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# THE SMALL BUSINESS HEALTH CARE CRISIS: POSSIBLE SOLUTIONS

## HEARING

BEFORE THE

## COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

FEBRUARY 5, 2003

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COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP

ONE HUNDRED EIGHTH CONGRESS

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# THE SMALL BUSINESS HEALTH CARE CRISIS: POSSIBLE SOLUTIONS

**WEDNESDAY, FEBRUARY 5, 2003**

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

The Committee met, pursuant to notice, at 10:05 a.m., in room SR-428A, Russell Senate Office Building, the Honorable Olympia J. Snowe, Chairman of the Committee, presiding.

Present: Senators Snowe, Bond, Burns, Bennett, Kerry, Levin, and Pryor.

Also Present: Senator Talent.

Senator BOND. It is now my pleasure, with mixed emotions but with high expectations, to turn over the gavel to the new Chair, Senator Olympia Snowe.

[Applause.]

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

Chair SNOWE. Thank you. I want to thank my colleague, Senator Bond, for this pleasant surprise because it truly is a privilege for me to be able to have this opportunity to Chair the Small Business Committee here in the United States Senate. I want to thank and acknowledge Senator Bond's exemplary leadership that he has provided on this Committee for many years. I cannot think of a more stalwart champion of small business.

As I convene my first hearing and begin to work on these issues and in my discussions with so many of you here in the audience, I can tell you he has set a high standard and I am looking forward to working with him on the issues that are affecting small business in America.

I also want to thank Senator Kerry for his stewardship. He has been a long-term advocate for small business and I know that he is going to continue to do everything that he can to enhance small business as a vital sector of this economy and he will continue his long-standing commitment to small business. I know he will be here shortly.

We also have new Members of the Committee that will be here as well, Senator Coleman, Senator Bayh and Senator Pryor. We are immensely fortunate to have the benefit of their insights and knowledge on this Committee, as well.

Finally, before I get started, I also want to welcome Senator Talent, also from Missouri, a newly elected Member to the United

States Senate. He is going to participate in this hearing today because Senator Talent, when he served in the House of Representatives, chaired the Small Business Committee, and also was a leading proponent of association health plans, as many of you know. So he will be participating here today and I know that he will be contributing significantly to this issue and others concerning small business.

Having served on this Committee throughout my tenure in the Senate, and earlier on its counterpart, I am eager to begin an ambitious agenda to address the wide-ranging challenges small businesses face.

In that light it is no coincidence I focus our very first hearing on the challenge that is not only a matter of urgency for small businesses, but is also of dual significance to our nation at a time when we are both exploring opportunities to help boost the economy and ways of reducing the stunning number of uninsured in America.

Knowing that small businesses are creating up to 75 percent of net new jobs in the country, knowing that they contribute 42 percent of all revenues while the SBA only consumes 0.04 percent of the Federal Budget, can there be any doubt that our investment in small business, whether in financial assistance, loan guarantees, or helping to reduce the overall cost burdens, pays tremendous economic dividends to America.

At the same time, with a shocking 60 percent of the 41 million uninsured in this country already either working full-time in small businesses, or depending on someone who does, we have an obligation to ensure that more of these individuals can receive insurance through their employers.

So when the Kaiser 2002 Employer Health Benefit Survey reports that only 61 percent of all small businesses are offering health benefits and that is down, I might add, from 67 percent just 3 years ago, is there any question that we are headed in exactly the wrong direction?

This is a crisis and it is even worse in businesses with fewer than 50 employees. Of those, only 47 percent currently provide health insurance benefits. The Department of Labor reports that only 24 percent of small businesses that employ low-wage workers offer health plans. So this is an emergency.

But there should be no mistake. It is not because small businesses do not want to provide these benefits. If there is one thing I have heard time and again in my meetings with small businesses in Maine and representatives here in Washington, it is that costs have skyrocketed to the point of being prohibitive. I have heard of premiums rising 50, 60 and 70 percent.

In the chart behind me, and I think it is illustrative of the problem that we are facing, two-thirds of all Americans rely on their employer for health insurance. We cannot afford the disturbing trends that are indicative in this chart of the kinds of increases that employers are facing with respect to health care insurance premiums.

The average cost for health insurance premiums rose 11 percent from 2000 to 2001 and then 12.7 percent from 2001 to 2002, the second consecutive year of double-digit increases. As a result, 22

percent of all firms increased employee deductibles in 2002 and 32 percent told Kaiser they are likely to do so this year.

The problem is all the more acute for small businesses. For those with fewer than 10 workers, the employer and employees together paid on average about 8 percent more in premiums than the amount paid by larger companies. For all firms under 200 employees, 84 percent indicated to Kaiser that cost was an important factor in not offering health care.

The result of all this is not hard to predict. Businesses can and clearly are dropping health benefits. Others struggle onward in providing coverage but only at the cost of the growth of the business or offering a package with higher premiums or a combination of both. We simply cannot go on in this direction.

I plan to introduce legislation to level the playing field between large and small businesses through association health plans. We want to give small businesses the same strength as unions and large companies to negotiate better rates.

Let there be no doubt, there would be cost savings. Indeed, a CBO report estimated in 2000 that on average premiums paid by small firms that purchase health insurance through AHPs could see, on average, a reduction anywhere from 9 through 25 percent.

Now I realize there is no single answer to this multifaceted problem and there are those with a divergent view and different ideas including medical savings accounts, flexible spending arrangements and tax credits to help defray the cost of accessing health insurance. But I do believe that AHPs would be a major step in the right direction and I am pleased we will have an opportunity to hear from a number of individuals who may have differing ideas on how to approach the problem, but who all have experience, expertise, and informed opinions on this pressing matter of national concern.

We are privileged this morning to have with us first, Secretary of Labor Elaine Chao, who has provided strong leadership on the President's behalf on this issue, as exemplified by a report the Department of Labor issued on AHP plans, as well as letters she sent last September to Senate leaders in support of this legislation.

Obviously, this is a critical labor issue as well as a challenge for small business and I thank her for her steadfast commitment for being here today and for improving the lives of American workers.

Of course, no one knows better than our second witness, who will be SBA Administrator Hector Barreto, just how crucial this issue is for small businesses. I know the health benefit crisis is of tremendous concern to the Administrator and I thank him for his dedication and for being here today, as well. I am looking forward to hearing what he will provide in terms of comments on this legislation.

Our third panel includes representatives of the small business community who believe this issue is so vital to their future that they have taken time to be here today and to share their views and experiences. I also want to acknowledge two small business owners from my State of Maine, Ms. Kathie Leonard and Ms. Anne Valentine, who will help lend a perspective on what this issue means in our State where 97 percent of the businesses employ fewer than 20 employees.

For our fourth panel, we will hear from those with a different perspective on approaching this crisis. I also want to thank them for contributing their thoughts and for appearing here today as we begin to proceed on this most vital piece of legislation to enhance the well-being of small business.

I would now like to turn to my colleague, Senator Bond.

Senator BOND. Madam Chair, I have been implored by my good friend, formerly of Missouri and now Montana, Senator Burns to make a short statement. On that condition, I would be happy to yield to him.

**OPENING STATEMENT OF HON. CONRAD BURNS, A UNITED STATES SENATOR FROM MONTANA**

Senator BURNS. I thank my good friend from Missouri for the statement.

Madam Chair, thank you very much for holding this hearing today. I am not going to get to stay. We have got an important vote coming up in the Energy Committee in about 7 minutes or so and I want to hustle over there.

This is very important and this is an area where there is conflict, as you well know, where States rights comes into it and everything that we try to do has far-reaching effects on industry and small business, on the insurance industry, and of course, our relationship with the States. So it sounds easy but we know there are a lot of complications to it.

Thank you for the hearing and I will be looking at the testimony of the Secretary of Labor and also from the Small Business Administration. It will be interesting what they have to say. But I will also read the testimony of the witnesses that you have today. Thank you for allowing me to make this statement because this is probably the most important thing that faces small business today.

Thank you very much.

Chair SNOWE. Thank you, Senator Burns.

Senator Bond.

**OPENING STATEMENT OF HON. CHRISTOPHER S. BOND, A UNITED STATES SENATOR FROM MISSOURI**

Senator BOND. Thank you, Madam Chair, for giving me the opportunity to say a few words.

It is a real pleasure to work with you in your new capacity as the Chair of the Small Business Committee. You have been a great, active Member of the Committee. I am grateful that you are taking the gavel, although it is with mixed emotions that I turn it over to you. I intend to work very closely with you but I think the Committee needs the vitality and enthusiasm of some new leadership and I have some other important pressing items that I have to work on, as well.

Your statement today and your willingness to call this hearing, as your first hearing on AHPs, indicates your commitment to this issue. Your powerful statement is a strong boost for us as we move forward on the push to get AHPs.

It is a pleasure, also, to see my new colleague from Missouri, Senator Jim Talent. As a Member of Congress on the House side, he was a champion of AHP legislation. As the former Chairman of

the Small Business Committee, obviously he understands these issues very well. I know he is going to be an active inter-meddler in the work of this Committee, and we are delighted to have so many Missourians involved in this effort. He will be a great addition to this battle because of his passion and commitment.

Chair SNOWE. There is no doubt where Missouri stands on this issue.

Senator BOND. However, we Missourians join Maine in championing AHP legislation.

Other Missouri natives include Senator Burns and Administrator Barreto. Pardon me for pointing out the fact that we do have a strong Missouri commitment.

During these tough financial times small business needs as much capital as possible to continue maintaining, growing, and providing jobs. I fought a few years ago, with your help and others, to get 100 percent deductibility for proprietorships which will take effect finally this year.

Runaway health care costs and health insurance are still issues to be addressed by Congress. In my opinion, the best way, to control costs in health care is through choice and competition, distinctly American ideals. These ideals can work in health care to provide innovation and encourage new ideas.

As many as 24 million individuals, or 60 percent of the 40 million uninsured Americans, are employed. That figure is shocking. That 24 out of 40 million have jobs but do not have health insurance. Many of them who are in the ranks of the "employed but uninsured" work for small businesses that would like to provide health insurance but cannot. Others are in the group that have provided health insurance coverage previously to their employees, but today's exploding and spiraling health care costs have driven many small businesses out of the market.

No one is hit harder by large premium increases than small business. We hear about the cost explosion that insurers and health care providers are imposing on small business. Many small businesses find it virtually impossible to provide the coverage they would like to provide and know they should provide to their employees.

Our office continues to be flooded with calls and letters illustrating the dire need of small firms to obtain health insurance, competitively priced and comparable in quality to the insurance plans enjoyed by big businesses and unions.

I am convinced that the only solution is to allow small businesses across the country to pool together, access health insurance, gain the administrative benefits from larger memberships and get the bargaining power they need. This should provide small businesses the same opportunity as other large purchasers of health insurance.

AHPs, or association health plans, should reduce costs through greater economies of scale, to spread costs and risks, increase group bargaining power and generate more insurance options. They are not a new idea. They have been talked about and bandied about for almost a decade. During that period, what was once thought to be a manageable problem has become the crisis we have today.

Had we passed this AHP legislation, I am convinced we would not be seeing the problems we see today in small business.

The underlying AHPs principle is simple, the same principle that makes it cheaper to buy your soda by the case instead of individual cans. Bulk purchasing is why the large purchasers can get better rates. It is about time we bring the same Fortune 500 style health benefits to the nation's Main St. businesses.

President Bush has said it well: "It makes no sense in America to isolate small businesses as little health care islands onto themselves."

AHPs simply will mean more coverage, better coverage for employees, the companies, their families, and their children. It is time we take control for small businesses. They deserve a chance to channel these funds to other needs.

I look forward to working with you, Madam Chair, along with Senators Talent, Burns and the others on this important issue. I thank all of you for coming here to testify today.

Secretary Chao has been a very vocal, very eloquent spokesperson for the President's plans in this area. She is joined by Administrator Barreto, whose representation of the small business community will give AHPs a big push.

I apologize that I have other commitments, but I too will be reading the testimony, and I will be right behind you in the battle to get the AHP coverage that small businesses need. I thank you.

Chair SNOWE. Thank you, Senator Bond, for being such a leader on this issue. We appreciate it.

Senator Levin.

Senator LEVIN. I do not have an opening statement but I just want to reassure Senator Bond that I, too, have deep Missouri roots. I was a Harry Truman supporter.

[Laughter.]

Senator BOND. Actually, Carl, we are related, cousins-in-law, I think. Something like that, by marriage, so he is acceptable. Senator Pryor is in the Dunlop area, where Missouri done lop over into Arkansas. So the heartland, Michigan, Arkansas and Missouri, are well represented.

Chair SNOWE. I am feeling left out here. Senator Pryor, welcome to the Committee. We are delighted to have you on this Committee.

Senator PRYOR. I am excited to be here. Thank you.

Chair SNOWE. Secretary Chao, thank you as well for being here today. My colleagues and I would like to extend our best wishes to your husband, Mitch. We hope that he is successfully recovering and we thank you for taking the time for being here today. Tell him we are looking forward to having him back soon.

Secretary CHAO. Thank you very much. Mitch is indeed doing very well and I am now a great proponent for people taking the stress test. Thank you.

Madam Chair, I also have a written statement that is lengthier, and so I would like to submit that for the record and I will make a little summary of my remarks.

Chair SNOWE. Absolutely. It will be included in the record.

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

Secretary CHAO. Good morning Chairman Snowe, and other Members of the Committee. Thank you very much for providing this opportunity to discuss the President's agenda for giving Americans more access to quality, affordable health care, specifically through association health plans.

As the Chairwoman noted, more than 41 million Americans lack health insurance and 85 percent of the uninsured are in working families. Some of the uninsured are young and have minimal health problems. They are quite healthy. Other uninsured families have children and need access to basic care. Some face serious health issues requiring the most up-to-date and expensive treatment. There is simply no one-size-fits-all solution to all of these different health care needs. That is why the President has proposed a number of different remedies to the problems of health care costs and also lack of access.

These proposals, as the Chairperson has noted, include making medical savings accounts more widely available, medical malpractice reform, individual tax credits and association health plans, also known as AHPs which I am about to discuss today.

In my view, Madam Chair, the Small Business Committee is the ideal forum to discuss how to expand health care coverage because employer-provided health insurance pays for the health care of more Americans than both Medicaid and Medicare combined.

In order to extend health insurance to millions of additional working families, we need to find ways to encourage more employers to include health insurance as part of the compensation package that they offer to their employees. The sector that presents the ripest opportunities for making a real difference is indeed small business.

Right now, as you have heard, those who work in smaller firms with less than 100 employees make up 60 percent of the working uninsured and the problem is compounded in low-wage industries. In fact, only 34 percent of small employers in low-wage businesses—those where the median wage is $9.50 an hour or lower—are able to offer health insurance to their workers

Many small employers do indeed tell us that they want to provide health coverage but that, surprisingly, cost is not their only obstacle. There are legal barriers, market barriers, and the threat of fraud. All of these hurdles prevent a lot of small employers from being able to take care of their workers the way that they would like.

Association health plans are aimed squarely at filling this coverage gap that exists among small businesses. AHP will break down many of the barriers that small employers face that currently discourage them from offering health care insurance or perhaps make it impossible for them to do so.

As I said, cost is not the only hurdle but it is probably the most significant. Small company premiums are about 20 to 30 percent higher than those of large self-insured companies and that is because small businesses must take on significant administrative overhead costs when they decide to offer health coverage. They must bear the cost of insurance company marketing and under-

writing expenses. Furthermore, State benefit mandates also present more cost for the small group market.

All of these factors drive up costs for small firms that offer health insurance to their employees, although many are discouraged from offering coverage at all.

Small businesses are also especially vulnerable to insurance fraud, which drives up the cost for everyone and robs small employers of the funds that they could otherwise use to pay for stable, reliable coverage. Small employers are at constant risk of wasting scarce resources on insurance scams that collect premiums and default on their promise to pay claims.

At the Department of Labor, we are engaged in aggressive efforts to combat pernicious health insurance fraud. Many scams are operated as multiple employer welfare arrangements. It is important to point out that not all of these multiple employer welfare arrangements, or MEWAs, are fraudulent, but they have historically been difficult to regulate due to jurisdictional uncertainly.

Due to our enforcement efforts almost $9 million was recovered in the last fiscal year alone to help fraud victims cover their unpaid medical expenses. At the end of fiscal year 2002, the Department was pursuing 90 civil and 17 criminal investigations of fraudulent health plans and we are not letting up.

In addition to enforcement, however, we are also providing a lot of information to employers to help them manage their health plans. I have recently written to over 80 business association leaders asking them to distribute a Department of Labor publication entitled "How to Protect Your Employees When Purchasing Health Insurance". I also have with me a copy of the publication that the Department has put together on association health plans to help small employers know how AHPs could offer their employees affordable quality health plans. These tips are also on our web site and they offer a lot of tips for small employers.

In addition to our ongoing education efforts, the Department continues to work in close contact with State insurance departments and the National Association of Insurance Commissioners to protect workers and their families.

One important benefit of AHP legislation is that it will give Federal and State regulators much clearer lines of authority to regulate small employer health insurance. But it is also going to break down legal and market barriers to make it more attractive for small businesses to offer health insurance to their employees.

Under AHPs, small businesses would enjoy greater bargaining power, economies of scale, and administrative efficiencies as well as the benefits of a uniform Federal regulatory structure. To combat fraud, AHPs would have to meet Federal certification standards and comply with the Department's ongoing oversight.

So by grouping small employers together to purchase coverage, AHPs will be able to act like large employers and offer low-cost coverage to employees and their families.

AHPs will also give small businesses the benefits, again, of a uniform oversight system instead of having to comply with 50 different regulatory schemes. For AHPs that offer fully insured coverage, State insurance commissioners will be responsible for the solvency of the insurance company issuing the policy just as they are re-

sponsible for insurance policies issued to fully insured group health plans today. At the same time AHPs would be subject to both Federal and many State consumer protections.

I see that the red light is on. I ask that my full statement be placed in the record. I know, Madam Chair, that you are very concerned about this issue, and I commend your leadership in holding this hearing that talks about a very important issue surrounding health care, and one that potentially will offer great benefits to the millions of uninsured.

[The prepared statement of Secretary Chao follows:]

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

**February 5, 2003**

**Introductory Remarks**

Good morning, Chairwoman Snowe, Ranking Member Kerry, 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.

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, such small firm workers and their families comprise 60 percent of the working uninsured.[1] To increase health insurance coverage, the President has proposed a comprehensive reform agenda that includes tax credits for the purchase of individual coverage, 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 business employers and their employees.

**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 more than 100 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. [2]

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.[3]

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.[4] 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.[5] 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 why AHPs are part of the solution to expanding coverage, it's important to

understand the barriers that prevent many small employers from offering coverage today.

**Small Firms Face Numerous Barriers to Coverage**

Cost is clearly the biggest barrier for small employers 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.[6] Cost drivers include small businesses' administrative overhead, insurance company marketing and underwriting expenses, adverse selection, state regulatory burdens, and vulnerability to insurance fraud. Small firms are likely to offer less generous benefits and more of their premiums are consumed by administrative costs.

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.[7]

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.[8]

**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[9], insurers incur higher costs when providing health care coverage to small employers than to large employers. Insurers must market and distribute their policies to a very large number of unconnected employers. They typically must compensate agents for each small policy sold or renewed. Some costs, such as the cost of collecting detailed medical histories for purposes of medical underwriting, are layered on each time an employer changes insurers – and smaller employers generally tend to change insurers more frequently.

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

Faced with high premiums and limited budgets, small employers often share 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 process.

**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.[10]

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. [11] 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.[12]

**Vulnerability to Fraud:** Small employers and their employees are often victims of fraudulent schemes that promise low-cost health coverage. Many of these arrangements are multiple employer welfare arrangements (MEWAs). MEWAs are arrangements that provide health benefits to employees of two or more unrelated employers who are not parties to collective bargaining agreements. MEWAs are subject to a complex mix of state and federal laws and regulations. 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. Any new legislation aimed at expanding access to affordable health coverage must 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.

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.

**Education and Outreach:** Through our outreach, education and assistance programs, the Department's Employee Benefits Security Administration (EBSA, formerly the Pension and Welfare Benefits Administration) has made educating small employers a top priority.

The Department provides guidance to small employers on how they can avoid purchasing health coverage from fraudulent MEWA operators. In an effort to educate small businesses about these risks, I 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. I encourage interested small employers and employees to visit the EBSA website at www.ebsa.gov or call EBSA's toll-free hotline at 1-866-444-EBSA (1-866-444-3272) for further information about protecting themselves against fraud.

The Department 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, the Department 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. The Department's primary goals are to shut down such scam artists quickly, to appoint independent plan fiduciaries in order to protect plan assets, and to recover money for victimized workers.

To combat MEWA fraud and corruption, EBSA has implemented a two-pronged approach using both its civil and criminal enforcement authorities. Due to our enforcement efforts, almost $9 million was recovered in FY 2002 alone for innocent victims to assist them with unpaid medical bills. Most of the criminal MEWA

investigations have been jointly conducted with other agencies including the Department's Office of the Inspector General, the FBI and the United States Postal Inspection Service. As of September 30, 2002, EBSA was pursuing 90 civil and 17 criminal investigations of fraudulent health plans.

Examples demonstrating the level of fraud perpetrated by unscrupulous MEWA operators are numerous. In one recent prosecution, the Department obtained court orders to shut down an abusive MEWA called Employers Mutual, LLC, sixteen related entities, and the individuals who operate them. Employers Mutual offered health benefits in all fifty states and the District of Columbia, with over 22,000 individuals enrolled in its plans. After collecting over $14 million in employer premiums, Employers Mutual paid less than $3 million in claims. Nearly fifty percent of the contributions were diverted to the personal accounts of the principals and to pay administrative expenses. Through our timely enforcement actions, an independent fiduciary was appointed and the court approved an orderly method of resolving unpaid medical providers' claims in order to protect the plan participants from being pursued by the health providers. Criminal sanctions are also being pursued.

**The AHP Solution: Reduced Barriers**

Let me now turn back to our proposal to increase small employers' access to affordable health insurance through AHPs. In an AHP, the current 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. Federal certification demonstrating that legitimate and financially sound sponsors operate AHPs would provide small businesses with the

assurance that the Department of Labor has determined that the organization offering coverage is not a "fly-by-night" operation.

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. 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.

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. Fully insured AHPs would purchase insurance products with solvency standards and consumer protections regulated by the states.

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

**Broader Choice of Coverage:** Associations will be able to fashion coverage that best meets their members' needs, even choosing to offer more than one plan. By offering broader choices, AHPs will encourage healthy small business members to purchase coverage and pay into the premium pool, which, given the number of uninsured small business workers and dependents, should exert downward pressure on health care inflation.

**Expected Results of AHP Legislation**

**Cost Savings and Increased Coverage**: Small businesses obtaining insurance through AHPs could enjoy significant premium reductions. According to the Congressional Budget Office (CBO),[13] 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, more small firms will be able to provide coverage to their employees and families. Even firms that already offer coverage could obtain lower-

cost coverage through AHPs. As many as 2 million American workers and their families could obtain health insurance through AHPs. 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 uninsured 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 Hispanic Chamber of Commerce, Women Impacting Public Policy, 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**

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. Of these, 275,000 plans covering 67 million individuals are

self-insured, and therefore subject exclusively to DOL oversight. In addition, self insured multiemployer plans (established and operated jointly by a union and two or more employers) are overseen exclusively by DOL. These plans cover more than 5 million participants, not counting their covered dependents.

Rest assured, I will allocate the resources necessary to effectively carry out our AHP certification and oversight responsibilities with effective, efficient and timely regulation and enforcement. I am confident of our ability to administer the AHP program successfully.

**Certification and Oversight:** To ensure that unscrupulous promoters would not operate AHPs, only *bona fide* trade or industry associations that have been in operation for several years will be allowed to sponsor these arrangements. The Department will examine AHP sponsors and certify them if they meet this standard, as well as certain solvency and membership requirements.

**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. There will also be a funding mechanism in place to ensure that claims can be paid if an AHP becomes insolvent.

**Insurance Market Safeguards:** AHP legislation will include provisions to ensure that AHPs result in stable, reliable markets for health insurance. Spreading risk and costs across a large group of individuals is fundamental to effective health insurance. In the past, small group markets have sometimes been vulnerable to practices, such as adverse

selection or "cherry picking," that segregate good risks from bad. Such practices can make insurance unaffordable or unavailable for small firms when employees or their families become seriously ill. To prevent cherry-picking, AHPs and participating employers will not be allowed selectively to direct their higher-cost employees to the individual insurance market. AHPs must offer all available health policy options to all of the membership's employers and individuals. Legislation should also limit AHPs' ability to vary the premiums for their participating employers.

**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, the Women's Health and Cancer Rights Act, and the Newborn's and Mother's Health Protection Act would apply to AHPs.

**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 responsive solution to this problem. We at the Department of Labor stand ready to work with members of Congress and this Committee to help pass and administer legislation that expands health insurance coverage for working Americans.

[1] Department of Labor estimates of working families' health insurance status, based on the Census Bureau's annual March Current Population Survey.
[2] Derived from Medical Expenditure Panel Survey, Insurance Component. Low-paying small firms are those with fewer than 100 employees in which more than half of employees earn less than $9.50 per hour.
[3] Department of Labor estimates of working families' health insurance status, based on the Census Bureau's annual March Current Population Survey.
[4] National Association for the Self Employed.
[5] Transamerica Center for Retirement Studies.
[6] Actuarial Research Corporation.
[7] Mercer Human Resources Consulting.
[8] The 2002 Small Employer Health Benefits Survey.
[9] U.S. General Accounting Office, Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage, GAO-02-8; and Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market, GAO-02-536R.
[10] U.S. General Accounting Office, Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage, GAO-02-8; and Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market, GAO-02-536R.
[11] Gail A. Jensen and Jon Gabel, "State Mandated Benefits and the Small Firm's Decision to Offer Insurance," Journal of Regulatory Economics; 4:379-404 (1992).
[12] Gail A. Jensen and Michael A. Morrisey, Mandated Benefit Laws and Employer-Sponsored Health Insurance (Washington, DC: HIAA, 1999).
[13] Congressional Budget Office, "Increasing Small-Firm Health Insurance Coverage through Association Health Plans and Healthmarts," January 2000.

Chair SNOWE. Thank you. Thank you, Secretary Chao. I thought your testimony certainly gives credence to the significance of this issue and how important it is for small businesses and the role that obviously Department of Labor will play.

I thought the purpose of this hearing would be to sort through some of the issues, some of the concerns that have been raised with respect to this legislation. I know there have been concerns raised about whether or not the Department of Labor will have the sufficient resources and personnel to oversee the requirements of association health plans with respect to the certification process which you referred to, as well as the solvency standards.

I was wondering if you could share with the Committee, because this is an essential dimension to the whole issue and I think obviously one of the primary concerns that has been raised, whether or not the Department of Labor will be in a position to provide the kind of oversight that States do currently in regulating these plans: making sure that a problem is identified before the plan becomes insolvent, that the reporting is not essentially voluntary but that you have the strength of the statute to make adjustments in the event that it is essential with respect to the stop loss or to the solvency requirements.

If you could just share with the Committee some of the ideas that you have and how the process works currently, because you oversee 67 million American workers under current plans that are managed by the Department of Labor in the self-insured plan. I would appreciate your views on this because obviously it is going to be one of the central issues that we will have to explore and address.

Secretary CHAO. I would be happy to.

First of all, I have absolute confidence that the resources that are needed, should this become law, would be there. We have a full commitment to ensuring that association health plans will be administered in a way that will ensure the maximum benefits to uninsured working families and that any steps necessary to prevent fraud will absolutely be available.

So I am very confident about the resource issue. I think that is a red herring. This is the President's proposal. If this does become law, we will have the requisite resources and if not, we will ask for it and I am confident that we will receive it.

Chair SNOWE. How does the current process work with those that you oversee now under the ERISA program?

Secretary CHAO. I mentioned in my statement that the private sector employer-based, job-based benefits that employees, workers currently receive far exceeds the amount of people and benefits covered under Medicaid and Medicare combined. So our country has a very strong and long-standing history of a job-based employer-based benefit program.

Americans who receive employer-based health benefits, are protected under ERISA and ERISA is administered by the Department of Labor. As you mentioned, 67 million Americans—that is only a portion. Over 130 million Americans are covered by ERISA health plans and 67 million are in self-insured plans regulated solely by the Department of Labor.

We have a long history of protecting workers under ERISA. In addition, there have been a number of Federal health care laws that amended ERISA and gave the Department significant new responsibilities in recent years. They include, for example, HIPAA, which talks about portability, nondiscrimination, pre-existing conditions. We have the infrastructure to ensure that compliance takes place.

Additional health laws enacted that we are responsible for helping to ensure compliance with are the Mental Health Parity Act of 1996, the Newborns and Mothers Health Protection Act of 1996, and the Women's Health and Cancer Rights Act.

So we have the structure and the infrastructure and people already who have the expertise and the experience in seeing these health care programs. On top of that we have experience. We are the primary agency with experience in administering ERISA, which again oversees employer-based health benefits and other employer-based benefits at the worksite.

Chair SNOWE. Do you think this legislation would require any strengthening with respect to the potential for fraud, which is obviously another concern that has been identified given the previous experience back in the 1980s, most especially with the multiple employer welfare associations?

Secretary CHAO. I think fraud has to be attacked on three fronts. One is clearly education. We, in the Department, are working with other groups outside of government, as well as State and local governments to ensure that employers and employees understand the problems that they may encounter in purchasing health care. We want to make sure that they are smart consumers and that they make wise choices and that they check out the people they are doing business with when they purchase health care.

So we have launched a major education program to help health care consumers—the employers and the employees—to know how to purchase health care. The second prong of that strategy to fight fraud is enforcement, strong enforcement. We have over 100 cases pending. We have collected over $9 million dollars in the last year alone from fraudulent organizations that have used Ponzi schemes to entice employers to enter into their health care plan. So we have a very aggressive enforcement effort ongoing and under way to ensure that bad actors are rooted out, that they are put out of business, that new trustees are instituted, and that we try to recover as much as we can for those who have lost money through fraudulent schemes.

The third part of the strategy to prevent fraud is to ask for passage of association health plans, because the third part of the strategy is to make sure that there is a standard Federal regulation that is easier to understand and easier to administer so that we can catch some of these fraudulent organizations. Because these organizations are now preying upon the fears of so many Americans and they are growing regionally, they exceed the ability of any one State to catch them. So, in fact, association health plans with Federal regulatory standards will actually be much more helpful in fighting these fraudulent organizations.

Chair SNOWE. Thank you.

Senator Levin.

Senator LEVIN. Thank you, Madam Chair. I would like to make reference to a letter that I received from Blue Cross-Blue Shield of Michigan which has some very deep concerns about the AHPs. I just want to read a part of that letter and I would ask that the letter be made part of the record.

Chair SNOWE. Without objection.

[The letter follows:]

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Blue Cross
Blue Shield
of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

January 30, 2003

The Honorable Carl Levin
269 Russell Senate Office Bldg.
Washington, DC 20510
VIA FAX: (202) 224-1388

RE: Association Health Plans

Dear Senator Levin:

We would like to share with you our concerns about potential federal legislation pertaining to Association Health Plans (AHPs) that Congress may be asked to consider in the next few months. While this issue remains of concern to many constituent groups throughout the country, it remains an even greater concern to Blue Cross Blue Shield of Michigan and its 4.5 million customers.

The possibility of Association Health Plans being sponsored by a variety of business and professional groups could place Michigan in particular in a very difficult position. There are currently two types of AHPs that can be established. The first, self-funded AHPs, would be exempt from all state laws and oversight. The second, insured AHPs, would also be able to offer coverage nationally, just like self-funded AHPs, but they would be required to comply with oversight laws in just one state. Because the current regulatory environment in Michigan is basically non-existent except for BCBSM, Michigan would become a haven for AHPs that are trying to circumvent regulatory oversight in other states.

While AHPs have been proposed as a good idea for small business, they may actually be harmful to the small business insurance market. Opponents of AHPs including the National Governors Association, the National Conference of State Legislatures and the National Association of Insurance Commissioners, believe that AHPs will destabilize the insurance market and could actually lead to higher rates for small businesses that do not join them. Rather than providing relief to small businesses and expanding access to dependable insurance coverage, AHP provisions would instead generate greater opportunities for fraud and abuse to occur at the expense of the general public.

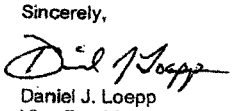
Association Health Plans
January 29, 2003

This is of particular importance to Michigan as it is one of only a few states that have not seen some type of regulatory rating reform over the last decade. The passage of some form of AHP legislation would increase the cherry-picking and adverse selection that is prevalent in Michigan. AHPs would weaken the existing insurance pool by allowing small businesses and individuals to opt for bare bones benefit packages in order to save money, switching back to BCBSM whenever they were in need of more comprehensive coverage. As the carrier of last resort, this is of critical concern for BCBSM who is the only health care carrier in Michigan who must accept applicants year round, regardless of health status. As a result, the healthy will obtain coverage through AHPs while the unhealthy will obtain coverage through BCBSM thereby destroying the basic concept of insurance pooling – balancing risk.

While we are actively working with members of the state legislature to ensure some type of regulatory reform occurs on the state level that would ensure fair and equitable insurance practices, we encourage you to oppose the AHP legislation that is being proposed. Enclosed is additional information outlining the detrimental effects this legislation could have on Michigan if implemented.

Thank you for your serious consideration and we look forward to discussing this issue with you.

Sincerely,



Daniel J. Loepp
Vice President
Governmental Affairs

Amy E. Bacsa
Manager
Federal Relations

Enclosure

cc: Richard Whitmer, President and CEO, Blue Cross Blue Shield of Michigan
Blue Cross Blue Shield Association

Senator LEVIN. One of the statements that they make in this letter is that the passage of some form of AHP legislation would increase the cherry-picking and adverse selection. AHPs will weaken the existing insurance pool by allowing small businesses and individuals to opt for bare bones benefits packages in order to save money, switching back to Blue Cross-Blue Shield whenever they were in need of more comprehensive coverage.

As the carrier of last resort, this is a critical concern to us. We are the only health care carrier in Michigan who must accept applicants year-round regardless of health status. As a result the healthy will obtain coverage through AHPs while the unhealthy will obtain coverage through Blue Cross-Blue Shield, thereby destroying the basic concept of insurance pooling, balancing risk. Could you comment on the cherry-picking problem that AHPs create?

Secretary CHAO. The concern that they point out about cherry-picking is one that I am very cognizant of and we would not want to see this happen. The whole point of having an association health plan package would be that we would allow small employers to pool their risks, to come together and pool their employees together so that the risk and cost of administering a health care program can be spread over a large number of people.

We want healthy workers to opt into the system as well. Because what is happening now is that the health care premiums are getting so high that healthy workers are saying, "I am pretty healthy, the risk of my having an illness is pretty low. So I am going to take a chance and I am not going to go and get health care insurance." That is not good. That is why we want to lower the cost of health care so that we can encourage more healthy workers to come back into the system. Cherry-picking would discourage this, would make it so that it is very costly and we would not want that to happen.

This is still legislation in the works and we want to make sure that as we go forward that cherry-picking does not occur and that people are not opting out of a program. We want to make sure that a larger pool of people would be included because after all, that is the purpose of the association health plans.

Senator LEVIN. There are lots of ways in which cherry-picking can occur. One way would be for a pool to be created, for instance, which would attract mainly the young and healthy workers by having very high copays.

Secretary CHAO. We would not want to see that happen either. As I mentioned, this is a bill that is going forward hopefully, and so let us work on that. I would want to work with you on that to make sure that this does not happen because we want to make sure that everyone is covered and we do not want those who are less healthy to be isolated.

Senator LEVIN. At a hearing in 1997, the Assistant Secretary of Labor at that time said that the Department of Labor did not have the resources to regulate the AHPs. This is one sentence from her testimony. Based on our investigative experience, we could review each pension plan once in 170 years. If you include health plans, once in 300 years. She said that an infrastructure adequate to handle the new responsibilities, replicating the functions of 50 State insurance commissioners, simply does not exist.

Now you indicated that you are confident the resources would exist.

Secretary CHAO. Yes, I am.

Senator LEVIN. We have, of course, in legislation and public statements, given assurances to all kinds of people over the years that resources would exist to carry out various programs. We have a special education commitment, the Federal Government will pick up 40 percent of the cost of special education, impose mandates, and we are nowhere near 40 percent. We have done the same thing now with the Department of Homeland Security. We have got commitments that we have all made that come nowhere close in the budget request, and other kinds of commitments which are made.

I know your intention there. I do not doubt that. I know you and I have no doubt about your honesty and sincerity when you make that statement. But what would the resources be? How many dollars would be required to regulate this program, in your judgment?

Secretary CHAO. First of all, let me emphasize again that the Employee Benefits Security Administration formerly called PWBA, Pension Welfare Benefits Administration, has a great deal of experience in this field already because we do administer ERISA and we do have the infrastructure with which to ensure compliance with a lot of the recent health care legislation. So for those who question the Department on that, I want to set the record straight.

We have begun to take a look at how much resources we need. We have some figures but I feel that it is a little premature to specify at this point. But we already do certification. We will need to beef up our enforcement a little bit.

I am confident that the resources will be made available and they will be readily obtainable.

Senator LEVIN. My time is up. If you can perhaps supply that to the Committee for the record when you have an estimate as to the cost of administering the program.

Secretary CHAO. I can give you an answer to that.

Senator LEVIN. Would you just say hello to Mitch for all of us.

Secretary CHAO. I sure will. Thank you.

Senator LEVIN. Thank you, Madam Chair.

Chair SNOWE. Senator Talent.

Senator TALENT. Thank you, Madam Chair.

I want to thank you for allowing me to be here today. This is a subject that I have worked on for some time and I do appreciate your allowing me to sit in.

Madam Secretary, thank you for your support of this. I think it is very meaningful to people in Missouri, particularly those who work for small businesses.

Of course, the Department already regulates today, does it not, all the plans covered under ERISA, the big company plans, the union plans?

Secretary CHAO. It sure does.

Senator TALENT. There are hundreds and hundreds of those plans, are there not?

Secretary CHAO. Hundreds of thousands, covering tens of millions of people.

Senator TALENT. I do not know how many association health plans would develop but the reserve requirements and the stop loss

requirements are so great that my sense is that only the largest trade and professional associations, maybe the Chamber, NFIB, the Restaurant Association and a few others would be able to do it. So maybe we are talking about adding another, I do not know, maybe 15 or 20 plans to your regulatory burden. That is what we are talking about, is it not? I mean, it is hard to estimate.

Secretary CHAO. Yes. First of all, I have to commend the Senator for your previous work in association health plans and also in the health care sector overall. I know that you are quite an expert in this area.

Senator TALENT. Officially, I will agree with you. For the record, I will agree with you.

[Laughter.]

Secretary CHAO. But you are right that the Department has a great deal of expertise. ERISA covers provided health benefits, and is under the Department of Labor. So we do have the experience. We have the people. They are available.

It may require some additional resources but I am confident, as I mentioned to the Senator, that we will have those resources.

Senator TALENT. An incremental increase in your regulatory burden, at best. As you say, you are already regulating plans that cover millions of people. These would be a few more plans. It is hard to say exactly how many would develop over time but not that many.

Now the cherry-picking argument, and this keeps coming back and back. It is like some kind of a monster from fiction. No matter how many swords you jam in it, it keeps coming back. But let me just tell you something that I did and do when I am on the stump talking about this or out in town hall meetings. I want to ask you if this surprises you.

I will explain association health plans to a group of people, usually those who are working for a small business, and I say to them now look, if you had an ongoing medical problem, a chronic problem, if you were a sick person in the sense that you had diabetes or kidney disease or something like that, and you had a choice between working for a very big company or a small company and the only factor in your mind was health insurance, and knowing nothing else about it, how many of you would want to work for the very big company?

You know what, Madam Secretary, nobody, when I have asked that question has ever said, knowing only that and controlling it in the way that I did, that they wanted to work for the small company. Does that surprise you?

Secretary CHAO. No, it does not and that points to a big problem.

Senator TALENT. The idea that the healthy people will go into the association health plans is, I think, exactly the opposite of the reality. It is the folks who have a problem who are now relegated to a market where health insurance is very expensive and is not very good, they are the ones who are going to want to go to association health plans, do you not think?

Secretary CHAO. You are absolutely right.

Senator TALENT. I especially like that Blue Cross is telling a lot of people that the healthy people will go to the bare bones AHPs and then if they get sick run back to the tremendously low cost,

high quality Blue Cross-Blue Shield policies, which certainly is not the experience that I have had talking to people in small businesses around the State of Missouri.

Let me ask you one other thing. Does the Department have figures as to how much of the business in the small group market is controlled by a few big carriers? Do you have those figures? Possibly not, because that is State regulated so you may not have that.

Secretary CHAO. I can get that for you, but you can imagine what the answer is.

Senator TALENT. I would be interested in seeing that because I think those carriers would probably stand to lose some business if association health plans were passed. What do you think? Maybe you do not want to answer that.

Secretary CHAO. I think that certainly is a concern of theirs.

Senator TALENT. I thank you and I see my time is up. Thank you, Madam Chair.

Chair SNOWE. Thank you.

Senator Pryor.

Senator PRYOR. Thank you, Madam Chair.

Let me say it is an honor to be on your Committee and I look forward to getting a lot of great things done here.

Thank you, Madam Secretary, for being here today. It is great to have you here and I know this is an issue that you are very passionate and very concerned about. As I travel the State of Arkansas, and it does not matter if I am talking to a member of a union or a small business owner, or a small family farmer, or an officer in a very large Fortune 500 company, immediately what they want to talk about is the high cost of health care. It is something that is growing at a rate that they just cannot keep up with. It is a very, very serious problem.

As I understand the proposal today, is that what you are trying to address is the high cost of health care and the access to health care?

Secretary CHAO. I am.

Senator PRYOR. Let me point out something that I know that the Members of this Committee are aware of and I know that you are aware, and I would just like to hear your thoughts on this. That is last year the Congressional Budget Office studied the AHP legislation that was introduced last year and determined that AHPs would likely provide health care coverage to about 4.6 million people. That sounds good.

However, all but about 330,000 of them are already covered today. So in other words, this proposal, based on what the CBO is saying, if I understand their report correctly, does not really expand health care coverage but will primarily go to members of our society who are already covered by health care. Is that your understanding of that?

Secretary CHAO. No, that is not really true because the spiraling cost of health care is an issue that we all need to be concerned about, because it is not static. It increases. So long as health care costs continue to increase, in fact, more and more people will opt out because of the high cost of health care.

So the association health plans will contribute to decreasing the cost of health care, by 13 percent or perhaps as much as 25 percent

on average. In addition, the number of people covered will increase as well. So I disagree with those figures.

Senator PRYOR. So what is the flaw in the CBO's logic or the flaw in their process?

Secretary CHAO. I think that is a static analysis. Basically, if health care continues to increase upward there will be those who will find it increasingly unaffordable. So let us say they are paying—I was looking for one figure. The average small business has seen an increase in their health care cost from about 11 percent to 18 percent. It is a magnitude that large.

Senator PRYOR. I hear it every day when I go out. I hear it every day.

Secretary CHAO. So when health care cost increases that much, there is going to be a concern obviously with the number of employers that would be able to offer that to their employees.

Senator PRYOR. The other problem the CBO report points to, and again, I would like to hear your comment on this, is that you create a kind of haves and have-nots situation or may exacerbate the problem that already exists. That is that the AHP legislation would, in fact, benefit some people. It would allow some people to get health care they do not already have. It would allow some to keep it and they might otherwise not be able to.

But also the downside might be that it might make health care more expensive for about 20 million other Americans that cannot get into an AHP. Do you have any thoughts on that?

Secretary CHAO. Our aim is to allow the association health plans to be a real option for a maximum number of Americans. The association health plan is not the only solution to the rising cost of health care in our country. It is one solution, a very effective solution I might add as well. But other solutions include medical malpractice reform. The high cost of litigation these days is shooting the cost of health care upward.

Senator PRYOR. It sounds like it is going up about 1 percent because of that, as I understand it.

Secretary CHAO. There are other components of the program that we suggest, as well. For example, tax credits, expansion of medical savings accounts, and association health plans.

Association health plans is not the only solution, but again it is a very important part of our nation addressing the rising cost of health care. As for these individuals who may have—let me just say something else about people who have to purchase individual insurance. Individual insurance may be available to some, but as you well know that is the most expensive form of health insurance. So that is not the most desirable.

Senator PRYOR. One last follow-up on that if I may, Madam Chair. There is something that Senator Levin alluded to a minute ago that you said that is not the intent of this and you hope it would not happen. That is the prospect of very high copays. What assurance can you give me and what assurance can you give this Committee that that will not happen?

Secretary CHAO. I think the cost share the employee bears is dependent upon the high cost of health care. Most employers want to provide health care insurance and benefits for their employees. If the cost of health care is low, they are going to take up a larger

portion of it. If the cost of health care increases, they will of economic necessity be forced to have their employees take a larger portion. But that is not the desired route. That is why holding down the cost of health care is important.

Small companies in particular, have premiums about 20 to 30 percent higher than large self-insured companies with similar claims per covered employee. So association health plans is a way to help smaller employers spread their risk and get the cost down and therefore allow a large number of employers to offer health care to their employees.

Senator PRYOR. Thank you, Madam Chair.

Chair SNOWE. Thank you. Now, I would like to welcome Senator Kerry. You missed all the nice things I said about you earlier.

Senator KERRY. I will give you a chance to say them again.

[Laughter.]

Chair SNOWE. You know, the thing that is interesting, Senator Kerry and I are Chair and Ranking Member of another Committee—Ocean and Fisheries Subcommittee. So he is going to see me more than he bargained for.

But it is a delight to work with you, Senator Kerry, on this Committee and I am looking forward to working with him and your stewardship of small business. I know you have been a strong proponent of small-business.

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

Senator KERRY. Thank you very much.

Madam Chair, thank you very much. It is nice to work with you. We have had a great tradition here. I thought we were going to end it for a while with me in the ascendancy, but we have had a great tradition of flipping back and forth in the Chairs and it has always been a pretty bipartisan Committee that has worked very effectively. So I look forward to working with you. I really do.

I welcome our new Members. On our side, Senator Pryor. I know he is not a Member of the Committee but I welcome Senator Talent. Jim Talent has worked hard on this.

Senator TALENT. Would you just yield for a second, Senator Kerry?

Senator KERRY. Sure.

Senator TALENT. If I could just say what a pleasure it was, when I did Chair the Committee in the House, to work with you in all capacities and with your staff.

I cannot, because of our conference rules, be a Member because Senator Bond is already on the Committee and does a great job. But it is just a pleasure to be on the same dias with you.

Senator KERRY. Thank you very much and I look forward to continuing that relationship and I appreciate your interest in being here today.

Madam Secretary, thank you for being here today and I join with our colleagues in wishing Mitch well.

Secretary CHAO. Thank you.

Senator KERRY. We are glad to have you here today.

I did want to take—if I can use my time also as Ranking Member—to make my opening as I ask a question or two.

I disagree with you about what is happening in the marketplace with respect to "most businesses want to provide insurance." The trend appears to be that most businesses in the country are moving away from defined benefit to defined contribution. It is a reflection of the effort to push off some of that responsibility and ask employees to go out into the marketplace and pay more of the burden, fend for themselves to a certain degree.

Now they are still helpful, it is still critical, they are still the massive base of our insured in the country. I think any solution to the current woes of the health care system is going to require building on the employer-based system to the degree that we can.

This hearing is obviously geared towards figuring out how we do that in a thoughtful, intelligent way that does not create other distortions in the marketplace. That is my concern.

More and more workers are telling us how they are being squeezed downwards. They are being squeezed downwards by the defined contribution requirements. They get a piece but it is never enough to keep up with the rate of increase, so they have to kick in more and more, essentially a pay decrease for them.

Also, the benefits that they were receiving are increasingly being squeezed.

I think that is the concern that a number of us have about the AHPs as currently proposed. I am for purchasing pools because you want to spread the risk. Insurance is inherently based on the notion of spreading risk. You try to figure out how broadly you can spread it in a way that maximizes the risk assumption and therefore minimizes cost, providing insurance geared to serve the group as a whole.

If you look at the problem of health insurance in America today, we have 41 million Americans that we know are uninsured. Eighty percent of them are in households with at least one employed worker. Half of these individuals are either self-employed or working for small businesses that employ 50 or fewer workers. But less than half of those small businesses now offer insurance, compared with almost 100 percent of the large employers.

So we have been working, in this Committee, for a number of years to try to narrow that gap. I recognize that is the purpose of today's hearing on AHPs. But these numbers make it clear that if we could somehow figure out a way to really broaden the risk pool, we can bring a lot of people into insured status.

It seems to me we ought to set principles up front of what kind of health insurance we want to offer people and then work from there. I think one principle is it has to be comprehensive; i.e., you do not shave down the benefits so much that people are not getting what really helps them.

Other principles—insurance has got to be affordable, obviously, and stable. It has got to be there and have some continuity to it and people have to know they are getting what they paid for.

That is what concerns a lot of us about the Administration's current proposal because there are two major disadvantages to it, I think, with respect to meeting those principles I just defined.

No. 1, I think AHPs have the potential of placing consumers at risk because you exempt AHPs from the State patient protections, the solvency requirements, and oversight. Now I have heard the

back and forth about how different individuals have a lot of experience in managing that, but the fact is the marketplace is failing today even under their management. An awful lot of our fellow Americans are complaining about the lack of accountability in the plans that they have.

So you have to build protections into the structure from the beginning and not, I hope, rely on some unknown regulator in a regulatory climate that we have not really seen to be particularly effective in the last year.

Secondly, with respect to the risk pool that I talked about, and I believe in the marketplace, I want to maximize competition and I want to maximize private enterprise capacity. But we all know that there are certain realities that drive the bottom line and determine profit. When you leave spreading risk to the marketplace, people try to avoid the most egregious payouts. It is a natural tendency. So there is the capacity, absent a structure that really pulls people in here adequately for AHPs, as proposed, to destabilize the small group health insurance market which in the end will result in higher premiums for those in other places.

Now, what do I mean by these concerns? Because the AHPs are not subject to state consumer protections, including for instance assured access to emergency care or Ob/Gyns, specialists of various kinds, mental health services, mandatory grievance procedure of some kind, appeals timelines, certain rights with respect to cloture in the process of knowing what you do or do not have. All of these are consumer protections that the States have spent more than a decade putting in place. I know the National Governors Association and others are deeply concerned about AHP structure as put forward with respect to these protections.

Secondly, because AHPs are allowed to self-insure and accept insurance risk not subject to state solvency requirements, you really do run the risk that the marketplace tendency to look for maximum profit, we have seen countless examples of fly-by-night companies that come along, they gouge people, and then when people's need is really there, they are gone. The money has been absconded with and there is no accountability. I do not think we should start out empowering entities to take advantage of people in the marketplace in that way.

Further, it is the natural tendency for AHPs to go out and find the people who are going to be at lowest risk. What is the best business practice? Do not have heavy payouts. If you are a start-up entity and you insure a bunch of people with MS or diabetes or some other problem, you are never going to make a profit. You are going to be bankrupt before you begin.

So your absolute tendency is to say we have got a bunch of young people over here working in this high-tech company. Let us grab them, that is a natural for us. Because their likelihood of getting sick is not very great. What happens is, as those people are pulled from the current small group system, you wind up leaving other people paying higher premiums because you no longer have the shared risk pool you had before.

Now see, this is not me speaking. This is not partisan. The CBO has estimated that nearly two-thirds of the cost savings AHPs would offer result from attracting healthier members from the pool

of existing workers. In CBO's analysis, 80 percent of workers would remain in traditional insurance and potentially be worse off if AHPs are created. That means 20 million employees and dependents of small employers could experience a rate increase under AHPs.

So I think these are very important issues to work through. I think a number of witnesses here today are going to share thoughts about how you can do this, expand the pools, but do it in a way that hopefully is not going to wind up with some of the downsides.

There is a philosophical question I want to ask. The Administration is currently proposing to give States more flexibility in the Medicaid and SCHIP programs, which a lot of people see as giving license to governors to squeeze downwards and follow the same trend that we just talked about because they are all under enormous pressure. They are going to be cutting Medicaid. Nobody knows how that is going to result. We are hearing stories of children who are now going to be withdrawn from the programs. So you are giving flexibility to the States at the same time that you are talking about federalizing much of the small group insurance market. I am wondering what the logic is, why it is desirable to increase State control for Medicaid and SCHIP while decreasing it for the small business health insurance?

Secretary CHAO. Medicare and Medicaid, as you know, are administered by the Department of Health and Human Services, and I think those questions are more properly directed to Secretary Thompson.

Senator KERRY. I am not asking about the Administration, I am just asking about the contradictory philosophy.

Secretary CHAO. The SCHIP program is also administered by HHS. I will speak on several of the concerns that you have raised.

First of all, I acknowledge in my prepared statement I submitted for the record that employees in small businesses do bear the brunt of cost increases in health care and the issue there is that we all want to see health care cost decrease. The association health plan is part of a multi-pronged strategy to do just that.

So I think most employers do want to offer health care benefits for their employees, they want to see their employees happy, well taken take care of, healthy. It is good for them. But they are increasingly hard-pressed to do so when the cost of health care is spiraling upward so rapidly.

Senator KERRY. We passed a tax credit, as you know, which is going to take full effect. So we do not yet know whether that, fully expanded, might be able to empower employers to offer health insurance without this downside impact.

Secretary CHAO. Well, the association health plan is one part of the solution. Other parts can be tax credits, expansion of medical savings accounts, and others.

The second issue raised, about cherry-picking, we discussed previously, prior to your arrival, and I share your concern about that. This is an issue that we are discussing and hopefully it will result in bills into which we will all have input.

I would be very willing to work with you and others. Several other of your colleagues have also mentioned concerns about that,

as well. It is not our intention, I think any of our intentions, to have a plan that would exclude all but the healthiest.

The third issue about the regulatory regime. The Department has a great deal of experience in ensuring compliance with ERISA and also a number of other health care regulations and legislation. We want the State structure largely to remain in place, which it will for fully insured AHPs. For self-insured AHPs, they will fall under a Federal regulatory regime. This clearer delineation of regulatory authority between State and Federal entities will help reduce fraud, such as has plagued NEWA's.

Senator KERRY. I appreciate the observations you have made. I am not sure it really reflects the differential in the approach. I am also concerned that we keep coming at this with a piecemeal approach and we have a little band-aid here and a little band-aid there, and it starts to bleed somewhere else as a consequence.

I look forward to working with you, and I hope we can find a way to avoid that unintended consequence law from taking hold here again.

I apologize to you and others for having been late here. We had the Moscow Treaty and the AIDS bill in the Foreign Relations Committee and that is why I was not able to be here earlier.

Madam Chair, I would ask that some letters with respect to this issue from a number of different groups be placed in the record, each of them major players in the insurance market, and all of them deeply concerned about the particular course that we are on at this moment.

Chair SNOWE. Without objection.

[The letters follows:]

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**J.R. Elpers, MD**, Chair of the Board • **Michael M. Faenza**, President and CEO

February 4, 2003

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

Dear Chairwoman Snowe:

On behalf of the National Mental Health Association (NMHA), I am writing 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.

Established in 1909, NMHA is the nation's oldest and largest advocacy organization dedicated to all aspects of mental health and mental illness. Improving access to mental health care is of primary concern to our organization, but bills to increase the availability of AHPs by exempting them from state health insurance reforms take the wrong approach and would undercut significant progress made at the state level to improve coverage of mental health services.

Millions of Americans who have health coverage are denied critical mental health care 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 costs 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,

Michael M. Faenza, MSSW
President and CEO

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United States Senate
428A Russell Senate Office Building
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Sincerely,

Michael M. Faenza, MSSW
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PRESIDENT: REP. KATHLEEN KEENAN, VT
VICE PRESIDENT: SEN. STEVEN GELLER, FL
SECRETARY: REP. CRAIG EILAND, TX
TREASURER: REP. FRANK WALD, ND

February 4, 2003

The Honorable Olympia J. Snowe
Chairwoman of The Small Business and Entrepreneurship Committee
U.S. Senate
Russell Senate Office Building, Room 428A
Washington, DC 20510

Dear Chairwoman Snowe,

On behalf of the National Conference of Insurance Legislators (NCOIL), I am writing to express NCOIL's concern regarding legislation that would exempt Association Health Plans (AHPs) from state law. This provision would have dire consequences -- undermining state health reforms, eliminating consumer protections, and threatening access for many small employers and consumers -- and should not be enacted.

NCOIL recently readopted an NCOIL *Resolution on Federal Preemption of State Laws Regarding Certain Health Insurance Arrangements*, reaffirming its position on the issue.

NCOIL is an organization of state legislators whose main area of public policy concern is insurance legislation and regulation. Many legislators active in NCOIL either chair or are members of the committees responsible for insurance legislation in their respective state houses across the country. NCOIL's goal is to help legislators make informed decisions on insurance issues that affect their constituents.

In recent years, state legislators have actively pursued legislation to protect small employers and consumers in the health insurance market. We have supported laws that have expanded coverage to help the uninsured, required important health benefits, established quality assurance standards, and provided independent, external review processes to help settle consumer grievances. NCOIL has also endorsed steps to provide strong solvency and fiduciary standards to ensure that health plans provide the benefits they promise.

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Exempting AHPs from state regulation would undermine many of the hard-fought victories state legislators have achieved on behalf of small employers and consumers. For example, state laws create subscriber pools that require healthy subscribers to cross-subsidize the less healthy. If exempted from state laws, AHPs would be able to "cherry-pick" the healthiest firms from these pools by offering them low premiums, but charging firms with older and sicker workers premiums that far exceed what would be allowed under state small employer health reforms.

This legislation would harm the majority of small employers who purchase state-regulated health insurance. The Congressional Budget Office (CBO) estimated that 80 percent of workers in small firms – 20 million employees and their dependents – would see premium increases, and another 10,000 of the sickest people would lose coverage entirely. This would be a significant step backward in NCOIL's efforts to ensure access to health care coverage.

As well as hindering reform efforts, exempting AHPs from state regulation would deny consumers important protections. State-issued solvency requirements ensure that consumers may have confidence they will receive the services for which they paid. However, the U.S. Department of Labor, which would regulate self-funded AHPs, has neither the funding nor the manpower needed to provide the oversight and protections states already guarantee.

States have successfully regulated the insurance market. States have also led the way in innovative insurance market reforms to address consumer needs.

NCOIL asks that you oppose efforts to exempt AHPs from state law and regulation. Should you have any questions or comments, we would be happy to discuss them with you.

Sincerely,

Rep. Kathleen Keenan (VT)
NCOIL President

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TREASURER: REP. FRANK WALD, ND

February 4, 2003

The Honorable John F. Kerry
Ranking Member of The Small Business and Entrepreneurship Committee
U.S. Senate
Russell Senate Office Building, Room 428A
Washington, DC 20510

Dear Ranking Member Kerry,

On behalf of the National Conference of Insurance Legislators (NCOIL), I am writing to express NCOIL's concern regarding legislation that would exempt Association Health Plans (AHPs) from state law. This provision would have dire consequences -- undermining state health reforms, eliminating consumer protections, and threatening access for many small employers and consumers -- and should not be enacted.

NCOIL recently readopted an NCOIL *Resolution on Federal Preemption of State Laws Regarding Certain Health Insurance Arrangements*, reaffirming its position on the issue.

NCOIL is an organization of state legislators whose main area of public policy concern is insurance legislation and regulation. Many legislators active in NCOIL either chair or are members of the committees responsible for insurance legislation in their respective state houses across the country. NCOIL's goal is to help legislators make informed decisions on insurance issues that affect their constituents.

In recent years, state legislators have actively pursued legislation to protect small employers and consumers in the health insurance market. We have supported laws that have expanded coverage to help the uninsured, required important health benefits, established quality assurance standards, and provided independent, external review processes to help settle consumer grievances. NCOIL has also endorsed steps to provide strong solvency and fiduciary standards to ensure that health plans provide the benefits they promise.

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Exempting AHPs from state regulation would undermine many of the hard-fought victories state legislators have achieved on behalf of small employers and consumers. For example, state laws create subscriber pools that require healthy subscribers to cross-subsidize the less healthy. If exempted from state laws, AHPs would be able to "cherry-pick" the healthiest firms from these pools by offering them low premiums, but charging firms with older and sicker workers premiums that far exceed what would be allowed under state small employer health reforms.

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As well as hindering reform efforts, exempting AHPs from state regulation would deny consumers important protections. State-issued solvency requirements ensure that consumers may have confidence they will receive the services for which they paid. However, the U.S. Department of Labor, which would regulate self-funded AHPs, has neither the funding nor the manpower needed to provide the oversight and protections states already guarantee.

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NCOIL asks that you oppose efforts to exempt AHPs from state law and regulation. Should you have any questions or comments, we would be happy to discuss them with you.

Sincerely,

Kathleen C Keenan

Rep. Kathleen Keenan (VT)
NCOIL President

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Senator KERRY. Thank you.

Chair SNOWE. Senator Bennett.

**OPENING STATEMENT OF HON. ROBERT F. BENNETT, A UNITED STATES SENATOR FROM UTAH**

Senator BENNETT. Thank you, Madam Chair and may I congratulate you on your assumption of the chairmanship of this Committee, and I look forward to your stewardship with great confidence.

As I listened to this entire conversation I am moved to make an observation that I think all of us should pay attention to. The employee bears all of the costs. Let us understand that. This is not well.

Having been an employer, I can tell you that if the value that comes from that employee's service is not sufficient to cover the cost of all of his so-called benefits, you do not hire him. We have the fiction in this country that the employee gets what he gets on his W-2 and that is what you have to cover.

You cannot afford an employee who does not return enough economic value to cover both what he gets on the W-2 and what is accrued to him in health care costs and what is accrued to him in unemployment insurance and what is accrued to him in whatever other benefits there are. The term benefit is a misleading term. It is part of the employee's compensation. If the employee does not create enough economic value to the company to cover all cost of his compensation, regardless of how it is disguised, you do not hire that employee.

So however we divide it up in accounting purposes, let us understand always it is the employee's money. The employee has earned it. The employee has generated enough economic value to the company to cover it. It is the employee who is paying for it.

Senator KERRY. Would my colleague yield for a point? This is an important point.

Senator BENNETT. Surely.

Senator KERRY. I am glad you are making it. I absolutely agree with you that the employee earns it one way or the other.

The question is what does the employee know that he or she is earning? If you have a defined contribution, the employee knows they are getting say $5,000 or whatever it is. The employee has to go out on the marketplace or somewhere and fend for themselves to get the benefits. Often the benefits are less available and/or less defined or less clear to them.

So in the negotiating process, this is where for a long time that they had a defined benefit itself. They knew they were getting 80 percent hospital cost, 20 percent contribution, Ob/Gyn services, emergency. You know what you are getting.

Now of course, it is the value of their service, but the difference we are fighting for here is the difference of the power of the employee in the marketplace and the capacity to actually get what you think you are getting in return for the work you are providing.

I would agree with you in terms of the definition but I think we have to keep our eye on what we are trying to protect.

Senator BENNETT. This is probably not the place to debate the issue, but at some point I would like to put on the table the idea

that the employee should not only understand what he is getting, the employee should control the money. If, in fact, the employee—and we tried to do that in the business that I ran—the employee was in the position to say, "Okay, my benefit package is worth X number of dollars and I get to decide how those dollars are spent." That is a radical idea—that I get to decide how my dollars that I have earned for this company, that I am getting in a compensation package, are spent.

At some point where we have more time and the clock is not running I would like to pursue that because I think it would change things enormously.

The primary problem with health care, in my view, is that the consumer of the health care is not the purchaser of the health care. That means that the provider, be it a doctor, a hospital, a clinic, a PPO, whatever it might be does not view the patient as the customer. The customer is the insurance company or the AHP or the Government. The customer makes the decisions as to what the provider will do and will not do and the patient is left out of those negotiations. The patient is paying for it, but has no economic power to determine what will happen.

That is the result of the third-party payment system that we are in. It happens whether the third-party payee is the employer or whether the third-party payee is the Government, which increasingly it is. Over 40 percent of our health care dollars spent in this country are controlled by the Government. The Government is the customer and the provider responds to the demands of the Government and the patient, very often, is left out.

I have told this anecdote before but it is true. I will just talk briefly about the Government and its impact. A woman said to me,

> "You know, I am a college graduate, I am a professional woman, I think I am pretty smart. I handle my mother's affairs. She is in her 80s. I have finally figured out how to deal with Medicare. I throw away everything unopened and at the end of each month I call the Salt Lake Clinic and say how much do I owe you. It saves me all of the problems."

She said,

> "Any thought that my 85-year-old mother could understand any of these documents is just ridiculous."

She said,

> "I cannot understand any of them, so I stopped reading them. I just simply throw away everything unopened from Medicare and then I call the provider once a month and say how much do I owe you and it just saves me a tremendous amount of time."

If we have reached that point in the complexity of the third-party payee system, we are in serious trouble.

Okay, my time is all gone in the debate of this circumstance but let me just say, Madam Secretary, I have received, as I am sure others have, but in my case I have received from the State of Utah a formal letter complaining about AHPs and telling us why they should be opposed. The legislation to which they refer is at the tail end of the last Congress and so the legislative numbers are wrong.

Could I give you this and get a formal response from the Department of Labor to the objections that they raise, so that we can place side-by-side an analysis of where these things are?

Secretary CHAO. I will be glad to.

Senator BENNETT. I will submit that to you.

Thank you for your appearance and for your service here. We have got to rework our way through this problem and I still feel the best way to get it done is to find some way to ultimately give the employee control over the employee's money that the employee has earned. With that kind of employee choice, I think market forces will assert themselves and the whole system will become more efficient because it is enormously inefficient today.

Thank you.

Chair SNOWE. Thank you, Senator Bennett.

I understand, Senator Talent, you have to leave. Would you like to make any additional comments?

Senator TALENT. I appreciate it, Madam Chair.

I kind of like that you can make an opening statement when you are about to leave the hearing. I do appreciate the chance to put a couple of remarks on the record of that nature.

I do agree with Senator Kerry, I think this is the place to begin debating these kinds of issues because there are real people who are really affected by what is going on out there.

When I did a tour on this, I went to Horizon Screenprinting in Cape Girardeau where their health insurance costs have, I think they said doubled in the last 3 years. Or Virginia Dooley, who is a friend of mine, who is a dentist in Booneville and is having trouble keeping a receptionist because she cannot compete on health insurance.

I have heard this story over and over again, they cannot compete with the big companies. The reason is the big companies, because they have big national pools, have much smaller administrative costs per employee than the small companies do. Then they have bigger purchasing power. They can self-insure so they can compete more effectively in the marketplace. All these efficiencies you get from having a national pool.

All association health plans will do is empower small businesspeople to do what big companies are already doing, evidently without destroying the health insurance market because we all like to have health insurance, do we not?

Now this argument about cherry-picking, the bill that we passed in the House, and the Chairman and others are going to put together a bill, it was "must offer must carry". So to do this, you had to be an association that existed for 3 years and then you had to offer health insurance to anybody who joined the association on the same terms as you offered it to anybody else.

Now common sense tells you, under those circumstances, who will go to the bigger pool? What small businesses will seek to join the association health plans? Those that are having trouble buying it on the small group market because they have sick employees.

So the cherry-picking argument is exactly the opposite of the truth.

I believe it is small groups with the less healthy employees who will first seek to join the association health plans. They will be able to insure them for the same reason that the big companies can, that Emerson Electric can in St. Louis, and Sprint can in Kansas City, because they have a big pool to work from.

