H.R. 660: THE SMALL BUSINESS HEALTH FAIRNESS ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS

OF THE

COMMITTEE ON EDUCATION AND THE WORKFORCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

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HEARING ON H.R. 660: THE SMALL BUSINESS

HEALTH FAIRNESS ACT

Thursday, March 13, 2003

U.S. House of Representatives

Subcommittee on Employer-Employee Relations

Committee on Education and the Workforce

U.S. House of Representatives

Washington, D.C.

The Subcommittee met, pursuant to notice, at 1:05 p.m., in Room 2175, Rayburn House Office Building, Hon. Sam Johnson, Chairman of the Subcommittee, presiding.

Present: Representatives Johnson, Ballenger, Platts, Tiberi, Cole, Kline, Blackburn, Andrews, Payne, Tierney, McCollum, and Case.

Staff present: David Connolly, Jr., Professional Staff Member; Kristin Fitzgerald, Professional Staff Member; Travis McCoy, Legislative Assistant; Ed Gilroy, Director of Workforce Policy; Greg Maurer, Coalitions Director for Workforce Policy; Christine Roth, Workforce Policy Counsel; Kevin Smith, Communications Advisor; Kevin Frank, Professional Staff Member; Counsel; Deborah L. Samantar, Committee Clerk/Intern Coordinator.

Michele Varnhagen, Minority Labor Counsel/Coordinator; Dan Rawlins, Minority Staff Assistant/Labor.

Chairman Johnson. A quorum being present, the Subcommittee on Employer-Employee Relations will come to order. The Subcommittee is meeting today to hear testimony on H.R. 660,

the Small Business Health Fairness Act.

I'm eager to get to our witnesses today, so I'm going to limit the opening statements to the Chairman and Ranking Member. Therefore, if other Members have statements, they will be included in the hearing record. With that, I ask unanimous consent for the hearing record to remain open for 14 days to allow Members' statements and other extraneous material referenced during the hearing to be submitted in the official hearing record. Without objection, so ordered.

OPENING STATEMENT OF CHAIRMAN SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

Good morning, Ms. Combs. Let me extend a warm welcome to all of you, to the Ranking Member, Mr. Andrews, and my other colleagues who are here today. As many of you know, this is Cover the Uninsured Week. That's one key reason we're here today. Today's hearing focuses on H.R. 660, the Small Business Health Fairness Act, and how this bill will expand access to health care for uninsured Americans.

We will hear from the Administration, a small business owner, and policy experts on the effects of association health plans on the uninsured.

As you recall last session, this Subcommittee took the lead regarding the rising costs of health care and how they impact employers and employees. In the last year alone, employers' health care benefits costs have increased by an average of 13 percent. In the year 2002, over 41 million Americans were uninsured. That means one in seven Americans went without health insurance.

You might ask just who these uninsured are. Well, they're working people who can't afford insurance, don't have access to insurance, or their employer can't afford to participate in a plan for them. Sixty percent, that’s 24 million, of uninsured Americans work in small businesses. Some of these people are offered insurance and turn it down, because they can't pick up their part of the tab.

As the latest Kaiser health poll report reveals, more Americans are worried about health care costs today than about losing their job, paying their rent, losing money in the stock market, or being a victim of a terrorist attack. Specifically, the report found that nearly 40 percent of Americans say they are very worried that their expenses for health care services or health insurance will increase over the next six months. Studies show health care costs are rising 15 to 20 percent a year under current rules. These same Americans are worried their income might not keep up with the rising prices in the next six months.

To combat these problems, I worked with a bipartisan group from the House and Senate to introduce the Small Business Health Fairness Act to create Association Health Plans (AHPs). This bill would allow small businesses to band together through associations to purchase quality health

care at a lower cost. It will significantly expand access to health coverage for many of the 41 million uninsured Americans. The bill will increase small businesses' bargaining power with health care providers, give them freedom from costly state-mandated benefit packages, and lower their overhead cost by as much as 30 percent.

These are all real benefits that many large corporations like General Motors, Frito-Lay, and U.P.S. as well as many unions, already enjoy because of their larger economies of scale. It's time we leveled the playing field for small business and gave them the health care clout they deserve.

It's time they had access to AHPs.

WRITTEN OPENING STATEMENT OF CHAIRMAN SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE – SEE APPENDIX A

Chairman Johnson I'd like to welcome all of our witnesses who are here today, and we look forward to hearing your testimony. But I now yield to the distinguished Ranking Member of the Subcommittee from New Jersey, Mr. Andrews, for whatever opening statement he wishes to make.

OPENING STATEMENT OF RANKING MEMBER ROBERT ANDREWS, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

Thank you, Mr. Chairman. Good afternoon, ladies and gentlemen. I'd like to thank you for your continuing interest in this subject, your good faith in dealing with the Minority, and your eagerness to present us with information. I enjoy working with you on this and look forward to it.

We believe that the highest priority in the area of health care in our country is dealing with the needs of more than 40 million uninsured Americans. For many years, people felt that economic growth would solve the problem of uninsured Americans. We had higher economic growth in the 1990s than we had in virtually any other decade since World War II.

But even in a decade where unemployment fell by more than 50 percent, where the welfare rolls dropped by 53 percent, where the equity markets nearly quadrupled in value, where the gross domestic product went from $3 trillion to nearly $10 trillion, despite all that growth, the number of uninsured people went up, not down, in the 1990s. So we understand there are systemic problems in the U.S. health care system that have led to this enduring and difficult problem.

We have three concerns about the Association Health Plan idea. The first is its relative lack of power or efficiency in dealing with the problems of the uninsured. Most adults who are

uninsured work, either full-time or part-time. But they work in low-wage, entry-level jobs, typically for employers who are in industries that have very thin margins. It is my belief that most of these employers would love to provide health insurance for their employees, but they're not in an economic position where doing so is viable.

Even if Association Health Plans work as their most avid backers hope they would, the impact on health insurance premiums would be such that growth might be moderated, or perhaps there would be a minimum or minor reduction in premiums.

That's not nearly enough to justify an employer who is operating on a 1 or 2 percent margin to spend $10,000 per family to buy family health insurance coverage for their employees. It just isn't going to make much difference for most of the uninsured people of the country, even if it works the way its proponents would advocate.

Our second concern is the effect that the AHP plan would have on some very important protections for consumers and patients in the country. All across the nation, people have lobbied their state legislatures to make sure that when a woman gives birth through a C-section, that there is a minimum stay in a hospital; that when a woman has a radical mastectomy, there is a minimum stay; that services such as colon cancer screenings or breast cancer examinations must be included in the package of benefits someone gets when they receive a health insurance policy. We are gravely concerned that AHP proposals would strip those protections from consumers across the country.

The third concern that we have is that we have some experience in ERISA when we compare an entity that is closely watched and regulated with one that's not. And I believe the AHP plan effectively creates a deregulated zone of federal law for health insurance.

You could make an argument that a similar deregulated zone exists in pension law with respect to 401Ks. Now, 401Ks have been a magnificent and positive thing for the country. We support them. We wish more people had more money and more of them. The Subcommittee's recent exploration, however, of the Enron scandal would show that there are some serious deficiencies in the protections that pensioners enjoy with respect to self-directed retirement accounts.

We had Mr. Tom Padgett, an employee of the Enron Corporation, testify before this Subcommittee some months ago. He's an individual who had $600,000 in his 401K in 1999 and $15,000 in his 401K by the time he testified before the Subcommittee, because he had all of his investment in the stock of his employer, which sadly turned out to be Enron.

I think that following that model and creating a protection-free zone in ERISA for health insurance would be a troubling prospect indeed. We don't want to over regulate. We understand that for employers to voluntarily adopt plans, the cost must not outweigh the benefit. But we're very concerned that these plans would raise the objections that I talked about.

Having said that, we think it's important to have hearings so people can argue and thrash out these questions, that we can ask questions and work together, learn more about this.

So Mr. Chairman, we look forward to hearing from the witnesses. I would ask for unanimous consent that statements in opposition to the AHP proposal from the National Association of Insurance Commissioners, the HIAA, the Health Insurance Association of America, Families U.S.A., the National Small Business United, and several others be admitted to the record.

Chairman Johnson. I'd be glad to do that. At the same time, I would ask unanimous consent to enter into the record all those who support this plan.

Mr. Andrews. Absolutely.

Chairman Johnson. Thank you. Hearing no objection, so ordered.

Our only witness on the first panel is the Hon. Ann Combs. And we appreciate your return.

As you all know, Ms. Combs is the Assistant Secretary of the Employee Benefits Security Administration (EBSA). Before her appointment, Ms. Combs was Vice President and Chief Counsel, Retirement and Pensions issues for the American Council of Life Insurers. During the Reagan and prior Bush Administrations, Ms. Combs spent six years as Deputy Assistant Secretary of Labor for EBSA. Her previous experience includes the National Association of Manufacturers and PriceWaterhouse, Inc.

On behalf of the Subcommittee, I welcome you back. Thank you. You may begin your testimony.

STATEMENT OF THE HONORABLE ANN L. COMBS, ASSISTANT SECRETARY, EMPLOYEE BENEFITS SECURITY ADMINISTRATION, U.S. DEPARTMENT OF LABOR, WASHINGTON, D.C.

Thank you, Mr. Chairman, and Ranking Member Andrews. I appreciate the opportunity to appear before the Subcommittee on this very important issue.

The Bush Administration is dedicated to helping small businesses gain access to affordable quality health insurance, and the AHP legislation introduced in the House by a bipartisan group of lawmakers is a critical part of our agenda.

As events occur around the nation during Cover the Uninsured Week, there is simply no better time for discussing this proposal that can do so much for so many American men and women who work for small businesses.

As the head of the EBSA, which would be directly responsible for the regulation, administration, and enforcement of Association Health Plans, I am personally dedicated to making sure this legislation will deliver the health care benefits it promises to American workers and their

families. And I have the full support of Secretary Chao and the Administration in this effort.

AHP legislation is the centerpiece of the President's efforts to expand health insurance opportunities for all Americans, and we're very pleased that you have made passage of this bill an immediate priority, Mr. Chairman.

Unfortunately, we have all become accustomed to hearing about double-digit health care inflation and the vulnerability of small businesses in the insurance market. But this Subcommittee, more than any other, recognizes that behind these statistics are millions of people who struggle to make ends meet to keep themselves and their families protected with quality health insurance.

Indeed, the statistics demonstrating the crisis facing small businesses and their workers are startling. Not only are small businesses half as likely to provide insurance to their employees when compared to larger firms, but also the costs of those that do provide coverage are 20 to 30 percent higher. Even worse, their costs are rising more than 60 percent more rapidly than costs for a larger firm.

Today's health insurance market has simply failed small businesses and their workers. The status quo has failed the small businesses that are the engine of our country's economic growth. The status quo failed the small businesses that create two out of every three new jobs in our country. And rising health insurance costs are the greatest impediment employers face that want to hire new workers, according to recent surveys by the Conference Board.

Small employers tell us that they want to provide coverage, but they can't because of costs, legal barriers, market barriers, and the threat of fraud. Association Health Plans are aimed squarely at filling the gap in coverage among small businesses. By banding small companies together, AHPs will give small employers many of the economic and legal advantages currently enjoyed by large employers and unions. Small businesses will enjoy greater bargaining power, economies of scale, and administrative efficiencies, as well as the benefits of a uniform federal regulatory structure.

The Bush Administration is committed to making sure that the benefits of AHPs are available to as many small businesses and workers as possible. They will work best if they broadly spread risk and make insurance affordable for qualifying individuals regardless of their health status.

H.R. 660 includes numerous provisions to encourage broad pooling of risk, and to protect against cherry picking of low-risk individuals. Only bona fide associations in existence for three years for purposes other than providing health insurance can offer an AHP. AHPs must offer all available options to everyone in the association. They must follow HIPAA's requirements to cover preexisting conditions, and to charge healthy and sick employees of the same company the same premium.

And this year's bill, H.R. 660, explicitly bars AHPs from charging one participating company more than others based on health status, unless the state law allows it and they choose to follow the state law. That means they cannot set prices based on participants' medical condition,

medical history, claims experience, their receipt of health care, genetic information, or disability.

Let me turn now to another important safeguard in the bill's solvency requirements. AHPs offering fully-insured health plans would have to comply with state solvency rules, just as fully-insured group health plans offered by large companies and unions do today. The AHP legislation would not undermine these protections.

AHPs that offer self-insured coverage that pay the claims out of their own funds will be subject to a single effective national certification solvency and oversight process that will be administered by the Department of Labor. Contrary to some critics' claims, self-insured AHPs will be fully regulated by the Federal Government.

To combat fraud and to further insure solvency, AHPs would have to meet federal certification standards and comply with rigorous ongoing oversight by the department. EBSA will examine AHP sponsors to make sure they are bona fide trade or industry associations, meet the membership requirements, and satisfy the solvency and financial rules necessary to establish a self-insured AHP.

The financial requirements are strong. They must set premiums and maintain reserves that are actuarially adequate to cover claims. They must maintain an additional financial surplus as a cushion. They must carry stop-loss insurance to cover unusually large claims. They must carry indemnification insurance to cover unpaid claims if the AHP terminates. And the Department of Labor will establish a fund to continue to pay premiums to a terminated AHP's indemnification insurance so that it will not lapse. These provisions parallel the requirements that states impose on health insurers, and are essential to insure that AHPs deliver promised benefits.

AHPs will also give small businesses the benefits of a uniform oversight system instead of having to comply with as many as 50 different sets of regulations. Associations will be able to fashion coverage that best meets their members' needs and budgets.

Finally, I would note that AHPs must comply with the full range of important federal standards passed by Congress for existing group health plans. These include the strict fiduciary and claims procedures of ERISA, as well as HIPAA, COBRA, Mental Health Parity, the Newborns' and Mothers' Health Protection Act.

What we are tackling here today is truly a crisis. “Uninsurance” is on the rise, and premiums are skyrocketing. Small business employees and their families are especially at risk of losing or being unable to obtain quality insurance coverage.

Fortunately, this crisis can be abated through a voluntary private market-based solution, AHPs. Small business insurance coverage can rise rather than fall if we act now. The Department of Labor has a long history of effectively regulating and enforcing federal laws regarding group health plans, as well as combating insurance fraud. We will confidently carry out the AHP responsibilities contemplated by the legislation with effective and timely regulation, oversight, and enforcement.

I'd be happy to respond to any questions the Subcommittee has, and I look forward to working with all of you to help enact and administer legislation that expands access to affordable quality health insurance for working Americans and their families. Thank you.

WRITTEN STATEMENT OF THE HONORABLE ANN L. COMBS, ASSISTANT SECRETARY, EMPLOYEE BENEFITS SECURITY ADMINISTRATION, U.S. DEPARTMENT OF LABOR, WASHINGTON, D.C. – SEE APPENDIX B

Chairman Johnson. Thank you. We appreciate your testimony.

Ms. Combs, let me ask you. Critics of the AHPs charge that the Department of Labor lacks the ability to oversee and regulate AHPs effectively. Are they right? If so, what can we do about it? And if they're wrong, can you explain why?

Ms. Combs. I'm convinced that the Department of Labor is fully capable of taking on the responsibilities that are contemplated in this bill, and of overseeing and enforcing the law with respect to AHPs.

We currently oversee 2-1/2 million health care plans. We cover 131 million Americans. And there are 67 million people who are in self-insured plans that are solely regulated by the Department of Labor. We have a good track record. Those plans provide good benefits, quality benefits, and do not present terrific enforcement risks. In addition, we are solely responsible for overseeing five million people who work in multi-employer union plans that are not covered by state regulation.

In addition to ERISA, as I mentioned, we administer COBRA, HIPAA, WHCRA, I could go through all of the acronyms, The Newborns' Act, and Mental Health Parity. We have a good relationship with the states in working with these issues. I know there are some differences in policy. But at a working level, I can assure you we work closely with the NAIC and the state insurance commissioners. We were just at their quarterly meeting this week, on Monday, working with them and explaining to them a new compliance assistance program we've put in place for health care.

We have a strong enforcement policy. We have 116 civil and 25 criminal investigations open right now into MEWA fraud, which is a problem.

So I'm convinced that we can do this. We have expertise in the health care area. Yes, if this legislation passes, we will need to take on additional responsibilities. We're fully prepared to do that.

Chairman Johnson. It appears that your Department recently released a report entitled Health Disclosure and Claims Issues, FY 2001 Compliance Project Report. Could you comment on its relevance to the Department's ability to oversee AHPs?

Ms. Combs. Sure. I think it's a good example of the kind of work we've been doing in recent years. The Department has really stepped up, in the last three to four years, its focus on health care. This was a project where we selected 1300 health plans to look at and see whether they were complying with all the new laws that had been enacted in the late '90s. You had HIPAA and the Women's Health Care Act, The Cancer Act, and those laws.

Chairman Johnson. Well, I'm sure you could think of another acronym.

Ms. Combs. There are many of them. But we went out and we actually looked at these plans to see if they were complying. We identified those areas where compliance was an issue, notice provisions, and we worked with the health plans to point out problems. We had great success and great cooperation from health plans.

In many instances, we would sit down with plans and identify a hidden preexisting condition exclusion that was in their policy, and they were willing to fix that. I think it demonstrates our experience and our knowledge. We took that report and used it to develop a compliance assistance program, where we're doing outreach with health plans, with the states, with the insurance commissioners. We developed model notice provisions so that people would know how to comply with the laws and audit checklists.

We're very proactive in this area, and we'll take that same kind of spirit and determination and apply it to AHPs.

Chairman Johnson. You also mentioned that critics charge that the creation of national AHPs will result in what's called cherry picking, by which they mean the market will be segregated into two groups, one that is young and healthy, and the other one that's elderly and sick. Can you review the reasons why you don't believe this is the case?

Ms. Combs. We're very concerned about cherry picking, and I know that the Subcommittee is and should be. We don't want to destabilize the insurance market. What we want to do is create a viable alternative for small businesses. So I think it is important, and the law does contain very significant protections to prevent cherry picking.

I mentioned several of them in my testimony. You have to be a bona fide association that isn't in existence just to sell health insurance. You have to make the options that you offer through the AHP available to everyone who is qualified to be a member of the AHP. You can't charge different individuals different rates based on their health status. That's a new addition to this year's bill, and I think a big improvement. It picks up health status that was included in HIPAA.

So there are a number of provisions here. And obviously, we want to work with the Subcommittee and with others to make sure that we're not creating a situation where people are only skimming off the healthy risk. We need broad pooling, that's what this is all about, to keep the costs down, and to make sure that insurance is available to people who need it.

Chairman Johnson. Thank you. One more question. We often hear about the importance of state mandates and consumer protection to the small group market. I understand that the financial

burden these mandates place on small business is responsible for one in every five decisions by a small employer not to offer insurance. In your opinion, should we focus on increasing the number of Americans with insurance, or focus on making sure every single state mandate is met?

Ms. Combs. I think we have a crisis facing the health insurance system, and I think that small businesses make up a disproportionate share of the people who are lacking insurance coverage. It's a balancing act, and the status quo is just not acceptable.

I think that benefit mandates do add to costs. There are protections in the AHP legislation. They would be subject to the federal mandates that Congress has seen fit to impose nationally, such as COBRA, HIPAA. They are subject to the claims procedures under ERISA. They're important. Fully-insured AHPs will continue to be subject to some of the state protections about market conduct and licensing of brokers and the insurance companies that write those policies and the external review systems in those states.

So we think it strikes an appropriate balance. But we do need to get costs down. We do need to make insurance more widely available. And the status quo has failed.

Chairman Johnson. Yeah. The ultimate goal is to get more Americans insured.

Mr. Andrews, do you care to query?

Mr. Andrews. I do. Thank you, Madam Secretary, for your testimony. As usual, it was well thought out, and we appreciate you being here.

Ms. Combs. Thank you.

Mr. Andrews. I agree with you there is a crisis in health insurance, and I agree that the data make it obvious that it's focused on what you refer to in your testimony as low-paying small firms. You define these firms as firms with a relatively small number of employees that pay no more than $9.50 an hour, on the average. I think that's the way you defined it, where only 34 percent of the employees employed by such firms have health insurance. I agree that that's the crux of the problem right there.

I'm extremely skeptical that the proposal that you embrace will do anything about that at all. And I want to walk through the numbers with you to point out the reason for my skepticism. If we take that $9.50 an hour and actually make it a little higher, take a person making $10 an hour working full-time, makes $400 a week gross pay. On page 11 of your testimony, you cite a CBO study that says that savings from AHPs could be as much as 25 percent for employers.

Let's assume that that's correct. I'm not willing to make that assumption. But for the purpose of this question, let's assume that that is correct. In the market that I live in, a family health insurance policy costs about $10,000 per family per year. If this plan went into effect and worked gloriously well and reduced the premium by 25 percent, that plan would cost $7,500 per family per year. If you divide that out, it comes to $144 a week. If the employer were to provide

two-thirds of the cost of that coverage for an employee, it would be about $100 a week.

Employers in low-margin companies that don't make much money are not going to take a $400-a-week employee and increase that person's compensation by 25 percent and spend $100 a week on their health care. I'm sure they would love to, but that's just out of the question for them doing. Under what set of circumstances are you arguing that the employee in that situation is going to get health care coverage because of this proposal?

Ms. Combs. I think that you're absolutely right. That is the toughest market to penetrate, if you will. I think this proposal will vastly improve the situation. There will be employees and employers who will be able to do it. There may be a second earner in a family who can actually take a significant portion of their wages and dedicate it to purchasing health insurance for their family.

Mr. Andrews. But I'm already assuming in my example that a third of the cost is paid by the employee, a person making $400 bucks a week taking $50 bucks a week out of that to pay for health care. I'm not sure that works either. But I've already assumed that it does. How is the employer going to come up with $100 per employee per week for an employee making $400 a week?

Ms. Combs. Well, the surveys of the employers show astonishing percentages of them, above 75 percent, say they would be very likely to try to offer health insurance. I don't think we're going to get 100 percent coverage. I don't think this bill will cover all 41 million Americans. I think we can make a real dent in it.

Mr. Andrews. I'm surprised that not 100 percent say they would offer health insurance, because the questions usually imply that it's affordable. This is not affordable. I grant you, if someone is making $45,000 a year, and it's in a higher-margin industry, if your 25 percent number has any reality to it, it might get more people covered. But your own data show that the vast majority of uninsured working people are low-wage people in low-margin industries, and I don't see where the coverage comes from.

Ms. Combs. Well, I think this is also a piece of how you tackle the problem of the uninsured. We're also looking at tax credits to help people in those situations purchase insurance.

Mr. Andrews. Does the President's budget include tax credits for uninsured people?

Ms. Combs. Yes. We have a proposal for tax credits for the uninsured.

Mr. Andrews. Is it in the budget?

Ms. Combs. I don't know the answer to that. I'll get back to you. We've supported that.

Mr. Andrews. But none of the President's tax cut proposal has a tax credit for uninsured people, does it?

Ms. Combs. I think it's separate from the growth package. The tax credit for the uninsured was just expanded through the Trade Adjustment Assistance. And there are other tax credits to help the uninsured. I think $1,000 for individuals and $3,000 for families is the refundable tax credit. That's aimed at helping those people who are really struggling and at a margin.

I think a 25 percent reduction in premiums is significant. I also think we can get there. I think this will create competition in the market. It will give small employers the kind of leverage they need to negotiate with insurers to drive prices down.

We have to tackle the problem of health care costs across the board. But I think this is an important piece of that, and I think it can really make health insurance available for a significant portion of the people.

Mr. Andrews. I don't dispute that a 25 percent reduction in premiums would be very significant. I would dispute whether this proposal would cause it. I think that's highly questionable.

I think that even if you assume that, when you look at the kind of employer and the kind of employee who's not getting coverage, the price just doesn't drop by nearly enough to put this anywhere within the employer's realm of possibility. No employer that I know who is hiring $10-an-hour people can afford to give that worker a 25 percent raise, which is what this really would be about, even if the employee covers a third of the cost herself or himself. So I think it's very important we not oversell the idea that this is going to get a lot of people covered who are not.

I think my time is probably up. You didn't turn the light on, which I appreciate. But I think it's unfair to my colleagues to not yield back, which I will do.

Chairman Johnson. Mr. Ballenger, do you care to question?

Mr. Ballenger. Yes, sir, if I may.

Chairman Johnson. We'll turn the light on for you, if that's okay.

Mr. Ballenger. I'd just like to say that I've been in business a long time, and I've been watching health insurance plans for 45 years. And I can remember back in the old days when you got a simple Blue Cross plan, and there were about two things it would cover. And no matter what happened, you paid all the costs for your employee, because health care was pretty cheap back in those days.

Later, you got into a regular plan that gave you full coverage for a whole bunch of stuff, and you still covered all the costs. And then you began co-payments when things started going up, and employees started figuring some of it out.

I think one of the strangest things that we're discussing on the floor today, and one thing that really proved a point to me, is the fact that we found out that when we were insuring ourselves we could cut our health insurance costs almost in half by not covering the delivery of children. The most expensive part of any health care plan, at least back in those days, was the fact that you

covered the birth of children.

We saw on “60 Minutes” not too long ago that the doctors and the hospitals and so forth were so likely to get sued that the most sensible thing to do was to say, “I'm sorry, we don't cover that. And we hope that you can find some way to take care of it.”

But anyhow, we just pulled delivery costs out of our health plan. We used to cover the families, and then we gave it to the employee to cover the families. We used to have no co-payments. Now we do have co-payments. We've got 225 employees. I think we fit some of this constituency that you're speaking of.

One of the things that maybe our friend from New Jersey doesn't realize about $10 an hour employees is that I'm not talking about right now, but two years ago. My pay is better than $10 an hour. But two years, you would very definitely offer health insurance, even though it costs a substantial amount of money, because you had to hold the employees.

Health insurance and retirement are two things that you've got to offer nowadays. And I would say that if we could somehow stop the increase in health insurance cost, this plan would work very well.

I know when we started there were no regulations. In fact, I think we had the plans that we're talking about. We belonged to a group of people that had a plan. And then all of a sudden, the government started regulating it, and we had to get out of it. The government has screwed up as many things as it's helped. And you've got to realize I'm biased.

You stated that you have regulated other plans and so forth? So you've got the experience to do this, even though the numbers would be greater. And common sense says that he, to a very large extent, is correct, that there are going to be 15 to 20 percent of the people that are never going to offer health insurance no matter what it is. It's just too expensive. It's a little bit like the people that you hire to pick cotton, or the people that you hire to cut down Christmas trees and things. They'll never get health insurance.

I realize that with Association Health Plans, in my considered opinion, the cherry picking used to be the big argument against them. And I think that according to what you all say here, that is pretty well taken care of. If so, all those names that he mentioned that might be against this plan would disappear, if there really were protection against cherry picking.

I don't really have any questions. All I wanted to do is preach.

Chairman Johnson. Well, you did pretty well. What I wonder are state mandates a problem for you, because that, apparently, is what's causing some of the prices to go up?

Mr. Ballenger. Yes, I think the state mandates may be a problem. If you're going to cover an employee with regular health care, and you've got to throw in mental health care, who knows what the cost of that is going to be. And slowly but surely, somebody is going to throw in dental costs as

well. All of these things may be forced by state and federal regulation. I hope they're not.

But anyhow, I thank you for your testimony.

Ms. Combs. Thank you.

Chairman Johnson. Does the gentleman from Hawaii wish to question? Mr. Case?

Mr. Case. Thank you, Mr. Chair.

I don't have any preaching to do. I just have some questions.

Chairman Johnson. That's allowed, too.

Mr. Case. Thank you. In my State of Hawaii we have a rather unique state law which requires prepaid health care through our employer system, and to a great extent if you are employed, you must be covered. And we have an exemption from ERISA that allows us to operate that system.

Now, that system exists for better or worse, and needs a little bit of amending. But I believe that I asked Secretary Chao in a previous hearing about the impact of this bill on that system. And I just don't know if you have an answer for me today. But if you don't, that's fine. I'm just reminding Secretary Chao that she undertook to respond to me on exactly how this might impact a pretty unique state law.

Ms. Combs. Yes, she asked me to look into that, and I do have an answer for you today.

Our reading of the bill is that it would not affect Hawaii's health law. How the bill would work is employers in Hawaii would be able to offer AHPs as an option, but they would have to include the benefits that were mandated by the State of Hawaii. That's unique to Hawaii because of your situation.

In the other states, they would not have to offer the benefit mandates, but in Hawaii they would have to offer those mandates that are in Hawaii's act. That would be the only effect. Otherwise, they would be able to offer it as another option for the workers in Hawaii.

Mr. Case. Okay. Thank you very much for that answer, first of all. That's helps. So do I understand, then, that in Hawaii, if an employer is required, under the provisions of state law, to offer health insurance because that employer meets the requirements of our law, that employer simply has an option under this bill to offer that insurance through an AHP?

Ms. Combs. That's right.

Mr. Case. Okay, thank you.

Nobody has said much about the provisions of this law relating to collective bargaining. But do I understand the bill correctly that if an employer and a representative employee group wish

to negotiate a different scheme, they can do so? Is it that open, that loose, that if there is a separately negotiated health care coverage system, that they can basically opt out of this law, or do they have to fit within the AHP process?

Ms. Combs. Typically I don't think we expect that many collective bargaining plans would join AHPs, because they negotiate the benefits between themselves, and in the multi-employer context, the participating employers. I don't think there's any restrictions in the law, and I'm not 100 percent sure we couldn't, but they couldn't agree to negotiate or bargain to offer a policy through an AHP. I don't think that's what people feel would typically happen, but I don't think there's any reason that it couldn't happen if the union and the employers agree that was the best and most efficient and cost-effective way to deliver health care.

Mr. Case. Was that true for government collective bargaining as well, or does this bill affect state and county government provisions of health insurance?

Ms. Combs. I don't know the answer to that. I'll have to get back to you for the record. I'm sorry.

(NOTE: This item was not submitted prior to the official printing of the hearing transcript. However, the item will be maintained upon its submission and available for inspection in the Majority office of the Committee on Education and the Workforce.)

Mr. Case. Okay, because again, in my state, as well as most states, we have pretty extensive coverage and my state negotiated through collective bargaining with public employees.

Ms. Combs. Well, one of the hopes is that if AHPs come into existence, and there is this ability for larger groups to negotiate reductions, that will create competition in the health insurance market in general. So even if they're not participating in AHP, the hope is that they'll be able to take advantage of some lower health prices.

Mr. Case. And finally, I'm not sure I understand the impact of this law, if any, on medical savings accounts. I just don't understand the connection there. Is there any?

Ms. Combs. I think they're on parallel tracks. I think you could have a medical savings account and use it to purchase coverage through the Association Health Plan. The medical savings account (MSA) is kind of a financing mechanism, and this is the actual delivery mechanism. So you would be able to take advantage of the tax advantages through the MSA to purchase an AHP.

