month (depending on average age of employees) for businesses with current coverage. Employers and employees will be responsible for a portion of the insurance premium.
- There will be an income limit in order to receive both the tax credit and the monthly premium payments. If any employee (NOT employer) of a small group earns over $50,000/year, they will not be eligible for the tax credits/premium payments. This will apply to both uninsured and insured groups.

Other states have experimented with reinsurance, tax credits, subsidies, basic health plans for small businesses, public program expansion, and programs to promote healthier lifestyles and manage diseases. Many states utilize reinsurance mechanisms in the small group market, with various degrees of success. The most recent effort by the state of New York in its Healthy New York program has utilized a retrospective reinsurance mechanism, subsidized

by state tax dollars, that has resulted in about 70,000 new insureds, all low wage workers in small businesses who were formerly uninsured.

As another example, in Maine, the state enacted the Dirigo Health Plan, intended to provide coverage for 180,000 state residents. The plan has two components: 1) expansion of Medicaid and SCHIP to parents with incomes up to 200% of the federal poverty line and to everyone earning less than 125% of the federal poverty line; and 2) establishment of a public/private plan to cover business with 2-50 employees, the self-employed, and unemployed and part-time workers. The plan is in its early stages of implementation, and state policymakers have high hopes for its success.

**Conclusion**

All of us recognize that it is very important to make health insurance available to small employers. The states have begun to address this problem, and will continue to do so. However, the problem is complex and does not lend itself to easy solutions.

The federal government and the states need to work with healthcare providers, insurers and consumers to implement true reforms that will curb spending and make insurance more affordable to small businesses. We stand ready to work with members of Congress to draft effective reforms that will address both the affordability and availability issues facing small businesses. Together, we are convinced, real solutions to this critical issue can be found.

Chair SNOWE. Thank you, Mr. Morrison.

Mr. Lindsay.

**STATEMENT OF WILLIAM N. LINDSAY, III, PAST CHAIR, NATIONAL SMALL BUSINESS ASSOCIATION, DENVER, COLORADO**

Mr. LINDSAY. Yes, Madam Chair.

Chair SNOWE. Thank you.

Mr. LINDSAY. Chair Snowe, Ranking Member Kerry, Senator Burns, my name is Bill Lindsay. I am here as the former Chair of the National Small Business Association, the Nation's oldest small business association.

I have spent a career running a small business designed to help other small businesses with their health insurance. I thank you for this opportunity to speak on this critical issue. As has been mentioned by all of the other presenters today, this is a very significant issue affecting our Nation's economy and small businesses.

Health care and the cost of insurance consistently rank as the top concern of our members. We may want to fix the issue with cost of insurance, but I urge you to heed the ethical credo of physicians, that is, first, do no harm.

NSBA has studied Association Health Plans, AHPs, and we are one of the few small business groups that oppose them. We are, however, supported through a coalition of numerous local, regional, and State Chambers of Commerce in our opposition. There are several misconceptions about AHPs that have been discussed today and I would like to speak about them briefly. There are four in total.

The first is that larger pools create bargaining clout. Pooling alone does not lower insurance rates. It depends upon who is in the pool. Otherwise, Blue Cross and Blue Shield, which insures arguably the largest number of small businesses in America, would have the lowest rates, and they don't. Eighty percent of cost for insurance is based upon cost of the claims. Cost of claims is not impacted by a larger national pool. Doctors and hospitals agree to discounts on who is insured in their area. If an AHP had five million members nationwide, but only several hundred in a local community, they would not be able to negotiate a lower rate than existing players in that marketplace.

The cost of administration in small business insurance is very, very important, but the question is how AHPs would impact that. You would still have the issue of billing and collections, bad debt, and all of the issues that insurance companies deal with right now.

The bill provides little protections against gaming, and in order to affect the cost of insurance, which I have mentioned before represents 80 percent of the total cost, AHPs would have to employ strategies that would adversely affect the rest of the market. Examples would be the ability allowed under HIPAA to have disparate rates based on the age of the applicants. That is permitted under HIPAA, and AHPs would be able to structure those rates so they would be able to appeal to younger and healthier workers. Also, the ability to exclude not only State-mandated coverages, but other forms of coverage that would be needed by those who have chronic health conditions.

A third point is that this bill would exempt AHPs from State solvency requirements. It has been discussed that there are provisions in the bill on solvency, but you have got to remember that the National Association of Insurance Commissioners and the vast majority of States have moved away from static requirements to risk-based capital requirements that index those solvency requirements based on the size and the growth of the pool.

The final misconception is that pooling cannot occur right now. In Senator Burns' State, in Montana, and in Mr. Morrison's State, there currently are opportunities for businesses to band together in MEWAs that are regulated by the State insurance department to create more market presence in that State, and those work very effectively.

The Mercer Report, and Senator, I have included my testimony for inclusion in the record. I would like to request that this also be included.

Chair SNOWE. Without objection, so ordered.

Mr. LINDSAY. It was commissioned by the National Small Business Association. It indicated that those with AHPs would see a rate reduction of up to 10 percent over a period of 4 years, but those not in AHPs will see premium increases of 23 percent or more, primarily due to risk selection. The overall net increase in the market would increase, and has been mentioned in previous testimony, the resulting increase would be over a million additional uninsured individuals.

Now, I know it is easier to criticize. The question then is, well, what is the solution? Chair Snowe introduced S. 723, the Simple Cafeteria Plan, which I think is a huge step and very positive for small business. But in addition to that, the National Small Business Association has spent the last 18 months studying this issue and we have put forth a comprehensive proposal for reform which would include the following parts.

Number one, looking at the issues, we would seek to require all individuals to have health insurance, either through Medicaid, Medicare, individual insurance, or traditional group insurance.

We would provide subsidies to low-income individuals, not to businesses.

We would provide a truly basic plan indexed to income levels so that the cost would be proportionate to income.

We would remove the tax subsidy for health plans that are richer than the basic benefit program and drive unnecessary utilization.

We would focus on quality, including public disclosure of health care quality within hospitals and physicians' offices.

We would tie malpractice reform to physicians who follow established protocols and proven clinical procedures.

And we would treat individual health insurance like group insurance for tax purposes to provide equity in the small business market.

Madam Chair, I thank you for the opportunity to present this information this morning and I hope it is helpful in your deliberation.

[The prepared statement of Mr. Lindsay follows:]

TESTIMONY OF

**William N. Lindsay, III**

**THE NATIONAL SMALL BUSINESS ASSOCIATION**

# Solving the Small Business Health Care Crisis:
## Alternatives for Lowering Costs and Covering the Uninsured

**Before the Senate Committee on Small Business**

**April 20, 2005**

Good morning Chairwoman Snowe, Ranking Member Kerry, members of the committee. My name is William Lindsay and I am here as the former Chair of the National Small Business Association. NSBA is the nation's oldest nonpartisan small business advocacy group reaching more than 150,000 small businesses nation-wide. I have spent my career running a small business whose mission was to help other businesses with selecting appropriate benefits packages. As both a small business owner and expert in the health care insurance field, I thank you for this opportunity to speak with you today.

As we all know, small businesses are being pummeled by the increasing cost of health care. Health care consistently ranks among the top concerns of our members and during NSBA's 2005 Small Business Congress, out of our top-5 voted-on priority issues, 3 deal with health care. As members of this fine committee, I am sure you hear on a daily basis the need for some small business relief in the form of small group insurance market reform. NSBA would agree that something must be done to alleviate this burgeoning burden small businesses face. We believe that, while targeted reforms will help, a comprehensive solution must be sought rather than placing a series of too-small band-aids on a problem that looks an awful lot like a broken leg.

**Oppose Association Health Plans**

There have been calls from various national small business groups to create Association Health Plans (AHPs). The push for AHPs are a reaction to the very dire circumstances small businesses currently face in the health insurance arena: huge premium increases, a lack of control and clout, the costly tangle of state and federal regulations, and fewer funding, carrier, and plan selection options than their larger counterparts.

Despite those good intentions, we are concerned that AHPs are not only a non-answer to the real issues driving cost, but will exacerbate the problems small businesses face. The primary focus and cost savings of AHPs is through circumventing state laws and rating rules. AHPs threaten to greatly worsen the market segmentation and risk-aversion that currently characterize the small group health insurance market, which are at the root of the health care crisis uniquely faced by smaller firms. AHPs might be good for small business associations (like NSBA) who want to run them, but NSBA believes that they will not be good for the small business community at-large, whose interests we are bound to represent.

*Bigger is Better?*

One of the fundamental precepts that underpins the arguments of those advocating for AHPs is the idea that big pools will equal bargaining clout. In almost every market in the world, the larger the quantity you buy of something, the lower its per-unit price. In the health insurance market, however, the make-up and location of that pool are both far more important factors in establishing a price than size alone.

A pool of 1,000 people with an average age of 40 could demand (and receive) a much better rate than a pool of 50,000 people with an average age of 55. Moreover, when a plan is negotiating reimbursement with providers, a local hospital or physician will be driven by how many patients the plan will bring them. A local plan with a total of 100,000 lives will be able to drive a much better deal than a big national plan with 5 million lives, only 15,000 of which are local.

The risk profile of the group and their geographic concentration are the two most important factors in negotiating rates for small business health insurance. Unfortunately, AHPs create significant problems on both fronts.

*Risk Selection*

The insurance industry competes based largely upon each company's ability to attract better risks (i.e. healthier people). AHPs are likely to function in the same way. While AHPs could not exclude any specific qualified association member, risk selection is a much more subtle and powerful phenomenon than such blatant discrimination alone. In fact, such selection would be the crux of AHPs' competitive advantage, reaped though benefit manipulation and rates charged.

By carefully designing benefit packages that will be relatively unattractive to older and less-healthy populations, AHPs will be able to simultaneously attract a higher proportion of younger and healthier individuals in their pools, thereby driving down their expected claims costs and, thus, their premiums. According to a June 2003 study by Mercer Risk, Finance and Insurance, the "morbidity" (measure of a firm's overall sickness) of firms enrolling in AHPs would be 21 percent lower than the average small business, leading to a 12.3 percent increase in the morbidity rate of the uninsured.

Currently, the rates that can be charged in the small group market are regulated by the states. Most states have "rate bands" of varying degrees that define the window in which rates can fluctuate and on what basis they can fluctuate. Other states have a form of community rating in which rates are essentially the same for all participants. Self-insured AHPs would not have to use rate bands at all. If an AHP with a wide rate band (or no rate band) were to sell into a community-rated state, the consumer choices would be stark. The AHP rates for younger, healthier groups are likely to be significantly less while AHP rates for older, less-healthy groups are likely to be higher than the average rate in a community-rated state. It is easy to see what will happen: younger, healthier groups will join AHPs, and the rest will not. Of the horror stories we hear daily about premium hikes faced by small businesses, the most egregious examples (those who have seen rates go up by 70 percent or more in one year) are often from cases where the group has entered a higher age bracket. AHPs will make these situations even worse.

Since apportionment of health risk is ultimately a zero-sum game, lower premiums for those participating in AHPs will mean higher premiums elsewhere. These increases will drive more healthy people away from the traditional pools and into AHPs. Those AHPs that attract significantly better risks can be highly profitable. But AHPs that refuse to engage in this sort of risk selection, as well as traditional plans that are forbidden by state law from doing so, will fall

into what is known as a "death spiral," where higher premiums chase away better risks, which leads to still higher premiums. The end result will be the destruction of the traditional insurance market for small firms and the displacement of millions of currently insured individuals. The most effective way for such a pool to achieve lower premiums is to attract better risks. To deny that such will occur is to deny the effect of market forces.

Two types of associations seem most likely to offer AHPs: national vertical trade associations (representing a specific industry, e.g. banking, restaurants) and national general small business groups (such as NSBA or NFIB). A vertical trade group that believes that its trade population is relatively young and healthy is likely to start an AHP, and expect it to be successful. Similarly, a vertical trade group that believes its trade population is relatively old and unhealthy is unlikely to be able to sustain an AHP. In other words, affected trade associations and their health insurer partners would behave predictably and according to their organizations' financial interests. Risk selection would be part of AHPs from the very beginning. To believe otherwise is to refuse to acknowledge the way small group insurance markets function now, in spite of heavy state regulation.

It also is likely that there would be a number of national general small business AHPs. These associations would market nationally to potential members, largely on the basis of premium. Given that these groups would all have the same regulatory advantages, they would succeed or fail almost entirely on their ability to attract and maintain a healthier population.

*Cost and Access*

Proponents claim that AHPs will save their members significant amounts of money. In fact, a Congressional Budget Office (CBO) paper estimated that businesses switching from an existing state-regulated pool to an AHP would see their premiums decline by 13 percent, a fairly substantial savings. However, most (almost two-thirds) of those savings come from the risk selection described above. According to the CBO paper, AHPs would achieve cost savings by draining away healthier individuals from the state-regulated pools, thereby forcing premiums to go yet higher for the majority of the market. The CBO estimates costs will decline for the 20 percent of businesses that join AHPs, but will, therefore, go up for everyone else. That increase in costs will add to the already rising ranks of uninsured by more than one million if AHP legislation passed, according to the Mercer Report.

Proponents of AHPs hope that premium savings will cause new individuals to be insured. However, the CBO paper cited above clearly shows that the overwhelming number of participants in AHPs will be those who switched from a traditionally insured plan to an AHP. CBO believes that these switchers would outnumber the newly insured by nearly 14-to-1. We also must point out that the higher premiums for non-AHPs could lead to greater numbers of uninsured individuals, exactly the opposite of the outcome desired by proponents.

Proponents of AHPs say that associations will act in their members' best interests and avoid these practices. But, to serve their members and to attract new members, AHPs will have to keep premiums as low as possible.

Contrary to the rosy picture painted by proponents of AHPs, we fear this legislation would only serve to dig the small business health market even deeper into a hole of adverse selection, further distorting an already perverted market. Those who have the least need for health care services will be able to buy health insurance cheaply (and insurers and AHPs will find this business very profitable). But those who are at greatest risk of illness will be least able to afford coverage, and insurers will find ever-more creative ways to avoid selling coverage to those with greatest need.

AHPs may cause a number of currently uninsured Americans to get coverage. However, we believe that it will, over time, cause even more small business owners and employees to reduce and give up coverage due to cost increases.

If this hastened train-wreck is what occurs from AHPs, matters will not be politically or economically sustainable unless Congress embarks on exactly the kind of national mandate-setting and market regulation that all 50 states are struggling with right now (and which AHPs are a rebellion against). Some might think that would be a good thing, but one suspects that it would be very difficult to generate a majority for AHPs if it was understood this kind of additional federal intervention would be necessary in a few years.

**NSBA's Comprehensive Solution**

In attempting to create positive health care reform for small businesses, one quickly bumps up against the reality that the small business problems cannot be solved in isolation from the rest of the system. Since small businesses purchase insurance as part of a larger pool with shared costs, the decisions of others directly affect what a small business must pay and the terms on which insurance is available to them. It has become clear to NSBA that—to bring meaningful affordability, access, and equity in health care to small businesses and their employees—a broad reform of the health care system is necessary. This reform must reduce health care costs while improving quality, bring about a fair sharing of health care costs, and focus on the empowerment and responsibility of individual health care consumers.

*The Realities of the Insurance Market*

Small employers who purchase insurance face significantly higher premiums from at least two sources that have nothing to do with the underlying cost of health care. The first is the cost of "uncompensated care." These are the expenses health care providers incur for providing care to individuals without coverage; these costs get divided-up and passed on as increased costs to those who have insurance. This practice is known as "cost-shifting."

Second is the fact that millions of relatively healthy Americans choose not to purchase insurance (at least until they get older or sicker). Almost four million individuals aged 18-34 making more than $50,000 per year are uninsured. The absence of these individuals from the insurance pool means that premiums are higher for the rest of the pool than they would be otherwise. Moving these two groups

of individuals onto the insurance rolls would bring consequential premium reductions to current small business premiums.

Implicit in the concept of insurance is that those who use it are subsidized by those who do not. In most arenas, voluntary insurance is most efficient since the actions of those outside the insurance pool do not directly affect those within. If the home of someone without fire insurance burns down, those who are insured are not expected to finance a new house. Not so in the health arena. Moreover, individuals' ability to assess their own risk is somewhat unique regarding health insurance. People have a good sense of their own health, and healthier individuals are less likely to purchase insurance until they perceive they need it. As insurance becomes more expensive, this proclivity is further increased (which, of course, further decreases the likelihood of the healthy purchasing insurance).

*Individual Responsibility*

There is no hope of correcting these inequities until we have something close to universal participation of all individuals in some form of health care coverage. NSBA's plan for ensuring that all Americans have health coverage can be simply summarized: 1) require everyone to have coverage; 2) reform the insurance system so no one can be denied coverage and so costs are fairly spread; and 3) institute a system of subsidies, based upon family income, so that everyone can afford coverage.

Of course, the decision to require coverage would mean that there must be some definition of the insurance package that would satisfy this requirement. Such a package must be truly basic. The required basic package would include only necessary benefits and would recognize the need for higher deductibles for those able to afford them. The shape of the package would help return a greater share of health insurance to its role as a financial backstop, rather than a reimbursement mechanism for all expenses. More robust consumer behavior will surely follow.

Incumbent on any requirement to obtain coverage is the need to ensure that appropriate coverage is available to all. A coverage requirement would make insurers less risk averse, making broader insurance reform possible. Insurance standards would limit the ability of insurance companies to charge radically different prices to different populations and would eliminate the ability of insurers to deny or price coverage based upon health conditions, in both the group and individual markets. Further, individuals and families would receive federal financial assistance for health premiums, based upon income. The subsidies would be borne by society at large, rather than in the arbitrary way that cost-shifting currently allocates these expenses.

Finally, it should be clear that coverage could come from any source. Employer-based insurance, individual insurance, or an existing public program would all be acceptable means of demonstrating coverage.

*Reshaping Incentives*

There currently is an open-ended tax exclusion for employer-provided health coverage for both the employer and employee. This tax status has made health insurance preferable to other forms of compensation, leading many Americans to be "over-insured." This over-insurance leads to a lack of consumer behavior, increased utilization of the system, and significant increases in the aggregate cost of health care. Insurance now frequently covers (on a tax-free basis) non-medically necessary services, which would otherwise be highly responsive to market forces.

The health insurance tax exclusion also creates equity concerns for small employers and their employees. Since larger firms have greater access to health insurance plans than their smaller counterparts, a greater share of their total employee compensation package is exempt from taxation. Further, more small business employees are currently in the individual insurance market, where only those premiums that exceed 7.5 percent of income are deductible.

For these reasons, the individual tax exclusion for health insurance coverage should be limited to the value of the basic benefits package. But this exclusion (deduction) also should be extended to individuals purchasing insurance on their own. Moreover, the tax status of health insurance premiums and actual health care expenses should be comparable. These changes would bring equity to small employers and their employees, induce much greater consumer behavior, and reduce overall health care expenses.

*Reducing Costs by Increasing Quality and Accountability*

While the above steps alone would create a much more rational health insurance system, a more fair financing structure, and clear incentives for consumer-based accountability, more must be done to rein-in the greatest drivers of unnecessary health care costs: waste and inefficiency. Increased consumer behavior can help reduce utilization at the front end, but most health care costs are eaten up in hospitals and by chronic conditions whose individual costs far exceed what any normal deductible level.

There is an enormous array of financial pressures and incentives that act upon the health-care provider community. Too often, the incentive for keeping patients healthy is not one of them. Our medical malpractice system is at least partly to blame. While some believe these laws improve health care quality by severely punishing those who make mistakes that harm patients, the reality is that they simply lead to those mistakes—and much more—being hidden.

Is it any wonder that it is practically impossible to obtain useful data on which to make a provider decision? Which physician has the best success-rates for angioplasty procedures? Which hospital has the lowest rate of staph infections? We just don't know, and that lack of knowledge makes consumer-directed improvements in health care quality almost impossible to achieve.

Health care quality is enormously important, not only for its own sake, but because lack of quality adds billions to our annual health care costs. Medical errors, hospital-acquired infections, and other forms of waste and inefficiency cause additional hospital re-admissions, longer recovery times,

missed work and compensation, and death. The medical costs alone probably total into the hundreds of billions of dollars.

What financial pressures are we bringing to bear on the provider community to improve quality and reduce waste? Almost none. In fact, we may be doing the opposite, since providers make yet more money from re-admissions and longer-term treatments. It is imperative to reduce costs through improved health care quality. Rather than continuing to pay billions for care that actually hurts people and leads to more costs, we should pay more for quality care and less (or nothing) when egregious mistakes occur.

Two broad reforms are urgent:
*Pay-for-Performance.* Insurers should reimburse providers based upon actual health outcomes and standards, rather than procedures. In some pilots, CMS and Medicare have already begun this process. Evidence-based indicators and protocols should be developed to help insurers, employers, and individuals hold providers accountable. These protocols—if followed—could also provide a level of provider defense against malpractice claims.

*Electronic Records and Procedures.* From digital prescription writing to individual electronic medical records to universal physician IDs, technology can reduce unnecessary procedures, reduce medical errors, increase efficiency, and improve the quality of care. This data also can form the basis for publicly available health information about each health care provider so that patients can make informed choices.

Substantial cost containment is embodied in the NSBA Health Policy outlined above. Limits on the tax exclusion will drive individuals to become less dependent upon third-party payers in their medical transactions. More of a consumer-based market will develop for routine medical care, thereby putting downward pressure on both prices and utilization. Through both increased consumer awareness and specific quality-control methods, costs can be reined in and small businesses can get back to doing what they do best rather than searching for affordable health care: creating jobs.

**Targeted Solutions**

While we would argue that a comprehensive policy is truly the way to fix the health care market, we do realize that our plan is aggressive and would likely not happen over-night. In the mean-time, NSBA would support a series of more targeted solutions to provide some relief to small businesses and their employees.

After several years of relative stability on the health care front, the patch-work of 1990s reforms have begun to fray and come apart. Small employers are once again facing annual double-digit increases, the cost, control, and quality improvement promises of managed care have fallen short, and Congress is once again considering legislation that will make the situation far worse. To

compound matters, the recent recessionary environment ballooned the number of uninsured to a staggering 45 million.

Nearly every substantial reform that Congress has enacted on health care during the last decade has driven up health care costs and insurance premiums. Medicare reforms, insurance market reforms, mental health parity revisions—all have responded to some real problem, but they have all piled on new costs or shifted costs to the private sector. That being said, NSBA would like to highlight the important reforms made to Medical Savings Accounts through the creation of Health Savings Accounts (HSAs). HSAs respond to unfairness in our tax policy, and they also generate a level of "consumer behavior" that can provide a significant component of an over-all market-based cost containment strategy. However the creation of HSAs is just the beginning of many smaller, more targeted reforms that need to be addressed.

*Expansion of HSAs*

HSAs are tax-free savings accounts that people can set up when they purchase a high-deductible policy to cover major medical expenses. Money from the HSA can be used to pay for routine medical expenses or saved for future health needs, while the major medical policy helps cover big expenses, like hospital stays. Unlike MSAs, however, HSAs allow for both employer and employee annual contributions and unused funds to rollover. Individuals with an HSA can contribute up to 100 percent of the annual deductible of their health insurance program. HSAs also have lower minimum required deductible and out-of-pocket limits. Perhaps one of the most important changes from MSAs to HSAs is the fact that anyone can participate, there are no longer restrictive limits on the program.

While HSAs have been available for a little more than one year, there are still further actions Congress should take to expand the program. Individuals participating in an HSA should be allowed to deduct the premiums for the high-deductible health insurance policies from their taxable income in conjunction with an HSA. Increasing the tax benefit to these plans will increase affordability. NSBA also would support President Bush's proposal to help individuals and families who work for small businesses fund their HSAs. Under the proposal, small business owners would receive a tax credit on HSA contributions for the first $500 per worker with family coverage and the first $200 per worker with individual coverage.

*Pool Small Businesses Locally*

Encourage the development of local employer health care coalitions that would assist small employers in obtaining lower rates for coverage through group purchasing. Such coalitions also would assist small employers in learning about existing local health insurance plan options, how to be a wise health insurance purchaser, the issues of health care costs, health care quality and the availability of health care providers within their communities. Such local employer health care coalitions would continue to be subject to their respective state laws. Therefore, there would continue to be a level playing field for all employers providing insurance in the small employer market. These coalitions already exist in many states, providing choice and savings for their members every day

*Reform HRAs and FSAs*

In 2002, Bush highlighted Health Reimbursement Accounts (HRAs) which are similar to MSAs, but can only accept employer contributions, and employees cannot keep their excess funds. Though HSAs and HRAs are somewhat similar, HRA reform would also help those individuals seeking a low-deductible plan but would also like a savings account to help pay for medical costs. Reforming the HRA structure includes: allowing employees to contribute, allowing employees to roll excess funds into retirement plans, and, most importantly, allowing small business owners to participate. Like so-called cafeteria plans, HRAs specifically exclude owners of non-C Corporations from participating. This is a major obstacle that must be overcome if small companies are ever to take advantage of the potential of these plans.

On the subject of cafeteria plans (Section 125 plans), it should be noted that reforms of these plans also could be an important factor in increasing the ability of small business employees to fund various kinds of non-reimbursed care. Two major roadblocks are in the way. First, small business owners generally cannot participate in cafeteria plans. Second, these plans have annual "use-it-or-lose-it" provisions, which cause some to spend money that did not need to be spent, but cause many more to never contribute to the plan in the first place. Fixing these two mistakes would be a real benefit to small business employees struggling to meet their out-of-pocket medical bills.

*Create Health Insurance Tax Equity*

After 16 years of struggle and unfairness, small business owners were finally able to deduct all of their health insurance expenses against their income taxes in 2003. Unfortunately, we are still only part-way to real health insurance tax equity for small business. Except for business owners, workers are allowed to treat their contributions to health insurance premiums as "pre-tax." This distinction means that those premium payments are subject neither to income taxes, nor to FICA taxes. While the owner of a non-C Corporation can now deduct the full premium against income taxes, that entire premium is paid after FICA taxes. Compounding matters, these business owners pay both halves of the FICA taxes on their own income for a total Self Employment tax burden of 15.3 percent.

Right here in Washington, D.C., the cost of a Blue Cross/Blue Shield family policy in a small group plan has topped $12,000 per year. A business owner who makes $60,000 and purchases this plan for his or her family pays $2,000 in taxes on that policy. A worker who makes $60,000 and has the same plan pays nothing in taxes on that policy. By treating this business owner the same way that everyone else in this country is treated, we can give him or her a 15 percent discount on health insurance premiums.

*Reform the Medical Liability System*

The enormous costs of medical liability and the attending malpractice insurance premiums are a significant factor pushing health care costs higher and restricting choice and competition for

consumers of health care. Triple-digit increases in malpractice premiums over the last five years have been common in many states and specialties.

These costs have a distorting effect on the health care system by causing physicians to retire early, change their practices to serve lower-risk patients, move to states with reformed malpractice laws, and concentrate their practice in high-profit centers, making quality health in rural areas and smaller towns increasingly difficult to come by. All of these changes restrict competition and the ability of employers to negotiate lower reimbursement rates. But the most profound affect of the liability system is the "defensive medicine" that is practiced by many risk-averse providers. Unnecessary, purely defensive procedures, cost the health care system untold billions each year and drive up premiums for all of us.

Legislation introduced in the 108th Congress would have capped non-economic damages at $250,000. While many supported this, the legislation was stalemated in the Senate. In the 109th already, however the Senate GOP leadership has placed medical malpractice as one of their top priorities and the outlook is better than it was in the 108th. NSBA supports the elimination of junk lawsuits and reasonable caps as a means to slow the increasing costs we all pay.

*Pay-for-Performance*

NSBA is a strong advocate for pay-for-performance initiatives. One of the biggest usurpers of health care dollars is due to poor quality leading to further complications and cost. Quality health care is a major factor in reducing the cost of care, and providers must be compensated accordingly. The implementation of a third-party payer system has removed levels of accountability from all sectors of the current health care market where individuals, health providers and insurance companies have very different interests at heart. Individuals want ease and affordability, take very little responsibility in their care and do not generally make educated choices in terms of providers, procedures and costs.

NSBA strongly supports the Centers for Medicare and Medicaid Services (CMS) new pay for performance policy change. CMS has taken a lead in implementing policy changes that will increase the importance of quality care. Through their reimbursements, CMS will now be requiring hospitals to comply with certain quality standards. Those that do not will see a small percentage of their reimbursements withheld. This kind of thorough evaluating and monitoring of care is necessary in providing patients with the highest quality care possible.

*Improvements in Technology*

Improved and standardized technology is necessary to gauge provider quality and ensure simple mistakes are not made as rampantly. Individuals should all have a privately owned, portable electronic health record. This would enable individuals and their doctors to access the record without having to wrangle a massive paper trail.

The system currently used for prescriptions also is outdated. NSBA would urge the use of technological devices when issuing prescriptions in order to avoid costly and dangerous mistakes.

The medical industry will need to establish a set of protocols by which doctors, hospitals and other care-givers can be evaluated. Improved technology will help providers report on their compliance with these protocols. Such information should be made widely available to the consumers of health care.

*Protect the Small Employer Health Market from Gamesmanship*

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 ensured that small groups could not be denied coverage by any insurer offering small group coverage in their state. The federal law, however, does not ensure that this coverage would be affordable, though states generally have implemented "rate bands" that provide some upper limit on rate increases for particular groups.

The individual market, however, is generally free of the guaranteed issue requirements enacted by HIPAA. Only those who had other insurance within the previous six months would be free of exclusion. This difference in rules between the individual market and the small group market means that premiums for younger and healthier individuals are almost always lower in the individual market than in the small group market. The opposite is generally true for older and less healthy individuals: their premiums are less in the small group market than in the individual market. This dynamic understandably leads some employers to purchase less expensive individual coverage on behalf of their employees, when they can qualify for low rates. When significant illness occurs, the individual premium escalates sharply, and the business will often switch to a small group plan, where they must be accepted and where the premiums will be much lower.

While this entire process is perfectly rational from the employer's perspective, it forces small group premiums to be higher than they otherwise would be. We believe that premiums would be lower and overall access to health insurance higher if this practice were discouraged, perhaps through a surcharge when the business re-enters the small group market (much like the penalty for early withdrawal of IRAs). Another way would be to clarify that employer-paid premiums in the individual market are taxable to the employee.

*Help the Uninsured through Tax Credits and Current Programs*

Much of the question of adequate health insurance coverage is really a question of affordability. There is probably no more efficient way to provide public subsidies for health insurance than through a system of tax credits, scaled to income, and targeted at individuals, such as those proposals that the President has put on the table. Further expansions of Medicaid and SCHIP programs to serve uninsured populations should also be considered.

It is NSBA's philosophy that, while these piecemeal changes will have a very positive effect on small businesses, there ought to be a long term health market reform movement. A health care system that embraces individual choice, consumerism, recognition for quality services and affordability is paramount.

I would like to again thank you Chairwoman Snowe, Ranking Member Kerry for this great opportunity to speak with you on such an important and timely subject.

Chair SNOWE. Thank you. Thank you, Mr. Lindsay.

Obviously, we have heard a variety of views here this morning, or this afternoon now.

I am going to turn to Senator Burns for my turn because I know he has got other appointments and this has gone on longer than we anticipated, so Senator Burns, you may proceed.

Senator BURNS. I just have one question, and I just went through the testimony of just about all of you last evening. Let me ask Mr. Nichols, Mr. Morrison, and Mr. Lindsay, are all three of you proposing some sort of a taxpayer subsidy to take care of individual plans or group plans?

Mr. NICHOLS. Senator Burns, I think it is fair to say that if we are going to achieve significant expansion of health insurance coverage, we are going to have to have public monies. It is not our place to advocate that today. It is our place to tell you the implications of your choices. I will say I think that is where we will eventually head and that is what I would like to see.

What we are trying to do, I think, is indicate we share your goal. Your goal is to try to find a way to get small business much better access to the same kinds of coverage large businesses have, and we are simply trying to say, compared to AHPs, there are better alternatives and those alternatives include having all firms join together, have the same kind of rules apply inside a new pool as outside the pool, make sure the solvency stays where it is, and if you really want to expand coverage and you are ready to make that choice, then you can subsidize it with tax credits or whatever and we can help you design that, too.

Mr. MORRISON. Senator Burns, I think your question hits on one of the major issues that is key to providing more affordable insurance to more small businesses and their employees all across the country. Right now, as you know, 1-in-5 Montanans don't have any health insurance. That is about 170,000 of us. Most of those uninsureds want to provide insurance to their families and the employers want to provide it to their employees, but they can't find it at a level they can afford.

I had a conversation recently with a guy in Livingston who owned an auto mechanic garage, and I was there at the coffee shop and he came in. He was wearing his coveralls. He had grease still on his hand. He came down, taking a few minutes away from work, and he said, I am here because I want to provide health insurance to my employees. And I said, how much can you provide? How much can you pay? And he said, $100 a month. And I said, how much can they pay, and he said $50 a month each. For $150 a month each, they can't find a product, and so, therefore, they go bare.

Well, meanwhile in Montana, hospitals provide treatment to the uninsured to the tune of $100 million a year and we are leaving $7,000 per year on the table in that shop that wants to be going toward defraying that cost shifting, but it can't find a way to do it.

And so as we develop alternatives, both as State policymakers and Federal policymakers, the key, I think, is to provide access to health insurance that requires each individual and each employer

to pay as much of their fair share as they can afford to pay and then step up to the level of being insured.

Senator BURNS. In other words, you subscribe to a subsidized taxpayer subsidy.

Mr. MORRISON. Well, what we did in Montana, as you may know, with our State House Bill 667 is we provide tax credits, tax credits to small businesses that are currently insured with two to four employees. That allows them to defray on an annual basis the cost of their health insurance premiums, and then for businesses that are currently uninsured, we allow them to join a purchasing pool, and the purchasing pool has rates that are discounted, as well.

Now, that purchasing pool does receive some revenue from I–149, which is the tobacco tax initiative that the people of Montana enacted by a vote of over 60 percent of the people. It creates a special revenue account and some of that revenue goes in to helping provide that purchasing pool access at an affordable price to several thousand Montana small employers.

Senator BURNS. Has this plan passed, or is it pending?

Mr. MORRISON. This has been enacted by the legislature and it is pending signature by the Governor.

Senator BURNS. How long is that tobacco money going to last?

Mr. MORRISON. We don't know exactly how long it is going to last. We were pretty conservative in the way we set this up to make sure that we took account of the possibility of a significant decrease in the expected revenue over time.

Mr. LINDSAY. Senator, if I may, you asked the question of me, as well, and just to respond, I think that our view is that the only way we are going to fundamentally reform our health insurance system and be able to control costs is we have got to get everybody covered. And the question is, how do you do that if you are going to be covering very low-income individuals?

I would also comment that we already have substantial subsidies right now just in the form of the way our tax code works, and unfortunately, our tax code, because of the tax-favored nature of insurance, encourages people to buy greater and greater insurance coverage, more than they need, because it is tax-deductible. Our approach would limit that tax deduction and use the resulting tax dollars to subsidize those that are low-income.

Senator BURNS. Well, I am just looking at the possibility of no matter where the cost shifting happens, whether it happens at the hospital or at the doctor's office or the insurance companies, it happens. And so I just want to clear that up on where do you want to subsidize. Evidently, all three of you agree that that is the case.

Thank you very much, Madam Chair.

Chair SNOWE. Thank you, Senator Burns, and thank you for being here today and for your contributions. Sorry the hearing went so long.

But I think it illustrates how compelling this issue is and the problem, and it obviously does require a diverse approach. This is one such approach. I am interested in hearing the varied views represented here on the panel today and I would like to get to the heart of some of these issues for a moment, and I won't prolong it because I know it is late and I understand, Mr. Mansell, you have

an appointment. So I will finish up because Senator Kerry had a speech, so he had to leave.

You heard some of the comments here today, and we obviously have three panelists who are opposed and expressed concerns about the way in which Association Health Plans are structured, what is going to impact the State markets. Obviously, there is a significant problem.

Doug, you continue to provide insurance for your employees, much to your credit, given the soaring increases occurring in the State of Maine. It is a market dominated by one or two, maybe three carriers at best, but one predominately. That is true of many markets throughout the country. That is why you have seen so many—and because so many insurers have fled the small group markets, ultimately, you have been left with paying whatever costs are available for health insurance plans for your employees and for your families.

You have heard some of the concerns here today about the idea of Association Health Plans. Is there anything you want to address in respect to that, whether it is on the adverse selection, cherry-picking, the impact on the State market, risk pools, so on?

Mr. NEWMAN. I guess I would start off by saying that the one unacceptable course of action is the status quo. I talk to small businesses every day in my association with NFIB and ABC and other groups. I mean, I have run into hundreds of them in the course of various things and I agree with what everybody else said. Health insurance has overtaken workers' compensation, regulation, taxes, all the traditional issues we talk about. It has just overtaken them all by leaps and bounds.

What I think is needed to avert what could be a disaster, particularly in State Medicaid systems, is we need to get some relief focused and funneled to small businesses, the 10-, the 20-, the 30-person firms, as soon as possible, and the reason I was so anxious to come down here today was just to convey that thought, that it is getting dire out there and that my business and many other businesses like mine are literally on the verge of just saying, OK, we can't go on.

Health insurance is going to have to be one of the last checks I write, because I need health insurance to keep my employees. I don't know if I want to be in business. I don't want to be one of those businesses that doesn't offer health insurance.

So we need action and we need it very quickly, and I understand that Association Health Plans aren't the total solution. I tend to disagree with some of the theories put forth by other folks about cherry-picking. I think the real danger that is going on now is economic cherry-picking. Those people who are finding a way to make it happen and making it happen, those that just can't swing it anymore or can't get into the market are not doing it and that is putting a huge burden on States.

I think that NFIB, for example, an organization we are involved with that does great work for small business, there are no barriers to entry to NFIB. Another group, ABC, if you happen to be a contractor, you can join. The entry fees to these organizations are very, very modest. There are no barriers to entry. Anybody with one person or 50 could join NFIB tomorrow and your legislation

would require NFIB to offer them that rate. There wouldn't be that sort of cherry-picking. Every small business, essentially, in the country will be eligible for an Association Health Plan.

I think some of the other concerns, there might be some reasons why, but I think your legislation probably addresses some of those, as well.

But I think the most important thing to remember is that we are on the verge of a crisis out there. Seventy percent increases aren't sustainable. They are just literally not sustainable. And if we don't do something in the next year or two, I won't be offering health insurance. I know of dozens, if not hundreds, of other businesses that aren't going to be offering health insurance, and then where are we going to be? I don't think we have the time to go down a path of more comprehensive solutions. I think immediate action is needed, and I think this would provide immediate relief to a lot of small businesses and I don't think, personally, I don't think that the detriment that has been described by others would necessarily result.

Chair SNOWE. I appreciate your comments and I thank you for taking the time to fly down here and be here today.

You know, it is interesting, because I think we have to get to the real world solutions given the crisis that has surrounded small business regarding this particular issue that has emerged as the number one issue for a very good reason, if you look at that chart and what you are experiencing in your own world.

Mr. Mansell, you are saying your association would expand, is that the potential here?

Mr. MANSELL. No. No.

Chair SNOWE. No, not in terms of your members, but in terms of the ability to provide——

Mr. MANSELL. Well, actually, what our association would like the ability to do would be to group our people together and be able to purchase from an insurer, our current insurer.

Chair SNOWE. Right.

Mr. MANSELL. We are not interested necessarily in becoming an insurance company. That is not the direction our association is interested in. We are interested in being able to group purchase insurance at a better rate. We do not have a "cherry-picking problem." The association doesn't choose its members. They come to us basically through being hired at real estate companies and joining local boards and State associations and so forth.

Chair SNOWE. Well, how do they join your association? What questions do you ask, if any, other than paying dues?

Mr. MANSELL. The questions we ask is, are you licensed by the State, if there is a license law, and will you abide by the code of ethics of the National Association of Realtors. Other than that, you are in. It is not a real heavy entrance barrier for folks to get into the association. The ability for people to play with that, "cherry-pick," as it has been talked about here, in our association, that isn't even in the realm of possibility. We are not interested in this from a standpoint of generating revenues. We don't need the revenues. We need the insurance, and our association would act as a facilitator to get this done, not as somebody that is going to collect revenues.

Chair SNOWE. And that is one of the points in this legislation. But again, I am open to discussion on some of these questions. But on the reserve requirements, when we are talking about—Senator Kerry is referring to $2 million. Well, the reason for that is so there wouldn't be the ability to charge excessive premiums unnecessarily for the members.

Mr. MANSELL. Right.

Chair SNOWE. And so that is the reason for that cap. But again, we can look at that particular issue. But I thought it was compelling, what you had mentioned, that 77 percent of your realtors want to be able to participate. I mean, that, again, I think, speaks to the large question here that is at stake.

Mr. MANSELL. It is a very serious problem. The other part of our group who are insured are insured mainly on individual policies and the problem they have is that as soon as they have any sickness in their family, they get canceled. And so it is a real serious problem for our group, even those that are willing and able to purchase insurance. There are some serious barriers, and that is why grouping together would be so valuable for us.

Chair SNOWE. Mr. Haynes, you have heard some of the points that are mentioned, and I know you want to be able to—you had the experience, I gather, on a State-by-State basis, is that correct?

Mr. HAYNES. We are doing it today.

Chair SNOWE. You are doing it today?

Mr. HAYNES. For the big businesses in our association.

Chair SNOWE. I see.

Mr. HAYNES. The carrier is willing to go through all the hurdles and the administrative obstacles caused by complying, but the carrier will not, and we have not been able to find anyone who will accept in that program a bottler with less than 50 employees. In fact, everybody basically below about 125, they sort of push away and don't want to do. It is only the big businesses that they are willing to go through the State mandates because there is enough business there, there is enough revenue there to handle the administrative expenses.

The other thing, just a couple of points I might respond on. The mandate issue, the perception is that the problem with mandates is that we don't want to provide coverage for breast cancer screening or prostate cancer screening or something like that. Nothing could be further from the truth. We provided that when we had a small group program and we would provide it today. Our smaller bottlers want to provide health care benefits to their employees that are comparable to the larger bottlers. If they don't, they lose those people and lose their ability to survive.

The issue with the mandates is not an individual mandate or a couple of mandates, it is 50 different sets of mandates. It is simply the administrative burden associated with complying with all sorts of different requirements and preparing all the documentation, training all the people who have to understand what the mandate is in that State.

An example would be we have got, within our existing program, we have got somewhere in the range of six or seven different definitions of when a dependent must remain in the program because there are lots of different State rules on it. Some States say as long

as they are a full-time student. Some States say as long as they are a part-time student with X-numbers of hours. Some say until the age of 21 regardless of status. So if you have got 25 or 50 people that you are trying to add to a program from one of these smaller bottlers and there are four different definitions of dependent coverage, preparing all the documentation eats up the potential for including them in the program, so we can't get them in.

And a lot of the mandates—another one we have is we have got a program that basically encourages employees to order prescription drugs by mail order. Well, there are States that prohibit creating any sort of incentive for mail order pharmacy prescriptions. So we have got some States where we can do it and some States where we can't, which is different documentation, different training for the people who are handling the claims management.

We are able to do it as long as there is critical mass within an individual participant, but we simply can't extend it to the small businesses, which is the disparity issue that is really troubling.

Chair SNOWE. And what was the feedback from your membership, for example, on your plans in terms of—-because this whole race to the bottom, the idea there are going to be bare-bone plans and trying to get around State mandates. I mean, what was the feedback in terms of designing a plan that was good for your members?