Now one other point, Madam Chair, and I do appreciate your generosity, and maybe it is because we served together for a long time in the other body.

This CBO report—we had a hearing specifically on the CBO report. The gentleman who did the report admitted in the hearing that their findings were based on the assumption that association health plans would offer less generous benefits then are now available on the small group market, which is clearly not true. It unravels their whole analysis. All the other studies that have looked at this have found, as common sense would tell you, that it would reduce the number of uninsured by millions of people.

I will just close by saying, I should declare my own or at least familial interest in this. My brother runs a tavern in St. Louis. I like to talk about it, Madam Chair, and I hope you can come if you ever come to Missouri. It is called Chuck's Bar and Grill, and my brother's first name is, you will not be surprised to hear, Chuck.

It is a great business and he has a number of great employees and he cannot offer them health insurance and not because he does not want to. It's because of the hassle to him and my sister-in-law, who run the place, of going out in this market and finding health insurance, much less the cost, just makes it prohibitive, impossible.

If he could join the Chamber of Commerce or the NFIB or the National Restaurant Association, they send him the benefits that are available and he tells his employees, here is how much I can pay per month, you pick what you want. Would he get health insurance for his employees? The answer is yes. That is all that this bill is about.

I thank you, Madam Chair, again for your generosity.

Chair SNOWE. Thank you. I appreciate your contributions and I appreciate the comments and insight offered by Senator Bennett, as well.

Just to wrap up, I think obviously there are wide-ranging views on this subject and I happen to think that it is important to also look at the legislation that has been introduced. There are specific requirements and provisions in this legislation to address the issue of cherry-picking. It would require compliance with the Health Insurance Portability and Accountability Act that was passed back in 1996, which you mentioned, Secretary Chao, which is very important here. That would preclude adverse selection.

We will hear additional panelists here today that perhaps could offer suggestions on how we can improve upon the language. But the point is not to do an end run around the current system. No one is suggesting that larger companies and unions who are currently self-insured and therefore exempt from State mandates and compliance with State regulation, are offering poor quality health insurance packages.

In fact, to the contrary. From all the small businesses that I have talked to, they want to offer the very best policy. They just need to get the best price, the most affordable price. Because obviously as a small business the costs are very high. They pay a disproportionate increase in terms of administrative expenses. They will pay a higher cost because there are fewer to which to spread the risk.

In my State, our experience is yes, we have state purchasing pools, except they are so small that they do not offer affordability.

There are not enough employees in the pool to spread the risk. So that, in essence, becomes the problem. That is why they have opted for the idea of association health plans as another avenue as one of the many solutions to this national problem when it comes to the uninsured. Something is obviously wrong with the current system.

I did not see, in looking at this issue, and I am new to this issue in terms of being Chair of the Small Business Committee, small businesses trying to do an end run around the current system. They would be more than happy to be able to access health insurance in their particular State. They cannot. It is a question of accessibility.

So they are saying what else can we do, because we want to provide this benefit to our most valuable employees? They are what makes us competitive. Small businesses cannot compete with larger companies if they are not offering these health benefits. That is the problem.

So I would hope in the ensuing debate on this issue that we look at the specifics of the legislation so that we can determine what is truth and what is false when it comes to charges, counter-charges, points, counterpoints. Because I have read about this cherry-picking and the legislation explicitly prohibits this practice because, as Senator Talent indicated, only bona fide associations in existence for 3 years for purposes other than for health insurance purposes will be able to offer AHPs. You cannot deny access to anybody because of their health status.

So I am really sort of perplexed about some of these arguments and I am going to have to sift through them. We have claim reserves. That is required. That is absolutely a reserve sufficient for unearned contributions. We have aggregate excess stop-loss requirements, specific excess stop-loss, indemnification insurance, surplus, minimum 500,000, no greater than 2 million. But the legislation also states additional requirements of allowing additional reserves and excess surpluses, stop-loss insurance as may be deemed appropriate by the Secretary, taking into account the recommendations of the Solvency Standings Working Group by regulation and/or negotiated rule-making.

Now I would hope that as we begin this debate that we can sort of decide what, in fact, are very good provisions, what needs to be strengthened. But in the final analysis, we all agree that small businesses should have access to additional options for health insurance that makes it affordable because as this chart behind us indicates with these rates of increases of premiums disproportionately affecting small businesses, we have a problem. We need to address that problem. There are many ways of addressing the uninsured and this happens to be one route towards that process.

So when I hear there is no oversight, that is not true. I hear we are going to allow fraud because there will not be sufficient regulations to prevent that or oversight to ensure that we can guard against it. That is not true.

But if there are other ways to improve the language in this legislation, I would tell my additional witnesses I welcome it because we want to really sort this out and to strengthen the legislation so that we can move forward.

Secretary CHAO. Madam Chair, thank you very much for summarizing it so succinctly. We are very committed to pushing forward association health plans. We want to work with you and your Committee on any issues or concerns that you may have.

I might just add on a closing note, I do want to emphasize that there are so many solutions that have been suggested and recommended that we have seen there is no one-size-fits-all solution.

I think there is one other principle that we need to keep in mind as we talk about accessing quality and affordable health care, and that is timely health care benefits.

Chair SNOWE. I could not agree more, Madam Secretary, and I truly appreciate the time that you have given us here today. I am looking forward to working with you on this legislative issue.

Again, give our best to Mitch. Thank you.

Secretary CHAO. Thank you very much.

Chair SNOWE. Now I would like to welcome the SBA Administrator, Hector Barreto. Thank you for being here today.

We appreciate it. Please proceed, and welcome to the Committee. We appreciate your patience and your willingness to be here to share your thoughts as a major advocate of small business, and to lend your perspective on this issue.

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

Mr. BARRETO. Thank you very much, Madam Chair.

I very much appreciate the opportunity to be here and to talk about an issue that is so important to small business owners.

I also want to thank Secretary Chao for her contributions to this discussion, this very important discussion, and identifying ways that we can increase access to affordable, quality health care for small businesses.

I would also ask to submit my written testimony for the record as well.

Chair SNOWE. Without objection, so ordered.

Mr. BARRETO. Small business owners tell me all the time that this is one of the most important issues that they face, and that the problem of access to affordable health insurance has grown considerably for them in recent years.

I know you have heard the numbers, devastating double-digit premium increases each year for small businesses. The steeply rising cost, added to a long list of other factors, have forced many small business owners to stop offering insurance coverage all together. For some, the expense has meant that it has never been an option.

Is it any wonder that most of America's uninsured citizens either work for a small business or are self-employed themselves, or have a head of household who works for a small business? This impacts the ability of small businesses to compete for the skilled employees they need to grow and prosper. The availability and quality of health care benefits is often a deal breaker for employees when they are looking for a new job. Without prompt action, this crisis will only grow.

The urgency of this issue cannot be underestimated, nor can the opportunity to do something about it be ignored.

I have been exposed to this issue throughout my life in a very personal way. I grew up in a small business, I then worked for a small business. I became a small business owner myself, and finally I served as the head of a small business association. I have seen firsthand just how difficult it is for these businesses, which provide the backbone to our Nation's economy, to secure the health care that they and their employees want and need.

As SBA Administrator, I have had the chance to visit with small business owners all over the country wherever I go. They inevitably ask me what can they do and what can the folks that represent them in Washington do to make health care more affordable for them. My job, as head of the SBA, is to help small business owners and their employees. My agency is the Government entity they look to when they are in need, and we are not able to help them when they ask about this, their greatest concern, the one that impacts their employees and their families so much.

The SBA ought to be able to give small business owners an answer when they call and ask about health care. That answer ought to be credible referral to associations they can join to purchase health insurance at a lower cost. A key answer to the health care question for small businesses ought to be AHPs.

Madam Chair, when you invited me to speak on this panel, you asked that I also speak specifically to the impact that high health care costs have on the Hispanic population. I regretfully report that the news is not good. Hispanics are now the largest minority group in the United States and they are also the least insured ethnic group. Approximately one-third of all Hispanics do not have any insurance at all, and another 15 to 20 percent are underinsured. Millions of Hispanics are self-employed or work for small businesses which are unable to provide them with the health insurance coverage they need.

I would also report that this is very similar in many other emerging markets. African-Americans, Asian, women-owned business owners face the same problems.

Given the staggering cost faced by all small businesses, President Bush has placed increased access to affordable health care at the top of his comprehensive small business agenda. The President wants to make it easier for small employers to pool together to offer their employees the same sort of affordable health coverage options that many large corporations and labor unions can currently provide. The President knows that this can be achieved through AHPs.

Removing legal barriers and allowing AHPs to flourish would bring cost savings to small businesses by reducing daunting administrative cost and introducing the discounts that come with high volume purchasing. That common sense approach is backed by thorough research, including a recent report on AHPs by the Department of Labor, and a study from my Office of Advocacy released last week.

Ultimately, AHPs will mean the expansion of access to health benefits for millions of uninsured Americans and more coverage choices for small firms. Once Congress passes legislation enhancing AHPs, SBA will be able to connect small business owners with the best solutions for providing health insurance to their employees,

while the Department of Labor will implement the necessary programmatic structure. I look forward to the supporting role that the SBA will play.

I want to thank Secretary Chao again for the leadership that she has shown on AHPs. Her commitment to this issue has been admirable and I know that small business owners struggling to make ends meet are appreciative of her efforts.

I hope that Secretary Chao and I, on behalf of President Bush, can work closely with you and all Senators this year so that small businesses and the 57 million Americans who work for them can gain access to better, more affordable health coverage.

Until we come up with a solution that crosses State lines, I do not think we can solve this problem. The time to act is now. Continuing to do nothing to address this crisis is unacceptable.

Thank you, Chair Snowe and Ranking Member Kerry for affording me the opportunity to speak to you today about this very important topic and I look forward to answering your questions.

[The prepared statement of Mr. Barreto follows:]

**Statement of Hector V. Barreto**
**Administrator**
**U.S. Small Business Administration**
**Access to Affordable Health Care**
**Senate Committee on Small Business and Entrepreneurship**
**February 5, 2003**

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

For many small business owners, this is the most important issue they face. The problem of access to affordable health insurance has grown in recent years. Without prompt action, this crisis will only become more acute. According to a recent survey of small business owners by the National Federation of Independent Business (NFIB), the cost and availability of affordable health insurance continues to be the biggest problem facing small businesses. More small business owners cite health insurance (23%) than they do even taxes (20%) or poor sales (17%) as the chief impediment to their success.

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

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

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

As Administrator of the SBA, I have had a chance to visit with small business owners throughout the country. During this time, I have visited 26 states and have participated in numerous business roundtable discussions. No matter the topic of these discussions, small business owners inevitably ask me at these gatherings what we in Washington can do to make health care more affordable for them. They tell me time and time again that their inability to find access to affordable, quality health care is their biggest concern.

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

Studies bear witness to the truth of these anecdotes. Though businesses large and small have experienced rises in health insurance premiums disproportionate to inflation, small businesses have been particularly hard-hit. For instance, while premiums for the largest companies (5,000+ employees) grew by 10.8% in 2001, premiums for companies with ten or fewer employees grew by an astounding 16.5% that year. Even before these recent increases, small businesses were already struggling to keep health care affordable for their employees.

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

This lack of readily available quality health insurance has even forced many small business owners to stop offering insurance coverage altogether. A recent study by the Kaiser Family Foundation (Kaiser) showed that only 49% of small firms (defined as firms with fewer than 100 employees) offer coverage, due in large part to surging health premiums. By contrast, 98% of all large firms offer health benefits.

This disparity grows even greater at small low-wage firms, defined as firms at which more than 50 percent of all employees earn less than $9.50 an hour. Only 24% of all low-wage small firms offer health benefits, as opposed to 95% of all low-wage large firms.

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

When small companies do offer health benefits, they typically offer a narrower range of options than do larger companies. According to the Kaiser study, 71% of small firms that provide health benefits only offer one plan to their workers, with the primary reason cited for offering just one option being that the companies receive better deals from insurers by requiring all or most employees to join the same plan.

Madam Chair, you had asked that I specifically speak to the impact that high health care costs have on the Hispanic population and the employees of this Nation's two million Hispanic-owned businesses. The news is not good. Now the largest minority group in the United States, Hispanics are also the least-insured ethnic group. Approximately one-third of all Hispanics do not have any insurance at all, and another 15% to 20% are underinsured. Millions of Hispanics work for small businesses which are unable to provide them with the health insurance coverage they need.

A report by the Tomás Rivera Policy Institute (TRPI) of Claremont, CA focusing on Hispanic firms in Southern California demonstrates the depth of this problem within the Hispanic community. Over one-third of the 273 Hispanic-owned firms covered by the study did not provide employee health insurance. The report found that the lack of coverage was worst among smaller firms, firms headed by Hispanic executives with little or no college education, and businesses more likely to employ Hispanic labor.

I witnessed this problem first-hand as vice chairman of the board of the U.S. Hispanic Chamber of Commerce and as chairman of the board for the Latin Business Association in Los Angeles. Member companies constantly asked me how they could provide health care to their employees. Unfortunately, the associations for which I worked could not find cost-effective solutions for these businesses due to the restraints placed upon them by current law. As a result, these associations could not do anything to assist the least-insured segment of our country.

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

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

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

Small employers are forced to seek health insurance for their workers as separate entities, making it more expensive or even impossible for these firms to purchase insurance coverage. AHPs would allow these small businesses to join together, affording them the

benefits of uniform federal regulation and greater economies of scale enjoyed by large employers.

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

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

Legislation introduced in the 107th Congress which would have enhanced AHPs would have allowed small businesses to save on average somewhere between 9% to 25% of the cost of their health care premiums, according to a study by the Congressional Budget Office (CBO). With the cost to small businesses of providing insurance decreasing so dramatically, the CBO study indicated that 330,000 people without health insurance would have been covered had Congress passed that legislation.

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

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

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

work for them, can receive access to better, more affordable health care coverage through the strengthening of AHPs. Until we come up with a solution that crosses state lines, I do not think we can solve this problem for small businesses. The time to act is now. Continuing to do nothing to address this crisis is unacceptable for millions of small business owners.

Thank you, Chairwoman Snowe and Ranking Member Kerry, for affording me the opportunity to speak to you today about this very important topic. I look forward to answering any questions that you might have.

Chair SNOWE. I appreciate it, Mr. Barreto.

You heard some of the issues that were raised here this morning, and I would appreciate your response to some of these issues. I know that Blue Cross-Blue Shield held a press conference yesterday and indicated their position that AHPs allow cherry-picking; and that the Department of Labor cannot handle AHPs. This is again going back to the issue of oversight and stringent regulations; they bring no savings, administrative or otherwise, to small business.

Again, we want to pass the right legislation in this respect. As I said earlier, we are not trying to circumvent the current system. I have not certainly detected from small businesses their interest to avoid providing a quality health care package at an affordable rate to their employees.

That is the mystifying part about this because small businesses want to have access to a package that they otherwise do not have currently because they do not have choices and they certainly do not have the kind of price that they can afford to provide this kind of benefit to their employees.

Can you get through some of the fact and fiction here, from your perspective, on this issue?

Mr. BARRETO. Absolutely and thank you for the opportunity, and thank you for the question, Madam Chair.

I am very familiar with Blue Cross-Blue Shield. As you know, I used to own an employee benefits company and worked with that fine company. I have not spoken to Blue Cross-Blue Shield since they made that announcement. I did speak to the Chief Counsel of Advocacy who actually put together the report that was referenced by some of the comments that were made yesterday and I can tell you what he has told me.

As you know, the Office of Advocacy is a very important function for small businesses. They are an independent agency. They are responsible for doing a lot of the research on the issues that are important to small businesses. They have told me, and the Chief Counsel has assured me, that their research indicates that AHPs will actually do those things that you mention, provide more access to health care and lower the cost of health care.

That is very, very important. They will also allow the opportunity for a lot of those folks that we mention, 60 percent of those uninsured are small business people or work for small businesses, to get access for the very first time.

So their understanding and sense and perception of what that report said is very different than some of those comments that were made. They wholeheartedly believe that AHPs will be a very good solution, not the only solution, but a very important solution for a lot of those small businesses who, for lack of a better word, are suffering, truly suffering, and have been suffering for some time now.

Chair SNOWE. It appears to me that we certainly have to work through some of these issues so that we can rebut and refute some of the inaccuracies because I do think that that is critical.

Frankly, as I said earlier, if I think we can identify some weaknesses in this legislation then I want to address it. But I have been looking at this legislation and reading the provisions that do prohibit cherry-picking, adverse selection. They cannot just pick a cer-

tain group of people to be part of that association. It has to be open to all members, regardless of health status, regardless of pre-existing conditions.

In terms of lower administrative costs, AHPs have been studied in the past, but the fact is they will yield lower costs for small businesses because obviously, it does not stand to reason, they cannot spread that cost in their own business. It is very difficult. It is much more cumbersome, much more arduous for small business to go through all of the paperwork, to search out different entities and options for health care. It becomes a major burden for small business, and trying to undertake that at the time they are managing a small firm with very few employees.

Mr. BARRETO. It truly is, Senator Snowe. It can be a devastating situation. I cannot help but notice that chart and I was in business during a lot of that time, working with small businesses, helping them try to get access to health care. I can tell you that about the time that those premiums started increasing is about the time that there was less choice for small businesses, the time that large insurance companies started merging together, the time when some insurance companies got out of the market altogether and did not provide any option for small businesses.

So what we know very dramatically is that when there are not options, when there is not competition, the exact reverse happens. Less people get insurance and the cost of being able to provide that insurance for the people that want it goes dramatically up.

It is impossible to be able to run a business when you are getting double-digit increases in your health insurance premiums every single year whether you are sick or not. You are absolutely right, Senator, you cannot pass those costs on to your businesses.

Finally, what it does is put small businesses in the role of giving the bad news to their employees. They are constantly giving the bad news, we have to change plans, we have to change doctors, they reduced our benefits this year. Finally, we cannot provide any health insurance for you at all anymore.

So this is something for which it is now time. As you said, it is not a new idea. These are concepts that have been talked about for a long time. But when I travel around the country, small business people are looking to us to provide that leadership and to come up with a solution for them at this time.

There can never be a better time to do so than right now, especially when those businesses are struggling as much as they are.

Chair SNOWE. I think this graph behind me certainly does illustrate the sum total of the problem. With the top line being obviously the rise in health insurance premiums and then the second line is the medical inflation. You can see the gap in that, just how much higher health insurance premiums have increased compared to medical inflation. Then overall inflation and then, of course, workers earnings and then overall inflation.

You can see the huge gap that exists and the fact is health insurance premiums are on a very disturbing trend and its upwards. That is the problem.

I have heard from small businesses who tell me that they do not have any claims on their policies and they are going up with major percentage increases every year, that is making it very difficult.

What will your role be as Administrator of the SBA in conjunction with the Department of Labor in overseeing association health plans?

Mr. BARRETO. We will work very closely with Secretary Chao and obviously the Department of Labor will come up with the protocols and be responsible for the implementation of any legislation, should legislation be passed. But we see our role as very much an advocate for those small businesses.

We get millions of small businesses that come to us every single week. I will give you an example, our web site right now, we get 1.5 million visits to that web site. Not hits, visits.

Of course, we have an incredible network of district offices in every State in the union. We have incredible resource partners, thousands and thousands of resource partners and offices.

We would use our network to communicate with and educate small businesses. I oftentimes say that small businesses do not know what they do not know, and especially with an issue as important as health care.

So we would play, I think, a very important role in facilitating the information. Once solutions are brought forward, to be able to help people access those solutions, identify those solutions, refer those solutions, we would play that role, as well as others, in working together with our partners on this Committee and also with the Secretary of Labor.

Chair SNOWE. Obviously you could play a role in education, could you not, in terms of what is offered in the benefits and so on? Again, guarding against what happened in the 1980s concerning multiple employer welfare associations and the fraud that emerged.

Do you think that the requirements in this legislation, calling for an association that has been organized for 3 years and been in existence for 3 years, helps to guard against the type of fraud and corruption we have seen in the past?

Mr. BARRETO. Absolutely, and I would say that AHPs are very different than MEWAs. Obviously, MEWAs can be organized to provide benefits and they do not have district requirements that are going to be required of the AHPs. At the end of the day I know that something that is very important in the legislation is that bona fide organizations are going to be the ones that are providing these benefits. In other words organizations that do other things other than just provide health benefits.

If there was not this dramatic need, I venture to say that many of these large organizations, organizations like NFIB with 600,000 members, the U.S. Chamber with hundreds of thousands of members and employees that are represented by their companies, would not even be looking at this issue.

But they are hearing the same things that we are hearing, that their members are desperately in need of a solution and these organizations will be on the front lines. Obviously they will be held to very strict standards. I think the legislation that is being developed and that is being proposed will ensure that these types of fraud and these types of problems that have occurred in the past with other types of entities do not occur in AHPs.

Chair SNOWE. Do you think that the Department of Labor will be in a position to provide stringent oversight in monitoring these

activities and preventing the type of fraud that did exist in the past so that small businesses are not a victim? I think that is one of the issues. Can we protect consumers from fraud? Will fraud emerge from this? Or do we have sufficient protections in this legislation that will not either allow or cultivate that kind of a circumstance?

Should we be giving more resources to the Department of Labor with respect to this? Does it require additional personnel?

Now some would suggest the Department of Labor cannot be as responsive as local governments and State governments can be to these types of activities and obviously they have had many years of history regarding that oversight. But the Department of Labor has had more than 30 years, in terms of the self-exempt plans.

Mr. BARRETO. I agree with many of the comments that were made today by Secretary Chao and Senator Talent. I think they made a very compelling case for the important work the Department of Labor has already done in regulating some of the largest plans in the country, the work that they do with regards to pensions.

They have protected the interest of Americans for many, many years. I do not see that being any different as they go forward. There is a high level of commitment and understanding about this issue.

I think also what was stated is that we are not talking about hundreds of thousands of AHPs. Probably at the end of the day, with the standards that are going to be brought forward, there will not be that many AHPs. We do not know the exact number but when you have organizations like, as I mentioned, large Chambers of Commerce, the Restaurant Association who represent millions of small businesses, they will really be on the front line.

So I have every confidence that the Department of Labor and all of those responsible for making sure AHPs do their job will be up to the task.

Chair SNOWE. You obviously had an experience as a businessman. It has just been my impression, in talking to a number of small business people, and with your past experience can you comment on the suggestion as well, that somehow businesses are just looking to provide the lowest common denominator when it comes to health care coverage? Would you address that?

Mr. BARRETO. Absolutely, I would be happy to comment on that.

I think that when I hear that, I see that sometimes as a symptom of a greater problem. What I mean by that is that for many years now small businesses have just been throwing up their hands and saying we cannot deal with this anymore. Now we have to make a choice of whether we are going to keep our doors open or not.

So when you hear things like they are passing more of these costs on to the employees or they have decided not to offer the coverage anymore, it is not out of desire.

Actually, I have heard some surveys that have been done in large organizations that say that if we could provide a better way to access it, a more consistent cost that they could plan, a comprehensive set of benefits, they would be very interested in doing it.

I would also say, and I think this point has been made, is that it is good business for them to do it. When they are competing for employees, oftentimes the first question that a very talented employee asks coming in the door is, "tell me about your benefits package". Almost before they talk about what the salary is going to be and what vacation is, I want to know about your benefit package.

That oftentimes puts small businesses on the defensive. Sometimes, they do not have an answer to that. Sometimes, they do not have a benefits package to offer. So if they could do it, if there was an opportunity through AHPs where they could offer this kind of coverage, I believe that many of them would take advantage of that opportunity, some because they feel so strongly about it, and some because it is just good business.

When small businesses are creating two-thirds to three-fourths of all the net new jobs, this problem is only going to get larger if we do not do something about it. So I believe, and my experience working with small businesses is, if we can provide them a solution they will step up to the plate and they will do what they need to do to cover their employees.

Chair SNOWE. I appreciate it, Mr. Barreto.

I am looking forward to working with you on this issue and obviously with the small business community and others. Obviously, I think we should attempt to address any concerns that have been addressed in the development of this legislation to ensure that it meets its objectives.

I hope that we can continue to work on this issue and obviously, the feedback that you get from the small business community nationally would also be appreciated as we proceed.

I certainly am very grateful for your input and leadership that you have given on this issue and understanding the concerns of small business with respect to providing this invaluable benefit, incalculable to employees of small business.

I think given the size of the uninsured, the working uninsured, I think most people think the uninsured are unemployed when it is not so. It is predominantly the working uninsured and predominately in small businesses and their families.

So we really have to tackle this issue without, I think, undercutting the current system that does exist but offering other choices in addition to other proposals that have been offered to address this very vital issue.

Mr. BARRETO. Thank you very much, Madam Chair. I also look forward to working together with you and I commend you for your leadership in putting the focus on such an important issue for small business. I congratulate you for a very auspicious start of your Committee.

Thank you very much.

Chair SNOWE. Thank you.

Now we will bring forward the third panel, Ms. Kathie Leonard, Co-founder and President, Auburn Manufacturing in Mechanic Falls, Maine; Ms. Anne Valentine who is President of SmartCatalog from Portland, Maine; Mr. Jack Faris, President and Chief Executive Officer, National Federation of Independent Business; Ms. Terry Neese, President and Co-Founder of Women Im-

pacting Public Policy; Mr. Harry Alford, President and Chief Executive Officer of the National Black Chamber of Commerce; and Mr. Cliff Shannon, President, SMC Business Councils, representing the National Small Business United and SMC Business Councils.

Welcome. We will start with you, Kathie. I want to ask each of you to summarize your statements and we will include the entire text of your statement in the record.

**STATEMENT OF KATHIE M. LEONARD, CO-FOUNDER AND PRESIDENT, AUBURN MANUFACTURING, INC., MECHANIC FALLS, MAINE**

Ms. LEONARD. Thank you, Madam Chair, and Members of this Committee. I am grateful for the opportunity to explain how impossible the task of offering good health care insurance coverage has become for small businesses like mine. I have been in business for 23 years and the health care financial burden we shoulder has grown tremendously over the years.

Today we find ourselves in a crisis situation that we did not create and that we cannot control. It is frightening to even think about but we may not be able to continue offering this benefit if present trends persist.

My company, Auburn Manufacturing Incorporated, makes industrial textiles that save energy and protect people, plants, and equipment from high heat, substituting safe textiles for those once made with asbestos. We began with a small two-person operation in 1979 and now employ about 50 people in our two Maine manufacturing plants. We believe we are successful because of our innovative approach to manufacturing, marketing and administration.

Employee benefits are no exception. We offered a tax-deductible child-care plan in the early 1980s. We built fitness centers in both of our plants in the mid-1980s, and we even bought a company-owned lakefront lodge in Maine in 1989 for employees and their families to enjoy through the use of a lottery system.

Health insurance benefits were added with some innovation, as well. Our first plan paid 75 percent of the premium for both the employee and his or her family, which was unheard of at the time. We wanted employees to participate in the cost of health care insurance so that they would perceive it as a benefit. By paying for the majority of premiums for both the employee and his or her family, we were contributing to the family's health which we believed would help maintain a stable and productive work force.

That was back in the mid-1980s when an individual premium ran about $650 a year. While all the other benefits mentioned above are still intact at much the same cost as when they were introduced, health care insurance costs have spiraled out of control despite our best efforts to slow the trend over the years.

These two graphs quickly point out how dramatically these costs have risen over more than 15 years. The first graph tracks annual health insurance premiums per employee since 1985. We can see that the cost has risen from about $650 per year to $3,400 per year. That is a five-fold increase or an average of almost 25 percent per year for the 17-year period. These cost increases averaged about 22 percent over the past 10 years and 18 percent over the

past 5 years. So the growth rate has reached alarming levels, regardless of where we begin to gauge the trend.

To make the changes even more dramatic, I note that the benefit has been ratcheted down from a full choice indemnity plan with no deductible in the 1980s to an HMO in the 1990s to a preferred provider plan with a $250 deductible today. So we are not even comparing apples to apples, but rather more like apple cores to apples.

The second graph tracks the company's cost as a percentage of sales since 1988. Back then, this benefit accounted for about .6 percent of our sales, whereas today it consumes 1.2 percent of our revenue dollars. I was not so alarmed about this until I was presenting on this topic last year along with a major employer with 10,000 lives in their self-insured plans. During that presenters remarks he shared with the audience the fact that his company's health care insurance costs were about .6 percent of sales then. He then stated that if those costs ever approached the 1.2 percent level, which is the way they were trending, the company would not be able to afford the benefit. His comments confirmed for me the reality of this situation which is that while big business is struggling with these high costs, too, they are only now approaching the level of plight that small business was enduring almost 15 years ago. It is not surprising to see why we are ready to throw in the towel.

One more number to consider is this, health insurance premiums now represent about 20 percent of our payroll costs. Because we only pay 60 percent of the premium today, that brings the actual cost of the benefit to about 12.5 percent of our payroll with the employee picking up the other 8 percent.

The employer's share of Social Security, at 7.65 percent now looks like a real bargain by comparison.

The blame for high health care costs is shared by many interests. The Federal Government, for Medicare reimbursement shortfall to States, (the State of Maine, for instance, gets reimbursed only 88 cents for every dollar spent on Medicare patients); The pharmaceutical industry, the insurance companies, doctors, hospitals, State-mandated benefits, and large numbers of uninsured consumers of health care services.

You will note that business, large or small, is not a contributor to the high cost. We simply began offering health insurance benefits as a way to maintain a competitive work force.

Now we are spending huge amounts of our time and money researching health plans every year and making decisions about health insurance that seriously impact the health and wealth of our employees and their families. No matter how hard we strive to improve employee health, our costs will not decline thanks to community rating which tosses us in a pool with everyone else.

Small business finds itself in a hopeless situation with a few grim choices left. No. 1, to drop the benefit entirely. No. 2, to continue to reduce the benefits as premiums increase, or No. 3, to self-insure, an option for some of the larger of us small businesses. Our company has adopted that plan, which has helped to lessen increases somewhat.

In my opinion, this voluntary business-subsidized health care system we have now is broken and the real fixes must come from

the Federal Government since it holds the purse strings on Medicare and Medicaid. The establishment of national association health plans is a good first step, since these plans would supersede the State-mandated benefits and community rating systems that unfairly burden small business.

If premium increases can be reduced in the short-term with these association health plans, we may be able to hang on a little longer while other national long-term approaches are developed.

I very much appreciate being invited to speak to you about the health care crisis as it affects my business and I truly hope that my experience will help you to develop some desperately needed ways to lessen the financial burden of health care costs which unfairly falls on the shoulder of small business.

Thank you.

[The prepared statement of Ms. Leonard follows:]

Kathie Leonard
President & CEO
Auburn Manufacturing, Inc.
February 5, 2003

Thank you, Madam Chairman and Members of the Committee. I am grateful for the opportunity to explain how impossible the task of offering good healthcare insurance coverage has become for small businesses like mine. I've been in business for 23 years, and the healthcare financial burden we shoulder has grown enormously over the years. Today we find ourselves in a crisis situation that we didn't create and cannot control. It is frightening to even think about, but we may not be able to continue offering this benefit if current trends continue.

My company, Auburn Mfg., Inc., makes industrial textiles that save energy and protect people, plant and equipment from high heat, substituting safe textiles for those once made with asbestos fiber. We began with a small 2-person operation in 1979 and now employ about 50 people in our two Maine manufacturing plants. We believe we are successful because of our innovative approach to manufacturing, marketing and administration.

Employee benefits are no exception. We offered a tax-deductible child care plan in the early 80's; we built fitness centers at both plants in the mid-80's; and we even bought a company-owned lakefront lodge in Maine in 1989 for employees and their families to enjoy through the use of a lottery system. Health insurance benefits were added with some innovation as well. Our first plan paid 75% of the premium for both the employee and his/her family, which was unheard of at the time. We wanted employees to participate in the cost of healthcare insurance so that they would perceive it as a benefit. And by paying for the majority of both the employee and his/her family, we were contributing to their family's health, which we believed would help maintain a stable, productive workforce.

That was back in the mid 80's when an individual premium ran about $650/year. While all the other benefits mentioned above are still intact at much the same cost as when they were introduced, healthcare insurance costs have spiraled out of control, despite our best efforts through the years. These two graphs quickly point out how dramatically these costs have risen over more than 15 years.

The first graph tracks annual health insurance premiums per employee since 1985. We can see that the cost has risen from about $650 per year to $3400 per year. That's a 5-fold increase, or an average of almost 25% per year for the 17-year period. These cost increases averaged about 22% over the past 10 years and 18% over the past 5 years. So the growth rate has reached alarming levels regardless of where we gauge the trend. To make the changes even more dramatic, I note that the benefit has been ratcheted down from a full-choice indemnity plan with no deductible in the 80's to an HMO in the 90's to a Preferred Provider Plan with a $250 deductible today. So we're not comparing apples to apples, but rather more like apple cores to apples.

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One more number to consider is this: Health insurance premiums now represent about 20% of our payroll cost. Because we only pay 60% of the premium today, that brings the actual cost of the benefit to about 12.5% of our payroll, with the employee picking up the other 8%. The employer's share of Social Security at 7.65% now looks like a real bargain by comparison!

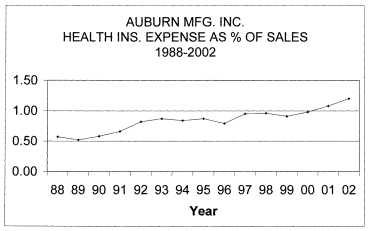
The blame for high healthcare costs is shared among many interests: 1) The Federal Government for Medicare reimbursement shortfalls to states (Maine hospitals get reimbursed only $.88 for ever dollar spent on Medicare patients); 2) The pharmaceutical industry; 3) Insurance companies; 4) Doctors; 5) Hospitals; 6) State mandated benefits; and 7) Large numbers of uninsured consumers of healthcare services.

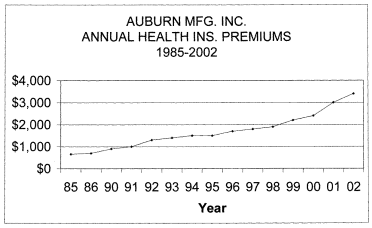
You'll note that business – large or small -- is not a contributor to the high cost. We simply began offering health insurance benefits as a way to maintain a competitive workforce. Now we're spending huge amounts of our time and money researching health plans every year and making decisions about health insurance that seriously impact the health and wealth of our employees and their families. And no matter how hard we strive to improve employee health, our costs will not decline, thanks to community rating, which tosses us in a pool along with everyone else.

Small business finds itself in a hopeless situation with a few grim choices left: 1) to drop the benefit entirely; 2) to continue to reduce the benefit as premiums increase; or 3) to self-insure, an option for some of the larger small businesses. Our company has adopted that plan which has helped to lessen increases somewhat.

In my opinion, this voluntary, business-subsidized healthcare system we have now is broken, and the real fixes must come from the federal government, since it holds the purse strings on Medicare and Medicaid. The establishment of national Association Health Plans is a good first step, since these plans would supersede the state-mandated benefits and community rating systems that have unfairly burdened small business. If premium increases can be reduced in the short-term with these Association Health Plans, we may be able to hang on a little longer while other national, long-term approaches are developed.

I very much appreciate being invited to speak to you about the healthcare crisis as it affects my business, and I truly hope that my experience will help you to develop some desperately needed ways to lessen the financial burden of healthcare costs, which unfairly falls on the shoulders of small business.




**Based on Single Premiums.**
**1985 - Annual premium $660.**
**1991 - Annual premium $1,000.**
**Increase of 50% in 5 year period, or 8%/year.**
**2002 - Annual premium $3,408.**
**Increase since '91 of $2,408, or 240%, or 22%/year.**
**In last 5 years, increase of $1,608, or 89%, or 18%/year.**

Chair SNOWE. Thank you.
Anne.

**STATEMENT OF ANNE VALENTINE, PRESIDENT, SMARTCATALOG, PORTLAND, MAINE**

Ms. VALENTINE. Thank you.

Madam Chair, thank you for focusing today's hearing on affordable health insurance for small businesses. I consider testifying before you a unique opportunity and a uniquely American privilege.

I am a small business owner in Portland, Maine. My company publishes college course catalogs on paper and online. I started off in a simple way, in the basement of my home as a matter of fact. I had no venture capital, just a little money to buy a computer and put in a second phone line.

We are still a small company and mostly self-funded but we have a national client base and a recognized brand that we have worked hard to develop through service, excellence and perseverance. Growing my business has been an organic process, one which more often feels like growing costs than revenue.

For example, the first time I rented office space, I could not sleep for days worrying about how I would pay the rent. Now that is the least of my worries. Each time you take on a new cost it seems insurmountable but within a few months the income will catch up and costs that seemed impossible become part of a normal check run, except for health care.

That is a cost whose growth outstrips my business's ability to catch up. You never get out in front of that one. Just when you think you have a handle on it, the premiums go up.

In 2001 I bought our first group health insurance, a PPO from Anthem Blue Cross. I contribute 50 percent to an individual premium and three out of four of us participate. At the time of the initial purchase the only viable plans presented by our agent to us were the Anthem Blue Cross options.

Last year, that policy came up for renewal. When I reviewed the numbers it became clear that we could not simply renew at the current rate. Were we to do so, the monthly premium would increase 20 percent. Only after choosing an alternate plan from the same insurer and incurring twice the deductible and double the copay, were we able to cap the premium increase at 8 percent. Bear in mind that we have never had a major claim on our policy.

The effect that such increasing costs have had on our actual coverage and sense of well-being is significant. When you combine a high deductible and rising premiums with the typically modest salaries of small business, what you have left is catastrophic coverage. Quality metrics, physician networks and advances in medical technology are meaningless if they are above the reach of the deductible.

My staff is small but wonderful. In fact, any customers listening to this today would be surprised that the company is not much bigger than it is. They do such a good job and constantly amaze me with their talents.

Unfortunately, I am powerless to protect them from the trends in the health care market, trends which create a psychic break with employees where one did not exist before. After all their hard

work, it is heartbreaking to have a discussion about benefits which will negatively impact their income. It is not just a lessening of compensation, it is a withdrawal on the ledger of employee trust.

Further, health insurance cost put me at a disadvantage in retaining staff in a competitive labor environment. No matter what the unemployment statistics are, good people are hard to find and expensive to train. Small businesses like mine have no dead weight. If you have a staff of three, one person leaving is a crisis.

Early on, I lost a valued account because of staff turnover. The value of that account over a few years would have easily paid for another position but they left for a job which included benefits I could not offer.

I am not an expert in the health care or health insurance field and I do not want to be. I run a publishing company. Buying insurance is very stressful for small business people because you are never quite sure if you have got the best deal. You suspect there is something better but do not have the resources or time to find out what it is.

When I am not wearing the hat of a business owner, I serve on the board of our local Chamber's health purchasing alliance. We are group of small businesses who decided to band together to purchase health insurance like a large business. It was our original intent to leverage the larger numbers on our rolls to get a better deal from insurers.

Last year the alliance sent out a request for proposals to three insurance carriers operating in Maine. Of those carriers, one simply opted not to bid at all because of the small population we represent. One responded that they do not sell to associations. The remaining provider may or may not be able to offer a significant savings on our premiums.

Small business people want to do the right thing and the best thing for their employees. No one wants to offer bare bones plans, nor can we be competitive in hiring if we do. But in markets with limited choice and no viable association plans to turn to, we have been relegated to a virtual single-payer system that cannot support our need for stable premiums with decent benefits.

Were we able to work with other businesses across State lines and follow one set of rules, we would clear many of the current obstacles and problems in one sweep. Association health plans can significantly help me and other small businesses purchase more affordable health care.

First, with increased bargaining clout and following one set of rules and regulations, we would be able to create robust benefit packages that are competitive with those of larger firms.

Second, we would be able to compete more effectively for skilled workers and even keep some of our young people from leaving the State for better jobs.

My business model has been described as the perfect mix of bricks and click technology that can thrive in the post dotcom world. Our success is proof that you can build on a good idea without investing huge amounts of capital. The jobs in my company are not many, but they are completely new jobs to Maine. Since our customers are all out of state, the income we bring in is completely new income to Maine.

I am proud of that achievement. Yet despite our reach into a national market, the local landscape of health care costs impedes my ability to create new positions at home and grow my company.

When I landed my first big account as a businessperson, I thought I had experienced the best part of entrepreneurship. But that is not really the best part about owning a business. Creating a new job is. Telling a hopeful applicant that they have the job and knowing that you have contributed not just to that individual but to the well-being of their family is worth all of the work.

Unfortunately in Maine, the limits on our health care options keep people from being hired, from staying in our State, and from reaching for a higher educational attainment. It also reduces our ability to attract new businesses to the State who are used to a more competitive health care market.

We need the kind of alternatives that association plans represent, choices that result in new jobs which are at the core of a healthy community and a sustainable future.

Thank you, Madam Chair, for the opportunity to present my story. I look forward to your leadership on tackling this issue.

[The prepared statement of Ms. Valentine follows:]

**ANNE VALENTINE**
**PRESIDENT**
**SMARTCATALOG**
**FEBRUAY 5, 2003**

Madame Chair, Ranking Member Kerry and Members of the Committee, as a member of the Portland Chamber of Commerce and the United States Chamber of Commerce, I would like to thank you for focusing today's hearing on affordable health insurance for small businesses. I consider testifying before you a unique opportunity and a uniquely American privilege.

I am a small business owner in Portland, Maine. My company publishes college course catalogs on paper and online. I started off in a simple way, in the basement of my home as a matter of fact. I had no venture capital, just a little money to buy a computer and put in a second phone line.

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Growing my business has been an organic process, one that more often feels like growing costs than revenue. For example, the first time I rented office space I couldn't sleep for days worrying about how I'd pay the rent. Now that's the least of my worries. Each time you take on a new cost it seems insurmountable, but within a few months the income will catch up and costs that seemed impossible become part of a normal check run.

Except for health care. That is a cost whose growth outstrips my business's ability to catch up. You never get out in front of that cost. Just when you think you have a handle on it, the premiums go up.

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Last year that policy came up for renewal. When I reviewed the numbers it became clear that we could not simply renew at the current rate. Were we to do so, the monthly premium would have increased 20%. Only after choosing an alternate plan from the same insurer incurring twice the deductible and double the co-pay, were we able cap the premium increase at 8%.

Bear in mind that we have never had a major claim on the policy.

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When I'm not wearing the hat of a business owner, I serve on the board of our local Chamber's Health Purchasing Alliance. We are a group of small businesses who decided to band together to purchase health insurance like a large business.

It was our original intent to leverage the larger numbers on our rolls to get a better deal from insurers. Last year the Alliance sent out a request for proposals to three insurance carriers operating in Maine. Of those carriers, one simply opted not to bid at all because of the small population we represent; one responded that they do not sell to associations; and the remaining provider may or may not be able to offer significant savings on our premiums.

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Unfortunately in Maine, the limits on our health care options keep people from being hired, from staying in our State and from reaching for a higher educational attainment. It also reduces our ability to attract new businesses to the State who are used to a more competitive health care market. We need the kind alternatives that Association Plans represent—choices that result in new jobs that are at the core of a healthy community and a sustainable future

Thank you Madame Chair for the opportunity to present my story. I look forward to your leadership on tackling this critically important issue.

Chair SNOWE. Thank you very much.

Mr. Faris.

**STATEMENT OF JACK FARIS, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, WASHINGTON, D.C.**

Mr. FARIS. Madam Chair, thank you for the opportunity to be here today and thank you for putting my written statement in the record.

Chair SNOWE. Absolutely.

Mr. FARIS. The bottom line is if Wal-Mart employees have it, why cannot Sarah's Hardware Store have it? It is a matter of fairness, and that is what association health plans are all about.

There is a great need in the small business community which we hear over and over again because we bear the burden of so many of the uninsured who work for small companies. All of our research tell us the No. 1 reason why companies cannot cover is cost. What drives cost? Administrative costs drive it. Almost 30 percent, in some States over 30 percent, of the cost of health care premium is administrative costs. It is because of our small size.

When it comes to benefits, we look at mandates, and over 1,500 new mandates in the States have been added in the last few years. Every time a mandate is passed, we get more costs. For every 1 percent of cost increase, 300,000 lose health care coverage.

We would like to do what we did with Governor Clinton in Arkansas many years ago in 1989, when he agreed to a starter insurance policy for small business in that State. We would like a starter insurance policy for all Americans. In the State of Arkansas, 1 out of 30 employees work for Wal-Mart and nationally 1 out of 23 retail employees work for Wal-Mart. If it is fair for Wal-Mart, why is it not fair for Sarah's Hardware?

When it comes to association health plans, we hear all of the negatives on the health care plan. They are primarily in the red herring category because they have not read the legislation that we are proposing and we are supporting and promoting.

Criticisms like cherry-picking based on pre-existing conditions, or portability, non-discrimination, special enrollment and renewability provisions—they are all in the red herring category. When you look at the problems with MEWAs in the past, we do not have that. We have a Federal consumer protection under AHPs, certified by the Department of Labor, who have been supervising all of the ERISA plans of all the major companies.

If a mechanic who fixes the Chevy pickup truck cannot get insurance, why should the person who works on the line or the chairman of General Motors get the same insurance? It is not fair.

The anti-consumer folks are saying that competition is going to drive up costs. Somebody has not read economics 101. Competition historically drives down costs and increases quality.

Why then would people be opposed to association health plans? They are voluntary, private market. They spread the risk, provide more Federal coverage, and more coverage for even liabilities that are criminal in nature that the States do not currently have, yet take no tax dollars.

Why would somebody be opposed? We found three groups opposed. No. 1, we have found that Blue Cross-Blue Shield opposes it. They have 85 percent of the market. We call that a "duh" factor, Senator.

If I owned a bank and I had 85 percent of the banking business in America, I would not want another bank to be able to start.

So all of the red herring issues in their press release yesterday and press conference, you need to go to the web site and see how they spend most of their time talking about the evils of mandates and how much they increased coverage. If I had 85 percent of the market, I would not want a competitor. So frankly the Blue Cross arguments, I do not listen to that well.

No. 2, insurance commissioners, some of them. I understand that. We talked about it. That is the reason that in the bill being proposed, in the work we are working on, we support even more stringent regulations than any State today has on financial solvency and the fair treatment of those covered. It also means that the coverage is even more stringent than what is required of the labor unions and the Fortune 100 self-insured health plans.

Why do we want small business to have more stringent requirements? Does it mean we think that they are out to defraud, whereas big business and big labor would not? I do not think so.

What about the third group? The third group are those people not only in this city but other places, who want a government-run system. They do not want a successful private system.

Why then would they be opposed to something like AHPs? Because it can be successful. Not covering every American with health insurance, but causing the small business marketplace where the uninsured work to have the possibility, voluntarily, of getting insurance. That is why we are here today.

Medical savings accounts? Yes, they need to be expanded, by being able to have portability of all of the deductible plans that we have been proposing, and that the President has put in on flexible spending accounts. To be able to take moneys and roll those dollars over, $500 over to the next year, is very important. Individual tax credits are very important.

These things we can do. What we do not want to do is take the patient who is very ill and do radical surgery. We talked about it in 1993 and 1994, that is not a course for this country to take.

This is a believable, doable plan. If, in fact, there are problems with it, the unintended consequences, we can correct them, we can identify them, and we can fix them. Those who do not want to give us a chance should not go back home for reelection saying they are for small business.

Thank you for the opportunity to be here today and join with these others. When we hear small business owners from your State, the independent State, talking about how important this is, it is what resonates in every small business around the country. Not just our 600,000 members, but all 23 million small businesses.

Thank you again.

[The prepared statement of Mr. Faris follows:]

Testimony of
Jack Faris, President
National Federation of Independent Business

On behalf of the 600,000 members of NFIB, I want to thank you for inviting me to testify today about the worsening health care crisis that faces small business. Since 1986, the cost of health insurance has been the top concern of our members. So it is very appropriate that your first hearing as Chair of the Small Business Committee focuses on this problem.

Because of the current structure of the health care industry, too many small business owners and their employees do not have access to affordable health insurance. When I talk to small business owners as I travel the country, I am amazed to find so many of them—those without health insurance—who are not, in fact, going to the emergency room for their every medical need. They're going to their doctors, and they are writing their own individual checks for treatment, prescription drugs and even their occasional ER visits.

A recent Census Bureau report says slightly more than 41 million Americans now lack health coverage. The number of people covered by employment-based health insurance declined a point to just under 63 percent in 2001. The Census Bureau says the drop-off in employer health coverage occurred in the small business sector, largely in firms with fewer than 25 employees. It's no coincidence that these events are taking place as the cost of insurance continues to skyrocket—double-digit increases year after year, pricing more and more small firms out of the market.

It is critical that small employers have the ability to offer health insurance to their employees. Competition for skilled men and women is keen. Medium to large companies attract those employees because the companies can offer insurance and other benefits.

Certainly, the issue is more complex than the small business dilemma. As I noted a moment ago, health insurance costs for all Americans are rising by double-digit percentages every year, after a brief respite in the mid '90s. As noted recently in the Washington Business Journal, the consulting firm Hewitt and Associates suggests premiums will increase by an average of about 15 percent this year. Last year's increase was almost 14 percent. For NFIB members, on average, premium increases are ranging from 25-50%.

Our population is aging and requiring more care. New technologies deliver miraculous—but expensive—solutions to cure disease and extend lives. Prescription drug makers flood TV with new products, encouraging us to ask our doctors if those little pills are right for us.

In the search for a solution, consider the two extremes: universal health care and individual coverage.

I think we are all pretty familiar with the concept of universal health care. It is still very much on the minds of some in Congress. The devil is in the details, whether it comes in the form of government-run health care or mandates on employers to provide it in the workplace.

As for individual coverage, it wouldn't sit well with large employers and labor unions because health care is a very important part of the compensation package and contract negotiations. In addition, there are serious questions about how to be certain that every individual would purchase health insurance—and how some would be able to pay for it.

The solution lies somewhere in between the two extremes. Let us hope that we can move toward that solution quickly. The problems facing small business owners, their employees, and families must be addressed as part of that debate.

We understand that no one solution will help all of the 41 million uninsured. Therefore, we propose a multi-faceted approach that will help move countless numbers of Americans off the rolls of those without health care. We are aggressively urging enactment of legislation to permit Association Health Plans—AHPs—to operate nationwide. We encourage the expansion of medical savings accounts—MSAs—and flexible spending accounts. We support tax credits for the purchase of health insurance.

Association Health Plans will allow small business owners to band together across state lines through their membership in recognized trade and professional associations to purchase health care for their families and employees. Organizations such as NFIB, the U.S. Chamber of Commerce and the National Restaurant Association would be able to offer insurance to their members.

AHPs would help rural states by giving employers who are members of associations or trade groups another option—particularly important in rural areas where only one or two choices are available today.

Association Health Plans will make health insurance more affordable for small businesses. The Congressional Budget Office has estimated that small firms obtaining health insurance through AHPs will realize premium reductions of 13 percent on average. In fact, reductions range from 9 percent to 25 percent. It is estimated that more than 300,000, up to as many as two new million employers, employees and their families would be able to obtain health care coverage if given access to Association Health Plans.

Creation of nationwide AHPs is really a matter of righting a wrong which has plagued small employers for years: Currently, labor unions, medium-sized companies and the Fortune 500 companies have the ability to offer health benefits to their employers under ERISA (The Employee Retirement Act of 1974). This law exempts those companies and the unions from the cumbersome task of having to comply with the varying rules, regulations and benefit mandates of the 50 states. Small firms have no such exemption.

We must address the growing cost of those benefit mandates. The idea that insurance should pay for the wide range of medical treatments and services covered by state mandates while laudatory, is unaffordable and therefore unrealistic.

The Council for Affordable Health Insurance says that since January 1970, mandates have increased 25-fold. Last year alone, the organization has discovered 125 new mandates introduced in states across the country. The number of benefit mandates is now approaching 1300.

Sponsors of such mandates say their proposals will only add a few pennies to the premium for a health insurance policy—and that's true for each *one* mandate. But PricewaterhouseCoopers has estimated that mandates overall raise the cost of health

insurance by 15 percent. The result is a significant increase in the number of small employers who can no longer afford to offer health insurance to their employees.

Association Health Plans would solve that problem to some extent for small business owners. However, state and federal lawmakers must come to grips with the reality that continually mandating new coverage does nothing to address the problem of providing basic, affordable health insurance to all Americans.

Let me also address some of the criticisms, which we believe are falsely made, against Association Health Plans. As many of you know, some insurance companies are not fond of the competition that AHPs would bring to bear. In fact, many insurance companies raise untrue allegations about AHPs. The allegation that AHPs will cherry pick good risks ignores several facts. Current law prohibits any group health plans (including AHPs) to exclude sick or high-risk individuals, or employers with high claims experience, from the health plan. AHPs are subject to all the preexisting condition, portability, nondiscrimination, special enrollment and renewability provisions under HIPAA.

Only bona fide associations, which are in existence for three years for purposes other than, providing health insurance, can operate an AHP. This prevents insurance companies from setting up sham associations for the purpose of excluding high risks.

Insurance Companies also like to refer to AHPs as multiple employer welfare arrangements (MEWAs). However, the AHPs established in legislation introduced last year are not MEWAs. A MEWA can be operated by any organization for the sole purpose of providing health insurance to multiple employers. They are not required to meet the explicit and strict solvency standards of an AHP. In fact, many of the problems that MEWAs have created are explicitly prevented by the stringent mechanics of the AHP legislation.

To prevent fraudulent plans from forming, the bill requires the plans put up and maintain capital surpluses before they can be certified. In addition, plans must maintain sufficient claims reserves, stop loss insurance and indemnification insurance to guarantee that claims will be paid even in the event of financial difficulty or plan termination. The bill also gives clear and strong regulatory authority to ensure that the Department of Labor in partnership with state regulators are able to ensure that AHPs will meet the very strong certification and reserve requirements provided in the legislation.

Ours is by no means a complete solution to this most vital national challenge. Our goal as a nation must be to make certain that no person in need will ever be left unattended. We cannot afford to wait for the "perfect" solution. There is none. The longer we delay, the more we will hear the calls for government-provided health care, and certainly, *that* is not the perfect solution.

Thank you for holding this hearing today and inviting me to testify on behalf of NFIB members. We very much appreciate your support for Association Health Plans and pledge to do all that we can to enact this legislation into law.

## NFIB MEMBERS' EXPERIENCE WITH HEALTH CARE CRISIS

"I am the CEO of Bluff City Beer Co. in Cape Girardeau, MO. We have 48 employees. Our health care insurance census is as follows: 44 Employees, 10 Family Members, 5 Children. In fiscal year 1999-2000, we were with the Principal Insurance Group and the PPO Healthlink. The care was for 90/10 in program and 70/30 out of program. We had preventive care, RX Card ($7, $15, $25) and $10 co-pay. The premium for this was $110,000 per annum. In fiscal year 2000-2001, the proposed increase for the same coverage was $84,000 or 75%, raising the premium to $194,000. This is an outrage. We shopped around and ended up with Blue Cross/Blue Shield Insurance through the Alliance PPO. The quote was $168,000, a $57,000 increase, which is 51%. There are no other providers or PPOs in Southeast Missouri. Blue Cross has 68% market share. In March of 2002, we received our 2002-2003 renewal premium rate for the same number of people at $230,000, which is a 37% increase. Instead of renewing at this package level we opted for coverage that provides 80/20 in program and a 50/50 out of program with no preventive care, RX Card ($8, $25, $45) and $20 co-pay. This brought our new premium to $194,000. This is a 15% increase that is not half as good as our old plan, but it's all we can afford. It takes disposable income from the employees and I feel it is highway robbery. We are faced with going to self-insurance or offering our employees even less and that will place us at a competitive disadvantage. It will be harder to retain qualified employees."
**-Billy Bess; Bluff City Beer Co.; Cape Girardeau, MO**

"About six years ago I felt my company was doing well enough to offer health insurance to my employees. Prior to that I just could not afford it. I was just trying to stay in business. I found the best deal I could and offered to pay half of the employee premium. The employees were very grateful and most participated. Since that time premiums have doubled and a lot of employees dropped out. I can't afford to pay a higher percentage, and the employees can't afford to pay either. Every year we get a 20 to 30 percent increase, and every year more employees drop out and blame the company when there is nothing I can do."
**-Gregg Milu; Unique Originals; Miami, FL**

"Our health insurance premiums increased 30+% during 2002 to stayed with the same plan. The firm has always absorbed these out of control increases, but won't be able too much longer. We had to downgrade our coverage a notch this time just to get close to the premium increase in

2001. My agent has already forewarned me to expect a 27% to 30% increase in premiums at this coming renewal in June."
**-Harry McComb; Coldwell Banker Boyd & Hassell, Inc.; Hickory, NC**

"My health insurance costs increased 79% this year. As that was unacceptable, we looked around (few choices for a rural small business) and found a provider whose premiums were "only" 52% higher! Then, in the middle of our contract year, my husband turned 55 –his premium went up over $200 (which is about 33%)!!!!!! With me approaching my 55th birthday and my office manager turning 50, I'm sure this will be the last year that we will be able to provide insurance. This may mean losing employees I'm afraid. We need to get AHPs passed quickly!!"
**-Nancy Mackay; Copperstate Specialties; Globe, AZ**

"The Music Room, Inc. provides health insurance for all employees, with employees paying for additional coverage for dependents. We do not provide dental or obstetrics coverage except in the case of complications. Present coverage is with Blue Choice program of Blue Cross Blue Shield. Every year, we find it necessary to shop for lower rates because premiums increase every year. We have reduced our costs as much as possible by increasing deductibles, but we have reached the point where we may have to make the disagreeable decision to ask employees to pay a percentage of costs and consider doing away with group insurance completely."

"We have been in business for 47 years and feel an obligation to provide health insurance for our employees, but in an age of shrinking profits, we wonder how long we can continue to do so. We wonder how any individual can survive without medical insurance, and in checking credit for sales; we find that most bad credit bureau reports are due to large medical bills the prospect has been unable to pay. We understand that large corporations can buy medical insurance at much lower rates than can a small business, If a group of small businesses could combine to earn a lower rate, it should help to resolve this inequity."

"Every year it becomes more difficult to afford salaries needed to attract capable employees and pay the benefits that are sorely needed. How can we continue to pay escalating medical costs with no way in sight to increase our income? In our most recent renewal, we were forced to increase amounts employees have to pay for office visits to primary care physicians from $15 to $35 and for prescription drugs from $5 to $15 co-payment for generic drugs, and from $15 to $30 co-payment for "Brand Name in Formulary" per prescription. Percentage payable (unless otherwise specified) is 80% with Out-of-Pocket limit per calendar year increased from $1000 to $2000. These changes were made to keep premiums within what we considered to be an affordable range but our cost increased to the point that we still may be forced to have employees pay a percentage of the premiums."
**-Don Everett; The Music Room, Inc.; Rome, GA**

"As to the costs to our company to provide coverage, we have not only suffered the disproportionate increase of these costs over the years, caused by the many mandated benefits, but we have spent countless hours researching, assessing, and applying to different insurers to

get the best rates. We have paid membership fees to organizations for no reason other than to get access to their group plans, for which we would otherwise not qualify. We have even established a separate corporation to permit putting some staff on another program more suited to their needs that would have been too costly to offer to the entire staff. Our employees, meanwhile, have suffered from a shortage of choices due to the limits set by the insurers, in terms of available physicians, prescriptions and treatment options. They have had to change service providers when we have been forced to change insurers. They are required to follow approval procedures that waste their time and frustrate them. And they often fail to appreciate the cost our company incurs in providing a service whose value so often appears not in line with its cost."
**-Hanns Derke; Advanced Machinery; New Castle, DE**

"I own a small HVAC company, Climate Control Inc., located in Leesburg, Indiana. I started the business in 1972. From the beginning one of my goals was to grow the company and still remain profitable. To reach these goals involves adding both office and field staff members. One of the tools to use to enable us to "attract the best" is fringe benefits. Health care insurance is on the top of that list of wants for most prospective employees. So, beginning in the late 70's my company purchased health care insurance for all our staff and paid the entire premium, which was less than $50 per month per person. From those heady days we have, out of financial necessity, digressed to only paying for the employee and employees paying for dependent coverage to raising the deductible to now having an MSA; however the premium costs may force me to cancel our health care insurance altogether. In my trade we pay a person for many more hours than can be billed to a customer. We need to drive from one house to the next, order parts, take vacations and have sick days. Therefore our billable hours for the year end up in the 1200-1500 range. A health care insurance plan that has a $500 deductible, $10 co-pay and 80/20 coverage will cost between $700-$1400 per month per person or $7-$14 per billable hour per person. This amount does not include the insurance cost for office staff, which could cause it to double. I don't like knowing we may have valuable staff members uninsured, but the cost of health insurance has just gone beyond our ability to pay."
**-Tom Moore; Climate Control; Leesburg, IN**

"It is an extreme hardship on small businesses to provide health insurance to employees as well as providing insurance for yourself. I am a widow, self-employed, and my health insurance is an expense I can hardly afford. I have a $5,000 deductible and my cost is $297.93 per month, this amount increases some 35-40% every six months. I am now at the point of having to cancel my health insurance, it really boils down to keeping a roof over my head, and simply covering expenses both business and personal."
**-Karole Egan; Karole Textile, LLC.; Greenville, SC**

"My company has always furnished health insurance for our employees. We are in a group with Blue Cross, Blue Shield of Kansas. Our rates have increased 61% from 1995 to 2001. We received our renewal contract yesterday with a 47% increase over last year. This leaves me wondering what my next move will be, do I try to find less expensive rates or deduct part of the

premium each month. Our total premium for 2 single, 1 husband and wife, and 1 family policy has increased from $2126.61 to $3134.66 monthly. This policy has a $1000 deductible per person (we pay half of each occurrence until we meet that).
**-Jim Brewer; Jim's Propane; Leon, KS**

"I pay $818 a month for my family, 2 adults and 2 children. We have no prescription plan, no co-pay for doctor visits and they don't pay for anything unless its over $2000. Every year the rates jump up $2400 and they give me less coverage."
**-Steve Drier; Houston Performance; Houston, TX**

"My name is Lan Turner, owner of my own small computer programming firm, at any given time, my firm employs between eight and ten people; we are truly a small business who is trying to provide for our employees and their health care needs.

I have four full-time employees who I am trying to provide healthcare service for through my business. In my attempt to do so, this is what we found.

We contacted a local health care insurance provider, Regence Blue Cross Blue Shield of Utah.

First Attempt:
We put forward the names of the four employees, they filled out all the forms and my company was given a "group plan" quote of $1,345.60 per month. This plan had a $500 deductible. I presented these numbers to my employees, and they determined that if I, the company, paid half their premium, not one employee would choose to participate, since this would take too much money from their monthly take home paychecks. The other problem I had was that I was at the minimum number of participants, so if one of my employees decided not to participate, the plan was null and void, since they would not consider us for anything smaller than four members.

Second Attempt:
Low and behold, we find out that a group policy is NOT the cheapest way to go, we looked through their individual policy plans, and if each one of my employees went to the insurance company individually, they were quoted the same insurance plan for almost one-third of the group plan cost.

Example: One individual who was quoted in the "first attempt group plan" a policy amount of $441.95 per month, this same employee was quoted in the individual plan a price of only $156 per month. Another employee who was quoted in the group plan at $387.45 per month was also quoted in the individual policy at $156 per month.