But again, we'll follow up with you for the record. H. R. 660 was just introduced, and I'm not exactly sure of the intricacies.

(NOTE: This item was not submitted prior to the official printing of the hearing transcript. However, the item will be maintained upon its submission and available for inspection in the Majority office of the Committee on Education and the Workforce.)

Mr. Case. I was just noting in some testimony, and I forget whether it was your testimony, the fact about the advocacy for improving the applicability coverage of medical savings accounts. And it

just occurred to me that I think I support the general direction of that testimony. But it also occurred to me that if you did provide that expansion of the ability to use MSAs, it might well enhance the utilization of this particular mechanism. Is that right?

Ms. Combs. I think that's right, and make it more affordable.

Mr. Case. Thank you. I yield back.

Chairman Johnson. You're right. It's an uninsured package. The medical savings accounts are not considered under this bill.

Mr. Kline, do you care to query?

Mr. Kline. Yes. Thank you, Mr. Chairman. And thank you, Ms. Combs, for being here and answering our questions.

This bill appeals to me very much both its goals and how it's laid out. But in looking at legislation since being newly elected to this Congress, this one is extremely confusing to me, because it seems that every claim is virtually countered by an opposite claim. And the critics of this bill say, for example, that not only will it not lower costs and expand coverage, but will in fact increase premium costs and not expand coverage at all. I'm looking at a claim here that will make coverage unaffordable for older and sicker groups.

Would you care to address either one of those?

Ms. Combs. I think the latter claim is really more relevant to the prior bill. I think there was concern that there was not sufficient protection in the legislation to prevent cherry picking on the basis of health status. The bill that's been introduced this session, H.R. 660, explicitly prohibits pricing on the basis of health status, or rating premium cost on the basis of health status.

So I think as I said in my testimony, that is a major improvement over the earlier versions of the bill. And I think that addresses a lot of the concerns expressed by people in the insurance market.

This bill, you know, shakes up the status quo. It's going to introduce more competition into the health insurance market, and that makes people nervous. We need to work together and we need to resolve that and make sure that doesn't happen. I think a lot of the concerns have been addressed, and I think we can continue to work to make sure that does not happen.

Mr. Kline. Thank you. I yield back, Mr. Chairman.

Chairman Johnson. Thank you. I think Mr. Andrews would agree that competition is healthy.

Mr. Andrews. Very healthy.

Chairman Johnson. Even among us. Ms. McCollum, do you want to question?

Ms. McCollum. Yes. Thank you, Mr. Chair. I have a few questions. I want to ask about a conversation that's kind of loosely being held here about what's going to be covered and what's not going to be covered; a comment about state mandates.

In Minnesota, we had to pass a law to make sure that insurance companies provided needles along with the insulin. In Minnesota, we've passed a law to allow women to see obstetrics and gynecology physicians within the plan assortments and offer that as primary care if that's what a woman chooses. I know many health plans don't cover contraception, yet they'll cover Viagra.

I want to know who are going to be the winners and losers in deciding what is mandated coverage and what is not. Because I find it rather interesting that the federal government is going to implement a plan in which all 50 states have all this flexibility and options when it comes to health care.

Then the other question I have has to do with status. I heard you talk about age. What about gender? What about age? What about what happens in those cases?

Ms. Combs. On the first question on mandates, I think that this bill represents a balancing of access to health insurance and the kind of "Cadillac" plans, as people call them, that cover broad and all varieties of benefit mandates that have been enacted over the years at the state level.

It does try to level the playing field and make available to small businesses the same sort of exemption from state benefit mandates that are available to large employers. One of the main reasons large employers self-insure is so that they don't have to comply with the 50 different states' benefit mandates.

Many of those plans continue to offer those same sorts of coverage. Covering obstetrics and gynecology is common, obviously, in self-insured markets. And I would expect, particularly since most of small business owners are women, maternity and child care delivery to be covered by these plans, or they're not going to want to participate in them because they're not going to cover a benefit that they need.

Ms. McCollum. That wasn't what I said.

Ms. Combs. I'm sorry.

Ms. McCollum. I said women in Minnesota have a choice of having their designee the obstetrics gynecology professional.

Ms. Combs. Oh, not having to go to a gatekeeper to receive it?

Ms. McCollum. That's correct.

Ms. Combs. Right. Well, that has not been passed as a federal mandate. But again, I think the market has moved in response to a lot of the discussions that have taken place over recent years about tightly-controlled managed care. The market has moved beyond that, I believe.

But you are correct that this bill would not require AHPs to offer that mandate. And it's a trade-off in terms of cost.

Ms. McCollum. I have to make a decision to vote on this bill, and I've been through some of these battles. We had a battle to pass a law that said diabetics who were receiving insulin could also have their needles covered. And I just want to know before I vote on this if I'm undoing that in my home state. Because I don't want to go back home, and have small business owners not realizing the plans that they are providing don't have these fundamental health care rights in them. So I'm trying to grapple with that.

But could you tell me how this is going to affect gender, and how this is going to affect age?

Ms. Combs. The bill does allow AHPs to underwrite insurance based on risk. They cannot charge different prices for health status, but they are allowed to charge different prices for age and gender. In many states a lot of insurers who underwrite charge different rates for age and gender.

Ms. McCollum. So if I hear you correctly, if I am a small business and we allow this plan to move forward, it's more expensive to cover women, because they become pregnant, or they would like to have access to contraception. I know we have laws in place against workplace discrimination but maybe subtly I won't hire women. Or maybe I don't start hiring older people, because they might be more predisposed to heart conditions.

What kind of guarantees are we going to put in these plans to protect consumers?

Ms. Combs. It is a very complicated piece of legislation, I will say, but as I understand it the bill would allow the AHP to underwrite on the basis of age and gender, which means they could charge different rates. But they couldn't charge individuals who work for a company differently. They couldn't charge the women more than they charge the men. What they could do if an employer had a work force that was much older than average, they could charge the employer a different premium if they chose to, but they wouldn't have to. This happens under state insurance laws in many states. It may not be in Minnesota, but many states do allow that. And again, the idea here is to give people access to health insurance.

I understand and I'm sympathetic to the issues and the concerns, but we're arguing for the status quo. This is a balancing act to give people access to insurance. The price should come down because of the risk pooling, because of the efficiencies, because of administrative costs. But there could be some differential based on age and gender and other factors, just as there are in states today.

Mr. Cole. [Presiding] Well, Madam Secretary, this is an interesting experience. It's very heady for me. It's like the first time your dad gives you the keys and walks out of the car, and equally as

frightening for the passengers in the back seat, too.

[Laughter.]

Mr. Cole. But anyway it's good to have you as a chaperon.

Mr. Andrews. It's like the movie Risky Business.

Mr. Cole. It is indeed. I wish I had had that much fun as a young man. Anyway, I have a couple of simple, direct questions, axiomatic, obviously. The legislation is complex. There's no such thing ever as the perfect bill.

Is there any reason to believe if we passed this legislation that it would make the situation worse rather than better? At the end of the day, wouldn't you logically expect there to be more people insured, or at least have access to insurance through their employer than is the case today?

Ms. Combs. Yes, I think it will improve the situation. And I think the best patient protection is access to health insurance.

Mr. Cole. We've had some speculation as to what employers will or will not do. Obviously, you never know until you actually pass the legislation and they're confronted with it. But isn't it fair to say we've had any number of associations of particular types of companies and industries, the U.S. Chamber of Commerce, the National Federation of Independent Business, that have come to us and asked, "If you can give us this ability, we really do believe our members, in significant numbers, will respond?" And that's going to enable them to offer a benefit to their employees that they can't currently manage to do.

Ms. Combs. Yes. There are over 80 associations representing small businesses, farmers, and others who strongly support this legislation.

Mr. Cole. And finally if we assume competition is a good thing, we assume we will have more companies and more associations offering insurance. As different companies begin to offer insurance more and more, won't that increase the pressure on those who don't in terms of competing for employees, and " keeping up with the Jones's", so to speak, in a competitive business environment?

Ms. Combs. Absolutely. The big picture is, we're facing long-term worker shortages, and people are going to need to compete to get the kind of quality workers they need. And health insurance is a very important part of the package. So I think there will be intense pressure to be able to make this benefit available.

Mr. Cole. I have no further questions.

Chairman Johnson. Mr. Tierney?

Mr. Tierney. Thank you, Mr. Chairman.

Ms. Combs, we meet again, over and over it seems. This is like in Groundhog Day.

Ms. Combs. It gets better every time.

Mr. Tierney. If you say so.

[Laughter.]

Let me see if we can put this in some perspective. Obviously, what's going on here is that everybody thinks that if we have a larger pool, that we're going to get a better deal on the insurance, right?

Ms. Combs. Yes.

Mr. Tierney. So what's to stop us from saying we can have a larger pool, and it just has to comply with the state regulations? You know, choose the most severe regulation that you have, make that your threshold, and say, "There you go. As long as your plan meets that threshold, then you can put this in place."

Ms. Combs. Well, I think the state benefit mandates do add substantially to the cost of health insurance, and that's one of the reasons that the bill allows the exemption.

Mr. Tierney. So the clear trade-off is that states that decide they need to protect their citizens are supposed to be kicked aside so that the price goes down. That's the essential trade-off. You lose rights and protections in return for a better price.

Ms. Combs. There remain in place, you know, central federal protections.

Mr. Tierney. But let me tell you, after just a quick review of this bill it will kick out 22 protections that the Commonwealth of Massachusetts has, right? The group that insures access to independent review: gone. A number of regulations that would insure appropriate access to care: gone. A number that would insure fair insurance premiums to small groups: gone. And others that would insure marketing protections: gone. Others that would insure health plans cover important benefits that go beyond the federal requirements like mental health parity, alcoholism treatment, maternity benefits, mammography screening, in vitro fertilization, well-child care, prompt payment rules: gone. Other regulations that would insure appropriate oversight of insurers: gone. Others that would prevent failures and insure payment of claims and promote access to the uninsured on many COBRA rules are all gone.

So that's what Massachusetts would be trading off if this bill went into effect. You would at least agree with me on that.

Ms. Combs. If I may offer a caveat. If the AHP were fully insured our reading of the law says that external review would continue to apply. People would still have access to that. The market conduct rules would continue to apply to the insurers. So in the insured AHP market, which we

frankly think will be the larger share of this market, some of those protections will remain. But you are right about the mandates.

Mr. Tierney. Most of those have gone by the by with this.

All right. So that's one problem we have. And obviously, it's going to be hard for Members from a state that has more protections to justify voting for something that basically just lessens protections for the citizens in their state.

The second part of this, we're talking about solvency protections. Will you compare with me what an adverse state, if there is such a thing, has for solvency protections, and how it compares against the solvency protections that you have in this bill?

Ms. Combs. I'm not familiar with the specific solvency requirements of particular states. But it's the same type, getting at the same issues. In this case, an actuary determines that the reserves are adequate to pay the expected claims. And then you have to have surplus on top of the reserves so that there's a cushion.

Mr. Tierney. Who would make the determination as to what the anticipated claims would be?

Ms. Combs. They have to get a qualified actuary who has to certify professionally that the reserves are adequate to meet the claims experience of the AHP.

Mr. Tierney. So they pick this person?

Ms. Combs. They pick the person, and that's filed with us and we oversee that. So if we ran into a problem with one, we would be able to check the other plans that use the same actuary.

Mr. Tierney. I always have concerns with that. It reminds me a little bit of Wall Street and having the accountants and the auditors watch each other back and forth.

What I want to address in the limited time that we have is have you done a cost benefit analysis of what the cost is going to be to the Department of Labor to regulate and enforce this?

Ms. Combs. Well, we've been looking at what it would take to implement this. We don't have dollar amounts or numbers of employees yet, because the legislation hasn't passed. But when it does pass, we'll be allocating the resources that are necessary to do it.

Mr. Tierney. Can I just interrupt you a second? Don't we generally get a push by the Majority on this side to always get a cost benefit analysis of things before they go through? And this hasn't been requested of your Department or you yet on this bill?

Ms. Combs. No.

Mr. Tierney. Because back in 1997, as I said, it's like Groundhog Day all over again. It's not the first time we've been around the track on a similar bill, and the Department of Labor estimated it

would take them 300 years just to review each and every AHP once. I mean, the regulatory process of having a national program is obviously going to be enormous. And I'm just curious as to what the cost is going to be on that, and how effective it's going to be.

We have all the states doing the job. I think most of them are doing a pretty good job. And now we run the risk of having a regulation really get watered down by expanding it nationwide and taking the states out of the pictures. You might want to address that.

Ms. Combs. Yes. You know, the previous Administration did not support this legislation, and they felt that they weren't willing or able to take it on. I disagree. I think we are able. I think they would have had the capability of doing it, and needed additional resources. We acknowledged we would need additional resources.

Mr. Tierney. Well, you know, give me a ballpark figure of additional resources, because I don't want to gloss over that.

Ms. Combs. I don't have a ballpark yet. But I recognize that this is an expansion of what we do right now when we're regulating self-insured employers and multi-employer plans in many ways.

Mr. Tierney. A huge expansion of what you're doing right now, right?

Ms. Combs. I don't know how many AHPs there are going to be. I mean I don't know where the 300 years came from. Frankly, I don't know what they assumed.

Mr. Tierney. It came from testimony in 1997.

Mr. Cole. I think the gentleman is close to exhausting his time.

Mr. Tierney. And I appreciate you allowing me to go over the time limit to get an answer from this witness. Thank you, I'm finished. We have rules of etiquette around here, so we're going to finish on that.

Ms. Combs. I don't have a cost estimate. We have not done cost estimates on how many employees we would have to hire. Essentially, we would be hiring. And the bill also gives us the ability to contract with the states to do some of this work. We would explore that. And as the legislation moves through the process, we'll gear up.

You know, as you said, we've been talking about this for several years, so I don't think it would be prudent for us to be implementing legislation that hasn't been enacted yet. And that's why we have not requested specific resources yet.

Mr. Tierney. Thank you. And I thank the Chairman for his usual courtesy.

Mr. Cole. Thank you. Mr. Payne, do you have any questions?

Mr. Payne. No. I'll reserve my questions for the next panel. Thanks.

Mr. Cole. Okay.

Thank you for your testimony, Madam Secretary.

Ms. Combs. Thank you very much.

Mr. Cole. I'd like to introduce the first witness on our second panel. Ms. Phyllis Burlage is the President of an accounting firm, Burlage and Associates, PA, based in Millersville, MD. She is testifying on behalf of the National Federation of Independent Business.

Our second witness is Ms. Alice Weiss, Director of Health Policy for the National Partnership for Women and Families, Washington, D.C.

Our last witness is Mr. Greg Scandlen. Mr. Scandlen is Director of the Center for Consumer Driven Health Care at the Galen Institute in Arlington, VA.

Please limit your statements, if you will, to five minutes. Your entire written statement will appear in the record. I remind the Members that the same five-minute rule for questioning witnesses applies to this panel after we receive their testimony.

So Ms. Burlage, if you would like to begin, please do so.

STATEMENT OF PHYLLIS M. BURLAGE, PRESIDENT, BURLAGE ASSOCIATES, PA, MILLERSVILLE, MD, TESTIFYING ON BEHALF OF THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Thank you. Good afternoon, Mr. Chairman and members of the committee. I want to thank you for inviting me today to talk about this important issue of affordable health insurance for small businesses. I'm pleased to be here on behalf of the National Federation of Independent Business, representing 600,000 members who face a similar challenge.

I own Burlage Associates. My name is Phyllis Burlage. We're a small accounting firm in Millersville, Maryland. My employees and I work together to help individuals in small businesses comply with federal, state, and local tax regulations. And I think you can say how important this bill is to me, because I should be tied to my desk right now with a ball and chain doing just that during tax season. But it was very important for me to come here and talk to you today.

Unlike other small women-owned businesses I know, I've been able to offer health insurance to my employees since the day I opened. And thankfully, I've been able to provide a comprehensive benefit and pay 100 percent of that cost. Each employee is eligible to participate after 30 days of working for me. I initially pay for my employees only, and I usually use family

and dependent coverage as a form of a raise.

I administer my own plan, and every year in March, I hold my breath when my renewal comes in. I've changed my policy four times in the last four to six years because of premium rates only. I have very few choices because of the many mandates in the State of Maryland.

Two weeks ago, I received my renewal in the mail. And my heart stopped, because my rate hike this year is 45 percent. Overall, I've had a 226 percent increase since 1996. How can any business absorb increases of this magnitude?

This year, our rates went from $226 to $265 per month for an individual, $476 to $557 for an employee and spouse, and skyrocketed to $750 a month to add a family, up from $650 only a year ago. Should I raise my clients' fees to cover this increased health cost? Will I lose clients to competitors if I do? It's a vicious cycle for me and for many business owners.

Each year, I search for a plan, because health insurance is important to my employees and me. My employees and I work together to evaluate our options, including higher deductibles and co-pays. But we know that in spite of our best efforts, the cost will increase every year, because our rates are based on the average age of our small group.

Since my group consists of three people, and we get a year older every year, there's no pool to offset that fact. At this rate, by the time I qualify for Medicare in 14 years, my premium will be $3,486 for me per month, and if I still have my group, $10,141 for my employees and me.

While I continue to struggle to provide affordable coverage, some of the big companies have announced record profits in the last few quarters. As an entrepreneur, I'm in favor of profits. But looking at double-digit annual increases, I believe the lack of competition in the small group market is making insurance company executives richer at small businesses' expense.

As many of you may know, recently in my home state of Maryland, Well Point Health Network, Incorporated, the biggest publicly traded Blue Cross and Blue Shield plan, attempted to purchase the non-profit Care First Blue Cross/Blue Shield Company. Fortunately, Commissioner Larson denied the conversion, citing basically the initial $119.7 million bonus plan for the Blues' executives. And despite state oversight, these insurance companies had found ways to cherry pick the healthiest individuals in order to increase their profitability, looking forward to this potential buyout.

The subject of health insurance comes up at every professional meeting I attend, both with other women-owned business owners and with my clients. We are afraid that we will not be able to cover our employees and ourselves, and consequently, we will not be able to attract qualified employees and compete in the market.

We need to be able to spread this risk out over more than our own employee group. The small business community is struggling each year to afford the cost of increasing premiums. It is for this reason that I support H.R. 660, the Small Business Health Fairness Act of 2003. AHPs will allow small business owners to band together across state lines to purchase health insurance as part

of a larger group, insuring greater bargaining power, lower administrative costs, and freedom from the cost of complying with 50 different sets of state mandates.

AHPs will level the playing field and give small employers the same privileges as their counterparts in labor and big business. In addition, AHPs will introduce into the marketplace competition and diversity that is needed to make health insurance premiums more affordable. Without the ability to shop for more affordable options, we are left with the choice to shift costs to our employees, or drop coverage. And if we drop coverage, we're just adding to the number of uninsured. Association Health Plans would help to end this nightmare.

Like most small business owners, I talk to a lot of people every day. To be competitive on Main Street, you have to keep your ear to the ground. I know from talking to other accountants that they and their clients need AHPs. They are a good, common sense solution to controlling the cost of quality health care.

Mr. Chairman, thank you.

WRITTEN STATEMENT OF PHYLLIS M. BURLAGE, PRESIDENT, BURLAGE ASSOCIATES, PA, MILLERSVILLE, MD, TESTIFYING ON BEHALF OF THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS - SEE APPENDIX C

Chairman Johnson. Thank you for your testimony.

Ms. Weiss, you may begin your testimony now.

STATEMENT OF PHYLLIS M. BURLAGE, PRESIDENT, BURLAGE ASSOCIATES, PA, MILLERSVILLE, MD, TESTIFYING ON BEHALF OF THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Good afternoon, Chairman Johnson, Ranking Member Andrews, and other Members of the Subcommittee. Thank you for the opportunity to testify today.

My name is Alice Weiss, and I'm the Director of Health Policy for the National Partnership for Women and Families, a non-profit, non-partisan advocacy organization that promotes work place fairness, policies that balance work and family, and access to quality health care for women and families.

As my written testimony discusses in greater detail, the National Partnership supports the efforts of this Subcommittee to develop solutions to the problems small businesses face in obtaining affordable health insurance. Today, I will offer the partnership's principles for reform, and explain how H.R. 660 falls short of these principles, and may ultimately hurt, not help, the uninsured.

Today's small business crisis has significant impact on women. Women are disproportionately likely to be either owners of or workers for very small firms. And as the National Partnership survey research shows, it is most often women that pay the price when health coverage is unavailable.

In the face of this crisis, it is critically important for Congress to act. We have developed four principles to evaluate proposals to improve health coverage access for small businesses.

First, proposals must cover the uninsured. With 41 million individuals now uninsured, proposals must provide new coverage, not just shift the already insured from one coverage to another.

Second, proposals must also provide small businesses and their low-income workers access to affordable and comprehensive coverage.

Third, these proposals can't ignore those who are most in need. One in four uninsured Americans has at least one chronic condition that puts them at greater need for coverage and at risk for discrimination. Legislation must help those in poor health, not just the healthy.

Finally, proposals must preserve strong consumer protections. All 50 states and the District of Columbia have passed tough consumer protections to stabilize the small group health insurance market. Strong protections are needed to lessen the likelihood of a new trend of fraud and abuse.

H.R. 660 offers Association Health Plans as a solution, but H.R. 660 is not the right policy option. It suffers from three basic problems.

First, despite proponents' claims to the contrary, H.R. 660 still allows AHPs to cherry pick the healthy and leave the less healthy behind.

Second, H.R. 660 preempts critical state oversight, denying consumers the protections they need to insure that AHPs will make good on their coverage promises.

Third, AHPs will be subject to nominal and inadequate federal standards and oversight under the Department of Labor, with no meaningful resources provided to DOL to help it undertake these new responsibilities.

H.R. 660 also fails to meet every one of the principles I have outlined. It simply offers no solution to the problem of the uninsured. According to CBO, less than 1 percent of the 41 million uninsured today will get new coverage, and AHPs would drive up costs for four out of five small business owners and their workers, more than 20 million individuals.

H.R. 660 also fails to insure access to affordable and comprehensive coverage. Because nothing in H.R. 660 prevents AHPs from saving money by paring down benefits and targeting the healthy, the cost of coverage for those remaining in the state-regulative market will go up, even as coverage options decline.

Under H.R. 660, healthy people win, while those most in need will lose. AHPs would leave the elderly, disabled, and chronically ill behind without help. And because women are more likely to use health care services and need expensive reproductive health benefits, women would also lose with AHPs.

H.R. 660 also undermines strong consumer protections. Virtually all state law protections, including patients' rights, rating rules, fraud and solvency, and direct enforcement protections, are eliminated for AHPs, and replaced with minimal federal oversight and weak solvency standards. For example, H.R. 660 would allow the AHP's own actuary to certify its solvency, a practice that would make even Enron executives blush. And by loosening the reins of oversight, the AHP legislation could increase the risk of fraud already rampant and on the rise.

Last year alone, 55,000 workers and their families were left uninsured due to association plan scams, amounting to $65 million in unpaid medical claims, and millions more in premiums paid for coverage that consumers never got. Although many small business owners and their workers are uninsured now, under H.R. 660, they could be paying for the privilege.

While we do not oppose the concept of AHPs and could support a proposal that met our criteria, H.R. 660 as now drafted fails to meet these criteria. And there are other ways to address the current small business health care crisis. Here are three examples.

One, small employer tax credits and new state-regulated purchasing pools could give small employers a new tax incentive to offer coverage, and would encourage states to create new pooling arrangements without undermining existing protections.

Two, allowing small employers to buy into FEHBP and state employee pools would give small employers new options to reap the benefits of better choice and lower cost that pooling on a large scale can provide, also without threatening consumer protections.

Three, building on existing public programs like Medicare, Medicaid, SCHIP would harness the cost savings reaped from public programs to target assistance to those most in need: low-wage, older, and less healthy workers.

The health insurance problems facing small employers are a major concern for women and families. However, we urge you to take a cautious approach to legislative action. H.R. 660 will likely do more harm than good for small employers and their workers alike without addressing the problem of the uninsured.

For H.R. 660 to work, it would have to provide meaningful assistance for the uninsured, prohibit wrongful discrimination and cherry picking, and create an effective oversight and enforcement mechanism, including strong solvency standards and sufficient resources to support DOL oversight. H.R. 660 as now drafted does not address these concerns. Significant changes are needed to address these real and critical flaws.

Thank you for your consideration of this important issue and for the opportunity to testify, and I'm happy to answer any questions.

WRITTEN STATEMENT OF PHYLLIS M. BURLAGE, PRESIDENT, BURLAGE ASSOCIATES, PA, MILLERSVILLE, MD, TESTIFYING ON BEHALF OF THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS - SEE APPENDIX D

Chairman Johnson. Thank you. I appreciate your testimony.

Mr. Scandlen, you can begin your testimony now.

STATEMENT OF GREG SCANDLEN, DIRECTOR, CENTER FOR CONSUMER DRIVEN HEALTH CARE, THE GALEN INSTITUTE, ALEXANDRIA, VA

Thank you. Mr. Andrews has cautioned the proponents of this bill not to overstate their case, and I think that is an extremely welcome comment. In fact, too often in the political sphere, both opponents and proponents overstate their cases, and I think that's happening with this issue.

It seems to me that Association Health Plans are a considerable contribution to solving some of the problems of the small group market. They're certainly not going to solve all the problems. They're not going to solve the problems of the uninsured. But they're a step in the right direction, and I think it can be a major component to a comprehensive approach to solving our health care problems.

Anyone who thinks that the small group market back in their home state in their home district is working just fine should probably vote against this bill. But I'm here to tell you that the mandates, the excessive regulations, the rating instructions, the level of competition, and the costs are going through the roof. If all of that is producing happy companies and happy employers, then nothing should be changed.

But, in fact, the current market is a disaster. Even at this moment, in your home district, there's probably an employer who is notifying his employees that he can no longer afford to carry the coverage. It's a tragedy out there. And frankly, I believe it is a consequence primarily of excessively zealous state legislators who have passed outrageous legislation.

I was very closely involved, with the NAIC twelve or more years ago when they were starting on their so-called campaign to reform the small group market. I predicted at the time that their reforms would result in chaos in the small group market. And I think time has borne me out. That is exactly what is happening today.

As I say, AHPs are only part of the solution. We also need to expand medical savings accounts. We need tax credits. We need malpractice reform. We need new ideas like the health

reimbursement arrangements that the IRS has just recently approved. We need more competition and more innovation in the small group, and every other insurance market in the United States. I think AHPs will contribute to the level of competition in a market where there are virtual monopoly conditions today.

The AMA did a very fascinating report on market concentration in health insurance. And in very many markets, there are two or three dominant players that control 70 percent or more of the market. That is a large part of the reason there's such a problem. These dominant carriers have a take-it-or-leave-it attitude. If you don't want what they buy, there's no place else to go. AHPs will give small employers an alternative and an option. It will also open up the market to ideas like medical savings accounts, which are also not the solution to all of our woes, but another contributor.

I live in Maryland. I have been a small employer. And I tell you, in Maryland, small employers cannot get medical savings accounts, because the Health Care Access Commission has added so many bells and whistles to them that they're impractical in that state.

In Connecticut, there is a mandate that requires no more than a $50 deductible for home health services. So in Connecticut, no one is allowed to have a medical savings account, even though the United States Congress passed the legislation about seven years ago. So there are huge problems out there.

Some of the criticisms that have been leveled, I think, are simply illegitimate. This notion that AHPs will only take the good risks and leave the bad behind, I think, is nonsense. In Senate testimony, Len Nichols testified that in Arkansas, they had exactly the opposite experience when the state formed a purchasing pool for small employers in that state. And they couldn't find an insurance company to take it, because the insurance companies all thought that the worst risks would join the association, not the best risks. There is no reason to think in a guaranteed issue environment that an Association Health Plan would only end up with the very best risks.

Another argument is that shady operators will come in and take the money and flee to Costa Rica, as happened with MEWAs. Now, I guess I'm an optimist, but I like to think that human beings learn from experience. And I think this bill builds in quite a number of safeguards to prevent that from happening this time around. MEWAs certainly were a disaster. They were unregulated by either of the states or the Federal Government, and that shouldn't be allowed to happen.

I think there are some legitimate criticisms of the legislation. Insurers will tell you if regulatory relief is needed, give us the regulatory relief, and we'll fix the problem. I think that's right. I'm not quite sure how to get there. I don't think Association Health Plans are the only way of doing this, but I think it's the only one way on the table right now.

Thank you, sir.

WRITTEN STATEMENT OF GREG SCANDLEN, DIRECTOR, CENTER FOR CONSUMER DRIVEN HEALTH CARE, THE GALEN INSTITUTE, ALEXANDRIA, VA – SEE APPENDIX E

Chairman Johnson. Thank you. We appreciate the testimony of all three of you.

Ms. Weiss, we answered most of those questions that you brought up earlier with Assistant Secretary Combs. I think that this is just another plan on the table from a smorgasbord of plans out there, all of which cost too much. And how we get the cost of health care down, I don't know.

But Ms. Burlage, it seems like we've got reports, papers, arguments, speeches, whatever. From your standpoint, does it make sense for us to pass legislation that could reduce some costs and cover more workers and families, whether it's 300,000 or if it's 8 million?

Ms. Burlage. Mr. Chairman, when my clients come to me and ask me about buying a new computer system, they want it to do everything that it can possibly do, including shine their shoes and digest their dinner. I tell them to make a list. And if they can find a system that will solve 80 percent of their problems, jump on it.

And that's the way I feel about Association Health Plans. They're a step in the right direction. They're going to help us. We need to take that step.

Chairman Johnson. Thank you. I appreciate that comment.

Mr. Kline, do you wish to question?

Mr. Kline. Yes. Thank you, Mr. Chairman.

Mr. Scandlen, let me say how much I appreciate your comment that the claims on both sides of this argument are extreme, which is probably too soft a word. It's amazing how one side is saying “up” and the other “down”, and one “black” and the other “white” and so forth. And I very much appreciate your comment.

I have just a couple of very quick questions, because there are so many. In your judgment, would AHPs actually reduce the administrative burden of small employers?

Mr. Scandlen. I think they might somewhat. I think more importantly, they would allow small employers to access professional benefits managers like large employers currently can. A 30-person print shop has a boss that really doesn't know anything about health care, doesn't really care anything about health care. If he could tap into the resources of a trade association to provide those kind of professional services, I think that would be a big help to him. Whether administrative costs are actually lowered very much, I'm not so sure. I think the bigger problem is the cost of the regulations.

Mr. Kline. Okay, thank you. And the issue here in large part is that we have state regulations, and federal regulations would be over-arching and change some of those. Is there any benefit to consistent nationwide regulation over the state regulations?