Mr. HAYNES. When we had them in our plan, the plan for the small members was comparable to the plan for the big members, which was comparable to the plan for big Fortune 500 companies, really no material difference. They wanted a comparable plan as long as the cost was reasonable, and that is what they would like today. Today, they have less comprehensive plans at higher costs.

Chair SNOWE. I appreciate that.

Mr. Nichols, Mr. Morrison, and Mr. Lindsay, obviously, you are on the other side of the equation on this debate. You have heard the concerns here expressed today and some of the issues surrounding the desire to have this plan for small businesses as an option. I mean, frankly, insurers are leaving the States, I mean, leaving very few left. That is true in the State of Maine, for example, as Doug will tell you. There are very few carriers left to offer any competitive pricing for insurance plans. So ultimately, what is the State's responsibility in that sense?

The goal of AHPs isn't to circumvent and to get out from underneath the State mandates. The goal and desire is to have a plan to offer their employees, hopefully with many of the benefits that are now required under State law. But right now, given what is happening in Maine and elsewhere across the country is that these pools are diminishing to the point there is no competitive ability to leverage a reasonable price for these plans.

I mean, we have a dominant carrier, which we know is true. The Government Accountability Office issued a report several years ago and we know. I mean, we know what the largest carriers for small group markets in most of the markets across America. So it is either one to three, maybe five at best. So there is no leverage for pricing, and so hence the crisis that we are facing and the soaring premiums.

So what is the responsibility of the States? How do you get around this? How do you solve this problem now if you don't have $75 billion to address some of the other plans that we are talking about here today, or $18 million the first 5 years and well beyond that? Do you see what I mean? I mean, there are a lot of other issues we can address, but right now, this is an option, and you are hearing it from small business in the real world experience. So what do we do?

Mr. LINDSAY. Madam Chair.

Chair SNOWE. Yes.

Mr. LINDSAY. In response to your question, I think as you have just identified, the problem we have in America is not availability of insurance, because HIPAA provided that for small businesses. The problem we have is the cost of the insurance. And the key fundamental issue is going to be—and of course, the majority of small business members, if they were told that they could purchase into a pool would want to do it, but no one has told them yet what it would cost, and that is the ultimate issue.

And so the question is, how is an AHP going to lower the cost? The reason why most of us are so concerned about the issue of selection is that when you deal with health insurance premiums, you have very few options to control costs. The first is you get costs down by having positive selection. The people who buy your product are healthier than those who buy someone else's product. You do that by tiering your rates based on age, because if you are an association, you want to have people benefit from your program and so you are going to want to keep that rate low.

The second way is by the coverage that you offer. If you offer the most comprehensive plan, you are going to appeal to people who are going to use that comprehensive plan and it is going to raise the rates. There is no magic here.

And then the only other third way would be negotiating better deals with providers. As I have already mentioned in my testimony, provider discounts are local based on the number of people in that market who participate, and you are going to be competing with already large payers who are in that market and getting the best possible rate.

So my view is the concern about AHPs, and it is a noble attempt and it is a very important attempt to address a difficult problem, but it is the effect it is going to have on the rest of the market that is so disturbing. The concern that I have is the public policy impact on those people who are currently insured who are not association members or who have older, less healthier workers, because it is going to be those people who get cost shifted to.

Mr. MORRISON. Madam Chair, first, the pleas of the people on that side of the table are similar to the ones that I hear all over Montana. No question about the urgency of this problem. Things do need to be done.

We believe that AHPs are not likely to deliver the kind of relief that some other approaches are. An important thing to realize about AHPs is the way they deliver benefit to anyone is by segmenting the market. It is the only way that an AHP can deliver a benefit, because the benefit of pooling in terms of saving money comes in terms of negotiating deals with insurance companies, and

when you are not negotiating a deal with an insurance company, pooling does not bring down rates. It stabilizes rates, but it doesn't bring them down.

And so the only way an AHP member gets a lower rate is if they can break off with a group of people in some fashion that have lower medical costs. And so we insurance regulators oppose that because we believe that the people who break off and will have lower costs are going to wind up being a minority and a majority are going to wind up being stuck with premium increases.

Now, there are some very constructive things that we can do. Number one, taking that money off the sidelines that I described. All of those small businesses out there that are uninsured right now, half nationally, 60 percent in Montana, want to be contributing something. Let us find a way to allow them to contribute what they can toward the overall cost of delivering health care.

Number two, personal health issues, dealing with people taking charge of their own health and being accountable for their own health. We have seen health management programs in workplaces in Montana that have resulted in flat insurance premiums over time because they get people's cholesterol down, their blood pressure down, they get them to stop smoking, control their weight, and so forth, and these have a real effect on the need for health care.

Number three, utilization, which is closely tied with advertising. The commercialization of some of these health care products and services has resulted in higher utilization than we used to have historically.

And then finally, some of these issues that Senator Clinton and Senator Frist have taken up in terms of eliminating duplication and inefficiencies in the communication process and so forth. These present some real opportunities to actually bring down the cost of delivering health care here in the United States, which is what is going to ultimately bring down the cost of health insurance for small businesses.

Chair SNOWE. So how long should small businesses wait? I mean, I think that is the point: How long should small businesses wait when they are in the midst of a crisis that is only growing? Corporations and unions are allowed to be exempt from State mandates, and they offer the most generous plans. Nobody is saying, well, we ought to fold them back into the State risk pools. It is a question of having the leverage to purchase at better price that no one is helping small business out with right now.

I don't know. It seems to me this is a practical approach, because it costs little money. It actually reduces Medicaid costs to the States. It will increase the number of insured and it will give them the ability to have a plan for their employees that actually, according to the Congressional Budget Office, will reduce premium costs, costs to the employers, as well. It has been documented by CBO that it would bring down the costs, so it is a start.

It may not be everything. We can address some of the other issues. But I don't see—I am having a hard time figuring out what is exactly the problem here in terms of practical application of this issue in allowing associations—allowing small businesses to cross State lines, because that is what it is all about. It is not trying to

bypass what you do every day, Mr. Morrison. I think it is a question of how best we get at this particular problem that is really leaving small businesses on, as the President says, on an island unto themselves right now because there is no lifeline. So that is one of the problems that we are grappling with.

Mr. NICHOLS. If I could, Madam Chair, I think in the attempt to create a level playing field for small business vis-a-vis the large businesses and unions you talked about, the AHPs do that. But in doing so, they make the field unlevel vis-a-vis those insurance products that are still regulated and fully insured in that market. And so in an attempt to solve one problem, you kind of make the other part unlevel.

What I am worried about is not the intent or the actions of these individuals or the people who are going to set up Association Plans for trade associations. They are going to take care of their trade members because they have got lots of reasons to keep them there. I understand that.

What I am worried about is precisely, Madam Chair, the urgency of employers looking for the cheapest possible way for them to buy insurance. When they are low risk, they will find the NFIB product, the general product to which they can enter for $50, very attractive. When they are not, Madam Chair, they will find it less attractive. They will then come back to the fully-insured sector where all those benefit mandates exist and those prices are going to just go up and up and up and up, and that is what we are worried about, not the motives of these individuals but the way the search for lower cost will play out in a real marketplace. That is what we are scared of.

Chair SNOWE. It is just giving them the option, though. I mean, I guess I am not sure why—if it is not competitive, they won't join.

Mr. NICHOLS. They will join, Madam Chair. The issue is what happens to those who can't join or don't want to join or find that the price to them in these unregulated situations are less appealing than they looked when their workers were all healthy. That is the question.

Chair SNOWE. OK. Mr. Haynes, I will give you the last word.

Mr. HAYNES Can I respond to all three, but particularly to Mr. Nichols, because I think analytically he is right in the sense that if only some part of small business can benefit from AHPs, then you have to look at where everyone else is.

My view is that there are trade associations out there that will cover most, if not all, of the small business community. You have broad-based associations like NFIB that I believe can—I think most small businesses are part of some association that is going to pursue one of these plans.

And here is the other fundamental thing, and I think it is missing in what we have all said, including me, and I think the exception is Doug Newman, because he points out something that I think is very powerful in this which is the profit motive. It is not true that the only money that an association can bring to its members by getting involved in this comes from adverse selection. There is the possibility of lowering administrative costs through group purchasing, but there is something really powerful, which is the profitability of the private commercial small group carriers, the

people who are currently supplying small business, and the fact is that trade associations are almost universally non-profits and whatever money we are making, we are returning to our members.

The Blue Cross system in the United States, just from what I have looked at on the Internet last night, looks to be making maybe as much as $5 billion a year selling small group insurance. Now, I think they can withstand some competition and still serve the small group market. I think they could afford to lose some of their more profitable pieces of business and still very adequately serve the small group market.

And I think that is really the concern that Len expresses, which is really what I see as the most fundamental concern. I think that is the answer to that. I think the people who are writing small group insurance can continue to do it even if there is a small amount of adverse selection.

Mr. LINDSAY. Madam Chair.

Chair SNOWE. Yes.

Mr. LINDSAY. One question you have asked repeatedly is this whole question that if large business can do it, if unions can do it, why can't small business do it, and I think that is a part of this issue. And I think that is a worthy challenge.

But I think the only way that you have a level playing field in that sort of intellectual foray is that insurance has to be mandated. The problem is, if we have—just by way of example, 5,000 businesses each with ten employees in a pool, 50,000, from a risk profile standpoint, they don't operate the same way that a 50,000 single-employer business does. A single-employer business that buys insurance buys it unemotionally for everybody. The CFO makes a decision based on what is right for the company and what is realistic for the employees.

In the example I used with 5,000 businesses, they are going to make a decision based on what is in their enlightened self-interest. What is covered in the plan? How much are the rates? So each of those 5,000 units are going to make individual decisions.

So we don't have a level playing field in terms of the analogy of small businesses being able to operate like a big business. And as long as insurance is voluntary, that is the problem. If this body were to make a decision that insurance was required, then associations could be able to work because then everybody would be on a level playing field.

The challenge that insurance companies have, and I would argue associations have, is the risk profile of people who come to them. In the insurance business, we call it adverse selection, and it is that adverse selection that would be the concern.

So the only way for an association to protect its members, not to game its members but to protect them, would be to put up these kinds of safeguards, and what we are talking about is that those protections then unlevel the playing field, because in the traditional fully-insured market, you can't do that under State law. And so it is the unintended consequences that are the concern.

Chair SNOWE. OK.

Mr. MORRISON. If I could just add to that briefly——

Chair SNOWE. OK.

[Laughter.]

Mr. MORRISON. When you are dealing with 5,000 employers, it is going to be hard to save administrative costs the same way as if you have one employer with that many employees.

Chair SNOWE. You have had the experience. Do you agree?

Mr. HAYNES. Absolutely not. Our administrative costs are comparable. We have 6,000 people in our pool spread across 12 bottlers and our administrative costs are, as far as I know, comparable to our largest bottler, which has 77,000 employees.

Chair SNOWE. You know, it is interesting, because it does document that administrative costs will come down. I mean, that is the analysis that we have been given with respect to that, obviously, because it will have greater efficiency.

Yes, Doug.

Mr. NEWMAN. If I could just make one final comment.

Chair SNOWE. Well, it is only fair to give a Mainer the final word.

[Laughter.]

Mr. NEWMAN. On the issue of mandates, because I think it is something that we sort of forget, and that is why are small businesses seeking out this huge expense of offering health insurance to their employees, and I think that one of the best controls and mechanisms that is around that is going to protect employees on the issue of mandates is employers are buying health insurance because they are accountable to their employees. And if I went out tomorrow and bought a really lousy health insurance plan, believe me, I would pay the price for it.

I think few businesses are likely to go down that path because we are accountable every day. It is a benefit we are trying to offer because we are trying to compete. So I don't think that the issue of mandates is about trying to buy a bare-bones product to go out there and save a whole bunch of money because you are going to be shooting yourself in the foot with your employees.

I think the elimination of mandates does one very important thing, is allows for innovation. I only have one choice a year in my health insurance. I might get two quotes, but it is the same choice for the same product. Everybody would agree on this panel that what we need to do in health insurance is create some innovation, try some new ideas, and get some personal accountability out there, and eliminating the mandates allows for that.

Chair SNOWE. Well, thank you all. Thank you, Doug. Thank you very much for being here and your willingness to testify and for your patience and endurance here today, for the hearing going much longer. But, you know, frankly, I thought it was very helpful to the discussion and I was actually very encouraged by some of the issues raised today and by Senator Kerry, Senator Burns, and others that hopefully will advance this debate and ultimately to reach some real concrete resolutions.

So thank you all very much, and the record for this hearing will remain open for an additional 2 weeks, until noon on May 4, for the submission of any additional testimony.

This hearing is adjourned. Thank you.

[Whereupon, at 1:29 p.m., the hearing was adjourned.]

# FOR THE RECORD

Air Conditioning Contractors of America

2800 Shirlington Road · Arlington, VA 22206 · (703) 575-4477 · Fax: (703) 575-4449

# TESTIMONY FOR THE RECORD ON HELPING SMALL BUSINESSES PROVIDE HEALTH COVERAGE AND LOWER COSTS

## BEFORE THE SENATE SMALL BUSINESS AND ENTREPRENEURSHIP COMMITTEE

## SUBMITTED BY GREG LEISGANG, CHAIRMAN AIR CONDITIONING CONTRACTORS OF AMERICA

## APRIL 20, 2005

Chairwoman Snowe and members of the Senate Small Business and Entrepreneurship Committee, on behalf of the Air Conditioning Contractors of America (ACCA), I ask that you please add our comments to the hearing record of April 20, 2005. ACCA is the national non-profit trade association that represents the educational, policy, and technical interests of the men and women who design, install, and maintain indoor environmental systems. We have over 50 federated chapters with over 4,000 local, state, and national members. In addition to being Chairman of the Board for ACCA, I am the owner of JonLe Heating and Cooling based in Cincinnati, Ohio. We strongly urge the Congress to adopt legislation providing for federally sanctioned Association Health Plans (AHPs).

By most estimates, approximately 45 million Americans are currently without health insurance. Of that figure, over 60% reside in a family where the head of the household is employed by a small business. AHPs would allow our small community-based contractors to pool their coverage in the same fashion as large and medium-sized companies. By passing legislation expanding the use of AHPs, your committee and this Congress can go a long way towards providing health insurance to millions of uninsured Americans.

The rising cost of health insurance is a major concern for our small business members. In a nationwide survey conducted last year our contractor members report that their health insurance premiums have increased steadily, with some contractors reporting increases of 20% and higher in their health insurance premiums in 2004. This underscores the point that under the current system, many small businesses cannot afford health coverage for their employees. This rapid rise of health care costs has priced insurance premiums beyond their reach. To make matters worse, the number of insurers that serve the small business market continues to dwindle.

When you consider that small firms pay on average 18% more for health insurance than a medium-sized company, this level of savings would help reduce the cost gap currently driving small business out of the market. For over 25 years, large and medium sized multi-state companies have been able to provide group health coverage for their employees under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA has helped drive down health care costs while still providing universal coverage for their employees. Today, over 115 million Americans are covered by ERISA plans.

In my capacity as Chairman of ACCA, I have heard over and over the commitment and desire our contractors have to providing health care insurance for their employees. In some cases, rising costs forced contractors to reduce coverage from the entire family to just the employee. As costs continue to rise, they are now faced with requiring employee participation for their individual coverage or not offering medical coverage entirely. In our most recent survey, 56% of our respondents reported lowering available health benefits in 2004 in response to the growing health insurance premiums.

Passing AHP legislation will immediately reduce the pressure on government sponsored programs, provide access to quality health care for millions of underserved Americans, and increase the overall revenue dollars that flow to the private insurance sector — all at no cost to the government (taxpayer). If you consider the number of people who would move from public health care to private health care, this could actually save the government a great deal. This proposed legislation is truly a win-win situation for small business owners as well as the U.S taxpayer.

Thank you for the opportunity to add our comments on this very important issue.

April 19, 2005

The Honorable Olympia Snowe, Chairwoman
Senate Committee on Small Business and Entrepreneurship
428A Russell Senate Office Building
Washington, DC 20510

Dear Chairwoman Snowe:

We, the undersigned health professional organizations, write to express strong concerns with the ***"Small Business Health Fairness Act of 2005 (S.406)"***, which would exempt association health plans (AHPs) from state regulation and oversight. While we understand and support the need to improve access to health care services, we feel strongly that preempting the authority of the states to regulate the delivery of health care services is not the answer to the problem.

AHPs are not a solution to the access and affordability problems facing small employers and their employees. In fact, we believe AHPs make the current problem even worse – resulting in higher premiums and less secure coverage for millions of workers employed by small businesses across the nation. In fact, the Congressional Budget Office (CBO) found that AHP legislation would trigger premium increases for 75 percent of small employers – representing over 20 million workers and dependents.

In addition to being health care professionals delivering critical services, some of our members own and operate small businesses. As small business owners, we see the value in local control of health care delivery, to include appropriate regulation of the insurance market and access to health care services. We urge the Congress to look at alternatives to AHPs that can have an immediate impact on access to health care services and health care insurance products.

Governors and state legislatures have done tremendous work to improve the quality of health care services the public can expect to receive today. We ask you to maintain the primary role states play in helping determine the appropriate delivery of quality health care services in the United States.

Thank you for your consideration of these views. For additional information, please feel free to contact Patrick Cooney at (703) 769-0020.

Sincerely,

***American Chiropractic Association***

***American College of Nurse-Midwives***

***American Podiatric Medical Association***

***American Psychological Association***

PRESS RELEASE

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**FOR IMMEDIATE RELEASE**

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**ORGANIZATIONS ENDORSE SIMPLE CAFETERIA PLAN LEGISLATION**

April 20, 2005 - *(Arlington, Va.)* – The Small Business Council of America (SBCA), the American Society of Pension Professional & Actuaries (ASPPA), the Small Business Legislative Council (SBLC) and the Employers Council on Flexible Compensation (ECFC) submitted comments today to a hearing held by the Senate Committee on Small Business and Entrepreneurship entitled: "Solving the Small Business Health Care Crisis: Alternatives for Lowering Costs and Covering the Uninsured." In their comments, the organizations strongly endorsed S. 723, the SIMPLE Cafeteria Plan Act of 2005, introduced by the Senate Small Business and Entrepreneurship Chair, Olympia Snowe (R-ME), and co-sponsored by Senators Kit Bond (R-MO) and Jeff Bingaman (D-NM).

"We applaud the efforts of Senators Snowe, Bingaman and Bond to enable the purchase of health insurance and other employee benefits by small business employees through a tax-qualified vehicle. The SIMPLE Cafeteria Plan will allow small businesses to offer the same health insurance and savings options currently available to employees of large companies and government agencies," said Brian Graff, Executive Director/CEO of ASPPA.

Paula Calimafde, Chair, SBCA, explained that "this bipartisan legislation would amend the tax code so that owners of small businesses, including sole proprietors, partners and all S-corporation stockholders, could participate in a cafeteria plan if they work in the business. This bill would enable them and their non-owner employees to be able to purchase employer-provided health insurance and other benefits with pre-tax dollars."

In addition, the measure would allow cafeteria plans to offer long term care insurance as an optional benefit. It would also permit the carryover of unused flexible spending accounts funds, as well as simplifying and increasing dependent care accounts for employers of all sizes. It also eliminates the despised "use it or lose it" rule, which causes employees to have their own salary revert back to their employer if they do not spend as much money on medical

care as they had anticipated. In effect, instead of being rewarded for being healthy (as is true with the Health Savings Accounts), the current rule causes employees to forfeit their own dollars to their employers because they did not need to spend those dollars on health care.

This legislation is important for all employees, but in particular for small business employees. This legislation will make it far easier for small business employees to be covered by a cafeteria plan so that they will be able to select the benefits that they need most in the same way that employees for mid- and large-sized businesses are currently able to do. Even more important, by giving the small business owners an incentive to sponsor cafeteria plans, this legislation will go a long way in helping small business employees afford health insurance.

"Small business employees are in need of access to health care in a cost effective manner. Congress understands how vital health care is for our citizens and has decided that individuals should be incentivized to undertake as much of the burden of providing for this health care as possible. S. 723 does this—small business employees would now be able to join their counterparts in mid- and large-sized businesses and save for health care and other employee benefits in a tax advantaged manner," said John Satagaj, President of SBLC.

A cafeteria plan is a flexible spending account created by section 125 of the Internal Revenue Code (IRC) that allows participants to pay their health insurance premiums and other employee benefit expenses through a tax-qualified plan. S. 723 would enable small business owners and their employees to be able to purchase employer-provided health insurance and other benefits with pretax dollars. It is a very popular plan with employees of mid- and large-sized businesses and of the federal government. Because of technical tax provisions which prevent small business owners from participating in the plan, it is seldom offered by small businesses.

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*For additional information about these organizations, please visit the following websites:*

*SBCA at www.sbca.net*
*ASPPA at www.asppa.org*
*SBLC at www.sblc.org*
*ECFC at www.ecfc.org*

# Comments Submitted to the Senate Committee on Small Business and Entrepreneurship

## Hearing on

## Solving the Small Business Health Care Crisis: Alternatives for Lowering Costs and Covering the Uninsured

**On Behalf of**

**The Small Business Council of America (SBCA)**

**The American Society of Pension Professionals & Actuaries (ASPPA)**

**The Small Business Legislative Council (SBLC)**

**The Employers Council on Flexible Compensation (ECFC)**

**April 20, 2005**

The Small Business Council of America (SBCA) is a national nonprofit organization that represents the interests of privately-held and family-owned businesses on federal tax, health care and employee benefit matters. The SBCA, through its members, represents well over 20,000 enterprises in retail, manufacturing and service industries, virtually all of which are stable small businesses that provide health insurance and retirement plans for their employees. The SBCA is fortunate to have the leading small business advisors in the country on its Advisory Boards.

The American Society of Pension Professionals & Actuaries (ASPPA) is a national society of retirement plan professionals. ASPPA's mission is to educate pension professionals and to preserve and enhance the private pension system. Its membership consists of more than 5,500 actuaries, plan administrators, attorneys, CPAs and other retirement plan experts who design, implement and maintain qualified retirement plans, especially for small to mid-size employers.

The Small Business Legislative Council (SBLC) is a permanent, independent coalition of over 60 trade and professional associations that share a common commitment to the future of small business. SBLC's members represent the interests of small businesses in such diverse economic sectors as manufacturing, retailing, distribution, professional and technical services, construction, transportation and agriculture. SBLC's policies are developed through a consensus among their membership.

The Employers Council on Flexible Compensation (ECFC) is a non-profit trade association committed to the study and promotion of defined contribution plans, 401(k) plans, cafeteria plans and elective compensation plans. Approximately 20 million Americans receive flexible benefits from the more than 2,800 ECFC members. Members are plan sponsors, corporations, governments, unions, universities and hospitals, as well as leading actuarial, administration, consulting, insurance and accounting firms that design and administer flexible benefit plans. Founded in 1981 by Fortune 500 corporations, Council members have great experience in designing and administering compensation and benefit programs that offer flexibility for employers and employees.

SBCA, ASPPA, SBLC and ECFC strongly endorse S. 723, the SIMPLE Cafeteria Plan Act of 2005, introduced by the Senate Small Business and Entrepreneurship Chair, Olympia Snowe (R-ME), and co-sponsored by Senators. Kit Bond (R-MO) and Jeff Bingaman (D-NM). We applaud their efforts to enable small business employees to purchase health insurance and other employee benefits through a tax-qualified vehicle. SBCA, ASPPA, SBLC and ECFC are in full agreement with Senator Snowe's comment: "It is unconscionable for Congress to do nothing while more and more Americans find themselves without health insurance. Establishing a SIMPLE Cafeteria Plan for small businesses will help them offer the same health insurance and savings options currently available to employees of large companies and government agencies."

This bipartisan legislation would enable small business owners and their employees to be able to purchase employer-provided health insurance and other benefits with pretax dollars. Specifically, it would amend the tax code so that owners of small

businesses, including partners and S-corporation stockholders who own more than 2 percent of the stock, could participate in a cafeteria plan if they worked in the business. They are excluded under current tax law because they are not "employees," even if working full-time, but rather are self-employed individuals and thus ineligible by definition. This bill, if passed, would enable them and their non-owner employees to be able to purchase employer-provided health insurance with pretax dollars. A cafeteria plan is a flexible spending account created by section 125 of the Internal Revenue Code (IRC) that allows participants to pay their health insurance premiums and other employee benefit expenses through a tax-qualified plan.

Modeled after the effective 1996 Savings Incentive Match Plan for Employees (SIMPLE) pension plan, the new SIMPLE Cafeteria Plan would allow most small businesses, many of whom are currently unable to satisfy the existing nondiscrimination cafeteria plan rules due to their size. The new SIMPLE Cafeteria Plan would provide a safe harbor for satisfying the nondiscrimination rules, in exchange for making a required annual contribution of 2 percent or a matching contribution of 3 percent to their employees' accounts for health insurance and other employee benefits. These plans are highly valued by employees for their pre-tax allowance.

The measure would also permit the carryover of unused flexible spending accounts funds, as well as simplifying and increasing dependent care accounts for employers of all sizes. It would also allow cafeteria plans to offer long-term care insurance as an optional benefit for the employees to select. It eliminates the despised "use it or lose it" rule, which causes employees to have their own salary revert back to their employer if they do not spend as much money on medical care as they had anticipated. In effect, instead of being rewarded for being healthy (as is true with the Health Savings Accounts), the current rule causes employees to forfeit their own dollars to their employers because they did not need to spend those dollars on health care.

This bill has been over four years in fruition. In addition to SBCA, ASPPA, SBLC and ECFC, the U.S. Chamber of Commerce, the National Federation of Independent Businesses (NFIB), the National Small Business Association (NSBA) and others have worked to help the Small Business Committee develop this measure.

This legislation is important for all employees, but in particular for small business employees. This legislation will make it far easier for small business employees to be covered by a cafeteria plan the same way that employees for mid- and large-size businesses are currently able to do, so that small business employees will be able to select the benefits that they need most. Even more important, by giving the small business owners an incentive to sponsor cafeteria plans, this legislation will go a long way in helping small business employees afford health insurance.

- **Employees of big businesses, mid-size employers, non-profits, schools, universities and the federal government appreciate the valuable benefits provided by cafeteria plans. Cafeteria plans allow workers to obtain and choose employee benefits that are tailored to their needs in a tax-advantaged manner.** Cafeteria plans allow employees to pay their portion of

health insurance on a pre-tax basis. They allow employees' payroll deductions to pay for their deductibles, co-pays, drugs, braces, eyeglasses, and other health care expenses, as well as dependent care, disability insurance and term life insurance. Workers are able to select the benefits that they need most and are able to save for these expenses by electing to have funds removed from their paychecks. This is the easiest way for employees to save for these necessary expenditures—note the dramatic success of employees saving for their retirement through 401(k) plans. **It is clear that cafeteria plans offer a successful approach to encourage employee participation in healthcare costs.**

- **Small businesses are at a double disadvantage when it comes to offering health care and other employee benefits to their employees. Their health care insurance premiums are higher because small businesses lack the bargaining power of larger businesses. Because most small businesses do not offer cafeteria plans, small business employees are not able to pay for their health care and other benefit expenditures on a pre-tax basis.**

- **Employees of small businesses are seldom offered this valuable benefit because many small business owners are precluded from participating in a cafeteria plan. Small business owners who operate in any entity other than a C Corp (or those that own less than 2 percent in a Sub-S corp) are not allowed to be covered by a cafeteria plan.** When small business owners cannot take advantage of the benefits offered by a cafeteria plan, they seldom have any interest in sponsoring such a plan. Even for those small business owners that are allowed to participate (e.g., a less than 2 percent stockholder in an S Corp or an owner in a C Corp), the existing nondiscrimination rules effectively preclude the owners from being able to use the plan except for de minimis amounts. Again, if the owners of a small business cannot benefit from the plan to a meaningful degree, it is not likely to be offered.

- **The legislation would create a safe-harbor cafeteria plan that would be modeled after the successful SIMPLE retirement plan model.** If a small business contributes a safe harbor contribution of 2 percent or matches employee contributions up to 3 percent of the employee's compensation, then in exchange for this required contribution, none of the nondiscrimination tests applicable to cafeteria plans and dependent care plans would apply.

- **This legislation would provide small business employees access to cost savings.** The SIMPLE retirement plan has demonstrated that small businesses are willing to absorb some additional cost for employees through contributions in exchange for relief from complex administration and discrimination tests. It is anticipated that the safe-harbor cafeteria plan patterned on the SIMPLE retirement plan would also be accepted and

adopted by small business. **Millions more small business employees would be likely to have health care insurance through the SIMPLE Cafeteria Plan, with some portion of the premium paid for by the employer and the remainder being paid for by the employee. Small business employees would also be able to select from other benefits that are most needed.** Congress has already decided that the SIMPLE plan provides sufficient benefits for the non-owner employees to justify the contributions for the owners—this SIMPLE Cafeteria Plan is patterned on the SIMPLE model and can bring valuable employee benefits, most importantly health insurance to small business employees.

- **The proposed legislation would allow cafeteria plans to provide employees with long-term care insurance.** Presently this valuable employee benefit is not allowed to be offered by a cafeteria plan. By allowing employees to purchase this valuable benefit on a pre-tax basis by payroll deduction, it is far more likely that employees will elect long-term care coverage. **This change would encourage more employees to finance their own long-term care, which shifts more of the burden of providing for the long-term care needs to individuals rather than the government.**

- **The proposed legislation would do away with the despised "use it or lose it" policy now applicable to flexible health care accounts.** If an employee has overestimated the amount of health care expenditures that he or she will have to pay during the year (over and above those paid by health insurance), then the excess amount is forfeited to the employer. Employers are currently prohibited from bonusing this amount back to the employee. Some employers apply these forfeited amounts to benefits for all the employees in the following year, but there is no requirement that they do so. Theoretically, the policy behind this unpopular rule created by the IRS was to make the flexible health care account more like an insurance policy. It is hard to imagine any insurance policy being purchased where the risk is limited to the amount of "premiums" paid and the "insureds" forfeit their own money if they cannot come up with enough expenses. Thus, comparing the "use it or lose it" rule of a medical reimbursement account under a flexible spending arrangement to health insurance (or any other kind of insurance) is unreasonable. The use it or lose it concept is unfair to employees and runs counter to public policy inasmuch as employees generally will not save as much as they are able to pay for health care expenditures because they are fearful of forfeiting their own money (their savings for health care expenditures) to their employer.

- **This legislation would change the nature of the health care flexible spending account to a reimbursement account so that it is similar to the dependent care account (the difference being that a cafeteria plan may reimburse the full elected amount during the year, while a**

**dependent care may only reimburse the account balance). The legislation would also cap the amount of the health care flexible spending account as dependent care accounts are capped. Similar to the President's proposal, the legislation would allow any funds left over in the health or dependent care flexible spending account at the end of the year to be rolled over to a 401(k) account (or other qualified retirement plan vehicle), an HSA or carried over to the next year.** Finally, employees terminating employment would be permitted to cash out their accounts, though doing so would subject the distribution to income tax.

- **These changes would encourage employees to select the appropriate amount required for health care expenditures rather than possibly choosing to estimate low so that they do not forfeit their own money to their employer. This would assist employees in dealing with rising health care costs and provide a vehicle for employees to save for these expenditures in a tax-free manner.**

- **The legislation would revise the discrimination tests applicable to the dependent care flexible spending account to enable all employees to use the benefit. The dollar amount would be increased to take into account today's cost of providing care for dependents.**

Small business employees are in need of access to health care in a cost effective manner. Congress understands how vital health care is for our citizens and has decided that individuals should be incentivized to undertake as much of the burden of providing for this health care as possible. S. 723 does this—small business employees would now be able to join their counterparts in mid-size and large businesses and save for health care and other employee benefits in a tax advantaged manner. Furthermore, all employees, regardless of the size of the entity they work for, should be able to have access to the same benefits under the tax code. Also, the initial cost of providing access to long-term care insurance in a tax advantaged manner is outweighed by employees taking ownership of the problem and financing their own long-term care. When it comes to health care the primary issue should not be short-term loss of revenue, but access to quality health care at the most reasonable price possible for the largest number of Americans possible.

Interestingly, this revenue argument is being advanced by a number of Senators in conjunction with contemplating the repeal of estate taxes—something that not only will hurt a great number of small businesses because of the loss of the step-up in basis but will also be a huge revenue drain on the country. If we have the funds to assist roughly 0.3 percent of the individuals in the country (this translates to 8,500 people) to leave enormous wealth to their families, then surely there must be money to help millions and millions of small business employees to gain access to health care insurance and other needed employee benefits.

*For additional information, please contact:*

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# Statement of Associated Builders and Contractors

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**Helping Small Businesses Provide Health Coverage and Lower Costs**

**Before the**
**Senate Committee on Small Business & Entrepreneurship**
**United States Senate**

**April 20, 2005**

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**THE VOICE OF THE MERIT SHOP™**

4250 North Fairfax Drive, 9th Floor
Arlington, VA 22203
703.812.2000 • www.abc.org

Associated Builders and Contractors (ABC) appreciates the opportunity to submit the following statement for the official record. We thank Chairwoman Olympia Snowe (R-ME), Ranking Member John Kerry (D-MA) and the members of the Senate Committee on Small Business and Entrepreneurship for addressing the problems that small businesses face today in providing quality health insurance for themselves and their employees.

ABC is especially proud to welcome Doug Newman, President of Newman Concrete Servies Inc, of Hallowell, Maine to Capitol Hill. Newman Concrete Services, an active member of ABC's Maine Chapter, has built a solid reputation for construction excellence and treating employees fairly. As a small business owner providing health care benefits to his employees, Doug has experienced firsthand the affordability crisis in Maine's health insurance market. Since founding Newman Concrete Services in 1996, Doug has built the firm into Maine's largest concrete contracting company with 50 full-time employees doing approximately $3.5 million in work annually.

ABC is a national trade association representing over 23,000 general contractors, subcontractors, material suppliers, and related firms from across the country and from all specialties in the construction industry in a network of 79 state chapters. Our diverse membership is bound by a shared commitment to the merit shop philosophy of awarding construction contracts to the lowest responsible bidder, regardless of labor affiliation, through open and competitive bidding. With more than 80 percent of construction today performed by merit shop contractors, ABC is proud to be their voice.

The construction industry, which represents close to 12 percent of the Gross National Product and 9 percent of the Gross Domestic Product, is an industry of small businesses, as 94% of all construction companies are privately held and the vast majority of construction companies are not incorporated. As the nation's second largest employer with nearly 7 million workers, the construction industry continues to create new and lucrative jobs each year. For every $1 million spent in construction, $3 million in economic activity is generated and 13 new permanent jobs are created.

A recent study conducted by the Construction Labor Research Council found that over the next ten years the construction industry will need an average of 185,000 new workers annually in order to meet its expected growth pattern. An additional 95,000 workers annually will be needed to replace current industry workers who are expected to retire during the next ten years. One of the key elements to attracting and retaining workers and remaining competitive in any industry is to provide high quality, flexible health benefit plans. Maintaining cost effective health insurance plans is a key ingredient in achieving this objective.

***The Associated Builders and Contractors - Association Health Plan***

Providing quality health care benefits has always been a top priority for ABC and its members. ABC operated an Association Health Plan (AHP) for nearly 43 years through the ABC Insurance Trust. Because of overwhelming costs of complying with overlapping, inconsistent and often incompatible state laws, our health insurance carrier was forced to drop their AHP coverage. Today, ABC continues to provide a full array of insurance benefits, but has been forced to work with multiple health insurance providers. ABC now serves as a broker, providing our membership with the most competitive carriers and rates in their area. ABC is a perfect example of how a trade or professional association, serving as a purchasing pool for employers, can have a significant impact upon the small employer health insurance market in both price and design.

The ABC Insurance Trust was founded in 1957 by five contractors who could not buy group health insurance for their employees in the open market due to their size. Until 1999, the ABC Insurance Trust served as a voluntary purchasing pool for members of the association. An important component of the plan's long-term success was that it was guided by contractor members who serve as trustees. As participants in the program, they acted in the best interest of their fellow members and their employees. Participation by the board of trustees is a key ingredient in aggregating the voice of employers to negotiate price and coverage with insurance carriers and other providers.

ABC's Association Health Plan program offered HMOs, PPOs, and traditional health insurance plans. All of ABC's plans provided wellness benefits with coverage for physicals and annual check ups. ABC continues to offer dental coverage, group life insurance, and disability programs to serve members of the association. A majority of those covered work for small construction firms with 10-20 employees.

ABC's Insurance Trust operates in full compliance with the Employee Retirement Income Security Act (ERISA) of 1974 reporting requirements, with the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 and with the Health Insurance Portability and Accountability Act (HIPPA) of 1996. Complying with the federal HIPPA legislation requires ABC and other associations to provide open access to all members and provide credit for prior coverage. In fact, Association Health Plans are specifically referenced and defined in the HIPPA legislation and are required to take all members under HIPPA guidelines.

Similar to the plans offered by large employers and unions, AHPs could provide economies of scale for small businesses in numerous areas. The ABC plan, which operated nationally, had total expenses of 13 ½ cents (13.5%) for every dollar of premium. These costs included all marketing, administration, insurance company risk,

claim payment expenses and state premium taxes. Alternatively, small employers who purchase coverage directly from an insurance company can experience total expenses of 35 cents (35%) for every dollar of premium or more. It stands to reason that small businesses that purchase coverage through an Association Health Plan can expect to save 15 to 20 percent, or more. Another component in the AHP is that any profit margin generated by the health plan in a given year does not go to the stockholders of the insurance company, rather they stay in the plan and inure to the benefit of participants by keeping costs lower in the future.

Bonafide trade associations like ABC have an established infrastructure that allows them to communicate with members more effectively because of their pre-established relationship. This allows associations and trade groups to provide employers with unique plan designs. This is a very valuable option for member companies of ABC in that it provides additional benefits over and above what many insurance vendors provide today. ABC has successfully tailored the products and services specifically for the needs of ABC contractor members. For example, all medical plans offered through the ABC Insurance Trust also provided vision coverage, which included coverage for safety glasses, an item unique to the construction industry.

***The Problem***

The health benefit programs offered by ABC are consistent with Congress' goal of meeting consumer demands for expanded benefits by providing high quality health benefit options. One of the principle reasons for Congress's enactment of the Employee Retirement Income Security Act of 1974 was to foster the growth of employee benefit plans by promoting uniform federal regulation of those plans.

However, despite the great need for increased health coverage and our members ability to deliver it, increasing federal and state regulations has not always had the positive impact that they purport for small employers. Conversely, it actually obstructs the development of innovative and effective health benefit programs.

A number of state reforms, such as those enacted in Maryland, have actually forced ABC to increase rates and reduce benefits in order to comply with the law. State health insurance reforms and community rating in New York forced ABC's insurance carrier to completely withdraw from the market for employers with less than 50 employees. When these and other state reforms occur, small employers are left with fewer alternatives for health insurance coverage for themselves and their employees.

Recent mergers of health insurance companies have also reduced competition and alternatives for employers who seek access to quality and affordable health insurance.

Today, there is a great need to bring more competition back into the system rather than continually reducing it.

***The Solution***

ABC strongly supports extending ERISA preemption of costly state mandated benefits currently available for larger, self-insured plans to bona fide association health plans and professional societies for small businesses. Without the benefit of ERISA's nationally uniform standards, many of the most creative, innovative and cost-effective employer-sponsored health benefit plans could not continue to exist because of the overwhelming costs of complying with overlapping, inconsistent and incompatible state laws.

Now more than ever, Congress needs to pass legislation that would extend the time-tested ERISA preemption to bona-fide trade associations. ABC strongly supports S.406, the "Small Business Health Fairness Act of 2005"and thanks Senate Small Business Committee Chair Olympia Snowe (R-ME) for taking the lead in sponsoring this vital legislation. The House companion measure (H.R. 525) is bipartisanly sponsored by Congressman Sam Johnson (R-TX), Small Business Committee Ranking Member Nydia Velazquez (D-NY), Education and Workforce Chairman John Boehner (R-OH) and Congressman Al Wynn (D-MD).

In conclusion, Association Health Plans provide affordable health coverage to small businesses, and extend coverage to uninsured people. While AHPs are not the only solution to America's health care crisis, AHPs are an essential component of the solution. AHPs are important for many working families employed in small businesses who otherwise could not afford coverage. Passage of the Small Business Health Fairness Act of 2005 will ensure that employees of small businesses receive the affordable, high quality health care coverage they both need and deserve.

ABC appreciates this opportunity to submit comments on an issue of great importance to our membership and small business owners across the country. We look forward to continuing a constructive dialogue on how to increase access to affordable and competitive health insurance for small businesses. ABC thanks Chairwoman Snowe and Ranking Member Kerry for their pragmatic leadership in addressing the health care concerns of our nation's small businesses.

# ***MEDIA ADVISORY***

## ASSOCIATION HEALTH PLANS

ABC TO TESTIFY AT TWO SENATE HEARINGS ON ASSOCIATION HEALTH PLAN LEGISLATION, WED. APRIL 20 AND THURS. APRIL 21

Contact: Gail Raiman, (703) 812-2073
Scott Brown, (703) 812-2062
Peter Mason, (703) 812-2069

For Immediate Release
April 18, 2005

WASHINGTON, DC – Associated Builders and Contractors (ABC), one of the nation's leading experts on Association Health Plan (AHP) legislation, will testify at two separate U.S. Senate hearings in favor of AHPs – Wed. April 20 and Thurs. April 21. ABC strongly supports Senate passage of S. 406, the Small Business Health Fairness Act of 2005, legislation introduced Feb. 17 by Sen. Olympia Snowe (R-Maine).

**Wednesday, April 20**

What: ABC testimony before the U.S. Senate Small Business and Entrepreneurship Committee on AHP legislation, S. 406.

Where: 428 Russell Senate Office Building

When: 10 a.m., Wed. April 20, 2005

Who: Doug Newman, president of Newman Concrete Services, Inc., Hallowell, Maine, a member of ABC's Maine chapter.

**Thursday, April 21**

What: ABC testimony before the full U.S. Senate Health, Education, Labor and Pensions Committee on AHP legislation, S. 406.

Where: 430 Dirksen Senate Office Building

When: 10 a.m., Thurs. April 21, 2005

Who: Joe Rossmann, ABC vice president of insurance, who has managed ABC's health benefits programs for more than 17 years. ABC is one of the nation's most experienced associations on AHPs, having provided association health benefits programs since 1957.

-more-

**ABC Media Advisory, Association Health Plans**
**Page Two**

ABC established its association health benefits plan in 1957 and through the years offered traditional health insurance plans, HMOs and PPOs to its members, many of whom were small business owners who would otherwise not be able to afford health insurance coverage for their employees. But in 2001, ABC was forced to discontinue the health insurance portion of its plan when ABC's insurance carrier terminated coverage due to incompatible and inconsistent state laws. ABC strongly supports passage of S. 406 which would give America's small businesses and their employees access to affordable health care coverage through Association Health Plans.

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*Editors Note:* Associated Builders and Contractors (ABC) is a national association representing 23,000 merit shop construction and construction-related firms throughout the United States. For more news and information on AHPs, visit http://www.abc.org/ahp

OFFICE OF THE GOVERNOR
STATE OF MISSOURI
JEFFERSON CITY
65101

MATT BLUNT
GOVERNOR

STATE CAPITOL
ROOM 216
(573) 751-3222

May 4, 2005

The Honorable Olympia Snowe
Chair, Small Business and
Entrepreneurship Committee
154 Russell Senate Office Building
Washington, DC 20510

Dear Senator Snowe:

As the newly elected Governor of the State of Missouri, I am committed to improving the state's entrepreneurial climate and increasing access to affordable health care for all Missourians. I would like to express my support for Association Health Plans (AHPs), which would make health insurance more accessible and affordable for small business employees and their families.