Now, I think we're getting somewhere, this is much more affordable, and so I approach the insurance agent and say "I'll just purchase individual insurance policies for each of my employees who want to participate!" Sounds great, right? Wrong, the Utah legislature passed a law forbidding me to do so. I, as an employer, cannot purchase the individual plans at a lower

cost for my employees, I have to, by law, purchase the more expensive plans as a group. The individual policy cannot be paid for you your employer. Now you tell me, why the hell not?"
**-Lan Turner; Gecko Software; Logan, UT**

"We are a small HVAC company with eight employees. We have been providing full coverage health insurance for our employees, with no cost to them. In the last two years we have seen over a 78% increase in our health insurance cost, per employee, with an additional 10% increase at time of renewal. If this continues we will have to quit providing insurance and with the other added cost of doing business may have to close out doors."
**-Lynn Kirsteatter; L&C Refrigeration and Heating, Inc.; Conver, WI**

"We are a small business of a father and son struggling to get a business started and keep it going. We have been in business for 11 years and 6 months. We have a strong base of customers and pride ourselves on our customer care and having a locally owned and operated business. That seems to be very important in our town to have someone you can trust to come into your business and home. But the reality is, health insurance premiums are killing us. We have gone from paying $1009 last year for my husband and myself, my son and his wife and two children to $1478 a month. We had a slow period and to keep bills paid and the insurance paid, my husband and I have had only 1 paycheck in the last 7 weeks. We in turn had to sell what few stocks we had so that we could make house payments and monthly bills. We feel very strongly about providing health insurance for our son and his family, and he in turn has not had a pay raise in 2 years because of health insurance. My husband is 55 years old and a diabetic and we cannot afford to be without insurance. We only make $325 a week in take home pay, (for both of us working) and we cannot afford our prescriptions without insurance. We feel responsible for our son's family, as he has made lots of sacrifices to help keep this business going. **PLEASE** help the little guy. We are the backbone of this country, and we are making the most of the sacrifices. Recently our insurance provider has filed Chapter 11 and told us we needed to get a new provider. Our cost went up $400 a month. We are now paying $1867 a month. Co-pays have gone up and our co-pay for the ER went from $50 to $200 and hospital admittance went from $100 to $850. We had to raise prices in our business, which I think is sometimes self-defeating if you lose customers or jobs because of the cost. I am not sure how we are going to make it, but we are not in the situation of not having insurance.
**-Linda Shields; D-Tect Alarm Specialists, Inc,; Pueblo, CO**

"It is becoming out of reach, our health care increased 21% last year and 41% this year. All companies seem to be about the same. We consider all options this year but if this keeps going we will have no choice but to drop our coverage, or to drop an employee."
**-Pat Roberts; Garen L. Kuhlmann, CPA, CHTD.; Smith Center, KS**

"We were stunned to receive our insurance renewal this year and find that our costs have gone up 41 percent! We are a small company with nine employees and, up to this point, have always offered full coverage for our employees in addition to vacation, sick leave, family-leave and other benefits. We feel we must offer a substantial benefit package in order to compete with nearby, large employers. Yet, a 41% increase is a direct blow to our bottom line. How can we be

expected to continue to survive like this when the playing field is not even? We MUST have AHPs in order to continue. There is no higher priority for our business!
**-Pamela Rees; Wm. Rees International; Rising Sun, IN**

"Health insurance costs have been paid 100% by Sebright Products, Inc. since 1984. Today we have approximately 70 employees and we have started passing on a part of our health insurance costs to our employees. We now charge all employees for a portion of their health care costs and have also reduced many health care benefits to offset rising costs. The rapid rise in cost is completely out of control."
**-David Sebright; Sebright Products, Inc.; Hopkins, MI**

"Control of escalating health care costs is the #1 issue at our office. Anthem Blue Cross Blue Shield continues a steady practice of cutting services while pushing premium costs to the point of unaffordability. The yearly rise in premium cost since 1995 is as follows:
1995 8%
1996 17%
1997 Not available
1998 8%
1999 1%
2000 35%
2001 20%
As a small business, we provide full coverage for our work force of 5 people who have never take a major medical claim. We will have to start considering having each employee contribute if costs continue to rise out of control. Efforts to help cut premiums such as taking a higher deductible have quoted with a net result of less coverage at a higher premium.
Prescription costs are another problem. Coverage base for "formulary" prescriptions continue to rise while physician prescribed drugs are routinely removed from the formulary. Dental coverage is less than half the actual physician charge. Yet we cannot get information from the insurer on coverage amounts so that we can "shop" for more reasonable rates. As these practices continue, the future of small business becomes ever increasingly in danger. We will drive our employees away into the waiting arms of large business competition that will flick us aside like a flea. We urge you to continue the fight for health care reform and for small business nationwide."
**-David Hughes; David C. Hughes Architects; Columbus, OH**

"As of October 1, 2002, my health coverage at an HMO for myself, the owner, and my spouse went up 35%! My company now will have to pay $11,393.88 for insurance this year, and I personally will pay $5696.94 of that as my share with the company. When I asked the marketing person at the HMO, she spoke the party line that legislation passed in Florida 2 years ago, allowed them to raise renewal rates by that much on single employee groups. In effect, I have seen my income and profitability reduced by 35%, and her only suggestion was that I of course could change health plans. However, because the major hospital in Leon county Florida doesn't want more competition to Blue Cross/Blue Shield, there are only a total of 4 health care providers available to small business owners here, and their rates are pretty much the same."
**-Richard Yood; R&Y Promotions & Awards, Inc; Tallahassee FL**

"We purchased our business in 1998. At the time there had never been group health insurance. We felt group health insurance was something we needed to offer our employees as it was the best way to get medical coverage. With a staff of 8, we will never be a large group, but we nevertheless, have a need for insurance. In 1998, our coverage cost approximately $1250 per month. Now, 5 years later we are paying just less than $2300 for the same coverage. In addition, we have been told that we can expect an increase of approximately 20% for 2003. $27, 600 per year for medical coverage for 4 single individuals, and 2 families is outrageous!"
**-Ed Stanfield; Glenn Brunk Stationers Inc.; Springfield, IN**

"Our company is a small forest consulting business in the state of Washington. We have been in business since 1960 serving various forest landowners. The following will give you our cost to full cover the employees we had from 1994 to 2001.
1994- $19,784
1995- $20,614
1996- $19,192
1997-$21,557
1998-$21,727
1999-$27,401
2000-$32,049
2001-$38,029
In 1994-1996, we had five employees, three spouses, and one child. In 1997-2001, we had 6 employees, three spouses, and one child. There is no way to give a raise to anyone. The increase in the premium is the raise."
**-Mike Jackson; Professional Forestry Service; Tumwater, WA**

"The skyrocketing cost of providing health insurance for employees is unquestionably an obstacle to future reinvestment in the business. We have experienced 30% to 33% increases in our premiums in the last two years. We are expecting similar or greater increases when we begin the renewal process. In 2002, health insurance costs will exceed 5% of sales. For comparison, our power cost is less than 2% of sales.
We currently have 24 full time permanent employees eligible for our health insurance benefit. Many of them are insured through their spouses so the number of employees on our health insurance hovers around 15. This number is actually down from 1996 yet the cost has risen dramatically.
Our employees pay approximately 20% of their premiums and the company pays the rest. In 1996, the business's portion of the health insurance premium was $37,484. Our cost for 2001 was $93,400. Keep in mind that this is for only about 15 participants with an average cost of $6,227 per participant per year. For 2002, that average cost was $7,656 and the company's cost was $114,840. For reference, gross sales are a little over $2,000,000. The employee's average cost was for a family $2340 per year and for someone single $1040 per year.
We have shopped around year after year but it has become a full time job just to educate ourselves about what is happening in the health insurance industry. Last year we looked at MSA and MERP programs which didn't fit out needs at the time. Since we are not able to pool with

other small manufacturers to form a larger group, our options are limited. We find ourselves hiring more temporary or part time people because we don't provide health insurance for those employees.
In order to continue to invest in productivity, our health insurance costs need to be contained. We need a solution in order to be able to continue to provide health benefits for our employees. If health care costs continue to increase, our legislators will find more and more of their constituents uninsured. This will happen even if we continue to provide health benefits by shifting more of the cost to the employee. They cannot afford the additional burden any more than we can."
**-Debbie Flood; Melron Corporation; Wisconsin**

"Currently we provide health insurance for our employees. Paying all of the expense for the individual. For family health insurance we pay for half of the total for the family. Four years ago we had a $500 deductible with 80% coverage and $1500 out of pocket total, then the insurance company paid for the rest. Two years ago we had to switch to $500 deductible 50% coverage and $4000 out of pocket before the insurance picks up the balance and now we are limited to 5,000,000 per person in our lifetime. As you can see our health insurance has continued to dwindle to a sorry state. I would call it calamity insurance at best with a limit. With all the changes that we have done to our insurance that equals less coverage with annual health insurance rates having doubled in four years. As an owner of a 15-employee business the cost of insurance can make the difference of being in the black or in the red. I am considering asking our employees to take a pay raise of $1.50 an hour and drop our health insurance all together. In doing so we would save over $40,000 a year."
**-David Sagmiller; Westland Seed, Inc.; Ronan, MT**

"We are a small thermoforming business located in mid-Michigan, I just received my new premium notice for the BCBS coverage for my employees. It was an increase of 23% over last year's costs. I currently cover 100% of both my employees and their families (Dental, Vision, RX, etc). I have had to change plans from BCBS traditional to a PPO Plan, increase my RX card to make up some of the increase. This is actually less benefits for my money. My health care costs are one of the top expenses of the company and I anticipate if this trend continues I will have to change to an employee share cost basis."
**-Glenn Rowe, Plastic Innovations and Tooling, Inc.; Clare, MI**

"I am a small business owner. We currently do provide health insurance for our 13 employees. I've just been notified that my insurance will be rising again in May. I'm now considering dropping this benefit because of the cost."
**-Matt Juneau; Volare Air Charter Co.; El Paso, TX**

"We have provided health insurance for our employees for the past ten years. This coverage has been at no cost to them. Every two or three years I have spent at least two months shopping for insurance because you know that the rate increase is coming. This is something that I would like to continue to provide to my employees (10) but the way the cost is increasing I just don't think that I can hold out much longer. When given a choice to pay for the coverage, most employees

cannot afford it or do not wish to. My total cost of health insurance last year alone was $31,200. This year with the increase it will be about $34,000. We are now faced with looking for insurance again or reworking our policy again. If something cannot be done soon to help the small business owners with insurance we will drop this benefit and then we all will pay for their medical bills!!!
**-Stan Bush; Chadbourne, NC**

"Our premiums have increased greatly in 2002. I am 63 years old and my insurance on my wife and myself went from $1025 per month to $1617 per month. I can't afford to keep paying increases such as this."
**-Harold Lee; Lee's Sausage Co. Inc.; Orangeburg, NC**

"I am the owner and sole veterinarian in my practice. I have 8 employees. I currently pay 75% of the health insurance costs for my full-time employees, as well as 75% discount on their pet's care. With the rising cost of health insurance, I'm not sure if I can still offer to pay the health insurance, leaving my employee's pets with better coverage than they enjoy. Is this fair? I don't think so!"
**-Kristine A. Sands, DVM; Apopka Veterinary Clinic, Inc.; Apopka, FL**

"We have dropped our previous medical insurance carrier in favor of our local Chamber of Commerce plan, which has 5 different insurance choices. We let each employee select the one they want and we pay 50% of the single or the family coverage. As expensive as it is, if you don't offer this coverage and pay a substantial portion toward the premium, you lose your best employees who will work for a company that provides the benefits they need."
**-Bill Cox; Market Products; Batavia, NY**

"My company pays about 75-80 percent of the premiums which have gone up about 40 percent in the last two years. My employees are struggling and my company is struggling to continue to pay for health insurance.... I would be very much in favor of association health plans that would increase our buying power when it comes to health insurance. Currently we are at the mercy of the insurance carriers who treat us like dirt and don't really want our business. We have to constantly jump through their hoops just to remain on the policy."
**-Brad Wagnon; Communications Network, Inc.; Muncie, IN**

"I am a small business owner. We have about 20 employees and we are about to have to cancel our plan because this is the second rate increase this year! I shopped around for quotes and they are all unaffordable, even though our group is a pretty "healthy" group. Here is a sample of some of our monthly premiums per employee:
Employee, age 50 and family.....$837 per month!!
Employee, age 35 and single.....$272 per month!!
Employee, age 36 and family.....$560 per month!!
The company pays half of the employees' premiums and this is becoming totally unaffordable, the employer AND the employee. Something has got to be done about this and right away, because we are only one of many small businesses that will no longer be able to provide health coverage.

Please consider this…also, a mental health parity bill will further destroy health insurance. Small business cannot afford this and we MUST stop the mental health parity NOW. Why am I picking on mental health? Because of the fact that diagnosis is purely arbitrary and not based on any scientific test, this allows the psychiatric profession to abuse the system—they have already been know to be the highest incident of fraud in the medical profession!
**-Debbie Aiken; Mr. Air; Alief, TX**

"My company has 28 full-time employees. In the past two years we have been hit with increases of 28% and 33% in our health insurance premiums. The uncontrollable cost of health insurance has become the SINGLE BIGGEST PROBLEM our company faces. We are rapidly approaching the point where we will have to drop our health care coverage, or reduce the quality of it to the point where it is of little value. Please….anything you can do to insure the passage of AHP legislation…ASAP…would be greatly appreciated."
**-Bob Sherman; Gordon Bernard Co., LLC; Milford, OH**

"I recently dropped all health coverage with Blue Cross/Blue Shield of Michigan because with four insured employees the last two premium increases, 27% and 34%, coupled with the new 10% surcharge for groups with less than ten, cost more than my small office could afford. My employees were upset to say the least that their new health coverage with Fortis was not as good as with the Blue's. Their prescription coverage was not as good either. The decision I made was hard but necessary. The last two premium increases forced me to give fewer raises than I had planned or had wanted to give my employees. These increases not only cost me as a small business but also cost my employees the full raises that they earned and deserved. My new health insurance with Fortis is mediocre at best but all I can afford. My employees need good health coverage at premiums that I can afford. We all work hard for our money and now we have to work even harder for less money. Relief is overdue!"
**-David Sutton; Drake Business Services, Inc.; Marshall, MI**

"My name is Dennis M. Brtva, O.D.. My business Dr. Dennis M. Brtva & Associates operates two optometrist offices located within Lenscrafters optical stores. I employ between 18 and 20 full and part time employees. For over 10 years I had a group insurance plan which I split the cost with my full time employees 50/50 for their major medical insurance. Through the years, as costs for their portion of the insurance increased the number of participants in the plan continued to dwindle. During the last two years that I had the plan in place we saw increases in our premiums of over 65% each year. After withstanding such increases and having dwindling participation I finally decided that it would be more affordable, for both my employees and myself, to drop our group coverage and increase their hourly wages."
**-Dennis M. Brtva, O.D.; Dr. Dennis M. Brtva & Associates; Bloomington, IL**

Chair SNOWE. Thank you.
Ms. Neese.

**STATEMENT OF TERRY NEESE, PRESIDENT AND CO-FOUNDER, WOMEN IMPACTING PUBLIC POLICY, OKLAHOMA CITY, OKLAHOMA**

Ms. NEESE. Good morning, Madam Chair.

As you know, I represent Women Impacting Public Policy. In case you cannot see them all behind me, there are 330,000 women and minorities that are pushing me this morning, African-Americans, Hispanics, Native Americans, Alaskan Natives, Pan-Asians, and they support this testimony.

There are 6.2 million women business owners today and we employ 9.2 million according to the Center for Women's Business Research. Congressman John Boehner of Ohio raised the alarm in citing the following appalling statistics. Nearly 130 million Americans, almost 80 percent of all workers, get their health insurance coverage through their workplace. Another 43 million have no health coverage at all.

Why is this appalling? Because premium rates for small plans three to nine employees increased 12 to 16 percent per year according to the Kaiser Family Foundation, with some small businesses experiencing up to 50 percent.

WIPP members are experiencing anywhere from 12 to 72 percent increases in their premiums this year. For example, Terry Neese Personnel Services just received our increase for the year. It was 12 percent and I was happy that it was 12 percent and only 12 percent.

A WIPP member in Virginia, Dot Wood, CEO of JDNW, just received her rate increase. It was 72 percent.

Another WIPP member, Dr. Karen McGraw from Marietta, Georgia, told us the lack of reasonable health insurance costs has been the major barrier to her growth and ability to hire good people. "We are a small certified women-owned business with two full-time employees. Due to growth and contracts won during the last 2 years, we had planned to hire two mid-level individuals, key mid-level individuals. Because his would require that we be able to offer good benefits we investigated group health insurance and were stunned by what we found. Our broker indicated that most firms did not even want to talk to firms our size, especially since the two owners are husband and wife. The two quotes we received were well beyond what we felt we could afford, $1,100 per month just for the husband and wife. We have work and we need help, but we put our hiring plans on hold hoping that legislative action could improve things for us."

In a recent survey to WIPP members, providing this benefit is the most important benefit they can give to their employees, for both moral and economic reasons. Small businesses must be able to provide Fortune 500 benefits to their employees.

Hewitt Associates, a prominent benefits firm, estimates that the annual amount employees will pay in premiums and other costs will rise by an average of $342 to $1,753. Employee raises are being eaten up by the rise in premiums, leaving them less disposable income to spend on goods and services. That is bad news for

the economy. If consumers are not spending on goods and services, small business will not see any reason to expand and the economy will further stall.

Not only are premium increases a problem but also finding a provider, having choices, managing high administrative costs, growth in litigation, fraud and abuse are problematic. According to the SBA, insurers of small health plans have higher administrative expenses than those who insure larger companies. Administrative expenses for insurers of small health plans make up 25 to 27 percent of premiums and 33 to 37 percent of claims. This compares with about 5 to 11 percent of large companies' self-insurance plans.

WIPP supports association health plans and we have for a decade now. AHPs have the potential to lower insurance premiums for small firms by freeing employers from direct and indirect State taxation, some mandated benefits, and the cost of compliance with multiple State regulations.

In terms of job growth, with the potential lowering of premium costs to the business owner, the possibility of using those costs to create one job in every small business could be huge for this economy.

The States have not been able to solve the health insurance crisis. Current AHPs under labor unions and Fortune 500 companies operate under ERISA regulations so why cannot small businesses have the same access, the same options, and the same opportunity?

Recently, I had a meeting with the Oklahoma insurance commissioner. He supports association health plans because of the lack of solutions coming from the States. He owned his own insurance company in his other life before he became insurance commissioner of Oklahoma.

WIPP would like to be able to offer association health plans as benefits to our members. We want to increase our membership. We do not want to cause any harm to our members and we believe AHPs are the key to increase our membership and get people off the uninsured list.

Madam Chair, our members have been working on this issue for almost a decade now. We believe we have got some momentum with you as Chair of this Committee and many others in the Senate. We look forward to working with you. Let us go make it happen.

[The prepared statement of Ms. Neese follows:]

Testimony Before

**U.S. Senate Committee on Small Business and Entrepreneurship**

# "The Small Business Health Care Crisis: Possible Solutions"

**February 5, 2003**

**Terry Neese**

**President**
**Women Impacting Public Policy**
www.WIPP.org

Good morning Madame Chairman and members of the Committee. My name is Terry Neese, President of Women Impacting Public Policy representing over 300,000 women business owners nationwide. We represent women and minority (African Americans, Hispanics, Native Americans, Alaskan Natives, Pan Asians) business owners and they support this testimony. I am also CEO of Terry Neese Personnel Services, with headquarters in Oklahoma City, Oklahoma.

Because WIPP is a small business association and the majority of its members are women and minority-owned businesses, we are uniquely qualified to speak on the devastating impact the lack of affordable health care has on its member businesses, on the working people of this nation, and on our economy. Over 22 million small businesses in America drive our economy, create nearly three quarters of the net new jobs and employ more than 50 percent of the workforce. Women Business owners number 6.2 million and employ 9.2 million according to the Center for Women's Business Research. Congressman John Boehner of Ohio, raised the alarm in citing the following appalling statistics: "Nearly 130 million Americans - almost 80 percent of all workers, get their coverage through their workplace. Another 43 million have no health coverage at all." Why is this appalling? Because premium rates for small plans, 3 to 9 employees, increase 12 -16 percent per year according to the Kaiser Family Foundation with some small businesses experiencing up to a 50 percent increase. WIPP members are experiencing anywhere from 12 – 72 percent increases in their premiums this year. For example, Terry Neese Personnel Services just received a 12 percent increase in our premiums. A WIPP member in Virginia, Dot Wood President and CEO of J D & W Inc., just received a 72 percent increase in her insurance premiums. Many small businesses can no longer afford to provide this vital benefit.

Another WIPP member, Dr. Karen McGraw from Marietta, Georgia told us the lack of reasonable health insurance costs has been the major barrier to her growth and ability to hire good people. "We are a small, certified woman-owned business with 2 full time employees. We

have operated as a sole proprietorship for 13 years and as an LLC for the past 2 years. We have used independent contractors and teaming with other small businesses to complete projects. Due to growth and contracts won during the last 2 years, we had planned to hire 2 key mid-level individuals. Because this would require that we be able to offer good benefits, we investigated group health insurance and were stunned by what we found. Our broker indicated that most firms didn't even want to talk to firms our size, especially since the two owners are husband-wife. The two quotes we received were well beyond what we felt we could afford ($1100 per month, just for the husband-wife owners). We have work, and we need help, but we put our hiring plans on hold hoping that legislative action could improve things for us."

In a recent survey to WIPP members, providing this benefit is the most important benefit they can give to their employees - for both moral and economic reasons. With the drastic premium increases, few can provide it fully and less and less can provide it even on a shared payment arrangement. Therefore many small business employees - and the employees' families – are becoming uninsured. Those employees, who are able, are fleeing to larger companies that provide the benefits. And the small businesses? They are losing critical staff and worse are unable to replace quality employees. Small business must be able to provide Fortune 500 benefits to their employees.

Hewitt Associates, a prominent benefits firm, estimates that the annual amount employees will pay in premiums and other costs will rise by an average of $342 to $1753. Employee raises are being eaten up by the rise in premiums, leaving them less disposable income to spend on goods and services – and that is bad news for the economy. If consumers aren't spending on goods and services, small business will not see any reason to expand, and the economy will further stall.

Not only is the U.S. health care system in crisis, but the most important and viable hope for economic recovery - the small business owner - is also in crisis.

Not only are premium increases a problem, but also finding a provider, having choices, managing high administration costs, growth in litigation, and fraud and abuse are problematic. According to the SBA, insurers of small health plans have higher administrative expenses than those who insure larger companies. Administrative expenses for insurers of small health plans make up 25-27 percent of premiums and 33- 37 percent of claims. This compares with about 5-11 percent of large companies self insurance plans.

We need to focus on providing affordable health care and ensure that employers who provide health benefits to their employees are not forced to drop their coverage because of rising premiums and high administrative costs. WIPP proposes and supports Association Health Plans that allow small businesses to pool their resources with other small businesses to purchase insurance at better rates. AHPs have the potential to lower insurance premiums for small firms by freeing employers from direct and indirect state taxation, some mandated benefits, and the cost of compliance with multiple state regulations. In terms of job growth, with the potential lowering of premium costs to the business owner, the possibility of using those costs savings to create one job in every small business would be huge!

The states have not been able to solve the health insurance crisis surrounding the small business marketplace. Current AHPs under labor unions and Fortune 500 companies operate under ERISA regulations, so why can't small businesses have the same access, the same options, and the same opportunity? Indeed, in recently speaking with the Oklahoma Insurance Commissioner, he supports Association Health Plans because of the lack of solutions coming from the states.

Women Impacting Public Policy would like to be able to offer Association Health Plans as a benefit to our members. We want to increase our membership, we sure do NOT want to cause any harm to our members and we believe AHPs are one key to increase membership and get more people off the uninsured list.

Madame Chairman and members of the Committee, the momentum for AHPs has picked up dramatically and WIPP is hopeful that the 108th Congress will enact Association Health Plan legislation.

Chair SNOWE. Thank you, Terry.
Mr. Alford.

**STATEMENT OF HARRY ALFORD, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL BLACK CHAMBER OF COMMERCE, WASHINGTON, D.C.**

Mr. ALFORD. Thank you, Madam Chair, for allowing the National Black Chamber of Commerce to be here and to enter our written statement into the record.

The National Black Chamber of Commerce is the largest business association that concentrates on the concerns, needs and best interests of African-American businesses in the United States, of which there are many. We have 191 chapters located in 40 states, and in eight nations.

We proudly want to voice the concerns of African-American businesses and tomorrow we launch what is known as the Gazelle Index. The Gazelle Index is a statistical sampling of the opinions and concerns of African-American businesses, which will be published every quarter from now on. ING Corporation is responsible for this and we are glad to be partners with them. The issue of health care and association health plans will certainly go into the survey in the short-term.

African-American businesses have been growing at a faster rate than any other segment. We have a million businesses. Ten years ago we had half that much.

The major reason for the growth has been the Civil Rights Act which has brought on the babyboomers, the first generation of college-educated people to be trained and to have tenure with Fortune 500 companies. We have people who are ready, willing and able to enter into the entrepreneurship market. It is growing well.

There are two major challenges for these entrepreneurs. One is capital access. We deal with that by working with the banks, with Wall Street, with the Federal Government. We encourage international trade which opens up venues such as the World Bank, IMF and other entities. We are working on capital access.

The second biggest challenge is health care costs. We are up against the wall. Our members cry out for us to do something about rising health care costs. We have met with insurance agents and brokers and they have all tried to come up with the solution of a health plan that can be affordable and accessible for our members.

It is like curing cancer. The first one who does it is going to be a hero and a very wealthy person. But so far it has not happened. It is also impossible under the current circumstances, the laws, the decentralization, the 50 State rules that you have to deal with, 50 insurance commissioners. It does not happen, it will not happen and it is broken, tore up. We need to fix it and good government is going to be the only way.

I think what you and certain Members of the Committee are doing is admirable. We support you to the fullest. Association health plans probably is going to be the key to this. If we do not allow it to progress and become a reality, not only do we have a crisis, we have a shame.

I think in this global market for America to be able to compete, the small business is going to be the link in the chain that must be the strongest. Thank you.

[The prepared statement of Mr. Alford follows:]

**"The Small Business Health Care Crisis: Possible Solutions"**

**February 5, 2003**

**Testimony Presented To:**

**Honorable Olympia Snowe**
**Chair**
**Committee on Small Business & Entrepreneurship**
**United States Senate**

**Presented By:**

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Madam Chair, other distinguished members of the Committee, thank you for giving the National Black Chamber of Commerce, Inc. an opportunity to speak before you regarding this very important issue. From a small business perspective the system for healthcare delivery is quite broken and the need to fix it should be paramount on the agendas of all leaders. You are certainly commended for your sincere concern and willingness to hear about possible solutions.

The National Black Chamber of Commerce, Inc. was founded in May, 1993. It has grown to be the largest business association dedicated to entrepreneurial development and economic empowerment within African American communities throughout the nation. We have over 191 affiliated chapters located in 40 states and eight nations. While we represent the interests of over 1 million Black owned businesses we have direct reach to over 90,000 entrepreneurs. Black owned firms are made up of C corporations (5.2%), Subchapter S corporations (3.6%), Individual proprietorships (89.5%) and Partnerships (1.7%). In terms of sales there are three categories: Services (54.7%), Retail Trade (29.1%) and Construction (16.3%).

We take much pride in being on the cutting edge of issues that affect our constituents. In fact, we are releasing to the world on this very day the new Gazelle Index. This is a partnership with ING Corporation and the National Black Chamber of Commerce. The Gazelle Index evaluates the attitudes and assessments of Black entrepreneurs by way of statistical sampling and survey. This survey will be updated quarterly and it is the only mechanism of its kind that will constantly tract the trends and development of Black business owners. The subject of Health Care will certainly be involved in upcoming studies and reported to the public.

Our businesses are the key to job creation and wealth building. Small business growth in African American communities will lead to new jobs. The African American community is comprised of 25% of its total population living under the poverty level. The fastest and permanent way to lead people out of poverty, poor healthcare and substandard education is a means for employment. Small business accounts for the vast majority of new employment in this nation. We want our segment of the population into the mainstream of the economy and off the dole.

There is one big problem with the above mission. With each job there should be health insurance. Unfortunately, there is not and, in fact, the possibility of health coverage for new employees is becoming more and more difficult. Even the retention of current healthcare coverage is becoming overwhelmingly difficult. Healthcare coverage at the NBCC national office was increased this year by 42%. Two years ago we had to cease offering healthcare coverage to 80% of our workforce. This has since become the top reason for attrition and has caused much difficulty in competing for the top echelon in the talent pool. This is not unique and our constituents complain about this problem constantly. It has become a national challenge and, indeed, a crisis.

The products of the Civil Rights Movement have been many. The most important trend is the large mass of first generation college graduates who have subsequently gained

valuable expertise and training via employment within the Fortune 500 and the Officer Ranks of our military. This group and their offspring are providing ready, willing and able entrepreneurs. The most precious commodity from an Americana perspective is the event of a new family run business. Too many times, this dream has to be deferred due to the simple fact that one principal in the family must retain employment so that healthcare can be provided for the rest of the family. Thus, we have a current system that stifles entrepreneurship. When my wife and I started on this venture of developing a National Black Chamber of Commerce, she could only work at night and on weekends because we could not afford to lose the healthcare coverage that was provided by her day job. It took us two years to be able to afford our own plan. This was not unique then and it is far more prevalent today. Remember, small business growth is the driver for employment. When there are obstacles to small business development it has a strong rippling effect on the job market.

Responding to the great need for affordable healthcare, the NBCC has made many attempts to create a plan that could be offered to our constituents. We have failed every time and it is mainly because of the decentralized oversite and regulation regarding insurance. We will not be able to adequately respond to this situation until there can be a way to provide a national plan. The President and certain members of Congress have proposed the use of **Association Health Plans**. We see this as the answer. A plan that can be offered to our constituents void of 50 different regulations (one for each state) and making coverage affordable.

Currently, the challenge of healthcare plan affordability rivals that of Capital Access. The US Department of Labor is correct in stating four of the biggest challenges under our current system:
*Cost is the biggest issue. For comparable coverage, insurers typically charge small businesses more per employee than large firms.
*In some states, insurance for some small firms is available only through a state-operated risk pool or from one insurance carrier.
*Small firms are often ill equipped to negotiate favorable terms with insurers because an individual firm does not represent a large enough block of business to merit insurers' individual attention.
*States typically require group health insurance policies to cover certain specified benefits, medical procedures, and treatments provided by specified health professionals, which also add to the cost of coverage.

The bottom line is too many of our small business owners cannot afford healthcare coverage for their employees. This can only be overcome by the inducement of incentives and the removal of barriers. Demanding that businesses provide insurance that they cannot afford will lead to job shrinkage and even business closings. Our economy cannot endure such bad policy. What is needed is a comprehensive national plan such as Association Health Plans. The National Black Chamber of Commerce, Inc. on behalf of 1 million Black business owners who have the charge of economically stimulating low income communities will support such legislation. We will actively participate in such a plan and fiercely promote it to our members.

This Committee's consideration of Association Health Plans is very much appreciated. America has many challenges in this new global economy. Our main advantage, and key to our future, is the growth and vitality of our small businesses. It is good government's duty to provide the necessary legislation that is conducive to small business growth.

Madam Chair, thank you again for this great opportunity. Please rely on the participation of the National Black Chamber of Commerce whenever it is needed.

Chair SNOWE. Thank you.
Mr. Shannon.

**STATEMENT OF CLIFF SHANNON, PRESIDENT, SMC BUSINESS COUNCILS, REPRESENTING THE NATIONAL SMALL BUSINESS UNITED AND SMC BUSINESS COUNCILS, PITTSBURGH, PENNSYLVANIA**

Mr. SHANNON. Good morning, Madam Chair. My name is Cliff Shannon. I am the President of SNC Business Councils, an independent, non-profit small business association headquartered in Pittsburgh with a regional office in Harrisburg.

On behalf of SMC's 5,000 member companies and their more than 100,000 employees, thanks for the opportunity to testify today. Thanks, too, on behalf of National Small Business United, with which SMC and several other nationally respected small business groups are affiliated, including the Council of Smaller Enterprises in Cleveland and the Small Business Association of Michigan.

SMC's group purchasing of health insurance is our most widely subscribed program. It dates back to the 1970s and about 3,500 of our member companies participate today. SMC's members will encounter an average health insurance premium hike in 2003 of more than 20 percent. This comes on top of several years of annual increases in the mid-teens, which doubled coverage costs during the preceding 5 years. We are now in a new cost cycle and average premiums are forecast to double in just 3 or 4 years.

But simply citing overall premium trends does not tell the full story. Adverse risk selection as practiced in different guises by health insurers in every State is roiling the marketplace, and it is adverse selection that needs to be addressed more precisely in AHP legislation.

What does risk selection consist of? Under Pennsylvania law a non-profit insurer sets an employer's premiums according to demographic factors including the average age of covered employees. I am 51 and I contribute to SMC employees having a relatively high average age. So coverage for me and my family costs SMC more than $900 per month. If the SMC average age was 10 years higher, the premium would be $1,100 per month. On the other hand, if we were all fortunate to be an average of 10 years younger where I work, the premium would drop to about $700 per month.

Pennsylvania law permits for-profit insurers, however to set premiums for individual companies via medical underwriting. Coverage may not be denied, of course, but employees medical profiles are used to determine employer's final health insurance rates.

How does this work? An SMC member company recently received from its non-profit carrier a 25 percent premium increase proposal for 2003 to a little over $400 a month for employee-only coverage. The employer sought a competing quote from a for-profit managed care plan that offered complementary benefits in network. The initial quote from there was less than $400 per month for employee. But after medical underwriting the for-profit carrier's final quote was $3,500 per month.

Under the umbrella of State regulations, rate regulations and mandates, this is the current marketplace, gradually segmenting

into the actuarially fortunate small employers and employees for whom coverage is affordable and the actuarially unfortunate who are being priced out of coverage. Federal deregulation of this market via association health plans will accelerate this process.

I do not believe any of my counterparts who are gathered here today or their organizations would engage in predatory risk selection. But let us just say I am not quite so high-minded. I would go out and first look for a bona fide, qualified, financially strapped business association in a State that allows medical underwriting—Pennsylvania, for instance.

Next would be finding an insurer with which to partner. I am confident that national carriers would entertain AHP participation, as well some health insurance companies that few or none of us have ever heard of.

Should my AHP in the making be self-insured or fully insured? Fully insured, I think, as a financial requirement for self-insured AHPs are problematic in my view. All that would remain then would be selecting several populous States with expansive coverage mandates for the initial marketing thrust and finalizing a profitable benefits and rate-setting strategy.

My AHP would offer high deductible coverages only, with explicit limitations on expensive services like maternity care, neonatal care, no reimbursement for diabetes supplies, cancer exclusions or limitations and so on.

My AHP would also cover no more than 50 percent of prescription drug costs with an annual dollar cap, and preventive care would not be covered at all. A participating employer could, of course, establish health reimbursement accounts to pay for health care expenses that would not be covered but I would use medical underwriting and corresponding pricing to winnow out groups with relatively sick populations and high medical claims.

Thusly sustained by rigorous risk selection, my AHPs rates would be far less than those paid by companies that remained in the State-regulated environment. My AHP would pay out correspondingly far less in covered benefits and my partners and I would make lots of money. That is unless or until Congress decided to step in and regulate the marketplace.

In the meantime, among the remaining majority of small businesses, most of whom these days are owned Babyboomers, health insurance premiums would rise faster and faster. Total health care costs within State-regulated pools would be spread among a smaller, less healthy population in which diabetics, leukemic children, sickle cell victims, people over 50, women of child-bearing age, and so on would be concentrated.

These unintended consequences cannot be prevented with at least some rate regulation and some consideration of minimum benefits.

In my written testimony are some alternative ideas for lessening the burden of health insurance coverage costs for small employers, which time prevents detailing now.

But please know, Madam Chair, I am in some serious pain here. I believe that association-based purchasing group purchasing is a fundamentally good concept. I am tortured by the thought that I

am sitting here criticizing that, even though I am doing so for good reason.

What I hope is that we can work out an arrangement to improve the legislation, to close some of what I think are fairly glaring holes in it and strengthen existing group purchasing programs, encourage new ones, particularly in States that have no such arrangements today.

[The prepared statement of Mr. Shannon follows:]

# PREPARED TESTIMONY OF CLIFF SHANNON

## PRESIDENT, SMC BUSINESS COUNCILS

### ON BEHALF OF NATIONAL SMALL BUSINESS UNITED

*Small Business Access to Health Care*

**Before the Senate Committee on Small Business and Entrepreneurship**

**February 5, 2003**

Madame Chairwoman and Ranking Member:

Good morning. My name is Cliff Shannon, and I am President of SMC Business Councils in Pittsburgh, Pennsylvania. SMC is a regional trade association for small business, headquartered in Pittsburgh with a regional office in Harrisburg. SMC currently numbers 5,000 affiliated companies, which employ more than 100,000 individuals.

SMC is also a longstanding member of National Small Business United, where I have served as a member of its Board of Trustees. NSBU is the nation's oldest bipartisan advocacy association for small business, representing over 65,000 small businesses in all fifty states. In addition to individual small business owners, our membership includes local, state and regional small business associations (such as SMC) across the country. Our association works with elected and administrative officials in Washington to improve the economic climate for small business growth and expansion.

I am pleased to appear before the committee to express our views on health care coverage for small businesses. 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 Committee on Small Business and Entrepreneurship 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, including SMC, 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.

Unfortunately, I must report that 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**

As mentioned in my introduction, we hope that 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—would 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 I believe that they will not be good for the small business community at large, whose interests we are bound to represent. I would like to take the balance of my statement to explaining our concerns, since I do not believe they are very well understood.

**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 (Maine-based organizations cannot vary rates by age or sex).

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 testify and stand prepared to answer any of your questions.

Chair SNOWE. Thank you, Mr. Shannon.

What do your members say about the health care crisis and what options do they prefer?

Mr. SHANNON. I think that many of them are asking themselves exactly where is it written down that private employers should provide health care benefits to employees. I think that is something that is permeating the business community from top to bottom right now.

Former Treasury Secretary O'Neill, former CEO of ALCOA, is a very, very outspoken health care policy person in my hometown. He asks frequently exactly what is the business? What is the requirement? What is the origin of the practice of small businesses, large businesses, mid-size businesses being obligated to provide health care benefits for their employees?

I think that is the prevailing view these days and it is emerging with ever more clarity as prices drive up, for small businesses, premiums towards or past what amounts to a monthly mortgage payment for employees.

Chair SNOWE. But do you not think that is a good goal, for businesses to want to offer a benefit to their employees? It has been historic and it creates a competitive tool. Obviously, as you heard from others who represent hundreds of thousands in the small business community, and I have heard from individual small business owners and others who want to provide it.

So there is nothing wrong with that. I mean, you described an AHP that you would design, but then what would be the point? Who would be attracted to that, in terms of your members? In fact, I would suggest you would lose members. The idea is to attract more people into the association and you do not do that by offering poor choices, higher prices and lousy coverage.

Mr. SHANNON. If my objective was to make profits, and in this economy and the system in which we work that is the objective, the AHP that I described is absolutely going to get created under the legislation as it is currently written.

If you will trace the recent history of managed care plans, in their initial incarnations, managed care plans went pell mell as fast as they could go to grab market share, to in effect recruit more members, to expand the geographic reach, the total dollar volume of their business.

In the current incarnation, having disappointed their shareholders with returns, I think you find managed care plans, for-profit and non-profit, much, much more preoccupied, almost exclusively preoccupied I would state these days, with how they can manage risks so as to earn profits. That is it.

I think if you could somehow or other get the people who are responsible for managing health insurance in this country in the room and get them under oath in a way that would be meaningful, that that is the answer you would extract. It is not just a foible in my imagination that I can sit and look at actuarial analysis that drives this kind of risk selection and say more than anything else it belongs on the curriculum of the Hogwarts School for Wizards and Witches. It is a true dark art.

As practiced in today's marketplace, it is absolutely penalizing those who have need for health care services and it is rewarding, if you will, or providing favorable treatment for those who do not.

Single white males, they are the coin of the realm in health insurance these days because they can go 10 years without going to the doctor. People who have health care needs though are being rapidly priced out of the ability to afford coverage.

Chair SNOWE. Mr. Alford.

Mr. ALFORD. Madam Chair, I think that is the Darth Vader approach to AHPs and I would think someone would have to be insane to do business with such a company. I think what we are looking for is a nice bourbon, not necessarily a fine scotch. What was just described was rotgut.

I do not think it is being realistic, with all respect.

Chair SNOWE. That is very descriptive but it makes the point.

I think the issue, as I see it, is having options and having access. In many parts of the country there are not those options and there is not that access. So it is not a question of choosing among a variety of affordable quality plans, it is either having no choices or maybe one choice or two choices that become unaffordable.

Mr. SHANNON. I do not want you or anyone else to take away the impression that I am opposed to association-based health insurance purchasing. I am not. I am absolutely not. I think it is a signal virtue in the market today in the States in which it functions well.

So one of the primary goals of this legislation is obviously to try and spread that virtue to other States. My worry is that as currently, or at least in the last iteration as written, the legislation honestly begs out for abuse in certain areas. Risk selection is the primary one.

If you can headquarter your AHP in a State that permits medical underwriting, you would be able to run a 50-state AHP that enforced medical underwriting in order to set rates. It is something that I do not think many people in Congress grasp, that in the immediate wake of HIPAA, which guaranteed portability, which guaranteed coverage in the event of a pre-existing condition, that the entire insurance industry shifted to medical underwriting as fast as it could. Because at the end of the day, in order to make money, the actuarial departments and the managers have decided that they must risk select.

The non-profit companies like the Blues that are, in most cases, restricted by State law from refusing coverage and restricted further in terms of how they can set their rates, are particularly concerned, I think, about AHPs as currently iterated because medical underwriting practiced by their for-profit competitors would put them at a significant disadvantage.

I am not here today to make an apology for Blue Cross-Blue Shield affiliates. Lord knows I have enough problems with them every day in my State. But it is a valid concern that medical underwriting will turn the community-rated pool within the States that are affected into something that more or less concentrates the less healthy people that I described. That loophole, which is very large from where I sit, needs to be closed.

Chair SNOWE. Why is there such a variance in opinion on that subject?

Mr. SHANNON. I do not know the answer to that. I can only suggest to you that—

Chair SNOWE. It is not happening in large firms and unions and other large organizations that are self-insured. We have not heard those kind of severe scenarios that you have described about AHPs. So I am not sure I understand what is the basis for your concerns and objectives here.

Mr. SHANNON. Let me describe it this way.

Within, let us say H.J. Heinz Company, which is headquartered in Pittsburgh, the benefits policy that is offered to employees needs to be a relatively Cadillac policy because there is a huge diversity of people located within that company. Older, younger, relatively sicker, relatively healthier, and so on.

Within a group purchasing coalition like mine, I will tell you that there is a fair amount of disagreement and a fair amount of revolving in and out of my group purchasing plan on the basis of what the particular health care needs are of many relatively small populations of small employers.

If I had nine employees and I had no diabetics, I would think paying the 2 percent increment let us say in premium applicable to providing or covering diabetic supplies was a bad idea. If I employed nothing but guys in their 20s, I would think covering maternity care in a significant way, which my association's policy do, would be a poor expenditure of my health care dollars. So on and so on.

We are talking about thousands of disconnected employers, each of whom have a general interest in healthy employees and decent coverage, but taken individually have widely varying needs for coverage for their employees.

On that basis, I think you are seeing in the marketplace in my State and in several other States serious disintegration of the marketplace into segments of relatively healthier and segments of relatively less healthy people as expressed by individual employment groups.

Chair SNOWE. Kathy and Anne, in Maine for example, can you tell us what your options were in the final analysis? Were there any options at all?

Ms. LEONARD. The last year before we went into this quasi-self-insured plan, we had two choices in our company, either Anthem—which bought out Blue Cross so it is now a for-profit organization, it is no longer Blue Cross-Blue Shield as a non-profit—and I believe Aetna had a plan.

Both had exorbitant rate increases to us. I think something like 60 percent, something along those lines. It was just prohibitive.

So that was it. We were down to two choices, both very, very poor choices. The competition has gone out of the system in the State of Maine because of community rating, whereby we have no control over the health of our plan. I can offer all of these healthy lifestyle options for my employees but it does not lower our rate because we are paying for everyone else in the system.

That is the key difference between small business and large self-insured. That is why they have not been feeling the pain until more recently. We are now all feeling pain because the system is

in a state of hyperinflation, certainly. But we have been feeling it a lot longer.

So the choices were very minimal years ago and that is why we opted out of that. It is also interesting to note that when I first started tracking these figures back in the mid-1980s, it was not—I lost my thought. I got caught up on the fact that I have been tracking these numbers since the mid-1980s. It is hard to believe that we are paying this much attention to it.

I have lost my thought. I am going to go to Anne and I will come back to it.

Chair SNOWE. I know, Anne, that you were talking about looking at State purchasing pools and I know that people have suggested that as an option. Obviously it was and still is perhaps in some States. But it is not really a viable option for many. It was not for you.

Ms. VALENTINE. Not at this point. We have been at it a year-and-a-half and we have yet to formalize a deal. In my own business I had presented to me three options but they were three Anthem options. Then there are two other options that people do not want to talk about but they are in the back of the mind of small business owners, the option to contribute much less, to participate much less, and the option to opt out altogether and not do anything. A lot of small businesses are going that route.

Ms. NEESE. Could I speak to that for a second?

Last year, Terry Neese Personnel Services were canceled three times, by our insurance carrier. The last time we were canceled—and by the way, when you are canceled, you literally take someone off working a desk for a good month to find another carrier.

So this person that we had taken off of a desk creating some income for us was searching for another carrier. Our last carrier said they were no longer going to be writing small group employer insurance in the State of Oklahoma. Blue Cross-Blue Shield has 90 percent of the market in Oklahoma.

So as my person tried to find another carrier, there was a marketing call that came into our office from an insurance agency wanting to provide us health insurance. So the person said, "Boy, I will take that call immediately."

She began to talk to the person about our health insurance needs and got down to making an appointment to actually see this person face-to-face. It was the insurance agency that had just canceled us that said they were no longer writing small group insurance in our State.

So the choices are interesting, to say the least, in how they decide they are going to pull out of a State but then turn around and our marketing to sell insurance in that same State.

If I could also speak just a moment to women business owners specifically, and the fact that they really want to provide health benefits and a lot of other benefits to their employees. As women, in terms of flexibility in the workplace, it is very important to us because we are not only taking care of our families but many times we are taking care of our mothers and dads along with that, and all of the various and sundry things that we do in running a household.

What we hear from our women business owners more than anything is that they want to provide the very best benefits that they can for their male and female employees because they know what it is like to try to juggle 50 things at one time.

I just want to put a plug in for all small business owners out there that really want to provide the very best care for their employees, so they know they retain them and they retain that talent and do not lose them to big businesses.

Ms. LEONARD. I would like to redeem myself and finish the thought that I lost a few moments ago.

When I started looking at this issue back in the 1980s and discovered that there was this difference between self-insureds and those of us who were not self-insured, I said, "Well, why do we not self-insure as small business people?" I was told no, no, no, you cannot afford to do that. You have to have at least 100 lives in a plan in order to self-insure, so that was the big prohibition.

Well, here I am in 2001 with 50 employees, able to self-insure because the premiums have gone up so precipitously that I can now afford to be self-insured. So now a small business such as mine at 50 people, still very small, can leapfrog those state-mandated benefits as well as being in the pool and go to the ERISA standards which regulate us?

So what we are finding is that small businesses—I cannot be the only one out there doing this—there are more and more of us getting out of those State plans anyway. We are going to find a way out of there.

Chair SNOWE. Just one other question, Mr. Faris. Obviously you all represent associations and large memberships. Has there been any concern expressed about the fact that your members could be subject to consumer fraud with the creation of these association health plans? Is that a concern of yours? Is that something that has been raised at all? Do you think that the consumer protections and the requirements of the Department of Labor and the pre-certification standards for creating these association health plans, and the monitoring will be sufficient to guard against any type of fraudulent activity?

Mr. FARIS. Thank you.

Secretary Chao and I have discussed this at length. The last thing we want in small business is to have fraud in a system that we will end up having to pay for. When you have six employees in a firm, 2.2 have the same last name. We are not talking about some distant situation of ownership. We are in it every day whether it is 50 employees, 5 employees, or what.

The guidelines for unions and big business have been covered under the DOL, the Department of Labor, for all of these years. They are supervising it and I cannot believe that the NFIB or WIPP or the restaurant association, or any other large broad-based membership in 50 States who has been around 60 years, who has a strong reserve, would be more prone to fraud and abuse than a Fortune 100 company or the unions. This really smacks of how we feel about entrepreneurs.

There are those in this town that really think that they should not trust people on Main Street to do the right thing for their em-

ployees, that if you do not work for the Government, then the Government should make that decision.

So no, there is not cry or concern. The cry or concern is that basically we have got to have some relief. If, in fact, we pass legislation and find out later that we have got a problem here or a problem there, then let us identify it and correct it.

We need a successful program. We need help. Give us the opportunity. Give us a chance. Give us the opportunity to have competition. If we can do it, fine. If we cannot, let us look for other solutions.

I go back again to the motivation that people bring up about fraud and abuse. We are talking about historical cases with MEWAs and other things that have been set up. We can learn from those. We can learn from fraud and abuse we read about on the front page of the papers with big business and big unions. What we want to do is to say give us a fair and level playing field. We will even take more supervision, more restrictions than the unions do and big General Motors does.

Why not give us a chance to correct our own problems at home? The fact is that we want to provide coverage. There is not anything in the Constitution that says this is required. It came out of World War II with wage controls. It came out of President Nixon in 1971 with price controls and wage controls. That is when business generated health care.

We are not saying do away with it. What we are saying is let us have a level playing field. Right now it is tilted. Who is suffering are the very people that we are supposed to be trying to help, the working uninsured.

Chair SNOWE. Thank you.

I appreciate all of you being here today and taking your time to share your experiences and perspectives on this legislation. Obviously, this debate is going to continue. I thank you.

One last panel. We have the fourth panel, Ms. Judith Lichtman, President, National Partnership for Women and Families; the Honorable Sandy Praeger, Commissioner of Insurance for the State of Kansas, representing the National Association of Insurance Commissioners; and Mr. Len Nichols, Vice President of the Center for Studying Health System Change.

Thank you for your patience. I appreciate it very much. I know the time is late and I am going to be going into another hearing shortly, not here, another Committee. But I do appreciate you taking the time to be here and sharing your thoughts. So please begin, Ms. Lichtman.

**STATEMENT OF JUDITH L. LICHTMAN, PRESIDENT, NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES, WASHINGTON, D.C.; ACCOMPANIED BY ALICE WEISS**

Ms. LICHTMAN. Thank you so much. Thank you for your new acquired leadership. We are honored to testify today.

I am Judith Lichtman and I am the President for the National Partnership for Women and Families, a non-profit, non-partisan, public advocacy organization that promotes fairness in the workplace, policies that help women and men meet the competing demands of work and family and access to quality health care.

As I know that you are aware, we have a much more complete testimony that we have filed and I am assuming that that will be accepted into the record.

Chair SNOWE. Yes, without objection, it will be included in the record.

Ms. LICHTMAN. Today's health care crisis disproportionately affects women and small businesses. As many of the previous witnesses testified, it occurred to me that there is really an enormous coincidence and consistency of agreement of the fact that there is a problem. There is a problem. We all agree.

What the disagreements are about really are, and they are considerable probably, on how to solve the problem.

The cost of private health care insurance has been increasing steadily and small businesses are experiencing the worst of this problem. Women are disproportionately likely to be either the owners of or the workers for very small firms. So most often, it is women who pay the price.

A survey of low wage, mostly smaller employers conducted for the Partnership and the Kaiser Commission on Medicaid and the uninsured demonstrates the problems that small firms and their workers face. These firms are less likely to offer coverage. When they do, it is often less generous with long waiting periods and higher cost sharing.

In the face of the crisis, it is critically important for Congress to act to provide access to affordable, quality health care coverage. We have developed a set of principles to help evaluate those proposals and we offer them as a way to solve the problems.

I want to say that sitting next to me is my colleague from the National Partnership, Alice Weiss, the Director of our Health Programs.

Proposals must cover the uninsured. With 41 million workers and their families now uninsured, any legislation has to be new coverage, not only shifting already insured from one type of coverage to another.

They must ensure access to affordable, comprehensive coverage. Low income workers have to be able to afford the new coverage and it must be comprehensive enough to cover the health care needs of the uninsured.

Three, they cannot 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 individuals who need coverage the most, not only the healthy.

Four, finally it has to preserve strong consumer protections. All 50 States and D.C. have passed tough consumer protections that have stabilized the small group health insurance market. Strong protections are needed to lessen the likelihood of a new trend of fraud and abuse.

Association health plans have been posed as a solution. But the AHP proposal offered in the last Congress is not the right policy option. Because there is no current bill now pending, my comments today are going to refer to the most recent House-passed version, H.R. 2563.

This proposal fails to meet every one of the principles I just set out. It simply offers no solution to the problem of the uninsured, and I refer back to the CBO study that says only about 330,000 of the uninsured will get new coverage. That is less than 1 percent of the 41 million uninsured today. In some ways, we worry that AHPs will make the problem worse, driving up cost for four out of five small business owners and their workers.

It fails to ensure access to affordable comprehensive health coverage. Because AHPs will try to save money by offering narrow benefits and providing coverage to only the healthiest of individuals, the cost of covering those left behind in the State-regulated market will increase and less comprehensive benefits will be available. In this way, the AHP bill will actually increase health costs for the majority of small businesses and their workers and coverage will actually be less comprehensive.

Under the AHP legislation, healthy people win while those in need will lose. AHPs would leave older, disabled, and chronically ill individuals behind without any help. Women will also lose, losing coverage for services they need that are now mandated under State law, including coverage for maternity, breast and cervical cancer, mental health and contraceptive services to name only a few.

Most importantly, the bill undermines strong consumer protection. Virtually all State oversight, including benefit mandates, rating laws, fraud and insolvency protections and direct enforcement was replaced with minimal Federal oversight and weak solvency standards.

For example, the bill would allow the AHPs own actuary to certify its solvency, a practice that would make even Enron executives blush. This lack of meaningful assistance or protections would create a new wild, wild west of insurance regulations for consumers.

By loosening the reins of oversight, the AHP legislation would increase the risk of fraud already rampant and on the rise. Last year alone, 55,000 workers and their families were left without health insurance due to association health plan scams amounting to $65 million in unpaid medical claims and millions more in health insurance premiums paid for coverage that consumers never got.

Although many small business owners and their workers are uninsured now, under the AHP legislation they could be paying for the privilege. While we are not saying that the concept of AHPs could never work, the bills offered so far fail to meet our criteria. If AHP legislation were to be crafted that addressed the criteria we outlined, we would gladly support it as a viable solution to the problems we face.

There are other ways to address the current small business health care crisis as well, and I am going to give you just quickly a few examples.

A small employer tax credit and new pooling. We would create a new tax incentive for small businesses to offer coverage and would be paired with Federal grants to encourage new State-regulated pooling arrangements enabling small employers to come together into larger groups, which some of your witnesses have already said they are very interested in seeing happen, to purchase health insurance.

An FEHBP or State employee pools. This would enable self-employed individuals and small business owners to buy into existing risk pools at the Federal and State level.

Three, and finally, building on public programs and that would build on existing programs like Medicaid and SCHIP and Medicare to cover the uninsured and could be more efficient than the purchase of private health insurance.

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 cautious approach to new legislation.

As I have mentioned today, the AHP legislation that we have seen and has been proposed in the past is not the right solution. The proposed AHP legislation will likely do more harm than good to 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 oratory language that pretends to address these concerns but that do not create flaws in the legislation that will be enough so that it could win our support.

Our legislative options exist. As I mentioned, all should be evaluated as you consider possible solutions to this enormous problem.

We thank you for your leadership and hope that we can work with you to solve the problem of the uninsured and the problems that small business employers face in coverage of themselves and their workers.

[The prepared statement of Ms. Lichtman follows:]

**Testimony of Judith L. Lichtman**

**President, National Partnership for Women & Families**

**Before the U.S. Senate Small Business & Entrepreneurship Committee**

**Hearing on "The Small Business Health Care Crisis: Possible Solutions"**

**February 5, 2003**

Good morning, Madame Chair, Ranking Member Kerry, and other members of the Committee. My name is Judith Lichtman and I am President of the National Partnership for Women & Families. Thank you for the opportunity to testify today at this important hearing on possible solutions to the small business health care crisis. I appreciate the opportunity to share with you the work that the Partnership is doing in this area on behalf of women and families and to recommend some guiding principles that the Committee should follow in developing legislative solutions to this crisis.

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 are now facing, both as small business owners and as their 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 jobs, or jobs in the retail and service sectors 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. And, women are not only more likely to use health care

services than men,[1] 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-income workers, legislation that ensures high quality affordable coverage is urgently needed.

My testimony today will discuss some of the barriers small employers and workers are now facing 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 the association health plan legislation that was offered by the President and supported by some in Congress last year, which we feel would do more to hurt the uninsured than help. Finally, I will offer some suggestions for alternate proposals members of the Committee should consider in addressing 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.[2] 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.[3] 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.[4] 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.[5]

The barriers that small employers face in finding and offering affordable health coverage translate to higher numbers of uninsured and underinsured workers and dependents. In 2001, nearly four in ten (39.3%) of the 24 million workers who were

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[1] Jacobs Institute for Women's Health & Kaiser Family Foundation, *The Women's Health Data Book, 3rd Edition*, December 2001, 177.
[2] U.S. Census Bureau, *Health Insurance Coverage: 2001*, September 2002, 1.
[3] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2002 Annual Survey*, September 2002, 18.
[4] In 2000, 60% of small firms with 3 to 9 employees offered coverage, but by 2002 the offer rate among these firms had declined to 55%. *Id.*, 34.
[5] *Id.*

uninsured worked for very small firms under 25 employees or were self-employed.[6] 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 health coverage for their families. Disproportionately likely to be either owners of or workers for small firms, women have much at stake in the health coverage crisis that small employers are facing.

***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 of those firms were very small firms of fewer than five employees.[7] And 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.[8] Women are also more likely to work for low-wage employers, about three-quarters of which are smaller firms.[9]

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.[10] 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.[11] 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.[12] The most disturbing finding was that the likelihood that a low-wage firm would offer health coverage declined as the

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[6] Fronstin, Paul, *EBRI Issue Brief: Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2002 Current Population Survey*, December 2002, 11.

[7] 98% of the 847,000 women-owned business in the U.S. in 1997 were small firms of fewer than 50 employees. U.S. Census Bureau, *1997 Economic Census: Women-Owned Business Enterprises*, March 29, 2001, 167.

[8] U.S. Small Business Administration, *Characteristics of Small Business Employees and Owners 1997*, January 1998, 3.

[9] Lake Snell Perry & Associates, *Low Wage Employers and Health Coverage: Findings from a National Survey*, January 2003 (Unpublished), 5 (referring to research conducted by Jonathan Gruber, Professor of Economics at Massachusetts Institute of Technology, determining that 73% of employers with at least half of their workers earning $7 or less per hour have fewer than 25 employees.)

[10] *Id.* This research was comprised of focus group and survey interviews with 1,200 "low-wage employers" conducted in June and July of 2001. For the purposes of this research, "low-wage employers" were defined as employers having at least 50% "low-wage employees" (employees earning no more than $8.50 per hour) for small and medium-sized firms with fewer than 500 employees, and employers having at least 25% "low-wage employees" for large firms with 500 employees or more. This research is still being finalized and is expected to be published early in 2003.

[11] *Id.*, 4.

[12] *Id.*, 5.

percentage of women workers increased.[13] 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.[14]

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.[15] 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.[16] 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.[17] By contrast, only a handful (3%) of all employers contribute less than 50% toward the cost of employee coverage.[18]

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.[19] 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 the next often cited reasons being to keep employees healthy or because it is "the right thing to do."[20] 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 intentions to do the right thing. Most of these smaller and low wage employers want to offer coverage for their workers and themselves – 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 more imperative than ever that Congress enact

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[13] *Id.*, 7. The survey found that low-wage firms' coverage offer rate declined steadily as the proportion of women workers a low-wage firm employed increased – 54% of low-wage firms employing predominantly men offered health coverage compared to 32% of firms with a workforce of 75% or more women.

[14] The survey found that while 42% of all low-wage firms offered coverage, only 37% of sales sector firms and 38% of service sector firms surveyed offered coverage. *Id.*

[15] *Id.*, 12. Average waiting period data from Kaiser/HRET, *Employer Health Benefits 2001 Annual Survey*, 53. (hereinafter Kaiser/HRET 2001)

[16] Lake Snell Perry, 15.

[17] *Id.*, 10.

[18] Kaiser/HRET (2001), 91.

[19] *Id.*, 13.

[20] *Id.*, 12.

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.[21] 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 providers and other private payers, driving up the costs for all privately insured individuals.[22] 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

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[21] Recent studies have demonstrated that uninsured and underinsured individuals often delay treatment or forego critical screening tests that lead to delayed diagnoses, life-threatening problems, and the possibility of premature death. *See, e.g.*, Connolly, Ceci, "Study: Uninsured Don't Get Needed Health Care," *Washington Post*, May 22, 2002, A03.

[22] *See, e.g.*, Dobson, Al, *Cost Shifting: An Integral Aspect of U.S. Health Care Finance*, Academy Health Conference Presentation: When Public Payment Declines Does Cost-Shifting Occur?, November 13, 2002.

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.[23] 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 will have no guarantee that they will get what they think they have bought.

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***

Association health plan (AHP) legislation was proposed by President Bush, sponsored in the Senate, and passed in the House during the last Congress as the answer to the problems small businesses and their workers are facing. This legislation has been 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.[24]

While it is unclear whether small employers indeed need new federalized AHPs to achieve these goals, it is very clear that several aspects of AHP legislation also pose serious risks for consumers. Although versions of AHP legislation have varied somewhat

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[23] Tu, Ha T. and Marie C. Reed, "Options for Expanding Health Insurance for People with Chronic Conditions," *Center for Studying Health System Change Issue Brief*, No. 50, February 2002, 2.

[24] Under the Employee Retirement Income Security Act of 1974 (ERISA), employer-sponsored group health plans are subject to indirect state regulation through the state's regulation of the insurance products employers offer to their workers. However, employers who "self-insure" these plans, those that bear some or all of the risk for providing the promised health benefits, are completely exempt from state regulation. 29 U.S.C.A. § 1144(b)(2).

over the past decade, most of them have suffered from three common elements that make the legislation problematic for consumers.[25] Because a new version of the legislation has not yet been introduced during this session of Congress, my testimony today will address these concerns specifically to the provisions of the most recent version of this legislation which was passed in the House as an amendment to the patients' rights legislation, H.R. 2563, the Bipartisan Patient Protection Act. The three most common concerns raised by consumers about AHP legislation like H.R. 2563 are that it would:

1. *Allow AHPs to "Cherry Pick" Healthy Risks*: These proposals give AHPs several new 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.[26] 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.[27] 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).[28] Finally, AHPs can boldly discriminate based on health status, charging higher rates for less healthy employer "groups," either at the outset or on renewal of coverage, thereby deterring these groups from joining the AHP.[29] All of

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[25] In the 107th Congress, this legislation was proposed by President Bush in his budget, sponsored in the Senate by Senators Hutchinson and Bond (S. 858, the "Small Business Health Fairness Act of 2001"), and passed by the House of Representatives as an amendment to patients' rights legislation (H.R. 2563, the "Bipartisan Patient Protection Act").

[26] All references to statutory text and language will be from H.R. 2563 PCS, the Bipartisan Patient Protection Act, as placed on the Senate Calendar. The bill empowers the Secretary of Labor to certify a self-insured AHP that restricts eligible participating employers to only "one or more of select trades, businesses, or industries." H.R. 2563 PCS, § 421(a) (creating new ERISA § 802(f)(3)), p. 190, l. 22.

[27] Under H.R. 2563, AHPs' degree of discretion over the benefit package varies somewhat based on whether it chooses to offer a self-insured or insured product. If the AHP is self-insured, it is exempt from all state benefit mandates and only ERISA's minimal benefit protections (e.g., portability and nondiscrimination, mental health parity, newborns and mothers hospital stays, and breast reconstructive surgery protections) apply. If the AHP plan is insured, that plan is subject to state benefit mandates in the state in which the insurance product is licensed, but no other state mandates will apply. And an AHP can purchase a product in a state with few benefit mandates, leaving the AHP with near complete discretion over the benefit package. *See* H.R. 2563 PCS § 421(a) (creating new ERISA § 805(b)), p. 202, l. 10.

[28] H.R. 2563 PCS, § 421(a) (creating new ERISA § 804(d)(1)), p. 198, l. 13. The bill does not define the term "geographically available coverage option".

[29] Although H.R. 2563 generally makes AHPs subject to ERISA's § 702 nondiscrimination protections for individuals (H.R. 2563 PCS § 421(a)(creating new ERISA § 804(d)(3)), p. 199, l. 4), and even includes special protections prohibiting AHPs from excluding individuals based on health status (H.R. 2563 PCS § 421(a)(creating new ERISA § 804(c)), p. 198, l. 1), the legislation in no way limits AHPs from charging more to the entire employer "group" based on the health status or claims experience of its members. And, since the legislation would allow AHPs to offer to groups of one individual (H.R. 2563 PCS § 421(a)(creating new ERISA §812(a)(7)(B)), p. 232, l. 3), technically AHPs would also be permitted to charge that individual higher rates based on health status.

these techniques would have the ultimate effect of enabling AHPs to enroll only the healthiest individuals, which would save money for the AHP, but would also leave out those who need coverage the most. AHPs' ability to "cherry pick" will also drive up the cost of coverage for less healthy individuals left behind in the state regulated market, causing some employers to drop coverage altogether.

2. *Preempt State Regulation*: 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.[30] 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. *Provide 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 the legislation neither authorizes nor pays for any new funds to assist DOL to fulfill its new role.[31] In order

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[30] Under H.R. 2563, AHPs can offer fully insured plans, self-insured plans, or both as coverage options. H.R. 2563 PCS § 421(a)(creating new ERISA § 802), p. 188, l. 22. If the AHP is offering an insured product, it is subject to minimal state regulation, generally with respect to benefit mandates, policy forms, and possibly a contribution tax – all other state requirements would likely be preempted. H.R. 2563 PCS § 421(a)(creating new ERISA § 812(d)(2)), p. 237, l. 10; H.R. 2563 PCS § 421(a)(creating new ERISA § 805(b)), p. 202, l. 10. If the option is self-insured, it is subject only to federal regulation and completely exempt from state regulation. H.R. 2563 PCS § 421(a)(creating new ERISA § 812(d)(1)), p. 237, l. 3.

[31] Under H.R. 2563, the only new funding stream created for DOL to fulfill its new role is an annual filing fee of $5,000 AHPs would pay, but those funds can only be spent on the certification of AHPs, not on other oversight or enforcement activity. H.R. 2563 PCS § 421(a)(creating new ERISA § 807(a)), p. 214, l. 3.

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. However, DOL's current enforcement policy for ERISA violations requires 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. By contrast, states routinely use their immediate cease and desist authority to help individual consumers before more are hurt by fraud and insolvencies.

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.[32] And the federal rules fail to provide any guarantee fund that will protect consumers and pay unpaid medical bills in case of insolvency, unlike states that routinely provide this protection.[33] 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 more clear that the AHP legislation that has been proposed in the past 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:

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[32] H.R. 2563 PCS § 421(a)(creating new ERISA § 806), p. 203; H.R. 2563 PCS § 421(a)(creating new ERISA § 807), p. 214.

[33] H.R. 2563 does establish a stop-loss insurance fund that AHPs would have to pay $5,000 into each year, but those funds could only be spent by DOL on maintaining stop-loss insurance policies for the AHP if it became insolvent, not directly on unpaid medical claims for consumers or providers. H.R. 2563 PCS § 421(a)(creating new ERISA § 806(f)), p. 207, l. 15).

- *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), the AHP legislation would provide new coverage to only 330,000 individuals.[34] 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.[35] 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.[36] 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.[37] Far from addressing the problem of the uninsured, the AHP legislation 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, the AHP legislation will actually increase health care costs for the majority of small businesses and their workers and will 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.[38] As I 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.

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[34] *Id.*, 14
[35] *Id.*
[36] *Id.*,15, 17.
[37] *Id.*, 14.
[38] *Id.*, 16-17. This finding relies in part on research presented in the CBO report that suggests that mere pooling of small employers may not be enough to lower premium costs dramatically enough to attract high numbers of new small employers. According to studies that have looked at California and other state experiences with purchasing cooperatives, while there may be some small discount that is reaped from small employers banding together as a group, the lower cost was not comparable to the price advantages large employers enjoyed. Primarily, the benefits of pooling were found to be improvements in choice, information, and a lesser administrative burden for small employers. *See Id.*, 9.

For these reasons, the AHP legislation fails to improve the affordability and the quality of benefits.

- *Hurts Those Most in Need*: With AHP legislation, 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, AHP legislation would preempt virtually all state benefit mandates, rating protections, protections against fraud and insolvencies, and direct oversight and enforcement.[39] The AHP legislation 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

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[39] In the most recent version of this legislation, H.R. 2563 which was enacted in the House of Representatives in August, 2001, AHPs would be completely exempt from all state regulation if they offer only self-insured plans; if they offer an insured plan, they can choose the state with the most minimal regulation in which to license the plan, and some of that state's regulations would apply to the insured AHP plan and completely preempt regulation by the other states.

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.[40] 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.[41] 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.[42]

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.[43] 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.[44] 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.[45] 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.[46] 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.[47]

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[40] CBO, 9.

[41] *Id.*, *citing* Stephen H. Long and M. Susan Marquis, "Pooled Purchasing: Who Are The Players?" *Health Affairs*, vol. 18, no. 4, July/August 1999, 105-111.

[42] Mila Kofman, Assistant Research Professor for Georgetown University's Institute for Health Care Research and Policy, has written and commented widely on concerns relating to association and MEWA fraud and has submitted written comments for the record of this hearing. *See* Mila Kofman, January 31, 2003 Letter to Chairwoman Snowe and Ranking Member Kerry. (hereinafter Mila Kofman Letter)

[43] U.S. General Accounting Office, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*, GAO/HRD-92-40, March 10, 1992, 2-3.

[44] Mila Kofman Letter, 2.

[45] *Id.*

[46] In launching this program, Secretary of Labor Chao underscored that scam health plans are a risk in this area, saying "[u]nfortunately, operators of insurance scams continue to prey on small businesses who are lured by offers of cheap coverage." "Secretary Elaine L. Chao Announces Assistance to Help Small Businesses Avoid Health Benefit Scams," *U.S. Department of Labor Pension and Welfare Benefits Administration Office of Public Affairs News Release*, August 6, 2002.

[47] *Id.*

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. 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, the AHP legislation 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 the AHP legislation. 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 the AHP legislation they 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.[48]

- 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.[49]

- 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:

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[48] Appleby, Julie, "More Patients Get Stuck with the Bills – Unlicensed Insurers Prey on People Desperate for Lower Rates," USA Today, May 1, 2002, 3B.
[49] Muller, Judy, "Insecure Insurance: Unmonitored MEWA Plans Stick Patients with Unpaid Bills," ABC News.com, March 6, 2002.

because she had to delay surgery due to the plan's failure, her vision in one eye is now permanently impaired.[50]

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, coverage under association plans 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

[50] Mila Kofman Letter, 2.

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 the Committee 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, the AHP legislation that has been proposed in the past is not the right solution to these problems. The proposed AHP legislation 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 leadership on this important issue and for the opportunity to testify today. I am happy to answer any questions.

Chair SNOWE. Thank you very much.

Ms. Praeger.