Mr. Scandlen. That is a very tough issue that I think is going to need to be addressed eventually. Obviously, the insurance market is already fragmented. You have larger employers that are self-insured that are ERISA protected and completely free of any state regulations. You even have small employers down to say 100 or so that are self-insured and free. Then you have mid-sized employers who are fully insured and not free of those regulations. Then you have different regulations on the state level for each of those Blue Cross plans, commercial carriers, individual market, small group market, and large group market. We already have a horribly fractured insurance oversight system that I think needs to have a sober look taken at it. And perhaps that implies federal oversight. I'm not sure. But what we have today is simply not working.

Mr. Kline. Thank you.

Ms. Burlage, I'm just still stunned that you have experienced a 226 percent increase in your premium since 1996.

Ms. Burlage. Yes, sir.

Mr. Kline. How in the world did you handle that? What did you do to offset that expense?

Ms. Burlage. Well, quite frankly, when I hire somebody, the cost of the insurance is built into the compensation package that I offer. So they may wind up with an hourly rate that might be considered to be below par simply because I'm going to be covering them with health insurance. And my employees know and understand that.

I also, as I have stated in my written testimony, tend to pay my employees with a lot of flexibility. I have a woman who raised her child up through the time she entered kindergarten by bringing the child into the office. So that kind of flexibility, and them knowing that the health insurance is literally a part of their hourly rate, has helped me. But it's reaching the point right now where I honestly do not know what I'm going to do in the coming years.

Mr. Kline. So in other words, you're driving down the salary or the wages that you can pay, in effect.

Ms. Burlage. Effectively. And quite honestly, because I do not have to pay payroll taxes on health insurance benefits, if I increase my employees' wage base through health insurance, it lowers my overhead as far as payroll taxes go.

Mr. Kline. Thank you very much. I yield back, Mr. Chairman.

Chairman Johnson. Thank you.

Mr. Andrews. I apologize for skipping over you.

Mr. Andrews. That's all right. I got so much time the last time, I guess that was my punishment. I'd like to thank each of the three witnesses for excellent and well-thought-out testimony. Thank you.

Ms. Weiss, I understand you may have a little person to start bringing to the office soon. I congratulate you on that great news.

Ms. Weiss. Thank you.

Mr. Andrews. I wanted to ask you which of your three proposals to increase health care coverage do you think would be most efficient. Would it be opening up the public programs, or expanding SCHIP, or would it be the pooling and the tax credit? If we could do one of those things, what would you recommend to us?

Ms. Weiss. I think if you want to look at the broader the issue of the small business and what they're facing, I think you would probably want to encourage them to offer the pooling arrangements and the tax credits as an option targeted at the small employers, and then provide subsidies to the states.

Mr. Andrews. Do you think that we should propose such a tax credit for all employers, including those who presently insure their employees, or only those who do not insure their employees, which is a very tough question?

Ms. Weiss. Right. I think that's an important issue. Unfortunately, as you already know, the way the current system is set up, all employers have a tax incentive to offer coverage. The idea behind offering small employers an additional tax credit or incentive is intended to try to get over the barrier, that I think was being referred to in the last question-and-answer period, about what the small employers are going to face in terms of whether or not they would be willing to actually take up coverage and get over the hump of affordability.

Mr. Andrews. Thank you.

Ms. Burlage, if I lived in Maryland, I'd hire you to do my taxes. You obviously seem to be very client-oriented.

Ms. Burlage. Thank you very much.

Mr. Andrews. You remind me of the accountant that does my family's taxes. They're also very personable and a very small firm. Since I'm going to publish my tax return on the Internet, which all of us non-profits do in these days of full disclosure, I want to make sure it's right.

I want to ask you your opinion of this idea. What if we said that we took a collection of consumer protections like you've heard about here today, coverage of mammograms and colon

cancer screenings and the rest, put them into one national standard, and said to the insurance industry, "If you meet this national standard, you can sell insurance in any state in the union." So if a carrier in Maryland or Ohio or California met strong consumer protection standards, they could sell their policy anywhere in the union. What do you think of that idea?

Ms. Burlage. Well, I know that because of the number of mandates the State of Maryland has, many insurance companies will not even come into the State of Maryland. If I look at the AARP magazine that comes out, and they talk about various insurance companies, or I see something on TV about call in about insurance, we call in, and they'll reply, "Oh, you're in Maryland? We're not coming there."

So I think if something could be done that would help to even out those bumps in the road as far as individual state mandates go, it would be a step in the right direction.

Mr. Andrews. Thank you.

Mr. Scandlen, I appreciate the very last paragraph of your testimony about not overselling the effects of this legislation. And by the way, I don't believe there would be any positive effects either. I just think that in a marketplace where about 80 percent of the working uninsured people make a very low wage in industries that have a very low margin that even offering a very deep discount to the employer is not going to make a lot of difference.

What would make a difference? You make reference to this. What in combination with some of the other proposals could make a significant improvement?

How would you reach universal coverage of people in this economy?

Mr. Scandlen. Well, I'm afraid that I would disagree with the premise, first of all. I, frankly, don't think we will ever get universal coverage.

Mr. Andrews. So how would you increase it to near universal?

Mr. Scandlen. Right. I think refundable individual tax credits would go a long way. As I cited in my example of a print shop with 30 employees, it has never made sense to me to rely on the owner of that print shop to be a provider of health insurance benefits.

Mr. Andrews. I'm sorry. When you say "refundable," you mean that if an individual doesn't make enough money to pay federal income taxes, they would still get a credit anyway, right?

Mr. Scandlen. Yes. And I think it should be equivalent to the subsidy that's currently provided to employer-sponsored benefits through the exclusion, which is about 35 to 40 percent. I think that would just be a starting place.

Mr. Andrews. Would you offer this to all uninsured people, or all people?

Mr. Scandlen. I would offer it to all people that are not getting coverage through their employer.

Mr. Andrews. Do you think that it would lead to a hemorrhaging where employers who do offer insurance would just stop doing it, because the public would now subsidize it?

Mr. Scandlen. I think many employers might very well do that. But I think they would continue to make a contribution towards that employee's health insurance premium, as they do now. And I think that's more appropriate, with the exception of large companies. The General Motors and GE's and those sorts of companies do a wonderful job of managing benefits programs. But the small to mid-size guys simply don't. And I think the public would be better served if they simply made a financial contribution to the cost of coverage for their employees.

Mr. Andrews. I would be interested, if you could supplement the record later with your estimate of how much that would cost the federal treasury.

I thank each of the three witnesses. Thank you.

(NOTE: This item was not submitted prior to the official printing of the hearing transcript. However, the item will be maintained upon its submission and available for inspection in the Majority office of the Committee on Education and the Workforce.)

Chairman Johnson. Mr. Tierney, the gentleman from Massachusetts.

Mr. Tierney. Thank you, Mr. Chairman.

Mr. Scandlen, most of the savings that we think might be generated from the AHPs under this bill, would they come from the fact that there would be a release from the state regulatory process?

Mr. Scandlen. Yes, I believe so, sir. Although I'm not quite clear on some of the provisions of the bill. For instance, it seems to me that it's deferring to the states on rating restrictions, on community rating and that sort of thing. And if the bill is doing that, then I think a large chunk of your savings would be lost.

Mr. Tierney. So the bill would be even less effective if that's what it does.

Mr. Scandlen. I believe so, sir.

Mr. Tierney. Now, the Congressional Budget Office looked at this bill, and they thought at best, it would save about 13 percent over the traditional premiums. So it indicates to me that maybe that's the case. I'll check that myself also.

Ms. Weiss, do you agree that most of the savings from any proposal like this are intended the come from the state regulatory process?

Ms. Weiss. Actually, I think the CBO report that you're referring to found that there were actually two sources of savings. One was the fact that they'd be out from under the state benefit requirements, and the second was the opportunity that the associations would have to design their own benefits package, and therefore, draw in healthy risk.

Mr. Tierney. So cherry picking.

Ms. Weiss. Cherry picking.

Mr. Tierney. Okay, thank you. Now, given that, Ms. Burlage, I was in a business pretty much like yours, only probably smaller, before I got to Congress. I had the same problems all the time. You get your premium notices, and you want to open the window and jump, and hope you're on the first floor.

Ms. Burlage. Yes.

Mr. Tierney. Just as a protest. You didn't really want to hurt yourself, right? But let me tell you,

[Laughter.]

if we went to a system like this, and, in fact, the reason to have that money was to get out from under regulation, I assume that being the good employer that you are, you still want to get a good policy for your employees.

Ms. Burlage. Of course.

Mr. Tierney. So would it affect your decision if you were going to try to get a policy where consumers can no longer have an independent external review of any claim that's denied? Is that going to impact your decision whether or not to go to that type of a policy?

Ms. Burlage. I have to tell you that, quite frankly, I guess it's like somebody who's hungry. If you haven't had a meal for a while, you're not really concerned what you eat. You just want to eat. And right now, my employees are much more concerned with the fact that they will have insurance.

Mr. Tierney. Well, you're covering them now, aren't you?

Ms. Burlage. I'm covered now. And they want to make sure that they stay covered.

Mr. Tierney. Right. So I guess my question to you is if you're now looking at a policy, and one of the things that it does not provide is an independent external review of claims that are denied, is that one thing you would factor in when determining whether or not you wanted to go in that direction?

Ms. Burlage. Probably not.

Mr. Tierney. You don't care.

Ms. Burlage. I probably would be more concerned with the premium and the co-pays.

Mr. Tierney. But not what it covers?

Ms. Burlage. Yes, what it covers. But are you talking about when I go to the doctor and I have my annual mammogram, or my well woman or my child coverage, is that covered?

Mr. Tierney. Let me ask you that, then. If you have a policy that doesn't cover mammography screening, would that be an impact on your decision?

Ms. Burlage. Yes.

Mr. Tierney. And if you had one that didn't cover well child care, would that be an impact on your decision?

Mr. Tierney. And if it didn't cover maternity benefits, would that impact your decision?

Ms. Burlage. Probably not.

Mr. Tierney. You wouldn't care if your policy covered maternity.

Ms. Burlage. I don't have anybody in my office that that would impact at this point.

Mr. Tierney. Well, suppose you did by the time you had to make this decision? Suppose you had Ms. Weiss with you?

[Laughter.]

Assuming you could afford the payroll of Ms. Weiss.

Ms. Burlage. Assume I could afford the payroll. Then at that point, yes. I want to be able to offer my employees the coverage that they need, and that's the question that you're asking me.

Mr. Tierney. It is. And I guess my point is, if you haven't guessed it already, is that a lot of these states have gone through this process and tried to determine what their citizens want in a policy, what protections they want, and then have imposed those regulations. And now we're sort of undoing that and going backward. And I think what I heard from you, for example, at least in Massachusetts, some of the things that we have in our legislation that would be protected would make a difference to you if those were gone out the window now.

Ms. Burlage. It might. But I also know that when I speak to my employees about coverage, and when I speak to other people about what they want, lots of people have a list of what they want. But a lot of times they back down when it comes down to what they need and what they will deal

with on a day-to-day basis. A lot of these items can be negotiable.

Mr. Tierney. Well, a young married couple might want to know that there are maternity benefits.

Ms. Burlage. But they might not be so willing to pay the extra for in vitro if they know what that's going to do to the increase in their premiums.

Mr. Tierney. Right. But they also want to have the mammography screening. I guess my point is that the states have gone through this process, and now on the federal level, we're just going to wipe it out, not just the in vitro, but also some of the other things that you would want or whatever. So it puts some complications in there.

Ms. Burlage. But I think that there is room for negotiation, and that it needs to be discussed.

Mr. Tierney. Well, I wish that the bill provided for that. I yield back the balance of my time.

Chairman Johnson. I think the gentleman's time is expired.

Mr. Tierney. You know, it's interesting.

Chairman Johnson. That's the way it is with the first-story man.

Mr. Tierney. I saw your incredible questioning at the beginning or statements at the beginning of the questioning period, and I thought you were using your own time until I realized the light wasn't on, and I thought maybe I'd steal some of that time. Thanks.

Chairman Johnson. It was Mr. Andrews' time you were stealing there.

Mr. Payne, do you wish to question? And let me advise the Members and the witnesses that we're about to get a vote called on the floor, so we'll hurry this through. Mr. Payne.

Mr. Payne. Okay. I thought I gave my time up on the last round, but I guess I better rest on this one too. Let me just say that the fact that this federal plan would override state plans, as Mr. Tierney mentioned, what happened in Massachusetts would certainly usurp a lot of the benefits that New Jersey consumers have. And so I don't know why it would be beneficial for us in New Jersey. I don't know what states it benefits.

Maybe Mr. Scandlen, since the Assistant Secretary is not here, you can answer some of these questions. First of all, it appears to me that there is the problem with health care, as Ms. Burlage was saying, we can pick and choose, which really makes a lot of sense for her firm. I think one of the problems with the health insurance in general is that it's a lot different from insurance in general.

They tell me that the concept of insurance is that you get large, large numbers of people, and you have some kind of actuarial table to show that so many people are going to die, for

example, for life insurance. But everybody's kind of thrown into those big numbers.

It seems like health insurance can almost never work because of the question of tailoring the policy to an individual's work place. Now, that makes sense for the individual in the work place. But to me, it destroys the whole concept of what insurance in general is supposed to be about; large numbers where out of every 10,000 people, four people are going to get run over by a bus. So you know that.

But if you kind of skew out and take people that are not going to have children, or maybe all men, so you don't carry maternity, I'm trying to figure out what the question is. But I have a problem with the sort of tailor-made cherry picking, and that's what MEWAs and all those are. I guess my question is do you think that we could ever have a system that's going to be affordable because of the manner in which insurance is done by small business in particular?

Mr. Scandlen. I understand exactly what you're saying, sir, and I appreciate the question. I think it's important to make a distinction between insurance and prepaid health care, and payment for ordinary health care needs. A lot of the things that have been mandated around the country are actually fairly low-cost services. Mammography screening doesn't cost very much. And that's exactly the sort of thing that should start us rethinking the way we finance this stuff. It would be appropriate for medical savings accounts or a health reimbursement arrangement, a pool of cash from which people can pay directly, rather than processing it through an insurance mechanism. It's a very expensive way of paying for a service like that, putting it through an insurance company.

At the same time, your idea of the massive insurance pool is absolutely right also. And that's what you need the high deductible, or the backup, or the stop-loss policy for, which is much more of a traditional sort of insurance that is there for catastrophic needs. Florence Lorel, the insurance commissioner here in the District, did some very nice articles making that distinction, and I could send them to you, if you'd be interested.

Mr. Payne. Okay. Thank you very much.

You know what? Since we're going to have a vote in a minute, let me tell you what I think should happen. I believe that the Federal Government should simply make a certain amount of money available to offset the cost of health insurance. I mean, to me it's almost like an entitlement. You said that you don't think that there would ever be universal benefit care, universal coverage, and it doesn't seem like it's going that way.

But to be truthful, it seems to me that everyone should be entitled to health care. I just think that it's a basic entitlement. And the way the costs keep going up, so many people uninsured, even working poor, cannot afford it.

I would just hope that one day we might decide that the cost of this is so high that the same way that we provide defense and other things that are very essential to our country. For example, our defense budget is going to be $400 billion this year, not counting Iraq. It's up to another $100 billion then.

Now, if we can do that yearly and provide for our common defense, it seems we could do the same to promote the general welfare as I learned in school, not to have the government simply say it costs too much. We want everybody to be healthy. They deserve it. And we should just have a line item for health just like we have for defense. But that's just my theory on it.

I'd like to yield back the balance of my time, Mr. Chairman.

Chairman Johnson. Thank you, Mr. Payne. We got through without the buzzer going off. That's marvelous.

I want to thank you all so much for your testimony. It has been very enlightening, and as we can see there is no agreement on either side. So we've got a long way to go. And frankly, I don't think any of us have the answer for how to deliver health care to the population and get more people insured, but we're going to try every way we can. So I thank you again for your time and testimony.

I don't know if you knew it or not, but Kristin Fitzgerald, this young lady behind us who is our aide, has been on leave for three months after having a baby. And we'd like to welcome her back to the Committee.

Thank you so much for your testimony. The Committee stands adjourned.

Whereupon, at 2:48 p.m., the Subcommittee was adjourned.

APPENDIX A - WRITTEN OPENING STATEMENT OF CHAIRMAN SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

OPENING STATEMENT OF REP. SAM JOHNSON (R-TX),
CHAIRMAN
SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS
THURSDAY MARCH 13, 2002

GOOD MORNING. LET ME EXTEND A WARM WELCOME TO ALL OF YOU, TO THE RANKING MEMBER, MR. ANDREWS, AND TO MY OTHER COLLEAGUES.

AS MANY OF YOU KNOW, THIS IS COVER THE UNINSURED WEEK. THAT'S ONE KEY REASON WE'RE HERE TODAY.

TODAY'S HEARING FOCUSES ON H.R. 660, THE *"SMALL BUSINESS HEALTH FAIRNESS ACT,"* AND HOW THIS BILL WILL EXPAND ACCESS TO HEALTH CARE FOR UNINSURED AMERICANS.

WE WILL HEAR FROM THE AMINSTRATION, A SMALL-BUSINESS OWNER, AND POLCIY EXPERTS ON THE AFFECT OF AHPS ON THE UNINSURED.

AS YOU RECALL, LAST SESSION THIS SUBCOMMITTEE TOOK THE LEAD REGARDING THE RISING COSTS OF HEALTH CARE AND HOW THEY IMPACT EMPLOYERS AND EMPLOYEES.

IN THE LAST YEAR ALONE, EMPLOYERS' HEALTH CARE BENEFIT COSTS HAVE INCREASED BY AN AVERAGE OF THIRTEEN PERCENT.

IN THE YEAR 2002, OVER 41 MILLION AMERICANS WERE UNINSURED. THAT MEANS THAT ONE IN SEVEN AMERICANS WENT WITHOUT HEALTH INSURANCE.

YOU MIGHT ASK, JUST WHO ARE THESE UNINSURED?

WELL… THEY ARE WORKING PEOPLE WHO SIMPLY DON'T HAVE ACCESS TO INSURANCE, CAN'T AFFORD IT, OR THEIR EMPLOYER CAN'T AFFORD TO PARTICIPATE IN A PLAN FOR THEM.

SIXTY PERCENT – OR 24 MILLION - OF UNINSURED AMERICANS WORK IN SMALL BUSINESSES. SOME OF THESE PEOPLE ARE OFFERED INSURANCE AND TURN IT DOWN BECAUSE THEY CAN'T PICK UP THEIR PART OF THE TAB.

AS THE LATEST *KAISER HEALTH POLL REPORT* REVEALS, MORE AMERICANS ARE WORRIED ABOUT HEALTH CARE COSTS THAN ABOUT:

- LOSING THEIR JOB,
- PAYING THEIR RENT OR MORTGAGE,
- LOSING MONEY IN THE STOCK MARKET,

OR

- BEING A VICTIM OF A TERRORIST ATTACK.

SPECIFICALLY, THE REPORT FOUND THAT:

> • NEARLY 40% OF AMERICANS SAY THEY ARE VERY WORRIED THAT THEIR EXPENSES FOR HEALTH CARE SERVICES OR HEALTH INSURANCE WILL INCREASE OVER THE NEXT SIX MONTHS;

STUDIES SHOW HEALTH CARE COSTS ARE RISING 15-20% A YEAR UNDER CURRENT RULES.

> • THESE SAME AMERICANS ARE VERY WORRIED THAT THEIR INCOME MIGHT NOT KEEP UP WITH RISING PRICES IN THE NEXT SIX MONTHS

TO COMBAT THESE PROBLEMS, I WORKED WITH A BIPARTISAN GROUP FROM THE HOUSE AND SENATE TO INTRODUCE THE *SMALL BUSINESS HEALTH FAIRNESS ACT* (H.R. 660) TO CREATE ASSOCIATION HEALTH PLANS (AHPS).

THIS BILL WOULD ALLOW SMALL BUSINESSES TO BAND TOGETHER THROUGH ASSOCIATIONS TO PURCHASE QUALITY HEALTH CARE AT A LOWER COST.

IT WILL SIGNIFICANTLY EXPAND ACCESS TO HEALTH COVERAGE FOR MANY OF THE 41 MILLION UNINSURED AMERICANS.

THE BILL WILL:

> 1) INCREASE SMALL BUSINESSES' BARGAINING POWER WITH HEALTH CARE PROVIDERS,
>
> 2) GIVE THEM FREEDOM FROM COSTLY STATE-MANDATED BENEFIT PACKAGES,

AND…

> 3) LOWER THEIR OVERHEAD COSTS BY AS MUCH AS 30 PERCENT.

THESE ARE ALL REAL BENEFITS THAT MANY LARGE CORPORATIONS LIKE GM, FRITO-LAY AND U.P.S. AS WELL AS MANY UNIONS ALREADY ENJOY BECAUSE OF THEIR LARGER ECONOMIES OF SCALE.

IT'S TIME WE LEVELED THE PLAYING FIELD FOR SMALL BUSINESS AND GAVE THEM THE HEALTH CARE CLOUT THEY DESERVE.

IT'S TIME THEY HAD ACCESS TO AHPS.

NOW I'D LIKE TO WELCOME ALL OF OUR WITNESSES. WE LOOK FORWARD TO HEARING YOUR TESTIMONY.

APPENDIX B - WRITTEN STATEMENT OF THE HONORABLE ANN L. COMBS, ASSISTANT SECRETARY, EMPLOYEE BENEFITS SECURITY ADMINISTRATION, U.S. DEPARTMENT OF LABOR, WASHINGTON, D.C.

TESTIMONY OF ANN L. COMBS
ASSISTANT SECRETARY FOR EMPLOYEE BENEFITS SECURITY
U.S. DEPARTMENT OF LABOR
BEFORE THE
SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS
COMMITTEE ON EDUCATION AND THE WORKFORCE
UNITED STATES HOUSE OF REPRESENTATIVES

March 13, 2003

Introductory Remarks

Good afternoon, Chairman Johnson, Ranking Member Andrews, and members of the Committee. Thank you for inviting me to discuss the Administration's initiatives to expand health insurance coverage, and specifically our support for Association Health Plans (AHPs) to increase coverage offered by small employers. This hearing is especially appropriate during Cover the Uninsured Week. I commend the Committee for holding a hearing on AHPs – a proposal that is directly responsive to the need to increase access to affordable quality health insurance.

I am testifying before you today on behalf of the Employee Benefits Security Administration or EBSA, formerly the Pension and Welfare Benefits Administration. EBSA is the primary agency that will be overseeing AHPs. Our new name reflects the Bush Administration's commitment to improved public service by making the agency more recognizable to those we serve. We want to enable Americans to better identify the federal agency that assists them in understanding and receiving their employment-based benefits, including health insurance. With this tradition in mind, I am committed to making effective oversight and enforcement of AHPs a top priority for EBSA.

More than 41 million Americans lack health insurance, and fully 85 percent of the uninsured are in working families – with most working at firms with fewer than 100 employees. In fact, workers in small firms and their families comprise 60 percent of the working uninsured. To increase health insurance coverage, the President has proposed a comprehensive reform agenda that includes tax credits for the purchase of individual coverage, expansion of the availability of medical savings accounts (MSAs), greater access to state-based high-risk insurance pools, medical malpractice reform, and AHPs.

As we all know, a great deal of work needs to be done, and I applaud the leadership of this committee for focusing on the health care needs of small employers and their employees. I especially want to thank Chairman Johnson and the bipartisan supporters on this committee for your leadership on AHPs. I look forward to working with you to pass this important legislation.

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 49 percent of these small businesses offer insurance, compared with 98 percent of larger firms with 100 or more employees. The picture is especially troubling at "low-paying small firms" (defined in a study as firms with fewer than 100 employees where more than half of the employees earn less than $9.50 per hour) where only 34 percent offer insurance to their employees.

The difficulties that small businesses face in trying to offer quality, affordable health insurance explain a significant part of America's uninsurance problem. Small firms employ 42 percent of all workers. Yet these workers and their families comprise 60 percent of the working uninsured.

We know that small employers want to offer health insurance to their workers and their families. Among 600 small businesses responding to a recent 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. Small business employees also value health insurance. According to a recent survey, health insurance was ranked as "very important" by 89 percent of small business employees. AHPs can help make coverage a reality for more small businesses – the challenge we face is how to make AHPs a reality.

While tax credits, MSA expansion and other policies will all help increase coverage, AHPs are aimed squarely at the gap in coverage among small businesses. In order to understand how AHPs will expand coverage, it's important to understand the economic and market 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 that want to provide health insurance. 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. Cost drivers include small businesses' administrative overhead, insurance company marketing and underwriting expenses, adverse selection, and state regulatory burdens. Small firms are likely to offer less generous benefits and more of their premiums are consumed by administrative costs. Furthermore, small firms' lack of market power increases their vulnerability to insurance fraud.

In addition, small employers' costs are rising more rapidly than those of larger employers. Total costs per employee increased by 18.1 percent at firms with 10 to 500 employees in 2002, compared with 11.5 percent at larger firms.

Employees in small businesses bear the brunt of these cost increases, according to a recent survey by the Blue Cross Blue Shield Association (BCBSA), the Employee Benefit

Research Institute (EBRI), and the Consumer Health Education Council. Of the 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.

Rising health insurance costs are a significant barrier for employers to hire workers and keep their businesses afloat. According to a recent Conference Board poll of 120 chief executives, health insurance costs were cited as the greatest impediment to adding workers in 2001 and 2002. Almost 82 percent of 1,017 members surveyed by the Connecticut Business and Industry Association in 2002 said rising health insurance costs were "an important factor" in decisions about whether to add workers. In April 2002, the Small Business Association of Michigan commissioned a poll on the impact of rising health care costs on small businesses. They found that nearly a quarter of all small business owners (and 40 percent of women and minority-owned businesses) fear the high cost of health insurance would force them out of business.

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 General Accounting Office, 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. Indeed, between 1995 and 1997, businesses with fewer than 10 workers were seven times as likely to drop coverage as the average business, and about 4 times as likely to add it.

Underwriting: 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, 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 cause the employer to pay much higher premiums.

Faced with high premiums and limited budgets, small employers often share the costs with their employees. In the worst-case scenario, healthy workers will balk at higher costs and may not accept the offer to purchase insurance, thereby 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 perilous outcome.

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.

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. 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.

Vulnerability to Fraud: Small employers are also especially vulnerable to health insurance fraud – scams that promise low-cost health coverage, but fail to deliver. 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. While many MEWAs operate successfully and provide reliable benefits, unscrupulous promoters have exploited MEWAs' complex regulatory and oversight structure to operate Ponzi schemes that collect premiums but intentionally default on benefit obligations. Fraud increases the cost for everyone, and the fear of being taken in deters many small employers from offering coverage at all. AHP legislation will help protect against this type of abuse.

Current Anti-Fraud Activities of the Department of Labor

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 that is certified, regulated, and closely monitored by the Department of Labor.

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 many cases, recovering money for their victims.

Education and Outreach: Through our outreach, education and assistance programs, EBSA has made educating small employers a top priority.

EBSA provides guidance to small employers on how they can avoid purchasing health coverage from fraudulent MEWA operators. In an effort to educate small businesses about

these risks, Secretary of Labor Elaine L. Chao recently wrote to over 80 business leaders and associations requesting them to distribute and follow simple tips drafted by EBSA, entitled "How to Protect Your Employees When Purchasing Health Insurance." These tips, which are also highlighted on EBSA's website, offer important warning signs for small businesses to consider about coverage that is "too good to be true." Checking simple information can alert small employers to fraudulent schemes. We 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.

EBSA also has published technical assistance materials for employers and service providers. Materials 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.

Enforcement: In addition to education efforts, EBSA continues to devote significant resources to enforce existing health laws and to work 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 abusive MEWAs. Our 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. As a result of our civil enforcement efforts, the Department achieved monetary results of almost $9 million in FY 2002, which helped strengthen the financial integrity of MEWAs or helped pay benefits for innocent victims 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 12, 2003, EBSA was pursuing 116 civil and 25 criminal investigations of alleged fraudulent health plans.

Examples demonstrating the level of fraud perpetrated by unscrupulous MEWA operators are numerous. In one recent prosecution, EBSA 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. Criminal sanctions are also being pursued.

The AHP Solution: Reduced Barriers, Reduced Costs, Reduced Fraud

With this background on the current small business health insurance market and EBSA's enforcement activities, let me now describe the advantages of AHPs. In an AHP, the current market and financial barriers that face small businesses would be reduced or eliminated. Small businesses would enjoy greater bargaining power, economies of scale, administrative efficiencies, and the benefits of a uniform regulatory structure, giving them more access to affordable coverage.

An AHP is basically an arrangement where a group of small employers join together through a *bona fide* association to purchase or provide health insurance coverage for their employees, under the protective umbrella of ERISA. In essence, AHPs would give small employers many of the economic and legal advantages currently enjoyed by large employers.

Bargaining Power and Economies Of Scale: By grouping small employers 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 potentially 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 uniform regulatory system. For AHPs that offer fully insured coverage, state insurance commissioners would be responsible for the solvency of the insurance company issuing the policy, just as they are responsible for insurance policies issued to group health plans today. It should be emphasized that under the current legislative proposal, the states will continue to play a vital role in making AHPs work. The goal of AHP legislation is not to undermine the states' authority to ensure insurer solvency or consumer protections; the goal is simply to allow AHPs to operate uniformly on a nationwide basis, without having to comply with the requirements of 50 different regulatory systems. Fully insured AHPs would purchase insurance products with solvency standards and consumer protections regulated by the states.

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 and there would be no confusion or uncertainty over whether the states or the Department of Labor regulate certain aspects of the entity.

Pooling Risk: AHPs would help ensure that small employers will not be denied insurance coverage or be 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 small businesspersons who are currently uninsured to purchase coverage and pay into the premium pool. Given the current number of uninsured small business workers and dependents, this broadening of the risk pool will exert downward pressure on health insurance premiums.

Cost Savings and Increased Coverage: Small businesses obtaining insurance through AHPs could enjoy significant premium reductions. According to the Congressional Budget Office (CBO), the average savings would be at least 9 percent and could be as much as 25 percent per employer. CBO further estimates that, because insurance will be more affordable, as many as 2 million Americans will be brought into the employment-based health insurance system. Indeed, CBO's predictions may be too conservative. A study by the CONSAD Research Corporation foresaw larger gains, estimating that up to 8.5 million workers and dependents could gain coverage from AHP legislation.

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 Black Chamber of Commerce, United States Hispanic Chamber of Commerce, Women Impacting Public Policy, American Farm Bureau, 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. " The American Society of Mechanical Engineers (ASME) looks to AHPs to help make health coverage more affordable for 19,000 of their members in nine states who have no access to the ASME group health plan due to the high cost of mandated benefits.

Ensuring That AHPs Keep Their Promises

EBSA has firsthand experience dealing with group health plan regulation, as well as combating insurance fraud. EBSA administers the Employee Retirement Income Security Act (ERISA), protecting approximately 2.5 million private, job-based health plans and 131 million workers, retirees and their families. Of these, 275,000 plans covering 67 million individuals are self-insured, and therefore subject exclusively to EBSA oversight. In addition, self-insured multiemployer plans (established and operated jointly by a union and two or more employers) are overseen exclusively by EBSA. These plans cover more than 5 million participants, not counting their covered dependents.