Of the 27 million working uninsured, 57 percent are working in firms with fewer than 100 employees. In my state alone, 65 percent of the uninsured population is employed. It is time to improve access to employer-based care and to act on this vital issue. S. 406, the "Small Business Health Fairness Act of 2005," introduced by Senators Talent, Bond and you would give small businesses the opportunity to offer health benefits, through AHPs.

I strongly believe that AHPs will help reduce the number of uninsured Missourians by allowing small businesses the same accessibility, affordability, and choice in the health care marketplace that big businesses now experience. Banding together across state lines under bona fide trade or professional associations, small business owners and their employees will benefit from the same economies of scale, purchasing clout, and administrative efficiencies that their big business counterparts currently enjoy. AHPs will provide greater portability of health insurance to workers and their families in the event of a job change.

While I appreciate the governors' efforts to reform their individual small group markets, it is necessary for the United States Senate to consider a multi-state solution to aid businesses and associations that have employees across state lines. Small businesses, which create the overwhelming majority of jobs in Missouri and throughout the nation, deserve to be treated fairly when they attempt to provide this most important benefit for their employees. I urge you to pass Association Health Plans and look forward to working with you to enact this legislation.

Sincerely,

Matt Blunt

li

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Phone 301-390-4405
FAX 301-390-3161
Email ssdaat@mindspring.com
Website www.ssda-at.org

Testimony of the

**Service Station Dealers of America and Allied Trades**

Submitted to the Senate Committee on Small Business and Entrepreneurship

**"Solving the Small Business Health Care Crisis:
Alternatives for Lowering Costs and Covering the Uninsured"**

April 20, 2005
10:00 am
428A Russell Senate Office Building

The Service Station Dealers of America and Allied Trades (SSDA-AT) represent over fifteen thousand independently-owned service stations and repair facilities. Through direct membership and with state affiliations, SSDA-AT has members in all fifty states. We want to thank the Chair for the opportunity to submit testimony for the record.

Our association has been following this legislation closely since its inception for the simple reason that for many of our members it may be the only way they can restore health care to their benefit offerings. Health care benefits have become out of reach for the average service station dealer and it may be the most troubling aspect of their business life. Even after witnessing several years of annual double-digit premium increases, it was still a shock when we began to hear about members dropping health care for their employees. Unfortunately, that has now become the rule rather than the exception. We view those small businesses that are still able to offer health care, even with a much larger employee contribution, as the lucky ones.

SSDA-AT views opposition to AHPs as condescending at best and discriminatory at worst. Many small business national associations have a strong history of efficient health plan management. The most popular fallacy the opposition keeps touting is the problem of cherry-picking the healthy members. It is common knowledge in association circles that this practice does not create a viable plan. (Some lessons were learned the hard way.) Please remember that small businesses are seeking a benefit for their employees. Why would we support a shoddy system that offered poor or faulty coverage to our employees? Small business owners will be on the same plans! There are stringent protections in the proposed legislation to prevent start-up associations whose sole purpose is to unscrupulously profit from health plans. We see no plausible reason to differentiate between associations and unions or large corporations.

It is frustrating from our perspective to hear very little discussion in the AHP debate about the dirty little secret concerning the complete lack of competition in the health care industry. Many industry experts acknowledge that this lack of competition is a major contributing factor to the high cost of health insurance. Major health insurance groups that are spending big to defeat this legislation would, more than likely, still control the larger part of association health insurance, although it would admittedly be more complicated and costly for them. As with any business, it is the threat of lower profits that concerns them.

At the core of this debate are the millions of uninsured Americans. In our industry, it bears repeating that more workers (middle-class tradespersons) are losing health coverage everyday because of the high cost. Our members have participated in lobbying efforts for this legislation and are always surprised by the response that the senator/representative is opposed/apathetic to AHPs because they don't solve the "health care crisis" in our country. Of course not! There will never be a single source solution to this "crisis" and any true effort will take years. This simplistic view ignores the obvious. There will be an immediate increase in American workers with health insurance as a result of the implementation of AHPs. This is a wonderful, workable first step towards solving the "health care crisis". We therefore urge your support and passage of Association Health Plan legislation.

Please contact Paul Fiore at 301-390-4405 on extension 102 with any questions pertaining to this testimony.

Testimony of

John F. Gay
Vice President, Government Relations
International Franchise Association

before the

Committee on Small Business & Entrepreneurship

Full Committee Hearing on
Helping Small Businesses Provide Health Coverage and Lower Costs

United States Senate

April 20, 2005

**Introduction**
Chairwoman Snowe, Ranking Member Kerry, and other members of the Committee, thank you for the opportunity to testify before you on helping small businesses provide affordable health coverage and lower costs. We applaud the introduction of S. 406, the Small Business Health Fairness Act of 2005, and thank you and your staff for listening to our concerns.

My name is John Gay and I am the Vice President of Government Relations for the International Franchise Association (IFA). Established in 1960, the mission of the IFA is to safeguard the business environment for franchising worldwide. IFA is the oldest and largest franchising trade group representing over 1000 franchisor, 7,000 franchisee and 400 supplier members.

**The Impact of Franchising**
Last year, the International Franchise Association Educational Foundation released the results of an unprecedented study of the economic impact of franchising on the economy. What we learned was eye opening: franchising is an enormous component of the U.S. economy.

This half-million dollar study conducted by PricewaterhouseCoopers found that the nation's more than 760,000 franchised businesses generate jobs for more than 18 million Americans (nearly 14 percent of the nation's private-sector employment) and account for $1.53 trillion in economic activity (9.5 percent of the private-sector economic output).

In Maine, Madam Chairwoman, there are over 3,000 franchised establishments directly employing more than 35,000 workers. And in Massachusetts, Mr. Kerry, there are roughly 13,300 franchised establishments that directly employ over 181,000.

**The Contribution of 767,483 Franchised Businesses to the US Economy**
**Indirect and Direct**

| | Because of Franchised Businesses (indirect) | Percent of the Private Sector Economy (indirect) | In Franchised Businesses (direct) | Percent of the Private Sector Economy (direct) |
|---|---|---|---|---|
| Jobs | 18,121,595 | 13.7% | 9,797,117 | 7.4% |
| Payroll | $506.6 billion | 11.1% | 229.1 billion | 5.0% |
| Output | $1.53 trillion | 9.5% | 624.6 billion | 3.9% |

**Direct Employment by Economic Sector**

| | |
|---|---|
| Information | 3,629,000 |
| Construction | 6,826,000 |
| Financial Activities | 7,807,000 |
| **Franchised Businesses** | **9,797,000** |
| Durable Goods Manufacturing | 10,335,000 |

*Note on the data: All data are from 2001, the most recent year available.*

Clearly, franchising is a critical engine of economic growth. Over 75 industries utilize the franchise model for distribution of products and services: everything from the familiar restaurants and hotels to lawn care, tax preparation, personnel services, movers; the list goes on.

Even in down times, franchising creates jobs. There are countless stories of people impacted by employer downsizing who have chosen franchising as a way of becoming their own boss and controlling their own destiny.

**About Franchising**
The terms "franchising" and "franchise" are often used interchangeably to mean a business, a type of business, or an industry. Strictly speaking, the "franchise" is the agreement or license between two parties which gives a person or group of people (the franchisee) the rights to market a product or service using the trademark and operating methods of another business (the franchisor). The franchisee has the obligation to pay the franchisor certain fees and royalties in exchange for these rights. In this sense, franchising is not a business or an industry, but it is a way of doing businesses.

There are two main types of franchises – product distribution franchises and business format franchises.

Product distribution franchises sell the franchisor's products and are supplier-dealer relationships. In general, the franchisor licenses the use of its trademark to the franchisee but may not in all cases provide the franchisee with a system for running its business. Examples of product distribution franchises are soft drink distributors, automobile dealerships, and gas stations.

Business format franchises not only sell the franchisor's product or service, with the franchisor's trademark, but operate the business according to a system provided by the franchisor. Among other things, the franchisor also provides training, marketing materials, and an operations manual to the franchisee. There are many examples of business format franchises, including – quick service restaurants, automotive services, lodging, real estate agents, convenience stores, and tax preparation services, to name a

few. The IFA represents business format franchising across an entire spectrum of industries.

The typical franchise company (franchisor) will have establishments that are operated by franchisees as well as establishments that are operated by corporate employees. Over three quarters of franchised establishments are owned by franchisees. The remainder are owned by the franchisor.

One of the wonderful features of franchising is its diversity. As I mentioned earlier, over 75 industries franchise – everything from plumbers to realtors, florists to hoteliers. Likewise, franchisees come from all walks of life. One thing many franchisees have in common is the difficulty they face in offering health coverage for their employees.

**Health Coverage**
The skyrocketing cost of health insurance is consistently cited as the No. 1 business concern of IFA members. The IFA and our members believe that passage of Association Health Plan (AHP) legislation is a first step towards providing affordable health coverage for small businesses.

Employer-sponsored health coverage is becoming harder for small businesses to provide for their employees and harder for working families to afford. According to recent reports, more than 45 million Americans are uninsured. That is *12 million more* than the entire population of Canada (*32.2 million*). And approximately 60 percent of those 45 million uninsured are employed by small businesses. But, small businesses have little buying power and few affordable options. Five or fewer insurers control at least three quarters of the small group market in most states.

Clearly, something must be done to slow the rate of health insurance price increases and to decrease the numbers of completely uninsured Americans. But reforming health care is a vastly broad and complex task. Rather than searching for one comprehensive solution, one of the various proposals raised over the past few years to incrementally reform the health care system is particularly promising: Association Health Plans.

Association Health Plans would allow small business owners to pool together through association membership to purchase health insurance, leveling the playing field by giving small business the same access to the cost-benefits that Fortune 500 companies and unions have enjoyed for decades. Health care coverage would become more affordable by spreading risk among a larger group, strengthening negotiating power with plans and providers, and reducing administrative costs. AHPs would allow associations such as IFA, or an association-like group, such as a franchisor, to buy thousands of health insurance policies at a lower per-policy cost and pass those savings – as much as 25 percent, according to the Congressional Budget Office – along to small business members and their employees. Others estimate that AHPs could reduce health insurance premiums for small businesses by between 15 to 30 percent.

While some opponents of AHPs fear that participants in insurance pools that cross state lines and are exempt from state insurance regulation could be denied consumer protections granted under state law, we urge you to consider that the same federal regulatory umbrella successfully regulates many of the largest labor union and corporate plans. In addition, other opponents of AHPs are concerned that by exempting these

plans from state benefit mandates (coverage requirements, which vary by state), the insurance market would be destabilized. However, limitations imposed by state mandates have had the effect of decreasing the insurance market for small businesses. Under S. 406, the Small Business Health Fairness Act of 2005, AHPs would be allowed to determine minimum health care coverage needs for their members. These determinations would not be based on the various mandates set out by the different states in which the AHP operates, but based on the specific needs of an association's members. AHPs would help develop a market that is presently constrained by state mandates. This would help stabilize the insurance market and keep the costs of AHPs lower than the health insurance presently available to small businesses.

Furthermore, proponents point out that AHPs are potential customers of large insurance companies. Depending on the size of the AHP, it may choose to either fully insure through an insurance company or to self-insure by paying claims from its own funds. Considering that AHPs will insure millions of presently uninsured, the insurance companies should rest assured that the increased competition from AHPs would be offset by the potential for increased business.

**Conclusion**

With the President and the U.S. House in support of AHPs again this year, IFA believes the environment is right for passing AHP legislation this Congress. IFA applauds Chairwoman Snowe and Ranking Member Senator Kerry for holding this hearing, fostering discussion, and leading the debate on AHPs in the Senate. The franchisee, franchisor, and supplier members of IFA stand ready to work with this Committee on this critical issue. Please feel free to call on the IFA in the future and thank you again for the opportunity to testify.

April 20, 2005

Senate Committee on Small Business and Entrepreneurship
428A Russell Senate Office Building
Washington, DC 20510

Re: April 20, 2005 hearing on "Solving the Small Business Health Care Crisis: Alternatives for Lowering Costs and Covering the Uninsured." Testimony submitted by John H. Graham IV, CAE, President and CEO, American Society of Association Executives, 1575 I Street NW, Washington, DC 20005.

**American Society of Association Executives**. The core purpose of the American Society of Association Executives ("ASAE") is to advance the value of voluntary associations to society and to support the professionalism of the individuals who lead them. ASAE's 22,000 members manage or work for virtually every kind of tax-exempt nonprofit organization, but predominantly trade and professional associations. The size and scope of the association sector continues to grow, along with its role in American life.

**Importance of Associations**. From early on in America's history, associations have been key vehicles for attaining higher quality or hard-to-attain products and services. This sense of collectivity, that individuals might enhance their access to personal and professional growth and a vast array of resources by belonging to a like-minded group, is at the core of all associations.

Associations are organized for the sole purpose of serving the needs of their members. By extension, many association member benefits ultimately serve the general public. For instance, an association that sets product standards ensures the integrity and performance of the industry it represents; but it also protects the health and safety of the consumers who ultimately use those products, and helps cultivate consumer confidence in the marketplace.

Associations are also organized for purposes greater than selling insurance, a critical distinction in the debate over the underlying motivation of the sector in the health insurance industry. Associations are not affinity groups or businesses with the goal of profiting from the insurance market. They are, however, already structured to represent their members, and possess the infrastructure,

administrative and communication mechanisms, and experience necessary to unify employers and employees into stalwart consumers of health services.

**The value of AHPs.** Association health plans (AHPs) are supported by more than 170 associations representing over 12 million employers and 80 million American workers. These associations' memberships also encompass a huge range of trades and professions. These associations are vital to enabling small businesses to compete in their marketplaces and be good community citizens.

According to the U.S. Small Business Administration, health care accessibility and affordability is a major issue facing small businesses and their employees today. The cost of health insurance to a small business is significantly greater than to larger employers, leaving millions of American companies without the purchasing power necessary to secure affordable health coverage. Employer-sponsored health coverage continued to decline in recent Census Bureau statistics because businesses with less than 25 workers were forced to drop coverage due to rising health care costs. Only about 55 percent of companies with 3 to 9 employees offer health benefits, and those employees pay an average of 17 percent more for health benefits than workers employed by large companies. Statistics show that about 51 percent of the roughly 45 million uninsured Americans either work in a small business or are a dependent of a small business employee.

Association health plans allow small business owners to pool together across state lines through their membership in a trade or professional association to purchase health coverage for their families and employees. Associations have been sponsoring health plans for more than 50 years. In 1990, there were reportedly more than 1,000 AHPs. Today, that number has dropped to fewer than 200 due to the tightening of state regulations over the past decade that have made operating an AHP across state lines an administrative nightmare. The Employee Retirement Income Security Act of 1974 (ERISA) preempts state regulations for corporate and union organizations, but not for AHPs.

Studies show that AHPs would save small business owners between 15 and 30 percent on the cost of purchasing health insurance, savings that would enable many more small employers to offer coverage and/or pay a higher share of workers' premiums. Additionally, AHP legislation would minimize the competitive disadvantage some small employers face in attracting and retaining quality employees.

Opponents to this bill have publicly claimed that AHPs would be bad for small businesses; yet AHPs are endorsed by the U.S. Small Business Administration as well as organizations protecting small business rights such as

the U.S. Chamber of Commerce and National Federation of Independent Business (NFIB).

**Conclusion.** The "Small Business Health Fairness Act" (S. 406), introduced by this committee's chair Olympia Snowe (R-ME), along with Sen. Jim Talent (R-MO), delivers relief from escalating health insurance costs that small businesses desperately need, while instituting extensive new protections to safeguard national AHPs from the fraud and abuse that can occur through non-legitimate, "sham" associations. Again, the structure and essence of associations offer a distinctive opportunity to assist employers and individuals who rely on these organizations for a host of benefits and services. ASAE strongly endorses AHP legislation as a solution to the critical problems of access and affordability, as well as a strong statement of support for America's small businesses.

Sincerely,

John H. Graham IV, CAE
President and CEO
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April 19, 2005

The Honorable John Kerry
Ranking Minority Member
Committee on Small Business & Entrepreneurship
United States Senate
428A Russell Senate Office Building
Washington, DC 20510

Dear Ranking Member Kerry:

I understand that the Committee is currently considering S. 406, the "Small Business Health Fairness Act of 2005," which would largely remove Association Health Plans (AHPs) from the oversight traditionally provided by state insurance regulators. Proponents of the bill believe that AHPs will make health insurance more accessible to small businesses. While perhaps well-intended, I am convinced that this legislation would create disastrous regulatory loopholes and, in doing so, open the door for fraud and abuse to flourish at the expense of an unsuspecting and vastly unprotected public. The dangers posed in that respect far outweigh and undercut, in my view, any possible benefit in terms of access from this legislation.

In May, 2002, I authored the enclosed report, entitled "Association Health Plans: Preemption of State Oversight Would Place Consumers and Small Employers at Risk" which predicted that, if enacted, previous AHP legislation would have exposed consumers to a "proliferation of plan failures and consumer losses." The report questioned the wisdom of the AHP preemption provisions, particularly in light of the extensive testimony and evidence uncovered by previous Congressional investigations of insurance and multiple employer welfare arrangement (MEWA) fraud. Having served as a federal prosecutor, as the Inspector General for the Department of Defense, and as the Chief Counsel and Staff Director of the Senate's Permanent Subcommittee on Investigations during the Subcommittee's investigation of MEWA fraud, I am very familiar with how quickly fraudulent activity can take root and flourish in the absence of rigorous and thorough oversight at the local level. The 2002 Report, which is also relevant to S. 406, examines AHPs in the context of that historical record, focusing on three specific areas of concern:

1. The AHP proposals ignore, at great peril, the lessons of history by creating regulatory loopholes for some of the same types of plans - including some MEWAs sponsored by legitimate associations - that, according to GAO, left

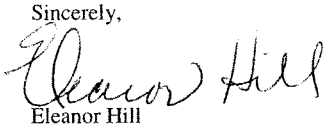
398,000 largely unprotected consumers with over $123 million in unpaid claims from 1988 though 1991. Senate and House hearings confirmed that, time and again, unscrupulous plan operators used a previous statutory preemption of state regulation to shield their fraudulent activities, generating huge profits for themselves and millions of dollars in losses for untold numbers of small business employees. In other cases, legitimate but inexperienced plan operators, without the watchful eye of state regulators, were unable to avoid insolvency. The problem was so great, and the federal oversight effort by the Department of Labor (DOL) so inadequate, that Congress responded by amending the law to specifically return regulatory authority to state authorities and DOL issued specific guidance emphasizing state authority in this area;

2. Like previous proposals, S. 406 would strip state regulators of any meaningful ability to oversee AHPs and protect consumers. It would deprive consumers of the states' considerable expertise and experience in preserving the solvency of health plans, assuring fair health insurance premium rates, requiring fair marketing to consumers, requiring adequate life-time maximums, and enforcing other basic insurance requirements. The states have spent significant resources and built a proven regulatory framework for insurance over the years. State regulators, equipped with the local presence and focused, proactive authority that is essential to an effective and timely enforcement capability, are the consumer's best "insurance" against disaster; and

3. In place of the extensive state regulatory framework, S. 406 and other AHP proposals would give the U.S. Department of Labor limited and clearly inadequate authority to effectively regulate AHPs. While AHP advocates claim that DOL oversight will suffice, the proposed legislation does not deliver anything near the resources or the tools needed to effectively deter and detect fraudulent activity in a greatly expanded universe of health plans. The new certification process is limited in scope and without necessary investigative and enforcement resources and authorities. There is no provision directing regular examinations of the plan by outside regulators: unlike state regulators, DOL oversight is largely dependent on self-reporting by the plans. Surplus provisions fall far below state requirements and reserve requirements are set by an actuary hired by the plan itself, and not an outside regulator. Finally, S. 406 ignores a long historical record that strongly suggests that DOL has for some time been ill-equipped and poorly prepared to undertake the kind of massive regulatory and enforcement effort that is required in the highly complex area of insurance and health benefits. Simply put, an under-resourced, offsite DOL certificate review is no match for the kind of sophisticated, unscrupulous and complex insurance scams that exist today.

For all these reasons, I am convinced that S. 406, and similar AHP provisions, would erase much of the progress that has, at great cost to consumers, been made in identifying and correcting regulatory loopholes over the years. Nothing in this legislation would prevent the same proliferation of plan failures and consumer losses that occurred when these types of organizations were last exempt from state regulation. The organizations may be described and defined differently today, but the kind of operation and the huge potential for fraud and abuse remain the same. If anything, the complexity of the new AHP proposal, the broad accessibility provided by the Internet and other advances in information technology, and increases in the extent and complexity of fraudulent insurance schemes are likely to generate even greater problems for consumers than those experienced during the last attempt to preempt state regulatory authority. In short, the lessons of the past dictate the need for great caution in an area known to be fraught with peril. Should the AHP provisions in S. 406 become law, small business employees and their families will, in my view, find themselves both unprotected and ill-equipped to deal with yet another wave of widespread fraud and abuse in the critical area of health benefits and insurance.

Sincerely,



Eleanor Hill

EH/cp
Enclosure

AMERICAN COUNCIL OF ENGINEERING COMPANIES

Written Statement of

Mr. Derrell E. Johnson

President, ACEC Life/Health Insurance Trust

For the Senate Committee on Small Business and Entrepreneurship

Solving the Small Business Health Care Crisis: Alternatives for Lowering Costs and Covering the Uninsured

April 20, 2005

ACEC is the business association of America's engineering industry, representing approximately 5,500 independent engineering companies throughout the United States engaged in the development of America's transportation, environmental, industrial, and other infrastructure. Approximately 65% of ACEC's member firms are small businesses employing less than 30 employees.

The rising cost of health insurance is a primary concern for small business owners in the engineering industry. ACEC strongly supports the *Small Business Health Fairness Act of 2005* (S. 406), which would help make health insurance more affordable and accessible for small engineering firms and their workers. ACEC strongly commends Chairwoman Snowe and other members of the Senate Small Business and Entrepreneurship Committee for cosponsoring this vital legislation and holding this hearing to examine this important issue.

**The ACEC Association Health Plan**

ACEC is one of the few national associations that currently sponsors a nationwide AHP. ACEC's AHP, formally known as the ACEC Life/Health Insurance Trust, has been providing affordable health benefits to engineering firms since 1965. Currently, our AHP provides health benefits to over 1,550 firms and 41,000 of their employees and their families nationwide. The AHP is governed by seven trustees who are appointed to four-year terms. The Trust contracts with a third party administrator, Health Plan Services. Trustmark Insurance Company of Lake Forest, Illinois is the underwriter for the plan and provides fully-insured health care benefits to participants.

ACEC's AHP is a model of how associations can help deliver affordable health benefits to working families employed in small businesses at affordable rates. Recognizing the unique needs of the engineering industry, the ACEC-sponsored AHP is an employee benefit program that is designed by engineers for engineers. Currently, there are approximately 100 different medical benefit plans, with a wide range of deductibles, from which members may choose. Most importantly, the ACEC AHP is very efficient in delivering health care benefits to small employers, with administrative costs of only 9.5%. This means that more than 90% of every dollar goes towards the purchase of actual health care benefits and services for the plan participants. This compares well to the administrative costs that small employers typically pay -- between 16% and 25% (at times even higher) -- when purchasing health insurance directly from an insurance company in state small group markets.

Despite the success of ACEC's AHP, there are many challenges hindering the potential of the plan today. The proliferation of mandates and regulations imposed on a state-by-state basis is the greatest concern. These mandates have vastly increased the degree of complexity of administration and have resulted in a host of compliance and regulatory initiatives that have added a significant burden to the administration of the plan. In the state of Maryland, for example, small group market regulations make it virtually impossible for ACEC's AHP to offer competitive insurance products to firms that employ less than 50 people. To date, ACEC's AHP has been able to continue its mission of providing affordable health benefits to small employers in other states despite these difficulties. However, as the amount of

regulations and mandates at the state level increases, the affordable coverage now enjoyed by our members will be jeopardized.

**Benefits of the *Small Business Health Fairness Act of 2005***

ACEC sees substantial benefits to both employers and employees in S. 406, the *Small Business Health Fairness Act*.

As you know, this legislation will provide small businesses with the opportunity to band together, under uniform federal regulation, through bona fide trade and professional associations to purchase affordable health benefits. Currently, small businesses have little buying power and few affordable options in today's small group markets. AHPs will level the playing field and give small employers the same or similar advantages enjoyed by Fortune 500 companies and unions in providing health care benefits. The inability of many small companies to offer reasonably priced health care to potential employees places them at great disadvantage in the marketplace when competing for quality workers. S. 406 will go a long way towards correcting this imbalance.

A problem contributing to double-digit premium increases for many small businesses is a lack of competition in small group markets. Over the last decade, many insurance companies have decided to pull out of state small group markets, leaving only a few large companies with increasing market power. Furthermore, the current environment in the states makes the creation of new AHPs virtually impossible. S. 406 would make it easier for existing AHPs like ACEC's to continue offering affordable health insurance products to their members. This legislation would also greatly expand the ability of associations representing other categories of small businesses to create an AHP, thus increasing competition in health insurance markets.

Under a single set of federal regulations ACEC's AHP would be able to operate with greater administrative efficiency. This translates into further health care savings for ACEC's members. Opponents of S. 406 allege that AHPs permitted to operate with preemption of state mandated benefit laws--similar to the exemption now granted to corporate and union plans--would result in workers receiving reduced health care benefits. ACEC rejects this notion. The reality for the engineering industry is this: Quality health insurance coverage is an *essential* part of the benefits package necessary to attract and keep good people in the competitive labor market. It has been our experience that if the quality of the health insurance products provided by our AHP decline, firms will go elsewhere to seek coverage. We must be able to offer quality insurance products that cover the range of services our members demand, with strong customer service to respond to claims, and do all of this at a fair and reasonable price. Passage of S. 406 will help us to achieve these goals.

ACEC also rejects the notion that AHPs under S. 406 will only be attractive to small firms with relatively younger, healthier workforces, thus causing "adverse selection" in health insurance markets. Because AHPs can provide health benefits to its member firms with administrative costs substantially less than can be obtained in state small group markets, we believe that AHPs can provide coverage to people of all ages and risks. For example, the average age of participants in the ACEC Life/Health insurance program is 41 years old, which is older than

the average labor force age of our country. Moreover, by expanding the availability of affordable health care benefits, S. 406 will enable younger, healthier, people who now *choose* to be uninsured due to the high cost of insurance, to obtain coverage. This will strengthen health insurance markets and help reduce the problem of the uninsured in America.

It is critical that Congress enact S. 406, the *Small Business Health Fairness Act*, to ensure that ACEC is able to continue delivering affordable and secure health care benefits to small employers through our AHP, and expand the ability of other associations to offer AHPs to their members.

Again, ACEC greatly appreciates the strong support for this bill from Chairwoman Snowe and other members of the Small Business and Entrepreneurship Committee, and looks forward to working with Congress to make health insurance more affordable for small businesses and working families.

The Honorable Olympia Snowe
Chairwoman, Committee on Small Business and Entrepreneurship
United States Senate
428A Russell Senate Office Building
Washington, DC 20510

Dear Madam Chairwoman:

**RE: Support for S. 406, *the Small Business Health Fairness Act of 2005.***

On behalf of the American Foundry Society (AFS), I would like to urge you and the Senate Committee on Small Business and Entrepreneurship to pass S. 406, the *Small Business Health Fairness Act of 2005*. This bill is a critical step needed to assist small businesses address the overwhelming rise in health care costs and become more competitive within the global marketplace.

AFS is the major trade and technical association for the foundry industry. AFS has nearly 10,000 members representing approximately 2,400 foundries, as well as suppliers and other industry affiliates. The American metalcasting industry provides employment for 225,000 men and women directly and supports thousands of other jobs indirectly. The industry supports a payroll of over $8 billion and sales of $34 billion. Metalcasting plants are found in every state, and the industry is made up of predominantly small businesses. Approximately 80 percent of domestic foundries have fewer than 100 employees.

The foundry industry is the cornerstone of manufacturing. Over 90 percent of all manufactured goods contain at least one casting. American metalcasters support every other manufacturing sector including agriculture, construction, railways, automotive, aerospace, communications, health care, defense and many more. Without castings, society would not be able to economically plant and harvest crops, transport people and materials, explore space, conduct medical operations, communicate electronically, defend our nation or support our military overseas.

Health care costs are the single largest cost above production for foundries and have been rising for this industry consistently over the last few years. And, with the American foundry industry facing such intense competition from foreign metalcasters, there is limited potential to raise prices to offset these additional operating costs. This means that the facilities either need to absorb cost increases or pass them on to their employees. For example, one foundry in the upper Northeast experienced a 14 percent increase in health care costs in 2004 and a 22.8 percent increase for 2005. In order to remain viable, the facility was forced to negotiate a 15 percent increase in the employee cost-share for health coverage.

American foundries need for the Senate to pass the Association Health Plan legislation (S. 406). The Congressional Budget Office estimates that this legislation could save small businesses as much as 13-25 percent on their health care premiums. Such a significant cost saving would allow facilities like the one in the upper Northeast to potentially lower the employee costs as well as price their castings to be more competitive against foreign manufacturers.

Thank you for your consideration of this important issue. AFS looks forward to the passage of the AHP legislation.

Sincerely,

Jim Keffer
President

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**Written Testimony of the**
**Hearth, Patio & Barbecue Association**

**Submitted for the record to:**

**Honorable Olympia J. Snowe, Chair**
**United States Senate – Committee on Small Business**

**"Solving the Small Business Health Care**
**Crisis: Alternatives for Lowering Costs and Covering the Uninsured."**

**April 20, 2005**

**Carter Keithley**
**President & CEO**
**Hearth, Patio & Barbecue Association**
**1601 North Kent Street, Suite 1001**
**Arlington, Virginia**

Madame Chair and distinguished members of the Committee, on behalf of the members of the Hearth, Patio & Barbecue Association (HPBA), I thank you for the opportunity to submit written testimony in support of association health plans as an option for securing better access to affordable health care for small businesses. The great majority of our members are small businesses (50 or less employees) and they have reported dramatic increases in health care premiums over the past three years. We believe that if Congress approves federal association health plan legislation (S. 406/H.R. 525), our members will be among the millions who will benefit and actually be able to afford health insurance once again.

Unfortunately, many of our members cannot currently afford the market premiums and they face stiff competition from larger employers who can offer great health benefits to employees. Our members represent a majority of specially-trained workers who sell and install fireplaces, wood stoves, and pellet stoves into peoples' homes. The ability of our smaller members to attract, and most importantly to retain specialized employees is crucial for their businesses' survival. It is extremely difficult to convince qualified potential employees to accept a job in a small business where the potential risk for physical injury is high, yet that cannot afford to offer health insurance.

In attempt to address the problem facing our members in search of affordable health insurance, HPBA hired an insurance broker in January 2002. The broker contracted with our association primarily to find insurance for our members who could not find affordable options on their own. Because the broker is still bound by each state's mandated benefits laws, the broker has written only two policies in the course of three years. The inability of a highly-trained insurance broker to find affordable health insurance speaks volumes about the pervasive problem facing small businesses in the health insurance market today. If a paid professional cannot find affordable health insurance for our members, how ever could we expect them to find it on their own?

We firmly believe that the quick passage of association health plan legislation (S. 406/H.R. 525) is the best way to secure access to health insurance for the 2,500 members of our association. Our members and their families deserve the chance to pay the same rates and enjoy the same types of health plans that larger companies can offer to their employees. Our small business members are being unfairly penalized at the expense of large insurers who monopolize many state markets and benefits regimes. Congress must level the playing field for small businesses and allow our members the option of participating in a federally-managed, private-employer health plan like the seventy-two million that the U.S. Department of Labor already manages.

It is obvious that the small business health insurance market is broken and is not meeting the needs of the people it is supposed to support – America's small businesses. Our association would appreciate the chance to offer a health plan to our members that they can afford, and that also meets their specific health care needs. A federally-managed, fully-insured association health plan is the answer to the insufficient, unaffordable, state-administered plans that our members can neither afford nor desire. Evidenced by the inability of a professional health insurance broker to find coverage for 99.9% of our members in three years, the status quo is clearly not an option.

Madame Chair, we congratulate you and support you in your efforts to push association health plans as an option for our members and for millions of other small businesses throughout the U.S. We wholeheartedly agree that this is by far the best option for our 2,500 members, and we ask that your colleagues join you in ensuring that federal association health plan legislation gets passed as quickly as possible. On behalf of the members of HPBA, I thank you for the opportunity to submit this testimony today.

**Written Testimony Submitted By**
**Karen Kerrigan**
**President & CEO**
**Small Business & Entrepreneurship Council**

**On**

***Solving the Small Business Health Care Crisis:***
***Alternatives for Lowering Costs and Covering the Uninsured***

**Before the**

**Committee on Small Business and Entrepreneurship**
**U.S. Senate**
**Olympia J. Snowe, Chairman**

**April 20, 2005**

**Small Business & Entrepreneurship Council**
1920 L Street • Suite 200 • Washington, D.C. 20036
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Website: www.sbecouncil.org

Chairman Snowe, Ranking Member Kerry and members of the Senate Committee on Small Business and Entrepreneurship thank you for the opportunity to provide written testimony for today's hearing on this most critical issue for America's small business and entrepreneurial sector.

The Small Business & Entrepreneurship Council (SBE Council) is a nonpartisan small business advocacy organization with more than 70,000 members nationwide. For more than ten years, the SBE Council (formerly the Small Business Survival Committee) has worked to advance policies that protect small business and promote entrepreneurship. My name is Karen Kerrigan and I serve as President & CEO of the SBE Council.

Despite progress on reform initiatives that are providing small business owners and their workforce with more affordable options for health insurance, certainly more needs to make the system more competitive to allow consumers greater access and choice.

The SBE Council advocates for and supports an array of reform initiatives that we believe will offer small business owners and their employee's greater access to affordable choices in health insurance. The general principles that underlie the initiatives we support are ones based on fairness and competition -- that is, policies should strive to treat all players big and small equitably, and where artificial barriers have limited the choices for consumers they should be reevaluated and modernized to encourage competition.

The SBE Council's support for Association Health Plans (AHPs), health savings accounts (HSAs), tax credits, the FICA deduction of health care for the self-employed and a nationwide marketplace for health coverage all support this equitable approach which, we believe, will empower small business owners and individuals through greater access and choice. In the end, this will lead to a more accountable system for all consumers.

The SBE Council appreciates the leadership of the Senate Committee on Small Business and Entrepreneurship for its continued focus on health insurance reforms. Clearly this challenging issue warrants a small business directed solution. Only 50% of firms with fewer than 100 employees provide insurance, compared with 98% of larger companies that do. The largest segment of America's uninsured either works for a small business, own a small business or are dependent on someone who does. Workers in small firms and their families comprise 60% of the uninsured.

Though health costs have not risen as fast this past year as in previous years, they still continue to have a harmful impact on most small firms. More capital and resources expended on such unmanageable costs, means less available for hiring, wage increases, business investment and expansion. The collective drain of ever-increasing health costs hurts our economy. After all, as Committee Members are well aware, the small business and entrepreneurial sector is the major source of job creation and innovation in our economy and keeping it productive and growing is critical to our economic health and competitive position in the global marketplace.

The passage and enactment of HSAs was a significant development for small firms and individuals. With small business owners saving significant dollars on health coverage costs through HSAs, and with studies demonstrating that the previously uninsured are accessing insurance through HSAs (as they did with their pilot project forerunner, the Archer Medical Savings Account), it is extremely positive that President George W. Bush, legislators at the state level and initiatives in the U.S. Congress are focusing on ways to increase HSA access through tax incentives and credits for individuals and small firms.

A recent survey by America's Health Insurance Plans (AHIP) found that nearly 438,000 people have enrolled in an HSA since they were signed into law, with most of the products being purchased by small businesses and individuals (79,000 small firm purchasers). Approximately 30% of the HSA purchasers overall previously did not have insurance, according to the AHIP survey, with 16% of new small business purchasers previously not offering insurance.

Legislation proposed in the Congress would give a further boost to the accounts by providing small business owners with a refundable tax credit for contributions to their employees' HSAs -- $500 per employee with family coverage, and $200 per worker with individual coverage. Implemented in tandem with legislation that would allow premiums for qualified high-deductible health insurance plans to be tax deductible, the SBE Council believes this approach would make a further dent in decreasing the number of uninsured. Added features include portability of coverage while allowing

individuals and families to accumulate savings for health expenses, or long-term health care needs.

A complimentary solution that would increase access to health coverage for individuals is the "tax credit" approach as outlined by President Bush, and represented in legislation in the U.S. House (co-sponsored by Reps. Mark Kennedy (R-MN) and Daniel Lipinski (D-IL) -- H.R. 765, the Fair Care for the Uninsured Act. H.R. 765 creates a new tax credit, available to uninsured Americans, of $1,000 for individuals, $2,000 for couples and $500 for dependents, with a maximum $3,000 for families. The credit, of course, can be used to buy a health insurance policy and gives individuals the freedom to choose their own benefits and cost-sharing features.

Creating health coverage tax equity for individuals, as this bill proposes, would make access to quality health care less of a financial burden for those who do not currently have health insurance through their employer. The "refundable" and "advanceable" features of the proposal add to the tax credit's practicality. H.R. 765 empowers individuals, creates more choice and fosters greater competition in the health insurance marketplace.

Detractors of the tax credit concept believe that the amount is not high enough to purchase private health insurance. While some research finds that the tax credit as proposed in H.R. 765 would provide an adequate cushion to pay between one-half to two-thirds of the average cost of health insurance, clearly the cost of insurance in some states will eat away at the value of the credit. That is why the inclusion of "high-risk pools", for example, in the tax credit legislation will be helpful for those with serious health conditions as coverage costs are capped.

Unfortunately, the regulatory burden in certain high-costs states will continue to hinder the full potential of certain federal solutions for individuals. That is why the SBE Council has fully supported federal legislation establishing a nationwide marketplace for health insurance that would allow individuals to leave the confines of their state to purchase a coverage plan that best meets their personal and financial needs. Such an approach was introduced in the U.S. House in previous Congress – legislation that would grant cross-border purchasing of health insurance – and we are looking forward to his reintroduction of the legislation in the near future.

As Committee Members are well aware, regulatory dysfunction at the state level is driving costs higher and serve as a significant barrier to affordable, competitive health plan choices for small business owners. That is why Association Health Plans (AHPs) are a common sense solution that would give small firms parity with larger enterprises, allow for greater bargaining power, and increase health plan choice. The SBE Council applauds the reintroduction of the Small Business Health Fairness Act (S. 406) and looks forward to working with our allies to advance this important piece of legislation through the U.S. Senate in the 109th Congress.

AHPs give small firms policy parity in that they are allowed to purchase insurance under the same uniform regulatory framework as larger businesses currently do. In essence, a "nationwide marketplace" brings that concept down to the individual level, allowing individuals to shop for a health coverage plan better designed for their personal and financial needs.

To conclude, the high cost of health coverage continues to eat away at the competitiveness of our small business sector. It serves as a significant barrier to entrepreneurship. Yet, it should not be a deterrent to individuals receiving coverage or pursuing their business ownership dreams. High costs and the fear of losing health coverage adds even greater risk to what already is a very risky endeavor – starting your own business. That is why giving individuals more options and choices for affordable coverage, and promoting portability and ownership in coverage is in the best interest of creating and maintaining a favorable climate for entrepreneurship.

Again, Chairman Snowe thank you for your leadership and for all you do for America's small business sector.

TIRE INDUSTRY ASSOCIATION

www.tireindustry.org

**Testimony of the**

# Tire Industry Association

**Submitted to the**

## Senate Small Business Committee

## Solving the Small Business Health Care Crisis: Alternatives for Lowering Costs and Covering the Uninsured

**April 20, 2005**

**10 a.m.**

**428A Russell Senate Office Building**

**Maryland Office:**
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Suite F
Bowie, Maryland
20716

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301.430.7280
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Madam Chair and Members of the Committee, on behalf of the 5,000+ members of the Tire Industry Association (TIA), thank you for the opportunity to submit testimony for the record. This hearing, "Solving the Small Business Health Care Crisis: Alternatives for Lowering Costs and Covering the Uninsured" is very important to the members of our association.

TIA is an international association representing all segments of the tire industry, including those that manufacture, repair, recycle, sell, service or use new or retreaded tires, and also those suppliers or individuals who furnish equipment, material or services to the industry. The Tire Industry Association (TIA) has a history that spans more than 80 years and includes several name changes. Originally known as the National Tire Dealers & Retreaders Association (NTDRA), the organization gave birth over the years to the American Retreaders Association (ARA) and the Tire Association of North America (TANA). ARA changed its name to the International Tire & Rubber Association (ITRA) and merged with TANA in 2002 to form the current Tire Industry Association (TIA), which now represents every interest in the tire industry.

The majority of TIA members are independent tire retailers. Our members have found it increasingly difficult over the years to offer quality health insurance to their employees. This is why TIA fully supports the Small Business Health Fairness Act of 2005 (H.R. 525/ S.406). We thank you, Madam Chair, for you unwavering support of Association Health Plans and for introducing this important Senate bill. The House version, introduced by Representative Sam Johnson (R-TX), currently has 135 bipartisan cosponsors and we urge every Member of Congress to support this crucial legislation. TIA truly believes that while AHPs are not a silver bullet to cure all ills with the health care system, they would go a long way to leveling the playing field and allowing small businesses to have access to quality, affordable health insurance across state lines, something that corporate American and labor unions already have.

TIA recently held a Legislative Summit and brought our members into town. AHP legislation was our top issue. One tire dealer took particular interest in the Association Health Plan legislation. Her name is Carmen Lesieur of Maynard & Lesieur located in Nashua, New Hampshire. The company was founded in 1928 as a local gas station by Leo Lesieur. Carmen is married to the grandson of Leo and joined the company in 1987 to help automate the business into computer world. She now works as the Finance/Computer & Human Resource Manager for the company. I would like to share Carmen's story with you.

Maynard & Lesieur, Inc., a retail/wholesale tire dealer, has between 35-42 employees working for the company as salesmen, delivery drivers, clerical and tire technicians. The average annual sales for the past 9 years are approximately $9 million per year. The average non management salary is $38K/annually. The average management salary is $58K/annually.

Through the years, the company has offered their employees, health insurance, life insurance, short-term-disability and recently added vision care and long term disability. The company pays 100% of life insurance premiums for the employees and 50% of all other insurance premiums (except for STD & LTD where the employee must pay 100%).

This is Carmen's story in her own words:

"Since 1989, Maynard & Lesieur, Inc. has been a member of the NH Auto Dealer's Association. This allowed the company to purchase lower health care coverage through the association. Membership of $200.00/annually is paid to this association. Although all health care premiums increased drastically throughout the years, being part of this association as a small business was better than receiving health care premiums as a single – stand-alone small business. Annual increases between 2% - 24% were the norm with last year's increase being between 32%-101% for most members of NHADA since a new state bill (SB110) passed. Maynard & Lesieur, Inc. saw an increase of 66%. With every major increase, less notification of rate changes with time to shop around for something else was suspect. Maynard & Lesieur, Inc. was often "stuck" with no other options but to take what NHADA offered because no one would offer bids.