**STATEMENT OF SANDY PRAEGER, COMMISSIONER OF INSURANCE, STATE OF KANSAS, REPRESENTING THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, KANSAS CITY, MISSOURI**

Ms. PRAEGER. Thank you, Madam Chair and good afternoon. It is a privilege to be here.

My name is Sandy Praeger and I am the newly elected Commissioner of Insurance for the State of Kansas. I have served in the Kansas legislature for 12 years, most recently as Senate Vice President.

While I am a new commissioner, I am not new to this issue. It is one we have grappled with for the last decade in our State.

I am testifying this afternoon on behalf of the National Association of Insurance Commissioners. The primary objective of insurance regulators is to protect consumers and it is with this goal in mind that I comment today generally on the small business health care crisis and, in particular the proposal to create association health plans.

At the start, I would like to emphasize that the States recognize the importance of ensuring that health coverage is affordable and available for small businesses. We offer the full support of the NAIC in developing legislation that will reach these goals.

States have acted aggressively over the past 10 years to stabilize and improve the small group market. The destabilizing effect of AHPs on this market would be disastrous. Are we ready for AHPs to replace the small group market?

States have enacted small group market reforms to pool risk and have created purchasing alliances that provide more choice for employees in small groups. In 2000, Kansas created the Business Health Partnership to help small businesses with affordable coverage by allowing plans to deviate from mandated benefits and to place annual caps on hospitalization.

Insurance regulators would like to work with the Chair and the Members of this Committee to develop legislation that would make insurance more affordable for small business and provide them with greater choices. But any such legislation must meet the following criteria.

First, higher risk employees must not be forced out of the market. Before State small group market reforms were implemented, if an employee became sick, the employer was shifted to a higher risk pool and often priced out of coverage. State small group market reforms forced insurers to treat all small employers as part of a single pool and allowed only modest variations in premiums based on risk. This spreading of risk has brought fairness to the market and must be preserved for the sake of higher risk employers.

Second, consumers must be protected from plan failures and fraud. Over 10,000 State employees nationwide oversee the business of insurance to ensure plans are able to pay claims. Through reporting requirements States receive the information they need to identify possible solvency problems and to force corrective action.

Yes, State regulation is costly but it is costly because it provides real protection for consumers. Adequate Federal regulation, I believe, would also be costly.

Insurance is a complicated business involving billions of dollars with ample opportunity for unscrupulous or financially unsophisticated entities to harm millions of consumers. The fact is 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.

Crucial to the long-term viability of insurance plans is the maintenance of sufficient capital and reserves. In particular, the capital reserve requirement in the bill for any and all AHPs is capped at no more than $2 million, no matter the size of the plan. States require capital surpluses to grow as their plans grow.

More troubling, even if the solvency standards were increased, oversight is almost nonexistent. Under the bill, the AHP would work with an actuary chosen by the association to set the reserve levels with little or no Government oversight to ensure the levels are sufficient or maintained. Also, the AHP would be required to self-report any financial problems.

Who can even think of this type of self-reporting after the experiences of past corporate fraud?

AHP plans should also be required, like other insurers, to contribute to State guarantee funds. These funds cover any unpaid claims should a plan go bankrupt. While the AHP legislation allows premium taxes to be collected, other assessments to finance guarantee funds or high risk pools would not be permitted, further shifting the burden to regulated products in the insured market.

Finally, patient rights must be preserved. Included in the current AHP legislative proposals is the broad pre-emption of consumer protection laws. These would include internal and external appeals processes, policy forum and advertising reviews to prevent unfair or misleading language, privacy protection including the selling of lists. Those would be pre-empted in the current AHP proposal.

Furthermore, there would be no entity to complain to if a patient 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 the same access to the same protections and complaint process.

In 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. However, the problem is complex and does not lend itself to easy solutions.

We request the opportunity to work with the Committee to develop effective reforms that will avoid the pitfalls of this legislation and effectively address both 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.

[The prepared statement of Ms. Praeger follows:]

# TESTIMONY

# OF THE

# NATIONAL ASSOCIATION OF

# INSURANCE COMMISSIONERS

## BEFORE THE

## SENATE SMALL BUSINESS AND

## ENTREPENEURSHIP COMMITTEE

## ON

## SMALL BUSINESS AND HEALTH CARE

**Presented by:**

**Sandy Praeger**
**Commissioner of Insurance**
**State of Kansas**

February 5, 2003

**Introduction**

Good morning Madame Chairwoman and members of the Committee. My name is Sandy Praeger and I am the newly elected Commissioner of Insurance for the State of Kansas. I was previously elected to three terms in the State Senate, being elected as Vice President of the Kansas Senate in 2001, and one term in the Kansas House of Representatives. I served as Chair of the Financial Institutions and Insurance Committee in the Senate and am the Past Vice Chair of the Health Policy Committee for the National Conference of State Legislatures. I am currently serving as Chair of the National Association of Insurance Commissioners' Health Insurance Task Force.

I am testifying this morning on behalf of the National Association of Insurance Commissioners (NAIC), the organization that 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 I comment today generally on the small business healthcare crisis, and in particular the proposal to create Association Health Plans (AHPs).

At the start, I 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. In 2000, Kansas passed legislation creating the Kansas Business Health Partnership, which allows for small groups to pool and establish their own set of benefits. It is not comprehensive insurance but it is a low cost alternative for businesses especially those with low wage workers.

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 Current AHP Legislation

### 1. The AHP Legislation 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. The AHP legislation in Congress 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.

In Kansas, we have association health plan legislation introduced this session that, without the proper safeguards in place, could disrupt the market. In fact some in the industry have proposed abolishing the small group reform in Kansas if we allow this kind of erosion into that market.

**2. The AHP Legislation 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 the AHP legislation 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. The AHP Legislation Would Lead to Increased Plan Failures and Fraud

Proponents of the 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 bill provides no new resources for regulating these plans.

While we acknowledge State regulation does increase 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 the bill the AHP would work with an actuary chosen by the association to set the reserve levels with little or no government oversight to ensure the levels are sufficient or maintained. Also, the AHP 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. The AHP Legislation Would Eliminate Important Patient Protections**

Included in the current AHP legislative proposals 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:

- Internal and external appeals processes.
- Investment regulations to ensure that carriers only make solid investments instead of taking on risky investments such as junk bonds.
- Unfair claims settlement practices laws.
- Advertising regulation to prevent misleading or fraudulent claims.
- Policy form reviews to prevent unfair or misleading language.
- Rate reviews. Insurance departments may review rates to make sure the premiums charged are fair and reasonable in relation to the benefits received.
- Background review of officers.

- Network requirements including provider credentialing and network adequacy, to ensure that plans offer a provider network that is capable of delivering covered services.

- Utilization review requirements to ensure that plans have acceptable processes and standards in place to determine medical necessity and to make coverage determinations.

While some of these protections may be offered by AHPs as a service to their association members, there would be no requirement that they do so, and no entity to complain to if a 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. The AHP Legislation Would Cut Funds to High Risk Pools and Guaranty Funds**

While the latest version of the AHP legislation 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.

The AHP legislation proposed in Congress 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 AHP legislation as currently drafted and urge 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.

Chair SNOWE. Thank you.
Mr. Nichols.

**STATEMENT OF LEN NICHOLS, VICE PRESIDENT, CENTER FOR STUDYING HEALTH SYSTEM CHANGE, WASHINGTON, D.C.**

Mr. NICHOLS. Thank you, Madam Chair. My name is Len Nichols and I am the Vice President of the Center for Studying Health System Change.

Our center is a non-partisan health policy research organization funded solely by the Robert Wood Johnson Foundation. We survey households and physicians, and we monitor 12 community's health systems quite closely as we watch national trends. This enables us to offer unique insights on developments in health care markets and their impacts on people.

As an economist, I have personally studied the decisions of small employers to offer health insurance or not for the last 10 years. My research ranges from statistical analyses with representative survey data to interviews with employers, coalitions, insurers, brokers, actuaries, regulators, legislators, and most recently site visit research conducted with my colleagues at the center.

Research, and my two older brothers who run small businesses, have taught me over the years that there are three goals in relation to health insurance when small-business think about this. They want it to be affordable, they want it to be simple, and they want it to be stable over time. All small group reform proposals should be judged by these criteria.

Employers offer health insurance to compete for workers who have enough market power to expect health insurance on the job. Most, but not all, of our workers fall into this happy category. Employers who do not offer health insurance by and large cannot afford it, mostly because their workers cannot afford to trade their already low wages for employer premium payments as their higher wage counterparts do at offering firms.

I know you are very concerned about cost, Madam Chair. I take your graph there quite seriously. I will use it myself from now on. But I will say it is worth noting a typical family policy today costs 28 percent of a typical worker's earnings. That kind of sums up how big a problem we have got. As your previous panels have made clear, this problem is getting worse over time as health care costs grow faster than wages.

We also know, as your opening remarks pointed out, small employers are much less likely to offer health insurance than are large firms. This disparity in offer rates is largely a function of cost, and also the types of workers each business needs to hire. Small firms do tend to pay lower wages and health insurance costs more for them because of the administrative cost reasons we have talked about before and as was mentioned I think this morning, administrative savings can be as much as 30 percent as a share of premium, which is quite substantial.

So the real question today is: Can AHPs be part of this solution? I think it is fair to say they may offer some advantages to some small employers, but without key safeguards—and I appreciate your willingness to think about modifications to the legislation that might provide those safeguards—without these key safeguards

AHPs also present significant risks to other employers and possibly to the small group market as a whole. As a result, I would encourage you to consider alternatives that may help small employers and their workers reach there common goals with much less risk and trouble.

AHPs could lower cost if they became large enough and once set up could add simplicity to small employer's lives. As you heard, as my brothers have taught me, that is the main thing. However, they must achieve a critical mass in order to offer these economies of scale so like those purchasing cooperatives in Maine and elsewhere they have got to grow or it is not going to work.

Plus, and this is a sad but I think true fact, they are not going to save as much from exemptions from benefit mandates as a lot of people seem to believe. I tend to agree with the CBO analysis that was done a few years ago, which cited an earlier study I had done by the way, which suggests that indeed mandates are going to save about 5 percent on average across the board.

The greatest risk AHPs present however has to do with stability of premiums over time. Some insurers fear that any pool formed for the express purpose of buying insurance would retain only high-risk enrollees. Our site visit team was told just last week in Arkansas that no insurer would even make an offer to small employer purchasing groups there who could have been formed under 2001 law.

Others fear the opposite kind of selection. Others fear that AHPs, since their advocates do seem to focus most on benefit mandates and State regulation, that AHPs would be the most appealing to low-risk firms credit in current small group pools. By attracting low risks alone, AHPs could ultimately, theoretically at least, force premiums outside AHPs to rise which could chase more good risks away from the commercial market.

This is the key point, if AHPs can restrict entry, the commercial carriers are bound by guaranteed issue laws that are enforced by State regulators, this could be a recipe for a classic death spiral of the small group insurance market. So what you want to do is make sure that entry is easy in both directions. There are ways to do that, that we can talk about later.

I do not really think a complete meltdown of the small group market is likely. I am old enough to believe inertia is a powerful force. But many may reasonably ask why take such a chance when there are alternatives that accomplish the objectives that may be much better and available.

You could, for example, allow small firms to buy into existing large pools. For example, the State employee pool or even FEHBP. The State employee pool is usually the single largest buyer in any State. Employers could contribute what they want governed by their competitors in the labor market and employees would make up the difference. Or you could use Medicaid or SCHIP dollars to subsidize those who turned out to be eligible.

With State employees as a base, the administrative cost per enrollee would be minimized, the enrollment apparatus would be very simple, and the risk pool would be very stable over time. This seems to me to be a way to combine all the goals you have.

You could allow small firms to form purchasing coalitions for the purchase of health insurance. As you pointed out, and the Maine experience makes clear, they have not grown nearly as much as the advocates thought they would. So I think it is fair to say experience would suggest they are never going to grow without some kind of help. They are never going to grow without either compulsion for everyone to buy through them, which is typically unacceptable. Or they are never going to grow without some kind of big time subsidy.

The third option would be to allow small firms to buy into Medicaid or SCHIP or some other hybrid State employer kind of combination. This one is particularly attractive for the lowest wage workers who may indeed be eligible for public programs today. This concept is similar to allowing employers to buy into the State employee plan. It is a bit more complex because the benefit package is more comprehensive in Medicaid generally, and Medicaid is going to be more complicated. This option requires employers to deal with Medicaid stigma issues, some of whom feel strongly about that. There are ways to deal with all these problems. But still, allowing small employers to opt in to the Medicaid purchasing apparatus would clearly offer administrative savings and a stable risk pool, compared to buying health insurance alone in the small group market.

So in conclusion, I would like to assert and we would be glad to explain further, that the most efficient way to increase health insurance coverage would be to subsidize low income workers directly and let them take it where they want to go. Unfortunately, I am afraid that AHPs do not stack up so well on the affordability and stability dimensions that are both critical to long run small group reform success.

I would encourage you to explore other options that permit small employers to buy into existing pools.

I would be glad to answer any questions.

[The prepared statement of Mr. Nichols follows:]

# ASSOCIATION HEALTH PLANS

# AND

# ALTERNATIVE WAYS TO INCREASE HEALTH INSURANCE COVERAGE

# AMONG WORKERS IN SMALL FIRMS

Statement of

Len M. Nichols*

Vice President

Center for Studying Health System Change

For

UNITED STATES SENATE COMMITTEE ON

SMALL BUSINESS AND ENTREPRENEURSHIP

Hearing to Examine the Small Business Health Care Crisis: Possible Solutions

February 5, 2003

*This statement reflects the views of the author alone and not those of the Center for Studying Health System Change, Mathematica Policy Research, or those of our sponsor, the Robert Wood Johnson Foundation. I am grateful to Kyle Kinner and Richard Sorian for comments on earlier drafts.

My name is Len M. Nichols and I am the Vice President of the Center for Studying Health System Change (HSC). HSC is an independent nonpartisan policy research organization funded solely by the Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research. Our recurrent nationally representative surveys of households and physicians, our site visits to monitor ongoing changes in the local health systems of 12 U.S. communities, as well as our monitoring of secondary data and general health system trends all enable us to provide policy makers with unique insights on developments in health care markets and their impacts on people. Our various research and communication activities may be found at www.hschange.org.

As an economist, I have studied the decisions of employers, and specifically small employers, to offer health insurance or not, as well as the general workings of small group insurance markets for the past 10 years. My research ranges from statistical analyses with nationally representative survey data gathered from employers to interviews with small employers, large employers, small business coalitions, insurers, insurance brokers, actuaries, state regulators, purchasing cooperatives, state legislators, and most recently site visit research conducted by myself and colleagues at the HSC.

I am sure this committee is well aware of the basic fact that small employers are much less likely to offer health insurance than are large firms. For example, in the most recent data, 47% of establishments with fewer than 50 workers offer health insurance, compared to 97% of establishments with more than 100 employees.[1]

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[1] Medical Expenditure Panel Survey, Insurance Component, 2000 data. www.meps.ahrq.gov.

There are many specific contributors to this disparity in offer rates, but one conclusion stands out in all my research and in the professional literature of economics as a whole: employers offer health insurance if they think they need to in order to successfully compete for workers. If they do not offer health insurance, by and large it is because they can attract and retain the workers they need without offering it.

Most of us, happily, have enough education and training to work in labor markets where health insurance is a normal and expected part of any and all compensation packages. Seventy nine percent of workers are eligible for the health insurance their employers offer. Indeed, most of us have never had a job offer without some kind of health insurance attached.

But while a distinct minority, some workers, typically those without much education or marketable job skills, often can only get jobs with no health insurance attached. And some firms, indeed a disproportionate share of small firms, mostly need the skills of these kinds of workers. These workers, along with the sometimes prodigious efforts by the small business owner and his or her family members, are sufficient to generate marketable products or services for many small businesses' customers. In competitive markets, if more skilled and highly compensated labor is not required, pretty soon profit margins are driven down to where more expensive labor actually could not be paid for, and that is when and why most small businesses who do not offer health insurance answer the question, "Why not?" with responses like, "Health insurance costs too much to provide to my workers. My business and I can't afford it." This kind of response is the source of the shorthand but reasonable conclusion that cost is the single most important thing when it comes to health insurance and small business.

Now, in economic theory and even in real life, workers who *do* have health insurance through their employer implicitly trade at least some of what they could have had in wages in exchange for their employers' premium contributions. (Whether wage offsets completely finance all employer payments is not settled in the economics literature, but this dispute is relatively academic for our purposes today, for the larger point is beyond dispute: all workers at offering firms trade some wages for employer premium payments, whether they know it or believe it or not). Workers with relatively low productivity or value added in the competitive marketplace, unfair though their compensation may seem from some perspectives, simply are not willing or able (given low discretionary income and competing resource demands) to trade some of their already low wages for health insurance, and this is how it comes to pass that small firms with low profit margins which employ these kinds of workers simply cannot and need not provide health insurance to remain in business.

So, the "root cause" reason some firms choose not to offer health insurance is that their workers' wages are just too low (relative to the current cost of health insurance). But wages and compensation are tightly linked to the market value of a worker's productivity, so it must be that their market productivity and purchasing power is simply too low to enable them to afford health insurance. It follows, then, that an efficient way to attack the root cause of lack of health insurance among workers in small firms, and among low income workers generally, is to increase their purchasing power with direct subsidies to them. Only with this increased purchasing power will they be willing to purchase health insurance for themselves and their

families. This is the conclusion reached by two recent specific analyses of this question.[2] These subsidies, by the way, could take the form of tax credits or other sorts of assistance, including eligibility for existing or modified public insurance programs like Medicaid or SCHIP, but those details and debates are also for another day.

For the agenda item at hand is association health plans. Where might they fit into this discussion, why are their advocates so strongly in favor of them as a solution for small businesses' health insurance woes, why are their opponents just as convinced that this type of reform would do more harm than good, and what other non-subsidy alternatives to AHPs might this committee want to consider?

Before answering these questions, let me provide just one more background or contextual statement. My research over the years strongly suggests that small businesses have three primary goals when it comes to health insurance: affordability, simplicity, and stability. It is therefore efficient to examine AHPs and feasible alternatives in light of how well they might help small businesses reach these specific goals.

**Affordability.** It is well known that small firms have to pay more for the same health insurance policy than do large firms because the administrative costs of selling insurance can be spread over so many fewer workers, and thus premium loading factors – the difference between premiums and expected claims costs -- are higher for small firms, perhaps as much as 20-30%

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[2] Ferry, Danielle, Sherry Glied, Bowen Garrett, and Len M. Nichols, "Health Insurance Expansions of Working Families: A Comparison of Targeting Strategies," *Health Affairs* v. 21 # 4 (July/August 2002); Bowen Garrett, Len M. Nichols, and Emily K. Greenman, "Workers without health insurance: Who are they and how can policy reach them?" WKKellogg Foundation Community Voices report, August 2001.

higher. Thus, any kind of larger group purchasing arrangement -- AHPs, small employer coalitions, allowing small firms to buy into state or federal employee plans or into Medicaid -- could in theory lower the administrative costs per worker which now drive small business premiums higher than they have to be. Analysts might quibble about which of these types of group arrangements would lower administrative costs more, but it really depends on the details of each and the ultimate size reached, so as a first order approximation it may be reasonable to agree that AHPs can look attractive on this front and thus it should be no surprise they have received so much attention.

The second dimension to affordability that is often mentioned in AHP discussions is the cost of benefit mandates and the potential gains if they could only be avoided. The effect of benefit mandates is perhaps one of the most contentious issues of factual debate in the small group health insurance market. Careful academic research tends to find little to no net effect of benefit mandates on premiums or employer offer rates, yet some small employers, and particularly some small employer advocates, appear to be convinced that benefit mandates are the major culprit in health care costs today.

A few facts can help make sense of these competing and heartfelt claims. Most insured workers work for firms that are not small. Many medium sized and most large firms self-insure, outside the commercial market, and are not subject to benefit mandates. Nevertheless, most of the benefits that are mandated by states for their small group market are actually provided by large self-insured firms even though they do not "have to." Indeed, causation runs from large firm coverage decisions, which are driven totally by labor market competition, to state mandates on

small firms, whose proponents argue for them as a matter of equity. In addition, many small firms that do offer are *high wage* firms, and they offer as rich a package as do the large firms, ordinarily. So, the bottom line here is that mandated benefits add relatively little to *average* insurance costs, and that is why most good academic research based on nationally representative data finds so little impact of them

At the same time, clearly benefit mandates must add to costs for those firms that were not offering particular benefits prior to the mandate's passage. The Department of Insurance of the State of Texas did a very comprehensive study in 1998 which concluded that the 9 mandates in Texas, which are not atypical and include inpatient treatment of alcohol and substance abuse, represented about 3% of claims paid in the two most recent years available.[3] I and colleagues,[4] as well as the CBO in a later study[5] both concluded that a reasonable interpretation read of the entire literature calls for an assumption that exemption from benefit mandates would save those firms that joined AHPs about 5% off their premium on average. Now 5% of a family premium these days is not a trivial amount of money, but please note that administrative load savings are likely to be 4 to 6 times larger as a percent of premium. It should also be noted that benefit mandates do add some value that should be weighed against cost. Research has shown that employee takeup of employer offers is higher in states with more mandates.[6]

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[3] www.doi.tx.st.gov
[4] Linda J. Blumberg, Len M. Nichols, and David Liska, *Choosing Employment-Based Health Insurance Arrangements: An Application of the Health Insurance Reform Simulation Model.* Final Report 0657-001-00, Department of Labor, Pension and Welfare Benefits Administration, March 1999.
[5] Congressional Budget Office. "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts," January 2000.
[6] Jensen and Morrisey, 2000.

By far the most important determinant of the cost of health insurance in any alternative arrangement, of course, is the risk pool one has access to, or more precisely, the relative health risk of those which whom you are pooled. I will return to this important point below, for it is complex enough to be best addressed when we consider the stability of premiums.

**Simplicity** in health insurance is practically a contradiction in terms, and most small business owners must depend on agents or brokers to guide them through the inherently complex maze of details involved in health insurance choices today. Information and education functions are essential in any small group market solution, and agents may provide the cheapest and most widely trusted source of this information that anyone can devise. If any entity like an AHP or purchasing cooperative tried to avoid agents altogether, they certainly could, but they would have to then build in the costs of providing information about health insurance choices to all participating employer and employees. This will necessarily "take back" some of the administrative savings from self-insuring and forming a larger agglomeration of small groups. On the simplicity front, allowing firms to buy into existing employee pools, like state employee pools, might be the clear winner.

**Stability**. Small business owners are typically not in the health insurance business. They do not have enough time to master constantly changing details that are not directly related to their own production, sales and delivery problems. They want a basic package to be competitive in the labor market, and they do not want to have to worry about premium fluctuations that will force them to start over at ground zero with a new set of insurance options. For lots of reasons, premiums in the small group market are more variable than in the large group market. Just last

week brokers reported to HSC researchers, including myself, of premium increases for small businesses in a given market that ranged from 10-90% in the last year. No business nor worker can sustain 90% increases of an item already as large as health insurance premiums are now. Now 90% might be an outlier, but there is considerable evidence that the variance of premiums over time for small groups is indeed larger than for larger groups, and so the basic interpretation of relative instability remains.[7] Just hearing about these kinds of experiences, and enough small employers have experienced them that almost all have heard about the possibility over time, makes a small employer think twice about offering health insurance since the prospect of having to take an important compensation piece away in the future is more painful than continuing to live with not offering it as they have in the past. So stability is extremely important to any effective reform of small group options.

And it is precisely along the stability dimension that I fear AHPs earn the lowest marks. We learned on an HSC site visit just last week that in 2001 the Arkansas legislature passed a law which allowed small employers to join together and purchase insurance together as a large group and to avoid benefit mandates. But no insurer there would agree to offer coverage to these groups because of their fear of eventual adverse selection. That is, insurers were afraid that any premium rate that would cover the average costs of those who would be attracted to join together in an association-like arrangement in the first place – an association whose sole purpose was to purchase health insurance – would be higher than the average costs of specific groups. The insurers expected specific low-cost groups then to opt out over time and the insurers feared being left holding the deteriorating risk pool bag of the shrinking association plan. If the Arkansas insurers were correct, and it is telling that all reached the same conclusion, this kind of

[7] Cutler, NBER working paper, 1995.

association could lead to rapidly increasing but actuarially fair premiums over time for well-intentioned members of the association plan. In the limit, this process is known as a death spiral.

Second, precisely because exemption from benefit mandates is such a strong motivation of proponents, many opponents of AHPs, including large insurers like Blue Cross Blue Shield plans which sell in the small group market, fear the opposite kind of selection into AHPs. They fear that more parsimonious benefit packages, and the ability to actively exclude small groups from the association and insurance product if not carefully proscribed, would siphon off all the good risks they need to keep in their blocks of business in order to keep their small group premium rates down. The CBO analysis of AHPs cited earlier estimated that 20 million workers would see their premiums rise if the AHP legislation of that day became law.

Aside from the obvious self-interested conflict here, there are fundamental issues at stake here. Essentially, self-insured AHP options, regardless of who runs them, could compete with commercial insurers and Blue Cross Blue Shield plans and anyone else – over who can package the best set of risk pools for the most small businesses. The analogy which proponents of AHPs sometimes invoke is that of large self-insured firms like General Motors or Xerox or Honeywell. Why should small firms not have the same power to self-insure? (They have the right now, but self-insuring a group with fewer than 100 members is rarely cost effective and highly risky).

Well, perhaps as a matter of fundamental liberty they should (and do) have the right to self-insure alone, but the analogy between AHPs and General Motors fails for a simple but powerful reason: General Motors self-insures *all* of its workers, it does not allow workers in California to

select one self-insured pool and workers in Flint to select another, nor can workers in Flint select among competing risk pools (as some AHP proponents would allow). Whereas an AHP by construction would be a set of very small employers, any of whom could bolt or join at open enrollment time or at will if another insurer was willing to take or free them. Thus the inherent *stability* of any AHP risk pool cannot be as great as the largest self-insured employer pools can maintain. Either the self-interested search for more homogenous risk pools and insurance products among low risk firms will exert constant pressure for the pool to deteriorate, as the Arkansas insurers feared (perhaps new AHPs will repeatedly be re-constituted as a best case scenario), *or* the AHP will likely attract the lowest risk businesses who are willing to forego mandated benefits (in the mistaken belief that down that path lies huge savings) and the commercial risk pools would deteriorate, as the Blues fear and CBO predicted. The analysis I and my colleagues did at Urban a few years ago (cited earlier) suggests that this fear of commercial risk pool meltdown is probably exaggerated by some, but some deterioration is inevitable and the risk of large effects is certainly not zero.

There is one other concern about AHPs that can be solved but needs attention and that is the matter of reserves and regulatory oversight of those reserves, since they would not be typically regulated by state insurance departments. There have been some relatively rare but painful episodes of multiple employer insurance arrangements in the past being operated by people who took the premiums and left employers and workers with an unenforceable guarantee of the coverage they had paid for in good faith. I am no lawyer but have talked to enough to caution you to pay particular attention to these details in any enabling legislation to ensure the creation of adequate reserves and the operation of some kind of guaranty funds oversight mechanism in the

event of miscalculations or financial meltdown or outright fraud, which does indeed happen in the real world.

So, are there better ways to provide small businesses with more affordable, simple, and particularly more stable health insurance options?

You may find it useful to have your staff review the set of proposals in an RWJF funded effort, spearheaded by Jack Mayer of the Economic and Social Research Institute, which were compiled into a book entitled *Covering America*.[8] There you will find quite a few specific ideas about how better pooling and purchasing arrangements – specifically for small employer groups and for those relatively few uninsured with no employment connection at all – may be constructed from existing institutions. I was one of the co-authors of one of the proposals, the risk sharing theory of which has been accepted for publication in an upcoming issue of the American Economic Review,[9] and I am also on the Advisory Panel to the Covering America project and so am familiar with the arguments advanced by the other nine proposal teams. I will summarize some options that come out of that work for you, omitting much subsidy mechanism, cost-control, and quality enhancement detail that your staff may want to peruse at some length later.

**Allow small firms to join existing state employee pools.** In many states, the single largest employer is the state itself. As such, states are often able to offer their employees a choice of plans and competitive low-load rates that are rarely possible for small firms. Many states also allow counties and even smaller administrative units to opt into their state employee plan. It

[8] Jack Meyer and Eliott Wicks, *Covering America*. Economic and Social Research Institute, 2002.
[9] John Holahan, Len M. Nichols, Linda J. Blumberg, and Yu-Chu Shen. "A New Approach to Risk Spreading via Coverage Expansion Subsidies," *American Economic Review* (forthcoming, May 2003).

would be fairly easy to allow small businesses to bring their employees into the state pool. Enrollment forms could be sent to small businesses with their tax forms each year, made continually available on web sites which most if not all states maintain now, and contributions – shared as employer and employees agree to on their own -- could be sent into the state monthly along with income tax withholdings. State employees might fear that small businesses who would join would be sicker than those who would remain outside the state pool, and that would be a risk, but two facts should calm. First, state employees tend to be older and sicker than workers in general. Second, since HIPAA imposed guaranteed issue for all products in small group markets, there is relatively little underwriting at the small group level anywhere any more, at least considerably less than there was prior to 1997 when typically only two products were guaranteed issue. This means any new firms likely to add coverage post-reform are more likely to be relatively low risk, and not high risk since universal guaranteed issue has already pulled the higher risk into the small group market. Finally, one could imagine requiring that all small employers purchase health insurance through the state pool, if they chose to offer health insurance (I am not advocating an employer mandate), which would purge any remaining fear or risk of adverse selection against the combined state employee-small business pool. This option would provide the maximum stability, simplicity, and affordability of all the options I can think of, with the added bonus of adding considerable choice of private health plan options for small firms' employees, something very few of them have today.

**Allow small firms to form purchasing cooperatives for the purpose of buying health insurance.** They have this right in most states now, and while some work well, this movement has surprised analysts with how it did not exactly take the small business sector by firestorm,

despite some obvious advantages over going it alone in small group purchasing.[10] There are many reasons for the disappointment, but the relevant advantages of the best of these vis a vis AHPs is that they have similar insurance rules as the outside market – AHPs by construction would be exempt from mandates and perhaps able to underwrite more aggressively as well – and they could achieve critical administrative economies of scale and sufficient size to reach risk pool stability over time. A fair read of our experience to date, however, must admit that pools formed wholly by small employers are not likely to be as large or as stable as pools that would marry state employees and small employers together. Federal policy makers could insure that any pools that are formed are governed by the same market rules as prevail outside the pools in each state, but short of subsidies there is not much policy can do to ensure critical mass.

**Allow small firms to buy their employees into Medicaid or SCHIP or some new hybrid state-employer program.** This option is more attractive for extremely low wage workers who might actually be eligible – for themselves or for their children – for public insurance today. The concept is similar to allowing employers to buy into the state employee plan. This is a bit more complex because the benefit package for Medicaid is typically more comprehensive than the private employment-based plans that are offered to state employees, and policy makers may prefer to allow small employers of low wage workers to somehow buy less generous plans, or provide subsidies to help them afford them afford the more generous Medicaid package. Plus this option requires employers to deal with Medicaid stigma issues, which some feel more strongly about than others. Opportunities to reduce stigma are manifest in many SCHIP plans and the Basic Health Plan in Washington state, for example. Also, Medicaid enrollees are probably more expensive than small employers' workers and their families, and Medicaid

[10] Elliot Wicks, "Health Insurance Purchasing Cooperatives," Commonealth Fund, November 2002.

typically pays providers lower than other payers, so these this too could create some start-up costs. Still, allowing small employers to opt-in to the Medicaid purchasing apparatus would clearly offer administrative savings and a stable risk pool compared to buying insurance alone in the small group market.

I would conclude by iterating the most effective way to bring about more coverage of workers in small firms is to subsidize workers directly. I would be glad to elaborate on those options at the convenience of the Committee. My bottom line judgment is that AHPs do not score as well as allowing small firms to buy into state employee plans on the three criteria I think small businesses care the most about, affordability, simplicity, and stability. However, as in all policy choices, there are complex tradeoffs involved in any change along these lines, only some of which are amenable to technical analysis or which can be articulated in brief testimony on one day.

I would glad to answer any questions this testimony may have raised, now or at a future time.

Chair SNOWE. I appreciate that.

First of all, I want to ask you, do you support the idea of AHPs or are you totally opposed? Obviously, as many have said earlier, it is a multidimensional problem that requires a multidimensional solution, frankly, in dealing with the uninsured. You have to break down the components of who is uninsured and how you are going to reach them and removing the barriers.

So this seems to be one mechanism of addressing it. Now you have raised questions and obviously we are going to be looking at those issues and I will get to that in a moment. But the concept, are you opposed to the concept of AHPs?

Ms. LICHTMAN. I am going to try my hand at this answer and say to you in advance that I do not mean to beg your question but I do not know how to answer it because I do not really know what the concept of an AHP is.

If you are asking me do I opposed the legislation as proposed, I oppose it. If you are asking me is it possible for people of goodwill to sit down and craft a piece of legislation, I do not care what you call it, that meets the criteria that the three of us sat down, I would say let us have a conversation. Of course, let us make up a word. I could support something that met our criteria.

But if the only thing I have to go on is what I have seen, and that is an AHP, I do not like it.

Ms. PRAEGER. I do think pooling mechanisms, finding ways to allow more small groups especially to pool their employees is something we have all been striving towards and we have done some, I think, fairly innovative things in Kansas.

The concern, I guess, with this current legislation is that it really does have the impact of destabilizing the market because, contrary to what some have said today, it is going to be the healthier groups that will look for more affordable coverage. They are the ones that will be able to find more affordable coverage and they are the ones that will pull out of the small group leaving the sicker in that small group and leaving us at the State level to try to figure out ways to deal with their——

Chair SNOWE. The current system denies most small businesses now, at least according to the testimony that we have received today and previously, that they do not have access under the current system. I mean, that is essentially the problem. Why would they not want to be able to get their choice in the State in which they are located? It seems the simplest approach to me, if I were small business, especially if you were a small business, fewer headaches.

So why would it not be much more efficient for them to try to secure that in their own States? The only reason why they cannot now is because it is not affordable or they do not have many options. The State purchasing pool, for example, is not working. At least insofar as I have heard from small business. It is just not large enough. They are offering catastrophic coverage in some of the plans. The Maine Chamber, it is like $5,000 and $10,000 catastrophic coverage now because it is becoming so prohibitive.

So the current system is obviously not working. They are looking for other options. Why cannot this be one dimension of that problem, looking at some of the issues? I am curious as to why some

of the language in this legislation does not satisfy your concerns? The current system is not working.

Mr. NICHOLS. Madam Chair, I think it is quite fair to characterize the current system as broken. I think you are right about that. Let us think about what are the elements of that brokenness, if you will. The fundamental problem here is cost. What people are searching for is a cheaper way to find health insurance. That very chart, that trend you are showing up there is all over the country. That is the one thing everywhere. The first thing people talk about is cost.

They are looking for a solution to cost. I do not mean to be disrespectful at all to the strong advocates, but in some ways it is like fool's gold. What they are looking for is big-time savings from benefit mandates. I submit to you they will not realize themselves. They are looking for big-time savings from pooling together. That could work if you pool together. But why would you want to pool together at a national level when you really want to pool together at the local level?

What I have learned over these years, and our center has made clear, all health care markets are local. Kind of like politics, if I remember from Massachusetts. All health care markets are local.

So the idea of pooling together, for example, just for purchasing power, it does not do you any good to have 1 percent of the national population, all the docs you want to treat small businesses are where small business workers live. So you need the pool to be local.

What you need, therefore, is a way to get these pools to work together. The flaw in the small group market from the small business's perspective is they are not adequately pooled. They are not pooled together enough so that they have the same stability the large groups have.

Chair SNOWE. Why is that? Like Wal-Mart. Wal-Mart was cited as an example, the largest retailer in the world. Now why is that any different than the large pool of small businesses?

Mr. NICHOLS. The Commissioner may be able to speak more definitely here, but I would just opine from the economist point of view, the issue is that people make money segmenting risk. It is much more efficient to sell insurance if you can sell the cheap policy to the healthy, the middle-sized policy to the middle risk, and very expensive policies to high risk. That is how you make money.

Chair SNOWE. But why are you saying that, because they cannot make the selection. So that is what I am curious about, why you are saying that. Because they are obviously prohibited in this legislation from denying access. They just cannot go around selecting based on health status. So why are you saying that?

Mr. NICHOLS. Let us go back and think about it. I think you are right that the intent of the legislation is to have open access. At least my concern is on the part where it says you have to be a member of the association, and the association has to have existed for 3 years. What if you happen to be a business that was not offering now? You could not offer now because the rates you are quoted are very high, just like you just described. You want to join a new association. Well, the new association cannot qualify, it has got to be 3 years old. You are not a member now.

So the question is: Can we put in the legislation rules that say new members can join and all members can have access to the pool just like an insurer is selling in a guaranteed issue environment has to take all comers? If you do that and you make it a true level playing field, then indeed there should not be near the risk selection problems.

Chair SNOWE. We have specific prohibitions. I always believe in looking at the legislative language because oftentimes we all talk rhetorically and one looks at it. I always ask the question did anybody read the bill? Because generally, that is overlooked in the process—oh by the way. So that is what I am interested in trying to resolve and I obviously cannot do it all here today.

It says "prohibition of discrimination against employers and employees eligible to participate." Then, of course, "under the terms of the plan all employees meeting the preceding requirements of this section are eligible to qualify as participating employers for all geographically available coverage options."

Obviously it would come under HIPAA, the Health Insurance Portability and Accountability Act. It would prevent or prohibit adverse selection. So that is not enough, it is not sufficient language?

Ms. LICHTMAN. Can I attempt an answer? I am going to call upon my colleague, Alice, if I do not amplify this as well as I intend.

The very language that you cite I had open here, so thank God I had read the right thing, and Alice had the right bill.

That language sounds good. It does not prohibit insurers from deciding what is geographically available. So in the first instance it could decide that some health standards are not geographically available.

Two, you have to read this with HIPAA. HIPAA prohibits discrimination against individuals, not groups. This piece of legislation defines a group as one person. So you could get around the antidiscrimination provisions in HIPAA by having an individual be a group in an AHP. What therefore AHPs would be allowed to do it is set rates geographically. They could target certain industries where people are healthier or not healthy. It would allow them to design benefit packages which is why you hear us say that we think this AHP language allows cherry-picking, and you say, "How can it allow cherry-picking?" I am reading right here, it does not allow that.

It is because HIPAA only protects individuals and this AHP language is pretty clear that a group could be a group of one person. That gets them out from under——

Chair SNOWE. That would be easily resolved, would it not? I mean, adjusting the language, I do not think that is obviously the intent of anyone regarding the legislation. Obviously, the intent is pretty clear. So it obviously could be adjusted in that sense if, in fact, that is a true interpretation of this legislative language. Lawyers have different opinions on this subject. I thought I would bring that up.

Ms. LICHTMAN. I was just going to say I am not an economist, but when anybody ever says I am not a lawyer I always get very nervous. I am not an economist, but I want to say something.

There are no cheap fixes, and I think that is what my economist and my insurance colleague is saying, that DOL's own guidance to

small employers says if it is cheap, you better worry about it. I think what we are saying is these problems are so complex, crying out to be fixed, but if indeed this legislation is going to allow fixes that do not cost very much money it is not going to do what it sets out to do.

The cherry-picking/discrimination part is one part, I think, of a larger constellation of problems that this sets out. Certainly we are terribly worried about the consumer fraud and the protections against solvency and God knows, lawyer that I am, I ought not to talk about that.

Chair SNOWE. I know that the Secretary has the flexibility under this legislation to adjust the solvency standards depending on the requirements. I mean, above the $2 million. There would be a rulemaking procedure here, as well, in governing this legislation. So many of those issues could be addressed. I am just saying it has a ways to go in the process even if it became law.

The issue that I am saying is this is an option for small business, so what is the downside in allowing them to have access to this option for coverage?

Ms. PRAEGER. Associations must take all members according to the legislation that is proposed and I agree with that. But they can rate-base on anything other than claims experience and the type of industry.

So I get back to this destabilizing. The problem for the small group is that if a group can get a better rate, they will prove to the AHP. As their rates go up because of their health status and other rating factors that are allowed, then they will move back as is required by HIPAA into our small group market and we have to take them back.

So I just think there is an incredibly destabilizing effect from the way it is currently crafted. I think putting additional solvency requirements is important, but again, if an AHP goes belly up, who pays the unpaid claims that are out there? Those are going to be costs that are shifted to other—

Chair SNOWE. Do you not agree small businesses are being treated differently though, from large businesses and other organizations that are allowed to be self-insured so they are exempt from State mandates?

I think this is another dimension to this question, Why should Small Business not have the same options as a large company?

Mr. NICHOLS. Could I just jump in? I would just say in general you are asking a very good question. Can legislation be written that would be a wise addition to the small group option? The answer is surely yes. What I have heard today is sincerity on the part of you and a number of Members that could make this happen.

The question, though, is can you do something that would not add to a risk? The first do not harm kind of thing. The danger about allowing an option that was differential in its treatment of small business than existing markets is that it could skew the thing even worse than it is now.

Yes, it seems like many of the features of the current legislation would provide options that large firms and union plans have. But at the same time you have to remember a fundamental difference in this kind of group and General Motors, as was invoked a num-

ber of times. When General Motors decides to self-insure, they insure all of their workers worldwide. When association health plans decide to self-insure, they insure a whole agglomeration of little bitty groups. Each little bitty group is always going to look for its own interest, and its own interest is going to find the cheapest way it can do it. That is what we want them to do. That is the way markets work.

Therefore you want to have the playing field level and not skewed. If one sector can offer products that do not have the benefit mandates, and Lord knows there are benefit mandates that I would not have voted for and I am sure you would not have either. Some of those should be repealed tomorrow afternoon. But that is something for the States to work out, it seems to me, in conjunction with there full range of options.

Ms. LICHTMAN. I want to say something about the enforcement point. You and I have worked together on civil rights enforcement, protecting discrimination against women, for instance, for more years than either one of us are going to count. You know better than I the debate that is raging right this second while we are sitting here about the failure of the Federal Government to enforce Title IX.

So I am ascribing the best good will to Secretary Chao. But I am saying to you unless there are very, very strong enforcement provisions in this legislation and real commitments for appropriations and authorizations, I do not see where that is coming from when we have State enforcement mechanisms in place that work. You cannot switch from something that works in many places to a promise or to a belief in somebody's goodwill because we know that those are temporarily.

Chair SNOWE. The last point.

Ms. PRAEGER. I think it is important, too, and Len made the point, that health care costs are going up. Our State employees health plan is the largest purchaser in the State. We are over 80,000 employees and dependents, and we are seeing premium increases anywhere from 20 to 35 percent.

So we have a real problem in this country with health care costs escalating and its being felt most particularly in the small group market.

I applaud your efforts in trying to address the problem but I guess I just am concerned that we do not just create another problem in the process.

Chair SNOWE. I am sure that we will be discussing this issue in the days ahead. I would also recommend, if you have any suggested language, I certainly would be interested in seeing it. Because I think that would also be helpful to this discussion, as well.

Obviously, this legislation has been around for the better part of a decade. So I think the question is whether or not we can move it through this process in addressing some of the issues that you have raised today.

I think undeniably there is a crisis in this market for working uninsured. I would like to be able to do what I can to advance this effort in Congress.

I would appreciate your suggestions on this issue and see if we can work through some of these issues. If you have some sugges-

tions for legislative language that you think would be helpful, I certainly would like to look at them.

I do not see AHPs as mutually exclusive from other options in addressing the uninsured. I think the question is whether or not this could be one of many tools in the toolbox to help address this issue.

I appreciate your thoughts and input here today. It has been very helpful and insightful.

Thank you. The hearing is adjourned.

[Whereupon, at 1:35 p.m., the Committee was adjourned.]

# POST HEARING QUESTIONS

**Post-Hearing Questions**
**Committee on Small Business and Entrepreneurship**
**to**
**Harry Alford, President and Chief Executive Officer,**
**National Black Chamber of Commerce**

**"The Small Business Health Care Crisis: Possible Solutions"**
**February 5, 2003**

**Questions submitted by Senator John Kerry, Ranking Member:**

1. What do you see as the major advantages of group purchasing arrangements for small employers?

   ANSWER: The two major advantages are access and affordability (for employer). The fact that there are competitive choices and that they are in the world of reality, via cost, can greatly improve the amount of insured families and individuals in the nation.

2. What are the major downsides of AHPs as proposed in last year's bill (S.858/ H.R.1774)? Will the new legislation that has just been introduced address these concerns? If so, please describe how.

   ANSWER: The NBCC did not evaluate or consider the past legislation.

3. If AHP legislation were enacted, does your organization have plans to form an AHP? If so, how many members are likely to be insured under your AHP, how many plans would you likely offer with how broad a range of benefits and premiums, and would you charge a fee to participate in the AHP? If you do not plan to form an AHP, why not, and is there another organization with which your trade association might pool to provide health insurance for your members?

   ANSWER: The NBCC has a reach of 95,000 Black owned businesses which is 10% of the total. We would pool our members with another organization to increase the pool and lower the risks and costs. Two organizations that would certainly be considered in our joining would be the US Chamber of Commerce and NFIB.

**Answers to Post-Hearing Questions**
**Committee on Small Business and Entrepreneurship**
**to**
**The Honorable Hector V. Barreto, Administrator,**
**U.S. Small Business Administration**

**"The Small Business Health Care Crisis: Possible Solutions"**
**February 5, 2003**

***Questions submitted by Senator John Kerry, Ranking Member:***

1. **In your testimony submitted for the record, you cite a survey finding, confirmed through your own extensive travels, that the "cost and availability of affordable health insurance continues to be the biggest problem facing small businesses." You note the problems of MEWAs and state that once Congress passes AHPs, under your leadership SBA will engage to connect small businesses. Does SBA coordinate education currently with the Department of Labor? With the Agency's contact with more than a million small businesses every year through its website and partners, what can SBA do immediately to inform small businesses about the issues involved with health care?**

Answer: SBA does not currently coordinate education efforts on Association Health Plans (AHPs) with the Department of Labor (DOL). SBA does however regularly coordinates with numerous federal agencies on issues of importance to small businesses and looks forward to working with DOL on connecting small businesses with AHPs were Congress to pass the appropriate legislation. SBA can continue to inform small businesses of issues involved in health care through its existing outreach infrastructure and will continue to receive feedback from small businesses about the staggering costs they face through, among other means, business roundtables regularly hosted throughout the country by SBA's Office of the National Ombudsman.

2. **In your testimony, you said that "as the head of an association, insurance companies constantly told [you] that they could not provide coverage to [your] members because, despite having thousands of members, [the association was] simply not big enough. [Your] pool of employers was too small." What association were you referring to and how many members were there?**

Answer: The association to which I referred in my testimony was the Latin Business Association in Los Angeles, for which I served as Chairman of the Board. It currently has more than 1,150 active members.

3. **Who conducted and what is the title of the study you cite in your written testimony regarding the disproportionate increase in premiums for small and**

**large companies? What did the study identify as the reason(s) for the difference?**

Answer: DOL wrote the study, "Association Health Plans: Improving Access to Affordable Quality Health Care for Small Business," to which I referred on page two of my written testimony regarding the disproportionate increase in premiums for small and large companies. The study cites several reasons for this disparity: higher administrative expenses, lesser buying power and disproportionate impact of state mandates on small businesses.

4. **In your testimony, you note that Hispanics are the least-insured ethnic group in the U.S. and that coverage is worst among smaller firms, firms headed by Hispanic executives with little or no education, and small businesses more likely to employ Hispanic labor. You also state that enhancing AHPs will level the playing field for small businesses and that AHPs will allow small businesses to have access to the same quality of health care across state lines. Mr. Administrator, do you believe that an AHP formed by the U.S. Hispanic Chamber of Commerce or Women Impacting Public Policy would be able to offer the same quality of benefits for the same price as an AHP formed by the U.S. Chamber of Commerce or the National Federation of Independent Businesses? Please describe the assumptions upon which your response is based.**

Answer: Strengthening AHPs will provide greater access to quality, affordable health care for all of those associations you cited above. Each individual association will have the ability to tailor coverage options for its members, allowing the U.S. Hispanic Chamber of Commerce to provide the highest quality health care possible under strengthened AHPs. I base this response on research about AHPs conducted by various private and public-sector sources, including the DOL study I referenced earlier as well as a report, "Study of the Administrative Costs and Actuarial Values of Small Health Plans," recently released by the SBA's Office of Advocacy.

5. **In anticipation of enactment of AHP legislation, what staff and funding in the FY2004 budget has the Administration requested for projected efforts to connect small businesses and educate them?**

Answer: President Bush has not requested funding for SBA in its FY 2004 budget specific for educating small businesses about the many benefits of AHPs were Congress to pass legislation strengthening them. SBA would educate small businesses about AHPs through its outreach infrastructure already in place for educating small businesses about its myriad of programs. This infrastructure includes its website, district offices and lending partners.

**Answers submitted to Senator John Kerry, Ranking Member**
**From Jack Faris, President, National Federation of Independent Business**

1. **What do you see as the major advantages of group purchasing arrangements for small employers?**

   - AHPs will provide small businesses the opportunity to band together through bona fide trade and professional associations to purchase affordable health benefits. By joining together, small employers will enjoy greater bargaining power, economies of scale, and administrative efficiencies. In this way, AHPs will level the playing field and give participating small employers the same advantages as Fortune 500 companies and unions.

   - AHPs will introduce more competition and choice into the health insurance marketplace. Small businesses have little buying power and few affordable options – five or fewer insurers control at least three quarters of the small group market in most states (GAO, 2002). This lack of competition is contributing to double-digit rate increases for many small businesses and a resulting rise in the number of small business employees who are uninsured.

   - Uniform federal regulation of AHPs will help small businesses lower their administrative costs because, by operating under federal law, AHPs can avoid the costs of complying with 50 different sets of state benefit mandates. In addition, AHPs that are operating on a national level will have greater bargaining power with insurers.

   - AHPs will make health insurance more affordable for small business through reduced premiums. The Congressional Budget Office (CBO) has estimated that small businesses obtaining insurance through AHPs will experience premium reductions of 13% on average and up to 25% (CBO, January 2000). That's about $450 to $1250 saved per covered employee. Some companies might save enough on their insurance premiums to offset the increase in wages for their lowest-paid employees.

2. **What are the major downsides of AHPs as proposed in last year's bill (S. 858/H.R. 1774)? Will the new legislation that has just been introduced address these concerns? If so, please describe how.**

   We do not see any downsides of AHPs as proposed in last year's bill. In fact, since the AHP concept was first introduced in legislation in 1995, we have worked very hard to accommodate the concerns of the legislation's critics.

Among the changes that have been made to the bill:

- Stronger solvency requirements were added to ensure that participants would always have their claims paid. State enforcement provisions were also strengthened to make it clear that states would have the authority to certify and enforce all substantive requirements of AHPs. The bill also clarifies that State regulators will be entitled to collect the required initial certification fee and all annual assessments, as well as impose the equivalent of their own "premium taxes" against AHPs, thus assuring they will have the resources necessary to enforce the bill's requirements.

- The legislation makes clear that AHPs are subject to all the preexisting condition, portability, nondiscrimination, special enrollment and renewability provisions under HIPAA. In no way will AHPs be able to "cherry pick" good risks.

- The legislation makes clear that AHPs are not just another name of Multiple Employer Welfare Arrangements (MEWAs). Federal consumer protections would exist for AHPs, unlike MEWAs. Those protections include strong solvency standards, including stop-loss and indemnification insurance, and strengthened sanctions, including criminal penalties, for violation of AHP standards.

3. **If AHP legislation were enacted, does your organization have plans to form an AHP? If so, how many members are likely to be insured under your AHP, how many plans would you likely offer with how board a range of premiums and would you charge a fee to participate in the AHP? If you do not plan to form and AHP, why not, and is there another organization with which your trade association might pool to provide health insurance for your member?**

At this point, NFIB is seriously considering forming an Association Health Plan if this legislation is enacted into law. The final decision would depend upon not only the how the law is written but also the rulemaking issued by the Department of Labor to implement the law.

NFIB serves more than 600,000 companies annually. With an average employee size of six and using an average dependent-to-employee ratio of 2.1, NFIB member companies represent approximately 7.6 million Americans. Today, only 61percent of all NFIB members offer health insurance as an employer-sponsored benefit. Until we know how the product will be priced it is impossible to predict what the market share for an AHP product might be.

We envision several types of plan designs with plan options for each. For example, the combined AHP offering might include a preferred provider organization major medical product, a medical savings account; a guaranteed issue limited medical policy and a health reimbursement account. This would allow for a range of premiums. Given NFIB's diverse membership, a range of options will be necessary.

4. **According to your web site, NFIB already offers health plans to its members. Regarding these current insurance plans:**

- **In how many states does NFIB currently offer health insurance to its membership? Why does NFIB believe AHPs are necessary if it can offer coverage now in so many states?**

NFIB currently offers the following health insurance products by state:
**Group Medical and MSAs-**
All States except:
AL, AK, CO, CT, FL, HI, KY, MA, MD, ME, NH, NJ, NY, OR, RI, UT, VT& WA
(MSA not available in ND and CA)
**Individual Medical** – All States except:
HI, ME, MA, NY, NJ, RI, VT, & WA
**Short-Term Medical** – All States except:
AK, HI, NY, NJ, & VT

NFIB's partner for these products is Fortis, Inc., which uses the J.L. Barnes Group as a broker and third party administrator. Fortis estimates they have had to file more than 1,000 plans to get this coverage. Due to the nature of the fully insured health marketplace each state has different requirements for plan design, reserves and distribution. AHPs are necessary in order to allow a carrier to offer insurance coverage to small businesses nationally without having to file and maintain more than 1,000 different products. The administrative costs alone are astronomical and Fortis still does not have products in every state. AHPs will provide the increased bargaining power to allow us to offer better and more diverse products to our membership.

- **For the products you now offer, can the premiums vary between your member employers based on the health status of their workers? For example, if one firm employed a woman with breast cancer, would that firm be charged more than a comparable sized firm in the same geographic area that did not have an employee with a life-threatening illness? Would the answers to these questions be different under the proposed AHP legislation? If so, please describe the differences.**

Any health plans that we offer follow HIPAA guidelines under which it is illegal to deny coverage based on the health status or claims experience of an individual or employees. The products we offer currently must also follow applicable state laws, including state health care mandates. Under an AHP regime, they would be subject to all the preexisting conditions, portability, nondiscrimination, special enrollment and renewability provisions under HIPAA. AHPs would also be subject to solvency standards, plan requirements and patient protections that in some cases would be more stringent that those required in many states.

- **Does NFIB currently offer insurance with Fortune 500-style benefits-as it has been suggested AHPs might provide-or is your emphasis on more basic plans such as medical savings accounts and high deductible plans?**

Current law prevents NFIB from offering Fortune 500-style benefits enjoyed by large unions and corporations to our membership. We are asking Congress to enact AHP legislation so our members will enjoy the same stability, uniformity and lower costs for health coverage. Please remember that small employers are having trouble competing for skilled men and women with medium to large companies that can offer generous health insurance and benefit packages. AHPs will offer our members competition and choice in small group markets where often only one insurance carrier currently exists.

**Post-Hearing Questions**
**Committee on Small Business and Entrepreneurship**
**to**
**Kathie M. Leonard, President, Auburn Manufacturing**

**"The Small Business Health Care Crisis: Possible Solutions"**
**February 5, 2003**

**Questions submitted by Senator Olympia J. Snowe, Chair:**

1. Please elaborate on your decision to self-insure – tell us why this was advantageous and why it's not currently an option for all small businesses. Has it saved your company money on its insurance costs?

**ANSWER:**

We decided to switch from a traditional health insurance plan to a self-insured plan in 2001 for economic reasons. Anthem Insurance had recently bought Blue Cross/Blue Shield of Maine, and at renewal time in mid-2001, we were informed that premiums for our existing plan would increase by 60%, or about $100,000/year. Even if we reduced the benefit levels, the best we could expect was a 44% increase. Aetna quoted us an increase of 38%.

The plan that we chose to replace our Anthem HMO was a self-insured Preferred Provider Plan. While the increase was still 38%, this plan offered us the chance to enjoy a credit on future increases if our employees stayed healthy. At renewal time in the summer of 2002, the increase for the same plan would have been about 15%. Although still high, this increase was somewhat less than the 22% average we had been experiencing over the previous 10 years. After some discussion with employees, we opted to raise the deductible to $250, which reduced the increase to about 9%, or about $20,000/year. Had we stayed with a traditional plan, it is likely that these increases would have been twice as high as those we experienced last year.

2. You mentioned that your company is self insured. Please describe the benefits that you provide for your employees under this plan. If there are more than one plan, please describe them in terms of the benefits they offer. In addition, please compare the benefits that your plan(s) offers with those that the State of Maine mandates fully insured plans to offer.

**ANSWER:**

Coverage differences between our old HMO and our new PPO plan are as follows. When not stated, the New PPO pays 90% of in-network charges and 70% out-of-network charges.

| | OLD HMO | NEW PPO |
|---|---|---|
| Office Visits | 100% | $20 Co-Pay |
| Coinsurance | None | In Network 90%<br>Non-Network 70% |
| Deductible | None | $250 Network (now)<br>$2000 Non-network/family |
| Inpatient Hospital | $250 per day/$2,000 per yr | 90%, $250 Per confinement Deductible in-network<br>70%, $500 per confinement deductible non-network |
| Preventive Care | Same as above | In-Network only $20 Copay |
| Lifetime Maximum | Unlimited | $2 million |
| Emergency Room | $25 Copay | $50 Copay |
| Outpatient Surgery | 100% after $100 deductible | 90/70% In & non-network, both with $250 per confinement deductible |
| Prescription Drugs | 3 Tiers $10/$20/$30 | Three Tiers $10/$20/$30<br>Oral Contraceptives Included |
| Lab & X-Rays | 100% | 90/70% In & Non-network |
| Inpatient Mental Hlth & Chem Dep | Listed 100% after $250 per day Copay<br>Unlisted: 80% up to 31 Days/member/year<br>Substance abuse: 90%<br>Up to 31 days per member/ Calendar year | 90/70% 10 days max/yr;<br>20 days max/lifetime |
| Outpatient Mental | $20 Copay | $35 Copay 20 visits/yr |
| Spinal Adjustments | 100% of 36 visits/yr | 90/70% $500/year max. |

| | | |
|---|---|---|
| Routine Eye Exams | 1 exam/year | Not covered |
| Home Health Care | 100% | 1 visit/day up to 100/year |
| Durable Med Equip | 100% up to $2,000/member Per year | $10,000 max/lifetime |
| Skilled Nursing | 100% up to 100 days/year | 90/70% In and non-network Up to 100 days/year |
| Well Newborn | 100% | 90/70% In and non-network First 7 days of life |
| Well Child Care | 100% | Includes immunizations 8 Days to 2 years |
| Well Woman | Not stated | 1 per calendar year |

Although this list of benefits is not complete, we chose these major items to demonstrate the differences in coverage between the former HMO plan, with all the Maine mandated benefits and community rating requirements and the self-insured PPO plan we now offer our employees. While the present plan is not as generous as the previous plan, our premiums are still almost 50% greater than what we were paying through mid-2001. The old plan was impossible to maintain, while the present plan, at $1,000 more in annual premiums per employee, is bearly affordable. Therefore, it is clear that even self-insuring does not solve the problem of skyrocketing healthcare costs, but only somewhat lessens the serious financial impact on our business and our employees' financial and physical well being.

Submitted by Kathie M. Leonard
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**Post-Hearing Questions**
**Committee on Small Business and Entrepreneurship**
**From**
**Judith L. Lichtman, President**
**National Partnership for Women & Families**

**"The Small Business Health Care Crisis: Possible Solutions"**
**February 5, 2003**

**Questions submitted by Senator Olympia J. Snowe, Chair:**

***1. If your group is a voice for women and families, and you think AHPs will cause an erosion of the mandated benefits, how do you explain a group like Women Impacting Public Policy with 300,000 members supporting AHPs?***

The views of advocacy organizations representing similar constituencies can often differ on policy solutions, based on each organization's individual analysis of possible costs and benefits of proposals to the constituencies they serve. This appears to be the case with the National Partnership and Women Impacting Public Policy (WIPP), although it may be worth noting that WIPP does not exclusively represent the interests of women business owners, according to its own testimony. Another example of this phenomena occurred at the hearing among organizations representing small businesses, which were also divided on the soundness of the AHP proposal, with the National Federation of Independent Business testifying in support and National Small Business United testifying in opposition.

Despite the disagreement between the National Partnership and WIPP regarding the solution to the problems discussed at the hearing, it is important that both organizations agree about the scope of the problem and its impact for women and families. Both organizations recognize that small businesses' lack of meaningful access to health insurance disproportionately impacts women small business owners and the women who work for them. The Partnership's own research, discussed in our testimony, underscored the risks many women working for small and low-wage firms face, as it found that the more women a low-wage firm employs, the less likely all workers are to be offered health coverage. This is clearly a problem that warrants a responsible solution – we hope to work with you to develop a solution that the Partnership can support.

**Questions submitted by Senator John Kerry, Ranking Member:**

***1. Opponents of AHPs say that they would "cherry pick" healthy risks, but the bill appears to include HIPAA nondiscrimination protections, along with other language prohibiting AHPs from discriminating or excluding individuals based on health status. Can you please explain why these protections are not enough to keep the AHP from selecting only healthy individuals?***

The HIPAA nondiscrimination protections and the other provisions preventing AHPs from discriminating based on health status are important, but even the protections in the most recently introduced version of the AHP proposal, H.R. 660, do not ensure the AHP will be barred from discriminating or deterring enrollment based on the likely health needs of small business groups.

While H.R. 660 would subject AHPs to HIPAA's nondiscrimination protections under section 702 of the Employee Retirement Income Security Act of 1974 (ERISA),[1] it is important to note that HIPAA's protections are limited. HIPAA protects *individuals* from being excluded from group health coverage or charged a higher premium based on a "health status-related factor," which is defined in the statute to include an individual's (or their dependent's): health status; medical condition (including both physical and mental illnesses); claims experience; receipt of health care; medical history; genetic information; evidence of insurability (including conditions arising out of acts of domestic violence); and disability.[2] However, the existing statutory protections provide no limits on insurers' ability to discriminate against, or charge higher premiums for, entire *employer groups* based on health status. Thus, in order to ensure small groups applying for coverage with the AHP adequate protection against being charged more based on the health status of the group, the legislation would need to make all of HIPAA's protections apply to the entire group, not just individuals in the group.

Although H.R. 660 includes improved language protecting employer groups against some discrimination based on health status, unfortunately the proposal still falls short in protecting against pricing discrimination that could lead to "cherry picking". H.R. 660 would bar AHPs from charging different contribution rates based on "health status-related factors," as defined under HIPAA, or based on the type of business or industry in which the employer is engaged.[3] However, the bill also includes a significant loophole, allowing AHPs and insurers offering coverage for AHPs to set contribution rates based on the employer group's claims experience or to vary rates to the same extent that state law allows existing associations to do so.[4] This loophole effectively undermines the other protections because AHPs could charge groups higher rates based on the group's past claims history (often a proxy for health status) or based on current usage of services. In fact, there is nothing in the legislation or existing law that would limit an AHP from charging higher rates as soon as anyone in the employer group makes

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[1] H.R. 660 § 2(a) (creating new ERISA section 804(d)(3)), page 15, line 4.
[2] 29 U.S.C.A. § 1172(a)(1).
[3] H.R. 660 § 2(a) (creating new ERISA section 805(a)(2)(A)), page 16, line 5.
[4] H.R. 660 § 2(a) (creating new ERISA section 805(a)(2)(B)), page, 16, line 12.

a claim, which would make the health status discrimination protections meaningless – AHPs might have to charge all groups the same at the outset, but if an AHP could increase the cost of coverage as soon as services were used, then the effect is discriminatory against the least healthy groups. In this way, AHPs' ability to charge higher rates based on past or current health status would allow them to effectively deter less healthy groups from enrolling or continuing coverage under the AHP.

And, as my testimony identified, this rating practice is only one of several ways the legislation would permit AHPs to "cherry pick" healthy individuals while leaving behind those most in need. This is still true under the most recently introduced version of AHP legislation introduced in the House in February of this year, H.R. 660. Under H.R. 660, AHPs could encourage only healthy individuals to enroll through benefit design, by excluding or limiting coverage for prescription drugs, access to specialists, mental health, or maternity benefits, for example.[5] H.R. 660 also permits AHPs to limit enrollment in the most generous coverage option based on "geographic availability" of the plan, thereby deterring less healthy groups from enrolling by denying them access to more comprehensive coverage.[6] And H.R. 660 permits AHPs with at least one self-insured coverage option to choose to offer coverage at the outset only to certain types of businesses or industries that may have lower health risk than others, despite the bill's stated prohibition against discrimination based on type of business or industry.[7] These options, combined with the rating practices described above, create opportunities and incentives for AHPs to try to game the system by providing coverage only to the healthiest individuals.

***2. Your testimony asserted that the Department of Labor has neither the resources nor the experience to oversee their new responsibilities for AHPs, but as Secretary Chao testified, DOL now has authority for regulating self-insured group health plans for about 67 million American workers and dependents. Does this experience and expertise make the Department qualified to take on the direct oversight of AHPs? If not, why not? What additional expertise would be required?***

Despite the Department of Labor's (DOL) exclusive authority to regulate coverage for the 67 million individuals in self-insured employer-sponsored health plans, DOL is not now qualified to take on the additional responsibilities that the AHP legislation would impose. DOL's current oversight of these plans under ERISA is fairly minimal and does not require DOL to directly monitor plans for compliance. For example, ERISA includes no standards for health plan solvency, nor does it require health plans to report to DOL on their solvency or require DOL to perform an independent financial audit to ensure that self-insured plans can bear the financial risk they are undertaking. With respect to ERISA's other requirements relating to information disclosure, fiduciary rules, claims and appeals requirements, portability and

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[5] AHPs would have full discretion over benefit design, except to the extent that they offered an insured product in a state with benefit mandates that applied. H.R. 660 § 2(a) (creating new ERISA section 805(b)), page 18, line 11.

[6] H.R. 660 § 2(a) (creating new ERISA section 804(d)(1)), page 14, line 17.

[7] H.R. 660 § 2(a) (creating new ERISA section 802(f)(3)), page 6, line 20.

non-discrimination, and other narrow benefit mandates, DOL's enforcement policy has historically been driven by responding to complaints, with few targeted initiatives to ensure compliance.

DOL's recent Compliance Project Report, in which DOL audited group health plans' compliance by randomly selecting 1,267 plans for conformity with newer HIPAA-related requirements under ERISA, is an important step towards improving their enforcement efforts, but it also highlights the problems that consumers could face if DOL were given increased responsibilities to regulate AHPs.[8] First, DOL's Compliance Report relied 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.[9] According to DOL's own testimony in 1997, it simply does not have the resources to directly oversee the plans it now regulates – in that testimony, DOL estimated that a complete audit of every pension and health plan it regulated would take 300 years. Unfortunately, neither H.R. 660 nor the Bush Administration FY 04 budget contemplate providing the new resources DOL would need in order to undertake these new responsibilities effectively.