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 at least three years will be allowed to sponsor these arrangements. EBSA will examine AHP sponsors and certify them if they meet this standard, as well as tough solvency and membership requirements. Certification is a "stamp of approval" signifying to small employers that an AHP will provide reliable, affordable health insurance coverage.

To combat fraud, 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 a financially secure and reliable operation. We will take that responsibility with the seriousness it deserves. Certified AHPs – both self-insured and those that purchase commercial insurance coverage – would be subject to rigorous DOL oversight.

To gain certification, a self-insured AHP would have to demonstrate that its premiums are adequate to cover its claims and operating expenses, that it has sufficient assets to ensure stability, and that it has secured backup insurance to cover unexpectedly high losses. In addition, a fund will be established under DOL oversight to continue to pay stop-loss indemnity insurance premiums to cover outstanding claims in the event that an AHP becomes insolvent and unable to maintain its coverage.

AHPs that purchase insurance coverage do not present the same level of financial risk as self-insured plans, but nevertheless will also be subject to DOL certification to ensure that the organizations offering the coverage are legitimate. We will work with the states and their insurance commissioners to establish appropriate procedures through their existing insurance regulatory programs to see to it that state-based solvency requirements and necessary consumer protections for insured products will benefit workers and their families with fully insured AHP coverage.

Safeguards Against Insolvency: An AHP that offers self-insured coverage will be required to establish premium rates that are adequate to cover claims and maintain adequate reserves, as determined by a qualified actuary. Self-insured AHPs will also be required to keep additional funds on hand to cover unexpected losses. AHPs will also have a funding mechanism in place to ensure that claims can be paid if an AHP becomes insolvent. These provisions generally parallel the requirements that states impose on health insurers, and are of the utmost importance to ensure that AHPs will deliver on their promises. Our goal is to require effective and strong solvency protections.

Safeguards Against Cherry-Picking: The Bush Administration is committed to legislation that broadly spreads risk and makes insurance affordable for all small employers regardless of health status. 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 "cherry-picking" by insurers 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.

The current AHP legislation is designed to ensure that AHPs pool risk broadly, and thereby make insurance affordable for all participating small companies – including those whose employees or employees' families suffer from ill health. Provisions directed at this purpose include:

- Only *bona fide* associations, which are in existence for at least three years for purposes *other than* providing health insurance, can operate an AHP. This protection ensures that AHPs cannot be formed solely for

the purpose of marketing health insurance, a practice historically associated with abuse. It also serves to provide a built-in incentive for AHPs to offer quality coverage; just as employers want to offer meaningful health benefits to attract and retain employees, bona fide associations will want to offer their members quality health coverage that will attract and retain association members.

- A self-insured AHP must represent a broad cross-section of businesses, allowing risk to be spread among diverse groups.
- AHPs and participating employers may not selectively direct higher-risk employees to the individual insurance market.
- AHPs must offer all available options to all employers and individuals in the association.
- The Health Insurance Portability and Accountability Act (HIPAA) will apply to AHPs. Under HIPAA, group health plans are subject to portability, pre-existing condition, nondiscrimination, special enrollment, and renewability provisions.
- The newest version of AHP legislation, H.R. 660, has been strengthened to ensure that AHPs could not charge a participating company or employee more than another on the basis of the health status of the companies' employees or their families, except as allowed under current state law.

These provisions constitute strong protections against cherry-picking, and we look forward to working with Congress to further ensure that AHPs cannot cherry-pick healthier groups and individuals.

ERISA, HIPAA and Other Laws: Like other group health plans, AHPs will be subject to the fiduciary requirements of ERISA, which sets 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 (MHPA), and the Newborns' and Mothers' Health Protection Act (the Newborns' Act) would apply to AHPs.

I am proud of the Department's efforts to ensure that American workers and their families benefit from the important federal protections passed by Congress in the late 1990s. EBSA announced on February 26, 2003, a new compliance assistance program to help group health plans successfully implement HIPAA, MHPA, WHCRA and the Newborns' Act. The new compliance assistance program was announced jointly with the results of a statistically valid audit of health plan compliance with these laws. These efforts are the most recent example of the Department's ongoing commitment to effective regulation, implementation and enforcement of federal health laws that benefit millions of Americans in both fully insured and self-insured health plans.

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 Association Health Plans are a substantial solution to this problem. The Bush Administration strongly supports AHPs, and stands ready to work with members of Congress and this Committee to help pass and administer legislation that expands access to affordable quality health insurance coverage for working Americans and their families.

APPENDIX C - WRITTEN STATEMENT OF PHYLLIS M. BURLAGE, PRESIDENT, BURLAGE ASSOCIATES, PA, MILLERSVILLE, MD, TESTIFYING ON BEHALF OF THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Testimony of Phyllis M. Burlage,
President
Burlage Associates, PA
before the
United States House of Representatives
Committee on Education and the Workforce
Subcommittee on Employer-Employee Relations

H.R. 660, the Small Business Health Fairness Act of 2003

March 13, 2003

Good afternoon Mr. Chairman and Members of the Committee. Thank you for inviting me today to talk about the important issue of affordable, accessible health insurance, especially for those owning or working for small businesses. I am pleased to be here on behalf of the National Federation of Independent Business (NFIB), representing 600,000 members who face a similar challenge.

My name is Phyllis Burlage, and I own Burlage Associates, PA, a small accounting firm based in Millersville, Maryland. At Burlage Associates, my employees and I work together to help individuals and small businesses comply with federal, state, and local tax regulations.

After passing the Certified Professional Accountant (CPA) exam and working for a larger firm in 1981, I wanted greater flexibility in my schedule. So, in 1986, I opened up my own business. Owning my own business has been rewarding, but the pressures and responsibilities are great. I am proud to say that I have grown my business by 20 percent since 1986 and, today, I serve over 300 clients! As you know, this is a very busy time of year for me but I am thankful for the opportunity to share my story with you, Mr. Chairman.

I have three employees whose skills vary with their level of experience. My right hand woman is thirty-four years old and has worked for me since 1995. She started as a secretary/clerk but has developed her position by assisting me with computer, accounting and tax projects. The other two women, one of whom is seventy years old, handle the bookkeeping, billing, filing, and assembly of tax returns and financial statements. In addition to my dedicated full-time employees, I hire a student during tax season to assist with computer input of tax return data. I am pleased to say that the students typically return annually until they graduate.

Like many entrepreneurs, I learned early that I could not compete with large corporations in the area of extensive benefit packages. Therefore, I pay in flexibility; by this I mean, flexible hours and a family-friendly environment. My employees bring their children into the office and they are allowed to work around their children's school schedules and

events. I have even gone the extra mile and provided a computer in their homes so they can "dial in" when their children are sick so they do not lose time away from work.

Unlike other small women-owned businesses I know, I have been able to offer health insurance as a benefit since the day I opened my business. I knew that I wanted to provide a quality plan – medical, dental and vision coverage, with a wide network of doctors. Thankfully, I am able to provide a comprehensive benefit and pay 100 percent of my employees' health care insurance. Each employee is eligible to participate after thirty days of working for me. I initially pay for the employee only. Then, I offer dependent or family coverage as a form of a raise. Right now, I pay for one of my employee's daughters. I would enjoy being able to pay for her husband's care but am unable to afford the expense at this time. I hope to begin paying for his health care in the future as a bonus to this employee.

Every year in March, I hold my breath when the letter comes from my insurance agent listing the rates for the upcoming year. I have had to change my provider from CareFirst to New York Life to Optimum Choice solely based on price. Maryland offers very few choices, as many providers will not come into the state due to the sheer volume of regulations and state mandates. I administer our plan and every year I look for alternatives: there are none. Two weeks ago, I received my renewal in the mail and my insurance is increasing again.

My rate hike this year is 45% with our health maintenance organization (HMO). This is real money since I absorb all the cost increases for my employees. Since 1996, my company has experienced a 226% increase in premiums – how can any business survive with these types of increases over just a few years? This year our rates went from $226 to $265 for an individual; from $476 to $557 for an employee and her spouse; and, the cost skyrockets to $750 a month to add a family, up from $651 only a year ago. I may have no choice but to raise my clients' fees to cover our company's health care costs, but in this economy, I may then lose these clients to competitors. It's a vicious cycle for business owners.

Each year, I search for a plan, and I remain quite surprised how difficult it is to find an insurer willing to write our policy. As I mentioned, I have changed plans three times in the past four years and am looking at changing this year as well. Health insurance is important to me and to my employees. We work together to evaluate our options, including higher deductibles and co-pays. But, we know that in spite of our best efforts, the cost will increase every year because our rates are based on the average age of the insured. And, since my "group" consists of three people, there is no pool to offset the fact that we get older every year.

While I continue to struggle to provide affordable coverage, some of the big insurance companies have announced record profits the last few quarters. I support businesses being successful, but when I am faced with double-digit increases every year or when my colleagues cannot provide insurance to their workers, I feel that the insurance industry is more worried about their profits than my ability to afford health care for my employees. I have to compete so why shouldn't insurance companies? Simply put, the lack of

competition in the small group market is making insurance company executives richer at small businesses' expense.

For example, recently in my home state of Maryland, WellPoint Health Network Incorporated, the biggest publicly traded BlueCross BlueShield health plan, attempted to purchase the nonprofit CareFirst BlueCross BlueShield. Fortunately, Commissioner Larsen denied the conversion, citing, "...that the decisions to convert and be acquired were inappropriately influenced by the prospect of large payouts for some individuals." By this, the Commissioner meant the initial $119.7 million bonus plan for the Blues' executives. In addition, the drive for profitability lead CareFirst to seek "excessive" premiums for policies for chronically ill members, and to drop some sick members when its FreeState HMO was merged into a new HMO, BlueChoice. What is so interesting about this situation is that, despite state oversight, these insurance companies found ways to "cherry pick" the healthiest individuals.

Administrative expenses also cripple small businesses providing health care. A recent actuarial study released by the U.S. Small Business Administration (SBA) shows that administrative expenses for health-insurance plans that cover small businesses are significantly higher than those that cover larger groups. Specifically, the SBA study reports that administrative costs for businesses, like mine, range from 33 to 37 percent of the cost of claims, as opposed to just 5 to 11 percent of the cost of claims for large companies' self-insured plans. We must stay focused on the true crisis in health care -- and in the economy as a whole -- the skyrocketing cost of health insurance.

In every professional meeting I attend with other women-owned small businesses, the subject of health insurance costs come ups. We are afraid that we will not be able to cover our employees and ourselves nor continue to attract qualified employees if we cannot offer coverage. But do not take this to mean that we want the government to do it. We are proud to be independent businesses and proud to take care of our employees. We just need an affordable solution. We need to be able to spread out the risk over more than our own employee group.

The small business community is struggling each year to afford the cost of increasing premiums. It is for this reason that I support H.R. 660, the Small Business Health Fairness Act of 2003, legislation endorsed by NFIB that would create Association Health Plans (AHPs). AHPs would allow small business owners to band together across state lines to purchase health insurance as part of a large group, thus ensuring greater bargaining power, lower administrative costs and freedom from the costs of complying with 50 different sets of state insurance mandates. Fortune 500 companies and labor unions already have this ability. AHPs will simply level the playing field and give small employers the same privileges as their counterparts in labor and big business.

In addition, AHPs will introduce into the marketplace much needed competition and diversity. Without the ability to shop for more affordable options, we are left with the choice to shift costs or drop coverage. Association health plans would end the nightmare of health care purchasing for small businesses.

Like most small business owners, I talk to a lot of people every day; to be competitive on Main Street, you have to. I know from talking to other women who own small firms that AHPs would be a great option for small business owners. I know from talking to other accountants that they and their clients need AHPs. Now, I'm a businesswoman, not a health policy expert, but I do know that there is a lot of debate about how to insure more Americans and how to help those currently insured continue to afford their coverage. AHPs are a good, common sense solution to controlling the cost of quality health care.

Mr. Chairman, thank you for allowing me to share my experience with you and the Members of the Committee. I look forward to the relief that will come from Congress enacting AHPs and I am happy to answer any questions that the Committee may have.

APPENDIX D - WRITTEN STATEMENT OF PHYLLIS M. BURLAGE, PRESIDENT, BURLAGE ASSOCIATES, PA, MILLERSVILLE, MD, TESTIFYING ON BEHALF OF THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Testimony of Alice M. Weiss
Director of Health Policy
National Partnership for Women & Families
Before the
U.S. House Committee on Education and the Workforce
Subcommittee on Employer-Employee Relations
Hearing on "H.R. 660, The Small Business Health Fairness Act"
March 13, 2003

Good morning, Chairman Johnson, Ranking Member Andrews, and other members of the Committee. My name is Alice Weiss and I am Director of Health Policy for the National Partnership for Women & Families. Thank you for the opportunity to testify today at this important hearing on H.R. 660, the Small Business Health Fairness Act. I appreciate the opportunity to share the National Partnership's views on this proposal and to recommend some guiding principles that the Committee should follow in developing legislative solutions to the crisis that small employers now face in finding affordable health insurance for themselves and their workers.

The National Partnership for Women & Families is a non-profit, nonpartisan advocacy organization that has long fought for women and families' rights to economic, employment, and health security. Formerly the Women's Legal Defense Fund, the Partnership has more than 30 years' experience promoting fairness in the workplace, access to quality health care, and policies that help women and men meet the competing demands of work and family. Over the past decade, the Partnership has advocated for sound reforms for our health care system to help the uninsured. Today, we are concerned about the access barriers that small employers, their workers, and other uninsured individuals are facing.

Women and families have a great deal at stake in the health coverage crisis that small businesses now face, both as small business owners and as workers and dependents. The vast majority of America's women-owned businesses are small firms and these owners are struggling to find affordable coverage for their workers. Women are also disproportionately likely to work in low-wage jobs, which are often in smaller firms, or in part-time or retail and service sector jobs, where health coverage is rarely offered. Women are also more likely to earn less than men and to be working single moms, making every decision about how to spend precious dollars for health coverage even more important. Women are not only more likely to use health care services than men, but they also need access to benefits that are more expensive during their prime working and childbearing years, including coverage for maternity, reproductive health, and contraceptive services. For both women small business owners trying to do the right thing for their workers and themselves, and for women workers, especially low-wage workers, legislation that ensures high quality, affordable coverage is urgently needed.

My testimony today will discuss some of the barriers small employers and workers now

face and offer principles to guide members of the Committee and other members of Congress in developing solutions to these problems, namely that legislation in this area must put the uninsured first, ensure access to affordable, comprehensive coverage, help those most in need, and preserve strong consumer protections. My testimony will also highlight serious concerns we have about H.R. 660, which we feel would do more to hurt the uninsured than help. Finally, I will offer some alternative proposals that Subcommittee members should consider to address this problem.

Small Businesses at Risk

Our health care system is in crisis, and small businesses and their workers are particularly at risk. The number of uninsured is again on the rise, with more than 41 million Americans going without health insurance last year. The cost of private health insurance coverage has also been increasing steadily, with last year's increases estimated at 10.5%, while increases for small employer coverage have been even higher, ranging up to nearly 15% for firms employing fewer than 50 people. The confluence of health care cost increases and the economic downturn has forced many employers to trim benefits or drop coverage altogether. The smallest employers have been hardest hit by these trends, with coverage declining by 8% in the past two years among very small firms with fewer than 10 employees. And very small employers, while always less likely to offer coverage than their larger counterparts, are struggling to continue to offer coverage. In 2002, just over half (55%) of all small firms with fewer than 10 employees and about three-quarters (74%) of small firms with fewer than 25 employees offered coverage, while nearly all (99%) large employers with 200 or more employees offered coverage.

The barriers that small employers face in finding and offering affordable health coverage translate into higher numbers of uninsured and underinsured workers and dependents. In 2001, nearly four in ten (39.3%) of the 24 million workers who were uninsured worked for very small firms under 25 employees or were self-employed. And, as more employers respond to cost increases by passing costs along to workers in the form of higher premiums, deductibles, and out-of-pocket cost-sharing, more workers may find themselves joining the ranks of the uninsured because they are unable to afford these higher costs. Women, who are disproportionately likely to be small business owners or workers, have much at stake in the health coverage crisis small firms now face.

Women Have Much at Stake

Women are disproportionately likely to be either owners of or workers for very small firms. Nearly all of the firms owned by women business owners in 1997 were small firms, and most were very small firms of fewer than five employees. Women workers made up nearly half (48.3%) of all workers at very small firms with fewer than 10 employees, a greater than average percentage based on women's overall labor force participation rate of 45% for firms under 500 employees. Women are also more likely to work for low-wage employers, about three-quarters of which are smaller firms.

Survey findings recently completed by Lake Snell Perry & Associates for a collaboration between the Partnership and the Kaiser Commission on Medicaid and the Uninsured paints

a stark picture of women workers' experience of coverage at these low-wage and predominantly small firms. According to this survey, low-wage firms are far less likely to offer health coverage, with only 42% of all low wage firms offering coverage, compared with 65% of all firms. Very small employers (3 to 9 employees) are the least likely to offer health coverage, with only about one in four (23%) of all very small firms offering coverage to their full-time workers. The most disturbing finding was that the likelihood that a low-wage firm would offer health coverage declined as the percentage of women workers increased. The survey also found that low-wage firms in the sales and service sectors, industries traditionally dominated by women, are the least likely to offer health coverage.

The Lake Snell Perry survey also suggests that coverage provided to low-wage workers may be less generous and will likely cost more for workers. For example, the study found that nine in ten low-wage firms impose some waiting period before workers can begin receiving coverage after they start working, with one in five (20%) of these employers imposing waiting periods of as long as 3 to 12 months, far longer than the national average of a 1.6 month waiting period for all firms. Smaller low wage firms were also less likely to offer full family coverage, leaving workers without the option of having their children covered through employment. And the survey found that smaller low-wage firms often do not contribute as generously toward the cost of employee coverage: one in four (23%) of smaller firms who offered coverage contributed only 50% or less. By contrast, only a handful (3%) of all employers contribute less than 50% toward the cost of employee coverage.

This survey also provides some important insights regarding low-wage and smaller business owners' experience of this coverage crisis. According to the Lake Snell Perry study, three out of four (76%) employers who gave a reason for why they chose not to offer health coverage cited high costs. Low wage and smaller firms are also motivated by the same reasons as other employers to offer coverage to their workers, with the majority (51%) saying they offered coverage to attract and retain employees, and others saying they did it to keep employees healthy or because it is "the right thing to do." The bottom line is that women pay the price – they pay as workers when they don't have access to affordable coverage and they pay as business owners when they can't make good on their intention to do the right thing. Most of these small and low- wage employers want to offer coverage – we need to do a better job of offering policy solutions that will assist them in helping their workers and themselves.

Principles for Legislation

Given the significant barriers that small employers and their workers now face in accessing health coverage, it is now imperative that Congress enact legislation to help small businesses and their workers access affordable, quality health coverage. We have developed the following principles to guide our analysis of whether legislative proposals meet the criteria needed to truly solve this problem:

- *Cover the Uninsured First*: Any legislation that is enacted must provide new coverage for substantial numbers of the uninsured as a top priority.

Merely shifting the already insured from one type of coverage to another - "churning" the marketplace - is not enough. With 41 million American workers and their families now uninsured and coverage rates declining, new legislative initiatives in this area must not only provide new coverage, but also guarantee that the new coverage mechanism neither disrupts the current system leading to greater numbers of uninsured, nor undermines access to care for those most in need.

- *Ensure Affordable, Comprehensive Coverage*: New coverage options will provide little help unless the coverage that is made available is both affordable to the low-income populations in need and comprehensive enough to meet the needs of the uninsured. Without guaranteeing these key components, legislative solutions may appear to solve the problem in the short-term, but only create more long-term problems for the newly insured and the system as a whole. If the coverage is too expensive, few will buy it. If the coverage offers only minimal catastrophic protection, but forces individuals to pay for most medical treatment, or excludes coverage for more expensive services like preventive screening tests, maternity coverage, mental health services, prescription drugs, or the treatment of high-risk or chronic illnesses, it will set in motion a new cost-shifting paradigm that could threaten to increase the ranks of uninsured. Research has shown that individuals without coverage for health services are more likely to delay seeking needed treatment, which can pose new health risks for individuals and drive up the costs of treatment. Individuals who are not covered for expensive treatments and can't afford to pay will seek uncompensated care through treatment in community health centers or emergency rooms. And research suggests that the ultimate costs of uncompensated care are disproportionately borne by hospitals, providers and health clinics, who make up for these losses by increasing their rates, driving up the costs for all privately insured individuals. Thus, if the coverage option fails to ensure access to affordable, comprehensive coverage, it not only imperils access for the uninsured, but also threatens to increase costs for the privately insured, possibly leading to an even greater number of uninsured.
- *Help Those Most in Need*: New coverage options must not marginalize or overlook those most in need of health coverage, including older, disabled, and chronically ill individuals as well as women, who generally use more health care services than men. About one in four (27%) uninsured Americans has at least one chronic condition that puts them at greater need for coverage and at risk for discrimination based on health status. A policy solution that ignores these populations fails to meet the needs of the uninsured and perpetuates wrongful discrimination on the basis of health status.
- *Preserve Strong Consumer Protections*: Over the past two decades, all 50 states and the District of Columbia have passed tough consumer protection laws in response to abuses in the small group health insurance market. These reforms have ensured greater stability in the

> small group market, protected against many forms of rating abuses such as discrimination based on health status or "cherry picking" healthy risks, and improved the quality of coverage that is available to small employers and their workers. States also have substantial direct oversight of insurance companies and can hold companies accountable for insolvencies, fraud, mismanagement, and misrepresentation. These benefit, rating, oversight, and enforcement protections must be preserved to protect small firms and workers from new instances of fraud and abuse. Without these critical protections, individuals paying into the system have no guarantee that what they paid for is what they will get.

In considering legislative solutions to the problems facing small businesses and their workers, the Partnership urges Committee members to keep these guiding principles in mind and apply them to assess the quality of proposals being offered.

Association Health Plan (AHP) Legislation Prompts Consumer Concerns

Members of Congress in both the House and the Senate have now introduced association health plan (AHP) legislation as the solution to the problems small businesses and their workers are facing. H.R. 660, the Small Business Health Fairness Act, is premised on the idea that new federal legislation is needed to allow small employers to band together and purchase health coverage through new, federally regulated "quasi-insurance" plans offered by associations. Proponents have argued that AHPs need exemption from state regulation to lower costs and improve access to health insurance, and to "level the playing field" between small and large employers, allowing small employers to compete with larger employers that now have the option of exempting themselves from state regulation by "self-insuring" the health plans they offer.

While it is unclear whether small employers need new federalized AHPs to achieve these goals, several aspects of H.R. 660 pose serious risks for consumers. H.R. 660 includes three basic provisions that make the legislation problematic for consumers:

> 1. *AHPs Are Allowed to "Cherry Pick" Healthy Risks*: Despite proponents' assertions that the H.R. 660 has "fixed" any "cherry picking" problems, H.R. 660 gives AHPs several ways to attract only healthiest individuals into the plan, leaving the more expensive unhealthy individuals for other insurers to cover. First, AHPs are allowed to offer coverage only to certain target industries, thereby excluding industries that have a history of higher health claims experience. Second, AHPs are given almost complete discretion over the benefit package design, enabling them to design a more minimal benefit package that will deter those who need more services from joining the AHP. Third, AHPs can offer different plans to different employer groups based on "geographic availability," a limitation that gives AHPs the opportunity to deter less healthy employer groups (e.g., from

rural or urban areas) from joining the AHP, by making the most generous benefit package available only to healthy groups (e.g., suburbanites).

Perhaps most importantly, although H.R. 660 bars AHPs from discriminating against individuals and employer groups based on "health status related factors" as defined in HIPAA, the bill still includes a critical loophole that will allow AHPs to boldly discriminate against the entire employer group based on claims experience. This means that AHPs will be able to charge higher rates for less healthy employer "groups," either at the outset or at the time the first claim for benefits is made, effectively deterring less healthy groups from joining or staying in the AHP. H.R. 660 also includes a second loophole that exempts AHPs from all of the group protections against discrimination if they are operating in a state that permits associations to vary contribution rates based on claims experience. Put simply, H.R. 660 claims to protect against AHP "cherry picking," but effectively opens the door to a range of rating abuses that will result in dramatic risk segmentation. These "cherry picking" techniques enable AHPs to enroll only the healthiest individuals, which would save money for the AHP, but would also leave behind those who need coverage the most. By allowing AHPs to abandon less healthy groups for the state regulated market to cover, H.R. 660 will drive up the cost of coverage for everyone in the state regulated market, causing some employers to drop coverage altogether.

2. *State Regulation is Preempted*: Depending on whether the AHP chooses to offer self-insured or insured health plans, AHPs are either mostly or completely exempt from state oversight and regulation under these proposals. States now regulate the small group health insurance market in three basic and fundamental ways. First, all states have enacted a number of benefit and access mandates designed to ensure consumers will get the insurance coverage they paid for. Such mandates now include requiring coverage of maternity benefits, mental health coverage, breast and cervical cancer screening, contraceptive drugs and devices, direct access to ob-gyns or nurse-midwives, to name only a few. Second, all states have enacted important rate reforms over the last two decades that have created greater stability in the small group insurance markets. These rating requirements generally limit how much an insurer can charge for coverage, with some setting "bands" of pricing (upper and lower limits for rates charged) and others limiting an insurer's ability to charge higher premiums or deny coverage based on health status. These requirements generally serve to protect small employers against unfair pricing and discrimination. Finally, states use their direct

oversight of insurers to protect consumers against unfair claims practices, false or misleading advertisements, fraud, and insolvency. The AHP legislation would generally remove all of these critical protections, denying consumers the substantive protections they need to ensure that AHPs will make good on their coverage promises.

3. *AHPs Subject to Nominal and Inadequate Federal Oversight*: In place of very specific and stringent state regulation, AHP legislation would establish only nominal and inadequate federal standards and oversight under the U.S. Department of Labor (DOL). DOL does not now have the resources to regulate these new plans directly, and neither the legislation nor the Administration's FY 2004 budget proposal authorize or pay for any new funds to assist DOL to fulfill its new role. In order to fulfill its role responsibly, DOL would need substantial new resources to be able to provide direct and immediate assistance and oversight with consumer complaints, as states now do. In 1997, DOL Assistant Secretary Olena Berg testified that DOL simply does not have the resources to directly oversee the plans it now regulates and estimated that a complete audit of every pension and health plan it regulated would take 300 years. As the funding for the agency that would have oversight for AHPs has not shown substantial increases in the past five years, it is unclear how their capacity to regulate AHPs could have improved enough to enable them to take on the significant new responsibilities created under H.R. 660.

DOL would also need to be able to initiate targeted enforcement actions against AHPs that failed to meet the new federal requirements. However, DOL's enforcement policy for ERISA violations has historically required proof of a pattern or practice of violations before an enforcement action is initiated – this would leave individual consumer complaints ignored or their resolution delayed as an investigation proceeds. DOL's recently released "Health Claims and Disclosure Issues FY 2001 Compliance Report" provides an important example of the problems consumers could face if DOL were given increased responsibility to regulate AHPs. Although this report represents an important step forward in DOL's oversight of health plan compliance with current requirements, it unfortunately falls short of the enforcement standards consumers need. First, the report relies on random sampling, not targeted direct reporting or oversight, to determine compliance – this means a number of non-compliant plans may be falling through the cracks. And, even though the report merely sampled compliance among a relatively small number of plans, the timeframe for DOL to report on its

> findings was too long to be meaningful or effective in protecting consumers – this report was just issued in January of 2003, reporting on plan's compliance in FY 2001. This type of oversight of health plan compliance lacks the stringency and intensiveness of targeted direct state oversight and would be far less effective to ensure consumer protection than the state mechanisms already in place.
>
> Perhaps most importantly, the new federal solvency standards for AHPs are minimal and weak. State solvency standards are tough enough to ensure that insurers can manage the risk they are taking on, requiring detailed annual reporting, audits by independent actuaries, and for insurers to meet strong risk-based capital rules that grow with insurer size. By contrast, the new federal requirements only require financial reporting after the AHP is near insolvency, allow AHPs' own actuaries to certify solvency, and set a low $2 million cap on surplus capital that is inadequate for larger plans. And the federal rules fail to provide a guarantee fund comparable to those common in the states that protect consumers and providers against insolvencies by paying all unpaid medical bills when plan funding fails. In short, the new federal oversight will not be strong enough to protect consumers against possible AHP fraud and abuse.

As this analysis demonstrates, consumers have much to fear from this legislation as it is now drafted: the loss of protections against discrimination, the loss of state consumer protections, and a new federal regulator with minimal oversight or ability to protect consumers. The relevant question for policymakers is whether the AHP proposal's benefits of providing new coverage for small businesses outweighs these clear and tangible costs. The principles I outlined above provide a helpful framework for making this determination.

AHP Legislation Fails to Meet Principles:

Applying the principles I outlined earlier for sound legislation to help small businesses and their workers, it becomes even clearer that H.R. 660 is not the right policy solution. In fact, the proposal fails to meet every one of the key principles for a responsible solution to the problems facing small businesses and their workers:

- *Fails to Provide Meaningful Help for the Uninsured*: AHP legislation simply offers no solution for the problem of the uninsured. According to the Congressional Budget Office (CBO), AHP legislation like H.R. 660 would provide new coverage to only 330,000 individuals. That amounts to less than 1% of uninsured Americans. CBO also determined that nearly all of the 4.6 million individuals who would be covered by AHPs would merely switch from one type of coverage to another. As discussed above, AHPs will save money by "cherry picking" the

healthiest individuals into their plans, leaving the less healthy behind to drive up costs in the state-regulated market. In part due to AHPs' ability to "cherry pick" these healthy risks, CBO found that 4 out of 5 of those covered by small employers today, about 20 million individuals, would end up paying higher premiums after the enactment of AHP legislation. CBO also estimated that at least 10,000 of those with the highest health care costs would lose coverage under AHP legislation because employers would be forced to drop coverage in the face of increased costs. Far from addressing the problem of the uninsured, H.R. 660 will only make the problem worse.