"With a 66% increase notification in January, 2005 effective February 1, 2005 Maynard & Lesieur, Inc. and its employees were facing a 33% increase each. We knew that we and our employees couldn't afford the old plan's premiums, let alone this increase. We faced a drop in health coverage enrollees with disqualification for the 75% eligible employee quorum that NHADA required. Fortunately, Maynard & Lesieur, Inc. found and joined (AWANE) Auto Wholesalers Association of New England. This was the only company that would bid against NHADA. This organization is self-insured in some areas, offered a comparable Anthem Blue Cross health coverage (not the same) for approximately a 6-10% increase across the board and more "Out-of-Pocket" for the employees. The membership fee was $685.00. The rates are below:

| 2005 Monthly Premiums | Health | Dental | Vision |
|---|---|---|---|
| Single | $ 372.00 | $ 32.50 | $ 8.91 |
| Employee/Spouse | $1192.00 | $ 84.50 | $20.63 |
| Family | $1632.00 | $137.50 | $29.50 |

***Note:*** *50/50 of these monthly premiums paid by employee & company*

"Maynard & Lesieur, Inc. offers the best benefits a non-chain, small business can offer their employees. If our employees can't afford to pay for health insurance coverage – who will pay for it? Very few of our employees own a home – they pay rent. They live pay check to pay check. They don't go to the doctors unless it is a visit to the emergency room. When some of them have been brought to court for not paying their medical bills, the judge sides against the hospital or doctor as these employees cannot afford to live. Many employees don't take health coverage for themselves and the use the State of NH's Healthy Kid's program to provide healthcare for their children. In the end, aren't we all paying for their healthcare?

"Since 1989, we've seen a 124% increase in premiums and approximately a 50% increase in payroll. We've had an average decline in sales of $250K/year during the past 4 years. The cost of living is increasing but we cannot afford to pay our employees more money to make ends meet. We've faced rising expenses in liability insurance, worker's comp, auto insurance, gas, taxes, utilities as well as bankruptcies, bad debt and frivolous law suits. We are at a major disadvantage compared to larger businesses. The impact of the competition from warehouse clubs and automotive chains are all eating away at the once very stable, prosperous 4th generation family business and we stand alone in our fight to stay afloat to offer the consumer competitive pricing, a quality product and excellent service. We are becoming dinosaurs in our environment and the government continues to close its eyes to our extinction."

Stories like Carmen's are all too common. She feels strongly that Association Health Plans would give her another alternative for insurance. In the big picture, this means more competition in the marketplace for all insurance yielding more affordable, better quality programs. She could get quotes from TIA, the Chamber, NFIB and any other associations that represent her business.

Carmen's experiences don't end there. She has dealt with many insurance problems throughout her lifetime. Here is more of her statement:

*Personal Background Experience with Health Coverage*

"My name is Carmen Venne Lesieur. I live in Hudson, NH and have been a resident of NH for my entire life. I have been married to Steven Lesieur for almost 28 years who also has lived in NH his entire life. Both Steven and I work at his family's retail/wholesale tire business located in Nashua NH that has been servicing the area since 1928. He is the President and I am the Finance Manager - the working 3rd generation in this business along with his two brothers and his 76 year old father who still comes into work at 4:30 a.m. and doesn't leave until 5:00pm six days per week. All of our three children have worked part-time for the family business with only one now working full-time.

"In 1978, I was employed by Wang Labs in Massachusetts with what I thought were excellent health & benefits package. However, because I was only married 4 months when I became pregnant, our insurance would not cover our medical bills for the pregnancy or the delivery. They said we had to be married for one full year before they would cover any pregnancy bills and they would only pay the baby's bills after it was 1 week old. My child was born 3 weeks early and stayed in the hospital for 1 week total. We were forced to pay for all of our medical bills despite the fact that we were paying for family coverage and we were in fact married. Total income was: $12K (in 1978). Total cost of the medical bills: $2.5K. This law was changed shortly after I had this child, but we still had to pay the bill.

"In 1987, I was employed by our family business and our first born child was diagnosed with Turner's Syndrome – a chromosomal birth defect with less than 2500 girls affected each year. She went undiagnosed for 10 years because we belonged to an HMO who would not give us a referral for additional tests that I had requested. We then changed insurance coverage when this diagnosis was made. Ten years of a child's illness was neglected because of greed.

"Upon diagnosis, our local pediatrician recommended we see a doctor in Boston, MA. This was the only doctor in the area who was familiar with this rare birth defect. Our insurance only covered $45.00visit out of the many $250.00+/visit because we were from NH and that was "the reasonable and customary fee of service". The Endocrinologist in Boston recommended that our daughter be placed on hormone therapy because she did not have any hormones and she was not growing. She was in the lower 10th percentile for height and weight at 10 years of age. Growth hormones were administered by injection

once a day for five years. This was not cosmetic but so she would be able to do "normal things". The cost: $500.00 week. Insurance paid 50% because they did not consider it an approved drug - it was considered "experimental". Our income at the time: $39K for a family of 5. Our average "out of pocket medical expenses for 5 consecutive years": $25K. We received no financial help from the state or any charitable organization because we earned more than was allowed: $32K. During these 5 years, we also paid for extensive dental work that was not covered as a medical necessity because they said it was cosmetic. However, our child couldn't close her mouth because her pallet was so narrow that it pushed her teeth forward extensively. Total cost: $7K. She also needed a hearing aid that insurance didn't cover. Total Cost: $1500.00 the first time – since then, we've paid as much as $3K for one hearing aid. During all of this time, we had health coverage.

"Two years after my daughter stopped taking GH, the FDA approved the drug for Turner's patients and our health care offered this very same drug to others under this insurance plan for a $5.00 co-pay....but we still had to pay back the $40K+ that we owed the drug company.

"Recently in August, 2004 my 72 year old mother-in-law was diagnosed with Idiopathic Pulmonary Fibrosis and was prescribed Interferon. This too is not covered under a prescription plan and the cost is $8K per month "out of pocket". Medicare will not pay for this drug even though it is the only current drug available to show any promise for this tragic disease. I think it's an absolute crime that my in-laws, who have worked all their lives, being frugal and saving away for retirement, are now going to lose everything so a drug company can recoup their losses in the development of the drug.

"I can't imagine how many other stories are out there like ours if we've been affected twice in the same family. Something must be done to hold health care providers accountable. You shouldn't have to pay $160/wk (often times without claims for many years) and then find out when you need the help - you aren't covered because it doesn't meet their "usual and customary ideals". Who is in control – the doctors or the health insurance companies?"

TIA receives calls almost daily from members looking for health insurance. We would like to be able to help them but without AHPs there are many roadblocks to offering a nationwide program. In a recent TIA survey, 84 percent of members who offer health insurance are facing increases in premiums this year. The survey results showed that the range of premium hikes ran anywhere from 5 to 150 percent, with the average increase between 20 to 30 percent. These rising prices will force many small businesses to ask their employees to contribute more toward their own benefits, limit coverage, raise deductibles or stop offering health insurance at all.

TIA urges every member of the Senate to cosponsor Chairman Snowe's Small Business Health Fairness Act, S. 406. It would be a big step in helping our country's small employers.

If you have any questions about TIA's testimony, please contact Becky MacDicken, TIA's Director of Government Affairs, at 800-876-8372 x 112.

# HOME BUILDERS AND REMODELERS ASSOCIATION OF MAINE

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April 19, 2005

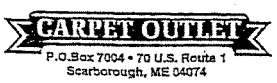
Senator Olympia J. Snowe
154 Russell Office Building
Washington, DC 20510-1903

Dear Senator Snowe:

You should be applauded for your tireless efforts to support and push for enactment of Association Health Plans (AHP's). Of the over 45 million uninsured Americans today, more than 60 percent are either self-employed or working in a firm with fewer than 100 employees. An AHP is an arrangement under which a group of small employers join together through a bona fide association to purchase or provide health insurance coverage for their employees. With AHP's, small businesses would enjoy greater bargaining power, economies of scale, administrative efficiencies, and the benefits of a uniform regulatory structure.

Since the idea's inception, consumer safeguards have been added to AHP legislation to address issues raised by the opposition. Provisions were added to strengthen the solvency rules for self-insured plans. (ERISA does not establish solvency standards for employer plans.) These new solvency standards include: a minimum surplus requirement of $2 million that can be increased by the DOL through negotiated rulemaking; required specific stop-loss insurance, in addition to aggregate stop-loss insurance, required plan termination indemnification for plans in financial distress; and required annual payments to an "AHP Fund" used to pay the claims of beneficiaries of plans in distress. In addition, minimum reserve language has been strengthened. The National Association of Insurance Commissioners and American Academy of Actuaries are included as partners in the process of establishing specific solvency requirements by rulemaking.

Only bona fide trade or professional associations, which must exist for at least 3 years for purposes other than offering health benefits, can sponsor AHP's. Plans must abide by all HIPAA rules and therefore cannot exclude high-risk groups or individuals. They must also comply with all federal health insurance requirements that provide consumer protections, such as COBRA, DOL's claims regulations, the Mental Health Parity Act, the Women's Health and Cancer Rights Act, and the Newborn's and Mother's Health Protection Act.



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Scarborough, ME 04074

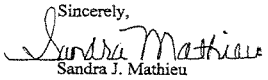
Currently, AHP legislation requires the Secretary of Labor to consult with the state governments in the regulation of AHP's domiciled within their borders, including certification of plans and solvency enforcement, according to the uniform standards established by the bill. States will be given the authority to assess the equivalent of premium taxes for new self-funded AHP's. This will ensure that States will not lose resources for state high risk and small business pools or other programs.

These provisions help ensure this legislation will provide small business owners, their employees and the self-employed with affordable and secure health care benefits. Claims made by the opposition that certain procedures or prescriptions would not be covered are simply scare tactics designed to suppress support for AHPs. AHP's would be certified by the Labor Department and would have to meet rigorous standards – stricter requirements than those followed by large, self-insured, multi-state corporations and labor unions – but, like those same large corporations and unions, would be relieved from the burden of complying with 50 different state mandates. If these health plan rules and regulations are good enough for large corporations and labor unions, why aren't they good enough for small businesses too?

The opposition, led by the likes of Blue Cross/Blue Shield, is spending a lot of money and energy to muddy up the waters, peddling potential horror stories and demanding expensive federal mandates that would gut the legislation, but in the end it's a question of fairness. If corporations and labor unions can operate under these rules – and are widely recognized as having some of the nation's best health plans – there's no reason small businesses shouldn't be allowed to do the same. The federal government should not play "favorites" by continuing to allow large companies and unions to obtain access to better, more efficient, more affordable health plans, while small businesses are shut out in the cold.

Thank you for understanding the problems facing small businesses in the health care market and for standing up to the big insurance companies and demanding that Congress work to fix the problem.

Sincerely,



Sandra J. Mathieu
Executive Officer

# Mental Health Liaison Group

March 14, 2005

The Honorable J. Dennis Hastert
Speaker of the House
U.S. Capitol
Washington, DC 20515

The Honorable Bill Frist, M.D.
Senate Majority Leader
U.S. Capitol
Washington, DC 20510

Dear Mr. Speaker and Dr. Frist:

The undersigned organizations in the Mental Health Liaison Group, a coalition of national organizations representing the diverse interests of the mental health community, wish to express our deep concern about current legislation that would exempt association health plans (AHPs) from state regulation.

As you know, legislation to increase the availability of AHPs by exempting them from state health insurance reforms has been reintroduced in the 109th Congress as H.R. 525 and S. 406. While we certainly understand and support efforts to increase the availability of health insurance to those who lack it, we believe this cannot come at the price of undercutting major progress made by the states in requiring better coverage of mental health services and other critical consumer protections.

Improving access to mental health care is of primary concern to our members. Millions of Americans who have health coverage are denied the mental health care they need because of discriminatory limits on their coverage. Each year, less than a third of adults and even fewer children receive the mental health services they need. This denial of care makes little sense as treatment success rates for mental illnesses are often better than those for many physical illnesses.

Americans from all age groups and all walks of life need better access to mental health care. Untreated mental illness costs the American economy at least $79 billion annually in lost productivity, absenteeism, unemployment and increased health costs. According to the CDC's National Center for Injury Prevention and Control, more than 30,000 Americans died from suicide in 2001 alone. Suicide is the third leading cause of death for young people aged 15-24 and the eighth leading cause of death for all U.S. men. While the elderly comprise 12 percent of the U.S. population, they account for 18 percent of suicides. Ninety percent of those who die by suicide have depression or another diagnosable mental or substance use disorder, underscoring the need for better access to mental health services.

The President's New Freedom Commission on Mental Health called the condition of our public mental health system "a shambles." To address the concerns we cite, President Bush called on Congress in 2002 to end discriminatory mental health coverage by health plans. In response, record numbers of Senators and Representatives from both political parties cosponsored mental health "parity" legislation in the 108th Congress. Over 36 states have passed some form of parity

National organizations representing consumers, family members, advocates, professionals and providers
c/o Peter Newbould, American Psychological Association Practice Organization, 750 First Street, NE, Washington, DC 20002

laws for those insurance plans governed by state law, and 32 states require insurance plans to cover or offer at least a defined minimum amount of mental health benefits. This hard-won progress in the states would be undermined by legislation that exempts AHPs from state consumer protections and replaces them with negligible standards.

Although supporters argue that this AHP legislation would lower the cost of insurance for small businesses and thus increase coverage, the Congressional Budget Office (CBO) has predicted that 80% of workers in small firms would in fact face premium increases. CBO also estimates that any increase in coverage would likely be minimal because most of those covered by AHPs would have been previously covered by traditional plans. Thus the tangible benefit of the legislation is elusive, but the cost to those needing mental health services could be great because the price for AHPs includes weakening of crucial state laws such as those that prohibit discriminatory limits on mental health. This is a price we cannot accept.

While our organizations focus on mental health care, we note that we are joined in our concerns by governors, insurance commissioners and attorneys general. Consequently, we respectfully ask you to reconsider legislation that would unwisely exempt AHPs from state regulation such as mental health parity laws and other consumer protections.

Thank you for your consideration of our views.

Sincerely,

American Academy of Child and Adolescent Psychiatry
American Association for Geriatric Psychiatry
American Association of Children's Residential Centers
American Association of Pastoral Counselors
American Association of Practice Psychiatrists
American Counseling Association
American Group Psychotherapy Association
American Managed Behavioral Healthcare Association (AMBHA)
American Mental Health Counselors Association
American Nurses Association
American Occupational Therapy Association
American Psychiatric Association
American Psychoanalytic Association
American Psychological Association
American Psychotherapy Association
Association for Ambulatory Behavioral Healthcare
Association for the Advancement of Psychology
Bazelon Center for Mental Health Law
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Clinical Social Work Federation

Clinical Social Work Guild 49, OPEIU
Depression and Bipolar Support Alliance
Eating Disorders Coalition for Research, Policy & Action
NAADAC, The Association for Addiction Professionals
National Alliance for the Mentally Ill
National Association for Children's Behavioral Health
National Association for Rural Mental Health
National Association of Anorexia Nervosa and Associated Disorders – ANAD
National Association of Mental Health Planning & Advisory Councils
National Association of School Psychologists
National Association of Social Workers
National Association of State Mental Health Program Directors
National Coalition of Mental Health Professionals and Consumers, Inc.
National Council for Community Behavioral Healthcare
National Mental Health Association
Suicide Prevention Action Network USA
Therapeutic Communities of America

N · A · W

**National Association of Wholesaler-Distributors**

**Statement of:** **National Association of Wholesaler-Distributors**

**Before the:** **Committee on Small Business and Entrepreneurship United States Senate**

**On:** **HELPING SMALL BUSINESS PROVIDE HEALTH COVERAGE AND LOWER COSTS**

**April 20, 2005**

*Statement of:*
**NATIONAL ASSOCIATION OF WHOLESALER-DISTRIBUTORS**

*Before the:*
**COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP**
**UNITED STATES SENATE**

*On:*
**HELPING SMALL BUSINESSES PROVIDE HEALTH COVERAGE AND LOWER COSTS**

**April 20, 2005**

The National Association of Wholesaler-Distributors (NAW), headquartered in Washington, DC, is the national voice of wholesale distribution, comprised of direct member companies and a federation of 120 national, regional, state and local associations and their member firms which, collectively, total approximately 40,000 companies operating at some 150,000 locations across the country. Wholesaler-distributors provide the link in the marketing chain between manufacturers and retailers as well as commercial, institutional and governmental end-users. While industry firms vary widely in size, wholesaler-distributors generally are small to medium size closely held businesses, which provide jobs to more than six million people and account for approximately $3 trillion annually in economic activity.

The employers affiliated with NAW consider it no less than a national disgrace that in this, the most prosperous society in the history of mankind, some 45 million Americans are medically uninsured and, as a consequence, lack access to quality, timely medical care, a circumstance that carries with it both public health and economic consequences. This problem, fed by rapidly rising health care costs and insurance premiums, is clearly one of national proportion and concern, which commands the attention of government at all levels on a priority basis.

As you know, employers are the primary providers of health insurance in America today. In that vein, there is good news in the fact that health insurance is nearly universally employed in wholesale distribution as a component of employee compensation. NAW's annual health benefits survey of wholesale distribution employers conducted earlier this year reveals that 99 percent of respondents offer some type of health insurance as an employee benefit.

The NAW survey brings additional good news: on average, employers assume 72% of the premium cost. Employer participation to this degree continues to provide a strong incentive for the employees of firms large and small to participate in their employer's health insurance plan.

Unfortunately, the 2005 survey results also reveal a noticeable decline (from 12% to 9%) in employers paying 100% of premium. The reason is cost.

Employer premium costs have been on the rise for several years, and the 2005 NAW survey reveals that premiums for employer-sponsored health insurance in our industry rose by an average of 13 percent, the fourth consecutive year of double-digit increases. Wholesaler-distributors with 25 or fewer employees have an average increase of 15 percent, while employers with 26 – 250 employees have a 14 percent average increase. It is not until you get to the industry's larger employers that the increase falls below the industry wide average.

It is alarming to consider how employers in the wholesale distribution industry are coping with anticipated double-digit premium increases for the foreseeable future. Ninety-eight percent of the respondents to the NAW survey reported that if premium costs continue to rise at or near the current rate, they will be forced to employ some combination of steps that will have the effect of increasing employees' out-of-pocket costs. The main components of this strategy include increases in employees' premium contributions, deductibles, and co-payments while some plan to scale back coverages. This is consistent with what wholesaler-distributors have told us in surveys in each of the preceding three years.

None of this is good news for workers. Indeed, this combination of increased cost and less coverage will severely weaken incentives to participate in employers' health insurance plans. Instead, many employees, particularly those who are young and healthy, as well as lower income workers will likely elect to drop out of their employer's plan and go without coverage.

In short, absent an abatement of the upward trend in employer health insurance premiums, the number of medically uninsured Americans is likely to continue to grow.

NAW believes that there are a number of ways to effectively address the cost issue that will have a positive effect in the context of health insurance coverage and access to quality, timely medical care. A brief discussion of two of the most important options follows:

First, state governments and the federal government must stop imposing additional design and benefit mandates on health insurance plans and the employers and workers who purchase them. An April 2002 report for the American Association of Health Plans (AAHP) prepared by Price Waterhouse Coopers titled *The Factors Fueling Rising Healthcare Costs*, outlines this concern well:

"Over 1,500 mandated benefits exist at the state and federal level, with many more on the horizon. Each mandate adds its own cost, and collectively they have significantly increased healthcare costs ... (S)tates have also enacted numerous process and provider mandates which ... have contributed to the overall cost impact of mandates on health insurance premiums ..."

The AAHP/Price Waterhouse Coopers report estimates that a combination of mandates and government regulation contributes 15 percent to the overall increase in health premiums.

Taken in light of the results of the NAW survey, this data suggests if policy makers wish simply to avoid adding too dramatically to the number of medically uninsured Americans, it is clearly necessary for government at all levels to refrain from adding additional cost-generating mandates

on health plans, their sponsors and beneficiaries. Enactment of *any* mandate that adds *anything* to the cost of offering health insurance as an employee benefit would be clearly at odds with this goal.

Quite the opposite, employers affiliated with NAW would find it refreshing indeed were state governments and the federal government to consider scaling back mandates already enacted, both reducing government-generated, coverage-killing cost and allowing the marketplace to resolve cost and coverage issues.

The latter consideration; providing for a more competitive marketplace in this area, leads to an additional suggestion: enactment of federal legislation permitting the formation and multi-state operation of association health plans (AHPs). In this regard, NAW strongly supports S. 406, the *Small Business Health Fairness Act of 2005* and wishes to congratulate you, Senator Snowe, for your leadership in introducing this important measure. NAW also wishes to thank Senators Bond, Coleman, Isakson, Thune and Vitter for being among the cosponsors of S. 406, a bill similar to bipartisan legislation (H.R. 525) approved on March 16th by the House of Representatives Committee on Education and the Workforce.

If the NAW survey tells us anything, it is that an adverse relationship exists between the cost of health insurance on the one hand and coverage on the other, and that the greatest problem employers in the wholesale distribution industry face in providing and maintaining health insurance benefits for their employees and their families, is cost. Additionally, we know that approximately four of five medically uninsured people have some connection to the workforce, and that a majority of those are in a family supported by a self-employed person or an employee of a small business.

Beyond that, thanks to a General Accounting Office report released in the spring of 2002 entitled *Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market (*GAO-02-536R), we know that the small group health insurance marketplace

is minimally competitive and, in some states, thoroughly uncompetitive. Unfortunately for smaller employers, this market condition leaves them with little from which to choose, and rates that are sustainable only in an uncompetitive environment driven by one or, at most, a few dominant health insurers.

The *Small Business Health Fairness Act of 2005* focuses squarely on these conditions. Through federally-certified AHPs, smaller employers now struggling in the small group market will benefit from added competition and choice, and enjoy the same regulatory advantages, administrative efficiencies, bargaining power and economies of scale now available only to large corporate and union plans.

The principle criticisms aimed at AHPs are discounted by any fair reading of the language of the bill itself.

Opponents contend that AHPs will be inadequately regulated "sham" organizations, exempt from state insurance regulation, and will sell insecure health coverage which will leave behind potentially millions of dollars in unpaid claims. In sum, opponents argue that AHPs are little if any different than widely discredited multiemployer welfare arrangements (MEWAs).

S. 406 tells us otherwise. First, only bona fide associations that have been in business for substantial purposes other than obtaining or providing medical care for at least three years may sponsor a certified AHP. Any such association must be established as a permanent entity, receive the active support of its members, require the periodic payment of dues for maintenance of membership, not condition membership or coverage under the plan on the basis of health status-related factors, and not condition membership on the basis of participation in the health plan. (See Sec. 801 (b), Sec. 802, and Sec. 803 (a)).

Second, Sec. 806 clearly establishes vigorous financial and solvency standards that self-funded AHPs must meet, including reserve requirements (Sec. 806 (a)(2)(A)), aggregate excess/stop loss insurance (Sec. 806 (a)(2)(B)(i)), specific excess/stop loss insurance (Sec. 806 (a)(2)(B)(ii)),

indemnification insurance (Sec. 806 (a)(2)(B)(iii)), and surplus of up to $2 million (Sec. 806 (b)). In addition, to ensure the continued payment of benefits by an AHP in distress, the bill creates an Association Health Plan Fund, funded by self-funded AHPs and earnings on Fund investments (Sec. 806 (f)).

Opponents further contend that AHPs will engage in adverse selection, undermining state regulated small group and individual markets.

Again, the plain language of S. 406 tells us differently. Sec. 804 (d) makes clear than no AHP may turn away any qualified employer from participation in the plan. Sec. 804 (d) further entitles all employers qualified to participate in the plan to obtain information regarding all of the plan's coverage options. Additionally, the plain language of Sec. 804 (c) prohibits any participating employer from excluding from plan coverage any employee based on a health status-related factor, and instead obtain similar coverage for that employee in the individual market. Beyond that, under Sec. 805 (a)(2), an AHP may not vary the contribution rates for any participating small employer on the basis of that employer's claims experience or the type of businesses in which that employer is engaged.

Further, it is important to note that AHPs would be subject to the Health Insurance Portability and Accountability Act (HIPAA) which, among other things, outlaws any denial of coverage based on health status or claims experience.

Finally, opponents contend that the Department of Labor lacks the capacity to adequately regulate AHPs as contemplated by the bill.

On July 9, 2002 Mark McClellan, then a member of the President's Council of Economic Advisors, appeared before the House Subcommittee on Employer-Employee Relations and addressed this concern, pointing to the successful regulatory framework that underpins the now three decades-old Employee Retirement Income Security Act (ERISA) "that has allowed

hundreds of thousands of employers to voluntarily provide affordable health care to employees..." Dr. McClellan pointed out, "ERISA plans cover nearly half of all Americans. ERISA governs not only large individual firms; it also governs multiple-employer union health plans." He went on to remind Members, "The existing ERISA regulatory structure in the DOL's Pension and Welfare Benefits Administration (now the Employee Benefits Security Administration) has been highly effective in preventing abuses ..." and logically concluded, "The Department is confident that it can take on these regulatory responsibilities ..."

In short, Mr. Chairman, DOL has the experience and expertise, and will have the resources necessary to meet its regulatory challenges under the *Small Business Health Fairness Act of 2005*.

Mr. Chairman and Members of the Committee, NAW and our affiliated employers are deeply concerned about the medically uninsured in our country. We believe this problem to be inextricably linked to skyrocketing health insurance premiums. Our own surveys make unmistakably clear that the cost of offering health insurance as an employee benefit is exerting ever-increasing pressure on the bottom lines of wholesaler-distributors. Employers in the industry are telling us with crystal clarity that a serious search has been and remains underway for effective ways to alleviate that pressure.

It is important that policy makers here in Washington and in state capitals act to relieve this growing difficulty. In an effort to reduce exploding health insurance costs, many employers in our industry and in others will be forced to put at risk both the productivity of their workforces as well as their company's competitiveness in labor markets, by further scaling back health insurance benefits. At the same time, however, employers realize that the short-term economic advantages associated with cost-cutting efforts in this area could well be diminished by the effects on premiums that provider cost-shifting ultimately exerts.

To protect our nation's employer-provided health insurance system and to enhance its ability to provide coverage to a wider array of our citizens, NAW urges an end to costly, government-imposed health care mandates, and greater competition and choice in the health insurance marketplace for smaller employers by enactment of S. 406.

Thank you.

**Statement of The**
**National Funeral Directors Association**

**On**

**Solving The Small Business Healthcare Crisis: Alternatives for Lowering Costs And Covering the Uninsured**

**To The**

**United States Senate Committee on Small Business and Entrepreneurship**

**April 20, 2005**

National Funeral Directors Association

The National Funeral Directors Association (NFDA) represents over 13,000 funeral homes in all 50 states. It is the leading funeral service organization in the United States, providing a national voice for the profession. NFDA has been the premier organization chosen by top licensed funeral directors for more than 120 years. NFDA members stand for credibility, ethics, excellence and trust.

National Funeral Directors Association
400 C Street, N.E.
Washington, D.C. 20002-5818
Phone: 202-547-0877 Fax: 202-547-0726
www.nfda.org

**Statement of the National Funeral Directors Association on Solving the Small Business Healthcare Crisis: Alternatives for Lowering Costs and Covering the Uninsured**

The National Funeral Directors Association (NFDA) represents more than 13,000 funeral homes in all 50 states. It is the leading funeral service organization in the United States, providing a national voice for the profession. NFDA has been the premier organization for funeral service professionals for more than 120 years. NFDA members stand for credibility, ethics, excellence and trust.

The average NFDA member operates one to two family-owned funeral homes, has fewer than 10 employees and performs approximately 200 funerals per year.

NFDA agrees that a crisis exists in the small business healthcare market. This crisis continues to grow and has been well documented. The number of uninsured Americans is now at about 45 million. More than 60 percent of them either work for a small business or depend upon someone who does.

Cost is the biggest obstacle for these firms. Insurers typically charge small businesses more per employee then large firms for comparable coverage. Small firms are usually ill equipped to negotiate favorable terms with insurers because an individual firm does not represent a large enough block of business to merit insurers' individual attention. States also typically require group health insurance policies to cover certain specified benefits, medical procedures and treatments, adding to the cost of coverage.

NFDA believes that association health plans (AHPs) are a practical, cost-effective, way of expanding health insurance coverage in the small business market without government mandates or expense. In a January 2000 report, the Congressional Budget Office (CBO) estimated that the average reduction in premium amounts for small businesses obtaining insurance through AHPs would range from 9 percent to as much as 25 percent.

The experience of NFDA members confirms the findings of the CBO study. In a January 2003 survey on this issue, over 92 of percent of responding NFDA members advised that they offer health insurance to their employees as part of their benefit package. Over 65 percent of these reported that premiums for that insurance have increased by 20 percent or more over the past three years. Over 36 percent of respondents reported that their premiums have increased over 30 percent during this time period. This has forced 32 percent of NFDA members responding to the survey to increase the amount that employees pay for health insurance, and 43 percent to reduce the coverage they offered. This situation is getting worse, not better.

This is not only a crisis of affordability and coverage. The inability to provide cost-effective health insurance also puts small business at a significant competitive disadvantage when hiring and retaining employees. No matter what the employment statistics are, good people are hard to find and expensive to train in any business. Small businesses have no superfluous employees.

When employees decline an offer of employment, or leave, because a small business cannot provide health insurance, it often means the loss of an opportunity to grow the business or an

actual decline in revenue. This is especially acute in funeral service, which as been experiencing a shortage of new entrants into the profession for the past several years. The difficulty of providing competitive health insurance coverage exacerbates the competition for employees and has serious economic consequences for NFDA members.

Small business owners want to offer useful health insurance plans that both they and their employees can afford. It is not in their interest to offer bare-bones plans. However, in markets with limited choice and no viable association plans, small business is relegated to a virtual single payer system that cannot provide affordable premiums and decent benefits. In a March 2002 letter to Senator Christopher S. Bond (R-MO), the General Accounting Office (GAO) advised that the five largest carriers represent 75 percent or more of the market in 19 of the 34 states GAO reviewed, and more than 90 percent in seven states. NFDA's survey is consistent with this pattern. Over 44 percent of NFDA members responding advised that Blue Cross/Blue Shield was their health insurance carrier. Twenty-six different insurance carriers provided the coverage for the other 55.6 percent.

While there is no single solution to the problem of the uninsured, AHPs are an essential component to any possible solution. AHPs will allow small businesses to work with each other across state lines and follow one set of rules. The enhanced bargaining power of much larger employee groups, wider health plan options and lower administrative costs will enable associations to create robust benefit packages that respond to the needs of their members, are competitive with larger employers and affordable for both small businesses and their employees. This will significantly reduce the number of uninsured workers in America and place small business in a much more competitive position with respect to hiring and retaining employees.

**Conclusion**

NFDA strongly supports legislation introduced in the 109th Congress to authorize association health plans (H.R. 525/S. 406). This legislation will permit small businesses to establish health insurance purchasing groups through their trade associations under the framework of the Employee Retirement Income Security Act (ERISA) of 1974. It will allow small employers to achieve the economies of scale necessary to obtain viable, cost-effective, health insurance for their employees and their families.

At the same time H.R. 525/S. 406 includes important safeguards to assure that AHPs protect consumer interests. These include strict requirements that permit only bona fide professional and trade associations to sponsor AHPs, stringent solvency standards, making it illegal to "cherry pick" or deny coverage to any eligible participant and strong enforcement tools for federal and state authorities to protect against fraud.

The need for this legislation has never been greater. Congress can and should unburden small business owners from the preoccupation of how to provide health care to their employees and free them to do what they do best – run their business and grow the American economy.

Thank you for allowing NFDA to comment on this important issue. Please include this statement in the record of the Committee's proceedings on this issue.

**Statement of National Lumber and Building Material Dealers Association**

**"Solving the Small Business Health Care Crisis:
Alternatives for Lowering Costs and Covering the Uninsured"**

**Senate Committee on Small Business and Entrepreneurship**

**April 20, 2005**

The National Lumber and Building Material Dealers Association (NLBMDA) appreciates the opportunity to submit the following statement for the official record. We commend Chairwoman Olympia Snowe (R-ME) for her leadership in calling this hearing and the members of the committee for tackling the serious problem of small business health care coverage.

NLBMDA is a national trade association representing more than 8,000 companies, 500,000 employees, and 20 state and regional affiliated associations serving the building supply industry. Our membership is comprised of primarily small, independent retail lumber and building material dealers serving residential builders. NLBMDA dealers are the suppliers of builders in every state and Congressional district in the country.

Typical sales of an NLBMDA dealer range from less than $1 million to over $10 million per year. The typical dealer employs from approximately 20 to 50 workers. The vast majority of NLBMDA dealers are small businesses, and many are multi-generational family-owned businesses that have served their communities for decades.

The challenge of providing health care coverage as costs continue to drastically increase is a significant factor in the building material industry. Our typical small dealer has an average profit margin of less than three percent. Expenditures on health insurance are the single highest operating expense behind salaries and payroll taxes, and have increased as a percentage of operating costs each of the past five years. A company operating at such low profit margins acutely feels even a modest increase in the costs of health insurance.

With 60 percent of America's uninsured population owning or working for small businesses, solutions must be found to increase the affordability of health insurance for those employers. Unfortunately, skyrocketing premiums have forced too many employers to either reduce benefits or drop coverage altogether. Providing health insurance is a vital tool to recruiting and keeping good workers, and dropping coverage is usually a small business owner's last resort, when the only other option is going out of business.

NLBMDA believes that Association Health Plan legislation (S. 406) is a critical component of meaningful reform for the small business health insurance market. Today, roughly half of our state and regional associations provide some sort of health insurance benefit to their members.

(continued)

40 Ivy Street, SE, Washington, DC 20003 ♦ 800.634.8645, 202.547.2230, fax 202.547.7640 ♦ www.dealer.org

For the most part, these arrangements are simply an endorsement of a regional or national plan or a brokerage service helping select individual company coverage, rather than an association-provided group plan. In the past, many were able to provide their own fully-insured plan, but the burden of complying with varying state mandates and regulations led many insurance companies to abandon the small business group market. In one example, our Ohio Lumbermen's Association operated a popular and successful Insurance Trust for 48 years. Before their carrier left the small business insurance market in 2000, the Trust had 131 participating companies, covering 1,205 employees and retirees. Unable to find an insurer to take over the Trust, it was disbanded and the association turned instead to an endorsement arrangement with a national insurer. Unfortunately, the higher costs – premiums increased by roughly 20 percent – and reduced benefits led many companies to look elsewhere for coverage and today only 53 companies participate, with 652 covered employees. If our goal is to cover more employees, not fewer, the system is clearly in need of significant reform.

Under Association Health Plans, small businesses would be able to pool their resources to access the same quality and type of coverage currently available to large corporations and unions. S. 406 would provide Association Health Plans the same ERISA exemption from state and local mandates that large corporations and unions enjoy today. NLBMDA further believes that Association Health Plan legislation would help reintroduce competition into the health care market. For many small businesses, there are only a handful of insurers to choose from, or in some cases even just one provider serving their state.

Trade associations have established relationships with their members that would facilitate the implementation of an AHP. One of the most frequently cited laments about the end of Ohio Lumbermen's Trust was the loss of the high-quality customer service participants received from the association. While this may seem a minor point, it is important to note that employees felt their claims received more personal attention as members of the association than as just another account number to a major national insurer. Additionally, the pre-established relationship enables the trade association to tailor their plan to address the specific needs of the industry, while still complying with Department of Labor oversight.

NLBMDA believes that Association Health Plans are one step towards long-overdue reform addressing the lack of affordable health care options. We encourage the committee to continue to seek new ideas for additional relief, including expanding tax credits and other such means to ease the burden on small business owners.

Independent dealers in the building material industry struggle daily to compete with national "big box" chains, which have access to more affordable health coverage and thus are at an advantage in recruiting employees, as well as given an advantage in holding down costs to remain competitive. Association Health Plans will help put independent dealers on a level playing field.

We thank President Bush and Secretary of Labor Chao for their continued leadership in support of AHP legislation, and are hopeful that the Senate will act to implement this critical reform in the 109th Congress.

*Representing, Educating and Promoting the Restaurant/Hospitality Industry*

1200 SEVENTEENTH STREET NW, WASHINGTON DC 20036-3097 202/331-5900 FAX: 202/331-2429 | www.restaurant.org

NATIONAL RESTAURANT ASSOCIATION®

April 19, 2005

The Honorable Olympia J. Snowe
Chairwoman, Senate Small Business and Entrepreneurship Committee
428A Russell Senate Office Building
Washington, D.C. 20510

Dear Chairwoman Snowe:

The National Restaurant Association — the leading representative for the restaurant industry which employs 12 million Americans — wishes to express its strong support for S. 406, the "Small Business Health Fairness Act of 2005, which you introduced. We would also like to thank you for conducting the April 20th hearing before the Senate Small Business and Entrepreneurship Committee on this legislation. S. 406 allows small businesses to access quality, affordable coverage through Association Health Plans (AHPs).

We share your commitment to improve access to affordable health care for the uninsured—60% of who reside in a family employed by a small business. Most eating and drinking places are single-unit operations with less than 20 employees. Cost continues to be the number one reason small businesses like restaurants can not afford to provide health benefits to their employees. S. 406 directly addresses this problem by allowing workers in small businesses and the self-employed to form voluntary groups and pool their purchasing power to ensure reasonably priced coverage.

S. 406 is fair, bipartisan legislation that establishes strict solvency standards, and protects against any possibility of adverse selection. Of all access measures, the Small Business Health Fairness Act would most efficiently bring down the cost of insurance, saving small businesses 15-30% by giving them the same marketed-oriented tools that corporations and union plans currently enjoy.

Thank you for your continued leadership on this important issue. We appreciate your efforts to help improve access to affordable and reliable heath care for small businesses.

Sincerely,

Steven C. Anderson
President and
Chief Executive Officer

Lee Culpepper
Senior Vice President
Government Affairs and Public Policy

April 19, 2005

The Honorable Olympia Snowe (R-ME)
United States Senate
154 Russell Senate Office Building
Washington, DC 20510
Fax Number: (202) 224-1946

**RE: Association Health Plan Legislation**

Dear Chairwoman Snowe,

As you and the Senate Small Business Committee consider alternatives for lowering health care costs and covering the uninsured, I hope you will consider the impact S. 406 (the Small Business Health Fairness Act) would have on our company and the independent small business owners who operate many of our restaurants.

Perkins Restaurant and Bakery franchisees (independent business owners) operate 332 restaurants and employ over 20,000 people.

The ability to offer an Association Health Plan arrangement to franchisees and their employees would:

- Reduce benefit costs by 10 – 16%
- Offer consistent benefits across the country
- Spread risks to keep future cost increases to a minimum
- Provide health insurance for previously uninsured individuals
- Employ more people.*

*Benefit costs are a part of the labor cost equation. When benefit costs are manageable, owners can add staff, which in-turn benefits their respective communities by reducing unemployment.

The Association Health Plan legislation is more than just reigning in the cost of healthcare – it's about jobs, too.

Sincerely,

Mark T. Hopkins
Sr. Director, Benefits & Systems
Perkins Restaurant & Bakery

Bill Forgione
Vice-President, Human Resources
Perkins Restaurant & Bakery

NATIONAL CONFERENCE *of* STATE LEGISLATURES

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*Maryland House of Delegates*
*President, NCSL*

James E. Greenwalt
*Director, Senate Information System and Administrative Services*
*Minnesota*
*Staff Chair, NCSL*

William T. Pound
*Executive Director*

March 16, 2005

The Honorable John Boehner
Chairman
Committee on Education and the Workforce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable George Miller
Ranking Member
Committee on Education and the Workforce
U.S. House of Representatives
Washington, D.C. 20515

Re: H.R. 525, the Small Business Health Fairness Act

Dear Chairman Boehner and Representative Miller:

On behalf of the National Conference of State Legislatures (NCSL) I am writing to express our opposition to H.R. 525, the Small Business Health Fairness Act. Despite sincere efforts to make improvements to the legislation to address state concerns, our key issues remain unresolved.

This legislation would:

- preempt state laws that provide critical protections to consumers and fails to replace them with adequate federal protections;
- destabilize the state small group insurance market, undermining previously enacted state and federal insurance reforms, and reintroducing practices that had been banned by those laws; and
- provide insufficient resources to the U.S. Department of Labor (DOL) to perform the necessary regulatory and oversight duties associated with regulating health insurers, providing fertile soil for unscrupulous entities to flourish unfettered by state laws, state lawmakers and state regulators.

We are mindful of the extreme hardship many small businesses face as they try to provide affordable and high quality health care coverage for their workers. NCSL remains committed to working with you and other members of Congress to find solutions that will provide high quality, affordable health care coverage for employees of small businesses and for all of our constituents.

Sincerely,

William Pound

William T. Pound
Executive Director

cc: Members, House Committee on Education and the Workforce

**Washington**
*444 North Capitol Street, NW, Suite 515*
*Washington, D.C. 20001*
*Phone 202.624.5400 Fax 202.737.1069*

**Denver**
*7700 East First Place*
*Denver, Colorado 80230*
*Phone 303.364.7700 Fax 303.364.7800*

*Website www.ncsl.org*

# STATEMENT FOR THE RECORD

# BY THE

# PRINTING INDUSTRIES OF AMERICA, INC. (PIA/GATF)

# BEFORE THE

# SENATE COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP

## "Solving the Small Business Health Care Crisis: Alternatives for Lowering Costs and Covering the Uninsured"

**April 20, 2005**

The Printing Industries of America, Inc. (PIA/GATF) is pleased to present this statement for the record before the Senate Committee on Small Business and Entrepreneurship, and thanks Chairman Snowe for holding a hearing to examine options for solving the ever-growing crisis of affordable, accessible health care for small businesses. PIA/GATF represents nearly 12,000 commercial printers, the vast majority of which are small businesses with an average of 27 employees. In annual surveys of PIA/GATF's membership, the cost of health insurance consistently ranks as one of the highest concerns facing the industry. Therefore, PIA/GATF advocates exploring alternatives to the current small-group insurance marketplace, and specifically supports legislation (S. 406, the Small Business Health Fairness Act) creating Association Health Plans (AHPs) as one such option.

*Small Business and the Uninsured: Getting Worse Before It Gets Better*

The lack of access to affordable health insurance for small businesses is not a new problem. Many industry organizations, including PIA/GATF, have proclaimed the situation to be a "national crisis" for several years, and the crisis continues to grow. U.S. Census Bureau reports from year-to-year quantify the escalating problem. In 2002, the U.S. Census Bureau cited the number of Americans lacking health insurance to be 43.6 million; 2003 reports cited the number to be 45 million. Small business owners and their families, as well as employees of small businesses and their families, comprise a major bloc of these uninsured. According to the National Federation of Independent Business, an organization representing small businesses within various industries, including printing, of

the roughly 45 million uninsured Americans, more than half are employed by or are dependents of someone employed by a small business. Allowing small business owners to band together across state lines in order to purchase health insurance through memberships in bona fide trade and professional associations is one alternative to curb this worsening problem.

*AHPs Would Provide Health Insurance Cost and Geographic Parity for Small Businesses*

In today's health insurance marketplace, small businesses are not afforded the same purchasing power, administrative efficiencies and choice in the marketplace that large corporations and labor unions currently enjoy. In the "Employer Health Benefits 2004 Annual Survey" conducted by the Kaiser Family Foundation, data showed that 73% of insured employees of small businesses were offered just one health insurance plan, while conversely 82% of employees in large firms had a choice of at least two health insurance plans. This is but one example of lack of parity small business owners and employees find in today's health insurance market, and one that AHPs could seek to level.