In order for DOL to responsibly and appropriately undertake its new responsibilities under H.R. 660 in a way that would ensure continued consumer protection comparable to that the states now provide under current law, it would need significant new resources and authority. First, it would need sufficient resources to add thousands of new investigators and other staff – the Employee Benefits Standards Administration (EBSA), the DOL agency charged with administering ERISA, will have a total of 930 people on staff nationwide in FY 04 under the President's budget request; that is less than one-tenth of the staff now employed by state insurance departments around the country to monitor insurers' compliance with state regulations. Federal staff would have to be increased substantially, and adequately trained, to ensure comparable protection. Second, DOL would need increased authority to directly monitor AHPs' compliance with new federal standards. In many cases, H.R. 660 grants permissive rulemaking authority, but fails to include adequate enforcement requirements and penalties DOL could seek in cases of non-compliance. Under current law, DOL has authority to directly enforce statutory and regulatory requirements, but penalties for noncompliance are often minimal in the health plan arena, leaving DOL without sufficient means to ensure compliance. Improved penalties and more direct oversight of AHPs' compliance is needed to make any new federal standards effective.

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[8] *See* Health Disclosure and Claims Issues: Fiscal Year 2001 Compliance Report, U.S. Department of Labor Pension and Welfare Benefits Administration, January 2003.

[9] Random selection and auditing are clearly important social science polling techniques to ascertain public opinion or track general trends, but they have no place as mechanisms for law enforcement.

***3. ERISA now has a number of substantive protections and benefit mandates applicable to all employer-sponsored plans. Are these comparable to the state regulations that the federal regulation will replace under the AHP bill? What are the major differences?***

ERISA does have a number of important requirements which provide a critical floor of protections for consumers in employer-sponsored health plan, but in most cases these protections are less stringent than the state protections that the AHP proposals like H.R. 660 would preempt. For example, ERISA requires all health plans to provide fair and timely decisions and allow for internal appeals of health plan denials of benefit claims. By contrast, all states also require insurers to provide internal decisions and appeals, but 43 states also require plans to allow individuals to seek an independent external review of a health plan denial. With respect to benefit mandates, ERISA now requires private employer-sponsored health plans to comply with certain requirements relating to mental health benefits, hospital stays for newborns and mothers following delivery, and breast reconstruction following mastectomies, but all of these so-called mandates only apply conditionally (i.e., they only apply if a health plan chooses to cover a related benefit). By contrast, state benefit mandates are more varied, addressing both access to needed services and providers, and many require all licensed insurers in the state to offer coverage for that service or benefit without conditions. Thus, the general differences between ERISA and state protections are the scope of the protections now in place under state law and the extent to which all insurers have to comply without exception.

**Terry Neese**
*President*

**Barbara Kasoff**
*Vice President*

**International Coalition Partner**

EuroAmerican Women's Council

**Europe – Greece**

**Coalition Partners**

Black Women Enterprises

Boardroom Bound

Business Women's Network

Catalina Magazine

Enterprising Women

Hispanics Impacting Public Policy

Kansas City Women Business Council

Lighthouse of Oakland County, Inc.

National Association of Female Executives

National Association of Small and Disadvantaged Businesses

National Association of Women Business Owners

National Business Association

National Indian Business Association

Native American Women Business Council

Policy and Taxation Group

San Francisco Small Business Network

Small Business Survival Committee

Women Construction Owners & Executives

Women Inc.

Women Entrepreneurs, Inc.

Women Involved-SouthEast

Women Presidents' Organization

**Post-Hearing Questions**
**Committee on Small Business and Entrepreneurship**
**to**
**Terry Neese, President and Co-Founder,**
**Women Impacting Public Policy**

**"The Small Business Health Care Crisis: Possible Solutions"**
**February 5, 2003**

**Questions submitted by Senator John Kerry, Ranking Member:**

1. What do you see as the major advantages of group purchasing arrangements for small employers?

RESPONSE: Small businesses simply do not have affordable nor reliable access to health insurance for their employees. A small business is not in the position to demand neither reasonable rates nor coverage from insurance carriers. If allowed to purchase as a large group, which AHPs would allow, affordable rates and adequate coverage can be negotiated on behalf of the small businesses participating in the group.

2. What are the major downsides of AHPs as proposed in last year's bill (S.858/ H.R.1774)? Will the new legislation that has just been introduced address these concerns? If so, please describe.

RESPONSE: WIPP does not feel that there are any downsides to the legislation. Our only regret is that it cannot offer a comprehensive fix for the larger health care issues that affect 41 million Americans who are currently uninsured. Formation of AHPS will go a long way toward insuring an estimated 8 million workers who are currently without health insurance.

3. If AHP legislation were enacted, does your organization have plans to form an AHP? If so, how many members are likely to be insured under your AHP, how many plans would you likely offer with how broad a range of benefits and premiums, and would you charge a fee to participate in the AHP? If you do not plan to form an AHP, why not, and is there another organization with which your trade association might pool to provide health insurance for your members?

RESPONSE: Under the safeguards contained in the legislation, an association has to be in existence for 3 years before it can offer insurance through an AHP. WIPP would not be eligible since it has only been in existence for two years.

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Len M. Nichols, Vice President, Center for Studying Health System Change
Responses to follow-up questions from Senate Small Business Committee members

From Senator Kerry:

1. What do you see as the major advantages of group purchasing arrangements for small employers?

*Group purchasing advantages derive from different kinds of economies of scale.*

***Purchasing and administering economies within the firm.*** *Large firms can spread the cost of a benefits manager or department over many workers, so the per worker cost of this crucial information gathering, processing and dissemination unit is small. Small employers, even if they can afford a benefits manager, would have a much higher cost per worker for these functions. Most small businesses cannot afford to hire a person to specialize in this, and so the only alternative is for the owner or general manager to add these functions to an already long list of duties. Since health insurance is a complicated product, it requires considerable time investment for the person selecting options and explaining them to employees, and many small business owners are deterred by these requirements.*

*In addition, large firms can often bargain with local providers (all health care markets are local) more effectively than small insurers, though large insurers typically can bargain the best of all. Large insurers also function as third party administrators for large self-insured employers but bargain on the basis of their own covered (insured) lives PLUS the self-insured lives whose plans they administer. The general point is, bargaining power vis a vis providers is also a matter of scale.*

***Selling economies of the insurer.*** *Selling costs are largely fixed in that they do not vary with the number of employees. Making a sale to a firm with 10,000 workers then costs less -- per worker -- than making a sale to a firm with 10 employees. These selling costs must be recouped in the premium. Broker commission rates are also higher for smaller groups, else no one would ever sell it, and ultimately this too flows back into insurer premium levels, for insurers pay the brokers.*

***Risk pool stability.*** *The larger the pool, the lower the variance of expected medical claims costs (the statistical law of large numbers is a good friend of large groups). It is theoretically possible for insurers to "make" a large group out of many small employers and for that risk pool to therefore be stable over time, but in practice small firms drop and add coverage at much higher rates than large firms, so that no pool formed exclusively among small groups can be as stable as a large firm or state employee pool. In practice as well, at least above a certain minimum size, most insurers price their products with two components, one based on the firm's own claims experience and one based on the pooled group's experience, so that even a*

*one-time shock to one employee's health costs – a single heart attack and attendant surgery or cancer therapy – can significantly affect a small firm's premium for years, even relative to premiums of otherwise similar small groups. This is why premium variance is higher for small firms than large. [see the references cited in my written testimony on this point in footnote 7].*

***Sufficient size to offer plan choice.*** *Plan choice is important because it allows employees to more precisely tailor their health insurance arrangement in ways that fit their preferences and family needs. Because insurers naturally fear adverse selection, none wants to compete with another insurer for merely part of a small group. Most insurers of small groups require at least 75% participation of all workers in the firm, and refuse to sell otherwise. This effectively forecloses the ability of small firms to offer a choice of health plans to their workers. However, for groups larger than 1000, offering choice is easy and common. Seventy-eight percent of workers in establishments with more than 1000 workers are offered a choice of plans, whereas only 22% of workers in establishments smaller than 50 offer plan choice. Virtually all state employee plans offer plan choice.*

2. What are the major risks of AHPs as proposed in last year's bill (S.858/H.R.1774)?

*The major risks are that they could lead to higher prices for some and unstable premiums for all. These risks follow from the increased health risk segmentation – healthier risks going into AHPs and less healthy risks staying out -- which AHPs would likely, perhaps unwittingly, promote.*

*Federal exemption from state benefit mandates would allow AHPs to offer less comprehensive benefit packages than other insurers in the small group market. AHPs then will be attractive to those groups with workers who are relatively healthy. This will lead to deterioration in the quality of the risk pool outside AHPs. This is both because they attract the healthy to start with, and if they become sick and are rated unfavorably within the AHP, they can always reenter the commercial small group market (thanks to HIPAA) at somewhat regulated rates (45 states restrict premium variance in this market). This is why CBO predicted premium increases for 20 million workers if AHPs became legal and widespread. A simple way to reduce this risk is to have the same benefit package rules throughout the small group market, within and outside AHPs.*

*The bill language as I understand it says any* **member** *of a bona fide association – one created for a purpose other than purchasing health insurance and in existence for at least three years prior to the President signing AHP legislation – cannot be excluded from the AHP's health plan offerings. This is not airtight – and indeed can be quite porous – when compared to insurance market regulations in most states. Guaranteed issue, which because of HIPAA is now the law in every state, says any group can buy any small group product at any time. The AHP language would permit denial to small firms who could be legitimately excluded from the association.*

*Thus, the guaranteed issue provision is only as good as the right to join the association sponsoring AHPs in the first place. That is the purview of the association leadership, not federal or state insurance regulators, and that creates an imbalance with insurers selling outside AHPs. This sort of thing is less of a risk if the sponsoring organization is genuinely open to all small businesses in the geographic area, but if not, then this could permit an effective screening device.*

*In addition, 45 states have restrictions on the premium variance that they allow. Most allow some variation among buyers of the same product, but limit it, and some prohibit the use of health status at all. Some versions of the AHP legislation I have seen would permit different groups to be charged different premiums without limit, which would allow de facto health screening by price within the AHP but not outside the AHP. This would be the worst possible outcome, and I believe it contradicts what some of the advocates of AHPs want (and have been promised). Other versions of AHP legislation close this loophole by prohibiting premium variance based on either claims experience of the group or the health status of any employee. The preferred way to avoid the danger of risk pool segmentation is to make it clear that the premium rating rules inside an AHP are the same as the premium rating rules in the small group market outside the AHP in each state. Otherwise, differential rating rules would tend to produce a healthier risk pool inside the AHP than outside in the commercial market where insurers are subject to different laws and regulations. This would not necessarily happen but it could, and the incentives would be to do this sort of rating over time, so unless you want it to happen, this potential loophole should be closed.*

3. Are there alternative ways to achieve the advantages of such arrangements without the risks? Please describe them in detail.

*In my written testimony I laid out three alternatives: (1) Allow small employers to buy into the state employee pool; (2) Allowing small employers to form their own purchasing pools; (3) Allow small employers to buy into Medicaid or SCHIP programs in their state. I will describe how each might work below.*

***State Employee Pool.*** *This is the most efficient way to accomplish our common objective of enabling small employers to purchase affordable, simple, and stable health insurance. Most state governments are the single largest employer in their state. As such, they can offer more choices at premiums with lower administrative loads than any small employer alone. Plus, because of their size, these risk pools are stable over time. In addition, state employees live and work all over the state, so states are accustomed to having employees enroll at a distance. Most now do it all on an intranet site which looks just like the world wide web and is accessible with any browser. These permit enrollees to review plan comparison information and make choices in the comfort of their home or work station. States often allow counties and even smaller government entities (like water districts, etc.) to join their purchasing pool, so some at least are already accustomed to enrolling multiple smaller entities into their systems. The range of plan choice and administrative savings that this kind*

*of pool can offer small employers can not likely be replicated by any other entity. The size of this combined pool – with state employees and workers in small firms – would command insurers' attention and enable the state to become as aggressive a buyer as any in the nation, in terms of demanding performance and accountability and the best possible prices from health plans. Employer and employee contributions could be sent to the state monthly with income tax payments.*

*Just as I wrote about having identical premium rating rules inside and outside an AHP is essential to avoid exacerbating risk segmentation, this is also important in the case of allowing small employers to buy into state employee pools. Post-HIPAA, all states have guaranteed issue of all small group products, but premium rating rules vary quite a bit, whereas most state employee plans have at most age rating and many have effective pure community rating across their whole insured population. So again, it would be important to insure that the rating rules inside the state employee + small business pool are the same as those that apply outside the pool in the remaining small group market. Over time, all or most small businesses would probably find the state employee pool a much better deal, but in the short run, risk selection problems could be created if the state employee pool was community rated and the small group market allowed fairly wide rate bands or if premiums were completely unrestricted. The simplest thing to do would probably be to allow age rating and nothing else both inside and outside the pool, but that may best be addressed at the state level. The important feature of federal legislation would be to specify the requirement that premium rating needs to be the same inside and outside all pools, and let the states decide how best to achieve that equivalence in their specific cases. This problem could also be solved by mandating that all small businesses which choose to offer health insurance must buy through the state pool, but that may be an unpalatable political requirement and can be avoided by requiring identical premium rating rules.*

***Encourage small employers to create their own pool.*** *These have already been set up with enabling legislation in many states. Some of these have worked well, most have not, and most states do not have ones that would be considered models. Fundamental prerequisites for success include having the same insurance market rules apply inside the purchasing pool as outside, and a critical mass of employers joining the pool to permit substantial economies of scale to be realized. Most pools that have faltered have done so for failure to achieve one or the other of these prerequisites. The former is a matter of state policy, and the latter condition is a function of how the pool markets itself. In principle though, a purchasing pool that was governed by the same rules as the outside market (especially premium rating rules) and that made it financially neutral for agents to sell in-pool products should be a viable competitor to going it alone, and if critical mass were achieved, could become the favored option of all or most small firms rather quickly. A very well-run small employer pool as an example is PacAdvantage, formerly known as the California HIPC, which was purchased by and is now run by the Pacific Business Group on Health.*

***Buying into Medicaid or SCHIP.*** *This has some of the advantages of the state employee pool option, but also has a few more hurdles to overcome (discussed below). This could work by having employers send the premium contribution of both themselves and their workers to the appropriate state agency monthly. Enrollment would probably have to be done with paper and pencil but there's no reason the forms could not be mailed to employers directly. Typically there is not as much choice of health plans within Medicaid or SCHIP as state employees see, but there is often more than most small employer workers ever see alone in the small group market. The Medicaid benefit package is typically richer than private plans because that program also serves highly vulnerable populations with special health care needs (e.g., the disabled, children of poor and often uneducated parents, etc.), so the SCHIP package (which is typically modeled after the two or three most popular employer-based packages sold in that state) may be more appropriate for this kind of buy-in.*

4. What are the major disadvantages or risks of the main alternatives?

***State employee pools.*** *No state does this now, though all could. The main opponents are insurers, who sometimes prefer to compete outside the structure of full price and benefit information and effective competition which state employee plans can (but do not always) impose. State employees might also worry about having their risk pool deteriorate, and that is why it is crucial to avoid risk segmentation by making premium rating rules inside and outside the pool be identical. So fear and misinformation about how this option might foreclose competition would be stirred up, whereas in fact the objective is to use the efficient structure of a large employer pool – in this case the state employee purchasing apparatus – to make market competition work better for ALL small businesses without harming state employees. As I stated in my written testimony, state employees tend to be older and sicker than workers in general, so the likelihood is that small business entry would improve the combined risk pool, but you could rate the populations separately and/or offer direct subsidies for higher risk enrollees.*

***An employer pool alone.*** *The problem cases have been those who were forced to operate with different rating rules than the outside market because state law treated these pools differently. Others failed to achieve critical mass because they tried to avoid or underpay agents. Insurance is a product that is sold and not bought (most people have to be talked into putting up money they have merely a probability of getting benefits from, and a fairly low probably in many cases at that), so agents are typically key to small group sales. Without critical mass, the administrative costs of setting up the pool alone dwarf the savings that can be obtained. If the pool can't offer something better than the current market – either price or choice or stability – they can't attract and hold members, and thus achieving critical mass is truly essential, and it has proven difficult in most cases in today's world.*

***Medicaid.*** *The problems here are the Medicaid benefit package has higher actuarial value than the private sector norm, stigma (it varies but can be high among small*

*business owners and workers), and potential provider resistance to a large population getting care through vehicles that typically force lower payment rates than they can get for other patient populations. Medicaid administrators have complex tasks and diverse populations to manage, so this is not as natural a fit as state employee plan benefit managers taking over another population that is quite similar to their typical enrollee. Still, it is an viable alternative option that could permit large scale economies to be reached, and by using SCHIP benefit packages and streamlined enrollment processes, this could offer significant savings over going it alone in the small group market in some states.*

5. What are the three most important facts about small employers and health insurance, and what are the main policy implications of those facts.

   *i. For the same benefit package, small employers must pay more (due to scale economies), and their premiums are more volatile (due to the law of large numbers) than is the case for large employers. Thus, the search for good ways to pool small employers together will continue.*

   *ii. The small employers who do offer health insurance do so because they think they must to attract the kinds of workers they want. These workers have enough labor market power to be able to get jobs with large firms that offer health insurance, and they command enough income to be willing to trade some earnings to at least partially finance their employers' premium payments. Firms like these are more likely to respond to subsidized premiums and pooling arrangements than small firms that do not now offer.*

   *iii. Firms that do not offer do not need workers who have much labor market power and the workers they do hire cannot by and large afford to trade wages for health insurance premiums. The best and only way to get many more workers like this covered is to subsidize them directly to buy insurance in group settings or to make them eligible for public insurance programs. The subsidy in any case will have to be large relative to the ultimate premium cost.*

6. How do fully insured AHPs compare in cost and benefits to plans that are self-insured? What is the basis for this difference in cost? What is your estimate of the percent of AHPs likely to be fully insured vs. self-insured?

   *I believe this question is getting at the important issue of, will the products offered to employers who join the AHP be self-insured or fully insured? The main direct cost advantages conveyed to self-insured AHP products vs. fully insured products of commercial insurers in the current bill language are benefit mandate exemptions, lower reserve requirements, and exemptions from state premium taxes. In addition, because of the potential for favorable risk selection, AHPs could experience lower cost enrollees. These advantages would significantly raise the likelihood that most AHPs would be self-insured. AHPs might, and I hope they would, buy reinsurance or stop-loss insurance for the pool as a whole,*

*but the other cost advantages would still be substantial. There is nothing wrong with self-insurance per se, and exemption from taxes is clearly a policy maker choice, but the solvency/reserve requirement issue seems like a technical one, and I believe Sandy Praeger, the Insurance Commissioner of Kansas who testified with me representing the NAIC stated that the stated reserve requirements are very low for the amount of risk that would be borne if AHPs grow as fast as they might. In other words, the premiums of self-insured products would be lower vs. fully insured alternatives if the rules applied to AHPs are different and less stringent than the rules applied to commercial insurers.*

7. Based on your research and experience, would an AHP formed by the US Hispanic Chamber of Commerce or Women Impacting Public Policy be able to offer the same quality of benefits for the same price as an AHP formed by the U.S. Chamber of Commerce or the National Federation of Independent Businesses?

   *Potentially in some markets, but not in most. The key concepts here are scale economies and the fact that health care markets are local.*

   *One might think that scale economies preclude competition between the Hispanic Chamber of Commerce and the US Chamber of Commerce. But health care markets are local. I have never fully understood the gain from a national pool for small businesses which rarely if ever span state lines. Geographic variation in health care cost and usage or practice patterns produces premium variation of 30-40% nationwide. Thus, for any national AHP to be successful, it will have to vary premiums locally. This means that effectively each local area AHP will compete against local insurers. So, where there are lots of Hispanic business owners who join the Hispanic Chamber of Commerce and are willing to provide health insurance to their workers – perhaps in Los Angeles, Houston, Miami, etc. – it may be able to offer products of comparable value as the US Chamber or NFIB or local Chambers might be able to. But, where there are not enough Hispanic business owners to provide at least 100,000 covered lives through a Hispanic Chamber of Commerce, I don't think they will be able to compete with a more generally accessible small business organization. And even where the Hispanic Chamber could compete with other associations, multiple associations competing for some or all of the same small businesses in a given area might increase fragmentation and instability in the small group market.*

From Senator Michael Enzi:

1. *and* 2. Looking at the current AHP legislation, do you believe it could be modified to prevent fragmentation of the small-group insurance market? If so how? *And* How could the current AHP legislation be changed to address your concerns about the stability of premiums and the possibility of adverse selection?

*I combined these two because the answers are the same. The simplest way to allow small businesses to pool themselves without risking instability due to fragmentation and adverse selection is to ensure that any newly empowered pool has the same insurance market rules as the remainder of the small group market. Guaranteed issue rules mean that anyone should be allowed to join the new pool. Benefit mandates should be the same in and outside the pool, and premium rating rules should also be identical. In this way, the economies of scale advantages of pooling and group purchase would accrue to any large grouping of small firms' employees but no unstable dynamic would be created that would disadvantage those who either chose or might be forced to remain outside the new pool. And finally, if the AHP is going to bear the risk of the combined small groups and be self-insured, similar solvency requirements that insurers face should be established so that the workers in this arrangement are at no more risk of insurer insolvency than workers in fully insured commercial products.*

*It may appear that large self-insured employers are able to avoid these specific features which prevent risk selection. However, they naturally achieve an exemption from selection because their workers were chosen to fill particular jobs, their "group" was not formed for the purpose of purchasing insurance. Thus, their risk pool is stable and has a small and constant percentage of high risk people. They also offer many of the benefits that are mandated in the small group market because their workers value them.*

3. To your knowledge, have any states established initiatives to allow small businesses to join existing state employee pools?

   *No. Washington state allows employers to pay premiums for workers who are eligible for their Basic Health Plan (due to low income), a state-only funded plan that was created before SCHIP to cover parents and older siblings of Medicaid eligible children, and Washington's state employee plan, Medicaid, and Basic Health Plan were all administered and plan bidding and enrollment were all administered by the same state agency, the Washington Health Care Authority. So this would be an example of how a state could easily do it, but there is no example of a pure small employer buy-in to state employee plans to my knowledge.*

**Post-Hearing Questions**
**Committee on Small Business and Entrepreneurship to**

**The Honorable Sandy Praeger, Commissioner of Insurance, State of Kansas**
**Representing the National Association of Insurance Commissioners**

**"The Small Business Health Care Crisis: Possible Solutions"**
**February 5, 2003**

**Questions submitted by Senator Olympia J. Snowe, Chair:**

**1a.** What more do you think the states can do to provide access to affordable health care for small businesses than what they have already done?

**A.** First, it is important to note that each state's small group market is different. There is no "one size fits all" answer because each market faces diverse challenges requiring diverse solutions.

However, there are some common, broad-based issues that I believe each state can consider to improve the insurance climate for small businesses in the state.

1. Each state can review the costs imposed by state regulation. Many states already allow small businesses to purchase slimmer benefit packages and just about every state is looking at how to reduce the regulatory burden on insurance companies without reducing consumer protections. In the end, however, these efforts will yield marginal savings.

2. States can consider creating even larger pools for small businesses. While small businesses are already pooled within the state borders, states (and especially smaller states) may need to look beyond their borders to regional pools. Or, states may consider combing the small group pool with other pools in the state. The key is creating larger pools, not fragmenting pools.

3. States can continue to examine ways to provide indirect subsidies through mechanisms such as high-risk pools and reinsurance pools that remove more costly beneficiaries out of the pool. However, as you know, state funding is very limited.

**1b.** At what point would it be appropriate for the federal government to have a role?

**A.** While states can be effective in reducing the cost of coverage, creating more competition, and making coverage more available, I do not believe there will be a drastic increase in small business participation until healthcare costs are brought

under control and premiums are subsidized. In a majority of cases, small business margins are just too low for employers to purchase insurance for their employees. This, combined with the uncertainty of future costs created by the rapid increase in healthcare spending, will always hinder small businesses participation. The federal government has the authority and resources to address these critical issues.

**Questions submitted by Senator John Kerry, Ranking Member:**

1. Can you please explain why the protections in the bill against "cherry picking" are not enough to keep the AHP from selecting only healthy individuals?

   **A.** In simple terms, there are four basic ways to "cherry pick" good risk: 1) benefit package design – if you don't cover cancer treatment those with cancer won't purchase the coverage; 2) denying coverage to unhealthy persons; 3) only offering coverage or providing service in certain geographic areas where there are healthier persons; and 4) charging extremely high premiums for higher-risk persons.

   The AHP legislation only addresses method #2. The HIPAA nondiscrimination rules and the requirement that an AHP offer coverage to all members, regardless of health status, only guarantee that all members can participate. However, the bill does not prevent the AHP from designing a benefit package would effectively exclude higher-risk persons, or from charging higher-risk persons very expensive premiums, or from limiting service areas or coverage areas to limit risk.

2. Are the ERISA protections and benefit mandates similar to state regulations?

   **A.** No, they are not even close. ERISA requires only a handful of benefits, and even then only in specific situations. For example, sufficient post-birth hospital stay is only required if maternity coverage is provided. States require licensed plans to provide a variety of specific coverages such as diabetic supplies, cancer screening and emergency room services.

   ERISA does not provide any real patient protections such as grievance procedures, external review, or access to specialists. ERISA also does not protect consumers from deceptive marketing practices or from insufficient provider networks. States provide these important protections, as well as trained staff to handle complaints and consumer questions.

3. Could you explain why states have enacted benefit mandates?

   **A.** State legislatures and governors have enacted benefits mandates for two basic reasons: 1) protect consumers, and 2) prevent "cherry picking."

Consumers have the right to know that when they purchase health insurance it will cover their health needs. States use benefit mandates to ensure that persons with specific diseases or disabilities are not excluded from coverage. They also want to ensure that insurers do not use benefit package design to limit risk.

It should also be noted that estimates of significant savings from elimination of benefit mandates are severely overstated. The higher estimates of savings typically assume the issuance of a plan without any of the mandated benefits. This simply would not occur because many of the mandates are very basic. Realistically, there could only be modest savings by allowing plans to trim some of the mandated benefits, but then the prospect of "cherry picking" becomes an issue.

**4.** Why is the NAIC concerned about the ability of DOL to enforce standards and protect consumers?

**A.** While the Dept. of Labor has extensive experience overseeing ERISA self-funded plans, as stated by Secretary Chao, AHP plans would require much different oversight. First, ERISA self-funded plans do not have solvency standards and are not subject to a rigorous, regular review of financial health. For ERISA self-funded plans the Department of Labor relies on its authority to require companies to use other assets to cover any shortfalls – assets associations simply would not have, and would not be required to provide. Second, the Department of Labor does not have the expertise or personnel to answer complaints from thousands of small companies, nor the authority under ERISA to protect the rights of these consumers.

**5.** What would be the impact of AHP legislation on high-risk pools and guaranty funds?

**A.** The most recent version of the AHP legislation does allow states to levy premium taxes on AHP plans to the extent they are levied on other health insurance plans in the state. However, other assessments are not specifically allowed. Most states use assessments on insurance plans based on market share to fund their high-risk pools and guaranty funds. The AHP legislation could significantly reduce funding for these entities.

**6.** What would be the impact on states in dealing with providers unpaid due to AHP insolvency?

**A.** The AHP legislation does require self-funded plans to contribute to a national guaranty fund, but the amount ($5,000 per year regardless of size) is far too small to pay unpaid claims in the event a plan becomes insolvent. This would leave providers with the options of trying to collect from the patient, trying to find relief from the state or federal government, or eating the costs. Inevitably, in the case of an AHP insolvency, the state would be called upon to help clean up a mess it did not create and find alternative coverage for the newly uninsured.

7. How will coverage be provided for groups who are priced out of the AHP market?

   **A.** If a higher-risk group sees its rates dramatically increase in the AHP market the group can find guaranteed issue coverage in the general small employer market. However, this does not mean that coverage will be affordable, especially if the better risk is "cherry picked" out of the general market. If coverage is unaffordable and the employer drops coverage, individuals in the group may qualify for the state high-risk pool, but many states do not have such a pool (24 states have high-risk pools that meet HIPAA standards) and in every state access is restricted.

**Questions submitted by Senator Michael Enzi:**

1. Looking at the current AHP legislation, do you believe it could be modified to prevent fragmentation of the small-group insurance market?

   **A.** Requiring the purchase of state-licensed insurance products that are subject to state rating rules and some minimum benefit standards could help address this issue.

2. How could the current AHP legislation be changed to address your concerns about the stability of premiums and the possibility of adverse selection?

   **A.** Requiring the purchase of state-licensed insurance products that are subject to state rating rules, state oversight, and state consumer protections, along with some minimum benefit standards, would go a long way in ameliorating these concerns.

3. To your knowledge, have any states established initiatives to allow small businesses to join existing state employee pools?

   **A.** No, not to my knowledge.

**Post-Hearing Questions**
**Committee on Small Business and Entrepreneurship**
**to**
**Cliff Shannon, President, SMC Business Councils**

**"The Small Business Health Care Crisis: Possible Solutions"**
**February 5, 2003**

**Questions submitted by Senator Olympia J. Snowe, Chair:**

1. **How do you answer your members who are unable to get health insurance under the current system, and are clamoring for more options?**

Every member-company of SMC Business Councils (indeed, every Pennsylvania employer) is able to purchase group health insurance coverage. Furthermore, there is no lack of coverage options from which they can choose. Health insurance marketplace pricing trends and affordability of adequate coverage, however, are acute, ubiquitous, and intensifying problems. In that regard, SMC's Board of Directors, comprised of 21 small business owners elected from among more than 5,000 in our membership, has concluded the proposed AHP legislation would (further) distort the market for health insurance, and would ultimately disadvantage many more of our member-companies and their employees than it would help.

That said, Senator Snowe's question undoubtedly would be answered differently by small business owners in different states. Attempting to construct a framework for analysis of the implications of federal intervention in state-regulated small group/employer health insurance markets on the basis of circumstances in Pennsylvania, or any other individual state or limited group of states, is bound to produce flawed solutions. An important aspect of policymakers' consideration of AHP legislation, therefore, ought to be how state-regulated health insurance markets are different and how each of them might be affected by enactment of AHP legislation.

Senator Snowe's laudable overarching objective is to improve the lot of the largest number of small businesses insofar as adequate, affordable health insurance coverage is concerned. That this problem is rapidly morphing into a crisis is clear, as was vivified by the testimony offered at the Committee's recent hearing. A generation of state and federal policymakers can attest to the difficulty and complexity of the attendant issues. Given her motivation and the need for action, Senator Snowe certainly deserves more encouragement and help from SMC than a critique of AHP legislation. Although not requested in her follow-up question, we nevertheless conclude the discussion below with a few ideas as to how previous iterations of AHP legislation might be improved.

We at SMC acknowledge there are states in which the concepts embodied in past and recently introduced AHP legislation may improve health insurance access and affordability for small businesses. We also acknowledge more than a little discomfort in

departing from generally unequivocal opposition to government mandates. But we are convinced enactment of AHP legislation would make adequate health insurance less affordable for most (but not all) small employers in some states (e.g., Pennsylvania, Ohio, and Michigan). And we suspect similarly negative consequences would manifest themselves to varying degrees in most states.

As indicated above, the assertion that all Pennsylvania employers can purchase coverage and can choose from among a variety of coverage options is relevant but not dispositive. Pennsylvania certainly has a history of group health insurance purchasing via business associations like SMC. More than 50,000 Pennsylvania small businesses participate in group purchasing of employee benefits. Neighboring West Virginia, however, has no association-based group purchasing of health insurance, nor is there any prospect of such arrangements developing in the foreseeable future. The state regulatory framework is not conducive to association plans, and the major insurers in the state have always treated association-based group purchasing as incompatible with their business objectives.

The particulars of each state's laws and regulations, the history and strength of business associations, and health insurers' marketing strategies help to determine whether and how well association health plans function in the state-regulated environment. In Ohio and Michigan, for instance, more than 100,000 small businesses purchase health care coverage through a number of mature, successful association health insurance programs. Colorado, however, has a state regulatory regime that does not allow for development of parallel association-sponsored programs, and all small employers purchase health insurance via a version of modified community rating. Also worth noting is the experience of SMC's independent counterpart association, the Small Business Association of New England (SBANE), which has not, for related reasons, been able to develop and maintain an association-based health insurance program in Maine or other states in the region.

Neither SMC, nor the national group with which it has affiliated, National Small Business United (NSBU), is able to predict how federal AHPs would change the small business health insurance marketplace in each of the 50 states. Notwithstanding hopeful claims made by those who have little or no direct experience in the field, it is doubtful that any person or any organization is currently able to predict outcomes in all states. Nevertheless, an examination of how we at SMC believe AHPs would alter the landscape in Pennsylvania points out the need to proceed cautiously.

SMC is partnered with two of Pennsylvania's Blue Cross Blue Shield affiliates: Highmark Blue Cross Blue Shield in western Pennsylvania and Capital Blue Cross in central Pennsylvania. As indicated above, through these two insurance partners SMC offers association-sponsored coverage to all of its member-companies. Coverage options range from a score of HMO, point-of-service, and preferred provider organization plans (including benefits and network choices), to traditional health insurance options with deductibles ranging from 0 to $1,500 per year, as well as several guaranteed-issue supplemental health, life, dental and vision coverage choices. Choice is a significant strength of our program.

Administrative costs as a portion of small businesses' premium dollars is a further positive aspect of group purchasing of health insurance benefits through SMC (and through other associations in our state). Reports provided to the Committee have administrative costs accounting for one-quarter or more of small businesses' health insurance premium dollars in states in which no association-sponsored group purchasing programs exist (e.g., Colorado and West Virginia). In contrast, SMC's program and others like it in Pennsylvania maintain average administrative costs of 15% or less, including 4-5% sales commission. This compares favorably with administrative costs expressed as a fraction of total medical claims for large, self-insured employers (less sales commissions, of course). For reference, SMC program administrative costs include a 2.5% Pennsylvania premium tax used to subsidize individual guaranteed-issue coverage in our state, 2% insurer profit margin, 4-5% for sales and marketing, 2% for enrollment and billing, and smaller increments attributable to subscriber services and claims administration, COBRA administration, and miscellaneous items.

Another substantial advantage of association-sponsored health insurance programs like SMC's is that a relatively large concentration of insureds within a health care services market area creates leverage to reduce per-unit costs of health care services. Delivery of health care services remains a local/regional business, and there is significant competition for patients in most states and regions. Insurers and health insurance purchasers negotiate discounts with hospitals and physicians located within a regional market, based on anticipated patient volumes. The one or two dominant insurers and/or the largest health benefits purchasers in a regional market typically are able to command the deepest discounts. "Usual, customary, and reasonable" charges for health care services paid by purchasers and health insurance subscribers with less leverage are significantly (often multiples) higher. Because SMC's health insurance programs account for tens of thousands of insureds within the Pittsburgh market area, and its partner BCBS insurer, the dominant carrier in the region, commands the deepest discounts for medical services, SMC members' premium dollars buy more health care services.*

In spite of these advantages, SMC members and all small businesses are affected to much greater extent by much larger and more important trends in health care. Non-administrative expense, also known as health care utilization, is demonstrably out of control. SMC is an acknowledged leader of efforts to contain health care costs, both regionally and statewide. The extent to which these efforts have failed to make a dent in the following national realities is depressingly apparent in our member-companies health insurance invoices:

- increased utilization of health care, due to incremental aging of the working population;
- increased utilization of health care, due to development of new, (usually) more expensive treatments and technologies;

* Perhaps some new discount models would be developed by AHPs, but it isn't apparent to anyone involved in association-based health insurance purchasing today how a national program, generating relatively dilute concentrations of subscribers within a given health care services market, would be able to command such discounts.

- disappearing limits/gatekeeping on commercial subscribers' access to health care services, driven by public opinion and commercial insurers' fears of Patient Bill of Rights legislation;
- national consolidation of the health insurance industry, which has reduced competition;
- regional consolidation of the health care delivery industry, which has reduced competition and enabled giant health care systems to win reimbursement increases from purchasers and insurers that would have been unthinkable ten years ago;
- stubborn resistance – by patients, payors, and providers -- to reforms that could reduce the estimated one-third waste/re-work/error embedded in delivery of health care services.

An important aspect of SMC's relationship with its health insurer partners is the special requirements Pennsylvania law imposes on Blue Cross Blue Shield (BCBS) affiliates as a condition for their singular tax-advantaged, non-profit status. Among these requirements: (a) BCBS rates are based on modified community pooling of all small group/employer purchasers; (b) BCBS affiliates must offer all small groups/employers, including the self-employed, the same range of coverage options; and (c) BCBS affiliates' premium rates for small groups/employers are strictly regulated by the Pennsylvania Insurance Department. Under Pennsylvania's modified community pooling limitations on the BCBS affiliates, rate differentiation among small groups/employers (1-49 employees) is permitted according to certain demographic factors: average age of insureds, size of group, location of business, type of business.* Under this demographic rating structure, rates are not permitted to deviate by more than 20%, higher or lower, from the calculated mid-point/average for each product offered by BCBS affiliates to their small group/employer customers.

For-profit insurers doing business in Pennsylvania are regulated much differently. Pennsylvania law, of course, does not contradict with pertinent federal law (i.e., HIPAA). Insurers, whether non-profit or for-profit, may not deny coverage on the basis of pre-existing medical conditions, and portability of coverage in the event of a job change is protected, too. Pennsylvania law (uncontradicted by HIPAA or any other federal statute), however, allows for-profit insurers to set health insurance premium rates for small groups on the basis of pre-existing medical conditions among covered employees and families.

*Average age is, by far, the most heavily weighted – and most controversial -- demographic factor, because it is the most actuarially important one in assessing relative health risk. Many Pennsylvania small business owners believe demographic rating is thinly disguised age discrimination. Demographic rating, however, is an increasingly common feature of state-regulated small group health insurance pricing. Some states allow insurers to add sex as a demographic factor, too (women generally being significantly larger users of health care services than men).

Most states limit or prohibit health insurers from setting small group/employer rates on the basis of the health status of subscribers. In Pennsylvania, however, for-profit insurers can and do use medical histories, detailed past medical claims information, and detailed medical histories of covered employees and families in order to set premiums for individual small groups/employers. HIPAA does not and will not prevent insurers from collecting this information. Furthermore, if an employee or an employer is found to have concealed relevant health status information from its insurer, it is considered fraud under Pennsylvania law.

If an affected insurer's actuarial analysis of health status information about covered employees and families discloses significant adverse financial risks in enrolling or renewing a particular small group, the for-profit insurer's quoted rate for the affected group will be significantly in excess of the BCBS affiliate's rate. (BCBS affiliates' state-approved, demographically banded rates are published.) In my oral testimony to the Committee, I recounted a specific example of this underwriting practice, in which a for-profit insurer's quoted rate after medical profile analysis was triple (more than $1,750/month/employee) the BCBS affiliate's rate. This sort of thing occurs routinely, and it is financially advantageous to the insurers.

How the small group market operates in Pennsylvania ought to be a particularly important consideration for the Committee, as the last iteration of proposed AHP legislation would have an AHP operate under the rate regulation regime of the state in which the AHP was headquartered. The permissiveness of a state's rate regulation structure, therefore, would be highly relevant to any AHP. To put a finer point on matters, we believe the opportunity for AHPs and, more particularly, for insurers considering AHP partnerships, to engage in medical underwriting on a 50-state basis would make Pennsylvania a relative hotbed of AHP development.

Another feature of Pennsylvania law (again, uncontradicted by HIPAA or any other federal law) is that it imposes no requirement that for-profit carriers offer coverage to all of the small-group market. No for-profit carrier in Pennsylvania currently offers group coverage for the self-employed, few offer coverage for two-person groups, and there are intermittent withdrawals from offering new coverage to groups with fewer than 10 employees.

The underwriting/marketing practices described above regarding for-profit insurers in Pennsylvania derive directly from actuarial realities (e.g., self-employed are older than average, and have larger average medical claims). In sum, they are the means through which for-profit carriers pursue a consistent business strategy of attracting and retaining actuarially attractive subscribers, and avoiding those who are more likely to use health

care services. This is garden-variety adverse selection. If federal pre-emption of state insurance mandates were to enable insurers and their AHP clients to delete most or all mandated health insurance benefits, it would produce adverse selection with a vengeance.

It is true that Pennsylvania's for-profit health insurers must abide by our state's health insurance coverage mandates in establishing the package of benefits and services that are covered by its small group/employer products. But the use of health status/medical underwriting to exclude (via pricing) those most likely to be affected by state coverage mandates (e.g., diabetics, AID/HIV patients, expectant mothers, etc.) greatly reduces the effect of the mandates on for-profit insurers' bottom lines.

Using health status to boost financial performance of a group insurance program isn't an exercise in rocket science. Avoid or reduce the incidence of newborns, diabetics, those who are middle-aged or older, African-Americans, and women, and most of the heavy actuarial lifting is done. In Pennsylvania, where for-profit carriers have the means to do this, their medical underwriting/pricing practices are segregating the small group/employer market into those who are actuarially attractive, and those who are not. Under this sort of segmentation, affordable coverage is readily accessible for those who present a low risk of using health care services. But for the remaining pool of small business employees and their families who are middle-aged or older, female, African-American, suffering from chronic or acute health conditions, etc., health insurance rates are rising very fast, and will continue to rise more and more rapidly.

These circumstances and the underlying trends are certainly not singular in the country. Since business associations like SMC have been able to form and maintain partnerships with only BCBS affiliates (and even the BCBS affiliates have been canceling some unprofitable association programs recently), association-sponsored health insurance programs are bearing the brunt of adverse risk selection. Among SMC's 5,000 member-companies, about one-third purchase more attractively priced health insurance coverage outside the association-sponsored program. They are able to do so because the health status of their workforce is such that a for-profit carrier is willing to insure for less than the published, demographically banded BCBS/association rate.

The marketplace isn't static, either. Each year scores of member-companies move out of and into the SMC-sponsored program, predicated on more or less favorable actuarial characteristics at the time of groups' annual health insurance coverage renewal. In other words, a member-company that has relatively few medical claims/low risks can save money by buying coverage elsewhere. But if health issues eventuate among that group of insureds and families, the member-company will find it financially advantageous to move back into the association-sponsored program the following year.

In reaction to these trends, the SMC Board of Directors authorized our association to establish an independent (for-profit) insurance agency several years ago. SMC's insurance agency is licensed to sell all carriers' products, and it does so on an account-by-account basis (i.e., what is best for the affected member-company). Does this create potential conflict/competition for SMC's association-endorsed arrangements with its

BCBS partners? Certainly. Is there a better solution for SMC or its member-companies in an increasingly predatory marketplace? Not one that is readily apparent.

AHPs, as currently envisioned in proposed legislation, would exacerbate the kinds of adverse selection problems described above in Pennsylvania, Ohio, Michigan, Mississippi, Virginia, and many other states. Due to the recent changes described in the preceding paragraph, SMC has the infrastructure, market position, and financial incentive to grow and profit from establishing or partnering in an AHP. The SMC Board of Directors almost surely would decline to go in this direction, but that decision would be made against a backdrop of certainty that one or several other qualified business associations would. Partnered with a financially strong insurer given a green light to use health status/medical underwriting to shape AHP participation, it would be a nearly can't-miss proposition for a qualified business organization to develop a financially successful AHP. Indeed, AHPs that wouldn't be developed according to this model either would be stymied by an inability to attract insurer participation, or would suffer the same consequences of predatory adverse selection that associations like SMC would face.

To suppose there aren't qualified associations that would be tempted to develop AHPs along this pattern, or insurers interested in pursuing adverse selection to the next opportune step, doesn't square with what is already happening in the marketplace, to say nothing of diverging from the experience of some conspicuously unfortunate chapters in the history of group purchasing of health insurance.

An AHP that operated as a fully-insured program would find little appetite among insurers for incurring financial losses – in the first year, let alone subsequent years. An AHP that operated as a self-insured program would have precious little cushion with which to endure even a single year of losses. At the first instance of financial necessity forcing premiums higher for participating employers, the most actuarially fortunate among these would be prone to switch to a cheaper source of coverage.

We acknowledge there may be a substantial population of small businesses that might benefit from AHPs, particularly in states in which association-based health insurance purchasing is unknown today. Nevertheless, in states like Pennsylvania, the certain consequence of AHP enactment would be more segregation in the state-regulated community pool of small employer insureds of those who are at relatively higher risk of needing health care services, and a predictable skyrocketing of health insurance costs for them and their employers. Since the Baby Boom generation would be most acutely affected among all cohorts of the populations, we suspect AHPs would produce a political inevitability in the form of pressure for Congress to impose federal rate regulation, mandated benefits, or even a national health insurance program.

We doubt it is possible for the Committee, or for Congress, to amend AHP legislation so as to prevent serious disruptions of existing small health insurance markets in every state. The risk of disruption prompted several modifications of AHP legislation during the preceding Congress. In our view, none of these suffice(d), but they at least implied the existence of potential problems.

We appreciate (and agree with) resistance to changes in AHP legislation that would undermine its principles and purposes. Imposition of any type of minimum insurance benefits under AHPs would be anathema. For the federal government to undertake direct insurance rate regulation would be similarly unthinkable. But some different approaches need to be investigated.

An area of potentially fruitful inquiry might be stepping back from the 50-states-or-else approach. As mentioned above, the circumstances in some states seem to offer better opportunities for implementing AHP legislation -- without triggering increased adverse selection -- than others. Perhaps the Secretary of Labor could be authorized to make an initial series of findings about a particular state market (e.g., that group purchasing of health insurance is undeveloped, that administrative costs are significantly higher than the national average, etc.) before an AHP could operate in that state. In other words, in the case of a state with no association-based group purchasing, administrative costs double or triple the national benchmark, etc., the potential benefits of allowing AHPs to operate would be much more easily recognized. In a state like Pennsylvania, however, in which group purchasing is already well-developed, administrative costs are relatively low, and unintended AHP consequences would seem to pose a much greater risk, the Secretary of Labor could decide not to allow AHPs to operate.

Such an incremental approach wouldn't prevent attainment of AHP critical mass; there are today demonstrably successful association health plans comprised of as few as 1,000 participating companies. What would be gained is reduced risk of doing harm, some implicit pressure for reforms on states with excessive mandated benefits and wrongheaded rate regulation strategies, and an opportunity for the Secretary of Labor, the Committee and the Congress to make AHP adjustments in the future.

A second amending possibility exists by embedding in law, rather than in the administrative discretion of the Secretary of Labor, recognition of rate regulation differences among the states. That is, why not make the operative rate regulation regime for an AHP that which exists in each state in which an AHP operates? Large commercial insurers already do this, and it would reduce the threat of exacerbated adverse selection.

A related idea, which would seem to be at odds with the federal role envisioned by AHP advocates, is explicit prohibition in the legislation of any form of medical underwriting/health status evaluation for purposes of setting AHP health insurance rates. Those of our association counterparts who have advocated AHP legislation have unanimously condemned medical underwriting. One might ask why there would be any opposition to prohibiting such practices explicitly – to which the only persuasive answer would seem to be that the results and harm of medical underwriting are outweighed by the principle that the federal government should be involved directly in health insurance rate regulation.

Finally, insofar as either of the two possibilities above is concerned, or any other idea that surfaces for improving AHP legislation, we at SMC want to emphasize the only selfish

interest we are seeking to protect is that of our member-companies. It has been whispered about that associations like ours, which already operate health insurance group purchasing programs, criticize AHP legislation in order to protect our individual association's interests. As indicated above, through our subsidiary insurance operations, every SMC member can purchase any health insurance product available in the commercial market. Furthermore, in the event AHP legislation were enacted by this Congress without any change from its last iteration, SMC would be well-positioned to establish and operate (successfully) a multi-state AHP. The only question would be whether the small business owners who govern our association would approve this step.

**Questions submitted by Senator John Kerry, Ranking Member:**

1. **What do you see as the major advantages of group purchasing arrangements for small employers?**

Group purchasing arrangements for small employers generally assure lower administrative costs, more favorable pricing of health care services by hospitals and doctors, and more benefits options and coverage choices for employers, employees and their families. In states in which there is no group health insurance purchasing for small employers, such arrangements have the potential to reduce administrative costs significantly, improve consumer services, simplify purchasing, leverage the best available discounts on health care services, and generate more benefits choices. However, in states like Pennsylvania, in which state-regulated group purchasing arrangements are already well-developed, these advantages are already demonstrably in place, and federal pre-emption of state regulation would most likely undermine these and exacerbate adverse selection.

2. **What are the major risks of AHPs as proposed in last year's bill (S.858/H.R. 1774)? Are these risks mitigated by the newly introduced legislation?**

The risk of (more) adverse selection in small group health insurance is the primary problem, and this concern hasn't been lessened by any of the legislative alterations made thus far. Once again, in states which lack, to date, group purchasing arrangements, there would be the potential for at least a substantial offset for intensified adverse selection in the form of lower administrative costs, hospital and physician discounts, and increased benefits choices for small businesses. But even in these states, the likelihood of overtly predatory risk selection practices via even a few AHPs, and the havoc such practices could play on states' community risk pools, ought to be of concern.

Adverse selection can play out in two general directions: rates and benefits. 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 (some states have very liberal rating rules; Michigan, for instance, essentially has no rating rules). If an AHP were to sell into a community-rated state while utilizing broad rate bands from another state, 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. The departure of these younger groups from the state-regulated pools will drive rates up dramatically.

Furthermore, this problem is not limited to states that community-rate. Any state that has imposed a rate band that is more narrow than that being used in the AHP domicile state will have the same effects. It is likely that a small number of states (or even a single state) with attractive rules will become the bases for almost all successful AHPs. Also, rating is not the only part of the AHP proposal that could lead to risk selection. Plan design (AHPs would not be subject to state benefit requirements) can also be a powerful tool to attract "the right risks."

It is important to note that the most outrageous cases we now hear about—small businesses with annual premium increases of 50-70 percent or more—usually see such huge increases because the group has moved into a higher age bracket. These businesses will see their plights made yet worse by AHPs, as further upward pressure is put on premiums for older groups.

Potentially most troubling, states like Pennsylvania and Michigan permit use of medical underwriting in the small group/employer market. Medical underwriting is the industry term for setting the rate for an individual group/employer according to an insurer's actuarial analysis of detailed health status information about each covered employee and, if applicable, their families. As practiced in the marketplace today, medical underwriting results in affordable coverage for actuarially attractive groups (most often defined by medical profiling of a group's population of insureds and their families), and increasingly unaffordable coverage for less actuarially attractive groups. As drafted in past years, AHP legislation would allow (indeed, encourage) development of medically-underwritten programs on a national basis.

As for adverse selection driven by benefits design, since some insurers already use price as a means to avoid insuring those who would use health care services mandated for coverage by individual states' laws, it is reasonable to suppose they would seize an opportunity simply to eliminate these health care services from AHP coverage options. For instance, a 50-50 prescription drug benefit with an annual maximum, coupled with a mandatory generic and 30-day limit on pharmaceutical mail orders, would not be appealing to a large fraction of the general population. (Members of the Committee

should ask themselves if they would purchase this kind of coverage.) Other benefits-driven adverse selection tactics would include limits on maternity care, exclusions for or limits on neo-natal care, limits on cancer treatments, and exclusion of diabetes testing and management supplies. The point of these benefits adjustments would be to deflect potential subscribers who would have heightened sensitivities (i.e., potential needs) regarding certain benefits – for which there is demonstrated high correlation with (unprofitable) shock claims.

Those who are not current with developments in the health insurance marketplace may doubt that predatory risk selection is increasing, and they may not wish to believe the legal opportunity to engage in same is sure to be answered by some who are prepared to take maximum advantage. The 21 small business owners who comprise the SMC Board of Directors do not labor under such delusions.

In a traditional, or even modified, community pooling arrangement, the healthiest people subsidize those who are not as healthy. Since even the healthiest among us will someday need health care services, this arrangement serves everyone's interests in the long run. Predatory underwriting and benefits design practices, however, undermine community pooling. If the healthiest cohort need only pay $100/month for coverage they are unlikely to need any time soon, those who are relatively less healthy and need health care services, or are more likely to need them in the relatively near future (e.g., women of child-bearing age, those over the age of 50), will pay relatively more. At a certain point in this progression, a point which is being approached rapidly, coverage becomes affordable only for those who don't need it. Community pooling is already under assault in most states, and AHPs would pose a direct, additional threat to community pooling in all states.

3. **We have been told that, under last year's bill (S.858/H.R.1774), AHPs would not be able to exclude any member from participation in their plans and that AHPs would be subject to protections offered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Could you explain some types of risk selection that could occur with AHPs under this legislation, give some examples of the benefits and rates different groups could be offered under this type of risk selection, and describe the impact of such plans on other small businesses buying insurance in the small group market?**

Both the proposed legislation and existing federal law guarantee association members would not be excluded from participation in an AHP. This is unequivocally true, and it is also unequivocally irrelevant in the context of pre-empting the states' health insurance regimes. Federal law does not regulate the pricing of health insurance, and proposed AHP legislation would not change this. Federal law also does not establish requirements for commercial health insurance coverage, and proposed AHP legislation would not change this.

The marketplace for small group coverage is already roiled by insurer practices, ranging from demographic rating to outright medical profiling, aimed at increasing profitability and reducing risks. The managed care industry not too many years ago underwent a nationwide consolidation. This occurred in response to the pounding it absorbed at the hands of investors who demonstrated they care (and therefore the publicly-traded managed care company ought to care) a lot more about profits than about market share. Indeed, insofar as potential AHP's are concerned, only those that are able to match or exceed medical and administrative expenses with premium income consistently will survive for very long. Insurers would abandon unprofitable fully-insured AHPs, just as they are abandoning unprofitable group purchasing relationships now, and self-insured AHPs which were unable or unwilling to face financial realities would die quick, painful deaths, too.

If one accepts that health care costs are currently beyond the control of even the largest purchasers of health care benefits, and that profits are driving and will continue to be the principal drivers in the health insurance industry, adverse selection must be understood to be the most powerful force in the marketplace. Use benefits and pricing to minimize the number of insured women of child-bearing age, and enormous neo-natal shock claims will be reduced. Similarly, African-Americans contract Type II diabetes at about twice the rate of Caucasians. Keep the African-American contingent of insureds in your health plan to a minimum, and avoid all of the downstream cardiovascular complications, limb amputations, renal failures, and blindness common to diabetes, to say nothing of the everyday expense of drugs and testing supplies, that go with the disease. (See sickle cell anemia, too.) And so on, and so on. At the end of the day, the preferred health insurance risk is a healthy, single white male in his 20's and 30's. Providing coverage for this fraction of the population is a profitable enterprise for insurers (and associations); all others are potential financial liabilities.

**4. Are there alternatives to AHPs that can achieve the advantages of such arrangements without the risks? Please describe them in detail.**

Apart from group purchasing, only a much more expansive government regulatory regime would seem to offer a theoretical possibility of delivering equivalent leverage for small businesses, expressed in terms of preferred coverage choices, administrative costs, hospital discounts, community pooling of risk, and insurance marketplace stability in price and benefits. In order for government regulation to deliver on all of these promises, however, a federal or state regulatory superstructure, including direct or indirect price controls, would need to be erected.

Moreover, even if such a regulatory edifice could be erected and managed constructively, the underlying impetus for skyrocketing health insurance costs would remain:

- A working population that is growing, on average, older and requires (and demands) more health care services.

- The continuing, miraculous march of health care technology that produces new life-saving, life-improving innovations daily, all of which cost more money.
- The end of managed care as cost containment for health insurance purchasers (see Patient Bill of Rights) and the assertion of shareholders' interests.
- The consolidation of hospitals and physicians into larger and larger bargaining units, which are forcing managed care companies and health insurance purchasers to increase reimbursements for the first time in a decade.

Until a magic wand of public policy can be found that makes ours a younger, healthier working population that is prepared to accept partial responsibility for health care costs, the hope that some new scheme for financing health care will fundamentally change the direction or velocity of health care cost increases seems to be a forlorn one.

In the meantime, the prospect of AHP legislation coming to the floor of the Senate conjures up several unhappy scenarios. For instance, Senators who are concerned about adverse selection could ask the Senate to vote on the question of prohibiting use of medical underwriting/individual health status in setting group insurance rates by AHPs. Others may seek consideration of amendments that would mandate specific coverage benefits for AHP subscribers (e.g., diabetes supplies, mom-and-baby benefits, etc.). State legislators who confront such legislative questions regularly can attest to the difficulty of deciding them.

In our response to Senator Snowe's follow-up question, we suggested consideration of some changes to AHP legislation. These changes would not produce a perfect result from anyone's perspective, but we believe they are possible avenues for proceeding with AHPs while minimizing the risk of large disruptions and intensified adverse selection.

First, perhaps AHPs could be limited to those states in which the Secretary of Labor finds there to be a need (i.e., lack of opportunity for small businesses to group-purchase health insurance, higher-than-average administrative costs embedded in small employers' rates, etc.). Businesses located in states in which AHPs would provide a real alternative to the status quo would be helped. But in states in which association-based group purchasing is already developed, and is demonstrably providing choice, lower administrative costs, and better value for small employers, small businesses could be insulated from predatory risk selection tactics.

5. **Most large employers self-insure and have been exempt for the last quarter century for the very laws and regulations from which this legislation would exempt AHPs. Yet we don't hear stories about risk selection problems in these employers' plans. How are AHPs different from these large employers, and what types of insurance plans might we expect AHPs to offer as a result of these differences?**

Large and small companies have the same motivations: to provide the best benefit package they can, one that serves the real needs of their employees at an affordable cost. But large companies and AHPs don't necessarily have the same motivations. Large employers know that they have a large pool of employees, some good risks, some bad risks, but it is actuarially stable. With the employer paying all or most of the premium, even the youngest and healthiest have little incentive to looks elsewhere for coverage, or to decline coverage.

In an AHP setting, however, the pool is made up of a large number of groups, each of which has complete autonomy; they can come, stay, or go at any time, based upon whether they can get a better deal in the AHP, out of the AHP, or with another AHP. If the AHP finds that it is attracting, vis a vis its AHP and non-AHP competitors, a large "unhealthy" population, it will need to alter its premium and/or benefits structure. Otherwise, it will collapse.

Large employer plans would have the same problems if they were being marketed outside of a controlled group. If, say, IBM were to allow other companies or individuals to buy into its employee health insurance plan, it would itself buy into a more complicated and difficult risk exposure management challenge (just an AHP would). It would, therefore, be surprising -- confounding, in fact -- to other large, self-insured companies if any large, self-insured entity offered to allow small employers to participate in its plan.

Large employers cannot, for legal and practical reasons, discriminate in hiring for reasons of medical condition, race, sex, etc. Instead, they hire for skill sets, and this approach to hiring produces an employee population that, as noted above, resembles the general population. Some employees will have babies, some will be African-American, some will have diabetes, etc., and the employer will not find it practical or productive to delete coverage applicable to their medical needs. A large employer can also administer effective, cost-efficient health education, wellness, and disease management programs (something that has proven impractical to administer effectively or efficiently on a multi-employer basis). But if and when costs of paying and providing certain employee benefits gets out of kilter, a large, self-insured employer can reduce the number of employees and/or reduces benefits.

Individual small employers may self-insure, too. But self-insured small employers generally find it more difficult to sustain this model. Among 10,000 employees there is a considerable financial cushion for shock claims. Among 100 employees and their families, however, a dozen shock claims in a single year can bring down the plan.

In a multi-employer self-insured plan, careful management is the best hedge against collapse. But even a modest up-tick in per-employee costs for participating companies, and/or a season in which a number of participating employers found financial advantage in placing their health insurance elsewhere, would place a multi-employer self-insured plan under immediate stress. Benefits could certainly be manipulated to reduce the risks of shock claims and volatility for participating employers. But the most successful ones would be confined to types of businesses in which limited benefits could be

complemented by/matched to an actuarially attractive insured population (e.g., a self-insured plan that limited itself to landscaping contractors with younger workers).

Once again, however, the success of the AHP would be directly linked to selecting out of the general population of small business employees those with the best health risk characteristics. Whether via a self-insured or fully-insured AHP, this type of risk selection would work to the disadvantage of the majority of the working population and the majority of small businesses that would remain in the state-regulated pool.

6. **If AHP legislation were enacted, does NSBU have plans to form an AHP? If so, how many members are likely to be insured under your AHP, how many plans would you likely offer with how broad a range of benefits and premiums, and would you charge a fee to participate in the AHP? If you do not plan to form an AHP, why not, and is there another organization with which your trade association might pool to provide health insurance to your members?**

SMC is an independent organization voluntarily affiliated with NSBU. Several SMC members serve on the NSBU Board of Trustees, and SMC members have in the past served as NSBU chairs. But SMC cannot speak for NSBU.

Discussions with my peer at NSBU and with NSBU trustees suggest strongly that the possibility of an NSBU-sponsored AHP would be considered, if the question presented itself after AHP legislation was signed into law. The outcome of this debate within NSBU, the characteristics of any AHP that NSBU might decide to develop, how an AHP would be governed, and even who could participate – all is a matter of conjecture at this point.

# COMMENTS FOR THE RECORD

**STATEMENT OF**
**THE AMERICAN FARM BUREAU FEDERATION**
**TO THE**
**SENATE SMALL BUSINESS AND ENTREPRENEURSHIP COMMITTEE**
**REGARDING**
**ASSOCIATION HEALTH PLANS**

**February 5, 2003**

Farmers and ranchers need lower-cost group health insurance of the type that can be made available through Association Health Plans (AHPs). Many producers find themselves unable to obtain group coverage.

Group underwriting standards have traditionally excluded companies where direct family members comprise more than one-half of a group's enrollment. Most farms are not large enough for farmers and ranchers to self-insure. Self-insurance allows larger employers to reduce their health care costs through exemption from mandates and community rating. Rate studies indicate that the difference between exempted coverage and coverage subject to mandates can exceed 25 percent.

Over 70 property and casualty insurance companies in the United States were started to help farmers and ranchers obtain 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. Some state Farm Bureaus have offered insurance coverage to their own members.

The Washington State Farm Bureau has been able to offer a group health insurance coverage plan because of a favorable association law, allowing Washington State Farm Bureau to provide coverage that is both extensive in its benefits and more affordable than the individual plans offered in the state. Washington State reached a critical period when Blue Cross Blue Shield plans stopped offering individual plans. After an agreement with the state government Blue Cross Blue Shield is once again offering individual coverage. The Washington State Farm Bureau plan was established some four and a half years ago, and has grown to the point where it now covers some 25,000 farmers and ranchers and has over $40 million in annual premiums. The plan offers guaranteed issue coverage to all its members. Each farmer/rancher member is offered a preferred or standard rate with a maximum premium rate differential spread of 30 percent. Even with its success several state mandated provisions, which would not be required under an ERISA self fund 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 State Farm Bureau plan or duplicate it, but are unable to establish such a program for their members because they cannot cross state lines or because state laws prohibit this type of plan. Each state requires

separate approval making it very difficult for multi-state plans to be implemented. It can easily cost millions of dollars to obtain a license to operate in each state and thousands of dollars to gain approval for each insurance policy offered within each state jurisdiction.

To further focus on the challenges farmers often face, we would like to point to a large dairy farmer cooperative located in the states of Oregon, Idaho and Washington. Comprised of 5,000 members they were hit this year with a 40 percent premium increase by their Blue Shield plan. Many members are faced with dropping coverage because of that massive cost increase. The cooperative would like to join the Washington State Farm Bureau health plan, but cannot because of the different state requirements and jurisdictions of the three states.

This is an excellent example of how enactment of health access plans can substantially improve health coverage for small business. AHPs would make it possible for standard benefits to be offered across state lines, and would allow health plans to make coverage available in all states while meeting the administrative and filing requirements of only the state where the plan is headquartered. The Washington State Farm Bureau could extend coverage in the two other states in the region using a state-admitted carrier. This would allow other regional plans to be developed and allow nationwide plans to be made available. The cost benefits of higher-volume plans would be extended to the smallest of employers and their employees.

The American Farm Bureau Federation has supported AHP legislation for several years as a means of enabling our state organizations to put together cooperative arrangements allowing them to make available to their 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. That trend is likely to continue and perhaps worsen. AHPs represent a major step that can significantly improve the prospects for better insurance coverage for farmers, ranchers and millions of others across the nation. We urge quick action to make AHPs available as a viable source of health coverage and look forward to working with the committee on this issue.

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*Statement of:*

**JAMES A. ANDERSON, JR.**
**VICE PRESIDENT-GOVERNMENT RELATIONS**
**NATIONAL ASSOCIATION OF WHOLESALER-DISTRIBUTORS**

*Before the:*

**COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP**
**UNITED STATES SENATE**

*On:*

**"THE SMALL BUSINESS HEALTHCARE CRISIS: POSSIBLE SOLUTIONS"**

**FEBRUARY 5, 2003**

Chairwoman Snowe and Members of the Committee:

I am James A. Anderson, Jr., Vice President-Government Relations for the National Association of Wholesaler-Distributors (NAW), headquartered in Washington, DC. NAW is the national voice of wholesale distribution, comprised of direct member companies and a federation of 131 national, regional, state and local associations and their member firms which, collectively, total approximately 40,000 companies operating at some 150,000 locations across the country. Wholesaler-distributors provide the link in the marketing chain between manufacturers and retailers as well as commercial, institutional and governmental end-users. While industry firms vary widely in size, wholesaler-distributors generally are small to medium size closely held businesses, which provide jobs to 6.8 million people and account approximately $2.7 trillion annually in economic activity.

At the very outset, let me state that the employers affiliated with NAW consider it no less than a national disgrace that in this, the most prosperous society in the history of mankind, over 41 million Americans are medically uninsured and, as a consequence, lack access to quality, timely medical care, a circumstance that carries with it not only public health consequences, but sweeping economic consequences as well. This problem, fed by rapidly rising health care costs and insurance premiums, is clearly one of national proportion and concern, which commands the attention of government at all levels on a priority basis. NAW therefore commends you for conducting this hearing and appreciates this opportunity to submit our statement for the record.

As you know, employers are the primary providers of health insurance in America today. In that vein, I am pleased to report that health insurance is nearly universally employed in wholesale distribution as a component of employee compensation. A survey of approximately 500 wholesale distribution employers conducted in the spring of 2002 reveals that 99 percent offer some type of health insurance as an employee benefit. A copy of the survey report is appended to this statement.

The NAW survey brings additional good news: on average, employers are paying nearly three-quarters of the premium, a feature that is relatively consistent among all company sizes. Clearly, this presents a strong incentive for the employees of firms large and small to participate in their employer's health insurance plan.

Unfortunately, that is where the good news ends.

Employer premium costs have been on the rise for several years, and the 2002 NAW survey reveals that premiums for employer-sponsored health insurance in our industry rose by an average of 19 percent during the preceding year. Wholesaler-distributors with more than 500 employees realized increases that averaged 16 percent. When these larger firms are factored out, the average increase for smaller employers comprising the balance of the industry actually reached 20 percent.

It is alarming to note that approximately one-quarter of the respondents to the NAW survey reported premium increases of 25 percent or more, and nearly 10 percent experienced increases of at least 33 percent.

It is even more alarming to consider how employers in the wholesale distribution industry plan on coping with anticipated double-digit premium increases for the foreseeable future. Ninety-five percent of the respondents to the NAW survey reported that if premium costs continue to rise at or near the current rate, they will be forced to employ some combination of steps that will have the effect of increasing employees' out-of-pocket costs. The main components of this strategy include increases in employees' premium contributions, deductibles, and co-payments. In addition, some plan to drop coverages, while others contemplate terminating their plans altogether.

None of this is good news for workers, particularly against the backdrop of rising medical costs and a sluggish economy. Indeed, this combination of increased cost and less coverage will severely weaken incentives to participate in employers' health insurance plans. Instead, many employees, particularly those who are young and healthy, as well as lower income workers will likely elect to drop out of their employer's plan and go without coverage.

In short, absent an abatement of the current and anticipated upward trend in employer health insurance premiums, the number of medically uninsured Americans is likely to continue to grow.