- *Fails to Ensure Access to Affordable, Comprehensive Health Coverage*: While AHPs would lower premium costs for the 4.6 million healthiest individuals that would be covered, AHP legislation like H.R. 660 would actually increase health care costs for the majority of small businesses and their workers and lower the quality of coverage for most affected. CBO found that AHPs would lower costs for small businesses in two ways – through preemption of state benefit and rating laws and by attracting healthier than average individuals to enroll. As noted above, AHPs would be left with almost unfettered discretion to design the benefits package as they choose and have several other ways of ensuring that only healthy individuals would join. Thus, in order to be successful and attract healthy risks, AHPs will save costs by trimming the benefits offered and keeping less healthy individuals out of the AHP. By trimming the benefit package, AHPs will effectively shift the cost of additional services to the individuals themselves, transferring health insurance costs to out of pocket costs, which will increase the actual spending by workers covered by the AHP. And, by disproportionately attracting healthy workers and keeping less healthy or older individuals out, the AHPs will increase the costs of coverage for those who remain behind in the state-regulated risk pool, thereby decreasing access to affordable coverage and likely lowering the quality of coverage that state-regulated insurers can provide. For these reasons, H.R. 660 will likely fail to improve the affordability and the quality of benefits.
- *Hurts Those Most in Need*: With AHP legislation like H.R. 660, healthy people win, while those most in need lose. Because AHPs would have to target the healthiest individuals in order to offer coverage at the lowest cost, older, disabled, chronically ill individuals, and individuals with mental health service needs will be left behind without help under this legislation. Women also have much to lose because they will likely lose coverage for the services they need that are now mandated under state law, including maternity coverage, preventive screenings and treatments for breast and cervical cancer, mental health services, and coverage for contraceptive prescription drugs and devices, to name a few. Precious federal resources should not be spent on subsidizing healthy people who are already insured while ignoring those most in need.

- *Undermines Strong Consumer Protections*: As is discussed above, H.R. 660 would preempt virtually all state benefit mandates, rating protections, protections against fraud and insolvencies, and direct oversight and enforcement. The proposal would eliminate virtually all of these critical protections, and replace them with minimal and inadequate federal oversight by the Department of Labor. No new benefit standards, rating protections, fraud and abuse protections, or protections against scams are created for the new federal authority. And the federal solvency standards, so critical to ensure that individuals ultimately get the benefits they are paying for from AHPs, are inadequate and self-serving. For example, the provision allowing the AHPs' own paid actuary to certify the AHP's solvency creates a clear "fox guarding the henhouse" problem. Taken as a whole, the legislation sacrifices critical protections consumers need without providing them with any place to go for meaningful assistance or protection if they have a problem, creating a new "wild, wild West" of insurance regulation at the federal level. There is no reason why these risks should be taken or imposed in an area where small employers and their workers have traditionally needed more, not less, help from regulators to protect them against fraud and abuse.

***AHP Legislation Could Exacerbate Threat of Fraud and Abuse*:**

AHP proponents often suggest that the concerns raised by CBO and others about the harmful impact AHPs could have on our health care system are unfounded or unproven, but members of Congress need look no further than recent history for evidence of the threats that AHPs pose to small businesses and their workers. Association health plans are not a new concept, and exist in many forms today. The most common forms of association coverage today are through state-sponsored health insurance purchasing alliances, multiple-employer welfare arrangements (MEWAs), and multiemployer union plans, also known as Taft-Hartley plans. Association coverage is now fairly common among small firms – a study in 1999 estimated that a third of very small employers with fewer than 10 employees and three in ten small employers with 10 to 50 employees purchase coverage through some type of group purchasing arrangement. While association coverage can improve small businesses' access to coverage, it can also be highly risky, drawing in small employers who think they are buying affordable coverage, but leaving them with unpaid claims or uninsured.

Over the past two decades, association health plan coverage has often proved unreliable and illusory due to scams, fraud, and mismanagement. In fact, fraudulent association plans and phony MEWAs victimized small businesses and consumers with fraudulent operations tens of times between 1988 and 1991 alone, leaving nearly 400,000 people with over $123 million in unpaid medical bills and thousands more without insurance. Patterns of coverage scams and fraud appear to be cyclical and tend to proliferate during coverage crises, when health premiums increase and employers struggle to find affordable coverage. Recent evidence suggests we are now entering another pattern of abuses. In 2002, insurance commissioners and the Department of Labor shut down two nationwide

association health plans scams, Employers Mutual LLC and the National Association of Working Americans/American Benefit plans, leaving over 55,000 workers and their families without health insurance and an estimated $65 million in unpaid medical claims. Over the last two years, insurance commissioners in Texas and Florida have shut down 11 such scams, which had defrauded more than 50,000 individuals. The Department of Labor acknowledged this trend of scam operations last year, and announced a new educational initiative to protect small businesses from fraudulent association coverage. Through August of 2002, the Department of Labor had completed over 450 civil and criminal investigations into MEWA fraud that affected 1.75 million individuals and involved over $115 million in unpaid claims, as well as the loss of millions of dollars more in health insurance premiums paying for coverage that was never provided.

Instead of providing meaningful protections against association plan fraud and insolvencies, the AHP legislation would exacerbate the situation by loosening the reins of regulatory control. As noted above, more stringent state oversight, enforcement and solvency protections would be eliminated for most AHPs. Regulation would fall to the federal government that would have few new resources or enforcement tools to ensure adequate oversight or real accountability if AHPs defraud consumers. State insurance departments employ over 10,000 individuals to oversee and investigate insurers' activities, but the DOL FY 2004 budget projections for total national staff employed by the agency that would oversee AHPs would be less than one-tenth of that amount, with even fewer individuals responsible for enforcement and oversight. Providing the Department with comparable staff and enforcement resources as what the states now have would be exceptionally expensive to do, and without such resources it will be very difficult for a large federal agency to act quickly enough to shut down these scam operations or to intervene before consumers are defrauded. That is why under current law, states are always the first on the scene to help consumers and have been more directly responsive to consumers' needs. There is no need to replace these effective state mechanisms, which are already in place and doing a very good job. By severing this lifeline of assistance, H.R. 660 will imperil small businesses, leaving them at greater risk for AHP fraud and insolvencies.

Members of Congress should keep this long history of association plan fraud and insolvency in mind as they consider H.R. 660. While it is critical to ensure that small businesses have new options to help themselves and their uninsured workers, it is important to remember that offering a false promise of coverage will not help cover the uninsured. Right now, millions of individuals who work for small businesses are uninsured, but under H.R. 660 these individuals could be paying for the privilege of being uninsured. Association health plan failures exact a human toll. There are thousands of hard-working Americans who thought they were doing the right thing by buying insurance to care for themselves and their families, but were left with broken promises, unpaid bills, and on the brink of bankruptcy when their association plan failed. Unfortunately, a number of these stories have been publicized in recent years in major national news stories:

- Terri Orr's husband Pete, of Montverde, Florida, had been diagnosed with cancer and found out in the middle of his treatment that her health plan was out of business – as a result, the couple faced $250,000 in

unpaid medical bills.

- Christine Sinclair of Los Angeles, CA, was left with $30,000 in unpaid bills to her oncologist after she discovered in the middle of her cancer treatment that her insurance company, Employers Mutual, LLC, was really a scam.
- Judy Coburn of California was also a victim of Employers' Mutual, losing about $12,000 because of the plan failure, but the real loss has been to her health: because she had to delay surgery due to the plan's failure, her vision in one eye is now permanently impaired.

These stories provide a human face for the thousands of individuals who have been hurt by fraudulent and mismanaged AHPs. As these examples demonstrate, far from being a panacea for the uninsured, AHP coverage could do more harm than good.

With these concerns in mind and in the interests of protecting women and families, the National Partnership has joined with the Blue Cross Blue Shield Association to lead a diverse coalition of over 50 organizations in advocating against the AHP legislation that has been proposed and in support of more responsible legislation that will meaningfully address these problems. This coalition represents consumer advocates, health care providers, health insurers, health insurance agents, women's health organizations, unions, advocates for children, the elderly and disabled, and others, demonstrating the breadth of concern about the legislation as it is currently being proposed. Recently, a group of advocates for the mentally ill and mental health providers also spoke out against AHP legislation, with 43 organizations signing onto a letter opposing AHP legislation. These advocacy organizations are joined by the major state government organizations, including the National Association of Insurance Commissioners (NAIC), the National Governors' Association (NGA), and the National Council of State Legislatures (NCSL), in opposition to this legislation. The Partnership is committed to working closely with these and other organizations to develop solutions that don't threaten our current health care system.

Alternative Proposals:

The Partnership encourages the Committee to consider other alternatives for legislation in this area that could provide greater assistance for uninsured small business owners and their workers without jeopardizing current coverage. While we are not suggesting that the concept of AHPs could never work to achieve this goal, we note that the legislation has not met these criteria in its many iterations over the past decade, despite ample consumer input. However, if AHP legislation were to address the criteria we have outlined, we would gladly support it as a viable solution for the problems we face. There are also a variety of alternative proposals that could achieve this goal and would already meet the principles I outlined earlier, including small employer tax credits combined with new pooling arrangements, new mechanisms to pool small employers in existing pools like the Federal Employees Health Benefit Plan (FEHBP) or state employee pools, and proposals that build on public coverage.

- *Small Employer Tax Credits & New Pooling*: This type of proposal would create a new tax incentive for small businesses to offer coverage,

thereby both encouraging them to insure their workers and making such coverage more affordable. The tax credit would be targeted to employers to ensure that coverage built on the existing employer-based system and the insurance coverage purchased with the credit would most often be a state-regulated product subject to all the state consumer protections, regulation and oversight that is needed to ensure that consumers get the coverage they are buying. The credit would be paired with a set of federal grants to encourage states or non-profits to establish new pooling arrangements that would enable small employers to come together into larger groups to purchase health insurance. As is noted above, the mere opportunity to pool together may not substantially lower the cost of coverage, although it would offer potential savings from the pool negotiating a better deal with insurers, would likely lessen the administrative burden for small employers, and could improve choices and the quality of coverage. Small employers would, however, get the benefit of the additional tax credit, which could also help lower costs and make the pools more attractive. And, unlike AHPs, these pools would be subject to state regulation and should have no opportunity to discriminate against groups or individuals based on health status. This federal-state partnership could offer innovative new options for small employers, without the risks that accompany the AHP proposal.

- *FEHBP/State Employee Pools*: This type of proposal would establish new mechanisms enabling self-employed individuals and small business owners and their workers to buy into existing risk pools like the FEHBP or the pools established by state government for public employees. This proposal would build on an established, stable, and well-regulated coverage option to give small businesses the chance to buy better quality and more affordable coverage through a pool that would better spread the health risks among a larger group.
- *Building on Public Programs*: Providing coverage for the uninsured by building on existing public programs like Medicaid, SCHIP, and Medicare could provide an even more efficient and effective way to cover the uninsured than options that rely on the purchase of private health insurance. All of these programs are tried, tested, and well-regulated, and all offer fairly comprehensive benefits for those in need. These programs are also already structured to serve those most in need, including low-income, elderly, and disabled individuals and individuals with other special health needs. And these programs provide coverage at a lower rate than the private health insurance market would – last year health care cost increases for Medicare and Medicaid were each below 10 % (7.5% and 8.7%, respectively), while private coverage increased by 10.5%. Thus, public coverage gives the federal government more for its money in covering the uninsured. Expansion options that would address the problems facing many small firms and their workers include expansion of Medicaid or CHIP eligibility to all individuals up to 200% of poverty and allowing near-elderly workers to

buy in to Medicare at 62. The former proposal would help lower-wage workers and their employers to access more affordable coverage; the latter could provide a more affordable coverage option for older workers, making coverage less expensive for remaining employees in the small group.

While none of these options would solve all the problems small businesses are facing, we think they are a more responsible approach and a great place to start. The Partnership stands ready to work with members of this Subcommittee and others to forge the right solutions to this problem and provide meaningful help to the millions of women and families that are now uninsured.

Conclusion:

The health insurance access problems facing the small employer community today are a major concern for women and families. Despite the urgent need for legislative action in this area, we urge policymakers to take a considered and cautious approach to new legislation in this area. As I have mentioned today, H.R. 660 is not the right solution to these problems. H.R. 660 will likely do more harm than good for small employers and their workers alike, without helping to address the problem of the uninsured. For AHP legislation to work, it would have to provide meaningful assistance for the uninsured, prohibit wrongful discrimination and "cherry picking," and create an effective oversight and enforcement mechanism including strong solvency standards as well as sufficient authorized and appropriated resources to fund such oversight. Mere horatory language that pretends to address these concerns but doesn't address the real and critical flaws in the legislation will not be enough to win our support. Other legislative options exist, including the new tax credit and pooling proposals, FEHBP and state pooling options and public program expansions – all should be evaluated as you consider possible solutions to this problem.

Thank you for your the opportunity to testify today. I am happy to answer any questions.

APPENDIX E - WRITTEN STATEMENT OF GREG SCANDLEN, DIRECTOR, CENTER FOR CONSUMER DRIVEN HEALTH CARE, THE GALEN INSTITUTE, ALEXANDRIA, VA

Testimony of Greg Scandlen
Director of the Center for Consumer Driven Health Care
Galen Institute
before the
Subcommittee on Employer-Employee Relations
Committee on Education and the Workforce
United States House of Representatives
Hearing on
H.R. 660: The Small Business Health Fairness Act
March 13, 2003

Chairman Johnson and Members of the Committee,

Thank you for this opportunity to share with you some thoughts on Association Health Plans and specifically H.R. 660.

I am Greg Scandlen. I am currently the director of the Center for Consumer Driven Health Care at the Galen Institute, a non-profit, non-partisan think tank specializing in health and tax policy and based in Alexandria, Virginia. I have worked in the past for the National Center for Policy Analysis, The Cato Institute, and my own consulting firm, the Health Benefits Group. Prior to this, I was the founder and CEO for four years of the Council for Affordable Health Insurance (CAHI), a trade association of small to mid-sized insurance companies that are active in the small group and individual insurance markets.

THE STATE OF THE MARKET

My most relevant experience is the twelve years I spent in the Blue Cross Blue Shield system, including eight years as the director of state research for the national association. In that capacity I worked hard to defeat the kind of state legislation that is now prompting the demand for association health plans. These included mandated benefits, of course, but also a whole universe of regulations and restrictions that are every bit as important as mandates – premium rating restrictions; premium taxes; restrictions on plan practices such as provider contracting, claims processing, contract language and appearances; market conduct audits; and a host of other petty but expensive requirements.

These regulations were difficult for Blue Cross Blue Shield plans to comply with. They were complex, and they tied our hands in our efforts to control health care costs. But I later discovered when I formed CAHI how much worse it is for multi-state commercial insurers. These companies try to do business in 20, 30, or more states. It is nearly impossible for them to even keep track of all the changing laws in so many states, let alone revise their contracts every year to stay in compliance. They have been forced out of many states because of incompatible and inconsistent regulations among them.

I was particularly involved with the National Association of Insurance Commissioners

(NAIC) when it was on a campaign to "reform" the small group market. I said at the time that these misguided efforts would destroy this market, and I think time has proven me right. I was, and continue to be, especially concerned about community rating and other forms of rating restrictions. When a state arbitrarily lowers the cost of coverage for an older and sicker population and raises the cost for the younger and healthier population, the older people will think it is a bargain, and the younger people will think it is not worthwhile. Younger people will drop out of the market and older people will jump in, which raises costs across the board and creates a death spiral of selection.

The federal guaranteed issue requirements contained in the Health Insurance Portability and Accountability Act (HIPAA) which prohibit denial of coverage for even the very sickest of the population, aggravate the problem and speed up the death spiral.

In short, the small group market today is a disaster. It is impossible to overstate the problems. Carriers have dropped out, leaving only one or two insurers in many areas. Employers are being rocked with premium increases as high as 50 percent in a single year. Because there are so few remaining competitors, the carriers have a "take it or leave it" attitude with their customers. The sickest groups try to keep on paying and the healthiest groups decide it isn't worth the cost and drop coverage altogether.

This is not a hypothetical problem. It is not a theoretical issue. It is happening right now. At this moment in your District there are employers who are telling their workers they can no longer afford to cover them. What else can they do? They can't raise prices and still stay in business.

Association Health Plans are no panacea. At most, AHPs will be another tool small employers can use to secure coverage for their workers. They may lower costs some. More importantly, they will inject more competition, innovation and choice in a market that is approaching monopoly conditions. (See "Competition in Health Insurance," AMA, January, 2003)

Greater competition should make health plans more responsive to the demands of their customers, improve service, expand benefit options, and increase the numbers of small employers who provide coverage.

They will need to be supplemented with some of the other ideas that President Bush has proposed, such as refundable tax credits, expanded medical savings accounts, allowing a roll-over of Flexible Spending Account balances, and medical malpractice reform. When you put all these things together you begin to have a comprehensive approach to solving these problems.

ILLIGITIMATE CRITICISMS

Let me address some of the criticisms that have been raised with AHPs.

"They will take only the good risks and leave the bad risks behind." There is no reason to think that is true. In fact, in testimony before the Senate Committee on Small

Business and Entrepreneurship, Len Nichols testified that in Arkansas just the opposite happened. The state had formed a purchasing pool for the state's small employers, but no carrier was willing to take the business because they figured only the highest cost groups would join. Further, HIPAA already requires that all small groups be guaranteed issue, so no group can be denied coverage, and H.R. 660 requires that all options be made available to all employers.

"Shady operators will come in and steal the money like they did with Multiple Employer Welfare Arrangements (MEWAs)." Fortunately, humans learn from experience. MEWAs were unregulated by either the states or the federal government. H.R. 660 includes a number of protections to prevent this sort of problem, including the need to get certified in advance, the requirement that only bona fide associations be allowed to offer coverage, and a number of solvency and reinsurance provisions.

"Important consumer protections will be lost." This is perhaps the most cynical argument, coming as it does from organizations that vehemently opposed these "protections" when they were passed. Every employer is currently free to escape all of these provisions by self-insuring their benefits. There is absolutely no restriction in law or regulation preventing them from doing so. Smaller employers have been reluctant to self-insure only because of their size, but it is not unusual today to see an employer with as few as 100 workers self-insuring their benefits. Why does a firm with 100 employees that buys insured coverage need more "protections" than one that self-insures the exact same benefits?

"AHPs won't actually save much money." That may be true in the short term, in which case they won't be very popular. Escaping mandated benefits and premium taxes might save 10% - 20% of premiums. Far more important is that AHPs will invite new competition in the small group market, which will foster innovation and potentially lower costs. Employers will have a new array of health plans and benefit designs to choose from, and there will be an incentive to provide better customer service. This may be the real fear of the critics who have become unaccustomed to competition.

LEGITIMATE CRITICISMS

There are a couple of legitimate criticisms of AHPs that need to be considered. Many insurers have told me that if regulatory relief is needed, we should give it to the carriers, and let them do the job. I happen to agree with this. It is excessive regulation that has destroyed the small group market. It would be far better to roll back those regulations so that all insurance providers can operate on a level playing field.

Further, I notice that H.R. 660 appears to defer to the states on premium rating restrictions (sec. 805(a)(2)(B)(ii)). This would be a huge mistake, and I urge you to reconsider. These rating restrictions have been far more important than mandated benefits in wrecking this market. Rating restrictions drive out the healthiest groups and raise rates for the remainder. We need to encourage participation by people and groups who are healthy so they will help subsidize the costs of the sick. Driving them out of the market does no favors to higher-risk people.

CONCLUSION

Overall, I applaud your work on AHPs and H.R. 660. I urge you not to expect miracles from this legislation. It will help change the current trend of more and more groups dropping coverage and will inject some competition to a market that is devoid of it. In combination with some of the other proposals before the Congress, it could make a significant improvement.

I will be happy to answer any questions you might have.

APPENDIX F – SUBMITTED FOR THE RECORD, STATEMENT OF THE HEARTH, PATIO & BARBECUE ASSOCIATION, ARLINGTON, VA

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Arlington, VA 22209 USA
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Email: hpbamail@hpba.org
Web Site: www.hpba.org

March 13, 2003

Statement of the Hearth, Patio & Barbecue Association
Employer Employee Subcommittee
Education and Workforce Committee
U.S. House of Representatives
Washington, D.C. 20515

Re: The Small Business Health Fairness Act and Association Health Plans

Dear Chariman:

On behalf of the 2,300 members of the Hearth, Patio & Barbecue Association (HPBA) – representing manufacturers, distributors, and retailers of fireplaces, woodstoves, pellet stoves, and barbecue grills – I urge the U.S. Congress to pass The Small Business Health Fairness Act and establish federal association health plans as an option for small businesses. More than 90% of HPBA members are small businesses, the majority of which employ 50 people or less. Many HPBA members cannot even afford health insurance for their employees. Those who can afford it have seen double-digit percentage increases in healthcare premiums over the past two years.

Smaller businesses are at a particular disadvantage when it comes to bargaining for reasonable health insurance. Federal association health plans would eliminate the need to seek out insurance brokers to find high-priced coverage with minimal benefits that vary from state to state. Furthermore, association health plans would allow the smallest fireplace shop to buy health insurance along with a pool of our 2,300 members at rates that a small company alone would never otherwise receive.

Association health plans would also contribute to lower instances of fraud and misrepresentation, as they would be federally managed and subject to strict ERISA provisions. These provisions require coverage to all populations, not just healthy individuals, so there could no instances of "cherry picking." Only bona fide trade associations that have existed for more than three years for purposes other than health care coverage can qualify. HPBA members would qualify for these benefits and deserve the chance to have the same healthcare that larger corporations can offer their employees.

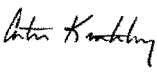
Critics may argue that federal oversight of association health plans would create an administrative burden that the Department of Labor cannot handle. In fact, the Department is already administering 67 million private, job-based health plans subject to ERISA protections, in addition to 5 million in the self-insured multi-employer plans. Adding the management of association health plans to the 72 million plans already being administered by the Department would not create any significant strains or administrative costs to that which is already being managed.

HPBA is currently using a health insurance broker through which members can attempt to locate affordable insurance in various states. However, because the need to comply with 50 different sets of state laws regulating insurance, the broker has been unable to provide substantial coverage on a consistent basis to all members across the country. HPBA is comprised of 14 regional affiliates, including several multi-state groups, and members who belong to the same affiliate – but live in different states – are not allowed the same types of coverage. A federally-managed association health plan would provide the consistency and availability across state lines that state-managed plans could never hope to achieve.

The Hearth, Patio & Barbecue Association fully supports the President, Secretary Chao, and the U.S. Small Business Administration's efforts to establish association health plans as an option for small businesses. I urge the U.S. Congress to support and pass The Small Business

Health Fairness Act and establish federal association health plans for the members of HPBA and the millions of other workers in America employed in small businesses.

Respectfully,



Carter Keithley
President & CEO
Hearth, Patio & Barbecue Association

APPENDIX G – SUBMITTED FOR THE RECORD, STATEMENT OF DONALD L. WESTERFIELD, Ph.D., PROFESSOR, WEBSTER UNIVERSITY, SENIOR FELLOW, NATIONAL CENTER FOR POLICY ANALYSIS

Testimony of
Donald L. Westerfield, Ph.D.
Professor, Webster University
Senior Fellow, National Center for Policy Analysis

Testimony Before the
Committee on Education and the Workforce
Subcommittee on Employer-Employee Relations
United States House of Representatives

H.R. 660: The Small Business Health Fairness Act

March 13, 2003

Chairman Johnson, and Members of the Committee:

I am honored to submit this prepared statement to discuss with you "H.R. 660: The Small Business Health Fairness Act." 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 books on health care issues: [1] 1) *Mandated Health Care: Issues and Strategies,* 2) *National Health Care: Law, Policy, Strategy*, and 3) *Insuring Uninsured Through Association Health Plans,* forthcoming this Spring. The latter book 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 H.R. 660, creating Association Health Plans.

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 and arbitrary regulations 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 get their benefits mandatory in the employer plans, and a spectrum of those who know of abuses and plan frauds by other 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 largely 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.

Perhaps I should call the Committee's attention to Section 805 (a)(2)(B)(ii) of H.R. 660, which seems to defer to the states on premium rating restrictions. *I agree with other scholars, analysts, and employer organizations that deference to the states on this issue would have devastating effects on efforts to form and maintain Association Health Plans.*

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 permit this practice. Additionally, Sections 804 and 805 of the of the proposed "Small Business Health Fairness Act of 2003" 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 and continue to do 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.

The 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.

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 to subject Association Health Plans to any arbitrary cross-subsidization scheme is another form of the "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 2003" 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 Education and the Workforce 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 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 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.

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[10] Conway, *op. cit.*

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	66.9	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[a]	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[o]	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	Lifewise, 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]

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 – 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)
Texas	59[a]	Employers Health Insurance Company	13.9	36.1	2	6.9
Utah	44	IHC Health Plans, Inc.	29.1	93.5	2	22.7
Vermont	6	MVP Health Plan	45.8	98.6	5	2.6
Virginia[a]	56	NA	NA	NA	NA	NA
Washington[p]	[q]	Premera Blue Cross	40.5	86.5	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[n]	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.

APPENDIX H – SUBMITTED FOR THE RECORD, STATEMENT OF THE AMERICAN FARM BUREAU FEDERATION

STATEMENT OF
THE AMERICAN FARM BUREAU FEDERATION
TO THE
SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS
HOUSE COMMITTEE ON EDUCATION AND THE WORKFORCE
REGARDING AFFORDABLE HEALTHCARE ACCESS

March 13, 2003

Of all the small businesses in need of lower cost group health insurance of the type that can be made available through Association Health Plans, the American farmer is perhaps one of the most in need. Our members are the smallest of small businesses and for the most part find themselves ineligible for small business group coverage.

Farmers and ranchers are disadvantaged by their family structure. Group underwriting standards have traditionally excluded companies where direct family members consist of more than one-half of a group's enrollment – the situation for many of our members. Farm and ranch businesses are also often excluded from the eligibility list of many commercial insurance carriers.

Additionally, most farmers and ranchers are not large enough to enter the arena of self-insurance, which through ERISA pre-emption allows larger employers to reduce their health costs through exemption from mandates and community rating

State Farm Bureaus helped start over 70 property and casualty insurance companies in the United States. Started to help farmers and ranchers who could not obtain coverage by commercial insurance carriers, today those carriers have flourished and provide vital coverage for equipment, crops and other risks associated with farming and ranching.

Likewise, today's farmers and ranchers are facing a critical need to provide their families and employees with affordable health care. A few of our state Farm Bureau organizations have offered insurance coverage to their members. They have for the most part been able to offer such coverage only on an individual basis. This often results in higher premiums than would be found in comparison to large employer group coverage.

The Washington State Farm Bureau has been able to offer group coverage. A favorable association law allows the state Farm Bureau to provide coverage that is both extensive in its benefits and more affordable than is the case for the individual plans offered in the state of Washington.

Farmers and ranchers should have options. Recognizing the need to help its membership, the Washington Farm Bureau established its health plan three and a half years ago. It has grown to the point where it now covers some 30,000 farmers and ranchers and has over $50 million in annual premiums. As a bona fide association, the plan offers guaranteed issue coverage to all its members, thus eliminating cherry-picking. Each farmer-rancher member is offered a preferred or standard rate with a maximum premium differential spread of 30 percent in rates. The health plan enjoys a 99.2 percent retention rate after 3 1/2 years of operation. Of those who join the health plan, over 25 percent enter with no prior health coverage. Even with its success, several

state-mandated provisions, which would not be required under an ERISA self-funded plan, have prevented additional flexibility that could further reduce the cost of the plan.

Many state Farm Bureau organizations would like to participate in the Washington Farm Bureau plan or duplicate it for themselves. But because they cannot cross state lines, or state laws prohibit this type of plan or do not allow the latitude needed to provide such a plan, they're unable to establish such a program for their members. Each state requires separate approval, making it impossible for multi-state plans to be implemented. Also, increased administrative costs can be directly attributed to the multi-state jurisdictions. It can easily cost millions of dollars to obtain a license within each state and thousands of dollars to gain approval for each and every insurance policy offered within each state jurisdiction.

The American Farm Bureau Federation has supported AHP legislation for several years as a means of enabling the Federation and its state organizations to put together cooperative arrangements allowing Farm Bureau to make available to our members more affordable group health insurance coverage.

Health insurance premiums have been skyrocketing, and it is having an increasingly adverse impact on the ability of our members to provide coverage for themselves and their employees. From all indications, that trend is likely to continue and perhaps worsen. AHPs represent a major step that if implemented correctly, can significantly improve the prospects for better insurance coverage for farmers, ranchers, and millions of others across the nation. We strongly urge adoption of AHP legislation and offer our help in molding language.

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APPENDIX I – SUBMITTED FOR THE RECORD, STATEMENT OF THE ASSOCIATION HEALTHCARE COALITION, WASHINGTON, D.C.

The Association Healthcare Coalition

THE HEALTH ORGANIZATION FOR BONA FIDE TRADE AND PROFESSIONAL ASSOCIATIONS

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Statement For The Record

The Association Healthcare Coalition

House Committee on Education and The Workforce

Subcommittee on Employer/Employee Relations

Hearing on H.R. 660, "The Small Business Health Fairness Act of 2003"

March 13, 2003

The Association Healthcare Coalition (TAHC) commends Chairman Sam Johnson (R-TX) for holding this hearing on the issue that is now most dramatically impacting small and medium-sized employers – the severe lack of access to affordable health care coverage. Congress must take action to address this issue in 2003.

TAHC strongly supports enactment of the Small Business Health Fairness Act of 2003 (H.R. 660), introduced by Reps. Ernie Fletcher (R-KY) and Cal Dooley (D-CA), to strengthen and expand Association Health Plans. This legislation, which was approved by a bipartisan majority of the House in 2001, is critical to the ability of small and medium-sized businesses across the nation to obtain access to affordable health insurance. TAHC commends Chairman Johnson and full Education and the Workforce Committee Chairman John Boehner (R-OH) for their support for Association Health Plans legislation, and looks forward to working with you other members of the House to see that this legislation is enacted by the 108th Congress. TAHC also commends President George W. Bush and Secretary of Labor Elaine Chao for their strong support and leadership on behalf of AHP legislation.

As skyrocketing health insurance premiums threaten the coverage of more and more small business workers, Congress must take action to address the underlying problem: a severe lack

of competition in health insurance markets. AHP legislation will address this problem by strengthening and expanding association-sponsored health plans, thus increasing competition and driving down health insurance premiums. This will ultimately increase access and

choice in affordable health plan options for working families employed in small and medium-sized businesses.

The Role of Associations in Health Care for Small Businesses

Bona fide trade and professional associations are a vital source of health care coverage for millions of American workers employed in small businesses. Some associations have been sponsoring health plans for over 50 years. TAHC's membership is composed of trade and professional associations organized for purposes *other than* selling health insurance, a critical distinction in the debate over the proper role of associations in health insurance. Our members are not affinity groups or businesses that simply come together to purchase insurance. Rather, bona fide associations, established and run by their employer-members, exist to serve the needs of their members and workers. Bona fide associations have an outstanding track record in providing high quality health coverage to small businesses and their workers.

Associations are vital to enabling small businesses to provide affordable health coverage to their workers. 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 health care needs of their membership. Associations offer a wide variety of approved health plans and managed care arrangements, both fully insured and self-insured. AHPs have already demonstrated that they can reduce health insurance premiums for small employers, compared with the cost of small employers purchasing coverage directly from an insurance company without the benefit of an AHP. For example, the AHP sponsored by the American Council of Engineering Companies has administrative costs of about 9.5% of premium. In contrast, a small employer on its own is likely to pay administrative costs of anywhere from 20% to 35% of premium when purchasing coverage in the existing small group marketplace.