Not only would AHPs provide parity between small businesses, organized labor and Corporate America, but AHPs would end the seemingly illogical discrimination certain geographic pockets of small businesses face today. For example, some PIA/GATF state affiliates currently provide AHPs to printing companies because the affiliate membership falls within state lines. However, not all PIA/GATF state affiliates are organized within state boundaries. For example, the Printing Industries of the Carolinas represents printing companies in both North Carolina and South Carolina. Because its membership reaches across the Carolinas state line, the Printing Industries of the Carolinas would be forced to comply with two sets of state mandates and administrative burdens should it wish to offer an AHP to its membership. The mandates and administrative complexities would effectively outweigh the cost-savings. Therefore, printing companies in North Carolina and South Carolina are less able to benefit from the types of state-based AHPs arrangements fellow printing companies in other states enjoy. Congress should allow AHPs to operate on a national basis so that <u>all</u> small businesses have the opportunity to seek alternatives to the current health insurance marketplace.

*PIA/GATF Affiliate Multi-State AHP Serves as Model for the Promise of National AHPs; Demonstrates Administrative Efficiencies that National AHPs Would Provide*

The current national debate over AHPs consists almost exclusively of theoretical examples of how AHPs would address the crisis of lack of access to affordable health care coverage. In fact, the example of the Printing Industries of the Carolinas stated above is in itself theoretical. However, certain state-based AHPs now in operation provide practical examples of the promise that a national AHP structure may hold for small businesses struggling to secure health insurance. One such plan existing within the PIA/GATF organization is the Graphic Arts Benefit Corporation (Corporation), which provides health insurance to members of the graphics arts industry and a small percentage of other self-employed individuals in the District of Columbia, Northern Virginia, and D.C. "collar counties" in Maryland.

The Corporation covers between 5000-6000 individuals, and, as shown in the mandatory small group market rate guide published every six months in the State of Maryland, the Corporation offers consistently lower rates than most major health insurance companies. The Corporation, while maintaining its comparatively low costs, still provides its members with a wide PPO network of doctors similar to those offered by large insurers. Its successful operation has been in place for over 20 years.

However, looking underneath the surface of the Corporation reveals the very types of administrative inefficiencies operating health insurance plans across state lines currently produces. For example, the State of Maryland maintains both financial auditing and market conduct auditing requirements that have cost the Corporation approximately $80,000 per audit ($160,000 total) in any given year, while the State of Virginia, District of Columbia and the U.S. Department of Labor, all of which also have oversight authority over the Corporation, do not require payment for audits. Under a national AHP structure, it's quite possible that this $160,000 administrative expense would not be incurred.

Additionally, varying reserves requirements set by states cause administrative burdens for the Corporation. The State of Maryland requires the Corporation to lower its premiums should reserves rise to a certain level, while the State of Virginia takes the opposite approach, requiring reserves to equate to a certain number of days. This inconsistency causes the Corporation to walk a fine line between maintaining reserves that are "too high" and "too low." The uneven balance between the patchwork of coverage mandates imposed by Maryland, Virginia and the District of Columbia also contribute to administrative nightmares. Even smaller expenditures made by the Corporation, such as the approximately $5000 per year cost to print three separate sets of health insurance plan guides for Maryland, Virginia and the District of Columbia, reflect administrative and cost inefficiencies.

The Corporation estimates that operating under a national AHP structure, in which elements such as audits, reserve requirements, coverage mandates and other administrative expenses were streamlined, it could save $50,000 per year. This $250,000 savings over a five year period would allow the Corporation to offer more affordable health insurance to its members, as well to potential new members in other states, such as Pennsylvania or West Virginia. The Graphics Arts Benefit Corporation and AHPs currently operated by other industry groups, though few in number, demonstrate the potential that a national AHP structure could have in curbing the rising ranks of the uninsured.

*AHPs Not "Risky" Propositions; Current Legislation Would Provide Strong Solvency Safeguards*

Despite the potential illustrated above, opponents of AHPs, such as insurance companies and state regulators, consistently hearken to the notion that a new national AHP structure is doomed to failure. Citing Multiple Employer Welfare Arrangements (MEWAs), previous plans that were conceptually similar to AHPs, opponents argue that AHPs regulated by the U.S. Department of Labor, rather than by state regulators, would promote "fly by night"

*Mark R. Warner*
Governor of Virginia
Chairman

*Mike Huckabee*
Governor of Arkansas
Vice Chairman

*Raymond C. Scheppach*
Executive Director

March 28, 2005

The Honorable Bill Frist
Majority Leader
United States Senate
Washington, D.C. 20510

The Honorable Harry Reid
Minority Leader
United States Senate
Washington, D.C. 20510

Dear Senator Frist and Senator Reid:

Rapidly escalating health care costs have posed a major challenge for states as we work to ensure that our citizens have access to affordable health insurance coverage. We are very concerned about legislation that could make this situation worse. Congress may soon consider proposals that would undermine our efforts by exempting Association Health Plans (AHPs) from state insurance reforms.

AHPs are health insurance companies sponsored by business and professional associations that would be granted a special exemption from state regulation, and would instead operate under limited federal rules and virtually no oversight. Under current AHP proposals, these types of insurers would be exempt from important regulations that our states have designed to ensure a healthy small insurance group market that can deliver affordable care to all participants.

As a result, AHPs would be free to selectively market to healthy groups by selling stripped down benefit packages that exclude benefits now required by the states. AHPs also would be permitted to increase premiums without limit for businesses with older, sicker workers, despite the fact that states strictly limit or prohibit these type of rating practices. People could purchase minimal AHP coverage when they are healthy, but then jump back to state regulated insurance when they need more comprehensive coverage in the state-regulated market.

This is a major problem since it would create two pools of individuals: relatively healthy people in the federal AHPs and older, sicker people in the state-regulated market. The result: spiraling premiums for most employers. The Congressional Budget Office in 2003 projected that AHP legislation would result in higher premiums for three out of four small employers if enacted.

Looking to the future, this legislation raises important questions about the future ability of our states to regulate health insurance at all. By allowing insurers who sell to AHPs to set up shop in a state with very lenient rules and oversight and market to small employers without meeting other states' rules, we would have limited ability to take action even where there is an obvious risk to consumers.

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Congress should be especially concerned about preempting state oversight given the long history of failures involving similar plans called Multiple Employer Welfare Arrangements (MEWAs). AHP legislation would exacerbate these problems by replacing state oversight with minimum certification by the U.S. Department of Labor, which has no capacity for regulating insurance arrangements.

We strongly urge you to recognize the critical role states play in making health coverage affordable and accessible for our citizens. Please do not support AHP legislation, which would only tie our hands and exacerbate the task before us.

Sincerely,

Governor Mark R. Warner
Chairman

Governor Mike Huckabee
Vice Chairman

April 18, 2005

The Honorable John F. Kerry
Ranking Member
Committee on Small Business and Entrepreneurship
United States Senate
Washington, DC 20510

Dear Senator Kerry:

On behalf of the National Partnership for Women & Families, I urge you to oppose S. 406, the federal association health plan (AHP) legislation, that will be discussed during this week's hearing on health care solutions for small businesses. This legislation is bad medicine for our nation's health care system, especially for women small business owners and their workers.

Instead of providing real solutions for those struggling to afford quality health coverage, S. 406 will make coverage more expensive for the vast majority of small businesses, price coverage out of reach for less healthy workers and employer groups, and could lead to even greater numbers of uninsured. The Congressional Budget Office (CBO) has estimated that AHPs would drive up health care premiums for 4 out of 5 small business workers and their families.[1] CBO also has found that the small number of uninsured Americans who would gain coverage under AHPs would be the healthiest small employer groups, while the least healthy, older, disabled, and chronically ill worker groups would be left with higher premiums and cost-sharing in the state-regulated market.[2] A 2003 Mercer study predicted even more dire results, estimating that as many as one million individuals could become uninsured if S. 406 were to become law.[3] The Mercer study also found that premiums for state-regulated small business coverage would increase by as much as 23%, and premiums for all small businesses would increase 6% on average.[4] Far from solving the problems small businesses are now facing, S. 406 would worsen our nation's already dire health insurance crisis.

Women in particular would lose under S. 406. The small business health care crisis has a significant impact on women. Women are disproportionately likely to be owners of, or workers

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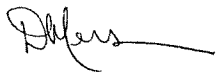
2 *CBO Paper: Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts*, January 2000, 14, 15, 17.
3 *Id.*
4 Mercer Risk, Finance & Insurance Consulting, *Impact of Association Health Plan Legislation on Premiums and Coverage for Small Employers* (prepared for National Small Business Association), June 2003, 2.
5 *Id.*

for, very small firms, and to suffer when health coverage is unavailable. Women covered by AHPs would likely pay more out-of-pocket for needed services, and women left out of AHPs would see their premiums increase in the state-regulated insurance market. Low-income and low-wage working women, many of whom are single mothers, would be at particular risk. Because AHPs would be exempt from most state benefit requirements, women enrolled in AHPs would likely lose access to essential health services, such as maternity benefits, breast and cervical cancer screening, minimum hospital stays following a mastectomy, direct access to an obstetrician/gynecologist, contraceptive drugs and devices, emergency services, and mental health benefits. Other critical state consumer protections would also be lost, including independent external review of health coverage disputes, rating rules to ensure fair pricing and affordable coverage, and direct assistance with complaints. Exemption from meaningful state oversight and protections would also leave those covered by AHPs vulnerable to fraud and insolvencies.

The National Partnership is committed to developing viable solutions to the problems small businesses face in obtaining affordable health insurance for themselves and their workers. An effective proposal to address these problems must offer meaningful solutions for covering the uninsured, provide access to affordable, comprehensive coverage for all small businesses, help those most in need, and provide strong consumer protections. It should also address the rising cost of health care. S. 406 falls far short of meeting these principles.

For these reasons, the National Partnership is helping to lead a coalition of more than 1300 national, state and local organizations in opposition to S. 406 – a list of these diverse organizations, including organizations representing consumers, patients, disease advocates, providers, labor unions, small businesses, local farm bureaus, and health insurers, is attached. We urge you to oppose this legislation, and look forward to working with you on options that will provide small businesses and their employees with access to affordable, quality health care.

Sincerely,



Debra L. Ness
President

April 19, 2005

The Honorable Olympia Snowe
Chair
Committee on Small Business and Entrepreneurship
United States Senate
Washington, DC 20510

Dear Senator Snowe:

On behalf of the National Partnership for Women & Families, I urge you to oppose S. 406, the federal association health plan (AHP) legislation, that will be discussed during this week's hearing on health care solutions for small businesses. This legislation is bad medicine for our nation's health care system, especially for women small business owners and their workers.

Instead of providing real solutions for those struggling to afford quality health coverage, S. 406 will make coverage more expensive for the vast majority of small businesses, price coverage out of reach for less healthy workers and employer groups, and could lead to even greater numbers of uninsured. The Congressional Budget Office (CBO) has estimated that AHPs would drive up health care premiums for 4 out of 5 small business workers and their families.[1] CBO also has found that the small number of uninsured Americans who would gain coverage under AHPs would be the healthiest small employer groups, while the least healthy, older, disabled, and chronically ill worker groups would be left with higher premiums and cost-sharing in the state-regulated market.[2] A 2003 Mercer study predicted even more dire results, estimating that as many as one million individuals could become uninsured if S. 406 were to become law.[3] The Mercer study also found that premiums for state-regulated small business coverage would increase by as much as 23%, and premiums for all small businesses would increase 6% on average.[4] Far from solving the problems small businesses are now facing, S. 406 would worsen our nation's already dire health insurance crisis.

Women in particular would lose under S. 406. The small business health care crisis has a significant impact on women. Women are disproportionately likely to be owners of, or workers for, very small firms, and to suffer when health coverage is unavailable. Women covered by AHPs would likely pay more out-of-pocket for needed services, and women left out of AHPs would see their premiums increase in the state-regulated insurance market. Low-income and low-wage working women, many of whom are single mothers, would be at particular risk.

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2 *CBO Paper: Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts*, January 2000, 14, 15, 17.
3 *Id.*
4 Mercer Risk, Finance & Insurance Consulting, *Impact of Association Health Plan Legislation on Premiums and Coverage for Small Employers* (prepared for National Small Business Association), June 2003, 2.
5 *Id.*

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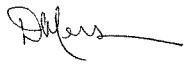
Because AHPs would be exempt from most state benefit requirements, women enrolled in AHPs would likely lose access to essential health services, such as maternity benefits, breast and cervical cancer screening, minimum hospital stays following a mastectomy, direct access to an obstetrician/gynecologist, contraceptive drugs and devices, emergency services, and mental health benefits. Other critical state consumer protections would also be lost, including independent external review of health coverage disputes, rating rules to ensure fair pricing and affordable coverage, and direct assistance with complaints. Exemption from meaningful state oversight and protections would also leave those covered by AHPs vulnerable to fraud and insolvencies.

The National Partnership is committed to developing viable solutions to the problems small businesses face in obtaining affordable health insurance for themselves and their workers. An effective proposal to address these problems must offer meaningful solutions for covering the uninsured, provide access to affordable, comprehensive coverage for all small businesses, help those most in need, and provide strong consumer protections. It should also address the rising cost of health care. S. 406 falls far short of meeting these principles.

For these reasons, the National Partnership is helping to lead a coalition of more than 1300 national, state and local organizations in opposition to S. 406 – a list of these diverse organizations, including organizations representing consumers, patients, disease advocates, providers, labor unions, small businesses, local farm bureaus, and health insurers, is attached. We urge you to oppose this legislation, and look forward to working with you on options that will provide small businesses and their employees with access to affordable, quality health care.

Sincerely,



Debra L. Ness
President

## Organizations and Public Officials Opposed to Federal AHP Legislation

Over **1,300** national and local organizations have joined in opposing federal legislation that would allow Association Health Plans (AHPs) to operate without state oversight. Concerns of the organizations are expressed in the many letters they are sending to Congress:

> *"The provisions in H.R. 660 that exempt AHPs from state regulation would be a disaster for people with diabetes."* **-- American Diabetes Association**
>
> *"By removing coverage for cost-effective benefits such as well-child care, the AHPs created by H.R. 660 could drive up the cost of health care."* **-- American Nurses Association**
>
> *"Elimination of the state role and replacement with weak federal oversight is a bad deal for small businesses and for consumers."* **-- State Attorneys General**
>
> *"This legislation would seriously undermine access to affordable health care for Latino small business owners and their workers."* **-- National Council of La Raza**
>
> *"Rather than solving the many health care issues, this bill would only serve to create additional barriers for many communities to have adequate access to quality, affordable health care."* **-- National Association for the Advancement of Colored People (NAACP)**
>
> *"AHPs would be free to selectively market to healthy groups by selling stripped down benefit packages that exclude benefits now required by the states."* **-- National Governors Association**
>
> *"Our understanding of the current AHP proposals before Congress leaves us with concerns that these plans would actually break up the large pools of small employers now required under state law, which would raise costs for many groups, possibly adding to the already high number of uninsured in Oklahoma."* **-- Tulsa Oklahoma Chamber of Commerce**

The following are just a few examples from the long and growing list (attached):

**Consumer Organizations:** National Partnership for Women & Families; American Diabetes Association; Consumers Union; Families USA; National Mental Health Association

**State Officials:** National Governors Association; Democratic Governors Association; Republican Governors Association; 41 Attorneys General; National Association of Insurance Commissioners; National Conference of State Legislatures

**Small Business Organizations:** National Small Business Association; Alaska Coalition of Small Business; Indiana Manufacturers Association; New Hampshire Business Council

**Local Chambers of Commerce:** 30+ Major Metropolitan Chambers Representing Thousands of Local Chambers of Commerce, including Oklahoma State, Washington State, Denver, and Indianapolis

**Local Farm Bureaus:** Mississippi Farm Bureau; Tennessee Farm Bureau – Rural Tennessee Health; Virginia Farm Bureau

**Provider/Physician Organizations:** American Academy of Pediatrics; American Nurses Association; American Optometric Association; American Psychological Association; American Chiropractic Association; National Association of Social Workers

**Labor Organizations:** AFL-CIO; AFSCME; American Federation of Teachers; CWA; IBEW; UAW

**February 15, 2005**

# Organizations and Public Officials Opposed to Federal AHP Legislation

**February 15, 2005**

***Over 1,300 Organizations Have Expressed Opposition:***

## State Officials:

**National Groups**

- National Governors Association
- Republican Governors Association
- Democratic Governors Association
- Attorneys General Representing 41 States*
- National Association of Insurance Commissioners
- National Association of State Mental Health Program Directors
- National Conference of Insurance Legislators
- National Conference of State Legislatures

## Chambers of Commerce:

- Albuquerque (NM) Chamber
- Arapahoe Chamber of Commerce (Nebraska)
- Ashland Chamber of Commerce (Nebraska)
- Black Chamber of Commerce of Greater Kansas City
- Blanding Chamber of Commerce (Utah)
- Bloomfield Chamber of Commerce (Nebraska)
- Boise Metro Chamber of Commerce (Idaho)
- Boston Chamber
- Broken Bow Chamber of Commerce (Nebraska)
- Buffalo-Niagara Partnership (New York)
- Carey Area Chamber of Commerce (Ohio)
- Cherry Creek Chamber (Colorado)
- Colorado Black Chamber of Commerce
- Colorado Hispanic Chamber of Commerce
- Council of Smaller Enterprises/Greater Cleveland Growth Association (COSE)
- Denver Metro
- Detroit
- Draper Chamber of Commerce (Utah)
- Duchesne Chamber of Commerce (Utah)
- Evans Chamber of Commerce (Colorado)
- Florence, Colorado
- Grand Rapids Area Chamber of Commerce
- Greater Akron Chamber (Ohio)
- Greater Cincinnati Chamber
- Greater Columbus Chamber (Ohio)
- Greater Des Moines Partnership (Iowa)
- Greater Indianapolis Chamber (Indiana)
- Greater Louisville, Inc. (Louisville, Kentucky Chamber of Commerce)

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* AK, AZ, AR, CA, CO, CT, DE, GA, ID, IL, IN, IA, KY, LA, ME, MD, MA, MN, MS, MO, MT, NV, NH, NJ, NY, NC, ND, OH, OK, OR, PA, RI, SD, TN, UT, VT, USVI, VA, WA, WV, WI

- Greater North Dakota Association
- Greater Pittsburgh Chamber of Commerce (Pennsylvania)
- Greater Seattle Chamber
- Heber Valley Economic Development (Utah)
- Herington Chamber of Commerce (Kansas)
- Hiawatha Chamber of Commerce (Kansas)
- Holton Area Chamber of Commerce (Kansas)
- Lake City Chamber of Commerce (Colorado)
- Lansing Regional Chamber (Michigan)
- Lehi Chamber of Commerce (Utah)
- Merrimack Valley Chamber of Commerce
- Metro Jackson, Mississippi
- Michigan Chamber of Commerce
- Midvale Chamber of Commerce (Utah)
- New Hampshire Business and Industry Association
- North Central Massachusetts Chamber of Commerce
- North Park Chamber (Colorado)
- Northern Kentucky Chamber of Commerce
- Northern Ohio Chamber of Commerce
- Oklahoma City
- Oklahoma State
- Oregon Association of Industries (Oregon State Chamber of Commerce)
- Palisade Chamber (Colorado)
- Paola Chamber of Commerce (Kansas)
- Ravenna Area Chamber of Commerce (Ohio)
- Salem Economic Development (Utah)
- Saratoga County Chamber of Commerce (New York)
- South Carolina Small Business Chamber of Commerce
- Spanish Fork Area Chamber of Commerce (Utah)
- Springfield Chamber of Commerce (Colorado)
- Springfield, Missouri Chamber of Commerce
- Springville Area Chamber of Commerce (Utah)
- Tacoma-Pierce County Chamber of Commerce
- Toledo Area Chamber of Commerce
- Tulsa, Oklahoma
- Washington State (Association of Washington Business)
- West Jordan Chamber (Utah)
- Woodson County Chamber of Commerce (Kansas)
- Worland Chamber of Commerce (Wyoming)
- Youngstown-Warren Chamber (Ohio)

**Farm Bureaus:**

- Alabama Farmers Association (ALFA)
- Mississippi Farm Bureau
- Tennessee Farm Bureau Federation – Tennessee Rural Health
- Virginia Farm Bureau

**Small Business Associations:**

- Alaska Coalition of Small Business
- Arizona Small Business Association
- Chamber of Commerce Service Organization - Pennsylvania

- 4D Industries (Oregon)
- Indiana Association of Community and Economic Development
- Indiana Manufacturers' Association
- Fargo-Moorhead Homebuilders' Association
- Ohio/Kentucky Concrete Pavement Association
- Mountain States Lumber and Building Materials Dealers Association (Colorado)
- National Small Business Association (Represents over 150,000 small businesses nationwide)
- New England Council
- New Hampshire Business Council
- New Hampshire High Tech Council
- Oregon Business Alliance
- Pittsburgh Technology Council (Pennsylvania)
- Priority Management (Colorado)
- Professional Musicians Of Arizona
- Rhode Island Small Business Association
- SMC Business Councils (Pennsylvania)
- Santaquin Economic Development Agency (Utah)
- Small Business Association of Michigan
- Small Business for America, New Mexico Chapter
- Utah Small Business Development Center – Utah Valley State College

**Labor Organizations:**

- AFL-CIO - American Federation of Labor and Congress of Industrial Organizations
  - Including 51 State Federations and almost 600 Central Labor Councils
- Alabama Education Retirees Association (AERS)
- Alabama Teachers' Union (AEA)
- American Federation of State, County and Municipal Employees (AFSCME)
  With additional letters from:
  - Alabama
  - Alabama Retired State Employees Association
  - Arizona
  - Colorado, Council 76
  - Indiana
  - Kansas Local 1715, Chapter 3371
  - Louisiana AFSCME Council 17
  - Nebraska
  - New Mexico
  - Ohio AFSCME Council 8
  - Ohio AFSCME Retiree Chapter 1184
  - Ohio Association of Public School Employees, AFSCME Local 4
  - Ohio Civil Service Employees Association (OCSEA/AFSCME Local 11)
  - Oklahoma Local 2406
  - Rhode Island Council 94
  - Utah Local 1004
  - Virginia Local 27
- American Federation of Teachers (AFT)
  With additional letters from:
  - Albuquerque, New Mexico Federation of Teachers
  - Arkansas Federation of Teachers
  - Colorado Federation of Teachers
  - Kansas Federation of Teachers

- Louisiana Federation of Teachers
- Oklahoma City Federation of Teachers
- Ohio Federation of Teachers
- Oregon Federation of Teachers
- Rapides (Louisiana)
- Utah American Federation of Teachers
- Atlanta Labor Council
- Boilermaker's Lodge 101 (Colorado)
- Cement Masons Local 577 (Colorado)
- Central Georgia Federation of Trades and Labor Council
- Colorado Education Association
- Colorado Federation of Public Employees
- Colorado Postal Workers Union – Colorado State Chapter
- Communications Workers of America (CWA)
- Culinary Union Local 226 (Nevada)
- Greater St. Louis Labor Council (Missouri)
- International Brotherhood of Electrical Workers (IBEW)
  With additional letters from:
  - Cleveland, Ohio Local 1377
  - Columbus, Ohio Local 1466
  - Dayton, Ohio Local 82
  - Kansas Local 304
  - Milan, Ohio Local 1194
  - Nebraska Local 1614
  - Oak Harbor, Ohio Local 1432
  - Ohio Local 2331
  - Oregon
  - Portsmouth, Ohio, Local 575
  - Steubenville, Ohio, Local 246
- International Union, United Auto Workers (UAW)
- International Union of Bricklayers and Allied Craftworkers
- Kansas Association of Middle School Administrators
- Kansas Association of Public Employees
- Kansas Postal Workers Union
- Labor Federation of Central Kansas
- Laborers' International Union – Local 149 – Aurora, Illinois
- Laborers' Local 424 – Missouri
- Middle Georgia Central Labor Council
- Missouri Steelworkers Union
- Montana Progressive Labor Caucus
- National Education Association – Kansas
- National Education Association – Wyandotte United UniServ (Kansas)
- National Education Association – Rhode Island
- National Education Association of Shawnee Mission (Kansas)
- Nebraska State Education Assoication
- Ocean State Action (AFT – Rhode Island)
- Ohio and Vicinity Regional Council of Carpenters
- Ohio Valley Council of Sheet Metal Workers
  - Sheet Metal Workers Local 24
  - Sheet Metal Workers Local 33
- Oklahoma Postal Workers Union

- Oklahoma Service Workers Union
- Omaha Education Association (Nebraska)
- Oregon Federation of Nurses
- Oregon School Employees Association
- Paper Allied-Industrial, Chemical and Energy Workers International Union (PACE)
- Pipe Fitters Local 120 (Ohio)
- Service Employees International Union (SEIU)
  With additional letters from:
  - Alabama
  - Arkansas
  - Colorado, Local 105
  - Georgia, Local 1985
  - Kansas, Local 513
  - Missouri, Local 2000
  - New Hampshire, Local 1984
  - Ohio, District 1199
  - Ohio, Local 3
  - Oregon, Local 503
  - Washington
- Shipbuilders and Boilermakers International Union – Virginia Chapter
- Teamsters Union – Maine
- Teamsters' 190 – Montana
- Teamsters Local 407 – Ohio
- Tile Layer Local 36 – Ohio
- UNITEHERE!
- United Food and Commercial Workers International Union
  With Additional Letters From:
  - Ohio (Local 1059)
  - Ohio (Local 1099)
  - Missouri (Local 655)
  - Nebraska (Local 22)
  - Washington State
- United Mine Workers of America (Ohio COMPAC District 6)
- United Phoenix Fire Fighters (Arizona)
- United Steelworkers of America
- United Teachers of Wichita, Kansas
- United Transportation Union – Louisiana

## Consumer/Advocacy Groups:

**National Groups**

- Alliance for Children and Families
- American Agricultural Movement, Inc.
- American Association of Pastoral Counselors
- American Association of People with Disabilities
- American Cancer Society
- American Congress of Community Supports and Employment Services
- American Corn Growers Association
- American Diabetes Association – With additional letters from:
  - Alabama Chapter
  - Alaska Chapter
  - Arkansas Chapter

  - Central Ohio Chapter
  - Cleveland Ohio Chapter
  - Colorado Chapter
  - Indiana Chapter
  - Iowa Chapter
  - Kansas Chapter
  - Louisiana Chapter
  - Maine Chapter
  - Minnesota Chapter
  - Montana Chapter
  - Nebraska Chapter
  - Nevada Chapter
  - New Hampshire Chapter
  - New Mexico Chapter
  - North Carolina Chapter
  - Northeast Ohio Chapter
  - Oklahoma Chapter
  - Oregon Chapter
  - Rhode Island Chapter
  - Seattle, Washington Chapter
  - Southwest Ohio & Northern Kentucky Chapter
  - Utah Chapter
  - Washington Chapter
- American Family Foundation
- American Homeowners Grassroots Alliance
- Americans for a Balanced Budget
- Anxiety Disorders Association of America
- Association for the Advancement of Psychology
- Bazelon Center for Mental Health Law
- Center on Disability and Health
- Child Welfare League of America
- Children & Adults with Attention-Deficit/Hyperactivity Disorder
- Children's Defense Fund – With additional letters from:
  - Ohio Chapter
- Coalition Against Insurance Fraud
- Consumer Federation of America
- Consumers Union
- Depression and Bipolar Support Alliance
  With additional letters from:
  - Depression and Bi-Polar Support Alliance of Ohio
  - Depression and Bi-Polar Support Alliance of Columbus, Ohio
  - Depression and Bi-Polar Support Alliance of Dayton, Ohio
  - Depression and Bi-Polar Support Alliance of Medina, Ohio
- Families USA
- Federation of Families for Children's Mental Health
- Federation of Southern Cooperatives
- Friends Committee on National Legislation
- Institute for America's Future
- International Certification and Reciprocity Consortium
- League of United Latin American Citizens (LULAC) – With additional letters from:
  - Arkansas Chapter

- Maternal and Child Health Coalition for Healthy Families
- National Alliance for the Mentally Ill – With additional letters from:
  - Arizona Chapter
  - Arkansas Chapter
  - Colorado Chapter
  - Georgia Chapter
  - Kansas Chapter
  - Louisiana Chapter
  - Maine Chapter
  - Montana Chapter
  - Nebraska Chapter
  - New Hampshire Chapter
  - New Mexico Chapter
  - North Carolina Chapter
  - Oklahoma Chapter
  - Ohio Chapter
    - Adams County (Ohio)
    - Allen, Auglaize & Hardin Counties (Ohio)
    - Athens County (Ohio)
    - Butler County (Ohio)
    - Clark County (Ohio)
    - Clermont County (Ohio)
    - Cleveland Metro (Ohio)
    - Fairfield County (Ohio)
    - Franklin County (Ohio)
    - Lancaster Area (Ohio)
    - Licking County (Ohio)
    - Logan & Champaign County (Ohio)
    - Mahoning Valley (Ohio)
    - Mercer, Van Wert and Paulding Counties (Ohio)
    - Portage County (Ohio)
    - Richland County (Ohio)
    - Ross/Pickaway Counties (Ohio)
    - Seneca, Sandusky and Wyandot Counties (Ohio)
    - Stark County (Ohio)
    - Warren County (Ohio)
  - Oregon Chapter
  - Rhode Island Chapter
  - St. Louis Chapter
  - South Carolina Chapter
  - Utah Chapter
  - Washington Chapter
- National Association for Children's Behavioral Health
- National Association for Rural Mental Health
- National Association for the Advancement of Colored People (NAACP)
  - Colorado-Montana-Wyoming State Conference of Branches
  - Iowa/Nebraska State Conference of Branches
  - North Carolina Chapter
- National Association of Anorexia Nervosa and Associated Disorders
- National Association of Farmer Elected Committees
- National Association of Protection and Advocacy Systems

- National Coalition for the Homeless
- National Council of La Raza
  - Utah Chapter
- National Farmers Organization
- National Foundation for Depressive Illness
- National Mental Health Association – With additional letters from:
  - California Chapter
  - Colorado Chapter
  - Franklin County (Ohio)
  - Georgia Chapter
  - Greater St. Louis Chapter (Missouri)
  - Illinois Chapter
  - Indiana Chapter
  - Knox County (Ohio)
  - Licking County (Ohio)
  - Louisiana Chapter
  - Lucas County (Ohio)
  - Miami County (Ohio)
  - Minnesota Chapter
  - Montana Chapter
  - New Mexico Chapter
  - Nebraska Chapter
  - North Carolina
  - Oregon Chapter (Mental Health Association of Oregon – MHAO)
  - Ottawa County (Ohio)
  - Stillwater-Sweetgrass Counties (Montana)
  - Summit County (Ohio)
  - Tulsa, Oklahoma Chapter
  - Union County (Ohio)
  - Utah Chapter
  - Wyoming Chapter
- National Partnership for Women & Families
- National Patient Advocate Foundation
- Planned Parenthood Federation of America
- Research Institute for Independent Living
- Soybean Producers of America
- Suicide Prevention Action Network
- Tourette Syndrome Association
- United Cerebral Palsy Association
- USAction
- Women Involved in Farm Economics

**Local Groups**

- 60 Plus Association - Virginia
- 9 to 5 National Working Women's Association (Colorado)
- AIDS Alliance Service (North Carolina)
- AIDS Prevention ACTION Network (California)
- AIDS Project of Arizona
- AIDS Response Seacoast – New Hampshire

- AIDS Survival Project (Georgia)
- ARC of Adams-Clay (Nebraska)
- ARC of Alabama
- ARC of Colorado
- ARC of Indiana
- ARC of Nebraska
- ARC of Norfolk, Nebraska
- ARC of Ohio
- ARC of Oregon
- ARC of Platte County (Nebraska)
- ARC of Sedgwick County, Kansas
- ARC of Tulsa, Oklahoma (TARC)
- ARC of Utah
- Adoption Options (Colorado)
- Advocacy Coalition of Seniors and People with Disabilities (Oregon)
- Alabama Council on Substance Abuse
- Alabama Watch
- Alaska Public Interest Research Group
- Alaskan AIDS Assistance Association
- Alaskans for Tax Reform
- Alliance Against Family Violence (Kansas)
- Allies With Families (Utah)
- American Association of University Women – Ohio Chapter
- American Association of University Women – Oregon Chapter
- American Lung Association – Alaska Chapter
- American Lung Association – Colorado Chapter
- American Lung Association – Kansas Chapter
- American Lung Association – Oklahoma Chapter
- Arkansas Interfaith Conference
- Arizona Association of Community Health Centers
- Association of Diabetes Educators in Utah
- Assistive Technology Through Action in Indiana (ATTAIN)
- Association of Community Organizations for Reform Now (California)
- Bethpage Omaha (Nebraska)
- Best Buddies International- Indiana Chapter
- Big Brother and Big Sister – Illinois
- Big Brothers Big Sisters of Southern Maine
- Blue Valley Community Action Partnership (Nebraska)
- Bosom Buddies of Georgia, Inc.
- Brain Injury Association of Colorado
- Brain Injury Association of Kansas and Greater Kansas City
- Brain Injury Association of Utah
- Buckeye Art Therapy Association of Ohio
- California Coalition for Mental Health
- California Pan-Ethnic Health Network
- Campaign for Better Health Care (Illinois)
- Campaign for Health Security (Oregon)
- Cancer World (Oregon)
- Catholic Charities of Colorado
- Catholic Charities of Colorado Springs
- Catholic Charities of Omaha, Nebraska

- Catholic Charities Pueblo (Colorado)
- Catholic Community Services of Utah
- Catholic Conference of Kentucky
- Center for Policy Analysis (California)
- Central Plains Area Agency on Aging (Kansas)
- Central Ohio Arthritis Foundation
- Centro De La Familia De Utah
- Centro Legal (Minnesota Minority Support Group)
- Chicano Awareness Center - Nebraska
- Child Connect (Nebraska)
- Children's Diabetes Foundation - Denver Chapter
- Children's First of Oregon
- Citizen Action of Arizona
- Citizen Action of Illinois
- Citizen Action of New York
- Citizen Action Network of Iowa
- Coalition for Accountable Government (Utah)
- Coalition for Independence (Kansas)
- Coalition of New Hampshire Taxpayers
- Colorado Classified School Employees Association
- Colorado Children's Campaign
- Colorado Coalition for the Homeless
- Colorado Consumer Health Initiative
- Colorado Developmental Disabilities Planning Council
- Colorado Forum on Community
- Colorado Hispanic Bar Association
- Colorado Minority Health Forum
- Colorado Programs for Children with Disabilities
- Colorado Progressive Coalition
- Colorado Women's Agenda
- Columbus AIDS Task Force (Ohio)
- Columbus Ohio Chapter of N.O.W.
- Community Action Directors of Oregon (CADO)
- Community Action Partnership – Nebraska
- Community Action Program (Utah)
- Community Connection (Utah)
- Community Connections (Nebraska)
- Community Harvest Food Bank of Northeast Indiana
- Community Humanitarian Resource Center (Nebraska)
- Community Support Services (Oregon)
- Concerned Christian Americans – Illinois
- Concerned Citizens With Disabilities Coalition (Utah)
- Congress of California Seniors
- Connecticut Citizen Action Group
- Cooperative Council of Oklahoma School Administration
- Crossroads Urban Center - Utah
- Damien Center – Indiana
- Day At A Time Club (Colorado)
- Denver, Adams and Arapahoe County (CO) CARES
- Diocese of Salt Lake City (Utah)
- Dodge County Teachers Association (Nebraska)

- Durango Ltd. (Illinois)
- Eagle Forum (Illinois)
- East Liverpool (Ohio) Breast Cancer Support Group
- Easter Seals Colorado
- Easter Seals Nebraska
- Easter Seals of Oklahoma
- Easter Seals Utah
- Ecumenical Ministries of Oregon
- El Centro (Kansas)
- El Comite – Colorado
- Electric League (Missouri)
- EMPOWER Colorado
- Equality New Mexico
- Families First (Georgia)
- Family Planning Association of Maine
- Family Planning Association of Northeast Ohio
- Family Ties Adoption Center of Colorado
- Family Voices (Colorado)
- Federation of Families for Children's Mental Health – Colorado
- Gathering Place (Nebraska)
- Georgia Abortion and Reproductive Rights Action League (GARAL)
- Georgia Rural – Urban Summit
- Georgia Watch
- Georgians for Healthcare
- Good Faith Fund (Arkansas)
- Granite State Independent Living Foundation (New Hampshire)
- Gray Panthers California
- Gray Panters of New Mexico
- Gray Panthers of Oregon
- Gray Panthers of Rhode Island
- Health Action New Mexico
- Health Care for All (Massachusetts)
- Health Law Advocates (Massachusetts)
- Healthy Kids Learn Better (Oregon)
- Healthy Mothers/Healthy Babies (Montana)
- Helena Indian Alliance – Montana
- Hispanic Center of Cache Valley (Utah)
- Hispanic Community Center (Nebraska)
- Hispanic Contractors Association (Colorado)
- Human Services Coalition of Oregon
- Illinois Caucus for Adolescent Health
- Image de Utah
- Improved Living (Nebraska)
- Indiana Association of Area Agencies on Aging
- Indiana Central Association of Diabetes Educators (ICADE)
- Indiana Coalition on Housing and Homeless Issues
- Indiana Pharmacy Alliance
- Individual and Family Counseling – Illinois
- Insure the Uninsured Project (California)
- Interfaith Service Bureau (California)
- Intermountain Planned Parenthood – Billings, Montana Chapter

- Intermountain Planned Parenthood – Helena, Montana Chapter
- Iowa Christian Coalition
- Kansas Advocacy and Protective Services
- Kansas Alcohol & Drug Services Providers Association
- Kansas Association of Community Action Programs (KACAP)
- Kansas Association of Retired School Personnel
- Kansas Association of School Administrators
- Kansas Association of Secondary School Principals
- Kansas Association of Special Education Administrators
- Kansas City Federation of Teachers & School Related Personnel
- Kansas Council on Developmental Disabilities
- Kansas United School Administrators
- Kentuckians for Health Care Reform
- Kentucky Minority Farmers Association
- Latin American Research and Service Agency (Colorado)
- Lincoln Education Association (Nebraska)
- Louisiana Juvenile Diabetes Association
- Louisiana Maternal and Children's Health Coalition
- Maine Consumers for Affordable Healthcare
- Maine Women's Lobby
- Maine Women's Policy Center
- Mental Health Consumer Advocates of Rhode Island
- Mana de Topeka (Kansas)
- MESA (Moving to End Sexual Assault) Administrative Office (Colorado)
- Minnesota AIDS Project
- Minnesota Lawsuit Abuse Watch (M-LAW)
- Minnesota State Council on Disability
- Mobile Health Outreach – North Carolina
- Montana Children's Initiative
- Montana Coalition for Competitive Choices
- Montana Council for Families
- Montana March of Dimes
- Montana NARAL
- Montana Peoples Action
- Montana Senior Citizens Association
- Montana's Child Project
- Multiple Sclerosis Society of Colorado
- Multiple Sclerosis Society of Indiana
- Multiple Sclerosis Society of Ohio
- Mutual Ground – Illinois
- NAF Multicultural Human Development Corporation (Nebraska)
- NARAL Pro-Choice, Ohio
- National Barter and Commodity Association (Formerly the Colorado Citizens for an Alternative Tax System)
- National Kidney Foundation of Georgia
- Nebraska AIDS Project
- Nebraska Arthritis Foundation
- Nebraska Tax Research Council
- Nebraska Urban Indian Health Coalition (Nebraska)
- Nebraskans for Equal Taxation
- Neighborhood Activists Inter-Linked Empowerment Movement (NAILEM) - Arizona

- Nevada Alliance for Retired Americans
- Nevada Cancer Institute
- Nevada Diabetes Assocaition for Children and Adults
- Nevadans for Affordable Health Care
- New Mexico Alliance for Retired Americans
- New Mexico Commission on the Status of Women
- New Mexico Teen Pregnancy Coalition
- New Mexico PACE
- New Mexico Public Interest Research Group
- New Mexico Voices for Children (formerly - New Mexico Advocates for Children and Families)
- New Hampshire Commission on the Status of Women
- New Hampshire Developmental Disabilities Commission
- New Hampshire for Health Care
- Noble/ARC of Central Indiana
- Noble/ARC of Greater Indianapolis
- North Carolina Center for Child and Family Healthcare
- North Carolina Committee to Defend Healthcare
- North Carolina Diabetes Prevention & Control
- North West Kansas Area Agency on Aging
- Northeastern Ohio Arthritis Foundation
- Northwest Ohio Arthritis Foundation
- Ohio AIDS Coalition
- Ohio Advocates for Mental Health
- Ohio Arthritis Foundation
  - Northeastern Ohio Chapter
  - Northwest Ohio Chapter
- Ohio Association of Mental Retardation
- Ohio Association of Second Harvest Foodbanks
- Ohio Citizen Advocates for Chemical Dependency, Prevention and Treatment
- Ohio Hispanic Coalition
- Ohio Mental Health Advocacy Coalition
- Ohio Speech Language-Hearing Association
- Ohioans for Diabetes Control
- Oklahoma Association of School Administrators
- Oklahoma Coalition Against Domestic Violence And Sexual Assault
- Oklahoma Drug and Alcohol Professional Counselors Association
- Oklahoma Education Association
- Oklahoma School Psychological Association
- OPTIONS for Independence (Utah)
- Oregon Alliance of Retired Americans
- Oregon Association of Retired Persons (AARP Chapter)
- Oregon Council of Senior Citizens
- Oregon Disabilities Commission
- Oregon Health Action Campaign
- Oregon Heart and Lung Association
- Oregon Law Center
- Oregon Special Concerns Ministry
- Oregonians for Health Security
- Organization of Rural Oklahoma Schools
- Paola Foster Grandparent Program (Kansas)
- Parent to Parent of Colorado

- Pennsylvania Arthritis Foundation
- Pennsylvania Coalition Against Domestic Violence
- People First of Nebraska
- People Living Through Cancer – New Mexico
- PFLAG – Salt Lake City, Utah
- Planned Parenthood Affiliates of Ohio
- Planned Parenthood of Alaska
- Planned Parenthood of Central and Northern Arizona
- Planned Parenthood of Central Ohio
- Planned Parenthood of Georgia
- Planned Parenthood of Greater Indiana
- Planned Parenthood of Kansas and Mid-Missouri
- Planned Parenthood of Mid/East Tennessee
- Planned Parenthood of Nebraska & Council Bluffs
- Planned Parenthood of Northern New England
- Planned Parenthood of Rhode Island
- Planned Parenthood of Utah
- Precita Park Democratic Club (California)
- Protectmontanakids.org
- Pulaski County Democratic Women (Arkansas)
- Pulaski County Young Democrats (Arkansas)
- Quality Care for Children (Georgia)
- Redemptorist Social Services Center (Missouri)
- Religious Action Center of Reform Judaism
- Retired Enlisted Association – Chapter 39 (Colorado)
- Rhode Island Cancer Council
- Rhode Island Kids Count
- Rhode Island Mental Health Coalition
- Rhode Island Poverty Institute
- Rhode Island Public Health Association
- Safe Kids – Safe Communities – Montana
- Self-Determination Resources (Oregon)
- Small Business Lobby (Virginia)
- South Central Kansas Area Agency on Aging
- South West Kansas Area Agency on Aging
- Special Concerns Ministry (Oregon)
- Sudden Arrhythmia Death Syndrome (Utah)
- Support Oregon Services Alliance
- Tennessee Association of Alcohol and Drug Abuse Services
- United Cerebral Palsy Association - Colorado
- United Cerebral Palsy Association – Nebraska
- United Cerebral Palsy Association – Oklahoma
- United Cerebral Palsy Association – Utah
- United Seniors of Oregon
- Universal Health Care Action Network of Ohio
- University of South Alabama
- University Village Association (Illinois)
- Urban League of Metropolitan Denver (Colorado)
- Urban League of Portland (Oregon)
- Utah Association of Counties
- Utah Center for Persons With Disabilities