NAW believes that there are a number of ways to effectively address the cost issue that will have a positive effect in the context of health insurance coverage and access to quality, timely medical care. I will briefly discuss two of the most important options here.

First, state governments and the federal government must stop imposing additional design and benefit mandates on health insurance plans and the employers and workers who purchase them. An April 2002 report for the American Association of Health Plans (AAHP) prepared by Price Waterhouse Coopers titled *The Factors Fueling Rising Healthcare Costs*, outlines this concern well:

"Over 1,500 mandated benefits exist at the state and federal level, with many more on the horizon. Each mandate adds its own cost, and collectively they have significantly increased healthcare costs … (S)tates have also enacted numerous process and provider mandates which … have contributed to the overall cost impact of mandates on health insurance premiums … Additionally, both the Senate-passed and House-passed patients' bill of rights legislation include numerous process mandates … that could increase healthcare costs."

The AAHP/Price Waterhouse Coopers report estimates that a combination of mandates and government regulation contributes 15 percent to the overall increase in health premiums.

Taken in light of the results of the NAW survey, this data suggests if policy makers wish simply to avoid adding too dramatically to the number of medically uninsured Americans, it is clearly necessary for government at all levels to refrain from adding additional cost-enhancing mandates on health plans, their sponsors and beneficiaries. Enactment of *any* mandate or liability-laden patients' bill of rights that adds *anything* to the cost, complexity and risk associated with offering health insurance as an employee benefit, would be clearly at odds with this goal. So, too, would passage of *any* of the mandated benefits bills widely discussed during the 107th Congress and likely to be reintroduced in this session.

Quite the opposite, employers affiliated with NAW would find it refreshing indeed were state governments and the federal government to consider scaling back mandates already enacted, both reducing government-generated, coverage-killing cost and allowing the marketplace to resolve cost and coverage issues.

The latter consideration; providing for a more competitive marketplace in this area, leads to an additional suggestion: enactment of federal legislation permitting the formation and multi-state operation of association health plans (AHPs). In this regard, NAW strongly supports the *Small Business Health Fairness Act*, the content of which was embodied in legislation introduced in 2001 (S. 858 and H.R. 1774, 107th Congress) and included in the House-passed patients' rights bill (H.R. 2563, 107th Congress).

If the NAW survey tells us anything, it is that an adverse relationship exists between the cost of health insurance on the one hand and coverage on the other, and that the greatest problem employers in the wholesale distribution industry face in providing and maintaining health insurance benefits for their employees and their families, is cost. Additionally, we know that approximately four of five medically uninsured people have some connection to the workforce, and that a majority of those are in a family supported by a self-employed person or an employee of a small business.

Beyond that, thanks to a General Accounting Office report released in April of last year entitled *Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market (*GAO-02-536R), we know that the small group health insurance marketplace is minimally competitive and, in some states, thoroughly uncompetitive. Unfortunately for smaller employers, this market condition leaves them with little from which to choose, and rates that are sustainable only in an uncompetitive environment driven by one or, at most, a few dominant health insurers.

The *Small Business Health Fairness Act* focuses squarely on these conditions. Through federally-certified AHPs, smaller employers now struggling in the small group market will benefit from added competition and choice, and enjoy the same regulatory advantages, bargaining power and economies of scale now available only to large corporate and union plans.

The principle criticisms aimed at AHPs are discounted by any fair reading of the language of the bill itself.

Opponents contend that AHPs will be inadequately regulated "sham" organizations, exempt from state insurance regulation, and will sell insecure health coverage which will leave behind potentially millions of dollars in unpaid claims. In sum, opponents argue that AHPs are little if any different than widely discredited multiemployer welfare arrangements (MEWAs).

The *Small Business Health Fairness Act* tells us otherwise. First, only bona fide associations that have been in business for substantial purposes other than obtaining or providing medical care for at least three years may sponsor a certified AHP. Any such association must be established as a permanent entity, receive the active support of its members, require the periodic payment of dues for maintenance of membership, not condition membership or coverage under the plan on the basis of health status-related factors, and not condition membership on the basis of participation in the health plan. (See Sec. 801 (b), Sec. 802, and Sec. 803 (a)).

Second, Sec. 806 clearly establishes vigorous financial and solvency standards that self-funded AHPs must meet, including reserve requirements (Sec. 806 (a)(2)(A)), aggregate excess/stop loss insurance (Sec. 806 (a)(2)(B)(i)), specific excess/stop loss insurance

(Sec. 806 (a)(2)(B)(ii)), indemnification insurance (Sec. 806 (a)(2)(B)(iii)), and surplus of up to $2 million (Sec. 806 (b)). In addition, to ensure the continued payment of benefits by an AHP in distress, the bill creates an Association Health Plan Fund, funded by self-funded AHPs and earnings on Fund investments (Sec. 806 (f)).

Opponents further contend that AHPs will engage in adverse selection, undermining state regulated small group and individual markets.

Again, the plain language of the *Small Business Health Fairness Act* tells us differently. Sec. 804 (d) makes clear than no AHP may turn away any qualified employer from participation in the plan. Sec. 804 (d) further entitles all employers qualified to participate in the plan to obtain information regarding all of the plan's coverage options. Additionally, the plain language of Sec. 804 (c) prohibits any participating employer from excluding from plan coverage any employee based on a health status-related factor, and instead obtain similar coverage for that employee in the individual market. Beyond that, under Sec. 805 (a)(2), an AHP may not vary the contribution rates for any participating small employer on the basis of that employer's claims experience or the type of businesses in which that employer is engaged.

It is important to note that in this regard, the *Small Business Health Fairness Act* goes beyond the Health Insurance Portability and Accountability Act (HIPAA) which, among other things, outlaws any denial of coverage based on the health status or claims experience of an individual.

Finally, opponents contend that the Department of Labor lacks the capacity to adequately regulate AHPs as contemplated by the bill.

Mark McClellan, then a member of the President's Council of Economic Advisors, appeared last year before the House Subcommittee on Employer-Employee Relations, and addressed this concern, pointing to the successful regulatory framework that underpins the nearly three decade-old Employee Retirement Income Security Act (ERISA) "that has allowed hundreds of thousands of employers to voluntarily provide affordable health care to employees..." Dr. McClellan pointed out, "ERISA plans cover nearly half of all Americans. ERISA governs not only large individual firms; it also governs multiple-employer union health plans." He went on to remind Members, "The existing ERISA regulatory structure in the DOL's Pension and Welfare Benefits Administration has been highly effective in preventing abuses ..." and logically concluded, "The Department is confident that it can take on these regulatory responsibilities ..."

The Secretary of Labor has since indicated her confidence in the Department's capabilities in this regard.

Chairwoman Snowe and Members of the Committee, NAW and our affiliated employers are deeply concerned about the medically uninsured in our country. We believe this problem to be inextricably linked to skyrocketing health insurance premiums. Our own survey makes unmistakably clear that the cost of offering health insurance as an employee benefit is exerting ever-increasing pressure on the bottom lines of wholesaler-distributors. Employers in the industry are telling us with crystal clarity that a serious search has begun for effective ways to alleviate that pressure. (I would add parenthetically that NAW is currently conducting a similar, follow-on survey, and preliminary data unfortunately appear to be highly reflective of that generated by its predecessor.)

It is important that policy makers here in Washington and in state capitals act to relieve this growing difficulty. In an effort to reduce exploding health insurance costs, many employers in our industry and in others will be forced to put at risk both the productivity of their workforces as well as their company's competitiveness in labor markets, by scaling back and even eliminating health insurance benefits. At the same time, however, employers realize that the short-term economic advantages associated with cost-cutting efforts in this area could well be diminished by the effects on premiums that provider cost-shifting ultimately exerts.

To protect our nation's employer-provided health insurance system and to enhance its ability to provide coverage to a wider array of our citizens, NAW urges an end to costly, government-imposed health care mandates, and greater competition and choice in the health insurance marketplace for smaller employers by enactment of association health plan legislation.

Thank you.

# Health Insurance Benefits Survey

April, 2002

# Health Insurance Benefits Survey

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# Objectives

This study was conducted on behalf of the National Association of Wholesaler-Distributors (NAW). NAW is exploring issues related to health insurance benefits in the wholesaler-distributor industry. More specifically, the survey examines information relative to the following:

- To determine whether companies offer health insurance as an employee benefit, and if so, what type(s) of plans are offered.
- To discover how many plan options are typically made available from which employees may choose.
- To determine whether plans are self-funded or fully insured.
- To ascertain if premiums are paid entirely by the employer or by contributions form both employee and employer and the percent of premiums typically paid by each.
- To determine the percent by which health insurance premiums have increased in the past year.
- To examine which actions employers may take to help cope with the increase in premiums.

# Procedure

During the mid part of March, 2002, an e-mail was broadcast to 4,573 wholesaler-distributors seeking their participation in an Internet-based survey relative to issues related to health insurance benefits in the wholesaler-distributor industry. The survey was prepared for the Internet and the access-site was hosted by Research Results, Inc., an independent market research firm located in Fitchburg, Massachusetts. This firm is responsible for the implementation and execution of this study and has prepared this report. As of March 27th , a total of 514 surveys were returned completed.

# Summary of Key Findings

**The information provided in this section presents an overview of the key findings of this study.**

- ✓ Virtually all responding wholesaler-distributors offer some type of health insurance benefit program *(only two respondents indicate no plan is provided).* The most commonly offered type of health insurance is a Preferred Provider Organization (PPO), which more than 80% of responding companies offer. This is followed by HMO and FSA *(Flexible Spending Accounts)* plans which are offered by just over 40% of firms. Larger companies are far more likely to offer FSA's and MSA's *(Medical Savings Accounts).*

- ✓ Overall, companies provide employees with an option for an average of 1.7 types of plans. The number of options provided increases with the size of the company. More than 60% of smaller firms provide just one option, however, among the larger companies, more than 60% offer more than one option and the average increases to up to 2.5.

- ✓ Most health insurance plans are fully insured. However, the larger the company, the more likely it is that the plan is self-funded.

- ✓ Eighty-six percent of responding companies report that both the employer and the employee contribute to the health care premiums. A higher percent of small companies report that employers alone pay the premiums. On average, employers assume 74% of the premium cost and employees 26%. This split is relatively consistent among all company sizes.

- ✓ Nearly one-third of wholesaler-distributors report health insurance premiums increased by more than 20% in the past year. The average increase is 19%. The increase is notably less among the largest companies. The increases are similar among the various types of insurance plans.

- ✓ How firms plan to react to these increases is relatively consistent among all companies. More than 80% will increase the employee premium contribution, and about three-quarters will also increase deductibles and the required co-payments.

# Overview of Survey Results

| *Annual Sales Volume* | *Percent* |
|---|---|
| Under $20 million | 21% |
| $20 million - $100 million | 50% |
| $101 million - $1 billion | 25% |
| Over $1 billion | 4% |
| Average | $121.4 Million |
| Median | $ 65.6 Million |

*Q.1 What is your company's annual sales volume?*

| *Number of Employees* | *Percent* |
|---|---|
| 50 and fewer | 21% |
| 51 to 250 | 52% |
| 251 to 500 | 13% |
| Over 500 | 14% |
| Average | 221 |
| Median | 159 |

*Q.2 How many employees does your company have?*

| *Health Insurance Plan Offered* | *Percent* |
|---|---|
| Yes | 99% |
| No | 1% |

| *Types of Health Insurance Plans* | *Percent* |
|---|---|
| Indemnity | 11% |
| HMO | 43% |
| PPO | 82% |
| Sec. 125 Flexible Spending Accounts (FSA) | 44% |
| Medical Savings Accounts (MSA) | 9% |
| Other | 8% |

*Q.3 Does your company offer health insurance as an employee benefit? If yes, What type(s) of plan(s) are offered?*

***Sales Volume***

| *Health Insurance Plan Offered* | *Under $20 Million* | *$20 Million to $100 Million* | *$101 Million to $1 Billion* | *Over $1 Billion* |
|---|---|---|---|---|
| Yes | 99% | 100% | 100% | 100% |
| No | 1% | 0% | 0% | 0% |

***Number of Employees***

| *Health Insurance Plan Offered* | *50 and Fewer* | *51 to 250* | *251 to 500* | *Over 500* |
|---|---|---|---|---|
| Yes | 99% | 100% | 100% | 100% |
| No | 1% | 0% | 0% | 0% |

*Q.3 Does your company offer health insurance as an employee benefit? If yes, What type(s) of plan(s) are offered?*

***Sales Volume***

| *Types of Health Insurance Plans* | *Under $20 Million* | *$20 Million to $100 Million* | *$101 Million to $1 Billion* | *Over $1 Billion* |
|---|---|---|---|---|
| Indemnity | 5% | 9% | 20% | 30% |
| HMO | 48% | 42% | 36% | 75% |
| PPO | 72% | 82% | 92% | 85% |
| Sec. 125 Flexible Spending Accounts (FSA) | 28% | 42% | 54% | 80% |
| Medical Savings Accounts (MSA) | 10% | 5% | 13% | 35% |
| Other | 9% | 7% | 9% | 10% |

***Number of Employees***

| *Types of Health Insurance Plans* | *50 and Fewer* | *51 to 250* | *251 to 500* | *Over 500* |
|---|---|---|---|---|
| Indemnity | 5% | 9% | 18% | 28% |
| HMO | 47% | 42% | 36% | 48% |
| PPO | 71% | 85% | 85% | 88% |
| Sec. 125 Flexible Spending Accounts (FSA) | 31% | 40% | 59% | 62% |
| Medical Savings Accounts (MSA) | 8% | 5% | 12% | 22% |
| Other | 7% | 9% | 3% | 10% |

# Other Types of Plans Offered

60/40 plan with own doctor

A network plan without a primary care physician

Dental (3)

Dental, Vision

Employee Paid Supplemental Insurance

Employee pays flat $50.00 per month company pays balance

EPO (2)

Long and Short Term Disability

Partially self funded

Point of Service – POS (11)

Prescription Card (2)

RX, Vision & Dental

Sec 125 Premium Only (2)

Self funded

Self funded to $10,000 deductible on doctor bill as

Short & Long Term Disability / Life Insurance

Teamsters union

Union welfare

United Health Care

| *Number of Plan Options* | *Percent* |
|---|---|
| One | 51% |
| Two | 36% |
| Three | 9% |
| Four | 2% |
| More than four | 2% |
| Average number of plans | 1.7 |

*Q.3b How many plan options do your employees have from which to choose?*

***Sales Volume***

| *Number of Plan Options* | *Under $20 Million* | *$20 Million to $100 Million* | *$101 Million to $1 Billion* | *Over $1 Billion* |
|---|---|---|---|---|
| One | 63% | 54% | 39% | 20% |
| Two | 31% | 35% | 43% | 40% |
| Three | 5% | 8% | 14% | 20% |
| Four | 1% | 1% | 2% | 10% |
| More than four | 0% | 2% | 2% | 10% |
| Average number of plans | 1.4 | 1.6 | 1.8 | 2.5 |

***Number of Employees***

| *Number of Plan Options* | *50 and Fewer* | *51 to 250* | *251 to 500* | *Over 500* |
|---|---|---|---|---|
| One | 61% | 53% | 45% | 35% |
| Two | 28% | 39% | 42% | 33% |
| Three | 10% | 6% | 6% | 22% |
| Four | 1% | 1% | 2% | 7% |
| More than four | 0% | 1% | 5% | 3% |
| Average number of plans | 1.8 | 1.6 | 1.8 | 2.1 |

| *Funding of Plan* | *Percent* |
|---|---|
| Self-funded | 40% |
| Fully insured | 66% |

*Q.3c Is (Are) your plan(s) self-funded or fully insured?*

***Sales Volume***

| *Funding of Plan* | *Under $20 Million* | *$20 Million to $100 Million* | *$101 Million to $1 Billion* | *Over $1 Billion* |
|---|---|---|---|---|
| Self-funded | 16% | 34% | 65% | 100% |
| Fully insured | 86% | 70% | 47% | 35% |

***Number of Employees***

| *Funding of Plan* | *50 and Fewer* | *51 to 250* | *251 to 500* | *Over 500* |
|---|---|---|---|---|
| Self-funded | 14% | 32% | 62% | 89% |
| Fully insured | 89% | 72% | 41% | 33% |

| *How Premiums Are Funded* | *Percent* |
|---|---|
| By the employer only | 14% |
| By employee only | 0% |
| Both the employer and employees contribute | 86% |

***Sales Volume***

| *How Premiums Are Funded* | *Under $20 Million* | *$20 Million to $100 Million* | *$101 Million to $1 Billion* | *Over $1 Billion* |
|---|---|---|---|---|
| By the employer | 32% | 11% | 7% | 5% |
| Both the employer and employees contribute | 68% | 89% | 93% | 95% |

***Number of Employees***

| *How Premiums Are Funded* | *50 and Fewer* | *51 to 250* | *251 to 500* | *Over 500* |
|---|---|---|---|---|
| By the employer | 30% | 12% | 3% | 6% |
| Both the employer and employees contribute | 70% | 88% | 97% | 94% |

*Q.3d How are premiums paid?*
*If "both," what is the percentage of the premium paid by the employer?*

| | *30% or Less* | *31% to 50%* | *51% to 75%* | *76% to 90%* | *More than 90%* | *Average Percent* |
|---|---|---|---|---|---|---|
| Percent paid by employer | 2% | 13% | 38% | 38% | 9% | 74% |

***Sales Volume***

| *Percent paid by employer* | *30% or Less* | *31% to 50%* | *51% to 75%* | *76% to 90%* | *More than 90%* | *Average Percent* |
|---|---|---|---|---|---|---|
| Under $20 Million | 1% | 4% | 63% | 21% | 11% | 70% |
| $20 to $100 Million | 1% | 12% | 39% | 40% | 8% | 74% |
| $101 Million to $1 Billion | 1% | 9% | 35% | 43% | 12% | 76% |
| Over $1 Billion | 5% | 0% | 58% | 37% | 0% | 73% |

***Number of Employees***

| *Percent paid by employer* | *30% or Less* | *31% to 50%* | *51% to 75%* | *76% to 90%* | *More than 90%* | *Average Percent* |
|---|---|---|---|---|---|---|
| 50 and Fewer | 0% | 19% | 33% | 33% | 15% | 74% |
| 51 to 250 | 2% | 15% | 37% | 28% | 18% | 72% |
| 251 to 500 | 0% | 8% | 43% | 37% | 12% | 75% |
| Over 500 | 2% | 2% | 49% | 35% | 12% | 75% |

| | *Less than 15%* | *15% to 25%* | *26% to 49%* | *50% or More* | *Average Percent* |
|---|---|---|---|---|---|
| Percent paid by employee | 17% | 44% | 23% | 16% | 26% |

***Sales Volume***

| *Percent paid by employee* | *Less than 15%* | *15% to 25%* | *26% to 49%* | *50% or More* | *Average Percent* |
|---|---|---|---|---|---|
| Under $20 Million | 16% | 33% | 21% | 30% | 30% |
| $20 to $100 Million | 17% | 45% | 24% | 14% | 26% |
| $101 Million to $1 Billion | 23% | 52% | 22% | 3% | 24% |
| Over $1 Billion | 0% | 74% | 21% | 5% | 27% |

***Number of Employees***

| *Percent paid by employee* | *Less than 15%* | *15% to 25%* | *26% to 49%* | *50% or More* | *Average Percent* |
|---|---|---|---|---|---|
| 50 and Fewer | 47% | 27% | 12% | 14% | 26% |
| 51 to 250 | 16% | 42% | 24% | 18% | 28% |
| 251 to 500 | 18% | 50% | 24% | 8% | 25% |
| Over 500 | 12% | 54% | 28% | 6% | 25% |

| *Percent of Premium Increase* | *Percent* |
|---|---|
| Less than 10% | 14% |
| 10% to 20% | 54% |
| 21% to 30% | 20% |
| 31% to 50% | 10% |
| More than 50% | 2% |
| Average | 19% |
| Median | 17% |

*Q.3e By what percent have your premium costs increased in the last year?*

***Sales Volume***

| *Percent of Premium Increase* | *Under $20 Million* | *$20 Million to $100 Million* | *$101 Million to $1 Billion* | *Over $1 Billion* |
|---|---|---|---|---|
| Less than 10% | 4% | 21% | 11% | 25% |
| 10% to 20% | 66% | 44% | 63% | 65% |
| 21% to 30% | 20% | 21% | 17% | 10% |
| 31% to 50% | 9% | 11% | 8% | 0% |
| More than 50% | 1% | 3% | 1% | 0% |
| Average | 20% | 20% | 19% | 13% |
| Median | 18% | 17% | 16% | 12% |

***Number of Employees***

| *Percent of Premium Increase* | *50 and Fewer* | *51 to 250* | *251 to 500* | *Over 500* |
|---|---|---|---|---|
| Less than 10% | 12% | 16% | 20% | 19% |
| 10% to 20% | 49% | 53% | 57% | 58% |
| 21% to 30% | 29% | 18% | 12% | 15% |
| 31% to 50% | 10% | 11% | 6% | 8% |
| More than 50% | 0% | 2% | 5% | 0% |
| Average | 20% | 20% | 20% | 16% |
| Median | 19% | 17% | 15% | 14% |

S

*Types of Health Insurance Plans Offered*

| *Percent of Premium Increase* | *Indemnity* | *HMO* | *PPO* | *FSA* | *MSA* |
|---|---|---|---|---|---|
| Less than 10% | 18% | 17% | 15% | 18% | 17% |
| 10% to 20% | 54% | 59% | 53% | 51% | 63% |
| 21% to 30% | 15% | 15% | 22% | 21% | 11% |
| 31% to 50% | 11% | 8% | 8% | 8% | 8% |
| More than 50% | 2% | 1% | 2% | 2% | 1% |
| Average | 19% | 17% | 19% | 19% | 19% |
| Median | 16% | 15% | 17% | 17% | 15% |

| *Reaction to Rising Costs* | *Percent* |
|---|---|
| Do nothing | 5% |
| Increase employee premium contribution | 84% |
| Increase deductibles | 74% |
| Increase co-payments | 73% |
| Drop coverage | 15% |
| Terminate health insurance as an employee benefit | 1% |

*Q.3f* *If premium costs continue to rise at or near their current rate, how will your company respond?*

*Sales Volume*

| *Reaction to Rising Costs* | *Under $20 Million* | *$20 Million to $100 Million* | *$101 Million to $1 Billion* | *Over $1 Billion* |
|---|---|---|---|---|
| Do nothing | 11% | 6% | 1% | 0% |
| Increase employee premium contribution | 78% | 80% | 92% | 95% |
| Increase deductibles | 63% | 74% | 78% | 85% |
| Increase co-payments | 59% | 73% | 84% | 70% |
| Drop coverage | 17% | 13% | 17% | 15% |
| Terminate health insurance as an employee benefit | 2% | 1% | 0% | 0% |

*Number of Employees*

| *Reaction to Rising Costs* | *50 and Fewer* | *51 to 250* | *251 to 500* | *Over 500* |
|---|---|---|---|---|
| Do nothing | 9% | 7% | 2% | 2% |
| Increase employee premium contribution | 79% | 81% | 91% | 93% |
| Increase deductibles | 65% | 74% | 77% | 81% |
| Increase co-payments | 67% | 71% | 79% | 75% |
| Drop coverage | 18% | 12% | 23% | 12% |
| Terminate health insurance as an employee benefit | 2% | 1% | 0% | 0% |

**Testimony presented to the Senate Committee on Small Business and Entrepreneurship**

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

**February 5, 2003**

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. Cliff Shannon has submitted testimony to you on behalf of

NSBU. COSE concurs with his statements; however, given our unique position in the marketplace, we felt the need to submit comments of our own.

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.

The House-passed version of the Patient's Bill of Rights in the 107th Congress allows for the formation of Association Health Plans (AHPs). COSE firmly believes that Association Health Plans are an appealing solution to increasing healthcare costs and access to healthcare. We stand in direct opposition 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.

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. While well intentioned, we believe AHPs threaten the stability of the health insurance marketplace and will 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 the AHP language as passed by the House last year becomes 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 as passed by the House in 2002 could potentially create a catastrophic environment whereby 40% of healthy members exit the program as they find lower premiums with an AHP. The result would force the program to raise rates for the 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 believe that adding another 20% to that cost increase 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, as designed in the 2002 Patient's Bill of Rights 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, as passed by the U.S. House last year, 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 such a proposal.

Thank you for your time. 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.

Associated Builders and Contractors (ABC) appreciates the opportunity to submit the following statement for the official record. We thank Chairwoman Olympia Snowe (R-ME), Ranking Member John Kerry (D-MA) and members of the Senate Committee on Small Business and Entrepreneurship for addressing the problem of the uninsured in America. It is our hope that this hearing will serve to promote Association Health Plans as one solution for reducing the ever growing number of uninsured in the United States.

ABC is a national trade association representing over 23,000 contractors, subcontractors, material suppliers, and related firms from across the country and from all specialties in the construction industry with a network of 81 state chapters, representing over one million employees. Our diverse membership is bound by a shared commitment to the merit shop philosophy of awarding construction contracts to the lowest responsible bidder, regardless of labor affiliation, through open and competitive bidding. With 80 percent of construction today performed by open shop contractors, ABC is proud to be their voice.

The construction industry, which represents approximately 12 percent of the Gross National Product and approximately 9 percent of the Gross Domestic Product, is an industry of small businesses; 94 percent of all construction companies are privately held, and 1.3 million construction companies are not incorporated. As the nation's second-largest employer, with over 6 million workers, the construction industry continues to create new and beneficial jobs each year. Construction spending has a stimulative effect on the economy. For every $1 million spent in construction, $3 million in economic activity is generated and 13 new permanent jobs are created.

To remain at the present level of activity, the construction industry needs an additional quarter of a million (250,000) workers per year to replace an aging and retiring workforce. One of the key elements to attracting and retaining workers and remaining competitive in any industry is to provide high quality, flexible health benefit plans. Maintaining cost effective health insurance plans is a key ingredient in achieving this objective.

In America today, there are nearly 42 million uninsured, and 60 percent of them are employed by (or family members are employed by) small businesses. Therefore, the problem of the uninsured does not solely lie with the unemployed, but also with the small businesses across the country who are unable to provide quality health care coverage due to skyrocketing costs. One solution to this growing problem is Association Health Plans.

*The Associated Builders and Contractors - Association Health Plan*

Providing quality health care benefits is a top priority for ABC and its members. ABC had operated an Association Health Plan for more than 40 years through the ABC Insurance Trust. Because of overwhelming costs in complying with overlapping, inconsistent and often incompatible state laws, our association health plan carrier was forced to drop their AHP coverage. Today, ABC continues to provide a full array of insurance benefits, but has been forced to work with multiple, regional health insurance providers. ABC now serves as a broker, providing our membership with the most competitive carriers and rates in their area. ABC is a perfect example of how a trade or professional association, serving as a purchasing pool for employers, can have a significant impact upon the small employer health insurance market in both price and design.

The ABC Insurance Trust was founded in 1957 by five contractors who could not buy group health insurance for their employees in the open market due to their small size. Through 2000, the ABC Insurance Trust served as a voluntary purchasing pool for members of the association. An important component of the plan's long-term success was that it was guided by contractor members who serve as trustees. As participants in the program, they acted in the best interest of their fellow members and their employees. Participation of the board of trustees is a key ingredient in aggregating the voice of employers to negotiate price and coverage with insurance carriers and other providers.

ABC's Association Health Plan program offered HMOs, PPOs, and traditional health insurance plans including both in-network and out-of-network benefits. All of ABC's plans provided wellness benefits with coverage for physicals and annual check ups. At its height, ABC's Association Health Plan covered over 50,000 lives. While ABC continues to offer dental coverage, group life insurance, and disability programs to serve members of the association, the program today covers just 15,000 employees and their families nationwide. A majority of those covered work for small construction firms with 10-20 employees.

ABC's Insurance Trust operates in full compliance with the Employee Retirement Income Security Act (ERISA) of 1974 reporting requirements, with the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 and with the Health Insurance Portability and Accountability Act (HIPPA) of 1996. Complying with the federal HIPPA legislation requires ABC and other associations to provide open access to all members and provide credit for prior coverage. In fact, Association Health Plans are specifically referenced and defined in the HIPPA legislation and are required to take all members under HIPPA guidelines.

Similar to large employers, AHPs could provide economies of scale to small businesses. The ABC plan, which operated nationally, had total expenses of 13 ½ cents (13.5 percent) for every dollar of premium. These costs included all marketing, administration, insurance company risk, claim payment expenses and state premium

taxes. Alternatively, small employers who purchase coverage directly from an insurance company can experience total expenses of 30 cents (30%) for every dollar of premium or more. It stands to reason that small businesses that purchase coverage through an Association Health Plan can expect to save 15 to 20 percent, or more. Another component of the AHP legislation is that any profit margin generated by the health plan in a given year does not go to the stockholders of the insurance company. Rather, it stays in the plan and inures to the benefit of participants by keeping costs lower in the future.

Bona-fide trade associations like ABC have an established infrastructure that allows them to communicate with members more effectively because of their pre-established relationship. This allows associations and trade groups to provide employers with unique plan designs. This valuable option allows ABC to offer additional benefits over and above what many insurance vendors provide today. ABC has successfully tailored the products and services specifically for the needs of ABC contractor members. For example, all medical plans offered through the ABC Insurance Trust also provide vision coverage, which includes coverage for safety glasses, an item unique to the construction industry.

***The Problem***

The health benefit programs offered by ABC are consistent with Congress's goal of meeting consumer demands for expanded benefits by providing high quality health benefit options. One of the principle reasons for Congress's enactment of the Employee Retirement Income Security Act of 1974 (ERISA) was to foster the growth of employee benefit plans by promoting uniform federal regulation of such plans.

However, despite the great need for expanded health coverage, ever-increasing federal and state regulations have not always had the intended positive impact on small employers. In fact, the regulations often obstruct the development of innovative and effective health benefit programs.

A number of state reforms, such as those enacted in Maryland have actually forced ABC to increase rates and reduce benefits in order to comply with the law. State health insurance reforms and community rating in New York forced ABC's insurance carrier to completely withdraw from the market for employers with less than 50 employees. When these and other state reforms occur, small employers are left with fewer alternatives for health insurance coverage for themselves and their employees.

Recent mergers of health insurance companies have also reduced competition and alternatives for employers who seek access to quality and affordable health insurance. Today, there is a great need to bring more competition back into the system rather than continually reducing it.

***The Solution***

ABC strongly supports extending ERISA preemption of costly state mandated benefits, currently available for larger, self-insured plans, to bona-fide association health plans and professional societies for small businesses. Without the benefit of ERISA's nationally uniform standards, many of the most creative, innovative and cost-effective employer-sponsored health benefit plans could not continue to exist because of the overwhelming costs of complying with overlapping, inconsistent and incompatible state laws.

Now more than ever, Congress needs to pass legislation that would extend the time-tested ERISA preemption to bona-fide trade associations. ABC strongly supports legislation that would provide for the creation of Association Health Plans, such as the Small Business Health Fairness Act of 2002. ABC looks forward to the reintroduction of similar legislation during the 108th Congress and will work to ensure its passage.

During the 107th Congress, the House of Representatives was able to pass a bipartisan access amendment, which included Association Health Plans, during House debate of the Bipartisan Patient Protection Act of 2001(H.R. 2563). This represents the fourth time the United States House of Representatives has passed an Association Health Plan provision in some form or another. ABC strongly urges the United States Senate to join their House counterparts and pass Association Health Plan legislation.

In conclusion, Association Health Plans would enable small businesses to provide affordable health care to their employees, thus significantly reducing the number of uninsured in America. While there is no single solution to the problem of the uninsured, AHPs are an essential component to any possible solution. AHPs provide working families the best opportunity to obtain the quality, affordable health coverage they both need and deserve.

ABC appreciates this opportunity to submit comments on such a vital issue. We look forward to continuing a constructive dialogue on how to increase access to affordable and competitive health insurance for small businesses and thus reducing the number of uninsured Americans.

The Association Healthcare Coalition
THE HEALTH ORGANIZATION FOR BONA FIDE TRADE AND PROFESSIONAL ASSOCIATIONS
Duane L. Musser, Executive Director - 512 C Street, NE, Washington, DC 20002-5809 - Ph: (202) 543-4455 - Fax: (202) 543-4586 - Email: DMusser@swaconsult.com

**Statement For The Record**

**The Association Healthcare Coalition**

**Senate Committee on Small Business and Entrepreneurship**

**The Small Business Health Care Crisis: Possible Solutions**

**February 5, 2003**

The Association Healthcare Coalition (TAHC) commends Chairwoman Olympia Snowe (R-ME) for holding the first hearing of the Senate Committee on Small Business and Entrepreneurship in the 108th Congress on the issue now most dramatically impacting small and medium-sized employers – the severe lack of access to affordable health coverage.

TAHC strongly supports enactment of the Small Business Health Fairness Act of 2001 (S. 858/H.R. 1774 in the 107th Congress), legislation 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 Chairwoman Snowe for her support for Association Health Plans legislation, and looks forward to working with her and other Senators to see that this legislation is reintroduced in the 108th Congress and considered by the Senate. TAHC also wants to commend 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 his 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.

**STATEMENT**

**BY**

**SENATOR CONRAD BURNS**

**SENATE SMALL BUSINESS HEARING:**

**"THE SMALL BUSINESS HEALTH CARE CRISIS:**

**POSSIBLE SOLUTIONS"**

**FEBRUARY 5, 2003**

Thank you, Madame Chairman. Chairman Snowe, Senator Kerry, Secretary Chao, Administrator Barreto and distinguished guests, I am pleased that this hearing has been convened to discuss a situation that is becoming quite serious to those in the small business community – health care. With small businesses responsible for most of the jobs in my home State of Montana, it is imperative that we do all that we can to encourage their success. It is also critical that we explore various alternatives to increase access to health care.

I continue to believe that somewhat of a multi-faceted approach may be the best way to address this problem. I have for many years, advocated the ideas of Medical Savings Accounts (MSAs) and, of course, tax credits for the purchase of health insurance. I firmly believe that exploring ideas like these will be an important step in providing better access and more affordable health insurance for the millions of self-employed individuals, their employees and families.

I think the fact that we are all here today signals the importance of this issue. The fact that this hearing has been convened is a result of the rising level of urgency that we all probably have found in visiting with constituents. I look forward to hearing from the various panels and listening to the discussion today. I thank Chairman Snowe, as this hearing is a significant step in the right direction to finding a solution to the complex problem of access to health care. I will continue fighting for the small businessmen and women of my State of Montana and this great country and look forward to working with all of you on this issue in the days and weeks ahead. Thank you.

**Affordable Healthcare Options for Small Business**

Good morning, Mr. Chairman and Members of the Committee. My name is Susan Buschmann and I am Vice-President of Mid-Missouri Office Machines, a third generation, family business, started by my grandparents 45 years ago. I thank you for the opportunity to speak on behalf of small businesses.

One of the major concerns facing small businesses is the continuing rising cost of providing quality healthcare to our employees and their families. Since 1996, healthcare for our company has gone from $6500.00 to $25,000 per year. If these increases were to continue at even close to the same pace, I do not see my company continuing to the fourth generation. Of more immediate concern, these costs already severely restrict our ability to invest in our business or hire additional employees. And, of course, from a larger perspective, that means it is much more difficult to grow and contribute more tax dollars as a result. Certainly, that's not an ideal situation to have, particularly during a difficult economy.

Over 60% of our insured population consists of small business owners, their employees and families. As a member of associations such as NFIB and NOPA, I firmly believe that Association Health Plans (AHP's) are necessary to make affordable healthcare options available to small businesses. AHP's would allow small businesses to band together across state lines through their membership in a trade or professional association to purchase healthcare coverage for their families and employees, therefore allowing us to obtain and retain qualified employees and provide working families with better benefits, without costing taxpayers one cent. AHP's can help reduce the number of uninsured and ease the burden on small business by giving them the same accessibility, affordability and choice in the healthcare marketplace that big business now enjoys.

Unfortunately, there has been opposition by some insurance companies to AHP's. Many insurance companies claim that AHP's will cherry pick good risks, which under current law is impossible. Current law prohibits any group health plans, including AHP's from excluding sick or high-risk individuals, or employers with high claims experience from the health plan. AHP's are subject to all the preexisting condition, portability, nondiscrimination, special enrollment and renewability under HIPAA.

I strongly believe if AHP's become law, our healthcare system will be fairer and more choices will be available to small business owners at a lower cost.

Thank you for your time and the opportunity to speak on behalf of all of us on Main Street.

**Maine Masonry co inc**

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207/883-6503 FAX 207/885-0972
www.mainemasonry.com

January 27, 2003

The Honorable Olympia J. Snowe
United States Senate
154 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Snowe:

Congratulations on your new position as Chairman of the Senate Committee on Small Business. Because Maine has a high percentage of small and family-owned businesses, I know you will do well at the helm in representing those interests in Congress.

In my view, one of the most pressing small business issues today is health insurance. That said, I was pleased to learn that you will soon be sponsoring legislation to create Association Health Plans (AHPs). I'd like to commend you for undertaking this important effort. As I'm sure you are no doubt aware, over the last four years, health care costs have been spiraling out of control, with no end in sight, and small businesses are either struggling to provide insurance for their employees, passing more and more of the cost increases along to those employees or find they simply can't afford to provide health insurance at all.

I own a small mason contracting company here in Scarborough Maine. Presently 51 of our 80 employees are enrolled in our health insurance plan. The other employees have either opted not to have coverage or they are covered by their spouse's policy with another company. In 2001-2002, our premiums increased 26 percent. However, in order to limit the increase to *only* 26 percent, we were forced to increase the deductible from $500 to $1,000, with the company picking up half of the $1,000 deductible for each employee.

This past September, Maine Masonry faced yet another premium increase of 34 percent. We were able to limit that increase to 13 percent, but only after increasing the deductible to $2,500, increasing the office visit co-payment from $10.00 to $20.00 and increasing the prescription drug benefit co-pay from $10/$20/$30 to $10/$25/$40. The company is now picking up $2,000 of the deductible for each employee.

Because we don't employ 100 people or more, we are not provided with any information regarding our loss experience for the previous years. If we knew what our losses were, we might be able to structure some type of prevention plan to help keep costs down. To the best of my knowledge, none of our competitors in the State presently provide health insurance for their employees. At Maine Masonry, we not only provide coverage, but we assume a great deal of the risk by committing to such a high percentage of the deductible. Yet this is something we feel strongly about doing because we want to retain loyal, skilled employees. Quite frankly, however, if we cannot find a more affordable plan next year, we may be forced to consider eliminating health insurance benefits altogether for all employees. As you might imagine, I hope I don't have to make that choice. But if something isn't done to create greater economies of scale and more bargaining clout for the small businesses of this country, my fear is that premiums will continue to soar beyond belief and, as a result, more and more people will find themselves without adequate health care.

Senator Snowe, I urge you to do everything you possibly can to see that Association Health Plan legislation is enacted into law this year so that the employees of small businesses can enjoy the same opportunities as other large insurance purchasers. If I can be of any assistance to you in that effort or provide further information about my particular situation, please let me know. I look forward to working with you.

Sincerely,

Ronald E. Clough
President

Feb-04-03 03:22pm From-American Optometric Association 703-739-9497 T-213 P.002/003 F-686

American Optometric Association
1505 Prince Street • Alexandria, VA 22314 • (703) 739-9200
FAX: (703) 739-9497

VIA FACSIMILE

February 4, 2003

The Honorable Olympia J. Snowe
Chair
Senate Committee on Small Business and Entrepreneurship
428A Russell Senate Office Building
Washington, D.C. 20510

RE: Hearing on "The Small Business Healthcare Crisis: Possible Solutions"
February 5, 2003

Dear Senator Snowe:

On behalf of the American Optometric Association (AOA), which represents more than 34,000 optometrists, students of optometry and optometric educators, I submit this letter for the record concerning the February 5, 2003, hearing on "The Small Business Healthcare Crisis: Possible Solutions."

We understand that the focus of the hearing will be directed toward proposed legislation to exempt association health plans (AHPs) from state regulation. The AOA is opposed to this legislation because it would undercut the traditional jurisdiction of state health insurance regulation and deprive patients of important state consumer protections.

Although AHPs may form self-funded plans under current law, states have retained regulatory authority over these plans and have required them to comply with state insurance standards. Permitting AHPs to circumvent state health insurance laws would trample on more than 70 years of precedence, and would add to the patchwork nature of health insurance coverage and regulation in this country.

The Congressional Budget Office (CBO) has warned that AHPs are unlikely to help many uninsured Americans and would primarily provide alternative coverage to people who already have insurance. According to CBO, AHPs would likely cause premium rates to increase for more than 20 million small businesses.

Allowing AHPs to ignore state solvency and patient protection standards would create a regulatory vacuum ripe for fraudulent activities. The history of multiple employer welfare arrangements (MEWAs), a forerunner to AHPs, is fraught with bankruptcies, fraud and unpaid claims that have scarred hundreds of thousands of Americans.

Feb-04-03 03:22pm From-American Optometric Association 703-739-9497 T-213 P.003/003 F-886

The Honorable Olympia J. Snowe
February 4, 2003

The National Governors Association (NGA), the National Association of Insurance Commissioners (NAIC) and the National Conference of State Legislatures (NCSL) have all expressed their opposition to the preemption of state laws regarding AHPs. The AOA joins these organizations on this important states' rights issue.

In light of the questionable benefits and the many potential pitfalls of exempting AHPs from state regulation, the American Optometric Association urges the Senate to respect state health laws and maintain the patient and consumer protections Americans deserve.

Thank you for your consideration of our views.

Sincerely,

J. Pat Cummings, O.D.
President

*National Tooling & Machining Association*

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January 31, 2003

BY EMAIL
ORIGINAL VIA U.S. MAIL

Senator Olympia Snowe
Chair
Senate Committee on Small Business & Entrepreneurship
428A Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Snowe:

National Tooling and Machining Association (NTMA), the only Washington based national representative of custom precision manufacturing companies throughout the United States, is writing to convey our strong support for the consideration and enactment of the Association Health Plan legislation during the 108th Congress. This legislation would expand affordable health benefits to working families employed in America's Main Street small businesses.

We are increasingly concerned that massive health insurance premium increases are placing millions of small business workers in jeopardy of paying higher out-of-pocket costs for health care, receiving reductions in benefits, or losing coverage completely. Double-digit premium increases will undoubtedly make it even more difficult for workers now uninsured to obtain badly needed coverage in the foreseeable future. We fear that the number of uninsured Americans will increase substantially over the next few years unless Congress takes action to address the problem of skyrocketing health costs for small businesses and their workers.

Currently, small businesses and the self-employed do not have the advantage of spreading their health insurance costs over large numbers of people, as do health plans sponsored by large corporations. Corporate and union plans have economies of scale, substantial bargaining clout, administrative savings from regulatory uniformity, and greater health plan design flexibility. Small businesses do not have access to these advantages.

Association Health Plans will rectify this inequity by allowing small businesses and the self-employed to participate in health plans sponsored by bona fide trade and professional associations under rules similar to those for corporations and unions. This will provide workers with the benefits of economies of scale, more bargaining power with large insurance companies, and savings from other operating efficiencies. The bill also contains strong new solvency standards and other consumer protections that will ensure that their benefits are secure.

It is time to level the playing field in health care benefits between America's Main Street small businesses and large corporations by enacting this legislation. We urge you to seize the opportunity to address this vitally important issue during the 108th Congress, and look forward to working with you and others in leadership to achieve this objective. I have attached a list of health care anecdotes from NTMA members for you to use as you see fit.

Sincerely,

Shane Downey
Director, Government Affairs

*National Tooling & Machining Association*

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January 30, 2003

The following are the responses from National Tooling and Machining Association members on the issues they are facing with the rise of health care costs.

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MWI, Inc. is a precision machine shop based in Rochester, NY with approximately 90 employees; 65 in Rochester, 15 in Connecticut, 5 in Indiana, and 5 in various other States.

In 1998, MWI had 89 employees and a total healthcare cost (MWI Costs) of $130,487 per year. The premium for healthcare coverage* was $122.26/mos for a single and $324.00/mos for families. MWI covered 98% of the single coverage and 75% of the family coverage for a total cost of $130,487/yr in 1998.

In 2002, MWI had 88 employees and a total healthcare cost (MWI Costs) of $293,835 per year. The premium for healthcare coverage* was $211.64/mos for a single and $560.89/mos for families. MWI covered 74% of the single coverage and 61% of the family coverage for a total cost of $293,835/yr in 2002.

In summary, MWI's total healthcare costs have increased by 125%, while providing our employees with 25% less coverage. Correspondingly, costs to the employees have increased by 678% for singles and 228% for families.

In order to keep costs to our employees down, MWI was forced to offer an alternate, 'lower' plan** in 2002. Approximately one half of our healthcare-enrolled employees dropped to this plan**.

Our healthcare premiums for 2003 are already being realized with increases of 13-15%, depending on the coverage/plan. MWI, Inc., for the 2nd straight year, will need to pass these increases on to the employees, as the Company cannot afford to take on any more expenses. To the average employee at MWI, this will be an additional 96% cost increase for single coverage, and 30% cost increase for family coverage.

Brian McMahon
MWI, Inc.
Rochester, NY

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Our company has seen premiums increase for family coverage of 35% since 01-2001.

Last year we told employees if there was an increase again we would have to pass it on to the employee or reduce their coverage. We opted for a payroll reduction for the

increase in premium. Any further increases will also have to be passed on to the employees.

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Just a little fodder for your health insurance issue (actually it should be hell-th insurance).

We have had to reduce our coverage from a ppo to hmo in order to reel in the costs. We will most likely have to reduce coverage again at the end of this year (November) Our employees now pay 40% of the premium. As our employees age (as most of us do) you can imagine the increases associated with that event alone. An example is a monthly premium of $1286 for a husband and wife (husband is 62).

Jay Bailey
Fischer Precision Spindles, Inc.
Berlin, CT

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Last year we received an 18% rate increase for our employee health coverage. We were forced to pass much of it along to our employees in the form of their first ever participation in paying the premiums. This year we have received a 14% rate increase, of course our employees are now sharing in that cost and feel the pain of the 14% increase on their portion.

Brian Deane
NuTec Tooling Systems, Inc.
Meadville, PA

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We just got our renewal for medical and dental insurance. Medical has a 30% increase again this year and Dental came back with a 40% increase.

Nancy Rauch
Tool Specialties Company
Haxelwood, MO

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My company is Accurite Machine & Mfg'g and is located in Louisville, KY. We started in 1993 with 3 employees and are now employ 15 people. From the start my company paid 100% of employees medical premium costs. That include spouses and children; however, we have been forced to pass costs to the employees over the last three years. We were carrying the "top of the line" coverage until 2001. Our deductibles and amount of coverage was above most of my competitors.

The breakdown below provides an insight into the impact medical insurance premiums have had upon our company and employees.

**If medical coverage had remained the same:**

Assuming I maintained the coverage I had and did not change anything in my policy, our monthly premiums were or would have been as shown below:

| | 1999 | 2000 | 2001 | 2002 | 2003 |
|---|---|---|---|---|---|
| Single | $124 | $148 | $177 | $251 | $334 |

| | | | | | |
|---|---|---|---|---|---|
| Employee + child | $236 | $283 | $337 | $478 | $633 |
| Employee + spouse | $249 | $298 | $355 | $503 | $670 |
| Family | $398 | $477 | $567 | $806 | $1072 |
| | | | | | |
| Percent increase | | 20% | 19% | 42% | 33% |

This equates to 269% increase in costs over 4 years.

**Actual medical premium costs and coverage changes that occurred**:
From 2001 to current date I have had to reduce coverage, increase deductibles and pass on costs to employees. The costs still have skyrocketed despite our efforts.

| | 1999 | 2000 | 2001 | 2002 * | 2003 ** |
|---|---|---|---|---|---|
| Single | $124 | $148 | $148 | $190 | $218 |
| Employee+ child | $236 | $283 | $285 | $362 | $413 |
| Employee + spouse | $249 | $298 | $356 | $381 | $436 |
| Family | $398 | $477 | $481 | $610 | $697 |
| | | | | | |
| Percent increase | | 20% | 0% | 7.6% | 14.4% |

- Starting in 2001 we were able to maintain our costs by increasing deductibles and reducing our coverage amounts. We were still ahead of most of our competition in medical coverage benefits and employees did not pay for coverage.
- In 2002 we were faced with a 42% increase. At that point we started with 15% co-pay by employees for the coverage they were using. Additionally, we, again, increased our deductibles and reduced our coverage.

My last increase for 2003 showed a same coverage increase of 33%. This year the company assumed 10% increase in its monthly premium. In order to reduce the employee's share of the cost, we, again, had to drastically reduce the coverage and increase the deductibles. They currently pay 16.42% of the monthly premium. Sadly, I find I am about on a par with my competition.

Paul Blandford
Accurite Machine & Mfg'g
President

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We've seen a dramatic increase in monthly premiums in recent years. In 2002, we increased our prescription co-payment from a flat $3 to $5 generic/$10 brand to help with the premium increase. However, our rates still increased by 23.8%. See below:

Blue Care Network (HMO)

1997 - 1998: 7.0%
1998 - 1999: 1.5%
1999 - 2000: 6.8%
2000 - 2001: 16.3%

2001 - 2002: 23.8% (28.5% initially)
2002 - 2003: 34.6%
If the monthly premiums continue in this upward trend, we will be forced to look at other alternatives for employee health benefits.

A.B. Heller, Inc.
Milford, Michigan

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Our health care costs have continually been on the rise increasing each year anywhere from 18% to 30%. As a result, we have been forced to reduce the quality of coverage to our employees each year, while increasing their portion of co-pay.
We have only 9 employees that wish to take advantage of the health insurance coverage we offer, and feel that due to that fact, we are penalized with higher costs. Rising costs of health insurance have caused a great burden on small business.

Cheryl Munsell
Southern Michigan Tool
Hillsdale, MI

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The following is the story of our latest renewal with our health insurance provider, Humana, for our HMO plan. Our initial renewal proposal contained an increase of 44.3%. This would have maintained our current health benefits with a decreased prescription benefit. Our current benefit had a $10 copay for doctor visits, $50 copay for emergency room visits, no cost for hospital stays. In 2002 we had a 15% increase in premium cost.

After a long negotiating process and the acceptance of reduced benefits, our final increase was 19.3%. We now have a $15 copay for primary care visits, $25 copay for specialist visits, $100 copay for emergency room visits, and a 10% deductible for hospital stays with an out-of-pocket limit of $2,000.

The Mastercraft Companies pay the entire premium for our employees, with any additional premium for other types of coverage (e.g., family, spouse) paid for by the employee. This has resulted in an additional $30,000 annual cost for the Companies. This comes at a time when all of our costs are increasing and our customers are looking for price decreases.

It seems ironic that in the richest country on earth, there are tens of millions of people without any health insurance at all. If the current trend of price increases continues, companies will drop health insurance coverage as a benefit. This will mean that even fewer people will have access to health care. I feel that only through AHP's or some type of community rated health plan will small businesses be able to compete with larger employers for quality employees and fulfill a societal obligation by providing health benefits. The alternative is some type of federally funded or nationalized type of plan which would be less than desirable.

Phoenix, AZ

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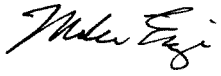
Health Insurance Increases

| | 2001 Rate | 2002 Rate | 2003 Rate |
|---|---|---|---|
| Keystone Health Plan East | | K$10 - RX 10/20 | K$15-RX 10/20/35 |
| Family | $657.70 | $691.30 | $792.20 |
| Husband & Wife | $469.70 | $494.00 | $621.00 |
| Parent & Child | $469.70 | $494.00 | $481.40 |
| Parent & Children | $657.70 | $691.30 | $481.40 |
| Single | $232.30 | $244.20 | $269.90 |
| | | | |
| Personal Choice | | | |
| Family | $780.39 | $926.32 | $1,033.14 |
| Single | $264.24 | $313.63 | $349.64 |
| | | | |
| Personal Choice 65 | $149.00 | $170.00 | $214.00 |

Note: In 2003 employees share of premium is 20%



Statement for the Record
Committee on Small Business and Entrepreneurship Hearing
"The Small Business Health Care Crisis: Possible Solutions"
Senator Mike B. Enzi
February 5, 2003

Thank you, Madam Chairman. Thank you for holding a hearing on this pressing issue. I look forward to your strong leadership in committee during this Congress. I'd also like to thank the panel members, specifically Secretary Chao and Administrator Barreto, for sharing their time and expertise with the committee today.

Small businesses are the lifeblood of Wyoming's economy. In 2000, 96.6 percent of businesses in Wyoming were small businesses. Most of us are aware that a small business is defined as having 500 employees or less. The typical Wyoming small business, however, does not have anywhere near 500 employees. It has one or two employees who double up responsibilities as owner, sweeping floors, cleaning toilets and balancing the books. And they do this on profit margins that most big businesses would write off as unworthy investments.

Small business owners are faced with a difficult decision when they must choose whether or not to cut their already slender profit margins and offer their employees health insurance. Most Wyoming small business owners are unable to take that risk.

Out of 50 states and the District of Columbia, Wyoming ranks 36th in the percentage of population without insurance and 47th in the percentage of businesses that offer health insurance to employees. I believe that if we can find a way to increase the ability of small businesses to offer health insurance, we will decrease the number of uninsured in Wyoming and across the nation. Extending health insurance coverage to the currently uninsured is a priority of the President's, it will be a priority in the Senate, and it already is a priority of mine.

I'm looking forward to the testimony of today's witnesses regarding association health plans (AHPs) as a potential starting point to address the small business health care crisis. AHP legislation comparable to House-passed legislation would allow trade and professional associations to offer health benefits to their members. Under AHPs, it is expected that health benefit costs would be decreased since AHPs would be exempt from state insurance laws and regulations and would provide small businesses with buying power and privileges similar to those of large businesses.

The two big issues that seem to divide the supporters and opponents of AHPs are (1) risk selection by AHPs of the healthiest consumers, which could mean higher premiums for everyone else, and (2) exemption from state insurance laws and regulation, which could put consumers at risk of inadequate or non-existent coverage.

We could go around and around just on these two issues, but what interests me is whether we can find some common ground. We should meet at a point that will give small businesses and their

employees another option through AHPs, while protecting the currently insured against major premium fluctuations. We also must work carefully to ensure that any AHP legislation doesn't decrease access to insurance coverage in the individual market. However, we already know that doing nothing will not provide more access to the uninsured, so we should look to improve upon current proposals for AHPs instead of just picking them apart.

AHPs are only one option for expanding health insurance access and choices for small business employees. I hope that the committee will build upon this hearing and explore other health insurance options, such as: 1) encouraging medical savings accounts, which stimulate the prudent use of healthcare services; 2) providing refundable tax credits to employees of small businesses, combined perhaps with reforms to the individual market or increased access to the small-group market; 3) allowing small businesses to join state-employee pools and to offer state employee benefit plans to their workers; 4) providing tax credits directly to small and low-wage businesses -- those that are least likely to offer insurance currently -- to encourage them to provide coverage to their workers; and 5) providing relief for small businesses from state and federal regulation as an incentive to provide health insurance.

I am also interested in hearing more about the President's plan for new health insurance options for the currently uninsured. When it comes to covering the uninsured, we need to consider all of these options since it is unlikely that any one initiative can solve this problem on its own.

Once again. I thank the witnesses for being here today and I look forward to your testimony.

STATEMENT OF EVAN R. GADDIS
PRESIDENT OF THE
GAS APPLIANCE MANUFACTURERS ASSOCIATION
SUBMITTED TO THE
SENATE COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP
IN CONJUNCTION WITH THE HEARING ENTITLED
"THE SMALL BUSINESS HEALTHCARE CRISIS: POSSIBLE SOLUTIONS"
FEBRUARY 5, 2003

Madame Chairwoman, Members of the Committee:

The Gas Appliance Manufacturers Association (GAMA) represents more than 200 manufacturers of residential, commercial and industrial space heating and water heating appliances and components. Many of our member companies also manufacture air conditioners and heat pumps. The heating, ventilation and air conditioning (HVAC) industry is a vigorous and vital part of the American economic engine.

We appreciate the opportunity to submit this statement to the Senate Committee on Small Business and Entrepreneurship in conjunction with the hearing entitled "The Small Business Healthcare Crisis: Possible Solutions." We respectfully request that this statement be made a part of the hearing record.

Like other U.S. manufacturers, GAMA's members must deal with a sluggish economy, cutbacks in consumer spending, stock market fluctuations, international trade uncertainties, shortages of skilled workers and other vagaries inherent in business. One other element of doing business, however, has spawned an impending crisis for some companies, with the potential to engulf many more—the skyrocketing costs for providing health care benefits to employees. This situation is particularly troubling because it could affect not only the financial stability of our member companies but also the well being of a significant portion of the U.S. workforce, given that an estimated 175 million Americans get their health insurance through their employers.

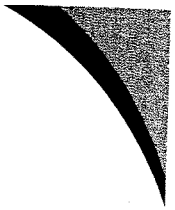
A number of studies commissioned by the manufacturing sector about the costs of health care agree that the costs to most companies for providing health care benefits rose on average more than 13 percent in 2002. An average 15 percent further increase is projected for 2003, and these double-digit yearly increases are expected to continue into the long term. In some cases, the rate of yearly increase has passed 20 percent already. These increases reflect all types of health insurance plans, prescription drug coverage, co-pays and spousal or family coverage. The result—some of our member companies may be forced to require their employees to pay significantly more for their health care benefits, to eliminate the benefits altogether or to move their operations offshore, where such benefits are not routine, in order to stay in business.

GAMA members can ill afford to pass on to consumers the rising costs of health care benefits. Foreign competitors who do not offer such benefits would seize the opportunity to undercut U.S. manufacturers' prices. Neither can our members afford to absorb the astronomical increases in health care benefit costs. For HVAC companies, reducing costs is essential for staying competitive in global markets.

The President and leaders of both parties in Congress have said publicly that all Americans should have access to high quality, affordable health care. Among the many issues which must be addressed to bring about this worthy goal is the skyrocketing cost to American businesses of employer-provided health care.

One proposal for addressing the issue, offered by the President, is to permit small businesses to band together and buy health insurance for their employees through a national trade association or professional society. By doing so, employers presumably could utilize their collective buying power to negotiate lower health care insurance premiums. The Congressional Budget Office has estimated that such a plan could reduce the costs to small businesses of providing health insurance for their employees by 13 percent on average. GAMA believes this approach is worthy of further research and consideration.

GAMA commends the Members of the Committee on Small Business and Entrepreneurship for holding these hearings on the issue of the costs of healthcare, and we pledge our support to you in finding practical solutions which will make the goal of the President and Congress a reality.



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**Dennis Jay**
Executive Director

*A national coalition of consumers, government agencies and insurers dedicated to combating all forms of insurance fraud through public information and advocacy.*

February 4, 2003

The Honorable Olympia Snowe, Chair
The Honorable John Kerry, Ranking Member
Senate Small Business and Entrepreneurship Committee
United States Senate
Washington, DC 20510

Dear Senators Snowe and Kerry:

On behalf of the Coalition Against Insurance Fraud, I am submitting comments for the record on the small business health care hearing that will be held on February 5, 2003.

The Coalition Against Insurance Fraud is a national broad-based alliance of consumer groups, insurance companies and state government agencies dedicated to combating all forms of insurance fraud through education and advocacy.

Insurance fraud is the second biggest economic crime surpassed only by income tax evasion. Small businesses are increasingly susceptible to becoming victims of a variety of insurance fraud scams.

Your hearing on the health care crisis facing small business is an important step toward understanding the pressures on the small business community to meet the needs of its employees and maintain a viable entity. But, the effect of fraud that will attack the viability of small businesses should not be minimized.

Efforts to expand the federal role in offering health insurance to small businesses and self-employed individuals have a sharp double edge.

On the one side, we see that it could help many small businesses expand needed health insurance to its employees – a noble purpose in its own merit.

On the other side, we see a troubling scenario – increased fraud schemes that cost small business millions of dollars, place consumers' health at risk and jeopardize the viability of small businesses.

Most insurance for businesses, including small businesses, is centered on the state insurance system, which has strict regulations that help assure that legitimate insurers are in the market place.

The Association Health Plan proposal now being discussed as a means to lower health care costs for small businesses places this state- regulated system at risk. The proposal calls for insurance coverage for small business to be exempt from state regulation of insurance. This will open the door for entities to avoid strict state solvency standards that may lead to some insurers not having the proper reserves to pay claims.

Avoiding state regulation also opens the door for rampant fraud against small businesses by allowing scam operators to market phony policies to small businesses at rates below market with no intention of paying claims.

Here are several recent examples of this type of fraud:

• Florida estimates that at least 15,000 policyholders have been duped by crooked group health plans that are unlicensed and stealing premium monies.

• Texas estimates that thousands of policyholders have lost at least $13 million in premiums including 8,000 Texans victimized by American Benefit Plans.

• Oklahoma is reportedly investigating 60 fraudulent schemes.

• Colorado has shut down at least 43 phony health plans.

• The U.S. Department of Labor is reportedly has 107 open investigations.

• The three largest national schemes – Employers Mutual LLC, American Benefit Plans and TRG Marketing – have collected more than $50 million in premiums from more than 65,000 people.

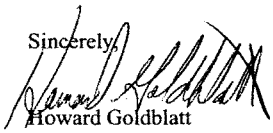
These scams have been operating under the current state-based system. We fear that if the Association Health Plan proposal is enacted, these scams will proliferate to a point that will jeopardize the economic vitality of small businesses and the quality of health care for individuals.

We recognize the desire to help small businesses acquire affordable health care for its employees. But, this worthy goal should not have the unintended consequence of unleashing new fraud schemes that may leave thousands of employees without coverage and with unpaid claims.

The Coalition Against Insurance Fraud respectfully believes that alternatives to the Association Health Plan proposal should be explored to assure the adequate health insurance for small businesses.

Please do not hesitate to contact me if I can be of any further assistance to you.

Sincerely,



Howard Goldblatt
Director of Government Affairs

2800 Shirlington Road · Arlington, VA 22206 · (703) 575-4477 · Fax: (703) 575-4449

# TESTIMONY FOR THE RECORD ON THE SMALL BUSINESS HEALTH CARE CRISIS: POSSIBLE SOLUTIONS

## BEFORE THE SENATE SMALL BUSINESS AND ENTREPENEURSHIP COMMITTEE

**SUBMITTED BY**
**JAMES HUSSEY, CHAIRMAN**
**AIR CONDITIONING CONTRACTORS OF AMERICA**

**FEBRUARY 5, 2003**

Chairwoman Snowe and members of the Senate Small Business and Entrepreneurship Committee, on behalf of the Air Conditioning Contractors of America (ACCA), I ask that you please add our comments to the hearing record of February 5, 2003. ACCA is the national non-profit trade association that represents the educational, policy, and technical interests of the men and women who design, install, and maintain indoor environmental systems. We have over 50 federated chapters with over 4,000 local, state, and national members. In addition to being Chairman of the Board for ACCA, I am the owner-operator of Marina Mechanical based in San Leandro, CA. We strongly urge the Congress to adopt legislation providing for federally sanctioned Association Health Plans (AHPs).

By most estimates, approximately 41million Americans are currently without health insurance. Of that figure, over 60% reside in a family where the head of the household is employed by a small business. AHPs would allow our small community-based contractors to pool their coverage in the same fashion as large and medium-sized companies. By passing legislation expanding the use of AHPs, your committee and this Congress can go a long way towards providing health insurance to millions of uninsured Americans.

The rising cost of health insurance is a major concern for our small business members. In a nationwide survey conducted last year our contractor members report that their health insurance premiums have increased an average of 61% over the last three years. This underscores the point that under the current system, many small businesses cannot afford health coverage for their employees. This rapid rise of health care costs has priced insurance premiums beyond their reach. To make matters worse, the number of insurers that serve the small business market continues to dwindle.

When you consider that small firms pay on average 18% more for health insurance than a medium-sized company, this level of savings would help reduce the cost gap currently driving small business out of the market. For over 25 years, large and medium sized multi-state companies have been able to provide group health coverage for their employees under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA has helped drive down health care costs while still providing universal coverage for their employees. Today, over 115 million Americans are covered by ERISA plans.

After traveling the country this past year in my capacity as Chairman of ACCA, I have heard over and over the commitment and desire our contractors have to providing health care insurance for their employees. Initially, rising costs forced them to reduce coverage from the entire family to just the employee. As costs continue to rise, they are now faced with requiring employee participation for their individual coverage or face loosing medical coverage all together. This forces American wage earners on to the public health systems and increases the cost to government.

Passing AHP legislation will immediately reduce the pressure on government sponsored programs, provide access to quality health care for millions of underserved Americans, and increase the overall revenue dollars that flow to the private insurance sector — all at no cost to the government (taxpayer). If you consider the number of people who would move from public health care to private health care, this could actually save the government a great deal. This proposed legislation is truly a win-win situation for small business owners as well as the U.S taxpayer.

Thank you for the opportunity to add our comments on this very important issue.

CHAMBER OF COMMERCE
OF THE
UNITED STATES OF AMERICA

R. BRUCE JOSTEN
EXECUTIVE VICE PRESIDENT
GOVERNMENT AFFAIRS

1615 H STREET, N.W.
WASHINGTON, D.C. 20062-2000
202/463-5310

February 4, 2003

The Honorable Olympia Snowe
Chairwoman
Senate Small Business & Entrepreneurship Committee
Washington, DC 20510

Dear Madam Chairwoman:

On behalf of the United States Chamber of Commerce, the world's largest business federation representing over three million employers and organizations of every size, sector and region, I would like to thank you for your sponsorship of legislation to establish Association Health Plans (AHPs) under ERISA. "The Small Business Health Fairness Act" will enable small businesses to provide valuable and affordable health benefits to their employees.

As you know, the number of uninsured Americans continues to grow and the escalating cost of providing health care benefits has left many small business owners and employees unable to find affordable health plans. It is time for Congress to allow small businesses the opportunity to band together through well-established, *bona fide* trade and professional associations to purchase affordable health coverage. AHPs will help level the playing field and give participating small employers the same advantages as large employers and unions. AHPs will help small businesses lower their health care costs through economies of scale, administrative savings, and design flexibility. Ultimately, AHPs will help expand access to many uninsured small business workers.

Again, I would like to thank you for your leadership and we look forward to working with you to address the many health care challenges confronting small businesses.

Sincerely,

R. Bruce Josten

STATEMENT OF THE
U.S. CHAMBER OF COMMERCE

BEFORE THE
UNITED STATES SENATE
COMMITTEE ON SMALL BUSINESS & ENTREPRENEURSHIP

February 5, 2003

# The Small Business Health Care Crisis: Possible Solutions

The U.S. Chamber of Commerce is pleased to submit the following statement at today's hearing on the issue of small business and health coverage. The Chamber is the world's largest business organization representing employers of every size, sector and region.

Small Business's Place in the Economy

It is important to understand why public policy that affects small business must be a high priority for lawmakers – and that is because small business is the engine that drives our nation's economy. According to 2000 U.S. Census Bureau records, just over 89 percent of the firms in this country are businesses that employ less than 20 people. Nearly one out of five employees in this country (18 percent) works for a company with fewer than 20 people, and 36 percent work for a firm with fewer than 100 people. When lawmakers in Washington pass legislation that impacts small business owners, those laws and regulations affect a lot of working American families.

Why Small Employers Offer Health Coverage

Small employers who offer health coverage do so because it is good business practice and because doing so helps them compete for workers. The fact that the tax code favors employer-provided coverage is also important. According to a 2002 survey by the Employee Benefits Research Institute/Consumer Health Education Campaign and the Blue Cross Blue Shield Association ("EBRI/CHEC-BCBSA"), 92 percent of employers said they offered coverage because it is the right thing to do.