Associations are uniquely structured to be part of the ERISA healthcare delivery system. Because they are already structured 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 the health care system as a whole, as well as to their members individually.

While AHPs have been serving small businesses and their workers with affordable health benefits for over 50 years, their ability to do so is severely declining. As inconsistent government mandates and regulations continue to proliferate in many states, 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. Among existing AHPs, they have very few options due to a severe lack of competition in the association market, and

many AHPs have been hit with large premium increases for their small employer members. For example, the American Council of Engineering Companies, which serves approximately 102,500 workers and family members across the nation, recently received a 28% premium increase from their insurance carrier. Excessive regulation and mandates in the state small group insurance markets has greatly hindered the ability of associations to serve small business members.

AHP Legislation

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 the same opportunities it has provided to their counterparts in large corporations and labor unions – affordable health care through economies of scale, greater bargaining power with large insurance companies, regulatory uniformity, and the freedom to design health plan options that meet working families' needs. The AHP legislation is the *only* federal policy option that levels the playing field between small business on one hand and large companies and union firms on the other.

The AHP legislation will put small employers and the self-employed on an equal basis with workers covered by large employer and labor union health plans by providing similar uniform regulatory status to health plans sponsored by bona fide associations. The bill will greatly improve the ability of AHPs to design health plan options that meet the needs of their members and control the escalating cost of health coverage. If small employers are to compete in the marketplace for high quality workers, it is vital that they have access to the same health benefit options as large corporations.

Conclusion

An expansion of AHPs is a market-oriented, supply-side solution that will foster growth and greater competition within the small group health insurance marketplace. This will ultimately bring about greater long-term price stability and reverse the trend of skyrocketing health insurance premiums for small employers. Thus, AHP legislation is essential to efforts to expand access to affordable health benefits for small employers and their workers.

TAHC urges Congress to expand access to affordable health insurance for working families by enacting AHP legislation. The time for elimination of the health insurance "double standard" for small business and the self-employed is long past due. TAHC looks forward to working with Congress on legislation to accomplish this goal.

For more information on The Association Healthcare Coalition, please contact Executive Director Duane Musser at 202-543-4455 or DMusser@SWAconsult.com.

APPENDIX J – SUBMITTED FOR THE RECORD, STATEMENT OF COUNCIL OF SMALLER ENTERPRISES, CLEVELAND, OH

STATEMENT PRESENTED TO THE HOUSE COMMITTEE ON EDUCATION AND THE WORKFORCE

Subcommittee on Employer-Employee Relations

By: Keith Ashmus, Chairman, Council of Smaller Enterprises
Cleveland, Ohio

March 13, 2003

Small Business Health Care Hearing

Thank you for giving the Council of Smaller Enterprises (COSE), the opportunity to submit written testimony on a subject that our 16,700 members in Northeast Ohio know intimately—health care. For your reference, COSE is the small business division of the Greater Cleveland Growth Association, one of the largest regional chambers of commerce in the country. More than 250,000 lives are covered through our group-purchasing plan.

As indicated above, affordable and accessible healthcare are top priorities for COSE and the Growth Association. COSE's group health insurance plan began 30 years ago to give our members, their employees and their families access to high quality, affordable health care coverage. In addition to offering benefits to businesses in the greater Cleveland area, we also provide group health insurance services in the Toledo, Lima, Findlay, Fostoria and Mansfield areas of the state. In Northeast Ohio, U.S. Census Bureau Statistics show that there are 553,281 non-government workers over the age 16 in the Cuyahoga County, Ohio geographic area. COSE covers 84,956 of those workers, or 15.4%, through its group purchased health insurance program. Over the past 3 years, almost 4,800 employers applied for group insurance coverage with COSE. Over 3,800 accepted coverage (79%).

COSE is also a longstanding member of National Small Business United, the nation's oldest bipartisan advocacy association for small business, representing over 65,000 small businesses in all fifty states.

The resurgent and dramatic rise in health insurance costs poses an especially difficult problem for small businesses. In fact, an on-line survey of COSE members in early 2002 reaffirmed that concern, with fully half of the respondents identifying health insurance as the most important short-term issue they face. Almost 70 percent of those responding said the issue was "very important " to their business, the largest issue by far in the survey.

Of particular concern to COSE and its members are the House-passed version of the Patient's Bill of Rights and the concept of Association Health Plans (AHPs). As you are aware, this bill passed in the House in the 107th Congress. Association Health Plans, on the surface, sound like an appealing solution to increasing healthcare costs and access to healthcare. Proponents say that AHPs will reduce healthcare costs by providing more access to less expensive plans and that the plans will be offered through "bona fide" member associations, such as chambers of commerce. COSE and other small business advocacy groups are opposed to the AHP language found in the 2002 House-passed Patients' Bill of Rights and any other similar legislation for two primary reasons:

- Segmentation of the marketplace due to adverse risk selection;
- Increased risk of program failures and regulation by the Department of Labor.

While well intentioned, we believe AHPs may threaten the stability of the health insurance marketplace and ultimately harm those they are intended to help. From our 30 years of experience with group purchasing, we can see that AHPs will segment the marketplace through risk selection. If AHPs become law, associations that sponsor them could theoretically design their own benefit packages that would be more attractive (and less expensive) to a young, healthy population. This leaves the unhealthy to higher premiums and further segmentation of the market. We concur with the following

statement from NSBU's testimony: "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."

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 would 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-AHP programs could lead to greater numbers of uninsured individuals, exactly the opposite of the outcome desired by proponents.

Based on the experience of the COSE program, AHP legislation could potentially create a catastrophic environment whereby 40% of healthy members exit the program as they find lower premiums with an AHP. To make up for their losses in our program, we would need to raise rates on remaining members by just over 20%. Conservative estimates are a 20% loss of healthy members and an additional 8% premium rate increase being needed. The costs of medical care and prescription drugs are going up over 13% per year based on surveys from national employee benefits consulting firms we speak with. We do not believe that adding another 20% to that the cost increases is not a way to stimulate small business economic growth engine.

We at COSE are also very concerned about the prospects for AHP programs to fail, leaving small employers and their workers and families without coverage. Ohio has

strong protections in the form of insurance reserve requirements. AHPs will be able to avoid those requirements in a number of ways. We have watched as several Multiple Employer Welfare Arrangements (MEWAs) have failed, despite being regulated by the Labor Deparment. We cannot play risky games with the health insurance of our small businesses across the country who will be unable to analyze the true financial soundness of AHP programs. When the inevitable failures occur, the consequences for faith in our market system will be severe.

COSE is not opposed to competition in health insurance marketplace. We support competition because it motivates us to continuously improve our program. Adopted and championed by COSE, the group purchased small businesses health insurance market has created programs that allow for choice. Without group purchasing, it is unlikely that many of the innovations of our own program would have come about. For example, COSE members have the ability to offer multiple health insurance programs that run within their own health insurance program. That being said, the answer to high insurance costs is not to create an uneven playing field and reduce the population across which risks are being distributed. AHPs simply will not solve the current problem and will create future ones. We would encourage the exploration of options for maximizing choice and flexibility (such as modifying Medical Savings Accounts), tort reform, increased access to information, patient responsibility, etc. before considering an Association Health Plan proposal. COSE is in the process of formalizing alternative ideas to Association Health Plans that are based on our experience with our group-purchasing program. We will make these available to the committee as soon as they are available.

Thank you for your time. In the meantime, if you have any questions about the COSE program, please contact us at ccaruso@clevegrowth.com, dpruce@clevegrowth.com or by calling 216-592-2342.

APPENDIX K – SUBMITTED FOR THE RECORD, STATEMENT OF THE SMALL BUSINESS ASSOCIATION OF MICHIGAN, LANSING, MI

Testimony submitted by the Small Business Association of Michigan (SBAM). Gary M. Woodbury, SBAM President and CEO and Rob Fowler, SBAM President and CEO – Elect.

Small Business Health Care Hearing

House Committee on Education and the Workforce
Subcommittee on Employer-Employee Relations

March 13, 2003

Gary M Woodbury, President and CEO
800 362-5461 gmw@sbam.org

Robert Fowler, President and CEO – Elect
800 362-5461 rdf@sbam.org

Small Business Association of Michigan
222 North Washington Square, Suite 100
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Dear Members:

Thank you for the opportunity to submit written comments on behalf of the Small Business Association of Michigan (SBAM). SBAM is a state based small business trade association representing 7,000 small businesses in all of Michigan's 83 counties. We are headquartered in Lansing Michigan and our primary mission is to promote free enterprise and the interests of Michigan small business through leadership and advocacy.

SBAM is also a member of the National Small Business United (NSBU) where SBAM members are active on their Board of Directors and advocacy efforts. NSBU is the nations oldest bipartisan advocacy association for small business, representing over 65,000 small businesses in all 50 states.

Scope of the Problem in Michigan

We are pleased to submit our comments on access to affordable health insurance for small business. The rising cost of health care is a national problem facing small businesses and their employees. According to the Kaiser Family Foundation, health care costs in 2001 rose 12.7 percent nationally. Premiums increases are especially dramatic in Michigan, where health insurance bills have risen on average 20 – 25 percent each of the last five years, resulting in more than a 150 percent health care premium increase for Michigan small businesses.

In April 2002, SBAM commissioned the polling firm EPIC/MRA to determine the impact of rising health care costs on small businesses. The study found that skyrocketing insurance premiums have forced small business owners to ask their employees to defer pay hikes, absorb higher deductibles and increase doctor visit and prescription co-pays. High health insurance costs mean that many small businesses have not been able to afford to fill job openings. The problem is so severe that nearly a quarter of all small business owners (and 40 percent of women and minority-owned businesses) fear the high cost of health insurance will force them to close their doors.

The survey is dramatic proof that this crisis – the more-than doubling of small group health insurance premiums over the past five years – is not only devastating the small business economy but also taking a serious financial toll on employees.

The cost of health insurance has gone up so high and so fast that the financial survival of many small businesses is at stake.

The Michigan Market.

Michigan has a unique problem in the small group market due to its status as a "community rated" state. Blue Cross Blue Shield of Michigan is Michigan's community pool for small group health insurance. It has 65 percent of the market and insures all groups at the same rate without the ability to adjust for age, gender or health status.

Health Maintenance Organizations have 25 percent of the Michigan small group market and can use age and geography to set rates. The private insurance market has only 10 percent of the small group market and has virtually no state underwriting restrictions.

Because Michigan has a large community rated pool, private insurance companies are able to take advantage by raising rates above the community rate for less healthy groups and lower rates below the community rate for healthier groups. This drives bad risk into the community pool.

The adverse selection of healthy risk by private insurance companies and dumping of bad risk into the community pool places Michigan in a poor position to respond to national changes that would exempt small businesses from state rating regulations.

Association Health Plans Spell Trouble for the Michigan Market.

AHPs are intended by their supporters to address 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. However, despite those good intentions, AHPs stand to greatly worsen the market segmentation and risk-aversion that currently characterize the small group health insurance market, and which are at the root of the health care crisis uniquely faced by smaller firms.

By carefully designing benefit packages that will be relatively unattractive to older and less healthy populations, AHPs will simultaneously attract a higher proportion of younger and healthier individuals for their insurance pools, driving down expected claims costs and, thus, their premiums. Since apportionment of health risk is mostly a zero sum game, lower premiums for AHPs will mean higher premiums elsewhere. These increases will drive healthier people away from the traditional state insurance 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 (such as Blue Cross Blue Shield of Michigan), 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 traditional state-based insurance pools for small firms and the displacement of millions of currently insured individuals. To serve and attract members, AHPs will want to keep premiums as low as possible. 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.

SBAM will oppose any AHP provisions that do not address the incidence of adverse selection occurring in state insurance pools. Further, AHPs must either utilize the rating regulations of the states or establish a federal rating regulation as a minimum means to reduce the negative impact of adverse selection.

Rating Reform in Michigan

With the prospects of passage of Association Health Plans at the Federal level, Michigan needs to change and soon. SBAM is advocating for Michigan to adopt the National Association of Insurance Commissioners plan for rating reform. This plan, which has been adopted by 37 other states, establishes "rate bands". Rate bands say to an insurer that if you are doing business in small groups in this state, then all of your rates must fall within a band from your highest risk rate to your lowest risk rate. A 50 percent rate spread is most common.

We are a unique state in that we have two sets of rules for health insurance carriers. One set of rules – P.A.350 for Blue Cross Blue Shield of Michigan –requires them to accept all risk and develop a community rate regardless of health status, age or gender. All other commercial carriers operate in our state without restriction on underwriting characteristics or rate spread. The result is that the commercial carriers identify groups with healthy employees and offer them rates that are lower than the community rate, and when they identify groups with unhealthy employees they price these groups higher than the community rate. Therefore, the community pool (Blue Cross Blue Shield) gets more unhealthy groups, while healthy groups are pulled away. This is known as adverse selection against the community pool or sometimes referred to by the unflattering term "cherry picking ".

From an insurance standpoint, this trend, if left unchecked, establishes the potential for Blue Cross Blue Shield of Michigan to become the country's largest scale death spiral of an insurance carrier. Some may not think it is a public policy issue to be concerned about the financial health of a company. However, because of PA 350, Blue Cross Blue Shield is this state's community pool. Every small business in Michigan is affected by what happens to Blue Cross Blue Shield.

It is our feeling that a competitive market for small group health insurance is critical to resolving the problem of affordable, quality health care. Competition is the best means to keep rates in check. It is possible that as the Michigan legislature moves forward on the rating reforms some carriers would leave the state if rate bands were established. We contend that those insurers who come to Michigan to select good risk only and who refuse to insure unhealthy groups may find it difficult to do business here if rate bands are adopted into Michigan insurance law. The practice of risk selection is hurting all small businesses and it needs to stop. Of course, the prospect of Association Health Plans as proposed in Federal legislation could have the impact of being the greatest Cherry Picker of all.

Individual Responsibility

Asking employees to finance a greater share of their health care cost is but one means of returning a sense of individual responsibility for persons seeking health care services. Whenever individuals are empowered to manage their own out-of-pocket expenses, they

will become true consumers of their health care services and will help in containing the overall cost of health care. For example, if an individual has the choice of a brand name drug with a $30 co-pay or a generic equivalent with only a $10 co-pay, they are likely to accept generic, thus lowering the cost to themselves and their insurer.

Medical Savings Accounts (MSAs) are a valuable tool to encourage individual responsibility for overall health. While MSAs are intended to make it easier for small businesses to provide health insurance to their employees, some restrictions put on MSAs impede their ability to do so. Insurance companies are reluctant to create MSA programs because the restrictions keep them from seeing a return on their investment. Changes must be made to MSAs in order for it to be a viable solution for small businesses and their employees to control their own health care costs.

The HIPAA law put several restrictions on the MSAs that could be eliminated to encourage greater use by small groups. Participation is limited to only 750,000 persons. MSAs are also only available to small businesses of 50 employees or less. HIPAA created a definition of "high-deductible" health plans $1,500 for an individual and $3,000 for a family. Employers and employees can both contribute to the MSA, however not in the same year. The amount that can be put into the account is also limited. Individuals can contribute 65 percent of the deductible, and employers can contribute 75 percent.

SBAM supports 100 percent tax deductibility for health insurance premiums paid by individuals for themselves and others.

Conclusion

SBAM believes that access to affordable quality health care is vital to all Michigan citizens. We look forward to working with the Senate Committee on Small Business and Entrepreneurship to help find solutions to this difficult problem. Mostly, we urge this committee to consider the adverse selection impact that the current proposal for Association Health Plans has on the 80 percent of small business employees who will not be able to take advantage of them and are left paying the rising cost of the state pools.

Thank you for the opportunity to present our testimony and we look forward to working with you on solutions to surging health care costs for small business.

Prepared by Scott Lyon
Vice President, Small Business Insurance Services
Small Business Association of Michigan (SBAM)
February 26, 2003
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Supplement to testimony of the Small Business Association of Michigan (SBAM) submitted March 13, 2003 by Barry Cargill, Vice President for Government Relations, Small Business Association of Michigan (SBAM).

Small Business Health Care Hearing

House Committee on Education and the Workforce
Subcommittee on Employer-Employee Relations

In a January 23, 2003 news release entitled "New Report Details High Administrative Cost of Small Group Health Insurance", the Small Business Administration's Chief Counsel for Advocacy Thomas M. Sullivan states, "One way to lower these costs would be to spread them across large groups of small employers through Association Health Plans." This paper analyzes that statement and the underlying challenges of Association Health Plans. These comments are based on my experience in managing large group purchased health insurance organizations and the historical effectiveness of group benefit regulations.

Objectives of Association Health Plan Legislation:

The objective of Association Health Plan Legislation - to increase access and affordability of health insurance for small business by expanding coverage to many workers, primarily at small companies, and their families who now have limited or no access to employer provided benefits - is a laudable goal. The proposed legislation attempts to make employer provided health insurance coverage more widely available and less costly. It proposes to achieve this goal by encouraging the formation of Multiple Employer Welfare Arrangements (MEWAs), albeit under a new name – Association Health Plans (AHPs) - bringing them under the ERISA exemption and assigning their regulation to the Department of Labor (DOL). Despite good intentions, this legislation is wrought with problems

and is very unlikely to achieve its goals, and very well could further harm the current small business health insurance market.

MEWAs – A Historical Perspective

Underlying the Association Health Plan concept is the long and, not very good history of, Multiple Employer Welfare Arrangements (MEWAs). With the passage of ERISA in 1976, responsibility for the regulation of MEWAs was unclear. MEWA administrators claimed exemption from state insurance laws under the ERISA preemption, and the Department of Labor was either unprepared, uninterested, or both in providing effective oversight for these programs. This regulatory disarray allowed the establishment of some self-funded MEWAs that were clearly mismanaged or, in some cases fraudulent and whose failures left many participants without insurance for which they had paid. In 1983, this regulatory problem was corrected and the regulation of MEWAs was returned to the states. In turn, many states subsequently passed laws and now actively regulate self-funded MEWAs. As we know from recent reports in the *Wall Street Journal* (Nov. 21, 2002) and other publications, returning regulation to the states has slowed, but not completely eliminated, the problem of fraudulent MEWAs.

While poorly managed, or some down right fraudulent MEWAs continue to make headlines, another type of MEWA has been providing access to affordable health insurance to small business owners, their employees and families for years. A chamber of commerce, trade association, or similar organization almost always forms these plans. Good examples of these types of organizations include the Council of Smaller Enterprises (COSE), the Small Business Association of Michigan (SBAM) and the SMC Business Councils. These programs, located in Cleveland Ohio, Lansing, Michigan and Pittsburgh, Pennsylvania, have many things in common. However, the defining characteristic of these programs seems to be that they were founded, and continue to be managed, by people with a single-minded determination to provide affordable health insurance to their members, not to generate profits for themselves from benefit plans. While Association Health Plan legislation seems to recognize this important characteristic and requires the plan to be established by an appropriate entity, including trade associations, chambers and a few others, the current language misses the point and opens the door to fraudulent programs that was closed in 1983 when oversight was returned to the states.

Department of Labor Oversight

One of the fundamental arguments for the formation of Association Health Plans is that their regulation would be transferred from the individual states back to the Department of Labor and, therefore can be established under a single set of rules by which they will be governed. The proponents of Association Health Plans believe these changes will encourage the establishment of many new AHPs by freeing them from compliance with different regulations in each of the 50 states, and allow them to deliver less expensive health care benefits by avoiding state mandates. This may or may not happen, and the potential for state regulation "shopping" - finding the state with loose or favorable regulations - and expanded fragmentation of the small group market is a very real possibility.

Administrative Costs and Association Health Plans

Proponents of Association Health Plans recognize that large companies are able to purchase health benefits for their employees at about the same price, but with lower administrative costs, than small employers. This advantage results in more of the benefit dollar being available to cover medical expenses (higher actuarial value). These proponents identify AHPs as a way to close the gap and lower the prices for small business. Information contained in the Small Business Administration Office of Advocacy Report, *Study of the Administrative Costs and Actuarial Values of Small Health Plans,* reports administrative costs in the range of 30% or more for small group health plans and implies that these costs would be substantially reduced through AHPs. In fact, 30% is at the upper end of the expense range, while expenses for an AHP are likely to be in the range of 15% - 20%. Therefore, the savings through an AHP are realistically in the area of 8%- 10% when compared to individual small group health plans. While an 8% - 10% reduction is significant, it is not likely to be a difference maker, thereby enabling many currently uninsured small businesses to offer coverage that they currently cannot afford. More importantly, the SBA study rightfully points out that many of the differences in administrative costs between small and large group health insurance will not be eliminated by AHPs. These include marketing and sales cost, billing costs, underwriting cost, and risk and profit charges.

AHPs also propose to lower costs by eliminating many state mandated benefits. While state mandated benefits differ from state to state, many cover essentially the same medical condition, and it is unlikely that these mandates generate 10% of the cost of a medical plan. Further, just because a benefit is no longer mandated does not mean that it would no longer be desired or offered. For example, it is hard to believe that a health plan that did not include coverage for maternity care would be

attractive to the general marketplace. Unless they were trying to "skim" the market, most association health plans, as large businesses do today, would still provide a high level of coverage independent of the mandate. It is hard to imagine the elimination of mandated benefits being worth more than a 2% - 5% reduction in plan cost. Further, as the SBA study rightfully points out, "The National Association of Insurance Commissioners, The National Governors' Association, and the National Conference of Legislators oppose association health plans that are exempt from state mandates because they would "threaten the stability of the small group market... According to their analysis, small firms with healthier employees would enroll in the new AHP, increasing premiums for the groups left in the small group market". This market segmentation is a very real outcome of association health plans that avoid state regulation and rate setting requirements. For the market to work effectively there must be a level playing field for all participants including those companies enrolled in an AHP and those buying coverage in the open market.

The belief that unifying AHP regulations under the DOL will spur the creation of many new AHPs is a stretch. I have seen little evidence that regulation is a significant factor in retarding the formation or growth of AHPs. Health insurance, like politics, is a local phenomenon and regulations did not prevent the formation or growth of the COSE, SBAM or SMC programs which now cover over 300,000 lives.

Today, many MEWAs are having trouble maintaining their enrollment levels, but the primary cause of membership loss is not regulation, it is the constantly evolving structure of the health care industry, the slow economy and the difficult cost trends found in today's market. Historically, trade associations, at the request of their members who were having trouble finding insurance at a reasonable cost - if they could find it at all, formed MEWAs. These programs were typically geographically spread-out and served companies in the 2 – 50 employee market. They chose to self-fund because insurers were reluctant to underwrite the companies even with the association acting as a consolidator or intermediary. The successful MEWAs had members with strong binds to the association sponsor and whose members took an active role in managing the program. Insuring small employer groups that health carriers were not interested in, MEWAs faced very little competition and enjoyed some measure of success; that is as long as they kept their rates affordable. Keeping their rates affordable was generally not a problem because the MEWA was under the control of the association managers and volunteer trustees who were themselves buying what they built. In my experience, the active involvement of volunteer trustees in the overall management of a group purchased program is critical to its long-term success.

In the last 10 –15 years, much has changed in the world of health care and health care delivery. Managed care has come and, in some cases, gone and commercial insurers now see their market as any local group. As premiums have increased and the number of large businesses has stabilized or declined, large health insurers and many brokers have redefined their market, and now try to build market share by actively pursuing companies that they have traditionally ignored. Put differently, growth in market share for insurers, or growth in commission revenue for brokers, is now dependent upon growing their share of the small group marketplace. Therefore, association sponsored MEWAs are under increased pressure from their members to find new solutions to rising costs, while remaining competitive and finding answers to the basic question of membership. Many programs face declining membership and serious questions regarding their long-term viability. Successful MEWAs must keep pace with the marketplace they serve. One way to do so is through the geographic concentration of membership, gaining mass, developing an acute understanding of its membership and the health care environment in which it operates, and expanding on the products and services they offer. This argues for local plans – like chambers or statewide group purchasers - and against national MEWAs that cannot hope to gain enough mass or knowledge of the member or marketplace to make a significant difference.

Association Health Plan Sponsors and Reserve Levels

Those in favor of AHPs, and those familiar with the problems created by poorly managed or fraudulent MEWAs in years past, recognize the need for bona fide sponsors and appropriate reserve levels. One way to attempt to solve the problem of AHP operators who are out to make a buck, as opposed to doing the best for their members, is to require that an appropriate entity sponsor the program. This looks good on paper, but will be ineffective in practice. It will simply force the operator who wants to begin a MEWA to shop for an association in need of money who will provide its name and logo in return for a fee or commission for its members who enroll. I have seen this practice before and there is no reason to believe that history will not repeat itself.

It is proposed that the regulation for AHPs include certain financial requirements. While these requirement levels are unclear, AHPs would be required to maintain reserves for unearned contributions, incurred and future liabilities, administrative costs, errors and other obligations. Additionally, AHPs would be required to maintain a surplus reserve of $500,000 - $2,000,000, and have a qualified actuary determine reserve levels for claims. Setting reserve levels is critical to the future ability of

an AHP to meet its obligations and this is precisely where the regulations of MEWAs in years past failed to protect the small business owner from fraudulent operators. If regulation reverts back to DOL, there does not appear to be a plan to prevent this from occurring in the future. In fact, the DOL has no history of regulating health insurance, something that the states have been

doing effectively since 1983. It is unrealistic to think that the DOL can build the expertise, infrastructure, or organizational structure to effectively carry out this task in a short time. What damage could be done in the small group marketplace while the DOL is ramping up is anyone's guess.

Conclusion

AHPs sound good on paper and in news releases, but it is difficult to find much to be truly excited about. If the goal is access to affordable health insurance, it is hard to imagine that AHPs will make much of a dent. In fact the CBO estimates that only 300,000 or so currently uninsured people would
become insured if AHP legislation was enacted. The other 4.3 million people who might find their way into an AHP would come from the ranks of the currently insured. These individuals could find themselves with less medical coverage and fewer safeguards than they enjoy today. Combine this very real possibility with the potential fragmentation of the small group market and it is easy to say that AHP legislation has badly missed its mark. While it may seem beneficial to replace 50 different sets of state regulations and mandates with one set of federal rules, allowing the debate over mandated benefits to shift from the state capitol to the nation's capitol, and allowing the DOL to establish a new bureaucracy to oversee the activities of AHPs and the small group health market, is a frightening proposition.

APPENDIX L – SUBMITTED FOR THE RECORD, STATEMENT OF THE DETROIT REGIONAL CHAMBER

United States House of Representatives

Small Business Health Care Hearing

House Committee on Education and the Workforce
Subcommittee on Employer-Employee Relations

March 13, 2003

Written Testimony of the Detroit Regional Chamber

Purpose of Detroit Regional Chamber's Comments

Honorable Chair, and distinguished members of the Committee. My name is Ed Wolking, and I am Senior Vice President, Strategic Directions, for the Detroit Regional Chamber.

Our purpose is to urge Congress to very carefully consider the issue of Association Health Plans (AHPs). First, AHPs will not lower overall health care costs. Second, Congress must objectively weigh the grave risks to the nation's small businesses and their employees if AHPs are not subject to proper safeguards.

Background of Detroit Regional Chamber

Detroit Regional Chamber is the largest metropolitan chamber of commerce in the nation, with more than 19,000 members, nearly all of which are small businesses.

One of our primary goals is to make health insurance accessible to all small businesses. We have been in the small group health insurance business since 1966. Our sponsored programs with Blue Cross and Blue Shield of Michigan (BCBSM) cover about 13,000 small businesses, 62,000 employees, and 137,000 total lives, including members of 56 local chambers and business organizations.

Our extensive services to independent insurance agents and small firms include:

- Helping small firms choose the most appropriate coverage for their individual circumstances
- Processing membership changes and updates within the BCBSM operating system
- Assisting with claims questions and resolving claims issues
- Helping members adjust their coverage in response to changing circumstances or escalating premiums

- Referring members to other insurance companies when Blue Cross coverages do not fit their needs.

As you can see, we offer these comments from our extensive background and familiarity with small group health insurance.

Association Health Plans Will Not Reduce Small Business' Health Care Costs

As the population ages and people experience longer life expectancy, the demand for health care increases geometrically. Life expectancy now averages 80 years, whereas health expectancy averages about 68 years. As expensive new technology comes to market (new equipment, treatments, processes, procedures, medications), prices also increase. But because of the rapidly aging population, demand rises faster than price, creating ever-escalating costs.

This is reflected in Exhibit 2 of the Kaiser Family Foundation and Health Research and Educational Trust annual study, "Employer Health Benefits, 2002 Summary of Findings." Overall inflation measured by the Consumer Price Index for the twelve months ending May, 2002 was 1.6%. Medical inflation was about 4% (down significantly from the levels of the early to mid '90s and slightly lower than the prior year). But employers' monthly insurance premiums rose dramatically during those twelve months, by 12.7%, continuing a trend that began in the 1998-1999 period.

Looking ahead, a Hewitt Associates forecast projects that American companies will face health care cost increases averaging 15.4% in 2003. Demand is the driving force in the growth in premiums.

These are challenging trends. As noted in the November/December, 2002 issue of *Enterprise*, published by the National Association of Manufacturers, "A 'triple whammy' threatens to unravel the fabric of the American employer-paid health insurance system.

"With a large portion of the American workforce aging or approaching retirement, ever greater prescription drug options and as new treatments and more sophisticated diagnostic procedures are employed by physicians, health care costs for the manufacturing industry have skyrocketed."

If a goal of AHPs is to lower health care premiums, millions of people will be very disappointed. These powerful forces will also hammer AHPs. If major national employers are having extreme difficulty with health care costs, including significant post-retirement liabilities, how will associations of independent small businesses fare any better?

Adding a level of largely unregulated competition will merely rearrange the pieces on the chessboard. It will not checkmate these driving forces.

Association Health Plans Will Lead to Large Pools of Uninsured

In many states, AHPs already exist, subject to the requirements of those states. In Michigan, for example, 136 associations and chambers of commerce sponsor small group

health programs underwritten by Blue Cross and Blue Shield of Michigan. In January, 2003, those programs covered:

- 52,079 businesses
- 305,266 employees
- 674,893 lives

Partly as a result of these programs, a higher proportion of Michigan's population is covered by health insurance compared to the average of the states. In the year 2001, 89.6% of Michigan's population was insured, versus 85.4% of the U.S. population.

If AHPs are not subject to the same state regulatory requirements, a tilted playing field will emerge within eighteen months to two years. AHPs will have a built-in price advantage. Younger, healthier risks will seek out the least expensive plans. AHPs themselves will also seek out younger, healthier risks to maintain and build their advantage. Older, less healthy risks will slide into the more expensive pools. As the process unfolds, a significant pool of uninsured businesses and people will emerge, and effective insurance pools will be destroyed. This "adverse selection" was occurring in most states before the state reforms enacted in the 1990s.