- Utah Coalition Against Sexual Assault
- Utah Family Voices
- Utah Hispanic Advisory Council
- Utah Independent Living Center
- Utah Issues
- Utah Progressive Network
- Utah State University – Center for Persons with Disabilities
- Victim Assistance Team of Grand County Colorado
- Virginia Coalition of Police and Deputy Sheriffs
- Voices for Utah Children
- Wahoo Education Association (Nebraska)
- Washington Citizen Action
- Wisconsin Citizen Action
- Wisdom of Wellness Foundation (Georgia)
- WISE Foundation (Tennessee)
- Women's Association of Northshore Democrats – Louisiana
- Women's Policy Group (Georgia)
- Women's Rights Organization (Oregon)
- Working for Equality and Economic Liberation (WEEL) – Montana
- Wyandotte/Leavenworth Area Agency on Aging (Kansas)

## Physician Groups:

**National Groups**

- American Academy of Child and Adolescent Psychiatry
- American Academy of Neurology
- American Academy of Pediatrics – With additional letters from:
  - Alabama Chapter
  - Arizona Chapter
  - Illinois Chapter
  - Indiana Chapter
  - Iowa Chapter
  - Louisiana Chapter
  - Minnesota Chapter
  - Montana Chapter
  - Nebraska Chapter
  - New Hampshire Chapter
  - New Mexico Chapter
  - North Carolina Chapter
  - Oregon Chapter
  - Rhode Island Chapter
  - Tennessee Chapter
  - Utah Chapter
- American Association for Geriatric Psychiatry
- American College of Foot & Ankle Surgeons
- American Psychiatric Association – With additional letters from:
  - Colorado Chapter
  - Kansas Chapter
  - Louisiana Chapter
  - Nevada Chapter
  - New Hampshire Chapter
  - New Mexico Chapter

  - Ohio Chapter
  - Tennessee Chapter
  - Utah Chapter
- National Alliance of Medical Researchers and Teaching Physicians
- National Hispanic Medical Association
- Pediatrix Medical Group
- The Society for Maternal Fetal Medicine

**Local Groups**

- Alabama Medical Association
- American Academy of Physicians – Nebraska Chapter
- American College of Cardiology – Alabama Chapter
- American College of Emergency Physicians – Alabama Chapter
- American College of Emergency Physicians – Rhode Island Chapter
- American College of Physicians – Colorado Chapter
- American College of Surgeons – Rhode Island Chapter
- Arizona Healthcare Association
- Arkansas Medical Society
- Bellevue Pediatric Center (Nebraska)
- Bennett Breast Cancer Center (Maine)
- Colorado Medical Society
- Family Medicine Specialists of St. George (Utah)
- Internal Medicine and Pediatric Medicine (Utah)
- Iowa Medical Society
- Missouri State Medical Association
- Nebraska Academy of Family Physicians
- Nebraska Academy of Physicians
- Nebraska Medical Association
- New Hampshire Health Care Association
- New Mexico Medical Society
- Ohio Academy of Pediatric Physicians
- Oklahoma Academy of Family Physicians
- Rhode Island Medical Society
- Rhode Island Neurological Society
- Rose Breast Center (Colorado)
- Utah Optometric Physicians
- Utah Progressive Network
- Utah Valley Pediatrics
- Virginia Medical Society
- Washington Healthcare Forum

## Provider Groups:

**National Groups**

- American Association for Marriage and Family Therapy
- American Association for Psychosocial Rehabilitation
- American Association on Mental Retardation
- American Chiropractic Association – With additional letters from:
  - Alabama Chapter
  - Arizona Chapter
  - Arkansas Chapter
  - Indiana Chapter

    - Kansas Chapter
    - Kentucky Chapter
    - Louisiana Chapter
    - Maine Chapter
    - Minnesota Chapter
    - Montana Chapter
    - New Hampshire Chapter
    - New Mexico Chapter
    - North Carolina Chapter
    - Oregon Chapter
    - Rhode Island Chapter
    - Tennessee Chapter
    - Washington Chapter
- American College of Nurse-Midwives
- American Counseling Association
- American Group Psychotherapy Association
- American Mental Health Counselors Association
- American Music Therapy Association
    - Colorado Chapter
    - Kansas Chapter
    - Nebraska Chapter
    - Utah Chapter
- American Nurses Association – With additional letters from:
    - Alabama Chapter
    - Arizona Chapter
    - Arkansas Chapter
    - California Chapter
    - Colorado Chapter
    - Illinois Chapter
    - Kansas Chapter
    - Maine Chapter
    - Minnesota Chapter
    - Montana Chapter
    - Nebraska Chapter
    - Nevada Chapter
    - New Hampshire
    - New Mexico Chapter
    - North Carolina Chapter
    - Ohio Chapter
    - Oklahoma Chapter
    - Oregon Chapter
    - Rhode Island Chapter
    - Tennessee Chapter
    - Utah Chapter
    - Virginia Chapter
    - Wyoming Chapter
- American Optometric Association – With additional letters from:
    - Alabama Chapter
    - Arizona Chapter
    - Arkansas Chapter
    - Indiana Chapter

  - Iowa Chapter
  - Kentucky Chapter
  - Louisiana Chapter
  - Montana Chapter
  - Nebraska Chapter
  - Nevada Chapter
  - New Hampshire Chapter
  - New Mexico Chapter
  - Tennessee Chapter
  - Utah Chapter
  - Virginia Chapter
  - Wyoming Chapter
- American Podiatric Medical Association
- American Psychiatric Nurses Association
- American Psychological Association – With additional letters from:
  - Arkansas Chapter
  - Colorado Chapter
  - Illinois Chapter
  - Indiana Chapter
  - Iowa Chapter
  - Kansas Chapter
  - Kentucky Chapter
  - Louisiana Chapter
  - Minnesota Chapter
  - Montana Chapter
  - Nebraska Chapter
  - Nevada Chapter
  - North Carolina Chapter
  - Ohio Chapter
  - Oklahoma Chapter
  - Oregon Chapter
  - Rhode Island Chapter
  - Tennessee Chapter
  - Utah Chapter
  - Wyoming Chapter
- American Psychotherapy Association
- American Society of Clinical Psychopharmacology, Inc.
- Association for Ambulatory Behavioral Healthcare
- Association of Women's Health, Obstetrics and Neonatal Nurses – With additional letters from:
  - Ohio Chapter
- Clinical Social Work Federation
- Employee Assistance Professionals Association
- Federation of Behavioral, Psychological and Cognitive Sciences
- National Association of County Behavioral Health Directors
- National Association of School Psychologists
- National Association of Social Workers – With additional letters from:
  - Alabama Chapter
  - Arkansas Chapter
  - Iowa Chapter
  - Kansas Chapter
  - Louisiana Chapter

- Maine Chapter
- Missouri Chapter – With additional letters from:
  - Central Region
  - Eastern Region
  - Southeast Region
  - Southwestern Region
  - Task Force on Disability Issues
  - Western Region
- Nebraska Chapter
- New Hampshire
- New Mexico Chapter
- North Carolina Chapter
- Ohio Chapter
- Rhode Island Chapter
- Utah Chapter
- Wyoming Chapter
- National Council for Community Behavioral Healthcare

**Local Groups**

- AAC Association (Nebraska)
- Access Utah Network
- Act Now Counseling (Utah)
- Action Counseling (Colorado)
- Acupuncture Association of Colorado
- Acupuncture Association of Utah
- Acupuncture Association of Washington
- Addiction and Behavioral Health Center (Nebraska)
- Advance Women's Health Care (Utah)
- Advantage Eye Care (Utah)
- AIM Institute (Nebraska)
- Affiliates in Psychology (Nebraska)
- Alabama Association of Home Health Agencies
- Alabama Association of State & Provincial Psychology Boards
- Alabama Council for Community Mental Health Boards
- Alabama Dental Association
- Alabama Department of Mental Health & Retardation
- Alabama Family Practitioners Rural Health
- Alaska Ophthalmological Society
- Alegent Health Psychiatric (Nebraska)
- Alternative Health Center (Utah)
- Alternative Pathways (Colorado)
- Alzheimer's Association of Great Plains, Nebraska
- Alzheimer's Association – Midlands Chapter (Nebraska)
- Alzheimer's Association of Oregon and Greater Idaho
- Alzheimer's Association of Rhode Island
- Alzheimer's Association of Utah
- American Society of Addictive Medicine – Kansas Chapter
- American Society of Addictive Medicine – Utah Chapter
- Andrus Vision Center (Utah)
- Arden Courts (Illinois)
- Arizona Osteopathic Association

- Arkansas Association for Marriage and Family Therapy
- Arkansas Chiropractic Legislative Council
- Arkansas Independent Living Council
- Arkansas Mental Health Counselors Association
- Aspen Therapy (Utah)
- Association of Community Service Agencies (California)
- Association of Oregon Community Mental Health Programs
- Association of School Based Health Centers (Oregon)
- Asthma and Allergy Clinic (Utah)
- Autism Coalition of Indiana
- Autism Society of Arkansas
- Autism Society of Nebraska
- Autism Society of Ohio
- Avenues to New Horizons (Nebraska)
- Avera St. Anthony's Hospital (Nebraska)
- A.W.A.R.E. Inc. (Mental Health Provider – Montana)
- Bear River Medical Arts (Utah)
- Bear River Mental Health Services (Utah)
- Beaver Valley Hospital (Utah)
- Behavioral Health Specialists (Nebraska)
- Bergan Mercy Child Development Center (Nebraska)
- Berner Eye Clinic (Utah)
- Black River Mental Health Services (Utah)
- Blue Valley Mental Health Center (Nebraska)
- Boulder County Partners (Colorado)
- Boulder Valley Women's Health Center (Colorado)
- Broadway Counseling Services (Colorado)
- Bungalow Care Center (Utah)
- California Council of Community Mental Health Agencies
- California Society for Clinical Social Work
- Care Oregon
- Cedar Springs Behavioral Health (Colorado)
- Centennial Mental Health Center (Colorado)
- Center for Counseling and Consultation (Kansas)
- Center for Human Development (Kansas)
- Center for Independent Living for Southwest Kansas
- Center for Psychological Services (Nebraska)
- Central District Health Center (Nebraska)
- Central Iowa Psychological Services
- Central Kansas Psychological
- Children and Adults with Attention Deficit/Hyperactivity Disorder (Ohio)
- Chiropractic and Spinal Rehabilitation (Colorado)
- Cincinnati (Ohio) Children's Speech Pathology Department
- City of Geneva Mental Health Board (Illinois)
- Clarian Health (Methodist Hospital, Indiana University Hospital, Riley's Children's Hospital) (Indiana)
- Clark County Mental Health (Oregon)
- Collidge Mental Health Center (Nebraska)
- Colorado Association of Surgical Technicians
- Colorado Counseling Association
- Colorado Dental Association
- Colorado Health and Hospital Association

- Colorado Osteopathic Society
- Colorado Podiatric Medical Society
- Community Adolescent Counseling (Colorado)
- Community Access Services (Oregon)
- Community Counseling Center of Fox Valley (Illinois)
- Community Nursing Services (Utah)
- Community Pharmacists of Indiana
- Community Providers Association of Oregon
- Council of Volunteers and Organizations for Hoosiers with Disabilities (Indiana)
- Council on Substance Abuse (Alabama)
- Counseling Associates (Utah)
- Counseling Center for the Rockies (Colorado)
- Coventry Group (Kansas)
- Crawford County Health Department (Kansas)
- Danville Services Corporation (Utah)
- Delta Resource Independent Living Center (Arkansas)
- Denver Naturopathic Clinic - Colorado
- DPF Counseling Services (Kansas)
- Dignity Health & Home Care (Utah)
- Direct Benefits (Minnesota)
- Elgin Mental Health Facility (Illinois)
- Family Counseling Service of Aurora, Illinois
- Family Life Center (Kansas)
- Fetzer OB-GYN (Illinois)
- First Call For Help (Nebraska)
- First Plan in Two Harbors (Minnesota)
- Fore Chiropractic Clinic (Kansas)
- Four Corners Community Behavioral Health (Utah)
- Four County Mental Health Center (Kansas)
- Franklin County Memorial Hospital (Nebraska)
- Full Circle Alternative Center (Colorado)
- Gabriel Chiropractic Office (Colorado)
- Geneva Mental Health (Illinois)
- Greenwood Health Center (Utah)
- Gynecology, Obstetrics & Infertility (Colorado)
- Healing Arts Center (Colorado)
- Heartland Counseling and Consulting (Nebraska)
- Higgins Center for Natural Health (Colorado)
- Highland Family Eye Care (Utah)
- Holladay Family and Child Guidance Clinic (Utah)
- Home Health Services and Staffing Association of New Jersey
- Hutchinson Psychological & Family Services (Kansas)
- Idaho Hospital Association
- Independent Living Resource Center (New Mexico)
- Indiana Association of Rehabilitation Facilities
- Indiana Pharmacy Alliance
- Institute for Alcohol Awareness (Fort Collins, Colorado)
- Institute for Alcohol Awareness (Greeley, Colorado)
- Intermountain Academy of Child & Adolescent Psychiatry
- Intermountain Health Care (Utah) – Heber Valley Medical Center
- Intermountain Health Care Diabetes Education (Utah)

- Iowa Breast Cancer Education-Action (IBCE)
- Iowa Dental Association
- Iowa Podiatric Medical Society
- Jane Phillips Nowata Health Center (Oklahoma)
- Johnson County Hospital (Nebraska)
- Josephine County Mental Health (Oregon)
- Kane County Hospital (Utah)
- Kansas Counseling Association
- Kansas Public Health Association
- KANZA – Mental Health and Guidance Center (Kansas)
- Kelly Roybal-Sanchez Pediatric Clinic (Colorado)
- Kentucky Dental Association
- Kentucky Mental Health Coalition
- Lane Independent Living Alliance (Oregon)
- Larimer Center for Mental Health (Colorado)
- Latimer County General Hospital (Oklahoma)
- Legislative Coalition of Virginia Nurses
- Leo Pocha Clinic (Montana)
- Leukemia Lymphoma Society of Oregon
- LifeWise Health Plan of Oregon
- Lincoln/Lancaster County Human Services Federation (Nebraska)
- Longmont Psychiatric Associates (Colorado)
- Louisiana Academy of Medical Psychologists
- Louisiana Association of Ambulatory Healthcare
- Louisiana Association for the Advancement of Psychology
- Louisiana Healthcare Commission
- Louisiana Mental Health Consortium
- LTC Resolutions (Indiana)
- Maine Association of Mental Health Services
- Maine Association of Substance Abuse Programs
- Maine HomeCare Alliance
- Maine Nurse Practitioners Association
- Marshalltown Cancer Support Group (Iowa)
- Medical Weight Management (California)
- Melham Medical Center (Nebraska)
- Mental Health and Guidance Center (Kansas)
- Mental Health Associates (Kansas)
- Mental Health Association of the Heartland (Kansas)
- Mental Health Care Associates (Nebraska)
- Mental Health Corporation (Colorado)
- Mesability (Colorado)
- Metro Chiropractic (Nebraska)
- Midwest Internal Medicine (Missouri)
- Midwest Parkinson's Awareness of Northeast Ohio
- Minnesota Association of Community Mental Health Programs
- Minnesota Council of Health Plans
- Missouri Ambulance Association
- Montana Academy of Ophthalmology
- Montana Academy of Otolaryngology
- Montana Association of Ambulatory Surgery Centers
- Montana Association of Independent Disability Services

- Montana Council of Community Mental Health Centers
- Montana Podiatric Medical Association
- Nebraska Chiropractic Physicians Association
- Nebraska Counseling Association
- Nebraska Dental Association
- Nebraska Health Care Association
- Nebraska Mental Health Centers
- Nebraska Methodist Hospital
- Nebraska Rural Health Association
- Neighborhood Health Plan of Rhode Island
- Nemaha County Breast Cancer Support Group (Nebraska)
- Nevada Dental Hygienists Association
- Nevada Health Centers
- New Hampshire Mental Health Coalition
- New Hampshire Mental Health Counselors Association
- New Hampshire Pastoral Psychotherapists Association
- New Mexico Heart Institute
- New Mexico Hospital and Health System Association
- New Mexico Orthopedics
- New Mexico Podiatric Medical Association
- New West Health Services (Montana)
- Niobrara Valley Hospital (Nebraska)
- Norfolk Psychological Service (Nebraska)
- Northstar Mental Health Services (Nebraska)
- Northwest Alzheimer's Association (Nebraska)
- Norton Health Care (Kentucky)
- Nurse Practitioners of Oregon
- Ogallala Counseling Center (Nebraska)
- Ohio Ambulatory Behavioral Healthcare Association
- Ohio Clinical Social Work Society
- Ohio Counseling Association
- Ohio Council of Behavioral Healthcare Providers
- Ohio Dietetic Association
- Oklahoma Association of Optometric Physicians
- Oklahoma Counseling Association
- Oklahoma Psychiatric Physicians Association
- Old Mill Counseling (Nebraska)
- Omni Behavioral Health (Nebraska)
- One Source (Nevada)
- Oregon Advocates for the Mentally Ill
- Oregon Association of Physicians' Assistants
- Oregon Centers for Mental Health and Addiction
- Oregon Health Sciences University
- Oregon Optometric Physicians Association
- Oregon State Denturists' Association
- Oriental Medical Association of New Mexico
- Palmer Chiropractic College (Iowa)
- Park City Family Health and Urgent Care Center (Utah)
- Parkview Medical Center Department of Pathology (Colorado)
- Pediatric Pathways (Colorado)
- Phelps Memorial Health Center (Nebraska)

- Phoenix Body Positive (Arizona)
- Phoenix Rising Center (Utah)
- Polk County Mental Health (Oregon)
- Professional Christian Counseling Services (Nebraska)
- Providence Medical Center (Nebraska)
- Pueblo Women's Center – Obstetrics and Gynecology (Colorado)
- Rainbow Center (Nebraska)
- Region VI Behavioral Healthcare (Nebraska)
- Rhode Island Association of Health Centers
- Rhode Island Coalition for Mental Health
- Rhode Island Council of Community Mental Health Organizations
- Rhode Island Dental Society
- Rhode Island Health Center Association
- Richard H. Young Hospital (Nebraska)
- River Park Psychology Services (Kansas)
- Riverton Eye Care (Utah)
- Rock County Hospital (Nebraska)
- Rural Counties Program, Spanish Peaks Mental Health Center (Colorado)
- Rural Health Management (Utah)
- Rural Hospital Coalition (Louisiana)
- Saint Francis Memorial Hospital (Nebraska)
- Sanpete Valley Hospital (Utah)
- Saunders County (Nebraska) Health Services
- School Nurse Organization of Oklahoma
- Serenity Place (Nebraska)
- Shopko Eyecare Center
- Southeast Kansas Independent Living Resources Center
- Southwest Prostate Cancer Foundation (Arizona)
- Southwest Utah Community Health Center
- Spa Area Independent Living Services (Arkansas)
- Saint Mary's Health Network – Nevada
- State of Mine – Mental Health (New Mexico)
- Stoney Ridge Day Treatment Center (Nebraska)
- Sundance Women's Healthcare (Utah)
- Swope Parkway Health Center (Missouri)
- Syracuse Chemical Addiction Treatment of Kansas
- Tennessee Academy of Ophthalmology
- The Home Team of Kansas
- The Psychology Clinic (Louisiana)
- Three Rivers Independent Living (Kansas)
- Topeka Independent Living Resource Center (Kansas)
- Town Center Chiropractic (Montana)
- Tri-County Hospital (Nebraska)
- Tri-County Mental Health Services – Maine
- Tualitin Valley Centers - Oregon
- Tulane University Health Sciences Center (Louisiana)
- Tulsa Regional Medical Center (Oklahoma)
- UPMC Health System (Pennsylvania)
- United Healthcare – Alabama
- Utah Counseling Association
- Utah Mental Health Counselors Association

- Utah Society of Pathologists
- Valley Community Clinic (California)
- Valley Counseling Services (Ohio)
- Valley County Hospital (Nebraska)
- Valley View Medical Center (Utah)
- Van WYK Family Chiropractic Center (Colorado)
- Virginia Academy of School Psychologists
- Virginia Association of Community Services Boards
- Virginia Association of Free Clinics
- Virginia Association of Hospices
- Vision Health Center (Utah)
- Wasatch Canyon Mental Health (Utah)
- Washington Massage Therapy Association
- Washoe Medical Center (Nevada)
- West Holt Memorial Hospital (Nebraska)
- Wills Chiropractic Clinic (Nebraska)
- Willowbrook Mental Health Center (Nebraska)
- Wiseman Chiropractic Wellness Center (Nebraska)
- Workman Chiropractic Clinic (Nebraska)
- Wyoming Counseling Association
- Wyoming Hospital Association
- Wyoming State Pharmacists' Association

### Health Insurance Trade Associations:

- Alabama Associated Life Insurance Companies
- America's Health Insurance Plans (AHIP) – With additional letters from:
  - Alabama Association of Health Plans
  - California Association of Health Plans
  - Georgia Association of Health Plans
  - Indiana Association of Health Plans
  - Kansas Association of Health Plans
  - Kentucky Association of Health Plans
  - Missouri Association of Health Plans
  - Nebraska Association of Health Plans
  - Nevada Association of Health Plans
  - New Jersey Association of Health Plans
  - New Mexico Association of Health Plans
  - North Carolina Association of Health Plans
  - Ohio Association of Health Plans
  - Virginia Association of Health Plans
  - Association of Washington Healthcare Plans
- American Managed Behavioral Healthcare Association
- American Republic Insurance Company (Iowa)
- Association of Health Insurance Advisors/National Association of Insurance and Financial Advisors – With additional letters from:
  - Indiana Chapter
  - Maine Chapter
  - Nebraska Chapter
  - Ohio Chapter
  - Oklahoma Chapter
  - Utah Chapter

- Blue Cross and Blue Shield Association
- Delta Dental Plans Association – With additional letters from:
  - Delta Dental Plan of Arkansas
  - Delta Dental Plan of Indiana
  - Delta Dental Plan of Iowa
  - Delta Dental Plan of Kentucky
  - Delta Dental Plan of Minnesota
  - Delta Dental Plan of New Mexico
  - Delta Dental Plan of North Carolina
  - Delta Dental Plan of Virginia
- Christiana Care Health Plans
- Cimarron Healthcare (New Mexico)
- Federation of Iowa Insurers
- Health Net (Oregon)
- Louisiana Pest Control Insurance Company (LIPCA)
- Lovelace Health Systems (New Mexico)
- Magellan Health Services
- National Association of Health Underwriters – With additional letters from:
  - Alabama Chapter
  - Arkansas Chapter
  - Central Arkansas Chapter
  - Georgia Chapter
  - Indiana Chapter
  - Maine Chapter
  - Minnesota Chapter
  - Nevada Chapter
  - New Hampshire
  - New Mexico Chapter
  - North Carolina Chapter
  - Ohio Chapter
  - Oregon Chapter
  - Rhode Island Chapter
  - Virginia Chapter
- Nebraska Association of Professional Insurance Agents
- Nevada Hometown Health
- NevadaCare
- PacifiCare of Nevada
- Principal Financial Group – with additional letters from:
  - Iowa Office
- Sierra Health Services (Nevada)
- Tufts Health Plan

# Solving the Small Business Health Care Crisis: Alternatives for Lowering Costs and Covering the Uninsured

**Hearing of the**
**Senate Committee on Small Business and Entrepreneurship**

**Wednesday, April 20, 2005**

**Written Testimony**

**Submitted By**

**Professional Photographers of America**

We offer our thanks to Chairwoman Snowe, Ranking Member Kerry and all of the committee members for the opportunity to offer written testimony regarding the availability and affordability of health insurance for small business owners.

Professional Photographers of America represents some 14,000 members and is the oldest and largest trade association for professional photographers; our members are engaged in all facets of photography and imaging. Three other photography organizations, Commercial Photographers International, the International Association of Professional Event Photographers and the Student Photographic Society; join us in this written testimony.

Photographers are among the smallest of small businesses. While there are some exceptions, the vast majority of professional photography studios are quite literally "mom and pop" operations. According to a survey of our members conducted in March 2005, the average photography studio has 2.04 full-time and 1.1 part-time employees – a number that includes the owner of the business. Only one of the 555 studios surveyed had more than 50 full-time employees; 98% of photographers surveyed had less than 10 full-time employees.

It is no secret to our members that the health insurance market for small businesses is in critical condition. The current state-based system simply has not worked. In addition to the double-digit annual premium inflation faced by the majority of photographers who purchase insurance through their own business, research now shows that a full 15% of our members rely on a second job to obtain their health insurance. Without a change in the legislative environment, there is little hope of the situation improving on its own.

Our members are entrepreneurs. Photographers are not interested in a handout – they simply want Congress to level the playing field, which is currently tilted to favor those businesses that offer national health plans: large companies and labor unions.

We have reviewed the two competing plans aimed at helping small business owners obtain health insurance: S. 406 the Small Business Health Fairness Act of 2005 (SBHFA) and S. 637 the Small Employers Health Benefits Act of 2005 (SEHBA). While both pieces of legislation are well-intentioned attempts to reduce the healthcare burden on

small businesses, we believe that S. 406, The Small Business Health Fairness Act is a more workable solution.

Our primary concern with SEHBA (S. 637) is the addition of another layer of bureaucracy and cost to the healthcare system – which is a result opposite our goal of reducing administrative and transactional costs. Moreover, the allotment of $18 billion to create "risk corridors" and subsidize participation by insurers creates an incentive for insurers to drop out of the program after a few years or to drastically increase premiums when the subsidy ends. Finally, because the OPM would be negotiating directly with insurers to set benefits and premiums, the ability of small business owners and their employees to select a plan tailored to their needs would be drastically impaired.

In contrast, we believe that S. 406, the Small Business Health Fairness Act has the potential to significantly reduce the administrative and transactional costs for employers in the individual and small-group insurance market. Since the types of organizations offering these plans are member-run and share a common interest or geographic area, S. 406 also provides the best means of ensuring that any health insurance plan meets the specific needs of small business owners and employees.

We are under no illusions that S. 406 is a perfect bill or that it is the solution for solving the problems of health insurance coverage and access for all Americans. However, it is an important step in addressing those issues. We urge the committee to approve S. 406, the Small Business Health Fairness Act, and in so doing, give small business owners and employees some hope for the future availability of health insurance.

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April 19, 2005

The Honorable Olympia J. Snowe
Chairwoman
Committee on Small Business
and Entrepreneurship
United States Senate
428-A Russell Senate Office Building
Washington, DC 20510

The Honorable John F. Kerry
Ranking Member
Committee on Small Business
and Entrepreneurship
United States Senate
428-A Russell Senate Office Building
Washington, DC 20510

Dear Madame Chairwoman and Senator Kerry:

We are writing to urge you to oppose legislation that would exempt association health plans (AHPs) from state regulation and oversight (S. 406).

Rising health care costs and the increasing numbers of Americans without health insurance is a major, national problem that requires action and attention. However, AHPs are not a solution to the access and affordability problems facing small-firms and would, in fact, make the current problem even worse – resulting in higher premiums and less secure coverage for the vast majority of small businesses. AHPs would also take away critically important consumer protections that millions of Americans rely on today.

Because of the serious concerns raised about AHPs, more than 1,300 national, state, and local groups oppose this legislation. Those opposed to this legislation include state officials (including the nation's governors, 41 state attorneys general, and the nation's insurance commissioners), provider and physician organizations, consumer groups, small business associations and state and local chambers of commerce, labor organizations, civil rights groups, and local farm bureaus. While our organizations may have varied interests and concerns, we are united in our belief that AHPs will hurt, not help, small businesses, workers, and their families.

Small employers struggling with higher health care costs and premiums would get no relief from AHPs. In fact, the U.S. Congressional Budget Office (CBO) and other credible, non-partisan studies have found that the vast majority of small employers would actually see their premiums increase under AHP legislation. The CBO found that AHP legislation would trigger premium increases for 75 percent of small employers – representing over 20 million workers and dependents.

While often touted as a way to expand access to coverage, all of the evidence suggests that AHPs would not be effective at reducing the number of Americans without health insurance coverage. All serious studies (by such organizations as CBO, the Urban Institute, and Mercer consulting) have concluded that AHPs would have a negligible impact on the uninsured or actually *increase the ranks of the uninsured at a time when over 45 million Americans lack any health insurance coverage.* Clearly, everyone can agree that Congress should not support proposals that would *expand the number of Americans without health insurance.*

We are also deeply concerned that AHPs would un-ravel states' small employer health reforms that have helped make health insurance coverage more stable and affordable – particularly for individuals and groups with high health care costs. AHPs exemption from state laws will allow them unfettered ability to increase premiums for small businesses as much and as often as they want when an employee gets sick. This will place workers with significant health care needs with the prospect of spiraling premiums and at serious risk of becoming uninsured. The CBO found that up to 100,000 of the most vulnerable workers would actually lose their coverage under AHPs.

Clearly we can all agree that any "solution" that fails to protect and insure society's most vulnerable citizens – those that actually require substantial medical care and attention – is simply unacceptable.

AHPs would also be exempt from the existing state consumer protections that millions of Americas rely on today, including the right to appeal to an independent panel when an insurer denies coverage for care. States also ensure that patients have direct access to specialty care, emergency care, and clinical trials for patients with life-threatening illnesses. AHPs will take away these critical protections, compromising workers' and consumers' access to quality care.

AHP legislation would also greatly undermine oversight over insurers, exposing consumers to unpaid medical bills in the event of insolvency or fraud. While states identify and take action against insurance scams, AHPs would effectively eliminate this critical oversight mechanism. All of the resources and tools state officials take to prevent and detect fraud would be eliminated for AHPs, placing consumers at great risk.

For all of these reasons, we urge you to oppose AHP legislation and instead focus on real solutions aimed at helping small businesses and expanding access to coverage.

Sincerely,

American Academy of Child & Adolescent Psychiatry
American Academy of Pediatrics
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
National Association of School Psychology
American Chiropractic Association
American College of Nurse-Midwives
American Counseling Association
American Diabetes Association
American Federation of Labor and Congress of Industrial Organizations
American Federation of State, County and Municipal Employees
American Federation of Teachers
American Managed Behavioral Healthcare Association
American Nurses Association
American Psychiatric Association
American Psychiatric Nurses Association
American Psychological Association
AIDS Legal Council of Chicago
Association of Health Insurance Advisors
Bazelon Center for Mental Health Law
Blue Cross Blue Shield Association
Citizen Action – Illinois
Citizen Action – New York
Clinical Social Work Federation
Coalition Against Insurance Fraud
Communications Workers of America
Delta Dental Plans
Families USA
International Brotherhood of Electrical Workers
National Association for Children's Behavioral Health
National Association of Social Workers
National Association of Social Workers – Rhode Island Chapter
National Association of Insurance and Financial Advisors

National Education Association
National Partnership for Women & Families
Planned Parenthood Federation of America
Project Inform – San Francisco
San Francisco AIDS Foundation
Service Employees International Union
United Auto Workers
USAction

cc: Members of the Senate Committee on Small Business and Entrepreneurship

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**TRSA** *Textile Rental Services Association of America*

Representing the Textile Rental Industry: Linen Supply, Uniform Service, Dust Control and Commercial Laundry Services

April 19, 2005

The Honorable Michael B. Enzi
379A Russell Senate Office Building
United States Senate
Washington, DC 20510

Dear Senator Enzi:

I am writing on behalf of the 1,100 member locations of the Textile Rental Services Association (TRSA) to respectively request your support of S. 406, the "Small Business Health Fairness Act of 2005," introduced by Senator Olympia Snowe. This legislation allows small businesses to acquire quality, affordable coverage for their employees through Association Health Plans (AHPs).

Since 1913, TRSA members have provided textile maintenance and rental services to commercial, industrial and institutional accounts -- over 90 percent of TRSA member companies are small businesses. Members of TRSA account for about 90% of the annual sales of the linen supply industry and about 75% of the sales of the industrial laundering industry. The combined textile rental industry had estimated 2004 sales of about $12 billion.

The soaring cost of health care is making employer-sponsored health coverage more difficult for businesses to provide their employees and many times out of the reach for ordinary working families. Nearly 44 million Americans are uninsured, with nearly 60 percent of those employed by small businesses. Allowing small employers to arrange their health benefits through associations will make coverage more affordable by spreading risk among a much larger group, strengthening negotiating power with plans and providers, and reducing administrative costs. AHPs will enable small employers the opportunity to offer employees more choices of health plans something that is virtually unworkable in today's healthcare market.

Furthermore, S. 406 provides the Department of Labor (DOL) explicit regulatory authority to ensure that AHPs are properly administered and implemented. Currently, DOL oversees ERISA protections covering 131 million workers, retirees, and their families. Of these, 67 million Americans are covered by self-insured plans and an additional five million individuals are covered by Taft-Hartley plans. AHPs would be subject to oversight that is even stricter than these plans. With this considerable experience already in place, DOL is fully equipped to implement and regulate AHPs when this legislation passes.

It's time to level the playing field and bring Fortune-500 style health benefits to America's small businesses. Please support S. 406 to help provide small businesses access to affordable, quality health care for their employees.

Sincerely,

David A. Rawlinson
Chairman

cc: Members of the Senate Committee on Small Business and Entrepreneurship

AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

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JOHN J. SWEENEY
PRESIDENT

RICHARD L. TRUMKA
SECRETARY-TREASURER

LINDA CHAVEZ-THOMPSON
EXECUTIVE VICE-PRESIDENT

April 18, 2005

The Honorable Olympia J. Snowe
Chair
Committee on Small Business and Entrepreneurship
United States Senate
Washington, D.C. 20510

The Honorable John F. Kerry
Ranking Minority Member
Committee on Small Business and Entrepreneurship
United States Senate
Washington, D.C. 20510

Dear Chair Snowe and Ranking Minority Member Kerry:

The AFL-CIO urges you to oppose the Small Business Health Fairness Act (S. 406), which would exempt Association Health Plans (AHPs) from state regulation. Although offered as a panacea for small businesses struggling to find affordable health care, AHPs would fail to provide real relief while making matters worse for those small firms that do provide coverage for their workers.

Because AHPs are exempt from state rules and coverage guidelines other insurers must follow, they can offer bare bones plans attractive only to young and healthy workers and would deter older workers with greater need for health care services. As a result, the vast majority of small firms that offer comprehensive coverage (75 percent) would see their premiums rise, affecting 23 million workers and their dependents, according to the Congressional Budget Office. As their premiums rise, some will be forced to eliminate coverage or price it beyond their workers' ability to pay.

In addition, S. 406 would permit AHPs to discriminate based on claims history, charging higher rates for less healthy employer "groups" upon enrollment and again on renewal of coverage. This, too, will deter less healthy groups from joining and prompt others to leave the plan upon renewal when premiums can be increased without limit. As employers drop comprehensive coverage or raise workers' costs and others are priced out of AHPs, the number of uninsured will grow by one million, according to a study by Mercer and the Small Business Association.

Furthermore, the legislation would exempt AHPs from important consumer protections enacted in every state, and strong state oversight is ceded to inadequate enforcement under the U.S. Department of Labor, putting consumers at a much greater risk for fraud and abuse. Strong state solvency standards that require audits by independent actuaries and funds adequate to pay claims would be replaced with new federal enforcement that allows AHPs' own actuaries to certify solvency and maintain reserves for paying claims that are lower than those recommended by the National Association of Insurance Commissioners. These weaknesses will actually exacerbate existing fraud by opening up a giant regulatory loophole. The GAO uncovered a wave of insurance fraud that has left over 250,000 people uninsured and saddled with $252 million in unpaid medical bills.

Rather than meaningfully address the very real problem of small businesses' access to health care, AHPs would put more consumers at risk of fraud, prompt premium increases for those small business workers who now have coverage and leave more workers uninsured. For these reasons, I urge you to oppose S. 406.

Sincerely,

William Samuel, Director
DEPARTMENT OF LEGISLATION

C: Members of the Committee on Small Business and Entrepreneurship

**Testimony of**
**James Schlicht**
**Chief Government Affairs & Advocacy Officer**
**American Diabetes Association**

**To the United States Senate Committee on Small Business and Entrepreneurship**

**April 20, 2005**

**Contact:**
**Angie Montes**
**Manager, Federal Government Affairs**
**American Diabetes Association**
**703-299-2087**
**amontes@diabetes.org**

Thank you for the opportunity to submit testimony on the impact of association health plans (AHPs) on Americans with diabetes.

As the nation's leading nonprofit health organization providing diabetes research, information and advocacy, the American Diabetes Association (the Association) has a significant interest in reducing the number of uninsured and underinsured in the United States. Unfortunately, as currently written, S. 406, the "Small Business Health Fairness Act," would not meet this goal and would be devastating not only for many of the 18.2 million Americans who currently have diabetes, but also for the more than 40 million who have a condition known as "pre-diabetes."

Diabetes is a serious, life-threatening, chronic illness for which there is no cure. Approximately 42,000 people suffering from diabetes live in each congressional district and that number is growing by an estimated 8% per year. In fact, current estimates by the Centers for Disease Control and Prevention reflect that one of every three children born in the U.S. after 2000 will develop diabetes in their lifetime. The number is even higher for minority children. While we do not have a cure for the disease, diabetes can be successfully managed with access to the necessary tools.

For people with diabetes, finding adequate health insurance coverage is as important as finding affordable coverage. The Association is committed to expanding the number of people with diabetes who have insurance coverage and to ensuring that such coverage meets their health needs. A critically important component of this effort has been state requirements that insurers provide adequate coverage for diabetes supplies, medication, equipment and education. Today 46 states require such coverage.

Failing to manage the disease also imposes high societal costs, including disability and work loss. In 2002, the total direct and indirect costs of diabetes were estimated at $132 billion and one in four Medicare dollars went towards diabetes care. We can reverse these trends, but to do so we need a health care system that allows diabetes patients to manage their care and one that provides the tools to help reduce the number of Americans who will be diagnosed with the disease. As currently written in S. 406, AHPs would unfortunately make this situation worse, not better.

The Association is very concerned about rising health care costs, the increasing numbers of Americans with limited health insurance, and the impact of these factors on people with diabetes. To this end, the Association released a report with Georgetown University, "Falling Through the Cracks: Stories of How Health Insurance Can Fail People With Diabetes," which shows that our current healthcare system is inadequate to meet the needs of many diabetes patients.

Each of the examples highlighted in the report underscores the need for diabetes patients to have health insurance coverage that meets three key components: availability, affordability and adequacy. For people with diabetes, having access to affordable yet inadequate health insurance is equivalent to being uninsured and still having to pay their insurance premiums and all of their costs for their life sustaining diabetes supplies and medications. As our report shows, many patients in this type of situation are forced into

reducing the number of times they check their glucose levels so as to ration their test strips, often times leading to hospitalization for high-cost complications.

The importance of available, affordable and adequate health insurance holds true across the spectrum of chronic diseases. The *New York University Law Review* found that medical bills are the single leading factor contributing to personal bankruptcy in the U.S.[1] The Association requests that the Committee will consider these critical factors as it searches for health insurance solutions for small businesses.

We are facing a diabetes epidemic in this country and simply cannot create health insurance options that leave diabetes patients unable to access the tools critical to their management of the disease. Forty-six states have recognized the importance of diabetes coverage and have passed legislation protecting people with diabetes. Under the proposed AHP legislation, these protections would be undermined and many people with diabetes working for small businesses would lose their current coverage for diabetes equipment and supplies. This coverage is critical for diabetes patients' ability to manage their disease. Cutting them off from these tools will only increase the number of destructive and expensive complications such as blindness, kidney disease, and amputation, leading to even higher societal costs. While the Association shares your concern about helping small businesses provide health insurance to their employees, we strongly believe that this version of AHPs is not the answer.

On behalf of the 18.2 million Americans with diabetes – a disease that crosses gender, race, ethnicity and political party; a disease that is among the most costly, debilitating, deadly and prevalent in our nation; and a disease that is exploding throughout our nation – thank you for the opportunity to submit this testimony. The American Diabetes Association is prepared to answer any questions you might have on these important issues.

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[1] Jacoby, M. B., Sullivan, T. A. and Warren, E., "Rethinking the Debates over Health Care Financing: Evidence from the Bankruptcy Courts," *New York University Law Review*, Volume 76, Number 2, May 2001: 375 – 415.

**Automotive Aftermarket**
Industry Association

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April 19, 2005

The Honorable Olympia Snowe
154 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Snowe:

On behalf of the ***Automotive Aftermarket Industry Association*** (AAIA), I want to thank you for your leadership and sponsorship of S. 406, the "Small Business Health Fairness Act of 2005". Passage of th legislation is a top priority for over 3,000 of our member companies.

AAIA is the leading trade association in the United States representing the interests of motor vehicle aftermarket. Our members, the majority which are small businesses, supply the products and services fundamental to proper maintenance and repair of vehicles. These products and services include replacements parts, accessories, service repairs and the tools and equipment to make the repair. The industry employs nearly 4.6 million people at more than 500,000 business locations across the country.

For the past several years, the cost of health insurance for the automotive aftermarket industry has beei increasing at double-digit rates. These cost increases have forced many companies to increase insurance premiums on their employees, reduce benefits, place limits on coverage and, in some cases, eliminate health insurance all together. In addition, small business typically have little buying power anc few affordable options since five or fewer insurers control at least three quarters of the small group market.

We believe S. 406 addresses many of the health insurance problems faced by small automotive aftermarket companies by creating federally regulated Association Health Plans (AHPs). These health plans would provide small businesses the opportunity to band together through bona fide trade and professional associations to purchase health insurance. By extending the Employee Retirement Securit and Income Act (ERISA) regulations to AHPs, small and mid-sized companies in the automotive aftermarket would have the opportunity to purchase health insurance under the same rules as Fortune 500 companies and labor unions. AHPs would allow small employers greater bargaining power, economies of scale, and administrative efficiencies when purchasing health insurance.

Through passage of AHP legislation, Congress can provide small business more choices for purchasing health insurance for their employees. Administrative costs associated with employer-provided health insurance should be reduced. As a direct result, more companies will be able to offer their employees comprehensive health insurance at more affordable rates.

Your leadership and sponsorship of this legislation is greatly appreciated by the many small businesses represented by AAIA. Please be assured that AAIA's membership stands ready to work with you to pas S. 406 during the 109th Congress.

Sincerely,

Kathleen Schmatz
AAIA, President and CEO

**Comments Submitted to the**
**Senate Committee on Small Business and Entrepreneurship**

**Hearing on**

**Solving the Small Business Health Care Crisis: Alternatives for Lowering Costs and Covering the Uninsured**

**April 20, 2005**

The Small Business Council of America (SBCA) is a national nonprofit organization that represents the interests of privately-held and family-owned businesses on federal tax, health care and employee benefit matters. The SBCA, through its members, represents well over 20,000 enterprises in retail, manufacturing and service industries, virtually all of which are stable small businesses that provide health insurance and retirement plans for their employees. The SBCA is fortunate to have the leading small business advisors in the country on its Advisory Boards.

The American Society of Pension Professionals & Actuaries (ASPPA) is a national society of retirement plan professionals. ASPPA's mission is to educate pension professionals and to preserve and enhance the private pension system. Its membership consists of more than 5,500 actuaries, plan administrators, attorneys, CPAs and other retirement plan experts who design, implement and maintain qualified retirement plans, especially for small to mid-size employers.

The Small Business Legislative Council (SBLC) is a permanent, independent coalition of over 60 trade and professional associations that share a common commitment to the future of small business. SBLC's members represent the interests of small businesses in such diverse economic sectors as manufacturing, retailing, distribution, professional and technical services, construction, transportation and agriculture. SBLC's policies are developed through a consensus among their membership.