Other important reasons for offering coverage are increased productivity because employees are healthy (64 percent) and reduced absenteeism (58 percent). Seventy-five percent of small employers said offering health coverage helps with employee recruitment as well as increasing loyalty and decreasing turnover (78 percent). More than half (57 percent) say they offer coverage because their competitors offer it or because employees demand or expect it (62 percent). However, employers do step up to the plate when required: nearly one-third of employers (30 percent) cited employee medical need for coverage as the reason why they offered benefits.

Why Small Employers DON'T Offer Coverage

Cost is clearly a barrier to small businesses being able to offer health coverage to their employees. In a separate study of small employers *(Kaiser Family Foundation-Health Research Education Trust 2002 Employer Survey, "KFF-HRET")*, 84 percent of employers cited high premiums as an important reason why they did not offer coverage. Not being able to qualify for group rates (45 percent) and administrative hassles (39 percent) were also cited as important reasons.

Similarly, the EBRI/CHEC-BCBSA 2002 survey found that 79 percent of employers stated that their business could not afford coverage as the reason they did not offer coverage. Finally, concern about revenue being too uncertain to be able to commit to a plan was also a reason (68 percent) for not offering coverage. This is an important factor

to keep in mind as the economy continues to struggle and as health plans' own commitment to the small business marketplace wavers.

Just because an employer doesn't offer coverage to its workers doesn't mean those employees – or the business owner – goes uninsured. Many (61 percent) employers said that because their employees were covered elsewhere, they did not need to offer coverage. When those circumstances change, or when the business owner himself needs coverage, small employers will seek out a group policy.

Small Business Employees and the Uninsured

During the late 1990s, more and more small businesses offered health coverage. From 1998 through 2000 – a time of strong economic growth – small employers (3 through 199 employees) increasingly offered coverage, from about 54 percent in 1998 to 67 percent in 2000 *(KFF-HRET 2000)*. This trend reversed, however, over the last three years, declining to 65 percent in 2001 and 61 percent in 2002 (*KFF-HRET 2002)*.

Uninsured individuals are overwhelmingly concentrated in smaller companies. More than one-third (34 percent) of employees at firms with less than 10 employees were uninsured in 2001, and 27 percent of employees in firms with 10 to 24 employees were uninsured. Along with coverage being harder to access and to afford, employees at small firms tend to earn less than their peers at larger companies, and larger employers often are able to pay a larger share of health plan premiums.

An alarming recent trend is the practice of employees electing to be uninsured – that is, declining their employer's offer of health benefits while not having another source of health coverage (through a spouse or parent or through a public program such as Medicare, Medicaid or the State Children's Health Insurance Program "SCHIP"). About one in six employees turn down the coverage offered them at work, mostly (61 percent) because they were covered by another plan. However, 20 percent said the coverage was too expensive to participate in the plan. Unfortunately, nearly one out of four (26 percent) of those employees who decline coverage go uninsured *(EBRI)*. This is a missed opportunity to improve the health and well-being of American working families, and one the Congress can easily remedy.

Small Businesses and Health Plan Costs

Health coverage also tends to more expensive on a per capita basis for smaller firms. Last year the average cost for employee-only health coverage was $3,060 but for small businesses (3 to 9 employees), the cost of employee-only coverage was $3,522 *(KFF-HRET 2002)* – a difference of 15 percent.

Some of the reasons for this cost difference include more state mandates and regulatory requirements on insured health plans (which most small businesses purchase because they cannot self-insure); a smaller pool over which to spread risk; and higher per capita administrative and marketing costs. And not surprisingly, recent cost increases are hitting smaller enterprises harder, too. Premiums increased an average of 12.5 percent in 2002 for employers with more than 200 employees, but 13.2 percent for employers with

less than 200 employees. Being able to self-insure health care costs helps to moderate those rate increases: rates increased 14.2 percent for fully insured health plans with conventional plan designs, but only 12.0 percent among self-insured conventional plans.

When asked how they would respond to a rate increase of 15 percent, 54 percent of small employers said they would change their coverage, and an additional 15 percent said they would drop their plans. If costs were to increase 25 percent, three out of five (59 percent) said they would change their health coverage but nearly one-quarter – 22 percent – said they would drop coverage *(EBRI/CHEC-BCBSA)*. This is significant because health plan costs are expected to rise 18 to 20 percent for small businesses over the coming year.

Furthermore, well-intentioned but costly proposals mandating coverage for mental health services, contraception, cancer screenings and a long list of requirements on health plans that has been offered in recent years as part of so-called "patients' rights" legislation will further drive up the cost of health coverage and put many small businesses within the danger zone of ceasing coverage altogether.

Recommendations

In some cases, small employers have been forced to get a new health plan because their insurer has left the marketplace, or employers have found that they have no other plan in their area to call for a rate quote when their current plan premiums skyrocket. State mandates on health plans have taken away health plans' ability to differentiate themselves in the marketplace and compete for customers by offering benefits tailored to meet their needs. When they leave the market, they leave businesses with one less place to go.

Unlike large businesses, small employers do not have the resources to self-insure under federal ERISA laws. Furthermore, more and more small businesses have employees in two or more states, and they have to arrange health coverage for their employees in each of those states. Under legislation like the "Small Business Health Care Fairness Act," small businesses could purchase coverage through associations and other organizations that meet federal requirements. No longer would small businesses be subject to state mandates and regulatory requirements that drive up costs, and small multi-state employers would enjoy a much simplified health care benefits program by being able to offer the same coverage to all their employees – just like larger businesses with whom they compete.

In addition to legislation permitting association health plans under ERISA, some other ways Congress can help small businesses and working families with their health plan costs include:

- Permitting insurance carriers to offer health plans free of state benefit mandates;
- Modifying the medical savings account program to allow both policyholders and employers to make contributions, lower the deductible thresholds, and permit full Medical Savings Account funding of the deductible;

- Modifying S-CHIP to make it easier for states to allow workers to use public program funds to cover dependent children in employer health plans instead of forcing them into a public program that is different from that of their parent(s);

- Permitting individuals who pay their health insurance premiums without employer assistance to take a full tax deduction for those costs; and

- Establishing a refundable tax credit for low-to-moderate-income individuals and families for the purchase of private health coverage, including a partial tax credit that can be applied to workplace coverage.

**Cautions**

What Congress should NOT do is:

- NOT expand medical liability to include employers who sponsor health plans;

- NOT impose even higher costs on those with health coverage by mandating coverage for costly services and benefits;

- NOT establish small business tax incentives for health coverage that are restricted to employers who previously had not offered a health plan (which penalizes employers who have struggled to offer coverage);

- NOT bias small business tax incentives to certain health plan purchasing arrangements.

**Conclusion**

Small business is the backbone of our nation and has driven much of the economic boom of the 1990s and suffered its share of the "bust." When small employers are confronted with health plan rate increases of first 20 percent and then 30 percent, they need to make adjustments to their overall business plan to compensate. Most small business's bottom lines just aren't growing at the same rate as their health plan increases.

Health coverage helps ensure access to care when you need it, and economic security for working families. Congress needs to make access to affordable health coverage for small business a priority for the health of working families families, and for the health of our economy.

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February 10, 2003

The Honorable Olympia Snowe, Chair
Committee on Small Business and Entrepreneurship
United States Senate
428A Russell Senate
Washington, D.C. 20510

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

Dear Senator Snowe:

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.

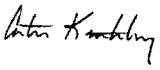
Critics may argue that federal oversight of association health plans would create an administrative burden that the Department of Labor cannot handle. In fact, the Department is already administering 67 million private, job-based health plans subject to ERISA protections, in addition to 5 million in 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

Statement for the Record
Ranking Member John F. Kerry
Hearing on the Small Business Health Care Crisis: Possible Solutions
Wednesday, February 5, 2003

Good morning. I would like to thank the Chair, Senator Olympia Snowe, for calling this hearing on the important topic of the small business health care crisis. We know that at least 41 million people are currently uninsured, an increase of 1.4 million since 2001. The consequences of being uninsured are now well documented: people without insurance are less likely to receive preventive and screening services on a timely basis; are less likely to receive appropriate care to manage chronic conditions; and are more likely to receive substandard care if hospitalized. As a result, they are in poorer health and at greater risk of dying prematurely.

Eighty percent of the uninsured are in households with at least one employed worker, and half of these individuals are either self-employed or working for small businesses employing 50 or fewer workers. But less than half of these businesses now offer insurance, compared with almost 100 percent of large employers. These numbers tell us that if we can help small businesses to provide health insurance to their workers, we will do a great deal to help Americans find a path to affordable and reliable health care. It will be a difficult task because the number of uninsured, the cost of healthcare, and the cost of health insurance are all rising, but it is clear that a small business strategy is essential to decreasing the number of uninsured and keeping our workforce healthy.

Madame Chair, I commend you for trying to bring to the Committee's attention a range of possible solutions to the small business health care crisis. As you know, some of us have serious concerns about the approach that the Administration has promoted under the banner of "association health plans." We're pleased that the Committee has been able to assemble a broad spectrum of witnesses, and I would like to thank all of you for appearing today. Your experience and expertise range from small business owners struggling to provide insurance for your employees to a state insurance commissioner who knows firsthand the hazards of inadequate or fraudulent health plans. The perspectives of a number of small business associations and of consumers will be presented as well. We're also very pleased that Dr. Len Nichols from the non-partisan Center for Studying Health System Change is here to share current health services research findings that can inform our deliberations. All of these perspectives will be helpful to this Committee as we wrestle with the difficult challenge of increasing access to quality health insurance for small businesses and their employees.

What are the characteristics of quality health insurance for small businesses owners, their employees, and families? The insurance must be comprehensive, affordable, and stable. It must also be responsible and not reduce costs only for the few small businesses that employ relatively young and healthy workers in low-risk industries while increasing costs for all others in the small group health insurance market.

I'm concerned that the Administration's Association Health Plan proposal won't meet those goals. AHPs, as the Bush Administration would authorize them, have two major disadvantages: (1) they will place consumers at risk because AHPs would be exempt from state patient

protections, solvency requirements, and oversight; and (2) they will fragment and destabilize the small group health insurance market, resulting in higher premiums for the majority of small businesses and their employees.

What do I mean by increased consumer risk? As proposed by the Administration:

- AHPs would not be subject to state consumer protections, including access to emergency care, direct access to OB/GYNs, access to specialists, provision of mental health services, mandatory grievance procedures, or required internal and external appeals timelines and rights. These are consumer protections the states have spent more than a decade putting into place.

- AHPs would be allowed to self-insure and accept insurance risk, but would not be subject to state solvency requirements that ensure that insurance companies have sufficient resources to avoid financial failure. AHPs are a variant on Multiple Employer Welfare Arrangements (MEWAs) created in the mid-1970s that have a long history of insolvency and disastrous failures. A 1992 GAO report, for example, documented that MEWA failures from 1988 to 1991 left almost 400,000 consumers with more than $123 million in unpaid claims.

- AHPs have great potential for fraud and abuse from unscrupulous, unlicensed health plans that collect premiums from employers and employees but then abscond with the funds rather than paying claims for health services provided. In the past 18 months, state insurance departments have experienced sharp increases in group health insurers who are operating without required state licenses, and state regulators are issuing cease-and-desist orders to protect employers and their employees. The Department of Labor, which would have oversight over AHPs, has much less capacity to provide this oversight.

Turning to the issue of destabilizing the small group health insurance market:

- AHPs are expected to focus on industries with younger, healthier employees and would offer them lower premium rates because they would not be subject to state regulations that require a minimum benefit package and that limit rate discrimination based upon age or health status. By removing these low-cost beneficiaries from the small group pool, leaving those who are sicker, use more health care, and, are therefore more costly to insure, AHPs will drive up insurance premiums for all other small employers.

- CBO in its January, 2000 report estimated that nearly two-thirds of the cost savings AHPs could offer would result from attracting healthier members from the pool of existing workers. In CBO's analysis, 80 percent of workers would remain in traditional insurance and potentially be *worse off* if AHPs were created. That means 20 million employees and dependents of small employers could experience a rate *increase* that could actually drive some people who currently have insurance out of the market.

As the National Governors Association concluded in its June 15, 2001 letter to the Majority and Minority Leaders of the Senate and House commenting on the AHP legislation submitted in the 107th Congress: "While the promise of lower rates and greater access to insurance sounds good,

the facts are that AHP legislation, as currently drafted, would result in less access for higher-risk companies that cannot join AHPs and less protections for the employees of those companies that can."

Finally, I'd like to pose a question to Secretary Chao that I hope can be answered for the record. Why is the Bush Administration proposing to give the States more flexibility in the Medicaid and S-CHIP programs while at the same time promoting AHPs that would *federalize* much of the small group insurance market? Proposing to place more control at the State level for Medicaid and S-CHIP presumably is intended to recognize the considerable differences in populations, health care needs, and health care delivery systems found across the states. The small group insurance market confronts these same conditions. By what logic then, is it desirable to increase State control for Medicaid and S-CHIP while decreasing it for small business health insurance?

What other options might be available? It is important to recognize that in 2003 small businesses will at last be able to deduct the full cost of providing health insurance for all employees, including the small business owner and his/her family, as a cost of doing business. Large employers have long enjoyed this economic advantage, and this Committee with bipartisan support has advocated this change in tax policy for years.

The challenge now is to develop more effective pooling mechanisms that can give small businesses more leverage in the health insurance market while still preserving essential consumer protections. I believe a number of our witnesses will have suggestions on how this might be accomplished, and I look forward to their testimony.

I have received comment letters from a number of groups and individuals with expertise in the health care crisis faced by small businesses and their employees. I ask Unanimous Consent to include them in our record. I would like to thank everyone for participating in today's Committee hearing. I look forward to reviewing the comments made today and to continuing our work on developing solutions to the small business health care crisis.

GEORGETOWN UNIVERSITY

Institute for Health Care Research and Policy

**VIA: FACSIMILE**

January 31, 2003

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

Dear Chairwoman Snowe and Ranking Member Kerry:

I write to submit comments for the record of the "Small Business Health Care Crisis: Possible Solutions" hearing that the Small Business and Entrepreneurship Committee will be having on February 5, 2003. As an academic researcher who has studied consumers' experiences with association coverage under current law and a former federal regulator at the U.S. Department of Labor, I wanted to offer some insights into the problems that small businesses and their workers are now facing under association health plan coverage.

First, I want to thank you for your leadership in investigating the crisis with health insurance for small businesses and self-employed people. In addition to unaffordable premiums and double digit increases, there is a significant and rapidly growing problem of small businesses and American workers being defrauded through phony health plans promoted through associations. I am sending the attached article to help you better understand this current problem.

As a way of background, researchers at Georgetown University's Institute for Health Care Research and Policy conduct a range of studies on the uninsured problem. We are focusing on private market obstacles that prevent consumers from buying health insurance for themselves and their families. We also are looking at reasons why people lose their private health insurance coverage. In my research, I have extensively studied the regulation of association health plans and the problem of phony health insurance sold through phony and legitimate associations.

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

The private market is experiencing what I believe to be a crisis -- the growing problem of criminals defrauding hundreds of thousands of working Americans and their families out of health insurance premiums. Operators of phony health plans target small businesses and self-

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employed people, collect premiums for non-existent health insurance, and leave patients with millions of dollars in unpaid medical bills and without health insurance.

Health insurance coverage scams exist because there is an unmet need for affordable health insurance. Criminals take advantage of small employers and self-employed individuals looking for affordable alternatives to traditional coverage.

The influx in scams occurs around the same time health insurance premiums increase substantially. Currently, health insurance premiums are increasing in the double digits. The last time premiums increased in the double digits was in the late 1980's and early 1990's. Between 1988 and 1991, health insurance scams promoted through group purchasing arrangements (e.g., MEWAs and associations) left nearly 400,000 people with over $123 million in unpaid medical bills, and thousands more were left without health insurance.[1]

We are currently at the beginning of a new trend. In 2002, two nationwide scams Employers Mutual LLC (shut down by Nevada's Insurance Commissioner and the U.S. Department of Labor) and the National Association of Working Americans/American Benefit Plans (shut down by Texas' Insurance Commissioner) sold non-existent health insurance through real and phony associations, leaving over 55,000 workers and their families without health insurance and with an estimated $65 million in unpaid medical bills. Employers Mutual LLC operated in every state. The National Association of Working Americans operated in forty-eight states. The following highlights state responses to this problem:

- 2002: the Texas Insurance Commissioner shut down an unprecedented number of illegal association health plans that had defrauded more than 20,000 Texans. Most recently (December 2002), Commissioner Montemayor issued an emergency Cease and Desist order directing 33 entities and individuals to halt unlicensed health insurance operations (unpaid medical bills will exceed $7 million).
- 2002: Commissioner Gallagher from Florida shut down at least seven arrangements covering nearly 30,000 Floridians, leaving many without health insurance and with unpaid medical bills.

In January 2002, the U.S. Department of Labor reported having 76 civil and 14 criminal investigations open. Most recently, the Department shut down a phony union, which left thousands of people with over $12 million in unpaid medical bills.

As employers continue to face double digit premium increases, they will continue seeking alternatives to traditional coverage and are at risk of being conned by criminals. Unlike a decade ago, these scams are nationwide (not just state specific or regional). They strike fast and spread quickly nationally. In 10 months, Employers Mutual LLC collected over $15 million in premiums. They name themselves after existing insurance companies (what I call corporate identity theft) to achieve name recognition from consumers. For example, the name "Employers Mutual LLC" holds remarkable resemblance to Employers Mutual Insurance Company -- a well-known insurer that has been in business for nearly a century. Promoters of scams are often repeat offenders, never having served jail time for their crimes.

For victims, this is worse than being uninsured. When one is uninsured there is no expectation of having one's medical bills paid. Here, the medical bills are not paid and consumers are defrauded of thousands of dollars paid in premiums for non-existent health insurance.

To help you understand the human toll of health insurance scams promoted through associations, I would like to share a couple of real life examples of how victims deal with this fraud -- not just the short term but the long term impact of these scams on victims.

- Judy Coburn thought that she had insurance. She is one of the 22,000 victims of Employers Mutual LLC. Judy only lost $12,000 (some in premiums, the rest she borrowed to have eye surgery). Unfortunately, Judy now has permanently impaired vision in one eye because she could not get her surgery quickly enough. So unlike other victims, she is lucky that she does not owe hundreds of thousands of dollars to her physicians. She will never recover her vision.

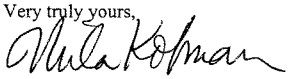
- Lisa Huffstutler, a victim of one of the scams shut down by Florida's Commissioner, was nine months pregnant when she figured out that her health coverage was a scam. She feared that her doctor would find out and would refuse to deliver her baby. In addition to worrying about giving birth to a healthy baby, Lisa agonized over whether she would be admitted to a hospital and whether she would have a doctor at her side for the delivery of her baby. Lisa's family accumulated thousands of dollars in medical bills.

Currently, there are tens of thousands of victims like Judy and Lisa and by the time this cycle of fraud ends, there will be hundreds of thousands of victims.

I urge you and members of this committee to figure out ways to improve consumer protections in this area perhaps by strengthening criminal sanctions to hold accountable perpetrators of fraud, empowering the U.S. Department of Labor with new administrative authority similar to what state insurance departments have already (e.g., ability to issue cease and desist orders without going to court), and strengthening regulation of group purchasing arrangements such as association health plans. I believe that efforts to deregulate or to preempt state-based protections and oversight over association health plans seem ill advised during a time when more is needed to protect small businesses and their workers.

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

Very truly yours,



Mila Kofman, J.D.
Assistant Research Professor

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[1] U.S. GENERAL ACCOUNTING OFFICE, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*, GAO/HRD-92-40, at 2-3 (Mar. 10, 1992) (hereinafter 1992 GAO Report).

GEORGETOWN UNIVERSITY

Institute for Health Care Research and Policy

# *Health Insurance Scams Promoted Through Associations: A Primer*

THE INSURANCE RECEIVER, Vol. 11, No. 3 at 10 (Sept. 2002)

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# HEALTH INSURANCE SCAMS PROMOTED THROUGH ASSOCIATIONS: A PRIMER*

7/1/02

*By Mila Kofman, J.D.

According to ABC News, Christine Sinclair has a rare and inoperable cancer. Chemotherapy each week costs $2,000. Her treating physician has informed her that the insurance company owes him more than $30,000 in unpaid bills and that he is not a "bank" for his patients. Christine is embarrassed and concerned that he will stop her treatment. She also worries about mortgaging her home to cover over $50,000 in outstanding medical bills.[1]

Christine was not uninsured when she incurred these bills. As a member of a professional association, she was enrolled in the association's health plan, which was through a company called Employers Mutual LLC (Employers Mutual). Christine believed that she had insurance to cover her cancer treatment.

Christine is one of 22,000 Americans who paid nearly $15 million in premiums to Employers Mutual, an illegal insurance arrangement according to regulators. State and federal regulators shut this company down when they discovered claims were not being paid. A federal judge determined that the management of Employers Mutual depleted its assets by paying itself excessive fees and diverting funds to personal accounts.[2] Although court documents indicate that many of the 22,000 individuals were left with over $6.5 million in unpaid medical bills, the extent of unpaid medical bills will not be known until all claims are filed with the independent receiver appointed by the federal court.[3]

Unfortunately, Christine's experience is not an isolated case. According to the U.S. General Accounting Office (GAO) and federal and state regulators, in the past two decades health insurance scams sold through both legitimate and phony associations have defrauded thousands of small businesses and self-employed individuals.[4] In the last six months, over 50,000 working Americans and their families have lost their health insurance coverage, and many of these victims are now faced with millions of dollars in unpaid medical bills that should have been paid by association health plans.

This primer focuses on health coverage scams promoted through real and phony professional and trade associations. Part I provides background information focusing on recently discovered scams. Part II discusses how the regulation of association health plans and other group purchasing arrangements has evolved in the last twenty-eight years. Part III concludes by looking at one federal proposal that has recently garnered support from the Administration. It examines its potential effect on current efforts by state and federal regulators to stop health coverage scams perpetuated through associations.

## PART I: BACKGROUND

### Association Health Plans

Millions of working Americans -- one out of every three businesses with fewer than ten employees[5] -- rely on group purchasing arrangements such as professional and trade associations, multiple employer welfare arrangements[6] (MEWAs), multiple employer trusts (METs), employer coalitions, and alliances for their health insurance coverage. These arrangements combine resources to "self-insure or self-fund" (pay into a fund that pays medical claims) or to "fully insure" (buy insurance from a licensed insurance company). Some arrangements, including professional and trade associations, e.g., the local chamber of commerce, provide health coverage as one of many benefits to their members. Other arrangements, e.g., Health Insurance Purchasing Coalitions (HIPCs), exist solely for the purpose of providing or buying health coverage or other types of insurance-related services for participating employers. Because federal law generally does not distinguish among different types of group purchasing arrangements, this paper uses the terms "MEWAs,""association health plans," and "group purchasing arrangements" interchangeably to describe an entity through which two or more employers and self-employed individuals obtain health insurance coverage.

Although many group purchasing arrangements have helped employers finance health benefits for their employees, such arrangements have also presented opportunities for unscrupulous individuals to defraud employers and their workers. Millions of American workers and their families have been left without health insurance and with millions of dollars in unpaid medical bills.[7]

2001 - the beginning of a real crisis

State and federal regulators believe that in the last two years, the number and magnitude of association health plan scams have grown and that such "illegal operations are rapidly growing and spreading around the country."[8] In the last year, the Texas Insurance Department shut down three illegal association health plans that had defrauded more than 20,000 Texans.[9] Since last year, Florida's Insurance Department has shut down six arrangements covering nearly 30,000 Floridians, leaving many without health insurance and with unpaid medical bills.[10] Oklahoma's Insurance Department has 60 open investigations.[11] In response to rapidly growing scams, Louisiana's Insurance Department recently created a MEWA Task Force responsible only for handling such scams.[12] In January 2002, the U.S. Department of Labor reported having 76 civil and 14 criminal investigations open.[13]

How does a health insurance coverage scam work?

Typically, promoters of scams target small business owners and self-employed individuals. As a way to attract a large volume of business quickly, they market health insurance scams through well-established trade and professional associations. They also establish their own associations. For example, operators of American Benefit Plans, an unlicensed entity according to court documents, sold their health plan through at least seven existing associations and four associations they created -- National Association for Working Americans, National Association of Working Americans, the United Employer Voluntary Employee Beneficiary Association, and the United Employee Voluntary Employee Beneficiary Association (emphasis added).[14] They enrolled over 32,000 people in forty-eight states.[15] Operators of Employers Mutual enrolled

22,000 people in fifty states by allegedly selling coverage through sixteen associations they established and through existing associations.[16]

Small businesses and self-employed individuals buy association coverage because it is less expensive than health insurance available in the commercial market.[17] For example, Employers Mutual charged a 50 year-old woman a monthly premium of $285 compared to $425 for comparable benefits from a licensed insurance company offered through the same association.[18]

Promoters claim that premiums are low because they have purchasing power when employers band together to negotiate with insurance companies. Additionally, they claim that they offer "ERISA plans" or union plans exempt from state insurance laws and that their low premiums result from this exemption. In reality, these claims are false.

Operators of scams collect premiums without intending to make good on their promise to provide health coverage. For example, Phillip Harmon was sentenced to eight years in prison as a result of massive fraud "inducing" employers to pay millions of dollars into a trust for "nonexistent" health insurance (covering 6500 individuals, primarily ministers of various churches and their families) nationwide. According to the U.S. Department of Labor's Report to Congress, "No insurance was purchased; rather, the money went to benefit Harmon and others.... The total amount collected by Harmon through the schemes (which also included an investment scheme) was approximately $40 million."[19]

Many operators establish scams collecting millions of dollars in premiums until state or federal regulators find them. While undetected, to continue attracting new business and to continue receiving premiums from existing clients, they pay small claims while delaying paying large ones. Ameri-Med collected $1.6 million in premiums and paid only $360,000 in claims, its operator diverted more than $900,000 for personal use.[20]

Operators of scams often are repeat offenders. Recently the Florida Insurance Department shutdown an entity linked with an individual who, according to the state, two years ago "pleaded guilty to healthcare fraud in connection with the embezzlement of some $8 million" through a phony union plan and a phony employer association.[21]

Double-digit cost increases and demand for alternatives

Health insurance coverage scams exist because there is an unmet demand for affordable health insurance. Criminals take advantage of small employers and self-employed individuals looking for affordable alternatives to traditional coverage.

Historically, MEWA fraud increased when premiums for health insurance increased substantially. For example, in 1988 employers faced double digit increases in premiums averaging 12.0%.[22] According to the General Accounting Office, MEWA problems increased between 1988 and 1991 -- MEWAs left thousands of people without health insurance and nearly 400,000 patients with medical bills exceeding $123 million.[23]

In 2001, businesses with three to nine workers paid an average of 16.5% more than in 2000.[24] In 2002, it is estimated that premiums increased by 15.6%.[25] In 2003, some analysts predict an

additional 20% increase.[26] As employers face double-digit premium increases, they will continue seeking alternatives to traditional coverage and are at risk of being conned by scams.

Victims are financially liable for unpaid medical bills

Small businesses and their workers defrauded by association health plan fraud have few legal options. In some cases court appointed receivers find some assets. In addition to prison sentences, courts can order restitution to be paid to the victims.[27] However, typically there are not enough assets to pay fully all outstanding medical bills. According to the GAO, only $9.6 million in assets were recovered, but over $123.6 million was owed for medical bills between 1988 and 1991.[28] State guaranty funds, designed to protect consumers when a licensed insurance company becomes insolvent, do not protect individuals covered through unlicensed association health plans.[29] Ultimately, patients are responsible for paying their doctors, hospitals, and other providers for services and procedures the patient received.

The states and the federal government have tried to address the problem of health coverage scams. The next section discusses how the regulation of association health plans has evolved in the last twenty-eight years.

PART II: SHARED REGULATION

Both states and the federal government regulate association health plans, although this was not always the case.

Evolution of federal and state regulation

When Congress federalized regulation of employee benefits by enacting the Employee Retirement Income Security Act of 1974 (ERISA), it severely restricted state authority to regulate group purchasing arrangements. Under the 1974 statute, states could not regulate group purchasing arrangements that were considered to be "employee welfare benefit plans," an ERISA plan.[30] The U.S. Department of Labor became responsible for regulating such arrangements. To determine if an arrangement was an ERISA plan, a state (and in many cases a court) had to apply a very technical and complex federal standard requiring a fact intensive inquiry.

ERISA replaced state-based standards with minimal federal standards to encourage employers to provide medical benefits to their workers. Some argued that fewer regulatory requirements make it less costly for employers to provide benefits. The federal statute required ERISA health plans to comply only with fiduciary standards and reporting and disclosure requirements, but did not require such plans to be licensed or to meet any solvency requirements.[31]

Broad preemption of state law had unintended consequences. When states tried to regulate group purchasing arrangements that were not subject to ERISA, its operators successfully claimed ERISA exemption from state law.[32] However, the U.S. Department of Labor claimed not to have authority over such arrangements because most were not ERISA plans.[33] Ambiguity about whether states had authority to regulate group purchasing arrangements, minimal federal

standards in ERISA, and limited oversight by the U.S. Department of Labor created opportunities for widespread fraud.

In response, in 1982 (effective in 1983) Congress amended ERISA to limit its preemptive effect on state law. As a result of these amendments, states can generally regulate group purchasing arrangements. More specifically, with almost no limitations, ERISA allows states to regulate MEWAs[34] – defined broadly to include all types of arrangements offering health coverage to two or more employers or self-employed individuals.

Current regulation

As a result of the 1983 amendments to ERISA, both state insurance departments and the U.S. Department of Labor regulate MEWAs. Most consumer protections are state-based, not federal-based. Also, state insurance departments have enforcement tools that the U.S. Department of Labor does not have, which affect its ability to regulate effectively.

States regulate both fully insured and self-insured group purchasing arrangements. States may require fully insured arrangements to obtain a license and insurers selling coverage through such arrangements must comply with state insurance laws. States may require a self-insured arrangement to be licensed as an insurer[35] or in states with MEWA-specific laws, to be licensed as MEWAs.[36]

State-based standards applicable to group purchasing arrangements are more comprehensive than federal standards. State insurance laws including licensing, solvency, benefit requirements, external appeal laws, and other consumer protections apply to group purchasing arrangements. Federal standards are generally limited to fiduciary obligations, disclosure and notice requirements, and more recently a requirement to register with the U.S. Department of Labor.[37] ERISA does not require MEWAs to be licensed and there are no federal solvency, external review, or other consumer protections similar to those found in state insurance law.

In addition to a broad range of state laws applicable to MEWAs, state insurance departments have enforcement tools not available to the U.S. Department of Labor. For example, state insurance departments can shut down insurance scams using administrative cease and desist authority without going to court. Cease and desist orders may be issued in an *ex parte* fashion in an emergency.[38] This authority allows insurance commissioners expeditiously to shut down a scam without having to go to court.

The U.S. Department of Labor must seek a temporary restraining order (TRO) and a preliminary injunction (PI) from a federal court to shut down a scam. A TRO and PI by a federal court require the federal government to offer sufficient evidence at a pre-trial hearing to prove that a violation of ERISA has occurred and to demonstrate that the government will probably prevail on the merits once the case is fully litigated. Unlike states shutting down illegal arrangements based on a failure to be licensed, the federal government must prove a violation of a fiduciary duty, which is financial in nature requiring evidence that assets have been misused. To gather enough evidence for a successful hearing in federal court, Labor's investigations may take several years. While being investigated, operators of scams continue collecting premiums.

Although both states and the federal government regulate group purchasing arrangements, health coverage scams continue. Operators of scams continue to use ERISA preemption as a shield to avoid state enforcement actions, challenging state authority by removing cases to federal court.[39]

Additionally, preemption ambiguities under ERISA continue to be exploited. For example, ERISA prohibits states from regulating union plans. Ambiguity over what a union plan is has resulted in health insurance scams promoted through phony unions.[40] According to the U.S. Department of Labor in one case, a MEWA called the International Professional, Craft and Maintenance Association Trust claimed exemption from state regulation as a Taft-Hartley plan. This phony union left 3000 workers with $2.3 million in medical bills and worker compensation claims.[41] The U.S. Department of Labor found another sham union called the International Workers' Guild (IWG), which left 3600 people in 32 states with approximately $25 million in claims.[42] State regulators believe that major impediments to effective state regulation include operators of scams using ERISA as shield to avoid state regulation and exploiting preemption ambiguities under ERISA.[43]

The next section discusses implications for policymakers and examines one federal proposal recently endorsed by President Bush.

PART III: POLICY IMPLICATIONS

The recent influx in health insurance scams sold through associations presents significant challenges for policymakers to address. One way to eliminate fraud is to provide universal access to affordable health coverage and thus eliminate the demand.

Absent comprehensive reforms, policymakers should improve oversight and clarify current state and federal regulatory authority. Further research is needed to evaluate the efficacy of state and federal regulation. Identifying differences among state enforcement and the federal government's approach will help inform public policy about most effective strategies to address fraud. Generally, new enforcement tools, stronger civil and criminal sanctions, and additional resources would help improve oversight. At a crucial time when incidents of fraud are on the rise, declining state and federal budgets and new priorities reflecting domestic security concerns may result in fewer enforcement actions.[44]

Instead of addressing the current crisis, some members of the U.S. Congress are considering federalizing the regulation of association plans by eliminating state authority to regulate such arrangements. A bill, which was added to the House-passed Patients Bill of Rights (H.R. 2563), would preempt state regulation of association health plans. President George W. Bush has actively promoted proposals to federalize association health plans.[45]

Similar bills have been introduced over the past twelve years but have been strongly opposed by prior administrations. David Ball, Assistant Secretary of Labor appointed by President George Bush, told the U.S. Senate in 1990, "In concept, MEWAs would appear to fill an important void in health-care availability. In practice, they may be subject to abuse. This is because they may have inadequate reserves, and therefore, be unable to pay claims. In the worse situation they

may be run by individuals who bleed them dry through extraordinarily high fees and outright embezzlement."[46] Seven years later, Olena Berg, Assistant Secretary of Labor appointed by President Bill Clinton, told the U.S. Senate Labor and Human Resources Committee, "While MEWAs may offer economy of scale advantages, their operation is often marred by entrepreneurs who market and operate them as Ponzi schemes. These operators unscrupulously promise health benefits, collect premiums from the employers for health coverage and then default on their obligations, leaving participants with thousands of dollars in unpaid claims."[47]

H.R. 2563 would federalize the regulation of association health plans by eliminating state authority and state-based consumer protections from applying to such plans.[48] Additionally, the bill's preemption provisions create new ambiguity under ERISA. For example, the bill would preempt state laws that "may preclude" or merely have the "effect of precluding" entities from selling to a federally licensed association.[49] Under this vague standard, it is difficult to determine which state laws are preempted. As discussed earlier, ERISA ambiguities help criminals avoid state regulation, resulting in small businesses and their workers being defrauded.

The bill does not provide the U.S. Department of Labor with new enforcement tools to strengthen its regulatory authority. To enforce the standards in the bill, the U.S. Department of Labor has to go to federal court.[50] And as discussed earlier, it is difficult to shut down a scam expeditiously when going to federal court.

Furthermore, it is unclear whether Congress will appropriate necessary additional resources to enable the U.S. Department of Labor to enforce the new standards. In 1997, in evaluating a similar federal bill, the Assistant Secretary of Labor Olena Berg told Congress that given its resources and the scope of its regulatory responsibilities, the Department could review each health plan under its jurisdiction once in 300 years. She said, "An infrastructure adequate to handle the new responsibilities (under a similar bill), replicating the functions of 50 state insurance commissioners, simply does not exist."[51] Recently, the GAO criticized the Department's ability to regulate stating, "The operational weaknesses and broader management issues ... could affect its ability to effectively and efficiently carry out its responsibilities for enforcing ERISA's employee benefit plan provisions."[52] Yet some policymakers believe that the U.S. Department of Labor will effectively regulate association health plans.

With limited federal oversight, more fraud may occur. Instead of replacing comprehensive state-based laws with a weak federal law, Congress should look for ways to address the current crisis of health insurance scams sold through associations, which defraud small businesses and leave thousands of working Americans without health insurance and with millions of dollars in medical bills.

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* Assistant Research Professor, Georgetown University Institute for Health Care Research and Policy. Before joining the faculty at Georgetown University, Ms. Kofman was a federal regulator at the U.S. Department of Labor, where she worked on federal legislation affecting association health plans in addition to regulating such arrangements. Prior to joining the U.S. Department of Labor, Ms. Kofman was Counsel for Health Policy and Regulation at the Institute for Health Policy Solutions, a non-profit, non-partisan firm, where she assisted small businesses in establishing health insurance purchasing coalitions. She also worked at the National Association of Insurance Commissioners, where she researched state regulation of Multiple Employer Welfare Arrangements. Mila Kofman holds a law degree from the Georgetown University Law Center and a Bachelor of Arts in Government and Politics from the University of Maryland, College Park.

[1]Judy Muller, *Insecure Insurance: Unmonitored MEWA Plans Stick Patients with Unpaid Bills*, ABC World News Tonight, Mar. 6, 2002, *available at* ABC News.com.
[2]Chao v. Graf, et al, CV-N-01-0698-DWH-RAM, at 6, 15-17 (D. Nev. Feb. 1, 2002) (court issued a preliminary injunction) (hereinafter Federal Court Order Employers Mutual). *See also* Complaint for ERISA Violations, U.S. Department of Labor, Chao v. Graf, Employers Mutual LLC, et al, CV-N-01-0698-DWH-RAM, at 8 (D. Nev. Dec. 13, 2001) (hereinafter Complaint Employers Mutual).
[3]Federal Court Order Employers Mutual at 6; Complaint Employers Mutual at 4. Official sources indicate that outstanding medical bills may be in the $20 million range.
[4]See Congressional testimony on MEWA fraud by Gregory McDonald, Associate Director, Income Security Issues, U.S. General Accounting Office, Testimony before the Subcommittee on Retirement Income and Employment, Select Committee on Aging, House of Representatives, Sep. 17, 1991 (hereinafter GAO Testimony); Testimony of Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration before the Senate Labor and Human Resources Committee, Oct. 1, 1997, at 9-11 (hereinafter Berg Testimony).
[5]Stephen Long and Susan Marquis, *Pooled Purchasing: Who Are the Players?*, HEALTH AFFAIRS, Jul./Aug. 1999, at 105, 107.
[6]A federal law called the Employee Retirement Income Security Act of 1974 (ERISA) defines MEWAs broadly to include employer purchasing coalitions, trade associations, or other group purchasing arrangements offering health coverage to two or more employers or self-employed individuals. ERISA § 3(40), 29 U.S.C. § 1002. Individuals who operate such arrangements no longer use the "MEWA" label because of the large number of MEWA insolvencies and fraud since ERISA was enacted.
[7]Berg Testimony at 9-11. For a discussion of civil and criminal MEWA fraud cases handled by the U.S. Department of Labor, see U.S. DEPARTMENT OF LABOR, PENSION AND WELFARE BENEFITS ADMINISTRATION, EMPLOYEE RETIREMENT INCOME SECURITY ACT REPORT TO CONGRESS for years 1994 - 1999 (hereinafter U.S. Department of Labor Reports to Congress).
[8]Telephone discussion with Fred Nepple, General Counsel for the Wisconsin Insurance Department, Chairperson of the NAIC ERISA Working Group (and a leading expert on association health plans and MEWAs) (Apr. 24, 2002).
[9]Aissatou Sidime, *Health Insurance Rip-offs Rising*, SAN ANTONIO EXPRESS-NEWS, Mar. 19, 2002, at 3E.
[10]*Gallagher Wins on Appeal Against Phony Insurer*, Florida Department of Insurance, Press Release, May 8, 2002; *Gallagher Orders Sixth Unlicensed Health Insurer To Stop Operations in Florida*, Florida Insurance Department, Press Release, May 14, 2002 (hereinafter Florida May 14, 2002 Press Release).
[11]One state regulator reported referring 12 cases for administrative action within one week. The same regulator indicated that she has never seen as many health coverage scams as she is seeing currently. Telephone discussion with Dalora Schafer, Director Life, Accident and Health Division, Oklahoma Insurance Department (Apr. 22, 2002).
[12]Telephone discussion with Ron Musser, Assistant Commissioner, Office of Financial Solvency, Louisiana Insurance Department (Apr. 5, 2002).
[13]Telephone discussion with Gloria Della, Public Information Officer, U.S. Department of Labor, Pension and Welfare Benefits Administration (Apr. 2002).
[14]Texas Petition for Temporary Restraining Order at 5, Texas v. American Benefit Plans et al., Cause No. GV200903 (Tx. D. Travis County Mar. 6, 2002) (hereinafter ABP Petition). ABP also allegedly sold coverage through the American Association of Agriculture, Forestry, and Fishing Workers; the American Association of Transportation, Communication, Electrical, Gas, and Sanitary Workers; the American Association of Wholesale Trade Workers; the American Association of Manufacturer Workers; the American Association of Service Workers; the American Association of Construction Workers; and American Association of Professional Workers. *Id. at* 6-7.
[15]Telephone discussion with Jon Nogarede, Assistant to Robert Loiseau, court appointed Special Deputy Receiver of American Benefit Plans (Apr. 4, 2002); Discussion with Dorien M. Rawlinson, Health Policy and Research Analyst, Colorado Division of Insurance (Apr. 5, 2002).
[16]Federal Court Order Employers Mutual at 2-3. Its operators even sold coverage to the National Writers Union whose membership includes freelance journalists.
[17]Operators of Employers Mutual charged below market rates. Complaint Employers Mutual at 8.
[18]Telephone discussion with Stephanie Goldberg, consumer covered by Employers Mutual LLC (Mar. 6, 2002).
[19]U.S. DEPARTMENT OF LABOR, PENSION AND WELFARE BENEFITS ADMINISTRATION, EMPLOYEE RETIREMENT INCOME SECURITY ACT 1998 REPORT TO CONGRESS 14 (hereinafter 1998 Report to Congress).
[20]A federal court sentenced Paul Pereira, its operator, to two years imprisonment for health care fraud and embezzlement. U.S. DEPARTMENT OF LABOR, PENSION AND WELFARE BENEFITS ADMINISTRATION, EMPLOYEE RETIREMENT INCOME SECURITY ACT 1999 REPORT TO CONGRESS 15.

[21]Florida May 14, 2002 Press Release.
[22]KAISER FAMILY FOUNDATION AND HEALTH RESEARCH AND EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS 2001 ANNUAL SURVEY 14 (2001) (hereinafter Kaiser Survey).
[23]U.S. GENERAL ACCOUNTING OFFICE, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements,* GAO/HRD-92-40, at 2-3 (Mar. 10, 1992) (hereinafter 1992 GAO Report).
[24]Kaiser Survey at 16.
[25]Projected by Hewitt Health Value Initiative, HEWITT ASSOCIATES, *Annual Health Care Cost Increases National Averages* (2001).
[26]California's public employees benefits program estimates a premium increase of between 20% and 25% next year. CalPERS, *2003 Health Plan and Premium Changes, available at* www.calpers.ca.gov (Apr. 17, 2002). A UCLA study estimates private premiums to increase by 20% in 2003. *Health Insurance: Premiums Expected to Rise 20% in 2003*, AMERICAN HEALTH LINE (Jun. 18, 2002).
[27]Operators of the International Forum of Florida Health Benefit Trust defrauded 43,000 individuals and left $29 million in unpaid medical bills. They pleaded guilty to embezzlements, kickbacks, and money laundering. In the plea agreement they agreed to pay $34.5 million in restitution to the victims. Peter Kerr, *3 Pleaded Guilty in Insurance Fraud Case,* NEW YORK TIMES, Dec. 30, 1992, at D3.
[28]1992 GAO Report 22.
[29]David Randall, Deputy Director, Ohio Department of Insurance, Testimony of the State and Federal Health Insurance Legislative Policy (B) Task Force of the National Association of Insurance Commissioners Before the Committee on Labor and Human Resources of the United States Senate, July 25, 1995, at 9 (hereinafter NAIC Testimony).
[30]ERISA § 514(a), 29 U.S.C. §1144.
[31]ERISA § 101-110, 404-413, 29 U.S.C. § 1021-1030, 1104-1113.
[32]U.S. DEPARTMENT OF LABOR, PENSION AND WELFARE BENEFITS ADMINISTRATION, MULTIPLE EMPLOYER WELFARE ARRANGEMENTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT: A GUIDE TO FEDERAL AND STATE REGULATION 1 (1992) (hereinafter U.S. Department of Labor MEWA Guide).
[33]Although there were no changes to Labor's jurisdictional authority, it now believes that it has broad authority to go after arrangements that are not ERISA covered plans when they handle ERISA plan assets, which occurs when employers covered by ERISA participate in the arrangement. U.S. Department of Labor MEWA Guide at 5.
[34]ERISA § 3(40), 29 U.S.C. § 1002.
[35]U.S. DEPARTMENT OF LABOR, PENSION AND WELFARE BENEFITS ADMINISTRATION, AO 90-18A (1990) (letter to J.Scott Kyle, Texas State Board of Insurance).
[36]NAIC Testimony at 9.
[37]The registration requirement was enacted in 1996. Six years earlier, Labor Secretary Elizabeth Dole asked Congress for authority to require MEWAs to register with the Department. See 1992 GAO Report; David Horowitz, *Uncovered: Health Plan Fraud Leaves Workers in Lurch*, ST. LOUIS POST - Dispatch, Aug. 21, 1990, at 6D (hereinafter Horowitz Article). In addition to these requirements, federal HIPAA portability and access rules amended ERISA and therefore apply to MEWAs.
[38]For example, Colorado's Insurance Department issued an ex parte emergency order against American Benefit Plans, ordering its operators "to cease and desist the unauthorized and unlawful transaction of the business of insurance in the state of Colorado." Case File No. 130120, Order No. 0-02-144 (Feb. 13, 2002).
[39]Operators of American Benefit Plans challenged Texas Insurance Department's authority by removing the case to federal court. *See* Texas v. Robert David Neal, et al., Case No. A–02-CA-220-SS, at 4-5 (W.D. Tx. May 22, 2002) (remanded to state court); Texas v. American Benefit Plans et al., Cause No. GV200903, at 7 (Tx. D. Travis County May 28, 2002) (ordered permanent injunction).
[40]In 1991, the GAO told Congress that the U.S. Department of Labor needs to issue regulations clarifying union status. 1992 GAO Report at 9. To this date, there are no final regulations although the Department issued proposed regulations in 2000.
[41]*Multiple Employer Welfare Officials Sued for Siphoning $2.3 Million in Plan Funds*, U.S. Department of Labor, Pension and Welfare Benefits Administration, Press Release, Aug. 5, 1996.
[42]1998 Report to Congress at 8. *See also Court Grants Preliminary Injunction, Continuing Freeze of Assets of Trustees and Administrator of New York-based Health Program*, U.S. Department of Labor, Pension and Welfare Benefits Administration, Press Release, Dec. 29, 1998.
[43]GAO Testimony 3-4.

[44]For a discussion of state budgets and priorities see John Engler, Michigan Governor, Testimony of the National Governors Association before the Senate Appropriations Committee on Homeland Security Funding, Apr.10, 2002. The Congressional Budget Office underestimated revenues for 2002 by $80 billion. CBO, MONTHLY BUDGET REVIEW (Jun. 14, 2002). President Bush described the FY2003 budget submitted to Congress as placing "highest priority on war against terrorism overseas and at home." OFFICE OF MANAGEMENT AND BUDGET, BUDGET HIGHLIGHTS (Feb. 4, 2002).

[45]WHITE HOUSE PRESS OFFICE, *Transcript: Bush Remarks on Health Care Reform*, Feb. 11, 2002; Elisabeth Bumiller, *Bush Proposes Insurance Plan to Businesswomen*, NEW YORK TIMES, Mar. 20, 2002, at A20; NEW YORK TIMES, *The 2000 Campaign; 2nd Presidential Debate Between Gov. Bush and Vice President Gore*, Oct. 12, 2000, at A22.

[46]Horowitz Article (Assistant Secretary of Labor's Testimony before the U.S. Senate Subcommittee on Investigations).

[47]Berg Testimony at 10.

[48]H.R. 2563 § 421(b) amends ERISA § 514.

[49] *Id.*

[50]H.R. 2563 § 424(b).

[51]Berg Testimony at 6.

[52]U.S. GENERAL ACCOUNTING OFFICE, *Pension and Welfare Benefits Administration: Opportunities Exist for Improving Management of the Enforcement Program,* GAO-02-232, at 3 (Mar. 15, 2002).

# Affordable Health Insurance for Small Business and the Uninsured

5 February 2003

Paul J. Kostek
Chair
American Association of Engineering Societies
1828 L St. NW
Suite 906
Washington, D.C. 20036

The American Association of Engineering Societies (AAES), its 26 member societies and the over one million U.S. engineers it represents, want to thank the Committee on Small Business and Entrepreneurship for the opportunity to submit the following statement for the record. AAES applauds the Committee for its work on the very important issue of health care.

AAES recognizes the importance of improving opportunities for all workers to gain access to health care coverage. Association Health Plans (AHP) increase access to affordable health care options for families employed by small businesses. Additionally, AHPs can reduce health coverage costs by 15-30% by allowing small businesses, the self employed, and professional societies to join together to obtain the same economies of scale, purchasing clout, and administrative efficiencies from which employees of large corporations and union health plans currently benefit.

As discussions get underway in this Congress on the topic of affordable health care, we ask that the following four principles be incorporated in any health care reform legislation:

·Remove barriers to small employers, the self employed, and professional society membership banding together to purchase fully insured health plans, thus expanding the market for insurers.

·Increase the choices of health plans available to small business employees and association members by preempting state mandated benefits for AHPs in the same manner as large employer and union plans are exempt from such mandates.

·Increase solvency standards and other consumer protections for self-insured AHPs thereby leveling the playing field between self-insured and fully insured plans.

·Apply the same patient protection provisions that health care reform initiatives apply to corporate plans and union plans.

AAES stands ready to support Congress in its efforts to provide all workers access to affordable health care.

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*AAES is a multidisciplinary organization dedicated to advancing the knowledge, understanding, and practice of engineering in the public interest. Our members represent U.S. engineering-with over one million engineers in industry, government and education. Through its councils, commissions, committees, and task forces, AAES addresses questions relating to the U.S. engineering profession.*

**Statement of Senator Mary L. Landrieu**
**Small Business Committee Hearing**
**"The Small Business Health Care Crisis: Possible Solutions"**
**February 5, 2003**
**9:30 a.m.**
**SR 428A**

Madam Chair, I would like to take this opportunity to thank you for holding this important hearing. Over the past several months, I have had the chance to spend a good bit of time in my home state of Louisiana, talking to Seniors, parents, school teachers, doctors, hospitals, small businesses, and large employers and while many of their concerns were different, they had one that was the same- the rising cost of health care. One in five non-elderly people in Louisiana are without health insurance. Fifty six percent of whom are full time, full year workers. Two hundred and thirty four thousand of these are children.

Why is this a small business problem? 1 in 4 uninsured workers in Louisiana are employed by a firm with less than 25 employees, surprisingly, this is less than the national average, where 1 in 3 uninsured workers are employed by a small firm. While this is not the topic of today's hearing, almost half of the uninsured in Louisiana make less than $20,000 a year and are not covered by Medicaid. The consequences of these statistics reach beyond the workers and their families. The rising insurance rates and the related cost of care are due in large part to the fact that while these Americans may not have insurance they still need health care and are often using more expensive routes to get it.

Today's hearing is the first of many, I hope, conversations about creative solutions to this staggering problem. While I understand that today's discussion will be centered on Association Health Plans, I would be remiss if I did not take this opportunity to offer up another solution, the

Access to Health Care Act, sponsored by Senator Collins and I, Act that among other things targets aid toward small businesses through tax credits for employee health insurance expenses and grants for health insurance purchasing groups, information dissemination, and access innovation. Understanding that no one solution will help all 41 million uninsured, helping small businesses defray the cost of providing health insurance to their employees is nonetheless a solid step towards addressing this problem.

Since it is the subject at hand, let me say a few words about Association Health Plans. Small business owners and association members from my state have urged me to address the disparities that appear to exist in the cost and availability of coverage for small businesses and large employers. No doubt, by joining together, small employers can enjoy greater bargaining power, economies of scale and administrative efficiencies. These are all good things and should be explored The Association Health Plans may be able to offer these benefits to their members. One of the things I would like to look at today is what exactly are the disparities between small business and large firm coverage. Understanding where this disparity comes from is a fundamental part of this equation.

There are several things that concern me about this approach, however. First, I have been contacted by my Governor and State Insurance Commissioner who are both in strong opposition to this approach. In Louisiana, the State insurance laws are specifically designed to protect the insured from abuse and rate hikes and to ensure that necessary benefits, such as mental health care and mammography services, are available. The approach taken by current legislation would exempt these plans from some of the most important requirements of state law. What's more

concerning perhaps, is that according to a recent CBO report, 20 million employees and dependents of small employers would experience a rate increase under AHP's, while only 4.6 would see a rate reduction. In addition, 10,000 of the sickest individuals could lose coverage all together. It seems to me that this is contrary to the very purpose of these plans.

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

Finally, I am concerned about what the introduction of these plans would mean for the small group market. Albeit, this market has its share of problems, but since CBO estimates that two-thirds of the cost savings would result from attracting healthier members from the pool of existing workers, it occurs to me that that could only result in a huge imbalance in the current market. In other words, we would be solving one problem by creating another.

Again, Madam Chair, I think that this hearing is an important one. It is my hope that we can use this opportunity to carefully examine these and other proposals. I look forward to the testimony of our distinguished panelists. Thank you.

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February 4, 2003

Honorable Elizabeth Dole
B1 Dirksen Senate Building
Washington, D.C. 20510

Dear Senator Dole:

On behalf of NAMI North Carolina I am writing to urge you to oppose proposed legislation to exempt association health plans (AHPs) from state laws and regulations.

NAMI North Carolina is the largest grassroots organization in the state representing individuals with mental illness and their families. As such, we have worked hard to improve consumer protections and insurance coverage of mental health services. Over 30 states have passed insurance parity legislation requiring comparable coverage for both mental and physical illness. We hope North Carolina joins those states in the very near future.

While we support the development of AHPs, we urge that you oppose passage of legislation that exempts AHPs from all state law and regulation, which would render state mental health parity and other laws useless. Many companies that now meet state requirements would be able to significantly reduce their benefits to the detriment of persons with mental illness. Indeed, federal AHP legislation would allow AHPs to legally discriminate against those with mental illness.

Access to health care coverage should be expanded without taking away critical coverage for mental illnesses. Thank you for your consideration.

Sincerely,

Beth Melcher, Ph.D.
Director, Public Policy

Cc: Kay Flaminio, Executive Director

# 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

National organizations representing consumers, family members, advocates, professionals and providers
c/o Peter Newbould, American Psychological Association Practice Organization, 750 First Street, NE, Washington, DC 20002

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

*Speaker Hastert and Dr. Frist*
*January 16, 2003*

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

The Nation's Leading Resource for the Self-Employed and Micro-Businesses

The National Association for the Self-Employed
Legislative Office
1225 I Street, NW, Suite 500
Washington, DC 20005
(202) 466-2100 • (202) 466-2123 Fax
Website: www.nase.org

**Written Statement of**
**The National Association for the Self-Employed**

**"The Small Business Health Care Crisis: Possible Solutions"**
**Senate Committee on Small Business and Entrepreneurship**
**February 5, 2003**

The state of health care among the nation's self-employed and micro-businesses is critical. According to a June 2002 study released by the National Association for the Self-Employed, more than two-thirds of micro-business owners say they are unable to afford health insurance for themselves or their employees. The study, "Affordability in Health Care," highlights the serious difficulties micro-businesses face regarding health care amid insurance rates that are significantly higher than those paid by larger businesses and coverage options that are much more limited.

Seven in 10 owners of the smallest businesses report they do not provide any type of health care coverage to eligible employees, according to the NASE "Affordability in Health Care" study. Costs are cited as the chief reason for this trend. Participants in the study say the situation is worsening as health insurance premiums for micro-businesses are increasing at double-digit rates while insurance benefits and plan choices are decreasing.

Access to affordable health care coverage for small firms – roughly half of all U.S. employer firms – is interwoven with the nation's broader health care crisis, affecting 53 percent of the private workforce. Census data indicates that among the estimated 43 million Americans without health insurance, 62 percent (24.5 million) are from families in which the head of household is self-employed or working for a company with fewer than 100 employees. On average, workers in firms with less than 10 employees pay 18 percent more for health insurance than workers at larger firms.

A study released by the General Accounting Office (GAO) in April reported that the self-employed and small businesses have been hit hardest by lack of competition in small-group

health insurance, a situation that is contributing to strong and sudden increases in premiums for coverage.

According to the NASE study, health care reform is at the top of the list of pressing issues micro-business owners would like the federal government to focus on in the months ahead. It also shows that the cost of health insurance premiums incurred by micro-businesses increased by an average of almost 13 percent from 2001 to 2002. With this in mind, it may not be surprising that 96 percent of micro-business owners believe the cost of insurance is unreasonable for their business. Nearly half (46 percent) say their employees cannot afford to share in the cost of coverage premiums. Among those companies who offer insurance programs, one in three (33.5 percent) report their employees share in the cost of premiums.

In addition to costs, administrative burdens also make it difficult for micro-businesses to provide health insurance, the survey reports. Thirty-six percent of respondents say that acquiring insurance presents too much administrative burden for their lean organizations.

A core issue is inequalities in the tax code in which self-employed individuals must pay self-employment tax on health insurance for themselves and dependents. Under the current tax code, micro-business owners are subject to federal income tax and self-employment tax that larger businesses do not incur. Micro-businesses also frequently miss out on the economies of scale available to bigger businesses when purchasing health insurance.

The NASE feels that Association Health Plans would give the self-employed and micro-business owners access to lower rates through consolidated buying power, as well as administrative efficiencies. On average, a worker in a firm with fewer than 10 employees pays 18 percent more for health insurance than a worker in a firm with 200 or more employees. Disturbingly, health insurance premiums for small businesses are again increasing at double-digit rates, while at the same time benefits and health plan choices are decreasing. AHPs can help remedy the severe lack of access to affordable health insurance for small businesses. Study participants said they would be much more likely to purchase health insurance if the right incentives were in place. Almost eight in 10 (78 percent) say they would participate in an AHP if they received group purchase price breaks. Three in four would be motivated to participate in such plans if they were able to have more choice in benefits, or if participation would lessen paperwork and administrative burden.

We also strongly support tax credits and deductions are also a viable solution to begin addressing the existing insurance inequities in the tax code. A new idea in tax policy is to create parity between employer provided health insurance and health insurance for the self-employed. The NASE supports both a refundable health care tax credit and a self-employment tax deduction for health insurance premiums.

We here in Washington D.C. discuss issues through facts, figures and legislative solutions. But there is also a personal face to the current health care issues that plague the self-employed and small business community. Recently, NASE Member, Lance Kisby, a Pediatric Dentist in Needham, Massachusetts had contacted the NASE office to tell his story on how the high costs of health care are affecting his small business. Dr. Kisby informed the NASE that in 2000 the cost of his health insurance premiums went up approximately 7%. In May of 2001, he received a notice that his premiums would be rising by approximately 30%. By September 2001, he received a second notice that in January of 2002 he would have yet another premium increase. Dr. Kisby maintains that these increases will cost him $6,000 more this year. These increases have forced him to pass along some of the cost to his patients by raising his fees 5% and to work longer more hours to cover the loss of profit due to the higher health care costs. Dr. Kisby remarks, "As a self-employed person, I recognize that there are so many hours in a week and that I can only raise my fees so much and still be competitive while also having money to feed my family."

Dr. Kisby's story characterizes the plight the self-employed face in attempting to acquire and provide affordable health coverage for themselves and their employees. Association Health Plans (AHPs) and health care tax incentives would go a long way to solve not only the problem of small business access to affordable health care but to also alleviate the growing ranks of the uninsured.

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Legislative Office
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**A Micro-business Owner Tells His Story**

**David Alders, Member of the National Association for the Self-Employed**

My family owns and manages an East Texas agricultural business that produces of cattle, poultry and Southern pine timber. We have owned our business for over 13 years, with three full-time employees and posting revenues in the neighborhood of half a million dollars. Our business provides health insurance for family members, but not for non-family employees. And the reason for that is simple: health insurance for small businesses is too expensive. And the reason for that is simple: Health care is too expensive.

Indeed, the cost of securing health care coverage for my family has roughly doubled in the past five years; or just shy of a 20 percent annual increase. Neither our annual revenue nor our net income grows at a rate remotely near that neighborhood. Our premiums have increased in spite of the fact that you can count on one hand the number of times members of my family have in the past five years made a visit to a healthcare provider for anything other than routine dental and eye exams, and our policy doesn't include dental. Not one member of our family has a chronic condition more serious than adolescence. And you can count on the hand of a really careless woodshop teacher the number of times we have been to the emergency room over that period (that's zero).

Our family has maintained some remote semblance of affordability in healthcare coverage only because we have increased the size of our deductible to its current household limit of $15,000 annually. If rates continue to increase, we will be forced to increase that deductible to the maximum available limit of $24,000 per year.

Of course, a consequence of our high deductible policy is a benefit that is too rare in America's health care system: the incentive to carefully scrutinize each health care provider's bill. It is this kind of individual accountability for health care cost containment, which, I think, is an inescapable requirement for meaningful health care reform. I hope that making the health

care consumer also the health care billing watchdog through the increased use of MSAs coupled with higher-deductible health plan options will characterize the future of the delivery of healthcare services in America. It seems to me that the competitive pressures unleashed by an increased availability of Association Health Plans also certainly would aid in slowing the rapid rise of health care costs.

Even were it not for the costs of insuring against healthcare needs, creating jobs in America is no easy task. America's micro-businesses generally do not secure financing at the prime rate, have no market research or personnel or advertising or logistics departments and no national distribution network. We just like being in business for ourselves; we like serving our customers who most often are our neighbors in our hometowns; we like competing, and we'd love to try it on a level field. But a level field is not an accurate depiction of the American business environment, not when, on average, workers in firms with fewer than ten employees pay 18 percent more than workers at larger firms.

**Statement of The**
**National Funeral Directors Association**

**On**

**The Small Business Healthcare**
**Crisis: Possible Solutions**

**To The**

**United States Senate Small Business And**
**Entrepreneurship Committee**

**February 5, 2003**

The National Funeral Directors Association (NFDA) represents 13,500 licensed funeral directors in all 50 states. It is the leading funeral service organization in the United States, providing a national voice for the profession. The NFDA has been the premier organization chosen by top licensed funeral directors for more than 120 years. NFDA members stand for credibility, ethics, excellence and trust.

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Phone: 202-547-0877 Fax: 202-547-0726
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**Statement of the National Funeral Directors Association on The Small Business Healthcare Crisis: Possible Solutions**

The National Funeral Directors Association (NFDA) represents more than 13,500 licensed funeral directors in all 50 states. It is the leading funeral service organization in the United States, providing a national voice for the profession. The NFDA has been the premier organization chosen by top funeral directors for more than 120 years. NFDA members stand for credibility, ethics, excellence and trust.

The average NFDA member operates one to two family-owned funeral homes, has fewer than 10 employees and performs approximately 200 funerals per year.

The NFDA agrees that a crisis exists in the small business healthcare market. The crisis continues to grow and has been well documented. According to a U.S. Department of Labor (DOL) study released in September 2002, the number of uninsured Americans is now at about 40 million. In 1999, health benefits were offered by just 47 percent of work sites with fewer that 50 employees.

Cost is the biggest obstacle for these firms. Insurers typically charge small businesses more per employee then large firms for comparable coverage. Small firms are usually ill equipped to negotiate favorable terms with insurers because an individual firm does not represent a large enough block of business to merit insurers' individual attention. States also typically require group health insurance policies to cover certain specified benefits, medical procedures and treatments, adding to the cost of coverage. In a January 2000 report, the Congressional Budget Office (CBO) estimated the average reduction in premium amounts for small businesses obtaining insurance through association health plans (AHPs) would range from 9 percent to as much as 25 percent.

The experience of NFDA members confirms the findings of the DOL and CBO studies. In a January 2003 survey on this issue, over 92 of percent of responding NFDA members advised that they offer health insurance to their employees as part of their benefit package. Over 65 percent of these reported that premiums for that insurance have increased by 20 percent or more over the past three years. Over 36 percent of respondents reported that their premiums have increased over 30 percent during this time period. This has forced 32 percent of NFDA members responding to the survey to increase the amount that employees pay for health insurance, and 43 percent to reduce the coverage they offered. A complete copy of the NFDA survey results is attached to this statement.

This is not only a crisis of affordability and coverage. The inability to provide cost-effective health insurance also puts small business at a significant competitive disadvantage when hiring and retaining employees. No matter what the employment statistics are, good people are hard to find and expensive to train in any business. Small businesses have no superfluous employees. When employees decline an offer of employment, or leave, because a small business cannot provide health insurance, it often means the loss of an opportunity to grow the business or the actual decline of business volume.

Small business owners want to offer useful health insurance plans that both they and their employees can afford. It is not in their interest to offer bare-bones plans. However, in markets with limited choice and no viable association plans, small business is relegated to a virtual single payer system that cannot provide affordable premiums and decent benefits. In a March 2002 letter to Senator Christopher S. Bond (R-MO), the General Accounting Office (GAO) advised that the five largest carriers represent 75 percent or more of the market in 19 of the 34 states GAO reviewed, and more than 90 percent in seven states. NFDA's survey is consistent with this pattern. Over 44 percent of NFDA members responding advised that Blue Cross/Blue Shield was their health insurance carrier. Twenty-six different insurance carriers provided the coverage for the other 55.6 percent.

While there is no single solution to the problem of the uninsured, AHPs are an essential component to any possible solution. AHPs will allow small businesses to work with each other across state lines and follow one set of rules. The enhanced bargaining power of much larger employee groups, wider health plan options and lower administrative costs will enable associations to create robust benefit packages that respond to the needs of their members, are competitive with larger employers and affordable for both small businesses and their employees. This will significantly reduce the number of uninsured workers in America and place small business in a much more competitive position with respect to hiring and retaining employees.

**Conclusion**

The NFDA strongly supports legislation that will permit small businesses to establish health insurance purchasing groups through their trade associations under the framework of the Employee Retirement Income Security Act (ERISA) of 1974, the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 and the Health Insurance Portability and Accountability Act (HIPPA) of 1996. AHPs allow small employers to achieve the economies of scale of large employers by combining into one large group, free from state-mandated benefits and coverage conditioned on the health status, claim experience or other risks of an individual business.

The need for AHP legislation has never been greater. Congress can and should unburden small business owners from the preoccupation of how to provide health care to their employees and free them to do what they do best – run their business and grow the American economy.

Thank you for allowing the NFDA to comment on this important issue. Please include this statement as part of the committee's record of the proceedings on this matter.

**National Funeral Directors Association (NFDA)**
**Member Survey on Health Insurance Costs and Availability**

The NFDA represents more than 13,500 licensed funeral directors in all 50 states. It is the leading funeral service organization in the United States, providing a national voice for the profession and dedicated to serving the public. The NFDA has been the premier organization chosen by top licensed funeral directors for more than 120 years. NFDA members stand for credibility, ethics, excellence and trust.

The average NFDA member operates one to two family-owned funeral homes, has fewer than 10 employees and performs approximately 200 funerals per year.

Following are the results of a January 2003 survey of NFDA members on their experience with health insurance costs and availability.