Small businesses in Michigan currently experience this form of adverse selection. The HIPAA carrier of last resort, Blue Cross, is required to accept all risk and places its small groups in community rating pools. On the other hand, except for the HMO markets, the rating and underwriting practices of other carriers are unregulated, and they select the better risks.

The result is Blue Cross' small group rates that are about 30% higher than they would otherwise be, according to William Bluhm, of Milliman USA, an actuarial expert who advised on the HIPAA legislation, as well as a Blue Cross population that is significantly older than the Michigan average and ever more expensive to insure. Left unchecked, adverse selection will result in spiraling premiums that produce ever-greater numbers of uninsured.

The antidote to adverse selection created by AHPs would be strong federal rating, benefit, and underwriting standards for all plans, which would necessarily supplant the standards of individual states. However, that raises a critical question.

Can National Standards be Effective?

The federal government has historically deferred on insurance standards to the states. This is a very diverse nation, and what makes sense in Maine may not make sense in California. Granted, the requirements of individual states, adds a layer of cost and complexity to group health insurance. But those requirements protect and insure a far greater number of people who are already insured, responding to the nation's regional needs.

On the other hand, could the federal government adequately assess and address health care needs within the individual states? And once a set of federal standards would be in place, would the legislative and executive branches have the will, the resources, and the

desire, to ensure compliance and keep up to date? What about the already-clogged judicial branch? Isn't that a form of national health care so many have railed against?

Some proponents of AHPs have argued that HIPAA and ERISA requirements will provide adequate protection against the tendency of insurers to avoid risk. We disagree. HIPAA left untouched the ultimate protection against risk – price. Only the individual states regulate price, within the HIPAA framework - - forty-seven of them utilizing some variation of the model act developed throughout the '90s by the National Association of Insurance Commissioners. Nor can we identify any ERISA regulations that will prevent adverse selection in small group health insurance markets.

The AHP concept is often described as a type of Multiple Employer Welfare Arrangement, or MEWA, regulated under ERISA Somewhat popular in the '80s, MEWAs have largely failed. Operating under federal law and superseding state law, most were inadequately designed, under-capitalized, under-funded, and inadequately regulated, becoming a big problem for the employers and people they promised to insure:

- They operated with little to no federal supervision or oversight.
- Many of them were undercapitalized and failed to cover the health benefits they promised.
- Many of them arbitrarily reduced benefits without communicating with their employers or their employees.
- Most of them went out of business.

AHPs operating similarly to MEWAs may very well meet the same fate.

Conclusion

Without proper attention to the issues above, Association Health Plans will be ineffective in controlling costs and eventually do more overall harm than good.

As a result, Detroit Regional Chamber encourages this distinguished Committee to seriously consider the impact current proposals will have on the cost of doing business for small firms. If the end goal is to reduce the cost of health care, while expanding access to health care, then Congress needs to provide the incentives for potential recipients to use health care programs.

We urge Congress to consider tax credits for small businesses that provide an agreed upon "Basic Health Insurance Coverage" for their employees. This should include 100% deductibility of paid insurance premiums, as well as other incentives that promote fairness and access for working Americans.

Thank you for the opportunity to submit remarks and please contact me with any questions. I can be reached at:

Ed Wolking, Jr.
313-596-0304, or ewolking@detroitchamber.com

You may also visit our website at www.detroitchamber.com.

APPENDIX M – SUBMITTED FOR THE RECORD, LETTER TO RANKING MEMBER ROBERT ANDREWS, FROM DONALD A. YOUNG, M.D., PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA (HIAA), MARCH 13, 2003

Health Insurance Association of America

Donald A. Young, M.D.
President

March 13, 2003

The Honorable Robert Andrews, Ranking Member
Subcommittee on Employer-Employee Relations
Committee on Education and the Workforce
United States House of Representatives
Washington, D.C. 20515

Dear Representative Andrews,

As the nation's most prominent trade association representing the private health care system, the Health Insurance Association of America ("HIAA") is writing to express its concerns about The Small Business Health Fairness Act of 2003 (H.R. 660), as well as companion legislation in the Senate. Our nearly 300 members provide health, long-term care, dental, disability, and supplemental coverage to more than 100 million Americans, including substantial coverage through employer-sponsored health insurance in the small group market.

By allowing the creation of "Association Health Plans" (AHPs), the bill would result in a two-tiered small group health insurance marketplace, one tier consisting of those who benefit from preemption of state health mandates and health plan rating restrictions, and another tier comprised of those who remain subject the current regulatory environment. We contend the AHPs envisioned by the legislation are unlikely to expand access to affordable health insurance coverage, would have inadequate financial protections to ensure their solvency, and will disrupt and unfairly segment the small employer insurance market.

Sound approaches to affordable health care are needed. HIAA supports sound approaches to helping small businesses better afford health insurance for their workers. A significant portion of the 41 million Americans without health insurance work for small businesses. However, we believe that enacting the AHP legislation offered today would create an unlevel playing field – one where federal law provides one set of favorable rules for those employers and employees who can join an AHP and a different, more expensive set of rules for those who don't – potentially resulting in an even greater number of uninsured Americans.

Small employers who can't or won't join an association should not be disadvantaged. We are concerned that the preferential treatment of AHPs with respect to state-mandated benefits and rating restrictions will create a two-tiered marketplace for small business owners seeking to provide health coverage to their employees, almost certainly resulting in a migration of small employers, particularly healthier groups, out of the general small group market into AHPs. Certainly, providing unfair advantages to only one set of small businesses does not create a competitive and healthy small employer insurance market.

1201 F Street, NW Suite 500 Washington, DC 20004-1204 202-824-1682 Fax 202-824-1651

We oppose an unlevel playing field. We urge the Congress to resist treating business owners and workers joining AHPs more favorably than those who do not have that option. Otherwise, premium rates will likely jump for those small employers left behind, forcing some to drop coverage, and destabilizing the entire small group market. In fact, the Congressional Budget Office estimates that 20 million people could see their insurance premiums increase as a result of the this type of AHP legislation.

AHPs could produce a number of other serious problems. If this proposal becomes law, it could increase the risk of fraud in the marketplace, leave consumers stuck with unpaid medical bills, and create the need for an expensive, new federal regulatory structure that duplicates one already in place in the states. Moreover, we believe the administrative savings expected from these AHPs, the purported source of much of the "cost savings" to employers, likely will prove less than many hope.

We agree with America's employers that we all need to find a way to make health care coverage more affordable. But, unfairly tilting the playing field to help some small businesses with health coverage, while almost certainly worsening the outlook for health coverage for others, is simply not the way to do it. For these collective reasons, we urge you to reject passage of this AHP legislation.

Sincerely,

Donald A. Young, M.D.
President

Health Insurance Association of America

Why Health Insurers Oppose "Association Health Plans"

AHPs are unlikely to expand access to affordable health insurance coverage.

- Researchers agree that AHPs would draw their membership primarily from currently insured small groups. A recent study by the Congressional Budget Office (CBO) found that new types of purchasing groups only minimally expand coverage for small firm employees, as most employers tend to substitute this new type of coverage for their current traditional coverage.[1]
- Two recent studies concluded that the purchasing groups were unlikely to reduce health insurance costs enough to entice small firms to purchase insurance if they do not already offer coverage.[2, 3]
- Another recent study of the small group purchasing arrangements now authorized in many states and available to small businesses found that such arrangements appear to create no significant cost savings for their participants.[4] The CBO study confirmed that AHPs do not produce efficiency savings for small employers, calling cost savings from group purchasing features "negligible."[5]

Inadequate financial protections undermine the stability of AHP coverage.

- The bill's financial solvency standards and procedures are "woefully inadequate" according to experienced state regulators. Reserve requirements for self-insured AHPs are capped, whereas state "risk-based capital" requirements ensure proper protections for large as well as smaller plans.[6]
- Unlike state-based protections which rely on guarantee funds, the AHP bill's foundation for financial solvency protections is a requirement that self-insured AHPs purchase private "indemnification insurance." This is an insurance product that does not exist today, and is structured in the bill to be a product that no prudent reinsurer would offer.
- State regulators conduct ongoing oversight of health insurers' financial soundness. H.R. 660 relies solely on "self-reporting" of financial problems by AHP actuaries; it has no ongoing federal monitoring procedures parallel to state procedures. Even if such responsibilities were added to the bill, it is highly unlikely that the Department of Labor would receive sufficient funds to adequately carry out the task.

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[1] Congressional Budget Office, "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts" January, 2000.
[2] Elliot K. Wicks and Jack A. Meyer, "Small Employer Health Insurance Purchasing Arrangements: Can They Expand Coverage?" May 1999. (Report prepared for the National Coalition on Health Care.)
[3] Len M. Nichols, "Expanding Health Insurance Coverage by Creating New Options: Some Thoughts on the Relative Attractiveness of Association Health Plans, HealthMarts and High-Risk Pools," 1999 U.S. House of Representatives testimony.
[4] Stephen H. Long and Susan Marquis, "Pooled Purchasing: Who Are the Players?" Health Affairs, July/August 1999.
[5] CBO, *op cit.*
[6] Testimony of Sandy Praeger, Kansas Commissioner of Insurance on behalf of the National Association of Insurance Commissioners before the Senate Small Business Entrepreneurship Committee, February 5, 2003.

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Why Health Insurers Oppose "Association Health Plans" - continued

AHPs will disrupt the small employer insurance market

- Under the proposal, insured coverage offered to employers eligible for AHPs will be exempt from state mandated benefits requirements. Healthier groups will be attracted to such policies, leading to precisely the type of risk segmentation that state health insurance reforms have sought to minimize.[7]
- The preferential treatment of AHPs with respect to benefits and rating will result in a migration of small employers, particularly healthier groups, out of the general small group market into AHPs. Rates will rise for those left behind, forcing some small employers to drop coverage, and destabilizing the entire small group market.
- The CBO study concluded that AHPs undermine state small employer rating reforms, which were intended to make coverage more affordable for high-cost firms. The resulting premium increases for high-cost firms in an AHP market may force some of them to drop coverage, leaving their employees uninsured.[8]

Establishing AHPs will result in wasteful regulatory duplication.

- With over 22,000 national associations and some 48,000 regional, state, or local organizations that potentially could sponsor AHPs, the Department of Labor would be shouldered with a huge regulatory responsibility, requiring a large new federal bureaucracy.
- Adding AHPs to the insurance market would further complicate the already complex regulatory environment. CBO notes: "Much uncertainty attends the overlapping of federal and state jurisdictions over AHPs ...."[9]

March 2003

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[7] Nichols, *op cit.*
[8] CBO, *op cit.*
[9] *Id.*

APPENDIX N – SUBMITTED FOR THE RECORD, STATEMENT OF NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

WRITTEN TESTIMONY

SUBMITTED FOR THE RECORD

BY

NATIONAL ASSOCIATION OF

INSURANCE COMMISSIONERS

FOR THE

HOUSE EDUCATION AND THE WORKFORCE COMMITTEE

HEARING ON THE

SMALL BUSINESS HEALTH INSURANCE COSTS

Hearing Date:
March 13, 2003

Date Submitted:
March 7, 2003

Introduction

The National Association of Insurance Commissioners (NAIC) represents the chief insurance regulators from the 50 states, the District of Columbia, and four U.S. territories. The primary objective of insurance regulators is to protect consumers and it is with this goal in mind that we comment generally on the small business healthcare crisis, and in particular legislation to create Association Health Plans (AHPs), H.R. 660.

At the start, we would like to emphasize that the states recognize the importance of ensuring that health coverage is affordable and available 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 ten years to stabilize and improve the small group market. Many states have even implemented laws that allow associations to provide insurance to their members. However, the members of the NAIC remain strongly opposed to the AHP legislation that has been offered in Congress. More can and must be done to make health insurance more affordable for small business employees, but the AHP legislation, as currently drafted, would do more harm than good.

A. What States and the NAIC Have Already Done to Address the Problem

Throughout the 1990's, the states and the NAIC have devoted significant attention to the problem of making health insurance available to small employers. We have taken a variety of approaches in this effort.

1. Small Group Reform

One approach the states have taken is small group reform. Before the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 46 states had enacted some kind of small group reform based in varying degrees on NAIC models.

In 1992, the members of the NAIC adopted the Small Employer and Individual Health Insurance Availability Model Act. It required the guaranteed issue of a basic and standard health benefit plan by all health carriers doing business in a state's small group market. It also required guaranteed renewability, subject to certain exceptions, and established rating bands to assure consumers are not priced out of the market and risk is spread over a larger pool. In essence, the block of small group business is treated much like large groups for rating purposes.

In 1995, the NAIC refined this model. The 1995 version required guaranteed issue and guaranteed renewability of all products offered by a carrier in a state's small group market. It also required adjusted community rating with adjustments permitted only for geographic area, age, and family composition.

Today, our members are examining the impact of HIPAA and determining what further efforts are needed by states to assist small businesses in the provision of coverage.

2. Purchasing Pools

Allowing small businesses to form purchasing pools, sometimes called purchasing alliances, is another approach that states have taken to make health insurance more available to small groups. By joining together, small groups can somewhat reduce their administrative costs, provide their employees with more choice, and command better prices.

The NAIC has devoted considerable attention to health insurance purchasing pools. In 1995 the NAIC adopted three model acts allowing for the creation of purchasing alliances. These models represent the NAIC's complete agreement with the concept that small employers should have the opportunity to join together to purchase health insurance.

At least twenty-two states have either adopted legislation that creates some kind of purchasing pool or have allowed purchasing pools to operate without legislation.

Again, the NAIC agrees that more needs to be done to expand coverage to small businesses. Reforms should be broad, addressing both the affordability of insurance (bringing down the cost of coverage to small businesses, possibly through financial incentives) and the availability of insurance (expanding choice and promoting competition). However, the AHP legislation is not the answer and would have the effect of reversing many of the gains that have been made over the last 10 years.

B. Specific Concerns About H.R. 660

1. H.R. 660 Would 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. H.R. 660 would undermine state reforms and once again fragment the market.

Each association would create its own risk pool that, due to the benefits provided, types of businesses in the association, or area serviced, could have significantly lower risk than the general market. While the bill does make some effort to reduce "cherry picking" the NAIC believes the provisions would be inadequate.

2. H.R. 660 Would Undermine HIPAA Reforms

The guaranteed issue requirements of the Health Insurance Portability and Accountability Act of 1996 allows small employers to switch from one plan to another without denial. If H.R. 660 were to pass, small employers would be able to purchase less expensive association health plan coverage that does not contain mandated benefits or comply with any other state requirements. When an employee needs better coverage, the employer would be free to enter the regulated small group market and be guaranteed the coverage under HIPAA.

This self-selection is extremely disruptive to the marketplace and will create a very unstable situation in an already fragile small group market, likely reducing the number of insurers willing to offer coverage in the general market. Insurance is of little use unless the costs of caring for the relatively few can be distributed among the many who are healthy. This is one of the key tenets behind HIPAA.

3. H.R. 660 Would Lead to Increased Plan Failures and Fraud

Proponents of AHP legislation claim that the Department of Labor already has sufficient resources to oversee the new plans and will be able to prevent any insolvencies or instances of fraud. 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, and the combined budgets of state insurance departments total more than $700 million. The AHP legislation, H.R. 660, provides no new resources for regulating these plans.

While we acknowledge adequate regulation costs, it exists to protect 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 the state, 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.

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. In particular, the capital reserve requirement for any and all AHPs is capped at $2 million -- no matter the size of the plan. Almost all 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 only $2 million would result in disaster.

b. AHP Finances Must Receive Greater Oversight

Even if the solvency standards were increased, oversight is almost nonexistent in the bill. Under H.R. 660 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 would be required to "self-report" any financial problems. As we have seen over the past year, relying on a company-picked accountant or actuary to alert the government of 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.

4. H.R. 660 Would Eliminate Important Patient Protections

Included in H.R. 660 is the broad preemption of consumer protection laws. Proponents of AHPs will 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 complex regulatory structure in place for insurers. Not only will mandated benefit laws be preempted, but other laws protecting patient rights and ensuring the integrity of the insurers would be preempted as well. A small sample of these laws and actions follows:

- Background review of officers.
- 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.
- 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.
- Internal and external appeals processes.

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 patients' rights are violated by the plan. State insurance regulators act on millions of consumer complaints every year and work hard to protect the rights of patients. AHP participants should have access to the same protections and complaint process.

5. H.R. 660 Would Cut Funds to High Risk Pools and Guaranty Funds

While H.R. 660 would allow states to impose premium taxes on AHP plans – to the extent they are imposed on other insurance plans – it preempts other state assessments. States often 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.

Conclusion

All of us recognize that it is very important to make health insurance available to small employers. The states have addressed this problem, and will continue to do so. However, the problem is complex and does not lend itself to easy solutions.

H.R. 660 would put consumers at significant risk and disrupt the health insurance market. The illusion of federal regulation based on company self-reporting of problems will lead to extensive failures. The fragmentation of the small group market will leave many small businesses with higher premiums, or no coverage options at all.

The NAIC opposes H.R. 660 as currently drafted and urges Congress not to adopt it. We stand ready, however, to work with this Committee and other members of Congress to draft effective reforms that will address both the affordability and availability issues facing small businesses. Together, we are convinced, the federal government and the states can find real solutions to this critical issue.

APPENDIX O – SUBMITTED FOR THE RECORD, STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA, WASHINGTON, D.C.

Written Statement in Opposition to H.R. 660

by

Ronald F. Pollack, Executive Director
Families USA

Submitted to the

Subcommittee on Employer-Employee Relations
Committee on Education and the Workforce
U.S. House of Representatives

Thursday, March 13, 2003

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Mr. Chairman and Members of the Committee:

I am pleased to have this opportunity to submit a written statement to you expressing Families USA's opposition to H.R. 660, the "Small Business Health Fairness Act of 2003." Families USA is the national organization for health care consumers. Our mission is to ensure that all Americans have access to high-quality, affordable health care.

After extended and careful consideration, we find that the current Association Health Plan (AHP) proposal poses a serious threat to our existing employer-based health insurance system and violates the important principle: Do no harm.

The current AHP legislative proposal (H.R. 660) is intended to help smaller employers and self-employed individuals come together to purchase health insurance coverage at lower cost. While the concept sounds reasonable—allowing small employers to come together to achieve cost-savings through greater bargaining clout and efficiencies of scale[1]—the current legislation has the potential to cause significant harm to the existing small employer insurance market.

In fact, small employers can come together under existing law to purchase health insurance. Nothing in current federal or state law *prohibits* small employers from forming associations.[2] In fact, one in four of all private employers and one in three of all small employers (those with nine or fewer employees) purchase insurance through group purchasing arrangements.[3]

Generally, any time more than one small employer comes together it is considered a Multiple Employer Welfare Arrangement (MEWA) under ERISA law and must comply with certain DoL registration requirements and basic fiduciary duties. In addition, both fully insured and self-insured MEWAs also are under state regulation. MEWAs must comply with state laws, including solvency standards to protect against plan financial failures, state consumer protection

laws, state rating laws, underwriting laws, and benefits mandates that protect against adverse risk selection and segmentation in the small group market.[4]

If small employers currently are able to band together to purchase health insurance, then what does AHP legislation accomplish? The key change is that AHPs will be able to operate outside of state insurance laws.

The proposed federal AHP legislation would federalize the regulation of Association Health Plans by eliminating state authority to regulate these arrangements.[5] H.R. 660 would create two types of AHPs—insured and self-funded. For *insured* AHPs, the insurance company would be required to comply with state laws regarding solvency requirements in the state where it is licensed, as is required under current law. However, the *plans* offered by insurance companies to AHP members would have to comply with the state consumer protection laws in *only one state* in which the plan is offered—even if it is offered in more than one state. Currently plans must comply with the laws in *each* state where the plan is offered. Logically, insurance companies would select states with the fewest consumer protections. Further, insured AHPs would *not* have to comply with state rating laws, limits on medical underwriting, and benefits mandates.

Even more problematic, *self-funded* AHPs would be exempt from *all* state laws and oversight—including solvency requirements, all consumer protections, premium rating laws, limits on medical underwriting, and benefits mandates.

After careful consideration, Families USA finds no evidence that exempting AHPs from state regulation will improve the situation for small employers. The current AHP proposal would not only fail to reduce average premiums for small employers, it would actually *increase* premiums for many of them. In fact, costs for some employers that now offer health insurance benefits would increase so significantly that they would be forced to drop coverage. In addition, an

exemption from state oversight would place consumers at great risk for enrollment in insolvent plans—whether the financial failure is due to deliberate fraud or poor management.

AHPs: Leave Many Small Employers Behind with Higher Premiums

States enact premium rating and underwriting laws to require that insurers "pool" all their small employers when setting premiums. With exemptions from these state laws, AHPs will divide small employers into high-cost and low-cost groups ("segment the market"). AHPs will be able to skim low-risk employers (those with a young, healthy workforce) from the existing state-regulated small group market by attracting them with cheaper premiums. At the same time, high-risk employers will be left behind with much *higher* premiums because they will no longer have the benefit of cross-subsidization of costs between high- and low-risk employers. The capacity of AHPs to significantly lower premiums is very much dependent on their ability to successfully "cherry-pick" healthy small business groups —to "rob Peter to pay Paul." *In fact, the CBO estimates that nearly two-thirds of the cost savings from AHPs would result from attracting healthier groups from the pool of existing insured small businesses.* Without state limits, many small employers with sicker or older workers will simply be driven out of the small group health insurance market by higher premiums. The CBO has estimated that 80 percent of workers would be worse off under AHPs: 20 million employees and dependents of small employers would experience a rate *increase.*[6]

Here I would like to be very clear about what H.R. 660 allows, as there has been some confusion in the past. When we point to the risk of cherry-picking, we are not referring to the ability of an AHP to deny coverage to individual employees at a small business that is in the AHP: This is clearly not allowed. Further, once an AHP or group of small businesses are defined, H.R. 660 prohibits the AHPs from varying the contribution rates (premiums) for any participating small

employer based on a *health status-related factor* of any of its employees (this is an improvement over the bill before the House in the 107th Congress that only prohibited contribution rate variation based on claims experience). This means that *within the group or AHP*, all participating small businesses must pay the same premiums without regard to the health of a particular business's employees. *However, an insurance carrier or a self-funded interest can target groups of small businesses or define AHPs in such a way that they* include *businesses with healthy workers and* exclude *businesses with workers more likely to file claims.* For example, AHPs have the freedom to offer coverage only to certain target industries or employer sectors and to exclude industries or sectors that have a history of higher health claims. There is nothing in H.R. 660 that prohibits discriminatory rate setting between these groups of businesses or AHPs. If a business has workers who are older or have health problems, it will likely not be in an AHP with low premiums. In fact, that business may find itself grouped or left in a pool with other high risk business and thus its premiums will rise.

In addition, H.R. 660 will give AHPs several other new ways to cherry-pick the small businesses with the healthiest employees than currently allowed under law. First, it is not clear from the legislation if the definition of "health status-related factor" is consistent with the current definition in the Health Insurance Portability and Accountability Act (HIPAA). If so, then an AHP could still vary rates for different small businesses *within* the AHP based on *age, gender, number of employees, and a range of other factors.* Second, AHPs can offer different plans to different groups of small businesses based on "geographic availability," thus allowing AHPs to deter employers from rural areas who may be at higher risk for making claims from enrolling because they are offered a less generous benefit package or simply no package at all. Third, even without the hook of "geographic availability," AHPs in H.R. 660 are given almost unfettered discretion to

design the benefit package in such as way as to be attractive to employers with healthy employees and unattractive to employers whose employees need more services—for example by offering a very minimal package of benefits.

I cannot emphasize strongly enough what this ability to cherry-pick means for many small businesses: AHPs will be designed so that they will serve only the small businesses with the healthiest employees and leave out small businesses with older or sicker employees—those who most need coverage. This ability to cherry-pick will drive up the cost of coverage for small businesses with a less healthy profile of workers who will then be left in an insurance pool by themselves.

Proponents of AHPs argue that small employers should be able to offer less generous benefits packages in order to bring down the cost of coverage. And, indeed, dropping state mandated benefits would be a major method that AHPs could use to reduce costs for some small businesses. The CBO estimated that one-third of cost savings in AHPs would come from sidestepping state benefits mandates. Obviously, the less generous benefits packages would be costly for the employees who need the benefits that are excluded. In addition, exempting AHPs from state benefit mandates will allow AHPs to cherry-pick small businesses with healthy people and segment the small employer insurance pool.

An exemption from key benefit mandates would allow AHPs to offer benefit packages that save money by excluding prescription drugs, mental health services, and maternity coverage, for example. But these cheaper, less comprehensive packages with lower premiums will attract small businesses with healthy people because they feel confident that their employees won't need the missing benefits. This same financial calculation makes the AHP plan less attractive for small businesses with workers who are likely to need these benefits—older workers, women, disabled

and chronically ill individuals, workers in industries with historically high claims experience, etc. Thus, the AHP can manipulate the benefits package to attract small businesses who have workers who are young and healthy and to discourage other small businesses. Once again, this "adverse risk selection" ultimately leads to increased costs for the small employers (and their workers) who are left behind to insure through the traditional, non-AHP market.

It is critical to understand that state rating laws, underwriting laws, and benefit and provider mandate laws are all designed to make coverage affordable and accessible for *all* small employers and their employees. We are willing to work with proponents of AHPs to design structures that would address the cherry-picking concerns I have raised. There also are some promising ideas about how small employers might be helped with the cost of insurance through a small employer tax credit. *But we are opposed to any design or structure that will lower the cost of premiums for a few lucky businesses with healthy workers* ***at the expense of*** *the small businesses with workers that are in less-than-perfect health.*

AHPs: Solvency Protections and Active Oversight Essential

In addition to our concerns about market segmentation, we are extremely concerned about protecting consumers from plan failures that leave consumers with unpaid medical claims. For self-funded AHPs, H.R. 660 would preempt states from continuing their traditional role of regulating such matters as solvency and consumer protections and place self-funded AHPs under the jurisdiction of the U.S. Department of Labor (DoL).

Proponents of AHPs argue that their proposal would allow pools of small employers to operate under the same rules as large, self-funded employers that are governed by ERISA. While this may sound reasonable at first glance, a large, self-funded employer is a very different entity from an AHP. When a large employer self-funds, the large employer has considerable assets,

revenue flow, and resources to handle fluctuations in the number of claims. Further, large employers tend to be more stable entities and to have a more stable workforce so that the level of claims is predictable.

An AHP is only a shell or skeletal structure created by an association of small employers and comprised of a board of directors. The assets of the small employers who are members are available to pay medical claims if the small employers sign a promissory note to put up their business assets against future unpaid claims. However, this places employers at very serious risk of financial ruin and bankruptcy. This is because it will be very hard to predict the claims that an AHP will experience: the average small employer's workforce is much less stable—the mix of healthy, sick, young, and old is changing—and small firms are more likely to come and go. If the actual claims level exceeds what was predicted, small employers have very little cash flow or liquid assets to make up the shortfall. Thus, a self-funded AHP must operate more like an insurance company to adequately protect its members—it must offer protection against unpredicted claims fluctuations—than is true of a self-funded large employer. These new "AHP insurance companies" for small employers would be created without any of the state laws and oversight that govern the solvency of other insurance companies. The only solvency protections that will exist are those that are required by the proposed AHP legislation.

While proponents of AHPs maintain that H.R. 660 "fixed" the solvency protection problems of past AHP proposals, we find that *the solvency requirements for self-funded AHPs are clearly inadequate.* Without elaborating on the details, provisions in the bill regarding minimum surplus, minimum reserve, and individual and aggregate stop-loss insurance must be enhanced to protect workers. Even if these solvency requirements were appropriately strengthened, in order to provide workers in AHPs real protection, the federal government must establish a true guarantee

fund sufficient in size to pay the unpaid claims of insured workers. The so-called "guarantee fund" in the AHP bill only pays the premiums for stop-loss and "indemnification insurance."[7] A true guarantee fund will require significant federal funding support from general revenues; fees or assessments from AHPs will not be adequate to create this guarantee fund.

In addition to the cost of a federal guarantee fund, we should not underestimate the cost to provide the Department of Labor with the enforcement tools, staff, and resources necessary to oversee these many new "AHP insurance companies" removed from state jurisdiction. The AHP proposal would, in effect, re-create a national insurance department to replicate the function of 50 state insurance departments. The DoL has testified in the past that it lacks the funding and manpower to take on this enormous responsibility and estimates that it could review each AHP only once every 300 years.[8] A General Accounting Office (GAO) report issued last year found that it would take DoL's current investigative staff 90 years to do a baseline assessment of noncompliance for pension plans alone.[9] Frankly, it is hard to believe that the DoL can suddenly identify sufficient resources and staff (with no new funding) to adequately take over the complex regulatory tasks of 50 state insurance departments.

Are opponents of AHP legislation over-reacting to the potential for fraud, abuse, and insolvency? History and recent events would indicate not.

In 1974, Multiple Employer Welfare Arrangements were exempted from state regulation and placed under the authority of the Department of Labor. The members of this Committee are aware of the disastrous results: MEWA failures in the four years from 1988 to 1991 left at least 398,000 consumers with over $123 million in unpaid claims, according to a 1992 GAO report. Through hearings and review of the situation, Congress decided that MEWA regulation had to be

returned to the states. We do not want to repeat this mistake by leaving AHPs exempt from state solvency and consumer protection laws.

The regulation of MEWAs or association-type health plans for small employers is an enormous task. Recent media reports have documented the failure of self-funded association-type health plans for small employers over the last six months. These failures have hurt more than 50,000 workers and their families by leaving them with millions of dollars in unpaid medical bills. That is more than twice the number of people hurt by the ENRON benefits plan failure.[10] State and federal regulators indicate that in the last few years, the number and magnitude of association health plans' abuses have grown and that such "illegal operations are rapidly growing and spreading around the country."[11] While some of the failed health plans were clearly fraudulent criminal schemes, others were sponsored by business groups that likely could have obtained certification as AHPs under the proposed legislation.

AHPs would also be exempt from state consumer protection laws that ensure that HMOs and other insurers do not wrongfully deny health care. The Supreme Court decision in *Rush Prudential HMO, Inc. v. Moran* provided a victory for patients by upholding the Illinois external appeal process that gives patients a right to have impartial health experts review the denial. This right would be meaningless for any worker receiving health coverage through an AHP. Nothing in the AHP legislation would replace that right to a fair and independent review that consumer advocates, policy makers, and regulators in 42 states have deemed to be essential to balance the power between consumers and health insurers.

States have passed many other health insurance consumer protection laws that would be immediately wiped out for any worker covered under an AHP. These laws protect access to specialists, continuity of care, the autonomy of the patient-physician relationship, the right to

emergency care, the right to full and fair disclosure of information about coverage, and the availability and timeliness of internal appeals of denials of treatment, to name just a few key protections. The policy decisions and best judgment of 50 state legislative bodies—reflecting the experiences and problems of people in their states as well as the political weighing of the costs and benefits of these protections—would be usurped.