The Employers Council on Flexible Compensation (ECFC) is a non-profit trade association committed to the study and promotion of defined contribution plans, 401(k) plans, cafeteria plans and elective compensation plans. Approximately 20 million Americans receive flexible benefits from the more than 2,800 ECFC members. Members are plan sponsors, corporations, governments, unions, universities and hospitals, as well as leading actuarial, administration, consulting, insurance and accounting firms that design and administer flexible benefit plans. Founded in 1981 by Fortune 500 corporations, Council members have great experience in designing and administering compensation and benefit programs that offer flexibility for employers and employees.

SBCA, ASPPA, SBLC and ECFC strongly endorse S. 723, the SIMPLE Cafeteria Plan Act of 2005, introduced by the Senate Small Business and Entrepreneurship Chair, Olympia Snowe (R-ME), and co-sponsored by Senators. Kit Bond (R-MO) and Jeff

Bingaman (D-NM). We applaud their efforts to enable small business employees to purchase health insurance and other employee benefits through a tax-qualified vehicle. SBCA, ASPPA, SBLC and ECFC are in full agreement with Senator Snowe's comment: "It is unconscionable for Congress to do nothing while more and more Americans find themselves without health insurance. Establishing a SIMPLE Cafeteria Plan for small businesses will help them offer the same health insurance and savings options currently available to employees of large companies and government agencies."

This bipartisan legislation would enable small business owners and their employees to be able to purchase employer-provided health insurance and other benefits with pretax dollars. Specifically, it would amend the tax code so that owners of small businesses, including partners and S-corporation stockholders who own more than 2 percent of the stock, could participate in a cafeteria plan if they worked in the business. They are excluded under current tax law because they are not "employees," even if working full-time, but rather are self-employed individuals and thus ineligible by definition. This bill, if passed, would enable them and their non-owner employees to be able to purchase employer-provided health insurance with pretax dollars. A cafeteria plan is a flexible spending account created by section 125 of the Internal Revenue Code (IRC) that allows participants to pay their health insurance premiums and other employee benefit expenses through a tax-qualified plan.

Modeled after the effective 1996 Savings Incentive Match Plan for Employees (SIMPLE) pension plan, the new SIMPLE Cafeteria Plan would allow most small businesses, many of whom are currently unable to satisfy the existing nondiscrimination cafeteria plan rules due to their size. The new SIMPLE Cafeteria Plan would provide a safe harbor for satisfying the nondiscrimination rules, in exchange for making a required annual contribution of 2 percent or a matching contribution of 3 percent to their employees' accounts for health insurance and other employee benefits. These plans are highly valued by employees for their pre-tax allowance.

The measure would also permit the carryover of unused flexible spending accounts funds, as well as simplifying and increasing dependent care accounts for employers of all sizes. It would also allow cafeteria plans to offer long-term care insurance as an optional benefit for the employees to select. It eliminates the despised "use it or lose it" rule, which causes employees to have their own salary revert back to their employer if they do not spend as much money on medical care as they had anticipated. In effect, instead of being rewarded for being healthy (as is true with the Health Savings Accounts), the current rule causes employees to forfeit their own dollars to their employers because they did not need to spend those dollars on health care.

This bill has been over four years in fruition. In addition to SBCA, ASPPA, SBLC and ECFC, the U.S. Chamber of Commerce, the National Federation of Independent Businesses (NFIB), the National Small Business Association (NSBA) and others have worked to help the Small Business Committee develop this measure.

This legislation is important for all employees, but in particular for small business employees. This legislation will make it far easier for small business employees to be covered by a cafeteria plan the same way that employees for mid- and large-size businesses are currently able to do, so that small business employees will be able to select the benefits that they need most. Even more important, by giving the small business owners an incentive to sponsor cafeteria plans, this legislation will go a long way in helping small business employees afford health insurance.

- **Employees of big businesses, mid-size employers, non-profits, schools, universities and the federal government appreciate the valuable benefits provided by cafeteria plans. Cafeteria plans allow workers to obtain and choose employee benefits that are tailored to their needs in a tax-advantaged manner.** Cafeteria plans allow employees to pay their portion of health insurance on a pre-tax basis. They allow employees' payroll deductions to pay for their deductibles, co-pays, drugs, braces, eyeglasses, and other health care expenses, as well as dependent care, disability insurance and term life insurance. Workers are able to select the benefits that they need most and are able to save for these expenses by electing to have funds removed from their paychecks. This is the easiest way for employees to save for these necessary expenditures—note the dramatic success of employees saving for their retirement through 401(k) plans. **It is clear that cafeteria plans offer a successful approach to encourage employee participation in healthcare costs.**

- **Small businesses are at a double disadvantage when it comes to offering health care and other employee benefits to their employees. Their health care insurance premiums are higher because small businesses lack the bargaining power of larger businesses. Because most small businesses do not offer cafeteria plans, small business employees are not able to pay for their health care and other benefit expenditures on a pre-tax basis.**

- **Employees of small businesses are seldom offered this valuable benefit because many small business owners are precluded from participating in a cafeteria plan. Small business owners who operate in any entity other than a C Corp (or those that own less than 2 percent in a Sub-S corp) are not allowed to be covered by a cafeteria plan.** When small business owners cannot take advantage of the benefits offered by a cafeteria plan, they seldom have any interest in sponsoring such a plan. Even for those small business owners that are allowed to participate (e.g., a less than 2 percent stockholder in an S Corp or an owner in a C Corp), the existing nondiscrimination rules effectively preclude the owners from being able to use the plan except for de minimis amounts. Again, if the owners of a small business cannot benefit from the plan to a meaningful degree, it is not likely to be offered.

- **The legislation would create a safe-harbor cafeteria plan that would be modeled after the successful SIMPLE retirement plan model.** If a small business contributes a safe harbor contribution of 2 percent or matches employee contributions up to 3 percent of the employee's compensation, then in exchange for this required contribution, none of the nondiscrimination tests applicable to cafeteria plans and dependent care plans would apply.

- **This legislation would provide small business employees access to cost savings.** The SIMPLE retirement plan has demonstrated that small businesses are willing to absorb some additional cost for employees through contributions in exchange for relief from complex administration and discrimination tests. It is anticipated that the safe-harbor cafeteria plan patterned on the SIMPLE retirement plan would also be accepted and adopted by small business. **Millions more small business employees would be likely to have health care insurance through the SIMPLE Cafeteria Plan, with some portion of the premium paid for by the employer and the remainder being paid for by the employee. Small business employees would also be able to select from other benefits that are most needed.** Congress has already decided that the SIMPLE plan provides sufficient benefits for the non-owner employees to justify the contributions for the owners—this SIMPLE Cafeteria Plan is patterned on the SIMPLE model and can bring valuable employee benefits, most importantly health insurance to small business employees.

- **The proposed legislation would allow cafeteria plans to provide employees with long-term care insurance.** Presently this valuable employee benefit is not allowed to be offered by a cafeteria plan. By allowing employees to purchase this valuable benefit on a pre-tax basis by payroll deduction, it is far more likely that employees will elect long-term care coverage. **This change would encourage more employees to finance their own long-term care, which shifts more of the burden of providing for the long-term care needs to individuals rather than the government.**

- **The proposed legislation would do away with the despised "use it or lose it" policy now applicable to flexible health care accounts.** If an employee has overestimated the amount of health care expenditures that he or she will have to pay during the year (over and above those paid by health insurance), then the excess amount is forfeited to the employer. Employers are currently prohibited from bonusing this amount back to the employee. Some employers apply these forfeited amounts to benefits for all the employees in the following year, but there is no requirement that they do so. Theoretically, the policy behind this unpopular rule created by the IRS was to make the flexible health care account more like an insurance policy. It is hard to imagine any insurance policy being

purchased where the risk is limited to the amount of "premiums" paid and the "insureds" forfeit their own money if they cannot come up with enough expenses. Thus, comparing the "use it or lose it" rule of a medical reimbursement account under a flexible spending arrangement to health insurance (or any other kind of insurance) is unreasonable. The use it or lose it concept is unfair to employees and runs counter to public policy inasmuch as employees generally will not save as much as they are able to pay for health care expenditures because they are fearful of forfeiting their own money (their savings for health care expenditures) to their employer.

- **This legislation would change the nature of the health care flexible spending account to a reimbursement account so that it is similar to the dependent care account (the difference being that a cafeteria plan may reimburse the full elected amount during the year, while a dependent care may only reimburse the account balance). The legislation would also cap the amount of the health care flexible spending account as dependent care accounts are capped. Similar to the President's proposal, the legislation would allow any funds left over in the health or dependent care flexible spending account at the end of the year to be rolled over to a 401(k) account (or other qualified retirement plan vehicle), an HSA or carried over to the next year.** Finally, employees terminating employment would be permitted to cash out their accounts, though doing so would subject the distribution to income tax.

- **These changes would encourage employees to select the appropriate amount required for health care expenditures rather than possibly choosing to estimate low so that they do not forfeit their own money to their employer. This would assist employees in dealing with rising health care costs and provide a vehicle for employees to save for these expenditures in a tax-free manner.**

- **The legislation would revise the discrimination tests applicable to the dependent care flexible spending account to enable all employees to use the benefit. The dollar amount would be increased to take into account today's cost of providing care for dependents.**

Small business employees are in need of access to health care in a cost effective manner. Congress understands how vital health care is for our citizens and has decided that individuals should be incentivized to undertake as much of the burden of providing for this health care as possible. S. 723 does this—small business employees would now be able to join their counterparts in mid-size and large businesses and save for health care and other employee benefits in a tax advantaged manner. Furthermore, all employees, regardless of the size of the entity they work for, should be able to have access to the same benefits under the tax code. Also, the initial cost of providing access to long-term care insurance in a tax advantaged manner is outweighed by employees taking ownership

of the problem and financing their own long-term care. When it comes to health care the primary issue should not be short-term loss of revenue, but access to quality health care at the most reasonable price possible for the largest number of Americans possible.

Interestingly, this revenue argument is being advanced by a number of Senators in conjunction with contemplating the repeal of estate taxes—something that not only will hurt a great number of small businesses because of the loss of the step-up in basis but will also be a huge revenue drain on the country. If we have the funds to assist roughly 0.3 percent of the individuals in the country (this translates to 8,500 people) to leave enormous wealth to their families, then surely there must be money to help millions and millions of small business employees to gain access to health care insurance and other needed employee benefits.

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*For additional information, please contact:*

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*Brian H. Graff, Esq., APM, Executive Director/CEO, ASPPA, 4245 N. Fairfax Drive, Suite 750, Arlington, VA, 22203, (703) 516-9300, bgraff@asppa.org*

*John Satagaj, President, Small Business Legislative Council, 1010 Massachusetts Avenue, NW, Suite 400, Washington, DC 20001, (202) 639-8500, email@sblc.org.*

*Bonnie B. Whyte, CFCI, CAE, President, Employers Council on Flexible Compensation, 927 15th Street, NW, Suite 1000, Washington, DC 20005, (202) 659-4300, bwhyte@ecfc.org*

April 19, 2005

The Honorable John Kerry
United States Senate
Washington, DC 20510

Dear Senator Kerry:

We are writing today on behalf of the American Cancer Society and its millions of volunteers and supporters to share our strong concerns about S. 406 the Small Business Health Fairness Act of 2005. The establishment of Association Health Plans (AHPs), as proposed and defined by this bill, would undermine important patient protections and could hamper our efforts to prevent, detect and treat cancer.

The American Cancer Society is strongly committed to the goals of this legislation as stated by its proponents: making quality health insurance more affordable and reducing the number of uninsured people in our country. However, the bill's exemption of AHPs from state-enacted regulations and patient protections means that in many states, participants in these health plans would lose their guarantee of coverage for such critical cancer screenings as mammograms and colorectal cancer screening tests.

For years, the Society has fought to ensure that cancer patients have access to high quality cancer prevention, early detection and treatment services. State oversight and consumer protections, including state insurance coverage requirements for mammograms, colorectal cancer screenings and other cancer screenings and treatments, are key to ensuring this high quality care and have helped to produce favorable health outcomes for people at risk for cancer or who already have cancer. Currently, citizens across the country are protected by a combined total of more than 130 different laws to ensure coverage for vital cancer screenings and treatments. Exempting AHPs from these coverage requirements will likely resurrect barriers to care that the American Cancer Society has worked tirelessly to break down.

We are also very concerned by the Congressional Budget Office's determination that most of the individuals who would be covered by AHPs are already covered by traditional health plans, and a very real possibility exists that costs for those with insurance today could rise to offset discounts given to AHPs. Objective estimates suggest that the number of individuals covered through small firms would only increase by about 330,000 under the AHP proposal, while 20 million private health insurance consumers would face increases in costs and 10,000 currently insured individuals could lose their health insurance altogether because of the offsetting increase in health insurance premiums. Further, the legislation enables AHPs to "cherry pick" healthy individuals, placing affordable care out of reach of those who need it the most, including cancer patients and survivors.

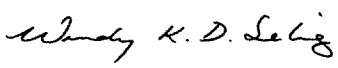
**National Government Relations Office**
901 E Street, NW, Suite 500 Washington, DC 20004 **t)** 202.661.5700 **f)** 202.661.5750

Given our assessment of the costs in terms of quality coverage and the likelihood that there will be more losers than winners under the AHP scenario, we have been exploring alternative approaches for meeting our mutual goals of improving access to care and reducing the number of uninsured. Among these possible approaches are premium subsidies, reinsurance pools, allowing buy-in to the Federal Employees Health Benefit Plan, or a combination of those alternatives. Our policy analysts have been evaluating various alternatives to AHPs, and we would be happy to meet with you to discuss them further.

We recognize the enormous difficulties that small businesses and their employees face in the health insurance market. Expanding the numbers of people with insurance coverage is a worthy goal for all of us, but we must be careful to make sure that we are delivering quality coverage in the process. Carving out more Americans from the protections afforded by their own states is not an acceptable price to pay. We stand ready to work with you and your colleagues to identify effective solutions.

Thank you for taking cancer patients and all Americans at risk of cancer into consideration as you address these difficult issues. If you have any additional questions, please contact Andrew Fish, Senior Director of Federal Government Relations (202-661-5709).

Sincerely,



Daniel E. Smith
National Vice President
Federal and State Government Relations

Wendy K. D. Selig
Vice President
Legislative Affairs

**Senate Committee on Small Business and Entrepreneurship**

**Association Health Plans**

**Statement for the Record by Joseph M. Stanton,**
**Senior Staff Vice President for Legislative and Political Relations**

**National Association of Home Builders**

**April 20, 2005**

On behalf of the over 220,000 members of the National Association of Home Builders (NAHB), I thank you for the opportunity to submit this statement for the record in support of S. 406, the "Small Business Health Fairness Act," and Association Health Plans (AHPs).

NAHB represents 220,000 members from across the United States, and the vast majority of NAHB members are small businesses who employ 10 or fewer employees. NAHB members are involved in home building, remodeling, multifamily construction, property management, subcontracting, design, housing finance, building product manufacturing and other aspects of residential and light commercial construction. Known as "the voice of the housing industry," NAHB is affiliated with more than 800 state and local home builder associations around the country. NAHB's builder members will construct about 80 percent of the more than 1.6 million new housing units projected for 2005, making the housing industry one of the largest engines of economic growth in the country.

Over the past 15 years, NAHB members have become more and more concerned with their increasing inability to provide health insurance coverage to their employees. As issues in the housing industry ebb and flow, the one issue we hear about from our members consistently is the rapidly rising costs of health insurance, and the rapidly rising occurrence of our members losing access to coverage because their local small group market provider will no longer cover their small business.

NAHB strongly feels that the health insurance market in the United States is severely broken when small businesses can no longer obtain coverage, or are forced out of coverage by double-digit premium increases year after year. The most recent U.S. Census Bureau estimate indicates that approximately 45 million Americans lack health insurance coverage—an increase of almost 1.5 million over their estimate in 2004 of 43.6 million. As has been the case for over a decade, the Census Bureau continues to believe that approximately 60 percent of the uninsured are employees of, or dependents of employees of small businesses. While these staggering numbers of the uninsured increase dramatically, and while small businesses continue to bear the brunt of it, Congress has not addressed the problem.

NAHB's members strongly support association health plans not because we believe they are destined to resolve the crisis in its entirety, but because we believe allowing AHPs to enter the marketplace at a level playing field will inject much-needed competition into the small group

marketplace. Today, small businesses like our members have very few choices for health insurance coverage—and many have none at all. Strong health insurance monopolies in most states dictate coverage to our members, who do not have the necessary size or economy of scale to shop around their business.

NAHB believes that bona fide associations are well-positioned to be able to negotiate on behalf of their members for more reasonable, and more widespread, high-quality, health insurance coverage. Allowing association members to band together across state lines will give them the economies of scale necessary to obtain reasonably priced coverage.

Health insurance coverage for employees is very important to our NAHB members. In our industry, which is extremely competitive, and in which we have suffered labor shortages for some time, the ability of a builder to recruit, train, and retain good, hard-working employees is essential to the builder's ability to meet contractual commitments, and have a solid team of reliable employees. As it becomes more and more difficult for builders to offer benefit packages that include stable, affordable health care plans, employees are more likely to leave smaller builders for positions other companies, who are able to provide a consistent benefit package. For many of our members, providing health insurance is a necessity that helps them to retain their best employees.

Importantly, NAHB supports association health plans because they will allow us to work to directly address the needs of our membership. Under the proposed legislation, an association would be required to set up a separate board of trustees for the AHP. In our case that means we would enlist many of our key members to sit on that board. Membership involvement in the development and management of the AHP is vital because it will ensure that the AHP provides the level and quality of coverage that the membership demands and that the association needs. In addition, NAHB feels that it is vitally important to note that the legislation would <u>require</u> associations to allow **all** members of the association to be eligible for participation in the plan, and to offer all participants access to **all** plans offered by the association's AHP. This is an important component because it ensures that all of our members can view the AHP program as important membership benefit.

NAHB believes that association health plans will offer millions of American small businesses the opportunity to obtain stable, affordable coverage. We believe that these types of plans—which level the playing field for small businesses—merit serious consideration and enactment by the U.S. Congress. Each year a handful of insurers continue to entrench themselves in their own segmented marketplace monopolies, while millions of Americans lose coverage or face premium increases so high that they must drop the scope of their coverage in order to hold on to even basic protections. Congress has an obligation to enact legislation to allow small businesses the same opportunity and access to health care that large corporations and labor unions now enjoy.

Thank you for allowing the National Association of Home Builders this opportunity to share our opinion on association health plans. We look forward to continuing to work with the committee to bring commonsense reform to ERISA, and give small businesses equal footing to obtain stable, affordable and quality health insurance coverage.

**North American Die Casting Association**

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708.292.3600 Telephone
708.292.3620 Fax

The Honorable Olympia Snowe
Chairwoman, Committee on Small Business and Entrepreneurship
United States Senate
428A Russell Senate Office Building
Washington, DC 20510

Dear Madam Chairwoman:

**RE: Urge passage of S. 406, *the Small Business Health Fairness Act of 2005.***

On behalf of the North American Die Casting Association (NADCA), I am writing to urge the Senate Committee on Small Business and Entrepreneurship to pass S. 406, the Small Business Health Fairness Act of 2005. This bill is necessary to help die casters address the overwhelming rise in health care costs and remain competitive against foreign manufacturers.

NADCA is the sole trade and technical association of the die casting industry. NADCA membership consists of both corporate and individual members from over 950 companies located in every geographic region of the U.S. As an important part of the larger metalcasting industry, die casting produces over one-third of all metalcastings. Die casters contribute over $7.3 billion to the nation's economy annually and provide over 65,000 jobs directly and indirectly. The die casting industry is comprised of many small businesses; over 60 percent of domestic die casters have fewer than 100 employees.

In recent years, the American metalcasting industry has been facing intense competition from foreign metalcasters. In fact, China recently surpassed the United States to become the number one producer of metalcastings in the world. The sky-rocketing cost of health care is a primary factor that prevents many domestic manufacturers from being able to price their pieces as low as their Chinese competitors who do not provide health benefits to their workers.

For American die casters, insurance costs are the largest expense above production, and these costs have been rising over the past few years. For example, Modern Die Casting, a small manufacturer in Elk Grove Village, Illinois, experienced a 23 percent increase in their 2004 renewal rate and a potential 40 percent increase in 2005! In order to continue health coverage, Modern Die Casting was forced to reduce benefits to bring the rate increase down to 22 percent and shifted one-third of its workers to part-time with no health benefits at all. Congress needs to do something to help facilities like Modern Die Casting.

The North American Die Casting Association strongly urges you and your committee to pass the Association Health Plan legislation (S. 406). The Congressional Budget Office estimates that small businesses obtaining health insurance through an AHP will save 13 -25 percent on their premiums. That type of cost savings would have a significant impact on this industry, allowing many U.S. die casters to lower their cost per piece and compete directly with their foreign competitors.

Thank you for your consideration of this important issue. NADCA looks forward to the passage of the AHP legislation.

Sincerely,

Daniel L. Twarog
President

# Statement of the U.S. Chamber of Commerce

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**ON:** **"SOLVING THE SMALL BUSINESS HEALTH CARE CRISIS: LOWERING COSTS AND COVERING THE UNINSURED"**

**TO:** **SENATE COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP**

**DATE:** **WEDNESDAY, APRIL 20, 2005**

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

The U.S. Chamber of Commerce is the world's largest business federation, representing more than three million businesses and organizations of every size, sector, and region.

More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. We are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large.

Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business—manufacturing, retailing, services, construction, wholesaling, and finance—is represented. Also, the Chamber has substantial membership in all 50 states.

The Chamber's international reach is substantial as well. It believes that global interdependence provides an opportunity, not a threat. In addition to the U.S. Chamber of Commerce's 98 American Chambers of Commerce abroad, an increasing number of members are engaged in the export and import of both goods and services and have ongoing investment activities. The Chamber favors strengthened international competitiveness and opposes artificial U.S. and foreign barriers to international business.

Positions on national issues are developed by a cross-section of Chamber members serving on committees, subcommittees, and task forces. More than 1,000 business people participate in this process.

The U.S. Chamber of Commerce appreciates the opportunity to submit the following statement for the official record. We thank Chairman Olympia Snowe (R-ME), Ranking Member John Kerry (D-MA) and members of the Senate Small Business and Entrepreneurship Committee for recognizing the problem of the uninsured in America. It is our hope that this hearing will serve to discuss and highlight Association Health Plans as one viable and innovative way to reduce the growing number of uninsured in the United States.

The U.S. Chamber of Commerce is the world's largest business federation representing more than three million businesses of every size, sector and region. While all employers have experienced substantial increases in health care costs over the past five years, small business owners have been hit the most severely. Struggling with skyrocketing premiums, these employers are forced to share this rising cost with employees by raising co-pays and deductibles in order to continue to provide any benefit at all.

Small businesses are the engine that drives our nation's economy and therefore must be a top priority for lawmakers. Nearly 90 percent of the firms in this country are businesses that employ less than 20 people. Many small businesses want to offer health insurance, not only because it is a good business practice that helps them compete for good workers, but because it is the right thing to do.

However, these small businesses face significant challenges in accessing affordable health insurance coverage. On average, their premiums are 20 to 30 percent higher than those of large, self-insured companies. Moreover, administrative expenses for small group plans account for 25 to 27 percent of premiums, compared to about 5 to 10 percent for large businesses.

Currently, more than 45 million Americans lack health insurance and approximately 60 percent of the uninsured are employed by small businesses or are dependent on someone who is. In 2003, there was actually an increase in employed workers who were uninsured. The percent of people covered by employment-based health insurance fell between 2002 and 2003 from 61.3 percent to 60.4 percent. Therefore, the problem of the uninsured does not lie solely with the unemployed, but more so with the small businesses across the country who are unable to provide quality health insurance due to the exponentially rising costs.

There is no silver bullet that will solve the problem of the uninsured. It is a complex problem that requires a multi-pronged, market-based approach. Cost and access are two of the most important factors to consider, both of which can be tackled with the advent of Association Health Plans.

The legislation being discussed today, S. 406, *The Small Business Health Fairness Act of 2005*, provides for the creation of Association Health Plans ("AHPs") which extend greater bargaining power, economies of scale, administrative efficiencies and uniform regulatory structures to small businesses. These advantages are currently

enjoyed by large corporations and unions. This legislation would extend the same federal laws governing health benefits to these small businesses. By allowing bona-fide trade and professional associations to offer health insurance to their membership – across state lines – AHPs will help lower the cost of obtaining quality health coverage for all small businesses.

AHPs would extend preemption of costly state mandated benefits, currently available for larger, self-insured plans, to bona-fide associations and professional societies comprised of small businesses. Without the benefit of the national uniform standards under the Employee Retirement Income Security Act ("ERISA"), many of today's most comprehensive, innovative and cost-effective employer-sponsored health benefit plans could not exist. The overwhelming costs of complying with the myriad of overlapping, inconsistent and incompatible state laws would be too great.

Unlike large employers, small businesses do not have the resources to self-insure under federal ERISA laws. Additionally, more and more small businesses have employees in two or more states, and usually have to arrange health coverage for their employees in each of those states. Under AHPs, small businesses would no longer be subject to multiple sets of varying state mandates and regulatory requirements that drive up costs. Multi-state employers would enjoy a much simplified health care benefits program offering the same coverage to all their employees- just like larger businesses with whom they compete.

Critics of opening the small group insurance market to more competition charge that AHPs will lead to "cherry picking" and destabilization of the small group market. In fact, AHPs are fully subject to the portability requirements contained in ERISA that prohibit discrimination based on health status. Sponsoring entities <u>must</u> extend coverage to <u>all</u> members eligible for membership benefits and may not vary employers' dues based on health status. In addition, the solvency standards, plan requirements, and patient protections included in the legislation are more stringent than those now required by some states. Plans must also comply with the extensive requirements under ERISA governing coverage of certain benefits as well as procedures for appeals of claims denials.

There is virtually no competition left in today's small group insurance market. The four largest health insurance firms account for 65 percent of the small group insurance market. What this number doesn't show is that in many states, especially in rural areas, the largest insurer is the <u>only</u> insurer. Small businesses are provided little opportunity to comparison shop for prices, products, as well as customer service. In some cases, small businesses have been forced to get a new health plan because their insurer has left the marketplace. In other cases, employers have no other plan operating in their area to call for a rate quote when their current plan premiums skyrocket. State health insurance mandates have taken away the health plans' abilities to differentiate themselves in the marketplace and compete for customers by offering benefits tailored to meet their needs. When plans leave the market, businesses have one less option to choose from.

Health plan mandates, rating reform, and regulatory requirements enacted by the states have driven up the cost of small group coverage and stifled competition. Small firms have few, if any, alternatives to their current health plan when presented with dramatic rate increases. AHPs will invigorate the market for small group coverage and provide competitive choices for both businesses and their employees.

The House of Representatives has passed legislation creating Association Health Plans seven times. With this committee's leadership, the U.S. Chamber of Commerce anticipates Senate passage of AHP legislation this year. This common-sense, revenue-neutral proposal will result in a more level playing field for small businesses who are losing good employees to larger firms who can provide better benefits.

Small business is the backbone of our nation and has driven much of the economic boom of the last decade and century. If these smaller enterprises continue to face annual premium increases of 20 to 30 percent, they will no longer be able to remain competitive and contribute to the growth of the U.S. economy.

The U.S. Chamber of Commerce appreciates this opportunity to submit comments on such an important issue. We look forward to working with you to identify and enact meaningful reforms to the small group insurance market, making healthcare more affordable and accessible for all Americans.

**Testimony of**

**Donald L. Westerfield, Ph.D.**

**Professor, Webster University**

**Senior Fellow, National Center for Policy Analysis**

**Testimony Before the**

**Committee On Health, Education, Labor, & Pensions**

**United States Senate**

# Small Business and Health Insurance: Easing Costs and Expanding Access

**April 21, 2005**

Mister Chairman, and Members of the Committee:

I am honored to submit this prepared statement to discuss with you "Small Business and Health Insurance: Easing Costs and Expanding Access." The theme of this Hearing is so very appropriate for the state of the small business health care market that we face today. With approximately 41.2 million persons uninsured, we must admit that the current health care system needs urgent national attention. These hearings that you are conducting in this Committee will help to focus attention and resources on this grave national health care crisis.

I have written three scholarly works on health care issues: [1] 1) *Mandated Health Care: Issues and Strategies,* 2) *National Health Care: Law, Policy, Strategy*, and 3) *Insuring America's Uninsured: Association Health Plans and Their Impact on the Uninsured.* The latter work specifically addresses issues this Committee is discussing today.

One solution to a major portion of the crisis of the uninsured in America is contained in the proposed legislation creating Association Health Plans as outlined in 109th Congress, 1st Session, S. 406 and H.R. 525, both entitled: "*Small Business Health Fairness Act of 2005.*"

The Small Business Administration estimates that only about 47 percent of small businesses (with less than 50 employees) offer health plans as contrasted with about 97 percent of large firms (with more than 50 employees). This gap between coverage in large versus small employers is unacceptable. The contrast is even greater between large employers and those with less than 5 employees.

As I review that arguments for and against the formation of AHPs, I see that the issue is divided into two major camps. Among those in the opposition camp, we typically find a combination of *large insurers* which stand to lose market share if the AHP becomes a national reality, a combination of *state regulators* who would impose unfunded mandates on AHPs and who risk losing administrative power and control at the state level, a combination of *special interests*, representing literally hundreds of narrow causes, who lobby states to have their benefits made mandatory in the employer plans, and a spectrum of those who know of abuses and plan frauds by non-AHP entities that resemble AHPs.

In the other camp are those who support AHPs – typically a spectrum of small employers who have businesses that range in size from 1 to 50 employees and have been subjected to skyrocketing rates and who have been abandoned by insurers no longer writing business in the small group market.

Market Concentration And Market Power - A number of economists have suggested that large insurer opposition to Association Health Plans, among other things, stems from their desire to retain their market position without the threat of competition from newly formed Association Health Plans. The large insurers have networks at the insurer level and at the provider level, enabling them to wield enormous market power in the small group market. Through establishment of national networks and contractual agreements

with provider networks, large insurers have accumulated disproportionate market shares and power in given geographical and market areas.

The General Accounting Office (GAO) [2] derived a table (attached), *Table 1: Number of Carriers, Largest Carrier, and Market Share Data for Small Group Health Insurance, GAO-02-5236R State Small Group Health Insurance Markets (March 25,2002)*, presenting the number of carriers, largest carrier, and market share data for small group health insurance for 37 states. It is interesting to observe from the table that Blue Cross and Blue Shield (BCBS) was the largest carrier in 25 of the 37 states, and that BCBS was among the top 5 largest carriers in all but 1 of the remaining 12 states. Additionally, the "five-firm concentration ratio" for the largest carriers represented 75 percent or more of the market in 19 of the 34 states supplying that data, and they represented greater than 90 percent of the market in 7 of those states. Their market shares have given them significant market/monopoly power in the small group market.

The concentration of market power can adversely affect the market for health plans. A review of the development of health plans in the State of New York is an eye opener for those who are not aware of the degree to which large insurers, those who typically oppose Association Health Plans, dominate the market. The 2001 study by Gerard Conway, [3] for the Medical Society of the State of New York is an education in market concentration. In Section IV of that study, Conway explains how "barriers to entry" such as regulatory barriers, advertising, exclusive contracts, networks, etc. are used to prevent or slow down the entry into a highly concentrated market. He states:

"All of these factors can operate as formidable barriers to entry for a new health insurance company trying to establish a foothold in a concentrated market, and even more so in the highly concentrated markets identified in this study."

Impact of State Mandates - The record of witness testimony before the U.S. Senate and before the U.S. House of Representatives indicates that insurers have practically abandoned the small group health plan market, due largely to the administrative hassle and financial burdens of state mandates such as "guaranteed issue" and "community rating." While these two state mandates, unfunded by the states, were designed with good intentions, they mandate coverage and rating that is contrary to sound business risk management. The mandates artificially superimpose a social welfare function upon small employers that causes them to pay for benefits that they do not want. Additionally, they are a major reason for small insurers to abandon whole markets in several states. Ray Keating [4], Economist for the Small Business Survival Committee, states: "For example, New Jersey imposed guaranteed issue in the individual market in legislation passed in 1994. From December 1994 to January 2002, among four insurers offering family coverage during this period, monthly premiums increased by 556% (Aetna), 344% (Blue Cross Blue Shield NJ), 612% (Metropolitan Life), and 471% (National Health Insurance).

In Kentucky, after the state adopted guaranteed issue and community rating in 1994, 45 insurers fled the state and premiums skyrocketed. Also in 1994, a similar scenario played out in New Hampshire in response to passing guaranteed issue and community rating. In

a November 1995 column, SBSC chairman Karen Kerrigan explained what happened in New York after it imposed guaranteed issue and community rating in 1992: "Since then, several major insurers simply stopped serving the market altogether ..."

Large insurers with large market shares, national networks, and excessive market power argue that AHPs should be subject to these state mandates. It is clear that the giant insurers have a vested interest in placing as many restrictions on the AHPs as is possible because the mandates are a form of "barriers to entry," that are designed to discourage the formation and development of AHPs. Additionally, as the size of the AHP increases, the giant insurer's relative market power decreases.

Community Rating Bands and Minimum Loss Ratios State Mandates - A January 2003 Small Business Administration study [5], "Study of the Administrative and Actuarial Values of Small Health Plans" (page 20) describes the community rating bands as "Twelve states have community or modified community rating which does not allow premiums to vary by health status and only allows differences in premiums for geographic area or family size or in the case of modified community rating, also (GAO 2001). In 35 states, there are rating bands that allow premiums to vary by health status and age but the variation is limited (e.g., plus or minus 10% or plus or minus 25% of a projected average rate)."

In commenting on the loss ratio mandate, the Small Business Administration study, just cited, states [6]:

"Loss ratios (ratio of medical expenses to premiums) are used by state insurance departments to assess solvency and document the need for rate increases. Several states require a minimum level of loss ratio for small group insurance. The minimum ratios are 65% for Florida, 50% for Minnesota, 75% for New Jersey, 75% for New York, 60% in Oklahoma, and 73% for West Virginia ..."

The Association Health Plans are preempted through ERISA from being subject to these mandates. Testimony from witnesses before the U.S. House of Representatives and before the U.S. Senate substantiate that these mandates contributed to small insurers' decisions to stop conducting business in the given states.

The Myth of "Cherry Picking" The old myth of "cherry picking" is presented by the large insurers in almost every Congressional venue. That argument is essentially that AHPs will admit only healthy groups and discourage unhealthy groups in the association. As a matter of policy, the Department of Labor would not permit this practice. Additionally, Sections 804 and 805 of the of the proposed "Small Business Health Fairness Act of 2005" regulate this type activity.

This "cherry picking" term could equally be applied to the underwriting practices of the large insurers themselves. For years, they have excluded whole segments of the small group market or geographical areas where their underwriters determined it was not

profitable to underwrite business. Just because they have done so, they should not claim that AHPs will follow their practices.

Innovative Health Plan Options - With approximately half of small employers not offering health plans, it is clear that something is wrong with the health care system. It is also clear that insurers are not offering plans that are affordable, or that the plans that they offer are not appropriate with respect to composition of benefits desired by employers, or both.

One of the main cost and desirability features of AHP plans is that the plans can be specially tailored to fit the specific needs and desires of the given workforce. Plans that must arbitrarily contain benefits and features that the employers and employees do not want and do not want to pay for often are the reason for "take up" rates to be low and for employees to prefer cash or no plan rather than be forced to take what they do not want.

Dr. Merrill Matthews [7] from the Council for Affordable Health Insurance, in his testimony before the Small Business Committee of the House of Representatives, asks for less regulations so that more options may be made available. He states: "I think if you were to remove some of those regulations, give them a little more freedom out there, you would find them creating policies that are very affordable in a lot of areas."

The AHP will allow employers to respond to the needs of the workplace, insuring more of the uninsured with health plans specifically designed to fit the needs of the workplace.

Cross-Subsidization In its testimony on February 6, 2002, Blue Cross and Blue Shield [8] argued that the AHPs should have to subsidize sick, high-cost groups while over-charging healthy, low cost groups across all products offered by the Association Health Plans. Not only does this *not* make sense from a risk management point of view, but it also requires the employer to bear the brunt of welfare functions that are more appropriately the responsibility of the state. Additionally, these mandatory subsidies are a form of indirect taxation and a monopoly barrier to entry.

There is a significant "social welfare loss" associated with charging a higher price than the value of the product in one market and providing an unearned subsidy to another part of the market or another market altogether. The Association Health Plans should not have to bear the financial and social burden of individuals that are not members of the employer's workforce and are not a member of a given AHP. Under the cross-subsidization scheme, the AHP would be forced to cover less healthy groups that do not join the AHP.

The argument, used by large insurers, to subject Association Health Plans to any arbitrary cross-subsidization scheme is another form of the "monopoly barriers to entry" encouraged by those insurers with excessive market power.

Uniform Regulation Under the Department of Labor - Perhaps the greatest argument for Association Health Plans is that they will be regulated by the Department of Labor and

preempted from mandates of the 50 states. The Department of Labor will be a watchdog to carefully enforce regulations under which the Association Health Plans will operate. By preempting state mandates, the AHPs will be able to form national organizations and not be whip-lashed by conflicting mandates from the 50 different state insurance commissions.

Solvency, Fraud, and Abuse - Section 806 of the proposed "Small Business Health Fairness Act of 2005" outlines the Department of Labor provisions for regulating the solvency and financial activities of the AHPs. The Honorable Elaine L. Chao, Secretary Of Labor, in her testimony before this Committee [9] stated:

"Let me take this opportunity to focus on the Department's current efforts to combat health insurance fraud. AHP legislation will help address this serious problem by providing an attractive, cost-effective alternative to fraudulent health plans.

The Department combats health insurance fraud through both education and enforcement. By educating small employers, we can alert them to ways they can protect themselves and their employees from fraudulent health insurance schemes. The Department also devotes significant resources to enforcement efforts. Our efforts have been effective in closing down fraudulent health plans and, in some cases, recovering money for their victims.

The Department of Labor has firsthand experience dealing with group health plan regulation, as well as combating insurance fraud. The Department of Labor currently administers Employee Retirement Income Security Act (ERISA) protections covering approximately 2.5 million private, job-based health plans and 131 million workers, retirees and their families."

Dangers of the Status Quo – The Committee On Small Business & Entrepreneurship is commended for conducting this hearing on a matter so vital to the health of this nation. The testimony of witnesses for Association Health Plans have given the Committee insights regarding the plight of small employers trying to offer a quality product at a reasonable price, while trying to provide health care coverage for their employees. It is evident from their testimony that we are in the middle of a health care crisis. Our health care system, with its patchwork of regulations in the various states is increasingly causing insurers to abandon segments of the small business market and, in some cases, abandon whole states due to state mandates.

Gerard Conway, [10] of the Medical Society of the State of New York, said it best when he argued that it would take years to build a network, especially in view of existing exclusive contracts (which are themselves monopoly barriers to entry) between existing insurers and providers. The large insurers got their start in a climate conducive to start-up and expansion because there were millions who were uninsured and that seemed to be a solution. We are now in an acute health care crisis that begs for immediate attention and action. The Association Health Plan will not be a total cure for the problem, but millions of the uninsured desperate for small group insurance need relief. From the news

releases and testimony before hearings it seems that those who have such strong opposition to the AHPs are those who typically stand to lose political control or market share. Similarly, it seems that those who are pleading for relief via the AHP are those throughout the small group market who have been disenfranchised in one way or another from coverage through an employer health plan.

The status quo is not working now. Our health care crisis will continue unless Congress is willing to take the bold step and help Association Health Plans cover millions of the uninsured, who urgently need help.

Perhaps the most important advantage of the Association Health Plan, in the eyes of the small employer, is that the AHP would allow them to be able to match the economies of scale and market power of the larger entities. The result would be greater affordability and greater availability of health plans to the uninsured.

Thank you for giving me this opportunity to present testimony regarding this health care issue that so gravely affects our nation.

**References**

[1] Westerfield, Donald L. *Mandated Health Care: Issues and Strategies* (New York: Praeger Publishers, 1991); Westerfield, Donald L. *National Health Care:Law, Policy, Strategy* (New York: Praeger Publishers, 1993); Westerfield, Donald L. *Insuring America's Uninsured: Association Health Plans and Their Impact on the Uninsured* (Washington, D.C.: National Center for Policy Analysis).

[2] Bond, Hon. Christopher "Kit". Private communication from Director , Health Care – Medicaid and Private Health Insurance Issues, transmitting GAO-02-536R State Small Group Health Insurance Markets [Table 1. Number of Carriers, Largest Carrier, and Market Share Data for Small Group Health Insurance Carriers, by State], March 25, 2002.

[3] Conway, Gerard. (2001) "Competition In The Managed Care Health Insurance Market In New York State: A Regional Analysis" Medical Society of the State of New York.

[4] Keating, Raymond, Small Business Survival Committee. Discussing "The Small Business Health Market: Bad Reforms, Higher Prices, and Fewer Choices" Testimony Before the Committee on Small Business, U.S. House of Representatives , 107 Cong. 2nd Sess., (July 11, 2002), Washington, D.C.

[5] Small Business Administration, Office of Advocacy. *Study of the Administrative Costs and Actuarial Values of Small Health Plans*, (January 2003), Washington, D.C.

[6] Small Business Administration, *op. cit.*

[7] Matthews, Merrill. "The Small Business Health Market: Bad Reforms, Higher Prices, and Fewer Choices" Testimony Before the Committee on Small Business, U.S. House of Representatives , 107 Cong. 2nd Sess., (July 11, 2002), Washington, D.C.

[8] Lehnhard, Mary. "Small Business Access to Health Care." Serial No. 107-41. Hearing Before the Committee on Small Business, U.S. House of Representatives, 107 Cong. 2nd Sess., February 6, 2002. Washington, D.C.

[9] Chao, The Honorable Elaine L., Secretary of Labor, Testifying before the U.S. Senate Committee on Small Business & Entrepreneurship, "The Small Business Health Care Crisis: Possible Solutions," February 5, 2003. Washington, D.C.