In closing, we share the concern of proponents of AHPs about the growing number of uninsured and, in particular, share the recognition that the rising cost of health insurance is a major barrier to small employers who want to offer coverage to their workers. We are ready and willing to work with Congress to help craft solutions to help more small employers provide health insurance coverage. But we must be sure that what we design does not deliver more harm than help to workers and owners of small firms.

[1] Proponents of AHP legislation maintain that group purchasing will achieve savings and Families USA does not challenge this assertion. However, when the bipartisan Congressional Budget Office examined this question, they found "...no substantial evidence that joining a purchasing cooperative produced lower insurance costs for firms." In fact, CBO points out that the minimal savings from group purchasing is unlikely to induce many small firms to add coverage *because the group purchasing option is already available to the vast majority of small employers*." (italics added). In addition to the CBO report, researchers examining data from 1993 and 1997 employer surveys found that the three largest statewide small-group purchasing alliances—in California, Connecticut, and Florida—did not increase coverage and did not reduce small group market health insurance premiums. Other noted researchers examining the issue have also concluded that AHPs "are not likely to produce a significant overall reduction in premiums or increase in coverage." William M. Mercer, Inc., a human resources business consulting firm, has stated that AHPs "...would provide no material opportunity for AHPs to reduce health insurance administrative costs for small businesses."

[2] Some states have "fictitious group laws" that prevent small employers from forming a group or association for the sole purpose of purchasing insurance. These laws require that the association have some other common legitimate purpose. These laws are designed to prevent the most blatant artificial segmentation of the small group insurance market and the higher premium consequences that it would have for the small employers who are not able to join the association.

[3] Stephen Long and Susan Marquis, "Pooled Purchasing: Who Are the Players?" *Health Affairs*, Vol. 18, no. 4, July/August 1999, p. 107. Group purchasing arrangements include Multiple Employer Welfare Arrangements (MEWAs), multiple employer trusts (METs), Health Insurance Purchasing Coalitions (HIPCs) professional and trade associations, employer coalitions, and alliances for their health insurance coverage.

[4] The DoL has made clear that state solvency laws are applicable to MEWAs and provide important protections against plan failure in addition to the protections provided by ERISA. However, there are problems with the definition of MEWAs in the ERISA law that allow some entities to assert an ERISA preemption shield that then requires states to go to court to assert state jurisdiction and regulate the entities (for example, in employee leasing company situations and certain other fraudulent underlying associations). This definitional confusion about the authority and scope of state jurisdiction over MEWAs has allowed some MEWAs to be poorly managed and also created opportunities for fraudulent association-type schemes. There is a definite need to provide some clarification and improvement in current MEWA law, but the proposed AHP legislation is not the best way to address flaws in the current MEWA laws.

[5] H.R. 660's preemption provisions also create ambiguity under ERISA. The bill would preempt state laws that "may preclude" or merely have the "effect of precluding" entities from selling coverage to a federally licensed association (see § 421(b) amending ERISA § 514). These ambiguities make it easier for fraudulent scheme avoid state regulation.

[6] Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts*, (Washington: Congressional Budget Office, January 2000).

[7] There are a number of problems with the reliance on stop-loss insurance and "indemnification insurance" in the current AHP proposal as mechanisms to make sure that individual workers are not left with unpaid medical claims. Five of the most important problems are: First, these mechanisms would provide payment directly to an AHP even if the AHP is mismanaged or fraudulent. There is no guarantee that the money would then go to pay workers' unpaid medical bills. Second, some risk is assumed by the AHP with stop-loss insurance and the protection of stop-loss insurance can leave a "gap" in unpaid claims before it provides help. The current AHP proposal allows AHPs to assume significant risk and leaves a significant gap because of a high attachment point. Third, stop-loss insurance may only pay a percentage of the claims when it does provide help, and may not pay claims for pre-existing conditions. Fourth, stop-loss insurance should help both when an individual claim is very high or the total of all claims is very high—individual and aggregate stop-loss. The AHP bill does not require both types of stop-loss insurance. Fifth, "indemnification insurance" as defined in the AHP bill does not currently exist. This product would need to be developed to fill in the gap left by stop-loss insurance when an AHP is mandatorily terminated. It is not clear why it would be a profitable endeavor to offer such a product.

[7] One of the primary reasons for these recent failures is the lack of clarity with regard to the states' ability to assert jurisdiction over these self-funded plans because of problems with the scope of the definition of MEWAs in ERISA. See footnote 19.

[8] Testimony of Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration, before the Senate Labor and Human Resources Committee, October 1, 1997, at pp. 9-11.

[9] U.S. General Accounting Office, *Pensions and Welfare Benefits Administration: Opportunities Exist for Improving Management of the Enforcement Program*, GAO-02-232, at p. 3 (March 15, 2002).

[10] One of the primary reasons for these recent failures is the lack of clarity with regard to the states' ability to assert jurisdiction over these self-funded plans because of problems with the scope of the definition of MEWAs in ERISA. See footnote 19. For a description of these failures, see Kofman, Mila, "Health Insurance Scams Promoted Through Associations: A Primer, *The Insurance Receiver*, Vol.11, no. 3, at 10, September 2002. *The Insurance Receiver* is the quarterly journal of the International Association of Insurance Receivers.

[11] Ibid citing a telephone conversation with Fred Nepple, General Counsel for the Wisconsin Insurance Department, Chairperson of the National Association of Insurance Commissioners' ERISA Working Group (and a leading expert on association health plans and MEWAs) (April 24, 2002).

APPENDIX P – SUBMITTED FOR THE RECORD, LETTER TO CHAIRMAN JOHN A. BOEHNER AND RANKING MEMBER GEORGE MILLER, FROM MIKE PICKENS, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) PRESIDENT, KANSAS CITY, MO

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

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WORLD WIDE WEB
www.naic.org

March 12, 2003

The Honorable John A. Boehner
Chairman
Committee on Education and the Workforce
U.S. House of Representatives
Washington, DC 20515

The Honorable George Miller
Ranking Minority Member
Committee on Education and the Workforce
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Boehner and Representative Miller:

As members of the National Association of Insurance Commissioners, we are writing to express our strong opposition to legislation introduced last week, H.R. 660, that would allow association health plans (AHPs) to form and operate in our states beyond the authority and outside the reach of proven state consumer protection and solvency laws.

Although we appreciate the sponsors' attempt to take into consideration state insurance regulators' concerns in this new bill, in total the bill is not an improvement over previous drafts. Similar to the bills introduced in the 107th Congress, H.R. 660 would: (1) permit risk selection thereby creating opportunities for "cherry-picking" among healthier groups; (2) allow inadequate capital standards and solvency requirements both of which are inferior to existing state standards; (3) eliminate proven state consumer protection laws, including those designed to allow consumer appeals of adverse plan decisions and those aimed at preventing and fighting fraud; and (4) allow AHPs to ignore state benefit requirements. We are extremely concerned that while longstanding state-based consumer protections would be eliminated, H.R. 660 would provide no additional resources to the Department of Labor to regulate AHPs or help consumers.

We want to reiterate our long-held position that the enactment of H.R. 660 or similar legislation would be bad for consumers and bad for our state health markets. AHPs would create an uneven playing field among small employers and their employees, and undermine our shared goals of creating access to affordable health care.

Just as the states have taken steps to reform the small group market and promote other market reforms, we remain committed to working with you to improve access to affordable health insurance for small businesses. However, eliminating the strong oversight role and consumer protection apparatus currently provided by the states and insurance commissioners would be an unwise decision and a bad deal for consumers. We urge you to oppose H.R. 660.

Sincerely,

Mike Pickens
NAIC President
Arkansas Insurance Commissioner

News Release

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FOR IMMEDIATE RELEASE

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NEW ASSOCIATION HEALTH PLAN LEGISLATION STILL BAD FOR CONSUMERS

The National Association of Insurance Commissioners (NAIC) today expressed disappointment—once more—with today's introduction of an Association Health Plan (AHP) bill the organization strongly feels is flawed. With only one notable change from the legislation introduced in the 107th Congress, the NAIC believes the sponsors are continuing to ignore severe deficiencies in legislation that will result in significant problems for consumers.

NAIC Objections to the Bill Being Introduced Today:

- **The bill still allows significant risk selection** ("cherry picking"). The change made in the latest bill is a welcome improvement, but is still insufficient to prevent blatant cherry picking by AHPs.

- **The bill still provides no additional resources to the Department of Labor to oversee AHPs.** The Department of Labor has no experience and no resources to oversee AHPs adequately. This will lead to plan failures, loss of coverage and unpaid provider claims. Moreover, aggrieved AHP consumers may not have recourse for help when there is a problem.

- **The bill still reduces funding for state high-risk pools and guaranty funds.** The bill limits the ability of the states to fund high-risk pools for the most vulnerable consumers and guaranty funds that protect consumers and providers when plans fail.

-MORE-

o **The bill still eliminates important consumer protections.** State patient protections, such as internal and external appeals, review of marketing materials, adequate network requirements, and many other protections important to local consumer needs and market conditions would be preempted.

o **The bill still fails to include adequate capital standards and solvency protections.** AHPs would be held to a far lower standard than other insurance companies in terms of needed capital and assets on hand to cover claims. This will leave AHPs vulnerable to failure, and consumers and providers vulnerable to loss of coverage and unpaid claims.

The NAIC members remain committed to working with Congress to improve access to affordable health insurance for small businesses. Unfortunately the legislation being introduced today fails on both counts.

About the NAIC

Headquartered in Kansas City, Mo., the National Association of Insurance Commissioners (NAIC) is a voluntary organization of the chief insurance regulatory officials of the 50 states, the District of Columbia and four U.S. territories. The association's overriding objective is to protect consumers and help maintain the financial stability of the insurance industry by offering financial, actuarial, legal, computer, research, market conduct and economic expertise. Formed in 1871, it is the oldest association of state officials. For more information, visit NAIC on the Web at www.naic.org.

APPENDIX Q – SUBMITTED FOR THE RECORD, STATEMENT OF NATIONAL SMALL BUSINESS UNITED

PREPARED STATEMENT TO THE HOUSE COMMITTEE ON EDUCATION AND THE WORKFORCE

Subcommittee on Employer-Employee Relations

NATIONAL SMALL BUSINESS UNITED

Hearing on H.R. 660, *"Small Business Health Fairness Act,"*

March 13, 2003

Honorable Chairman and Ranking Member:

Thank you for allowing National Small Business United to submit this written testimony to you regarding the high cost of healthcare for small businesses. On behalf of our more than 65,000 small businesses in all fifty states, as well as local, state and regional small business associations across the country, NSBU works with elected and administrative officials in Washington to improve the economic climate for small business growth and expansion.

Health care reform is extremely important to NSBU and its affiliates. In fact, health care reform is at the top of our priority issues for the 108th Congress and has been a priority issue for our organization for the last fifteen years. We are committed to working with the House Small Business Committee to see that this issue is addressed for small business.

I. How We Got Here

There was a time, not so many years ago, when health care reform was clearly the number one small business issue. Costs were escalating at double digits every year, small business health policies faced close health underwriting, many employees were saddled with significant pre-existing condition exclusions, some small businesses couldn't find coverage at any price, and millions could not afford the prices they were charged. Layered on top of these problems, we were looking down the barrel of proposals for having universal coverage mandated on all employers. Our health care "system" was facing crisis.

But several key events interacted to relieve the pressure of those times, without resorting to a fundamental reform of the system. First, the states (and later the federal government) reformed the small group insurance market to make

it more fair (though no less expensive). Second, managed health care began to kick-in, forcing cost discipline on providers and relieving the incessant upward push on premiums. Finally, Congress decisively defeated the employer mandates proposed by the Clinton Administration. The national upset over the issue helped pave the way for the Republicans to take over Congress.

But 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 enormous year-over-year premium increases, the cost, control, and quality improvement promises of managed care give every appearance of having run their course, and Congress is once again considering legislation that will make the situation far worse. To compound matters, the current recessionary environment is likely to further swell the ranks of the uninsured, which already number over 40 million.

In short, health care reform is once again the most pressing issue facing small business, and the most pressing domestic issue facing the nation. It is time to coalesce around a proactive agenda for reforming the health care system. These reforms should bring long-term stability, keep costs in check, be fair to all small businesses and their employees, and maintain the best health care in the world. Our national challenge is this: real solutions to these real problems will not always be easy, and they will not always be popular.

As we approach this challenge, however, let us keep in mind that every substantial reform that Congress has enacted on health care during the last decade has only 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. And these changes have contributed significantly to health care coverage costs that have put insurance out of financial reach for tens of millions and threatened tens of millions more with loss of health care benefits.

II. Needed Small Business Reforms

NSBU recommends that the states and Congress enact a series of health care reforms that could immediately reduce the health cost pressures that small firms and their employees face, improve health care access for individuals who would otherwise be uninsured, and increase the range of choices available to the underserved small business market.

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 would also 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 and therefore there would continue to be a level playing field for all employers providing insurance in the small employer market. Such local employer coalitions already exist, providing choice and savings for their members every day. Many of these organizations are part of NSBU.

Fix the Medical Savings Account Law. As currently structured, Medical Savings Accounts (MSAs) are confusing, restrictive, and largely unworkable for most Americans. Yet the promise of these plans is greater than ever. More and more health plans are moving toward higher deductibles, even though most out-of-pocket health care expenses do not qualify for any tax preference. MSAs respond to this 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. In addition, even in their limited use, MSAs have shown a powerful ability to cover the previously uninsured. About 40% of participants those who signed-up for MSAs during their first year were newly insured. To make them meaningfully effective for the future, though, we need the following changes:

- Allow both employers and employees to contribute to MSAs. Right now either may contribute, but not both. This restriction greatly inhibits the ability of individuals to collect sufficient funds into their MSA.

- Lower the minimum required deductible and out-of-pocket limits. Currently, participation in MSAs requires an insurance policy with a "deductible" amount of at least $1,700 for individuals and $3,350 for families. Lower minimum deductibles would make MSAs more attractive for many workers and ameliorate potential risk selection issues by making them more appealing to older and sicker individuals. Once individuals have a chance to "build up" their MSA funds, they will then be much more willing to have even higher deductibles.

- Remove the restriction that all family members who would be covered must be covered only by high deductible plans.

- Modify the current HMO Act to enable HMOs to offer high out-of-pocket plans. A large segment of the provider community is taken off the table by this provision and can make MSAs much less attractive.

- Remove the cap on the number of participants. Right now, only 750,000 individuals are allowed to participate in MSAs. With the other changes listed above, this cap would quickly be reached and MSAs would be unavailable to most small business employees.

Recently, the Administration highlighted Health Reimbursement Accounts (HRAs) which are similar to MSAs, but can only accept employer contributions, and employees cannot keep their excess funds. The objectives of MSAs could also be met by reforming the HRA structure: 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 could also be an important factor in increasing the ability of small business employees to fund various kinds of unreimbursed 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 sixteen years of struggle and unfairness, the dawning of 2003 has finally brought small business owners the ability to deduct all of their health insurance expenses against their income taxes. Great thanks is owed to the many members of this committee who labored to make this change a reality.

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 FICA fax 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—probably a greater savings for some than any other policy change we will discuss today.

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.

Protect the Small Employer Health Insurance 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.

There is certainly the potential to provide tax credits to small employers, as well, but we should be aware that such action is a potentially slippery slope. Which businesses would we subsidize? Do we subsidize businesses that don't currently provide health insurance? Tell that to the business that has been providing coverage for years. Do we subsidize businesses with low average wages? Plenty of them are highly profitable. We do not close the door to the possibility that an appropriate mechanism could be established to help smaller companies, but the potential problems, distortions, and inequities in doing so are manifold.

III. What Not to Do

Any new "improvement" to the private health insurance system that seeks to extend new benefits, provide new protections, or create new liabilities—no matter how well intentioned—should be carefully weighed against its cost. The worst case scenario is not no action, it is new federal action that increases expenses. All of these changes only pile more and more costs on a private system already tottering under the weight of its current load. We ask that the Committee members do all they can to educate themselves and their colleagues about this very complex situation.

There have also been calls from many of our brethren in the small business community to create a new form of federalized small business purchasing pools, run by associations. These Association Health Plans (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.

However, despite those good intentions, we are concerned that AHPs threaten to greatly worsen the market segmentation and risk-aversion that currently characterize the small group health insurance market, and which are at the root of the health care crisis uniquely faced by smaller firms. AHPs might be good for national small business associations (like NSBU) who want to run them, but NSBU believes 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 will be. 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. Those are simply the actuarial facts of the matter. 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.

So, 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 would present us with problems on both fronts.

Risk Selection. The insurance industry competes based largely upon each company's ability to attract better (i.e. more profitable) risks. 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.

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.

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. Fully insured AHPs would only be subject to the rate bands in their state of domicile and would use those rules in all other states in which they operate. If an AHP were to sell into a community-rated state (such as Maine, to pick one at random) with varying rates, the consumer choices would be stark. The AHP rates for younger, healthier groups are likely to be significantly less than for other groups, 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. Moreover, the out-of-state AHP is likely to be able to take into account all sorts of risk factors in setting their rates.

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.

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 want to keep premiums as low as possible. 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 NSBU 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. To disbelieve is literally "head-in-the-sand."

It is also 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.

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

The AHP Forecast. Despite the rosy picture painted by proponents of AHPs, we fear AHPs 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 be at ever-increasing pains not to sell coverage even to those who can scrape up a monthly premium payment that will soon surpass an average monthly mortgage payment.

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.

We thank you for the opportunity to submit our remarks. NSBU welcomes any questions or comments you may have, please feel free to contact us at (202) 293-8830 or via e-mail at mbrogan@nsbu.org.

APPENDIX R – SUBMITTED FOR THE RECORD, LETTER TO SPEAKER OF THE HOUSE, J. DENNIS HASTERT AND SENATE MAJORITY LEADER, BILL FRIST, M.D., FROM MENTAL HEALTH LIASON GROUP, C/O PETER NEWBOULD, AMERICAN PSYCHOLOGICAL ASSOCIATION PRACTICE ORGANIZATION, WASHINGTON, D.C.

Mental Health Liaison Group

January 16, 2003

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 members of the Mental Health Liaison Group, a coalition of national organizations representing the diverse interests of the mental health community, wish to express our opposition to legislation that would exempt association health plans (AHPs) from state regulation and thereby undermine state mental health parity laws and other critical consumer protections.

Bills to increase the availability of AHPs by exempting them from state health insurance reforms were introduced in the last Congress (H.R. 1774 and S. 858) and endorsed by the Administration. This year there will be a concerted effort to pass this legislation, which we believe would undercut significant progress made at the state level to improve coverage of mental health services.

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 by discriminatory limitations 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.

Moreover, untreated mental illness costs the American economy at least $79 billion annually in lost productivity, absenteeism, unemployment and increased health costs. Perhaps most tragic is the high rate of suicide in this country that undoubtedly results from inadequate mental health care as mental illness is associated with over 90% of all suicides. Each year over 30,000 Americans die from suicide and almost 650,000 individuals require emergency care for injuries caused by suicide attempts. Legislation that impairs state laws designed to improve access to mental health care can only weaken a mental health system that the President's New Freedom Commission on Mental Health recently described as being "in shambles."

To address some of these concerns, President Bush has called on Congress to enact full mental health parity requirements for group health plans, and Congressional support for such federal legislation is widespread. But, over 36 states have already passed parity laws for insurance plans governed by state law and more than 32 states require insurance plans to cover a minimum

amount of mental health benefits. These laws represent significant steps toward our goal of improving access to mental health care for all, but this progress would be undermined by legislation that would exempt AHPs from state consumer protections and replace 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 face premium increases. Under this proposal, AHPs would reduce costs by offering pared-down benefit packages excluding coverage of mental health services or prescription drugs, for example. These low-cost plans would appeal to those firms with primarily young, healthy employees, but as a result those in need of more comprehensive benefits would have to pay more for traditional coverage. According to CBO, a large majority of employees would remain in traditional plans with higher premiums.

CBO estimates that any increase in coverage would be minimal because most of those covered by AHPs would have been previously covered by traditional plans. Thus the benefit of this legislation would be small, but the detriment would be great because of the weakening of crucial state laws, such as those that prohibit discriminatory limits on mental health care by state-regulated plans.

In addition, by undermining state oversight of insurance agreements, this legislation would expose health care consumers to the fraud and abuse that multiple employer welfare arrangements (MEWAs), similar in structure to AHPs, have committed in the recent past. These plans left almost 400,000 participants with more than $120 million in unpaid medical bills for doctors, hospitals and other health care providers in the late 1980's and early 1990's.

Consequently, we urge you to oppose legislation that would exempt AHPs from state regulation such as mental health parity laws and other consumer protections. Thank you for your consideration of our views.

Sincerely,

Alliance for Children and Families
American Academy of Child and Adolescent Psychiatry
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
American Association for Psychosocial Rehabilitation
American Association of Pastoral Counselors
American Counseling Association
American Family Foundation
American Group Psychotherapy Association
American Managed Behavioral Healthcare Association (AMBHA)
American Mental Health Counselors Association
American Psychiatric Association

American Psychiatric Nurses Association
American Psychological Association
American Psychotherapy Association
American Society of Clinical Psychopharmacology, Inc.
Anxiety Disorders Association of America
Association for the Advancement of Psychology
Association for Ambulatory Behavioral Healthcare
Bazelon Center for Mental Health Law
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Child Welfare League of America
Clinical Social Work Federation
Depression and Bipolar Support Alliance
Employee Assistance Professionals Association
Federation of Behavioral, Psychological & Cognitive Sciences
Federation of Families for Children's Mental Health
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 County Behavioral Health Directors
National Association of Protection and Advocacy Systems
National Association of School Psychologists
National Association of Social Workers
National Association of State Mental Health Program Directors
National Council for Community Behavioral Healthcare
National Foundation for Depressive Illness
National Mental Health Association
Suicide Prevention Action Network
Tourette Syndrome Association

APPENDIX S – SUBMITTED FOR THE RECORD, NEWS RELEASE, "AHPs WILL INCREASE HEALTHCARE COSTS FOR CONSUMERS," BLUECROSS BLUESHIELD ASSOCIATION, CHICAGO, IL

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

News Release

Blue Cross and Blue Shield Association
225 North Michigan Avenue
Chicago, Illinois 60601-7680
www.BCBS.com

FOR IMMEDIATE RELEASE
March 13, 2003

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AHPs WILL INCREASE HEALTHCARE COSTS FOR CONSUMERS

Consumers In Every State Would Lose Key Protections

WASHINGTON – Small businesses and their employees across the country will be exposed to increased healthcare costs, widespread fraud, and fewer consumer protections if Congress passes legislation that exempts association health plans (AHPs) from state laws and regulation. AHP legislation introduced in the House was the focus today of an Education & Workforce Employer-Employee Relations Subcommittee hearing.

"Exempting AHPs from state regulation is not a prescription for affordability and access; it is a prescription for higher healthcare costs and more uninsured Americans," said Mary Nell Lehnhard, senior vice president, Blue Cross and Blue Shield Association (BCBSA), Office of Policy Representation.

(more)

House AHP Hearing/Add One

A Congressional Budget Office study found that 20 million employees and their families would experience an *increase* in their healthcare costs and as many as 100,000 of the sickest workers would lose their healthcare coverage altogether if Congress enacts AHP legislation.

A recent analysis from BCBSA found that AHPs could circumvent existing protections that give consumers peace of mind knowing that their healthcare benefits are safe and reliable. Examples of protections that would be lost if Congress enacts AHP legislation include:

- Texas consumers would no longer have coverage for mammography screening, substance abuse treatment, and direct access to OB-GYBNs;

- Arizona consumers and healthcare providers would no longer be able to rely on prompt payment rules; and,

- Ohio consumers would not be able to appeal claims denials through an external review board and AHPs would have no limit on how much and how often they raise premiums for sicker groups.

BCBSA is joined by a growing collection of influential groups – including the National Governors Association, the National Association of Insurance Commissioners, National

(more)

House AHP Hearing/Add Two

Small Business United, and many other consumer and business organizations – that believe AHPs *are not* a prescription for the uninsured.

For the entire 50-state analysis on consumer protections lost under AHPs go to www.bcbshealthissues.com/.

The Blue Cross and Blue Shield Association is made up of 42 independent, locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for 84.9 million – nearly 30 percent – of all Americans. For more information on Blue Cross and Blue Shield Plans, please visit www.BCBS.com. For more information on Blue Cross and Blue Shield Association's policy positions and the healthcare debate, visit www.BCBSHealthIssues.com.

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\2002-03\030313 House AHP Hearing.doc

50-State Summary:
Consumer Protections Lost under
Association Health Plan Legislation

Consumer protections that:	Number of States*
Ensure access to independent review:	
• Consumers can demand independent external review of claims denials	44
Ensure appropriate access to care. Insurers must:	
• Cover emergency services that a "prudent layperson" thought necessary	43
• Cover transitional care from a provider who leaves a network	38
• Cover non-formulary prescription drugs in certain situations	29
• Offer point-of-service option	20
• Allow direct access to OB-/GYNs	42
• Cover clinical trials	18
• Not "gag" providers' communications with patients	48
Ensure fair insurance premiums for small groups:	
• Insurers must limit how much they charge sicker groups	48
Ensure marketing protections:	
• Insurers must follow detailed requirements for marketing materials	50
Ensure health plans cover important benefits, such as:	
• Mental health parity that goes beyond federal requirements	33
• Substance abuse treatment	32
• Alcoholism treatment	44
• Mammography screening	50
• Minimum mastectomy stay	23
• Invitro fertilization	11
• Well-child care	32
• Prompt payment rules	50
Ensure appropriate oversight of insurers:	
• State handles complaints from consumers & providers	51
• State investigates, oversees, enforces rules (including financial penalties)	51
Prevent plan failures and ensure payment of claims:	
• Insurers must maintain surpluses that grow with size of insurer	51
• State oversees corrective action once insurer nears minimum standards	51
• State acts quickly to seize assets to pay claims	51
Promote access for the uninsured:	
• Mini-COBRA rules for small employers with fewer than 20 employees	40
• Insurers help fund state high-risk pools	26

January 30, 2003

Note: Includes the District of Columbia

*Denotes a mandated offer requirement

Texas: Consumer Protections Lost under Association Health Plan Legislation

Texas has consumer protections that:	Comparable Federal Rule for AHPs?
Ensure access to independent review:	
• Consumers can demand independent external review of claims denials	No
Ensure appropriate access to care. Insurers must:	
• Cover emergency services that a "prudent layperson" thought necessary	No
• Cover transitional care from a provider who leaves a network	No
• Cover non-formulary prescription drugs in certain situations	No
• Plans must offer point-of-service (or PPO) option	No
• Allow direct access to OB-GYNs	No
• Not "gag" providers' communications with patients	No
Ensure fair insurance premiums for small groups. There are limits on:	
• How much insurers can charge sicker groups[1]	No
• How much insurers can increase an employer's premiums when an employee gets sick	No
Ensure marketing protections:	
• Insurers must follow detailed requirements for marketing materials	No
Ensure health plans cover important benefits, such as:	
• Mental health parity that goes beyond federal requirements	No
• Substance abuse treatment	No
• Alcoholism treatment	No
• Mammography screening	No
• Minimum mastectomy stay	No
• Invitro fertilization*	No
• Well-child care	No
• Prompt payment rules	No
Ensure appropriate oversight of insurers:	
• State handles complaints from consumers & providers	No
• State investigates, oversees, enforces rules (including financial penalties)	No $
Prevent failures and ensure payment of claims:	
• Insurers must maintain financial surpluses that grow with size of insurer	No ($2M cap)
• State oversees corrective action once insurer nears minimum standards	No
• State acts quickly to seize assets to pay claims	No
Promote access for the uninsured:	
• Mini-COBRA rules for small employers with fewer than 20 employees	No
• Insurers must help fund state high-risk pool	No

January 30, 2003

[1] Adjustments for health status limited to +/- 25% of average rate (for class of business).

*Denotes a mandated offer requirement

Arizona: Consumer Protections Lost under Association Health Plan Legislation

Arizona has consumer protections that:	Comparable Federal Rule for AHPs?
Ensure access to independent review:	
• Consumers can demand independent external review of claims denials	No
Ensure appropriate access to care. Insurers must:	
• Cover transitional care from a provider who leaves a network	No
• Cover non-formulary prescription drugs in certain situations	No
• Cover cancer clinical trials	No
• Not "gag" providers' communications with patients	No
Ensure fair insurance premiums for small groups. There are limits on:	
• How much insurers can charge sicker groups[1]	No
• How much insurers can increase an employer's premiums when an employee gets sick	No
Ensure marketing protections:	
• Insurers must follow detailed requirements for marketing materials	No
Ensure health plans cover important benefits, such as:	
• Mammography screening	No
• Prompt payment rules	No
Ensure appropriate oversight of insurers:	
• State handles complaints from consumers & providers	No
• State investigates, oversees, enforces rules (including financial penalties)	No $
Prevent failures and ensure payment of claims:	
• Insurers must maintain financial surpluses that grow with size of insurer	No ($2M cap)
• State oversees corrective action once insurer nears minimum standards	No
• State acts quickly to seize assets to pay claims	No

January 30, 2003

[1] Adjustments for health status limited to 60% from average rate (for class of business).

*Denotes a mandated offer requirement

Ohio: Consumer Protections Lost under Association Health Plan Legislation

Ohio has consumer protections that:	Comparable Federal Rule for AHPs?
Ensure access to independent review:	
• Consumers can demand independent external review of claims denials	No
Ensure appropriate access to care. Insurers must:	
• Cover emergency services that a "prudent layperson" thought necessary	No
• Cover non-formulary prescription drugs in certain situations	No
• Allow direct access to OB-GYNs	No
• Not "gag" providers' communications with patients	No
Ensure fair insurance premiums for small groups. There are strict limits on:	
• How much insurers can charge sicker groups[1]	No
• How much insurers can increase an employer's premiums when an employee gets sick	No
Ensure marketing protections:	
• Insurers must follow detailed requirements for marketing materials	No
Ensure health plans cover important benefits, such as:	
• Alcoholism treatment	No
• Mammography screening	No
• Well-child care	No
• Prompt payment rules	No
Ensure appropriate oversight of insurers:	
• State handles complaints from consumers & providers	No
• State investigates, oversees, enforces rules (including financial penalties)	No $
Prevent failures and ensure payment of claims:	
• Insurers must maintain financial surpluses that grow with size of insurer	No ($2M cap)
• State oversees corrective action once insurer nears minimum standards	No
• State acts quickly to seize assets to pay claims	No

January 30, 2003

[1] Adjustments for health status limited to 35% of a midpoint rate for all small employers.

*Denotes a mandated offer requirement

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