**Table 1. Number of Carriers, Largest Carrier, and Market Share Data for Small Group Health Insurance Carriers, by State – December, 2000**

| State | Number of licensed carriers | Largest carrier | Market share of largest carrier (percent) | Market share of five largest carriers (percent) | Rank of largest BCBS carrier | Market share of all BCBS carrier(s) (percent) |
|---|---|---|---|---|---|---|
| Alabama | 10 | BCBS of AL | 87.4 | 93.8 | 1 | 87.4 |
| Alaska | 9 | Premera Blue Cross | 51.9 | 81.5 | 1 | 51.9 |
| Arizona | 53 | United Healthcare of AZ, Inc. | 24.5 | 68.9 | 2 | 20.8 |
| California[a] | 14[b] | Blue Cross of California[b] | NA | NA | 1[b] | NA |
| Colorado | 44 | Employers Health | 15.6 | 57.9 | 9 | 5.3 |
| Connecticut[c] | 47 | Anthem BCBS of CT, Inc. | 33.1 | 97.9 | 1 | 33.1 |
| Delaware[a] | 17 | NA | NA | NA | NA | NA |
| District of Columbia[a] | 9 | NA | NA | NA | NA | NA |
| Florida | 26 | United Healthcare of FL, Inc. | 21.6 | 64.6 | 2 | 26.9 |
| Georgia | [d] | BCBS Health Care Plan of GA[d] | 19.7[d] | 47.3[d] | 1[d] | 28.3[d] |
| Hawaii[a] | 4 | NA | NA | NA | NA | NA |
| Idaho[e] | 15 | Regence Blue Shield | 44.4 | 92.7 | 1 | 81.9 |
| Illinois | 36 | NA | NA | NA | NA | NA |
| Indiana | 77 | Anthem Insurance Company | 18.5 | 51.1 | 1 | 18.5 |
| Iowa | 54 | Wellmark, Inc.[e] | 46.5[e] | 76.7[e] | 1[e] | 52.8[e] |
| Kansas[a] | 35 | BCBS of KS, Inc.[f] | NA | NA | 1[f] | NA |
| Kentucky | 10 | Anthem | 43.7 | 89.2 | 1 | 43.7 |
| Maine | 13 | Aetna US Healthcare | 45.6 | 90.9 | 2 | 39.1 |
| Maryland | 18 | CareFirst, Inc. | 48.2 | 95.3 | 1 | 48.2 |
| Massachusetts | 24 | HMO Blue | 30.6 | 79.0 | 1 | 37.1 |
| Michigan[g] | 64 | BCBS of MI | 63.2 | 84.8 | 1 | 79.1 |
| Minnesota | 20 | BCBSM, Inc.[h] | 42.0[h] | 87.7[h] | 1[h] | 49.6[h] |
| Missouri[a] | 47 | Healthy Alliance Life Ins. Company | 18.9 | 51.8 | 1 | 32.2 |
| Montana | [i] | BCBS of MT | 40.8 | 78.0 | 1 | 40.8 |
| Nebraska[a] | 30 | NA | NA | NA | NA | NA |
| New Hampshire[a] | 9 | Healthsource NH | 40.0 | 75.2[j] | 2 | 35.2 |
| New Jersey[k] | 22 | Horizon BCBS of NJ | 30.1 | 84.4 | 1 | 46.0 |
| New York | 34[l] | Oxford[m] | 18.5[m] | 57.2[m] | 2[m] | 26.5[m] |
| North Carolina | 37 | BCBS of NC | 26.6 | 67.5 | 1 | 26.6 |
| North Dakota | 12 | Noridian/BCBS | 88.8 | 95.7 | 1 | 88.8 |
| Ohio[c] | 70 | Anthem BCBS | 32.6 | 66.4 | 1 | 32.6 |
| Oklahoma[a] | 64 | Group Health Services of OK[f] | NA | NA | 1[f] | NA |
| Oregon[a] | 13 | Likewise, A Premera Health Plan | 22.7 | 73.7 | 3 | 23.1 |
| South Carolina | 54 | PHP | 31.4 | 72.8 | 2 | 25.4 |
| South Dakota[a] | 15 | Wellmark BCBS of SD | 28.6 | 60.3 | 1 | 28.6 |
| Tennessee | 59 | BCBS of TN[n] | 54.7[n] | 81.1[n] | 1[n] | 61.4[n] |

| State | Number of licensed carriers | Largest carrier | Market share of largest carrier (percent) | Market share of five largest carriers (percent) | Rank of largest BCBS carrier | Market share of all BCBS carrier(s) (percent) |
|---|---|---|---|---|---|---|
| Texas | 59[a] | Employers Health Insurance Company | 13.9 | 36.1 | 2 | 6.9 |
| Utah | 44 | IHC Health Plans, Inc. | 29.1 | 83.5 | 2 | 22.7 |
| Vermont | 6 | MVP Health Plan | 45.8 | 98.6 | 5 | 2.6 |
| Virginia[e] | 56 | NA | NA | NA | NA | NA |
| Washington[g] | [q] | Premera Blue Cross | 40.5 | 88.5 | 1 | 78.8 |
| Wisconsin | 64 | United Healthcare of WI[h] | 16.1[h] | 45.4[h] | 2[h] | 9.1[h] |
| Wyoming | 14 | BCBS of WY[m] | 38.5[n] | 55.1[n] | 1[n] | 38.5[n] |

NA = not available.

Notes: Reported data are for December 2000 unless otherwise noted.

Ranking and market share data are based on the number of covered lives unless otherwise noted.

Three states did not respond to the survey: Nevada, New Mexico, and Rhode Island. In addition, five states responded but did not provide data on small group carriers or on market share: Arkansas, Louisiana, Mississippi, Pennsylvania, and West Virginia.

[a]Data are for December 2001.
[b]Data only include carriers regulated by the California Department of Managed Health Care.
[c]Data are for December 1999.
[d]Georgia reported that there are no standard reporting sources on the number of carriers and the total number of covered lives in the small group market, but estimated the number of carriers at about 100 and estimated the total number of covered lives to be 500,000. We used the estimated number of covered lives to calculate rankings and market share.
[e]Ranking and market share calculation are based on the number of covered small employer groups.
[f]Ranking is based on gross premiums.
[g]Data are for March 2001.
[h]Ranking and market share calculation are based on gross premiums.
[i]A Montana official estimated 10 or fewer carriers had plans that were approved for the small group market.
[j]New Hampshire did not report data for the five largest carriers. Market share calculation is based on the data reported for the two largest carriers.
[k]Data are for September 2001.
[l]Data are for January 2002.
[m]Data are for January 2001.
[n]Ranking and market share calculation are based on the number of covered employees.
[o]Data are for November 2001.
[p]Data are for various time periods in 2000 and 2001.
[q]Washington reported that 16 state-based carriers and an unknown number of out-of-state carriers offer health insurance in the small group market.

Source: GAO survey of state insurance regulators.

The views contained herein are solely the author's and do not necessarily represent the views of Webster University or the National Center for Policy Analysis.

Testimony Submitted To

**U.S. Senate Committee on Small Business and Entrepreneurship**

On

# "Solving the Small Business Health Care Crisis: Alternatives for Lowering Costs and Covering the Uninsured"

**April 20, 2005**

**Women Impacting Public Policy**
www.WIPP.org

Women Impacting Public Policy, representing over 505,000 women business owners nationwide, is pleased to submit testimony to the Committee on Small Business and Entrepreneurship on Association Health Plans (AHPs) and the health care crisis that currently faces employers and employees. We represent twenty-nine Associations as well as individual women in business.

Because WIPP is a small business association and the majority of its members are women and minority-owned businesses, we are uniquely qualified to speak on the devastating impact the lack of affordable health care has on its member businesses, on the working people of this nation, and on our economy. Small businesses in America drive our economy, create nearly three quarters of the net new jobs and employ more than 50 percent of the workforce. Women business owners number 15.6 million, employ 19.1 million workers and generate $2.5 trillion in sales according to the Center for Women's Business Research.

However, small businesses are facing increasingly high premiums which often force them to choose between expanding their business and providing basic health care for their workers. In fact, health insurance premiums have risen from 0.8 percent in 1998 to 13.9 percent in 2003, according to the Kaiser Family Foundation Annual Report. During the same time period, the percentage of workers without health insurance rose from 16.3 percent in 1996 to 18.7 percent in 2003, with workers accounting for 26.6 million of the 45 million uninsured. Sixty percent of the total number of uninsured is employed by one of America's small businesses.

Small business and particularly women owned small businesses are facing a health insurance crisis. An annual member survey recently conducted by WIPP was instructive to the health insurance crisis women owned businesses face and their overwhelming support of legislation designed to alleviate the burden that is health care. The survey found that:

- Health care was by far the most important issue on their minds, with 71% of our members saying that this issue was important or extremely important to them.
- 84% of WIPP members believe an overhaul of the health care system is necessary.
- WIPP members are seeking relief from the rising health insurance rates with a shocking 93% expecting rate increases in 2005.
- With regard to health care, our members overwhelmingly agree that Association Health Plans would be helpful to their small businesses (72%).
- Currently, small businesses have the ability to deduct the costs for health care coverage, and if that deduction were removed, 42% said that would force them to reduce the "employer-paid" portion, and an additional 42% said they would no longer provide health care coverage to their employees.

For WIPP members, providing health coverage is the most important benefit they can give to their employees. Our members have told us repeatedly that they want to offer health insurance because they believe it is the right thing to do and it makes good business sense. With the dramatic premium increases in the market, fewer employees can provide full coverage or even provide a shared payment arrangement. Fewer small businesses can offer health insurance. Therefore, many small business employees - and the employees' families – are uninsured. And the small businesses? They are losing critical staff and are unable to replace quality employees because they cannot provide comprehensive health benefits to their employees.

As an example of the increases WIPP members face, Terry Neese Personnel Services, located in Oklahoma City, Oklahoma just received a six percent increase in their premiums. Many other WIPP members have also experienced similar premium increases that make it extremely difficult to balance a competitive business with basic health care for their employees.

For example, Denise Higgins, President of Quasar Industries, owns a prototype manufacturing company in Rochester Hills, Michigan which employs 130 workers. Quasar Industries has been in business since 1967. One of Ms. Higgins' employees contracted a major illness last year and the company's insurance rates shot up 53.5%. After Ms. Higgins shopped around for new coverage, her rates went up 18% and she had to increase the employee share for the coverage. She spends $682,614 per year for the employer share of her health insurance.

Another WIPP member, Holli Dorr President of Hollister Construction Company, has had to reduce benefits, increase the employee share and increase the deductible this year. These are the stories WIPP members share with us from all over the country.

This problem is prevalent throughout the small business community. According to a Kaiser survey, only 52 percent of firms with 3-9 employees offered some form of health insurance in 2004, compared with 99 percent of all firms with over 200 workers. In fact, rates of uninsured workers increase as the size of the firm decreases. About 13 percent of the total number of uninsured workers are employed by a firm with 1,000 or more employees; but that number rises to 36 percent of total uninsured workers at firms with fewer than 10 employees. Indeed, options for small business are crucial to ensuring adequate coverage for American workers.

The Coalition for Affordable Health Coverage (CAHC), of which WIPP is a member, points to a recent National Health Interview Survey (NHIS) which shows that 41.6 million persons of all ages were uninsured in the 3rd quarter of 2004. 51 million have been uninsured for at least part of 2004 and 28.9 million have been uninsured for more than a year.

Not only are premium increases a problem, but also finding a provider, having choices, managing high administration costs, growth in litigation, and fraud and abuse are problematic. According to the SBA, insurers of small health plans have higher administrative expenses than

those who insure larger companies. Administrative expenses for insurers of small health plans make up 25-27 percent of premiums and 33- 37 percent of claims. This compares with about 5-11 percent of large company's self insurance plans.

We need to focus on providing affordable health care and ensure that employers who provide health benefits to their employees are not forced to drop their coverage because of rising premiums and high administrative costs. WIPP proposes and supports Association Health Plans that allow small businesses to pool their resources with other small businesses to purchase insurance at better rates. AHPs have the potential to lower insurance premiums for small firms by introducing more players into the market and carving downward pressure on premiums due to increased competition into the health care market. In terms of job growth, with the potential lowering of premium costs to the business owner, the possibility of using those costs savings to create one job in every small business would be huge.

States have not been able to solve the health insurance crisis surrounding the small business marketplace. Current AHPs under labor unions and Fortune 500 companies operate under ERISA regulations, so why can't small businesses have the same access, the same options, and the same opportunity?

Madame Chair and Members of the Committee, the momentum for AHPs has picked up dramatically and WIPP is hopeful that the 109th Congress will enact this important legislation for America's small businesses.

# APPENDIX MATERIAL

**Statement of Senator John Thune**
**Senate Committee on Small Business**
**April 20, 2005**

Thank you Chairwoman Snowe and Senator Kerry for holding this important hearing today. I would also like to thank our panelists for coming today and sharing their thoughts and experiences as we work to solve the health care crisis facing our small businesses - thank you Administrator Barreto and Secretary Chao. The rising cost of healthcare puts a strain on many facets of our society but especially on small businesses.

This strain has a trickle down effect onto the 57 million individuals employed by small businesses. It is estimated that about one-half of the 45 million uninsured individuals in the United States work for, or are family members of employees who work for, small businesses. I hear time and again about the struggles small business owners back in my home state of South Dakota have to pay for the yearly increases in health care coverage.

Over the past few years several proposals have been put forth to help address the rising cost of health insurance and the uninsured. One proposal that is specific to small businesses is S. 406, the Small Business Health Fairness Act of 2005. I am a co-sponsor of this legislation because I believe that allowing employers to pool together to purchase health insurance promotes competition in the marketplace and has the potential to create affordable health insurance for small firms.

This legislation also includes provisions that protect patients against discrimination as well as solvency standards to ensure that association health plans cannot leave employers and employees scrambling to find health coverage in the event their plan becomes insolvent.

It is time to think outside of the box and look at innovative ways to lower the cost of health insurance for the 71,400 small businesses and 88,350 uninsured individuals across South Dakota. This legislation is a great start towards addressing the problem of the uninsured in America and I look forward to working with Chairman Snowe and the rest of my colleagues to get this legislation passed in Congress and signed into law by the President.

**Senate Committee on Small Business and Entrepreneurship**
**Post-Hearing Questions Submitted to**

**The Honorable John Morrison, Montana State Auditor,**
**Commissioner for Insurance and Securities**

**"Solving the Small Business Health Care Crisis:**
**Alternatives for Lowering the Costs and Covering the Uninsured"**

**April 20, 2005**

**Questions from Senator Olympia Snowe, Chairwoman:**

**What further safeguards and solvency requirements would you include in the AHP legislation to provide further protections?**

The solvency standards and insurance requirements included in S. 406 would provide insufficient protection to consumers. This is not only the analysis of state insurance regulators, but also the American Academy of Actuaries. To provide reliable protection, the NAIC recommends applying to self-insured AHPs the same risk-based capital standards applied to other health insurers. The solvency standards, however, do not safeguard against market segmentation, which will make health insurance rates go up for most small businesses.

**Given that AHPs are specifically precluded from restricting entry into their plans on the basis of an individual's preexisting health conditions, what remaining concerns – if any – do you have for regarding adverse selection?**

By allowing AHPs to sell coverage exclusively to the members of the association, adverse selection is likely to occur within the broader small group market because associations with healthier risk pools will form AHPs and leave the small group market with higher rates. Further, under the rules of the bill, an AHP may very easily discriminate against small businesses within the membership of the association by:

1. Limiting coverage for high-cost procedures or services;
2. Limiting access to providers in certain higher-cost areas (state network adequacy laws are preempted so there would be not requirement to provide access to care in every area);
3. Limiting the coverage area to lower-cost areas (the bill specifically requires AHPs to offer coverage to its members only in areas in which the AHP operates); and,
4. Charging higher-risk members much higher rates.

By doing these things, the AHP will exclude or discourage higher-risk members from purchasing coverage from the AHP, even though they may "offer it" to every member.

The bottom line is this bill will make health insurance rates go up for most small businesses.

**Factoring in the extensive oversight and consumer protections contained in AHP legislation, what additional protections would you suggest to make AHPs even more resistant to fraud?**

Fake health insurance is a plague. The GAO found in 2002 that 144 fake insurers had sold some 200,000 policies and left over $250 million in unpaid medical bills. This fraud hurts thousands of small businesses and countless healthcare providers. Most of these scams claim to be "federally regulated" under ERISA. AHPs will expand the breeding ground for this kind of fraud.

The way to reduce fraud is to make sure small business health insurance is regulated by the states.

**What basis do you have, if any, for suggesting that associations will fail to offer affordable, quality plans that will satisfy their employee's needs and demands?**

Some associations may offer cheaper insurance coverage by reducing benefits, but most small businesses will see their rates go up due to segmentation.

**Shouldn't we be more concerned about fairness to small businesses, who don't have the same types of options and health plans as large corporations?**

Large corporations do have an advantage because they can cover a large pool of employees that is fairly predictable and relatively simple to administer. This is not the case with small employers, even if the AHP bill were to be enacted. The pool of employers participating in the plan (and the mix of risk) would vary from year to year and each small employer would have to be billed separately and would file claims separately. No large company would allow each of its divisions or departments to choose their own health care coverage each year. This would eliminate their economies of scale. This is what, effectively, an AHP would be like. The AHP bill would not "level the playing field," but would make health insurance rates go up for most small businesses.

**Would you consider existing corporate and union self-funded health plans to be insurance companies? If not, what is the difference?**

No, they only offer insurance to their employees or members. If they sold insurance to other entities, then they would be an insurance company and would need to be licensed as such. Importantly, though, many of the fake insurance scams that prey on our small

businesses pose as self-funded union plans. If this bill is passed, they will start posing as AHPs, too.

**Do you know how many of those 48 health plans would qualify as an AHP under the terms of S. 406? Will you supply list?**

We do not know how may would apply to be an AHP nor how many would qualify. The point is there are unscrupulous operators in the market who will claim to be exempt from state oversight in order to sell fraudulent products to unsuspecting employers or individuals. The AHP legislation would create another loophole by which they can claim exemption, thus encouraging more fraudulent behavior.

The NAIC does not have a list of all fraudulent plans. However, the states cooperated with the Government Accountability Office study of health insurance fraud, the results of which are summarized in the attached testimony before the Senate Finance Committee.

**Has the NAIC or any state organization analyzed market concentration among health insurers and the impacts on small business?**

The NAIC has not done such market research and we are not aware of a study by another state organization.

**Given the language in S. 406, and the application of state rating laws, how could AHPs "charge more for higher risk persons"?**

The only limitation the bill places on AHP premiums is that they may not vary based on "health status related-factors" or "type of business or industry." (Sec. 805a(2)(A)) This limitation is then weakened to explicitly allow AHPs to vary premiums based on claims experience and as permitted for association plans under State law. At the same time, State laws that limit the ability of insurers to use age, geography, duration, and many other factors to determine rates are preempted. Therefore, an AHP could vary premiums based on health status-related factors and type of industry, as allowed under state law, then use claims experience and other factors to increase rates even higher for higher risk persons or areas.

**<u>Question from Senator Conrad Burns</u>:**

**Given your objections to Association Health Plans as expressed in S. 406, I am curious to know what you think of various alternatives – how else could healthcare costs be lowered, without providing a solution primarily funded with taxpayer dollars?**

As I outlined in my testimony, the States are experimenting with several initiatives designed to slow the growth in health care costs and make insurance more affordable for small businesses. And, with tight state budgets throughout the country, these initiatives most often rely very little on taxpayer dollars.

Reinsurance funds, high-risk pools, quality and efficiency promotion, technology enhancement, disease management, lifestyle improvement, and many other promising proposals are being implemented or analyzed at the state level. Some have been introduced at the federal level as well.

In our own State of Montana, a new program has been enacted to offer tax credits to small businesses that currently provide health insurance to their employees. In addition, credits and an insured purchasing pool will be available to small businesses currently without coverage. Tax relief for small businesses to offset the cost of health insurance and purchasing pools that increase bargaining power – these are real solutions for small businesses.

There are many more ideas, and some will be more effective than others. The key to assisting small business is to stop rehashing failed concepts like AHPs and begin discussing other alternatives that will truly reduce healthcare spending and lower premium costs for small business owners and their employees.

**Questions for Len Nichols from Senator Olympia Snowe**

(1) Mr. Nichols, in your previous testimony before this Committee, you discussed how AHPs might help small businesses achieve specific goals related to relieving the small business health care crisis – namely, the *affordability* of health insurance premiums, simplicity in the health insurance process, and *stability* of the insurance markets. At the hearing, we heard from Tom Haynes, who testified about the Coca-Cola Bottler's Association's AHP – how it was more affordable in terms of administrative costs, and how well received it was by Coca-Cola's employees.

**Given the success of the Coca-Cola Bottler's Association AHP for small businesses before market conditions forced it out of business, how would the current AHP legislation make it easier for small business AHPs to stay in business, and to satisfy the affordability, simplicity, and stability concerns?**

***One essential virtue of an AHP from the point of view of its ultimate employer members is the insulation it provides from premium movements due to "other people's" costs. Commercial insurers and Blues frequently adjust premiums for an entire class of their small group clients when costs for any sub-group in the class rise more than expected. In that way premium stability might be enhanced within AHPs as envisioned by the current legislation. But of course, stability in the long run will depend upon how much pooling happens within the AHP's products and the actual cost experience of its members. Selection of low cost members whose costs remain stable will indeed lead to better affordability and stability within the AHP. The analytic critiques of AHPs that I have tried to articulate over the years center not on what might happen within the AHP per se, but might happen to the small group market as a whole if a "safe haven" for lower cost employers is created that is de facto not open to all. I say de facto because an employer would have to be a member of a bona fide association but more importantly because the rating rules within the new AHPs as I understand the legislation would permit each employer to be charged a different price based on their own recent or projected actuarial experience. Thus, higher cost employers can be chased back to the adjusted community-rating of the state-regulated small group market, and therein lies all the risk selection problems I and others tend to emphasize, primarily because we think the risk and full cost consequences across the entire small group market outweigh the potential gains granted to those who are within the AHP. One reason for this judgment is that even those who gain from the AHP in the short run may find their health care and premium costs rising later as workers age or new workers come on board with dependents who become seriously ill. When this happens, the other lower cost employers within the AHP will no longer want to be pooled with them. So the long run ability to create a safe haven from involuntary risk pooling may ultimately mean that only employers with young and healthy workers and dependents will be able to benefit from it. While the goal is laudable and I know you and your committee are trying hard to find better solutions for small employers, this does not strike me as the wisest path that could be taken.***

(2) Some opponents of AHPs have long maintained that states, not the federal government, are better able to regulate health insurance. Importantly, under the AHP legislation, the states would still primarily regulate fully insured AHPs, just as they regulate the traditional insurance market. In addition, self-insured AHPs must maintain adequate claims reserves, aggregate and specific excess stop loss insurance, indemnification insurance, and a surplus. The DOL, which regulates 300,000 similarly situated plans, is well suited to ensure that AHPs don't engage in fraud.

**Factoring in the extensive oversight and consumer protections contained in AHP legislation, which, I understand are tougher than some state requirements and requirements for larger employers' plans, what additional protections would you suggest?**

***Solvency reserves should be tied to premium volume, not set at a fixed amount which does not grow as total premiums collected, and health care services implicitly promised, do. The entire small group market will always function best if market rules are the same across the entire state. Thus, rating restrictions and benefit mandates that state legislatures have decided should apply in the larger small group market should also apply within AHPs. In some ways, AHPs have been conceived because some small businesses are convinced these existing state laws are wrong-headed. If that is true and can be shown in a convincing fashion, the proper response is to change the rating rules and benefit mandates for all small businesses, not just those who manage to find an attractive premium price within an AHP.***

(3) We have long heard from opponents that AHPs will undermine consumer protections – in terms of both mandated benefit laws and other laws protecting patients' rights. However, Tom Haynes, who ran Coca-Cola Bottler's Association's AHP, testified at our hearing to the success of AHPs. We also heard from Al Mansell, the President of the National Association of the Realtors, who testified as to how much AHP's would help his members secure affordable, quality health insurance. Associations are driven by their members, and these small employers will demand that their AHPs offer generous benefits because they will have to compete for talent with larger companies who offer generous benefits to their employees. The increased flexibility from being exempt from the mandates will mean that associations will be able to tailor their plans to meet their members' employees' needs. Finally, the competition between the different associations for members and participants in their plans will ensure that these plans offer competitive benefits at attractive rates.

**What basis do you have, <u>if any</u>, for suggesting that associations will fail to offer affordable, quality plans that will satisfy their employee's needs and demands?**

***I have long testified before this committee and others that employers who offer health insurance to their workers do so because they want to attract and retain workers who have good reason to expect it to be a normal part of the compensation package, and it follows that they certainly want that set of benefits to be satisfactory to their employees.***

***My criticism is not what AHPs will do for the favored members of the successful groups who join them; my criticism is the consequences further segmenting the already fragile small business market risk pool will have for all other small employers' workers. I am quite sure Mr. Haynes and Mr. Mansell would take care of all of their members. But they have no obligation nor should there be any social expectation that their association will enable higher-risk other employers to join their risk pool, and therein lies all the problems of risk selection which AHPs present.***

(4) Mr. Nichols, you have testified that AHPs will attract only the young and healthy, leaving older and sicker individuals for the traditional, existing insurance market. However, AHP legislation specifically states that an association offering an AHP must make the AHP available to all of its employers and their employees. Plain and simple: *AHPs will not be able to discriminate on the basis of an individual's health condition*. In addition, AHP's must comport with the requirements of HIPAA and other federal and state laws that prevent the exclusion of certain conditions from health insurance policies.

**Given that AHPs are specifically precluded from restricting entry into their plans on the basis of an individual's preexisting health conditions, what remaining concerns – if any – do you have regarding adverse selection?**

***They will not be allowed to discriminate against a sick member of a member employer group, that is correct, but AHPs will be allowed to charge different groups different premiums. This will be based on the group's risk profile and recent experience, so in that way groups that have high expected costs based upon the current health status of current employees or covered dependents will face potentially much higher pricing inside the AHP than outside.***

(5) James Robinson, a professor of health economics a Cal Berkeley, "calculates that the top 3 health insurance companies control 2/3 or more of the business in all but 14 states, with numbers reaching as high as 92% in Maryland and 98% in DC and northern Virginia, as reported in the Washington Post, January 12, 2005.

**Has the NAIC or any state organization analyzed market concentration among health insurers and the impacts on small business and their abilities to get affordable health insurance and choice?**

***It doesn't take another study to convince analysts that insurer market power is indeed a problem in the small group market, and that is why countervailing power on the demand side is both necessary and a good idea. All I am essentially saying is that countervailing power will be most effective if it is organized on behalf of ALL small businesses, rather than just on those who ultimately find the AHP vehicle attractive and available. Why not organize purchasing exchanges, along with state and/or federal employees, that enable economies of scale to enhance affordability and large risk pools to enhance stability for all small employers, or for that matter, for all people in the United States? That seems to me to be a more promising path than AHP legislation, however well-intentioned the drafters.***

**Questions for Len Nichols from Senator Conrad Burns**

Given your objections to Association Health Plans as expressed in S. 406, I am curious to know what you think of various alternatives—how else could healthcare costs be lowered, without providing a solution primarily funded with taxpayer dollars?

***This is a great question and requires quite a long and serious answer. I would be glad to talk about it at length with you or your staff. Briefly, there is no single silver bullet that will solve our health care system's problems. Purchasing organizations that allow businesses and individuals to benefit from economies of scale and risk pooling in private insurance markets are important, but so are better incentives for providers and patients to provide and seek evidence-based high quality care the first time and in-time, a rejuvenated technology assessment process that clarifies patient populations who can benefit from new products, procedures and techniques and who would be just as well if not better served by existing treatment, all of which requires an information system that can support high quality care delivery and performance-based payment reforms. At the same time, and primarily, we will need to re-examine our moral commitment to make sure all Americans have life-sustaining access to our health care table of plenty, and that means some of us will need subsidies from others of us, and for universal coverage to be part of the solution, some new tax-based financing will probably be necessary. Universal access through shared responsibility—among individuals, employers, and government—should be our goal.***

## POST HEARING QUESTIONS FOR MR. LINDSAY FROM CHAIR SNOWE

1) Mr. Lindsay, the National Small Business Association (NSBA) has asserted that bigger is not necessarily better when it comes to insurance pooling, and that the make-up and location of the pool are both moreimportant factors in establishing a price than the size of the pool. NSBA has also asserted that AHPs will engage in a "subtle" practice of adverse risk selection: "By carefully designing benefit packages that will be relatively unattractive to older and less-healthy populations, AHPs will be able to simultaneously attract a higher proportion of younger and healthier individuals in their pools." At the hearing, we heard from Doug Newman, who, like so many small business owners across the country, requires his employees to purchase a health insurance policy as a condition of their employment.

**Why wouldn't small business owners, like Mr. Doug Newman, benefit from being pooled with other small businesses across the country, thereby achieving greater bargaining power and economies of scale when it comes time to renew their insurance policies?**

> One of the fundamental precepts that underpins the arguments of those advocating for AHPs is the idea that big pools will equal bargaining clout. In almost every market in the world, the larger the quantity you buy of something, the lower its per-unit price. In the health insurance market, however, the make-up and location of that pool are both far more important factors in establishing a price than size alone.
>
> A pool of 1,000 people with an average age of 40 could demand (and receive) a much better rate than a pool of 50,000 people with an average age of 55. Moreover, when a plan is negotiating reimbursement with providers, a local hospital or physician will be driven by how many patients the plan will bring them. A local plan with a total of 100,000 lives will be able to drive a much better deal than a big national plan with 5 million lives, only 15,000 of which are local.
>
> The risk profile of the group and their geographic concentration are the two most important factors in negotiating rates for small business health insurance. While we have found that pooling does offer some help for small businesses, as seen through some of the successful state-run AHPs, they too are dealing with steadily increasing costs.
>
> Our argument against AHPs isn't that pooling doesn't help, but that it doesn't get at the root problem, which is the fact that health care costs too much. We also believe that due to some oversights in S. 406, these pools could be manipulated to consist of predominantly healthy small businesses. And while the rates may decrease for those in that AHP pool, the overwhelming majority of small businesses outside that pool will see increases in their state-run pool.

2) Mr. Lindsay, you testified that AHPs would not save small businesses much money. Referring to a Congressional Budget Office (CBO) report from 2000, NSBA has repeatedly stated that, "AHPs would achieve cost savings by draining healthier individuals from state-regulated pools, thereby forcing premiums to go yet higher for the majority of the market: and the "overwhelming number of participants in AHPs will be those who switched from a traditionally insured plan ton an AHP." However, earlier this month, the CBO issued a scoring report of H.R. 525, the House version of AHP legislation which claimed that about 620,000 more people would be insured through small employers that were previously uninsured. And that is on the low side. Other studies have predicted much higher numbers of newly insured. Despite utilizing a flawed analytical methodology regarding AHPs (the CBO severely underestimated the benefits of AHPs, ignored the benefits of increased competition and incorporated a flawed assumption about AHP adverse selection), the CBO estimated that about 8.5 million people would obtain health insurance through AHPs.

**How do you respond to Tom Haynes' testimony, about the real world cost savings associated with the Coca-Cola Bottler's Association AHPs?**

> According to Mr. Haynes' testimony, CCBA has implemented pooling mechanisms that include "a fully-pooled program for small bottlers under 100 employees; and another experience rated program for those bottlers with over 100 employees." Mr. Haynes goes on to say that the fully-pooled program was disbanded at the end of 2000, leaving the experience rated program the only one they are currently running. He goes on to state that since the elimination of the small

employers pool, those member companies have seen 20 to 25% increases while the experience-rated pool has seen increases of 9%.

The most updated report from the Kaiser Family Foundation puts health premium increases at an overall average of 11.2%, where small firms faced an 11.5% increase. The 9% increases noted by Mr. Haynes are from companies that would not typically be impacted by AHP legislation as they are larger companies with more than 100 employees whereas companies typically hindered by small group regulations generally have 50 or fewer employees. The savings CCBA may have reaped for these companies is not really comparable to the estimated savings proponents of AHPs have outlined. That being said, I do not have first-hand knowledge of what has happened to their pool in recent times, and would not presume to comment on their program and/or why the small employers have faced such significant cost increases. NSBA is incredibly sympathetic to this, we hear from our members on a daily basis about their astronomical premium increases. What we fear, however, is that the problem Mr. Haynes' members are dealing with could be exacerbated. Under AHPs, though there could be initial savings, there are no clear rules regarding the rates that are charged. Members of CCBA who would have initially had an average age of 40 and then due to staffing changes would then average 50 would see even more significant increases beyond 20% under AHPs because there are no rules regulating the limits to what an AHP can charge someone.

By carefully designing benefit packages that will be relatively unattractive to older and less-healthy populations, AHPs will be able to simultaneously attract a higher proportion of younger and healthier individuals in their pools, thereby driving down their expected claims costs and, thus, their premiums.

In regards to the various reports and the most recent study from the Congressional Budget Office referenced in your letter, I'd like to point out that the CBO's April 8, 2005 cost estimate states that of the 8.5 million people likely to gain coverage under an AHP, only 620,000 would be newly insured. A mere seven percentage of those covered would be a piece of the uninsured we are all working so hard to find a solution for. The remaining 93 percent would be taking advantage of the cost-shifting that makes AHPs so dangerous to the state-regulated markets.

## POST HEARING QUESTIONS FOR MR. LINDSAY FROM SENATOR BURNS

**3) Given your objections to Association Health Plans as expressed in S. 406, I am curious to know what you think of various alternatives – how else could healthcare costs be lowered, without providing a solution primarily funded with taxpayer dollars?**

The problem with finding solutions to the health care conundrum we find ourselves in today is that real solutions to real problems are not always easy, they are not always popular, and they are not always cheap. Small business problems cannot be solved in isolation from the rest of the system. NSBA believes that broad reform of the health care system is necessary. NSBA's comprehensive policy is to require individuals to purchase health insurance, while addressing quality and technology reforms as well as subsidies for low-income. Our comprehensive policy is not one free of cost to taxpayers, however over time, the money saved from a broad reform such as ours will significantly outweigh the initial costs.

In addition to NSBA's comprehensive policy, we would argue that there are a number of small business health reforms that would make a significant difference. Expanding HSAs by increasing the tax benefit to small business, and allowing self-employed individuals to treat health expenditures as pre-tax would both help. However, neither solution is cost-free.

Solutions that wouldn't cost taxpayers include: encouraging local pooling, eliminating frivolous medical liability suits, implementing pay-for-performance initiatives, improving and standardizing technology, and placing strong emphasis in quality care and quality measurements reporting. All of which will help the situation, but not solve the overreaching problem.

**Questions for Secretary of Labor Elaine L. Chao**
**Follow-up to April 20, 2005 Hearing on Small Business Health Solutions**
**Senate Committee on Small Business and Entrepreneurship**

## Responses to Questions from Senator Snowe (Committee Chair):

**Question 1(a): Do you agree with the CBO's estimates for additional staffing and appropriations that would be required for DOL to implement the AHP legislation? If not, could you please provide us with what you foresee as a more accurate estimate?**

**Answer:** CBO estimated on April 8 that the enactment of AHP legislation would require DOL to hire approximately 150 workers over the next three years to certify and regulate AHPs and would increase DOL's direct spending by approximately $55 million over the five-year period from 2006-2010. CBO further estimated that total government spending under the legislation, including direct spending, decreased federal revenues due to increased deductible health insurance coverage, and decreased spending on Medicaid due to increased access to health benefits, would be approximately $101 million over the five-year period from 2006 to 2010.

The Department cannot accurately estimate resource requirements until legislation has been finalized and we know the extent of the Department's jurisdiction and authority, as well as the legislation's requirements. Our costs will also vary depending on the number and types of AHPs that seek and obtain certification. However, I can assure you that the Department will request and allocate the resources necessary to implement the legislation and ensure the effective regulation of AHPs.

**Question 1(b): We have also heard varying estimates of the length of time it will take for DOL to implement certification and regulation procedures for AHPs. If AHP legislation were enacted today, could you please estimate how long it would take for DOL to implement both a certification and regulation infrastructure?**

**Answer:** I believe that the initial regulations establishing the certification infrastructure can be implemented within two years of enactment of the AHP legislation. As you are aware, the AHP legislation requires the Department to establish a 15 member Solvency Standards Working Group within 90 days of enactment. The legislation also requires that the Department take into account

recommendations made by the Working Group in prescribing initial regulations concerning maintenance of reserves and solvency requirements for AHPs.

Establishing the infrastructure necessary for the successful certification and regulatory oversight of AHPs would be a high priority of this Administration. I can assure you that the Department will assemble and acquire the resources necessary to ensure the timely and efficient implementation of the legislation's certification and other regulatory requirements. This process will require the issuance of proposed regulations, time for comments from the regulated community, and completion of economic and other regulatory analyses.

As I mentioned during the April 20th hearing, the Department previously demonstrated its capacity to assemble staff rapidly and expedite the drafting of complex regulations during the implementation of the Energy Employees Occupational Illness Compensation Program. Moreover, the Department already has extensive experience administering current ERISA provisions that apply to group health plans that cover tens of millions of Americans.

**(2) Could you please comment on the assertion: Would AHPs under the legislation be subject to regulation on financial solvency that is more stringent than what is required of unions and large employers?**

**Answer:** Yes. Self-insured AHPs will be required to meet strong solvency requirements that are not required of self-insured employer and union-sponsored group health plans today. These new standards include:

- **Reserve Requirements:** Self-insured AHPs would maintain cash reserves for unearned contributions, benefit liabilities (incurred and future), administrative costs, obligations of the plan, and margin of error. In addition to reserves for claims, AHPs must maintain surplus reserves of $500,000 to $2,000,000, depending upon the AHP's size. These reserves provide a cushion against variations in claims experience.

- **Stop-loss Insurance:** Self-insured AHPs would maintain both aggregate and specific stop-loss insurance coverage, with the levels of insurance determined by a qualified actuary. Stop-loss insurance provides essential protection against unexpectedly high claims that might otherwise exhaust reserves and surplus.

- **Indemnification Insurance:** Self-insured AHPs would be required to purchase indemnification insurance to pay claims in the event that the AHP becomes insolvent and terminates.

- **Premium Rates:** Self-insured AHPs would establish premium rates that are adequate to cover claims and maintain required reserves, as determined by a qualified actuary. A statement of actuarial opinion that the rates are adequate must be provided to DOL as part of the certification process.

- **AHP Fund:** Self-insured AHPs would be required to pay assessments to an AHP fund prior to certification and annually thereafter ($5000 and supplemental payments, if needed). If an AHP became unable to satisfy its financial obligations, DOL could assume trusteeship over the AHP and tap the fund to pay premiums to a stop-loss and/or indemnification insurer to ensure that consumers' outstanding claims for health benefits are paid.

- **DOL Regulatory Authority:** The legislation further provides the Secretary of Labor the authority to increase various solvency requirements by regulation as necessary.

Taken together with the affirmative duties and prohibitions against conflicts of interest that arise under ERISA's fiduciary requirements, these provisions provide strong protections to help ensure that claims for benefits will be paid.

**(3)(a) Do you agree that the AHP legislation would adequately protect both fully insured and self-insured plans? Could you explain any additional AHP protections that exist?**

**Answer:** Yes. Most of the protection for fully-insured plans will remain with the States, which, under the bill, will continue to oversee insurer solvency, market conduct and consumer protections.

Self-insured AHPs will be overseen entirely by DOL. As discussed in question 2, the solvency standards for self-insured plans are very strong and will be protective of plans, participants and beneficiaries. DOL will be prepared to take on this new responsibility.

In addition, the bill provides for an orderly shutdown procedure if a self-insured plan becomes financially unsustainable. In this instance, DOL would assume trusteeship of the AHP and see to it that its remaining claims are honored. AHPs will be required to purchase indemnification insurance coverage to pay claims in the event an AHP becomes financially unstable.

**(3)(b) Could you please explain the roles of both the DOL and the States in the regulation of fully insured AHPs?**

**Answer:** Fully insured AHPs will be subject to both federal and state regulation. The Department will regulate the AHP certification process and the states will be responsible for regulating the insurance coverage provided under the AHP, much as they do today for fully-insured single employer and multiemployer union plans. The states will retain regulation of solvency, prompt pay, market conduct, rating, and other consumer protection requirements under state law. The benefits required in an insured AHP will consist of the Federal benefit mandates and the disease-specific benefit mandates of the state in which the policy was initially filed and approved.

**(4) Could you please detail the many benefits that are included in the self-funded plans already administered by the DOL, and those benefits that we could similarly expect to see in AHPs?**

**Answer:** Health benefits offered by self-insured plans are commonly viewed as some of the most generous benefits available. Benefits in these plans are as good as, and often better than, benefits in the State-regulated market. According to a recent study carried out by KPMG, benefits such as prescription drugs, mental health care and well-baby care were richer than State requirements in 25 percent of self-insured plans surveyed. In the remaining plans, the benefits were comparable.

Self-insured plans provide rich coverage because large employers and labor unions are able to pool their employees together in a common health plan regardless of where they live. This results in administrative savings, economies of scale and other efficiencies. In addition, these plans have a strong incentive to offer generous benefits because it helps attract and retain good employees. AHPs should experience similar costs savings, and will also face similar pressures to offer quality benefits. The simple fact is that people want to buy good health insurance. The take-up rate among consumers has been very low in States that have allowed the sale of very basic benefit packages. This suggests that consumers' desire for comprehensive coverage will push AHPs to offer benefit packages comparable to those in the State-regulated markets.

**(5)(a) Secretary Chao, won't AHPs provide the American public with far more bang for their tax dollar?**

**Answer:** Yes. AHPs are a cost-effective alternative to government operated health plans, such as that proposed in S. 637. AHPs cost very little to the government because they are a market-based solution—there is no new program

for the government to directly administer. S. 637 would appropriate $18 billion over 5 years to run a program of risk adjustment and reinsurance for carriers participating in the program – contrast this amount to the relatively small CBO estimate of $101 million for AHPs ($55 million in DOL costs).

Passage of AHP legislation will remove existing legal and market barriers that dissuade small employers from providing the coverage they want to offer. Small employers and their associations are ready to establish plans under DOL's oversight. The net cost to the Federal government will be minimal.

**(5)(b) S. 637 creates a federally run national health plan, run by the Office of Personnel Management. Why is the DOL, with its many years of experience regulating large self-insured companies and union plans, a much stronger entity to certify and regulate AHPs or other entities offering national health care options for small businesses?**

**Answer:** DOL has years of experience overseeing workplace benefits offered by private employers, both large and small. Under DOL oversight, group health plan sponsors operate with a great deal of administrative flexibility, knowing that they will be held accountable if they violate their fiduciary duties under ERISA. This structure has resulted in a highly successful voluntary employee benefits system. We anticipate the same outcome under AHP legislation.

Under the current legislative proposal, AHPs would act as purchasers of coverage from insurance companies, or providers of coverage if they self-insure. DOL's role would be to ensure that AHPs adhere to the law and do not violate their fiduciary duties. In the context of the Federal Employees Health Benefits Plan, the Federal government is acting as an employer, purchasing coverage for its employees, and OPM is negotiating the purchase. OPM plays a fundamentally different role that is not appropriate for private sector employers.

## Responses to Questions from Sen. Burns:

**(1) Given your extensive experience with health plans at the Department of Labor, could you address for a moment the concern that some specialty groups have raised regarding premium increases resulting from implementation of AHPs for small businesses and the self-employed, which will then preclude them from obtaining health insurance? What provisions have been built into the legislation to keep this from happening? Is there any foundation for their argument?**

**Answer:** The Administration does not believe this is a valid argument because the legislation contains a number of provisions to ensure that AHPs do not "cherry pick" or otherwise discriminate against sicker workers.

First, AHPs would be required to comply with the Health Insurance Portability and Accountability Act (HIPAA), which prohibits group health plans from excluding high-risk individuals or employers with high claims experience.

Second, AHPs must offer all available health coverage options to all employers and individuals in the association.

Third, AHPs are prohibited from rating on the basis of the health status factors of the companies' employees or their families, except to the extent allowed under State law. AHPs also could not allow rates to vary based on the type of business or industry that participating employers are in.

Fourth, the bill would prevent AHPs and participating employers from selectively directing their higher-cost employees to the individual insurance market.

Finally, Self-insured AHPs must cover a broad cross-section of trades and businesses or industries, or must cover certain types of specific trades or businesses that have average or above-average risk profiles.

These provisions are designed to prevent market abuses and cherry picking.

**(2) What about the current consumer protection safeguards? Under S. 406, would State-driven consumer safeguards be strengthened or weakened? How would recourse for a consumer differ from the present system in contrast with Association Health Plans?**

**Answer:** Fully-insured AHPs will be subject to essentially the same consumer protection laws of the States that apply to insurers today, including solvency requirements, prompt pay laws, market conduct requirements, rating rules, and similar provisions. Self-insured AHPs would be subject to the same consumer protections that currently protect the 78 million Americans who receive their health benefits from self insured plans sponsored by large businesses and labor unions.

O