1. **Does your funeral home offer health insurance to employees as part of its benefit package?**

   Yes = 92.2% No = 7.8%

2. **Have health insurance premiums for your employees increased over the past three years?**

   Yes = 98.8% No = 1.2%

| Amount of Premium Increase | Percentage of Respondents |
|---|---|
| 15% | 12.8% |
| 20-30% | 34.6% |
| 31-49% | 19.2% |
| 50% | 11.5% |
| 60% | 2.6% |
| 70-75% | 1.3% |
| 100% | 3.8% |

3. **Have premium increases forced you to require employees to pay a larger share?**

Yes = 32.9% No = 67.1%

| Amount Employees Paying | Percentage of Respondents |
|---|---|
| 5% | 6.3% |
| 10% | 12.5% |
| 15% | 12.5% |
| 20% | 12.5% |
| 50% | 31.3% |
| 100% | 18.8% |

4. **Have premium increases forced you to reduce coverage?**

Yes = 43.8% No = 56.3%

5. **Have premium increases forced you to discontinue offering health insurance to employees?**

Yes = 2.5% No = 97.5%

6. **Who is your current health insurance carrier?**

Blue Cross/Blue Shield = 44.4%

Others (26 different carriers) = 55.6%

*Paul E. Patton*
Governor of Kentucky
Chairman

*Dirk Kempthorne*
Governor of Idaho
Vice Chairman

*Raymond C. Scheppach*
Executive Director

February 5, 2003

The Honorable Olympia Snowe
Chair, Senate Small Business and Entrepreneurship Committee
United States Senate
428A Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Snowe:

As you know, rapidly escalating health care costs have posed a major challenge for states as we work to ensure that our citizens have access to affordable health insurance coverage. We are writing to alert you to legislation that Congress may soon consider that would undermine our efforts by exempting Association Health Plans (AHPs) from state insurance reforms.

AHPs are health insurance companies sponsored by business and professional associations that would be granted a special exemption from state regulation, and would instead operate under skeletal federal rules and virtually no oversight. Under current AHP proposals, these types of insurers would be exempt from important regulations that our states have designed to ensure a healthy small insurance group market that can deliver affordable care to *all* participants.

As a result, AHPs would be free to selectively market to healthy groups by selling stripped down benefit packages that exclude benefits now required by the states. AHPs also would be permitted to charge higher rates to "older, sicker" groups, a practice banned in many states. People could purchase minimal AHP coverage when they are healthy, but then jump back to state regulated insurance when they need more comprehensive coverage in the state-regulated market.

This is a major problem since it would create two pools of individuals: relatively healthy people in the federal AHPs and older, sicker people in the state-regulated market. The result: spiraling premiums for most employers. The Congressional Budget Office projected that AHP legislation would result in higher premiums for four out of five small employers if enacted.

Looking to the future, this legislation raises important questions about the future ability of our states to regulate health insurance at all. By allowing insurers who sell to AHPs to set up shop in a state with very lenient rules and oversight and market to small employers without meeting any state's rules, we would be powerless to take action even where there is obvious risk to consumers.

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Congress should be especially concerned about preempting state oversight given the long history of failures involving similar plans called Multiple Employer Welfare Arrangements (MEWAs). In just the last six months, media reports have documented failures of MEWAs – including some sponsored by associations -- that have left over 100,000 consumers with unpaid claims. AHP legislation would exacerbate these problems by replacing state oversight with minimum certification by the U.S. Department of Labor, which has no capacity for regulating insurance arrangements.

We strongly urge you to recognize the critical role states play in making health coverage affordable and accessible for our citizens. Please do not support AHP legislation, which would only tie our hands and exacerbate the task before us.

Sincerely,

Frank O'Bannon

Governor Frank O'Bannon
Chairman
Human Resources Committee

John Hoeven

Governor John Hoeven
Vice Chairman
Human Resources Committee

*Representing, Educating and Promoting the Restaurant/Hospitality Industry*

1200 SEVENTEENTH STREET NW, WASHINGTON DC 20036-3097 202/331-5900 FAX: 202/331-2429

NATIONAL RESTAURANT ASSOCIATION®

Statement
of the
National Restaurant Association
for a hearing on
Small Business/Increasing Health Care Access
before the
Senate Small Business and Entrepreneurship Committee
February 5, 2003

One of the greatest challenges facing restaurants and other small businesses today is accessibility to affordable, quality health care. The National Restaurant Association is committed to increasing health care access for the uninsured—60% of who reside in a family employed by a small business. We believe that Association Health Plan (AHP) legislation offers a viable way to provide quality health care coverage to more individuals. We commend Chairwoman Snowe for holding this important hearing and for her support of Association Health Plans.

There are over 870,000 restaurant locations in the United States. The vast majority of these restaurants are small, single-unit operations, and seven out of 10 have less than 20 employees. The restaurant industry is also one of the largest employers in the country - employing an estimated 11.7 million people - making it the largest employer outside of government.

One of the primary obstacles to providing better coverage to more people is cost. Restaurateurs from around the country are reporting the same staggering premium

increases facing other small employers. For each of the last two years, the average premium increase for a tableservice restaurant was 23%. Many of our members tell us of increases in the 40-50% range. And unfortunately, analysts project similar increases for the foreseeable future.

Employees of smaller companies also pay more to offer health care than those of large employers. On average, a worker in a firm with less than 10 employees pays 18% more for health insurance than a worker in a firm with 200 or more employees.

The costs encountered in today's small group health insurance market not only makes it difficult for our employers to find affordable coverage, it is forcing those who wish to continue offering coverage to make difficult decisions. Many employers are either having to reduce coverage, pass on a higher percentage of the cost to their employees or have to discontinue offering coverage altogether.

Another challenge facing employers is a lack of choices when they are shopping for a health plan. In many states, the small group health care market only offers employers a small handful of choices. It is clear to us that additional competition is necessary.

If enacted, Association Health Plans would decrease costs for employers and provide needed competition. Employers would have more health plan options from which to choose, by allowing them to consider the health plan of a bona-fide trade association of their choice – whether that be a National Restaurant Association plan or a Chamber of Commerce plan. AHP's would also allow small businesses to take advantage of the same uniform regulatory status, economies of scale, purchasing clout, and administrative efficiencies that corporate and labor unions currently enjoy.

In addition, Association Health Plans would provide quality and reliable health coverage. Like corporate and labor union plans, AHP's would be fully regulated by the Department of Labor. In September, 2002, Secretary Elaine Chao issued a comprehensive report detailing DOL's readiness for assuming oversight of AHP's. Also in this report, Secretary Chao emphasized the numerous safeguards in the AHP legislation that are designed to protect consumers.

The National Restaurant Association believes Association Health Plans provide a great way to increase access to the uninsured. By removing some of the cost barriers and by instilling additional competition into the small group market, AHP legislation provides employers - particularly small employers - the tools they need to provide quality health care to more people.

# ASSOCIATION HEALTH PLANS

# AND

# ALTERNATIVE WAYS TO INCREASE HEALTH INSURANCE COVERAGE

# AMONG WORKERS IN SMALL FIRMS

Statement of

Len M. Nichols*

Vice President

Center for Studying Health System Change

For

UNITED STATES SENATE COMMITTEE ON

SMALL BUSINESS AND ENTREPRENEURSHIP

Hearing to Examine the Small Business Health Care Crisis: Possible Solutions

February 5, 2003

*I am grateful to Paul Ginsburg, Kyle Kinner and Richard Sorian for comments on earlier drafts.

My name is Len M. Nichols and I am the Vice President of the Center for Studying Health System Change (HSC). HSC is an independent nonpartisan policy research organization funded solely by the Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research. Our recurrent nationally representative surveys of households and physicians, our site visits to monitor ongoing changes in the local health systems of 12 U.S. communities, as well as our monitoring of secondary data and general health system trends all enable us to provide policy makers with unique insights on developments in health care markets and their impacts on people. Our various research and communication activities may be found at www.hschange.org.

As an economist, I have studied the decisions of employers, and specifically small employers, to offer health insurance or not, as well as the general workings of small group insurance markets for the past 10 years. My research ranges from statistical analyses with nationally representative survey data gathered from employers to interviews with small employers, large employers, small business coalitions, insurers, insurance brokers, actuaries, state regulators, purchasing cooperatives, state legislators, and most recently site visit research conducted by myself and colleagues at the HSC.

I am sure this committee is well aware of the basic fact that small employers are much less likely to offer health insurance than are large firms. For example, in the most recent data, 47% of establishments with fewer than 50 workers offer health insurance, compared to 97% of establishments with more than 100 employees.[1]

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[1] Medical Expenditure Panel Survey, Insurance Component, 2000 data. www.meps.ahrq.gov.

There are many specific contributors to this disparity in offer rates, but one conclusion stands out in all my research and in the professional literature of economics as a whole: employers offer health insurance if they think they need to in order to successfully compete for workers. If they do not offer health insurance, by and large it is because they can attract and retain the workers they need without offering it.

Most of us, happily, have enough education and training to work in labor markets where health insurance is a normal and expected part of any and all compensation packages. Seventy-one percent of all workers are eligible for health insurance through their own employer. Indeed, most of us have never had a job offer without some kind of health insurance attached.

But while a distinct minority, some workers, typically those without much education or marketable job skills, often can only get jobs with no health insurance attached. And some firms, indeed a disproportionate share of small firms, mostly need the skills of these kinds of workers. These workers who cannot command health insurance in the market for their labor services, along with the sometimes prodigious efforts by the small business owner and his or her family members, are sufficiently productive to generate marketable products or services for many small businesses' customers. In competitive markets, if more skilled and highly compensated labor is not required, pretty soon profit margins are driven down to where more expensive labor actually could not be paid for, and that is when and why most small businesses who do not offer health insurance answer the question, "Why not?" with responses like, "Health insurance costs too much to provide to my workers. My business and I can't afford it." This

kind of response is the source of the shorthand but reasonable conclusion that cost is the single most important thing when it comes to health insurance and small business.

Now, in economic theory and even in real life, workers who *do* have health insurance through their employer implicitly trade at least some of what they could have had in wages in exchange for their employers' premium contributions. (Whether wage offsets completely finance all employer payments is not settled in the economics literature, but this dispute is relatively academic for our purposes today, for the larger point is beyond dispute: all workers at offering firms trade some wages for employer premium payments, whether they know it or believe it or not). Workers with relatively low productivity or value added in the competitive marketplace, unfair though their compensation may seem from some perspectives, simply are not willing or able (given low discretionary income and competing resource demands) to trade some of their already low wages for health insurance, and this is how it comes to pass that small firms with low profit margins which employ these kinds of workers simply cannot and need not provide health insurance to remain in business.

So, the "root cause" reason some firms choose not to offer health insurance is that their workers' wages are just too low (relative to the current cost of health insurance). But wages and compensation are tightly linked to the market value of a worker's productivity, so it must be that their market productivity and purchasing power is simply too low to enable them to afford health insurance. It follows, then, that an efficient way to attack the root cause of lack of health insurance among workers in small firms, and among low income workers generally, is to increase their purchasing power with direct subsidies to them. Only with this increased

purchasing power will they be willing to purchase health insurance for themselves and their families. This is the conclusion reached by two recent specific analyses of this question.[2] These subsidies, by the way, could take the form of tax credits or other sorts of assistance, including eligibility for existing or modified public insurance programs like Medicaid or SCHIP, but those details and debates are also for another day.

For the agenda item at hand is association health plans. Where might they fit into this discussion, why are their advocates so strongly in favor of them as a solution for small businesses' health insurance woes, why are their opponents just as convinced that this type of reform would do more harm than good, and what other non-subsidy alternatives to AHPs might this committee want to consider?

Before answering these questions, let me provide just one more background or contextual statement. My research over the years strongly suggests that small businesses have three primary goals when it comes to health insurance: affordability, simplicity, and stability. It is therefore efficient to examine AHPs and feasible alternatives in light of how well they might help small businesses reach these specific goals.

**Affordability.** It is well known that small firms have to pay more for the same health insurance policy than do large firms because the administrative costs of selling insurance can be spread over so many fewer workers, and thus premium loading factors – the difference between

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[2] Ferry, Danielle, Sherry Glied, Bowen Garrett, and Len M. Nichols, "Health Insurance Expansions of Working Families: A Comparison of Targeting Strategies," *Health Affairs* v. 21 # 4 (July/August 2002); Bowen Garrett, Len M. Nichols, and Emily K. Greenman, "Workers without health insurance: Who are they and how can policy reach them?" WKKellogg Foundation Community Voices report, August 2001.

premiums and expected claims costs -- are higher for small firms, perhaps as much as 20-30% higher. Thus, any kind of larger group purchasing arrangement -- AHPs, small employer coalitions, allowing small firms to buy into state or federal employee plans or into Medicaid – could in theory lower the administrative costs per worker which now drive small business premiums higher than they have to be. Analysts might quibble about which of these types of group arrangements would lower administrative costs more, but it really depends on the details of each and the ultimate size reached, so as a first order approximation it may be reasonable to agree that AHPs can look attractive on this front and thus it should be no surprise they have received so much attention.

The second dimension to affordability that is often mentioned in AHP discussions is the cost of benefit mandates and the potential gains if they could only be avoided. The effect of benefit mandates is perhaps one of the most contentious issues of factual debate in the small group health insurance market. Careful academic research tends to find little to no net effect of benefit mandates on premiums or employer offer rates, yet some small employers, and particularly some small employer advocates, appear to be convinced that benefit mandates are the major culprit in health care costs today.

A few facts can help make sense of these competing and heartfelt claims. Most insured workers work for firms that are not small. Many medium sized and most large firms self-insure and are not subject to benefit mandates. Nevertheless, most of the benefits that are mandated by states for their small group market are actually provided by large self-insured firms even though they do not "have to." Indeed, causation runs from large firm coverage decisions, which are driven

totally by labor market competition, to state mandates on small firms, whose proponents argue for them as a matter of equity. In addition, many small firms that do offer coverage are *high wage* firms, and they offer as rich a package as do the large firms, ordinarily. So, the bottom line here is that mandated benefits add relatively little to *average* insurance costs, and that is why most good academic research based on nationally representative data finds so little impact of them

At the same time, clearly benefit mandates must add to costs for those firms that were not offering particular benefits prior to the mandate's passage. The Department of Insurance of the State of Texas did a very comprehensive study in 1998 which concluded that the 9 mandates in Texas, which are not atypical and include inpatient treatment of alcohol and substance abuse, represented about 3% of claims paid in the two most recent years available.[3] I and colleagues,[4] as well as the CBO in a later study[5] both concluded that a reasonable interpretation of the entire literature calls for an assumption that exemption from benefit mandates would save those firms that joined AHPs about 5% off their premium on average. Now 5% of a family premium these days is not a trivial amount of money, but please note that administrative load savings are likely to be 4 to 6 times larger as a percent of premium. It should also be noted that benefit mandates do add some value that should be weighed against cost. Research has shown that employee takeup of employer offers is higher in states with more mandates.[6]

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[3] www.doi.tx.st.gov

[4] Linda J. Blumberg, Len M. Nichols, and David Liska, *Choosing Employment-Based Health Insurance Arrangements: An Application of the Health Insurance Reform Simulation Model.* Final Report 0657-001-00, Department of Labor, Pension and Welfare Benefits Administration, March 1999.

[5] Congressional Budget Office. "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts," January 2000.

[6] Gail Jensen and Michael A. Morrisey, "Managed Care and the Small Group Market," in Michael Morrisey, ed., *Managed Care and Changing Health Care Markets.* Washington, DC: AEI Press, 1998.

By far the most important determinant of the cost of health insurance in any alternative arrangement, of course, is the risk pool one has access to, or more precisely, the relative health risk of those with whom you are pooled. I will return to this important point below, for it is complex enough to be best addressed when we consider the stability of premiums.

**Simplicity** in health insurance is practically a contradiction in terms, and most small business owners must depend on agents or brokers to guide them through the inherently complex maze of details involved in health insurance choices today. Information and education functions are essential in any small group market solution, and agents may provide the cheapest and most widely trusted source of this information that anyone can devise. If any entity like an AHP or purchasing cooperative tried to avoid agents altogether, they certainly could, but they would have to then build in the costs of providing information about health insurance choices to all participating employer and employees. This will necessarily "take back" some of the administrative savings from self-insuring and forming a larger agglomeration of small groups. On the simplicity front, allowing firms to buy into existing employee pools, like state employee pools, might be the clear winner.

**Stability**. Small business owners are typically not in the health insurance business. They do not have enough time to master constantly changing details that are not directly related to their own production, sales and delivery problems. They want a basic package to be competitive in the labor market, and they do not want to have to worry about premium fluctuations that will force them to repeatedly start over at ground zero with a new set of insurance options. For lots of reasons, premiums in the small group market are more variable than in the large group market.

Just last week brokers reported to HSC researchers, including myself, of premium increases for small businesses in a given market that ranged from 10-90% in the last year. No business nor worker can sustain 90% increases of an item already as large as health insurance premiums are now. Now 90% might be an outlier, but there is considerable evidence that the variance of premiums over time for small groups is indeed larger than for larger groups, and so the basic interpretation of relative instability remains.[7] Just hearing about these kinds of experiences, and enough small employers have experienced them that almost all have heard about the possibility over time, makes a small employer think twice about offering health insurance since the prospect of having to take an important compensation piece away in the future is more painful than continuing to live with not offering it as they have in the past. So stability is extremely important to any effective reform of small group options.

And it is precisely along the stability dimension that I fear AHPs earn the lowest marks. We learned on an HSC site visit just last week that in 2001 the Arkansas legislature passed a law which allowed small employers to join together and purchase insurance together as a large group and to avoid benefit mandates. But no insurer there would agree to offer coverage to these groups because of their fear of eventual adverse selection. That is, insurers were afraid that any premium rate that would cover the average costs of those who would be attracted to join together in an association-like arrangement in the first place – an association whose sole purpose was to purchase health insurance – would be higher than the average costs of specific groups. The insurers expected specific low-cost groups then to opt out over time and the insurers feared being left holding the deteriorating risk pool bag of the shrinking association plan. If the Arkansas

[7] David M. Cutler, "Market Failure in Small Group Health Insurance," NBER working paper, October 1994; Stephen H. Long and M. Susan Marquis, "Stability and Variation in Employment-Based Health Insurance Coverage, 1993-97." *Health Affairs* v. 18 # 6 (Nov-Dec 1999).

insurers were correct, and it is telling that all reached the same conclusion, this kind of association could lead to rapidly increasing but actuarially fair premiums over time for well-intentioned members of the association plan. In the limit, this process is known as a death spiral.

Second, precisely because exemption from benefit mandates is such a strong motivation of proponents, many opponents of AHPs, including large insurers like Blue Cross Blue Shield plans which sell in the small group market, fear the opposite kind of selection into AHPs. They fear that more parsimonious benefit packages (the goal of exemptions from benefit mandates), and the ability to actively exclude small groups from the association and insurance product if not carefully proscribed, would siphon off all the good risks they need to keep in their blocks of business in order to keep their small group premium rates down. The CBO analysis of AHPs cited earlier estimated that 20 million workers would see their premiums rise if the AHP legislation of that day became law.

Aside from the obvious self-interested conflict here, there are fundamental issues at stake. Essentially, self-insured AHP options, regardless of who runs them, could compete with commercial insurers and Blue Cross Blue Shield plans and anyone else – over who can package the best set of risk pools for the most small businesses. The analogy which proponents of AHPs sometimes invoke is that of large self-insured firms like General Motors or Xerox or Honeywell. Why should small firms not have the same power to self-insure? (They have the right now, but self-insuring a group with fewer than 100 members is rarely cost effective and highly risky).

Well, perhaps as a matter of fundamental liberty they should (and do) have the right to self-insure alone, but the analogy between AHPs and General Motors fails for a simple but powerful reason: General Motors self-insures *all* of its workers, it does not allow workers in California to select one self-insured pool and workers in Flint to select another, nor can workers in Flint select among competing risk pools (as some AHP proponents would allow). Whereas an AHP by construction would be a set of very small employers, any of whom could bolt or join at open enrollment time or at will if another insurer was willing to take or free them. Thus the inherent *stability* of any AHP risk pool cannot be as great as the largest self-insured employer pools can maintain. Either the self-interested search for more homogenous risk pools and insurance products among low risk firms will exert constant pressure for the pool to deteriorate, as the Arkansas insurers feared (perhaps new AHPs will repeatedly be re-constituted as a best case scenario), *or* the AHP will likely attract the lowest risk businesses who are willing to forego mandated benefits (in the mistaken belief that down that path lies huge savings) and the commercial risk pools would deteriorate, as the Blues fear and CBO predicted. The analysis I and my colleagues did at Urban a few years ago (cited earlier) suggests that this fear of commercial risk pool meltdown is probably exaggerated by some, but some deterioration is inevitable and the risk of large effects is certainly not zero.

There is one other concern about AHPs that can be solved but needs attention and that is the matter of reserves and regulatory oversight of those reserves, since AHPs would not be typically regulated by state insurance departments. There have been some relatively rare but painful episodes of multiple employer insurance arrangements in the past being operated by people who took the premiums and left employers and workers with an unenforceable guarantee of the

coverage they had paid for in good faith. I am no lawyer but have talked to enough to caution you to pay particular attention to these details in any enabling legislation to ensure the creation of adequate reserves and the operation of some kind of guaranty funds oversight mechanism in the event of miscalculations or financial meltdown or outright fraud, which does indeed happen in the real world.

So, are there better ways to provide small businesses with more affordable, simple, and particularly more stable health insurance options?

You may find it useful to have your staff review the set of proposals in an RWJF funded effort, spearheaded by Jack Mayer of the Economic and Social Research Institute, which were compiled into a book entitled *Covering America*.[8] There you will find quite a few specific ideas about how better pooling and purchasing arrangements – specifically for small employer groups and for those relatively few uninsured with no employment connection at all – may be constructed from existing institutions. I was one of the co-authors of one of the proposals, the risk sharing theory of which has been accepted for publication in an upcoming issue of the American Economic Review,[9] and I am also on the Advisory Panel to the Covering America project and so am familiar with the arguments advanced by the other nine proposal teams. I will summarize some options that come out of that work for you, omitting much subsidy mechanism, cost-control, and quality enhancement detail that your staff may want to peruse at some length later.

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[8] Jack Meyer and Eliott Wicks, *Covering America*. Economic and Social Research Institute, 2002. http://www.esresearch.org/RWJ11PDF/full_document.pdf.

[9] John Holahan, Len M. Nichols, Linda J. Blumberg, and Yu-Chu Shen. "A New Approach to Risk Spreading via Coverage Expansion Subsidies," *American Economic Review* (forthcoming, May 2003).

**Allow small firms to join existing state employee pools.** In many states, the single largest employer is the state itself. As such, states are often able to offer their employees a choice of plans and competitive low-load rates that are rarely possible for small firms. Many states also allow counties and even smaller administrative units to opt into their state employee plan. It would be fairly easy to allow small businesses to bring their employees into the state pool. Enrollment forms could be sent to small businesses with their tax forms each year, made continually available on web sites which most if not all states maintain now, and contributions – shared as employer and employees agree to on their own -- could be sent into the state monthly along with income tax withholdings. State employees might fear that small businesses who would join would be sicker than those who would remain outside the state pool, and that would be a risk, but two facts should calm. First, state employees tend to be older and sicker than workers in general. Second, since HIPAA imposed guaranteed issue for all products in small group markets, there is relatively little underwriting at the small group level anywhere any more, at least considerably less than there was prior to 1997 when typically only two products were required to be guaranteed issue and others were allowed to be underwritten. This means any new firms likely to add coverage post-reform are more likely to be relatively low risk, and not high risk since universal guaranteed issue has already pulled the higher risk into the small group market. Finally, one could imagine requiring that all small employers purchase health insurance through the state pool, if they chose to offer health insurance (I am not advocating an employer mandate), which would purge any remaining fear or risk of adverse selection against the combined state employee-small business pool. This option would provide the maximum stability, simplicity, and affordability of all the options I can think of, with the added bonus of

adding considerable choice of private health plan options for small firms' employees, something very few of them have today.

**Allow small firms to form purchasing cooperatives for the purpose of buying health insurance.** They have this right in most states now, and while some work well, this movement has surprised analysts with how it did not exactly take the small business sector by firestorm, despite some obvious advantages over going it alone in small group purchasing.[10] There are many reasons for the disappointment, but the relevant advantages of the best of these vis a vis AHPs is that they have similar insurance rules as the outside market – AHPs by construction would be exempt from mandates and perhaps able to underwrite more aggressively as well – and they could achieve critical administrative economies of scale and sufficient size to reach risk pool stability over time. A fair read of our experience to date, however, must admit that pools formed wholly by small employers are not likely to be as large or as stable as pools that would marry state employees and small employers together. Federal policy makers could insure that any pools that are formed are governed by the same market rules as prevail outside the pools in each state, but short of subsidies there is not much policy can do to ensure critical mass.

**Allow small firms to buy their employees into Medicaid or SCHIP or some new hybrid state-employer program.** This option is more attractive for extremely low wage workers who might actually be eligible – for themselves or for their children – for public insurance today. The concept is similar to allowing employers to buy into the state employee plan. This is a bit more complex because the benefit package for Medicaid is typically more comprehensive than the private employment-based plans that are offered to state employees, and policy makers may

[10] Elliot Wicks, "Health Insurance Purchasing Cooperatives," Commonealth Fund, November 2002.

prefer to allow small employers of low wage workers to somehow buy less generous plans, or provide subsidies to help them afford them afford the more generous Medicaid package. Plus this option requires employers to deal with Medicaid stigma issues, which some feel more strongly about than others. Opportunities to reduce stigma are manifest in many SCHIP plans and the Basic Health Plan in Washington state, for example. Also, Medicaid enrollees are probably more expensive than small employers' workers and their families, and Medicaid typically pays providers lower than other payers, so these this too could create some start-up costs. Still, allowing small employers to opt-in to the Medicaid purchasing apparatus would clearly offer administrative savings and a stable risk pool compared to buying insurance alone in the small group market.

I would conclude by iterating the most effective way to bring about more coverage of workers in small firms is to subsidize workers directly. I would be glad to elaborate on those options at the convenience of the Committee. My bottom line judgment is that AHPs do not score as well as allowing small firms to buy into state employee plans on the three criteria I think small businesses care the most about, affordability, simplicity, and stability. However, as in all policy choices, there are complex tradeoffs involved in any change along these lines, only some of which are amenable to technical analysis or which can be articulated in brief testimony on one day.

I would glad to answer any questions this testimony may have raised, now or at a future time.

**Pennsylvania Builders Association Testimony before the Senate Small Business Committee on**

**"The Small Business Health Care Crisis: Possible Solutions"**

**February 5, 2003**

**Background**

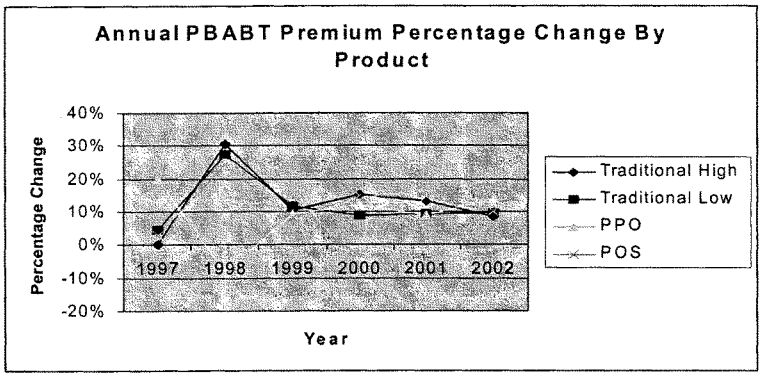
The Pennsylvania Builders Association (PBA) is a non-profit statewide trade association affiliated with the National Association of Home Builders and a network of 41 local associations throughout Pennsylvania. Headquartered in Lemoyne, Pennsylvania, it strives to represent the interests of nearly 12,000 employer members, and the nearly 500,000 employees and members involved in various aspects of Pennsylvania's home building industry. Our membership consists of 4,000 builder-members and more than 8,000 associate members who make their living as subcontractors, suppliers and other building professionals.

The residential construction industry is responsible for a significant portion of the economy in the Commonwealth each year. While our member firms range widely in size, we are an organization consisting predominantly of small businesses. While many of our members operate enterprises having 100 employees or more, between 60-70% of our builder members have ten permanent employees or less. When the effect of the economic activity of our members is "multiplied" by its ripple effect on local communities throughout the state, the importance of a vital home construction industry cannot be overstated.

In addition to representing the professional needs and interests of the building industry in state regulatory and legislative arenas, the PBA endeavors to provide other services and products to enhance the effectiveness and efficiency of its members' operations. One of the most significant support services we strive to provide is affordable group health insurance for our members. The PBA offers group health insurance to its membership through the PBA Benefits Trust (PBABT). The PBABT has had a valued relationship with each of the Blue plans across the state for more than twenty years. Given the aggregate size of our membership, historically we have been able to negotiate favorable group health insurance rates that have made it possible for many of our members to provide health coverage to their employees. Without the collective buying power of our association, most of our builder-members, simply because of their size, would be unable to negotiate favorable health insurance premium rates for themselves and their employees.

By seeking out favorable group health insurance contracts for our membership, PBA seeks to accomplish two important goals. First, the availability of affordable private group health insurance rates means that tens of thousands of individuals working in Pennsylvania's home building industry have the security of health insurance for their families. Second, since the cost of labor is passed to the consumer in the final price of a home, keeping health insurance costs down keeps the cost of new home construction down as well.

1. Keeping health insurance rates affordable is a matter of great significance to our membership, but we have seen in the past several years some very troubling trends developing. Group health insurance premiums, even for an organization as large as the PBA, have been rising. The following table illustrates the average annual premium increases by PBA Benefits Trust product family since 1997:




This equates to an average annual premium increase to our membership of approximately 12%, or a doubling of the average premium rate over six (6) years. Rates are estimated to increase in 2003 by 18-22% across all product lines for our members. What this chart does not reflect, is the masking of actual rate increases that exists as small employers migrate to reduced benefit plan options at renewal to mitigate premium cost increases.

2. The Pennsylvania Builders Association has been forced to make drastic benefit coverage and funding changes in an effort to mitigate the dramatic cost increases as described above. These changes include, but are not limited to, High Deductible plan designs, the termination of benefit rich managed care plan designs, tiered deductible and co-pay plan designs to shift more out of pocket responsibility to

the patient, dramatic increases in the premium cost sharing with employees, and the move to less expensive plan designs to help mitigate premium increases. In addition to the immediate effect of the cost-shifting or reduced benefit arrangements undertaken and outlined above, the PBA has endeavored to expand the role our members play in managing their health. They include expanded disease management programs and patient education programs. The affect of these efforts won't be measurable for a period of time.

3. It is a fundamental tenet of economic theory that, in a truly competitive market, production cost inputs will trend towards equality among equally positioned competitors. As a result, profit margins for all competitors can be expected to be low and to vary only to a small extent. In the absence of a major technological or production breakthrough by one competitor, in a healthy competitive market it should not be possible for any single competitor to dramatically outperform its competition.

No one has yet publicly suggested that the operations of the non-profit health insurers in Pennsylvania are significantly more efficient than their for-profit rivals. Therefore, the PBA can only conclude that the wide variation in reserve levels between non-profit and for-profit insurers indicates that the free market currently is not operating effectively within the health insurance industry in our state, and we suspect in other regions around the country.

When one enterprise in a market can consistently produce "net profit" (surplus) levels substantially beyond that of its competitors over time, it is an ironclad indication that the enterprise holds a dominant position in that market and is exercising market power. When one looks at the data regarding the market share that each of the Pennsylvania Blue Cross plans (Blues) hold in its region, it becomes clear that the Blues' high annual net operating incomes are the direct result of classic market dominance. Given the dominant position that each Blue holds in its region, classic economic theory would predict the robust financial results that each Blue is currently achieving.

**HEALTH INSURER MARKET SHARES BY REGION**

| Southeast PA | | Central PA | |
|---|---|---|---|
| Independence B.C. | 76.0% | Capital B.C. | 53.4% |
| Aetna | 18.8% | Health America | 14.7% |
| CIGNA | 2.8% | Keystone Central | 9.6% |
| Health Net | 1.5% | Geisinger | 5.8% |

| | | | |
|---|---|---|---|
| | | Aetna | 4.9% |

| Northeast PA | | Western PA | |
|---|---|---|---|
| N.E. Blue | 63.4% | Highmark | 65.4% |
| Geisinger | 19.9% | Health America | 10.5% |
| Aetna | 8.6% | UPMC | 9.3% |
| Health Net | 4.9% | American | 5.4% |
| Health America | 2.9% | Aetna | 5.2% |

Source: Testimony of Pennsylvania Medical Society.

As shown above, the Blues' market shares range from a "low" of 53.4% for Capital Blue Cross in Central Pennsylvania to a staggering 76.0% for Independence Blue Cross in Southeastern Pennsylvania. Furthermore, in each of the Blues' regions the next most dominant insurer controls less than 20% of the market. The above market share figures are classic indications of dominant market power, which inevitably is accompanied by the very market distortions that appear to be present in Pennsylvania's current health insurance market.

An enterprise that finds itself in a position of such market dominance can increase profits in three key ways. First, as the dominant **seller** of an essential product in a given market, it can set its premiums and terms of insurance for its customers without much threat from competitors. Second, as the dominant **buyer** of medical services in the same market, it can set its cost inputs at depressed levels and make other demands of its relatively captive "suppliers". Finally, having amassed large operating reserves, it is in a position to cut prices temporarily when necessary to discourage competitors from entering its market.

In recent years, growth in surpluses and premium levels are indicative that the Blues may have used their dominant market power to increase their net income using these techniques. For example, the chart below sets forth the annual percentage premium increases for the Blues for the past six years compared to the premium increases of Pennsylvania for-profit health insurers.

| YEAR | Annual HMO Premium Increases (%) [1] | |
|---|---|---|
| | Blue Cross Companies[2] | Other Insurance Companies |
| 1996 | 3.3 | -4.9 |
| 1997 | 7.9 | 1.8 |
| 1998 | 13.1 | -0.7 |
| 1999 | 12.8 | 16.1 |
| 2000 | 9.6 | 5.8 |
| 2001 | 9.0 | 7.1 |
| **Annual Average** | **9.3** | **4.2** |

Notes: (1) The increase calculations have focused on HMO operations for data compatibility purposes.
(2) The Blue Cross Companies include Keystone Central, Keystone East, Keystone West, Gateway, HMO Northeast and Health Guard.

Source: Annual Statements filed with the Pennsylvania Insurance Department.

In sum, absent a competitive health insurance market, the PBA and consumers in general have few if any opportunities to participate in the management of their health insurance premium increases. And more importantly, in the absence of either market pressure and/or regulatory requirement, the Blues have little incentive to invest their increasing surpluses in innovative ways to benefit the consumer. This paints a bleak picture of the future of healthcare costs in Pennsylvania and all markets where similar market dominance exists when the dominant market providers aren't motivated to create a marketplace conducive to lower health care costs.

AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

815 SIXTEENTH STREET, N.W.
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***LEGISLATIVE ALERT!***

(202) 637-5090

February 5, 2003

Senator Olympia J. Snowe, Chair
Committee on Small Business and Entrepreneurship
United States Senate
428A Russell Senate Office Building
Washington, D.C. 20510

Dear Chairwoman Snowe:

On behalf of the 13 million members of the AFL-CIO, I am writing in opposition to legislation that would exempt Association Health Plans (AHPs) from state regulation. Although offered as a panacea for small businesses struggling to find affordable health care, AHPs would fail to provide real relief even while making matters worse for those small firms that do provide coverage for their workers.

Existing AHP proposals offer minimal benefits, attractive only to young and healthy workers, and they would deter older workers with greater need for health care services. In fact, the Congressional Budget Office has estimated only 330,000 – or less than 1 percent of the uninsured – will be newly insured through AHPs, but 4 out of 5 workers in small firms will see their premiums increase.

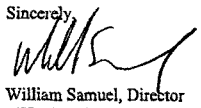
In addition, AHPs are permitted to discriminate based on health status, charging higher rates for less healthy employer "groups," either at the outset or on renewal of coverage. This, too, will deter less healthy groups from joining and prompt others to leave the plan upon renewal when premiums can be increased without limit.

Furthermore, AHPs are exempt from important consumer protections enacted in every state, and strong state oversight is ceded to inadequate enforcement under the U.S. Department of Labor, putting consumers at a much greater risk for fraud and abuse. Strong state solvency standards that require audits by independent actuaries and funds adequate to pay claims would be replaced with new federal enforcement that allows AHPs' own actuaries to certify solvency and sets a low $2 million cap on surplus capital regardless of the number of insured in the plan.

Recent media reports have documented the failure of a number of association-type health plans over the last six months. Collectively, these plan failures left over 100,000 consumers in almost every state with more than $30 million in unpaid medical bills and absolutely no recourse. Such cases of fraud have historically occurred more frequently in periods of health care cost increases like we are experiencing now.

Rather than meaningfully address the very real problem of small businesses' access to health care, AHPs would put more consumers at risk of fraud and prompt premium increases for those small business workers who now have coverage. For these reasons, I urge you to oppose Association Health Plans.

Sincerely,



William Samuel, Director
DEPARTMENT OF LEGISLATION

C: Members of Committee on Small Business and Entrepreneurship

## Statement of Senator James M. Talent (R-MO)

*"The Time to Act on AHPs is NOW"*

**Senate Committee on Small Business and Entrepreneurship**
***"The Small Business Healthcare Crisis: Possible Solutions"***
**February 5, 2003**

Good morning. I would like to thank Chairwoman Snowe and Ranking Member Kerry for holding this important hearing, and for inviting me to join the Committee Members on the dais.

I would like to begin my remarks by saying something we can all agree on: A major concern facing small business owners is access to quality, affordable health care. Of the 39 million Americans who lack health insurance,[1] more than 80% are workers and their families.[2] The lack of health insurance in America disproportionately affects workers in small businesses.[3] About 6 of every 10 uninsured Americans are in families headed by workers who are self-employed or who work at firms with fewer than 100 employees.[4] Workers at the smallest firms are far less likely to be covered on the job, and far more likely to be without insurance from any source.

Association Health Plans empower small business owners, who otherwise cannot afford health insurance, to offer "Fortune 500" company quality health insurance to their employees. AHPs allow national trade and professional associations, from the National Federation of Independent Business to the Missouri Farm Bureau, to respond to the needs of their membership and sponsor health care plans. In other words, AHPs are a solution to a problem that does not discriminate by locale – it helps the small business owner in cities and towns as well as the farmer and rancher. Any small business owner can buy into these plans for themselves, their employees, and their dependents.

Association Health Plans would cover large groups, enjoy large economies of scale, and have the option to offer self-funded plans that would not have to provide any profit margin for insurance company profits. Importantly, AHPs would expand health care coverage to millions of Americans at no cost to taxpayers.

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[1] Robert J. Mills, "Health Insurance Coverage: 2000," *Current Population Reports* P60-215, U.S. Bureau of the Census, September 2001.
[2] Ken McDonnell and Paul Fronstin, *EBRI Health Benefits Databook* (Washington, DC: EBRI, 1999).
[3] "Association Health Plans: Improving Access to Affordable Quality Health Care for Small Businesses," U.S. Department of Labor, released September 13, 2002, at 4.
[4] National Association for the Self-Employed, "Affordable Health Care: Conditions Critical for Self-Employed, Study Shows," Press Release, June 18, 2002.

**Statement of Senator James M. Talent**
*"The Small Business Healthcare Crisis: Possible Solutions"*
Senate Committee on Small Business and Entrepreneurship
February 5, 2003

**Background**

Association Health Plan legislation was first introduced in the 104th Congress to give small businesses the same health care advantages of cost and efficiency as large single employers and unions. Since its inception, AHP legislation has been improved to strengthen solvency requirements and state enforcement provisions.

During and since my tenure as Chairman of the House Committee on Small Business, I have championed AHP legislation as a means to reduce the number of uninsured in Missouri and across the country. AHP legislation was included in the bipartisan Patients' Bill of Rights legislation that passed the House last Congress. In the Senate, my colleague from Missouri, Senator Bond, has made AHPs a frequent subject of his remarks as the Chairman and then Ranking Member of the Small Business Committee. The new Chairwoman of the Small Business Committee, Senator Snowe, is continuing to build momentum on this issue, and I commend her for her leadership in holding this hearing to emphasize the value of AHPs to small employers and their millions of employees nationwide.

Now is the time to enact AHP legislation. Not only does it have bipartisan support in the legislative branch of government, but President Bush has voiced his strong support as well. Specifically, President Bush has stated:

> "I strongly support association health plans. That means that small businesses will be able to pool together and spread their risk across a larger employee base. It makes no sense, no sense in America, to isolate small businesses as little health care islands unto themselves. We must have association health plans."[5]

Given the bipartisan, bicameral support in favor of AHP legislation to solve the health care crisis facing small business owners and their families, there is no reason not to act this Congress to make Association Health Plans a reality. AHP legislation will not only save small businesses money, it will save lives.

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[5] "Women Entrepreneurship in the 21st Century Summit," March 19, 2002. U.S. Department of Labor, September 13, 2002.

**Statement of Senator James M. Talent**
*"The Small Business Healthcare Crisis: Possible Solutions"*
Senate Committee on Small Business and Entrepreneurship
February 5, 2003

**A Solution to the Health Care Crisis**

There are approximately 600,000 uninsured Missourians.[6] Of these people, there are approximately 66,000 children who are uninsured. The number of uninsured in Missouri represents approximately 10% of my state's population – and this is unacceptable.

AHPs are a part of the solution to help create access to health care. The Congressional Budget Office (CBO) has estimated that small businesses obtaining insurance through AHPs will enjoy premium reductions of 13% on average.[7] The average reduction amount ranges from 9% to as much as 25%.[8] Because insurance will be more affordable, more small firms will provide it to their employees and families.

According to the CBO, an additional 330,000 (and as many as 2 million) American workers and their families would obtain health insurance through AHPs.[9] But these predictions may be too conservative. 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.[10] And, offering an alternative to red tape and reams of paperwork to provide insurance on an individual or a small group basis is another benefit of AHPs.

**Breaking Insurance Monopolies**

Perhaps it comes as no surprise that insurance companies like Blue Cross and Blue Shield (BCBS) do not like AHPs. One would guess that these insurers would welcome AHPs as an opportunity to make a lot of money by selling possibly tens of thousands more policies. However, that does not seem to be the case. And why not? Because insurers have a monopoly on health insurance through their ironclad grasp of market share. Insurers have no incentive to change the status quo and conduct business otherwise because they are exempt from antitrust laws. In other words, the largest insurers may choose to maintain their monopolies and resist change to the detriment of small businesses and their families.

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[6] Census Bureau, 2002 Population Survey.
[7] "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts," CBO, January 2000.
[8] "Association Health Plans," at 5.
[9] "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts."
[10] "Affordability in Health Care Survey: Trends in American Micro-Business," a survey conducted for the National Association for the Self-Employed by Research USA, Inc., released June 2002.

**Statement of Senator James M. Talent**
*"The Small Business Healthcare Crisis: Possible Solutions"*
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I share the opinion of many of my colleagues that health insurers are motivated by profit, not consumer concern. The General Accounting Office has found that the five largest carriers, when combined, represent 75% or more of the market in 19 of the 34 states GAO reviewed, and they represented more than 90% in seven states.[11] Moreover, 25 of 37 states identified BCBS as the largest carrier offering health insurance in the small group market.[12] In addition, the median market share of all the BCBS carriers in the 34 states supplying information was about 34%.[13] In Missouri the five largest carriers have a 51.8% market share, and all BCBS carriers have a 32.2% market share.[14]

The CBO estimates that AHPs will offer health insurance premium reductions of between 9% and 25%.[15] That's about $450 to $1,250 per covered employee.[16] Clearly, these reductions are going to hurt the bottom line of insurance companies and reduce their stranglehold on small business purchasing options.

I believe in free market principles of competition, and health insurance companies appear unwilling to play by any rules except the ones they set. That's not the American way, but that's why health insurers like the status quo – to protect their monopolies.

**Now is the Time to End the Crisis**

Now is the time to end the health care crisis in this country by enacting AHP legislation. Health insurance costs are hitting companies' bottom lines. The situation is bleakest for the smallest companies, whose costs are highest and rising most quickly. Their premiums increased 16.5% on average in 2001.[17] And premiums are likely to grow more quickly this year than last.

AHPs will make more affordable insurance options available to small businesses. As mentioned, CBO has estimated that small businesses obtaining insurance through AHPs will enjoy premium cuts averaging between 9% and 25%. The smallest firms stand to save the most from AHPs since they face the highest administrative expenses and have little buying power and few affordable options. AHPs will give small firms administrative savings, more purchasing power, and new, more affordable choices.

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[11] GAO letter to the Hon. Christopher S. Bond, "Private Health Insurance: Number and Market Share of Carriers in the Small Group Market," March 25, 2002.
[12] Id.
[13] Id.
[14] Id.
[15] "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts."
[16] Assumes premiums of $5,000 per employee. "Association Health Plans," at 6. Mercer Foster Higgins reports that health benefits cost $4,924 per employee on average in 2001. Id.
[17] "Association Health Plans." at 6.

**Statement of Senator James M. Talent**
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Importantly, passing AHP legislation would unburden small business owners from worrying about how to provide health care to their employees owners to doing what they do best – running their businesses.

Again, I thank Chairwoman Snowe and Ranking Member Kerry for holding this hearing, and for allowing me the opportunity to share important arguments in favor of AHP legislation. Now we need to take the next step toward making this goal a reality for small businesses. I urge my colleagues to support efforts toward passing AHP legislation to make health care affordable for millions of uninsured Americans.

**Testimony of**

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

**Testimony Before the**

**Committee On Small Business & Entrepreneurship**

**United States Senate**

**The Small Business Health Care Crisis: Possible Solutions**

**February 5, 2003**

Madame Chair, and Members of the Committee:

I am honored to submit this prepared statement to discuss with you "The Small Business Health Care Crisis: Possible Solutions." 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 America's Uninsured: Association Health Plans and Their Impact on the Uninsured,* 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 the proposed legislation 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 on AHP 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 abandoned by insurers no longer writing business in the small group market.

**Market Concentration And Market Power -** A number of economists have suggested that large insurer opposition to Association Health Plans, among other things, stems from their desire to retain their market position without the threat of competition from newly formed Association Health Plans. The large insurers have networks at the insurer level and at the provider level, enabling them to wield enormous market power in the small group market. Through establishment of national networks and contractual agreements with provider networks, large insurers have accumulated disproportionate market shares and power in given geographical and market areas.

The General Accounting Office (GAO) [2] derived a table (attached), *Table 1: Number of Carriers, Largest Carrier, and Market Share Data for Small Group Health Insurance, GAO-02-5236R State Small Group Health Insurance Markets (March 25,2002)*, presenting the number of carriers, largest carrier, and market share data for small group health insurance for 37 states. It is interesting to observe from the table that Blue Cross and Blue Shield (BCBS) was the largest carrier in 25 of the 37 states, and that BCBS was among the top 5 largest carriers in all but 1 of the remaining 12 states. Additionally, the "five-firm concentration ratio" for the largest carriers represented 75 percent or more of the market in 19 of the 34 states supplying that data, and they represented greater than 90 percent of the market in 7 of those states. Their market shares have given them significant market/monopoly power in the small group market.

The concentration of market power can adversely affect the market for health plans. A review of the development of health plans in the State of New York is an eye opener for those who are not aware of the degree to which large insurers, those who typically oppose Association Health Plans, dominate the market. The 2001 study by Gerard Conway, [3] for the Medical Society of the State of New York is an education in market concentration. In Section IV of that study, Conway explains how "barriers to entry" such as regulatory barriers, advertising, exclusive contracts, networks, etc. are used to prevent or slow down the entry into a highly concentrated market. He states:

"All of these factors can operate as formidable barriers to entry for a new health insurance company trying to establish a foothold in a concentrated market, and even more so in the highly concentrated markets identified in this study."

**Impact of State Mandates** - The record of witness testimony before the U.S. Senate and before the U.S. House of Representatives indicates that insurers have practically abandoned the small group health plan market, due largely to the administrative hassle and financial burdens of state mandates such as "guaranteed issue" and "community rating." While these two state mandates, unfunded by the states, were designed with good intentions, they mandate coverage and rating

that is contrary to sound business risk management. The mandates artificially superimpose a social welfare function upon small employers that causes them to pay for benefits that they do not want. Additionally, they are a major reason for small insurers to abandon whole markets in several states. Ray Keating [4], Economist for the Small Business Survival Committee, states:

"For example, New Jersey imposed guaranteed issue in the individual market in legislation passed in 1994. From December 1994 to January 2002, among four insurers offering family coverage during this period, monthly premiums increased by 556% (Aetna), 344% (Blue Cross Blue Shield NJ), 612% (Metropolitan Life), and 471% (National Health Insurance).
In Kentucky, after the state adopted guaranteed issue and community rating in 1994, 45 insurers fled the state and premiums skyrocketed. Also in 1994, a similar scenario played out in New Hampshire in response to passing guaranteed issue and community rating. In a November 1995 column, SBSC chairman Karen Kerrigan explained what happened in New York after it imposed guaranteed issue and community rating in 1992: "Since then, several major insurers simply stopped serving the market altogether ..."

Large insurers with large market shares, national networks, and excessive market power argue that AHPs should be subject to these state mandates. It is clear that the giant insurers have a vested interest in placing as many restrictions on the AHPs as is possible because the mandates are a form of "barriers to entry," that are designed to discourage the formation and development of AHPs. Additionally, as the size of the AHP increases, the giant insurer's relative market power decreases.

**Community Rating Bands and Minimum Loss Ratios State Mandates -** A January 2003 Small Business Administration study [5], "Study of the Administrative and Actuarial Values of Small Health Plans" (page 20) describes the community rating bands as :

"Twelve states have community or modified community rating which does not allow premiums to vary by health status and only allows differences in premiums for geographic area or family size or in the case of modified community rating, also (GAO 2001). In 35 states, there are rating bands that allow premiums to vary by health status and age but the variation is limited (e.g., plus or minus 10% or plus or minus 25% of a projected average rate)."

In commenting on the loss ratio mandate, the Small Business Administration study, just cited, states [6]:

"Loss ratios (ratio of medical expenses to premiums) are used by state insurance departments to assess solvency and document the need for rate increases. Several states require a minimum level of loss ratio for small group insurance. The minimum ratios are 65% for Florida, 50% for Minnesota, 75% for New Jersey, 75% for New York, 60% in Oklahoma, and 73% for West Virginia ..."

The Association Health Plans are preempted through ERISA from being subject to these mandates. Testimony from witnesses before the U.S. House of Representatives and before the U.S. Senate substantiate that these mandates contributed to small insurers' decisions to stop conducting business in the given states.

**The Myth of "Cherry Picking" -** The old myth of "cherry picking" is presented by the large insurers in almost every Congressional venue. That argument is essentially that AHPs will admit

only healthy groups and discourage unhealthy groups in the association. As a matter of policy, the Department of Labor would 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, 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, used by large insurers, 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 Small Business & Entrepreneurship is commended for conducting this hearing on a matter so vital to the health of this nation. The testimony of witnesses for Association Health Plans have given the Committee insights regarding the plight of small employers trying to offer a quality product at a reasonable price, while trying to provide health care coverage for their employees. It is evident from their testimony that we are in the middle of a health care crisis. Our health care system, with its patchwork of regulations in the various states is increasingly causing insurers to abandon segments of the small business market and, in some cases, abandon whole states due to state mandates.

Gerard Conway, [10] of the Medical Society of the State of New York, said it best when he argued that it would take years to build a network, especially in view of existing exclusive contracts (which are themselves 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.

**References**

[1] Westerfield, Donald L. *Mandated Health Care: Issues and Strategies* (New York: Praeger Publishers, 1991); Westerfield, Donald L. *National Health Care:Law, Policy, Strategy* (New York: Praeger Publishers, 1993); Westerfield, Donald L. *Insuring America's Uninsured: Association Health Plans and Their Impact on the Uninsured* (Washington, D.C.: National Center for Policy Analysis, Forthcoming).

[2] Bond, Hon. Christopher "Kit". Private communication from Director , Health Care – Medicaid and Private Health Insurance Issues, transmitting GAO-02-536R State Small Group Health Insurance Markets [Table 1. Number of Carriers, Largest Carrier, and Market Share Data for Small Group Health Insurance Carriers, by State], March 25, 2002.

[3] Conway, Gerard. (2001) "Competition In The Managed Care Health Insurance Market In New York State: A Regional Analysis" Medical Society of the State of New York.

[4] Keating, Raymond, Small Business Survival Committee. Discussing "The Small Business Health Market: Bad Reforms, Higher Prices, and Fewer Choices" Testimony Before the Committee on Small Business, U.S. House of Representatives , 107 Cong. 2nd Sess., (July 11, 2002), Washington, D.C.

[5] Small Business Administration, Office of Advocacy. *Study of the Administrative Costs and Actuarial Values of Small Health Plans*, (January 2003), Washington, D.C.

[6] Small Business Administration, *op. cit.*

[7] Matthews, Merrill. "The Small Business Health Market: Bad Reforms, Higher Prices, and Fewer Choices" Testimony Before the Committee on Small Business, U.S. House of Representatives , 107 Cong. 2nd Sess., (July 11, 2002), Washington, D.C.

[8] Lehnhard, Mary. "Small Business Access to Health Care." Serial No. 107-41. Hearing Before the Committee on Small Business, U.S. House of Representatives, 107 Cong. 2nd Sess., February 6, 2002. Washington, D.C.

[9] Chao, The Honorable Elaine L., Secretary of Labor, Testifying before the U.S. Senate Committee on Small Business & Entrepreneurship, "The Small Business Health Care Crisis: Possible Solutions," February 5, 2003. Washington, D.C.

[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[c] | 70 | Anthem BCBS | 32.6 | 66.4 | 1 | 32.6 |
| Oklahoma[a] | 64 | Group Health Services of OK[f] | NA | NA | 1[f] | NA |
| Oregon[a] | 13 | 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] |

**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 | 83.5 | 2 | 22.7 |
| Vermont | 6 | MVP Health Plan | 45.8 | 98.6 | 5 | 2.6 |
| Virginia[e] | 56 | NA | NA | NA | NA | NA |
| Washington[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.

Testimony of Thomas E. Woods
President of TE Woods Construction, Inc.
For the Senate Small Business Committee
Hearing February 5, 2003

My name is Thomas E. Woods and I am the President of TE Wood Construction, Inc. in Blue Springs, Missouri. My wife and I started our construction business over twenty years ago and we have seen our healthcare costs increase dramatically since the 1980s for ourselves and for our employees. At the inception of our business, my wife and I were the only employees and we obtained health insurance for ourselves at that time. Before we obtained additional employees, my wife was diagnosed with an illness. As our business grew, and the number of our employees grew, we decided to find a separate health plan for our business. Unfortunately, due to the "pre-existing" clause in my wife's and my coverage, we were unable to have coverage under the plan that our employees currently use. Therefore, I have two small business insurance stories to share with you today.

My wife and I have seen our premiums go up from $225 a month in the late 1980s to more than $1200 a month for the two of us today. Our deductible has changed from a $500 family deductible to a $1500 per person deductible and our prescriptions have gone from being covered within the plan, to a copay situation in which we spent nearly $2,000 for prescriptions in this year alone. Unfortunately, we are unable to utilize the healthcare coverage that our employees use; however, their premiums and copays have also increased dramatically.

Since we obtained health insurance for our small business employees, the cost of the plan has gone up approximately 20 percent each year. This year, we were forced to drop the coverage from 90/10 to 80/20 in order to keep the costs of health insurance from increasing further than they did. And it is possible that, if health insurance costs continue to increase at their current rate for small businesses, we will have to drop coverage even further.

As a small business owner, I have very few options. I must bring in carriers that provide less competitive coverage and that are not well rated, or I bring in good carriers and the costs are so astronomical that health care coverage becomes .5 percent to 1 percent of my business' operating costs.

As an example of what I have to compete with, I recently hired an employee who came from a major corporation. This corporation provided health care benefits for him and he paid for additional coverage for his wife and two children. His monthly payment for coverage at that corporation was $80. When this man came to work for my business, his cost increased to $600 a month. Either my small business must pay him more monthly to stay competitive with corporations or he must take a significant hit in salary in order to come to work for us. You know what the outcome is in this scenario.

In addition, if the cost of health insurance coverage for small businesses were lowered, I could provide better coverage to my twenty employees, entice more qualified employees and, in the end, charge less for our company's services as our monthly overhead would be considerably lower. As it is, with the majority of our employees being men between the ages of 20-30, their cost for individual coverage last year was $93. The cost of coverage for the same people this year is $143. That is a $50 a month increase or a 53 percent increase. There is no way that our business could increase its prices to the same degree to cushion this burden.

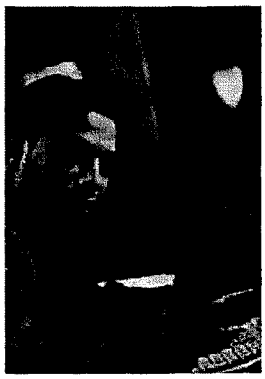
The other option that many small businesses are moving towards is not providing coverage. That is not an option that my wife and I would consider, but many other small businesses in my area do not provide health care for their employees simply because of the costs.

Thank you for allowing me the opportunity to share with you my health insurance concerns.

Embargoed Until 9/13/02 10:00 a.m. EST

# ASSOCIATION HEALTH PLANS

## IMPROVING ACCESS TO AFFORDABLE QUALITY HEALTH CARE FOR SMALL BUSINESSES



U.S. Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210

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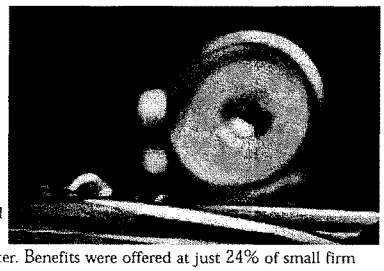
# Association Health Plans: An Overview

**Health Coverage Lags Among Small Businesses**

Thirty-nine million Americans lack health insurance. This number has grown by about 8 million over the last decade.



- Among private-sector firms with fewer than 50 employees, health benefits were offered at just 47% of work sites in 1999, compared with 97% among larger firms.
- Considering only low-wage work sites, where at least half of the employees earned less than $6.50 per hour, the disparity between small and large firms is even greater. Benefits were offered at just 24% of small firm low-wage work sites, compared with 88% of large firms.

Small employers, especially those that employ low-wage workers, have difficulty providing health benefits.

- Cost is the biggest issue. For comparable coverage, insurers typically charge small businesses more per employee than large firms.
- In some states, insurance for some small firms is available only through a state-operated risk pool or from one insurance carrier.
- Small firms are often ill equipped to negotiate favorable terms with insurers because an individual firm does not represent a large enough block of business to merit insurers' individual attention.
- States typically require group health insurance policies to cover certain specified benefits, medical procedures, and treatments provided by specified health professionals, which also add to the cost of coverage.

In a voluntary health benefits system, how can small employers be encouraged to offer coverage? The challenge is to create incentives and remove barriers. Preemption of 50 state insurance regulatory regimes under federal ERISA law has allowed large employers and unions to provide cost-effective health benefits. A federal structure for small employers would bring stability, uniformity and lower costs for health care coverage.

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# ASSOCIATION HEALTH PLANS: A KEY PART OF THE SOLUTION

- AHPs will provide small businesses the opportunity to band together through trade and professional associations to purchase affordable health benefits. By joining together, small employers will enjoy greater bargaining power, economies of scale, and administrative efficiencies. In this way, AHPs will level the playing field and give participating small employers the same advantages as larger employers and employers who provide benefits through Taft-Hartley plans (plans sponsored jointly by a union and two or more employers).

- AHPs will allow bona fide trade and professional organizations to offer health benefits to their memberships under uniform federal regulation.

- AHPs will help small businesses lower their administrative costs and receive more favorable treatment from insurers. In addition, by operating under federal law, AHPs can avoid the cost of state benefit mandates.

## How AHPs Would Work Under House-Passed Legislation

**Under new law, AHPs would be certified by the U.S. Department of Labor (DOL) and would have to meet certification standards developed by DOL.**

- Only bona fide trade or industry associations that have been in operation for three years or more could sponsor AHPs, helping to ensure that AHPs would not be formed solely to market insurance.

- AHPs would have to meet strict requirements designed to protect participants and maintain solvency.

**AHPs could purchase coverage from insurance companies, or if they cover enough participants, they could self-insure (pay claims from their own funds).**

- Self-insured AHPs would be subject to solvency requirements designed to ensure that they maintain adequate funds to pay claims. As an added protection for participants, a fund would be set up under DOL direction to ensure that outstanding claims are paid if an AHP becomes insolvent.

**The legislation includes numerous provisions designed to prevent AHPs from "cherry picking" the healthiest population of workers.**

- A number of provisions would ensure that AHPs draw from a diverse risk pool. Only bona fide associations that are in existence for three years for purposes other than providing health insurance would be eligible to operate an AHP. A self-insured AHP must represent a broad cross-section of trades and businesses or industries. Alternatively, it may represent one or more trades with average or above average health insurance risk or claims experience. AHPs

must offer coverage only to employers and individuals with specified, meaningful connections to the association and must offer all available options to all with such connections.

- The legislation contains important protections to prevent AHPs from cherry picking in the health insurance market. The legislation makes clear that AHPs must comply with the Health Insurance Portability and Accountability Act (HIPAA), prohibiting group health plans from excluding high-risk individuals or employers with high claims experience. The legislation limits AHPs' ability to vary the premiums of lower and higher-cost employers. It would prevent AHPs and participating employers from selectively directing their higher-cost employees to the individual insurance market.

**The AHP Advantage**

- Some small businesses now provide health coverage through programs sponsored by trade and professional associations. Under current federal law, however, these health programs are considered multiple employer welfare arrangements (MEWAs) and are subject to state insurance laws and regulations.

- These programs are hampered by the administrative burdens and high cost of having to comply with the requirements of up to 50 state insurance regulators, including state-mandated benefit requirements.

- Additionally, the legislation includes new protections to avoid the problems associated with abusive and fraudulent MEWAs. Some MEWAs have been used by unscrupulous promoters who sell the promise of inexpensive health insurance, but intentionally default on their obligations - leaving employers and their workforce with unpaid claims and no coverage. AHPs will be subject to rigorous and nationally uniform financial solvency standards, as well as DOL's certification and oversight.

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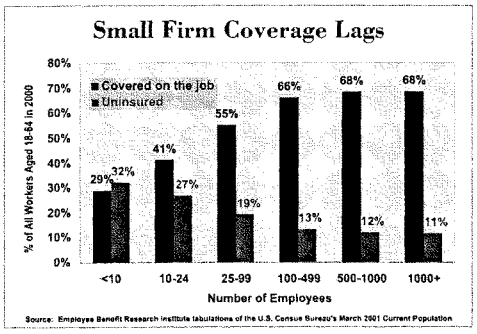
# SMALL BUSINESSES LACK HEALTH COVERAGE

- Thirty-nine million Americans have no health insurance.[1] More than 80% are workers and their families.[2]

- The lack of health insurance in America disproportionately affects workers in small businesses. About 6 of every 10 uninsured Americans are in families headed by workers who are self-employed or who work at firms with fewer than 100 employees.[3] Workers at the smallest firms are far less likely to be covered on the job, and far more likely to be without insurance from any source.




[1]Robert J. Mills, "Health Insurance Coverage: 2000," *Current Population Reports* P60-215, U.S. Bureau of the Census, September 2001.
[2]Ken McDonnell and Paul Fronstin, *EBRI Health Benefits Databook* (Washington, DC: EBRI, 1999).
[3]National Association for the Self-Employed, "Affordable Health Care: Conditions Critical for Self-Employed, Study Shows," Press Release, June 18, 2002.

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# AHPs Will Help Small Businesses And The Uninsured

AHPs will combat uninsurance by making available a wide variety of more affordable insurance options. As a result, more small companies will offer insurance. Companies that offer coverage now may be able to lower employees' premiums so more workers will sign up.

- AHPs will make health insurance more affordable, especially for small business. The Congressional Budget Office (CBO) has estimated that small businesses obtaining insurance through AHPs will enjoy premium reductions of 13% on average.[1] The average reduction amount ranges from 9% to as much as 25%.

- Because insurance will be more affordable, more small firms will provide it to their employees and families. According to CBO, an additional 330,000 (and as many as two million) American workers and their families would obtain health insurance through AHPs.[2]

- These predictions may be too conservative. Among 600 small businesses responding to a recent survey,[3] 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.

- One way AHPs will boost coverage is by relieving small businesses from costly state benefit mandates. Such mandates are responsible for one of every five small employer decisions not to offer coverage.[4] Another study reported that mandates raise premiums by 4 to 13%, and that up to one-quarter of uninsured Americans lack insurance because of state mandates.[5]

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[1] "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts," CBO, January 2000.
[2] Ibid.
[3] "Affordability in Health Care Survey: Trends in American Micro-Business," a survey conducted for the National Association for the Self-Employed by Research USA, Inc., released June 2002.
[4] Gail A. Jensen and Jon Gabel, "State Mandated Benefits and the Small Firm's Decision to Offer Insurance," *Journal of Regulatory Economics*, 4:379-404 (1992).
[5] Gail A. Jensen and Michael A. Morrisey, *Mandated Benefit Laws and Employer-Sponsored Health Insurance* (Washington, DC: HIAA, 1999).

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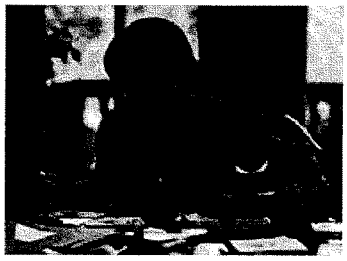
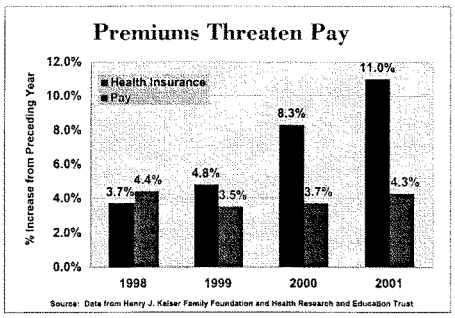
# AHPs Make Room for Better Pay

- In our competitive marketplace, companies must make trade offs between their employees' pay and the increasing cost of health insurance and other benefits. When health insurance costs surge, pay increases tend to suffer.

- Health insurance costs are accelerating and outpace pay growth by a wide margin. The potential for increased pay growth is diminished with rapidly rising health costs. Although pay growth has held steady, it is likely to slow.






- Small companies are especially pinched. Their premiums grow the most quickly, rising 16.5% in 2001 for firms with fewer than 10 employees. And now Congress is considering raising the minimum wage by $1.50 per hour (H.R. 665 and S. 964), or slightly more than $3,000 per year for a full-time employee.

- Fortunately, AHPs can offer some relief. CBO estimates that AHPs will offer premium reductions of between 9% and 25%.[1] That's about $450 to $1,250 per covered employee.[2] Some companies might save enough on their insurance premiums to offset the increase in wages for their lowest-paid employees.

[1] "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts," CBO, January 2000.

[2] Assumes premiums of $5,000 per employee. Mercer Foster Higgins reports that health benefits cost $4,924 per employee on average in 2001.

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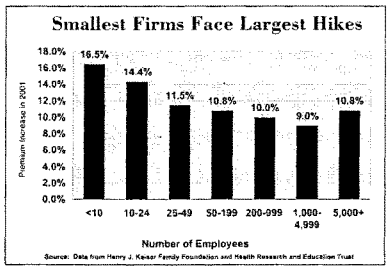
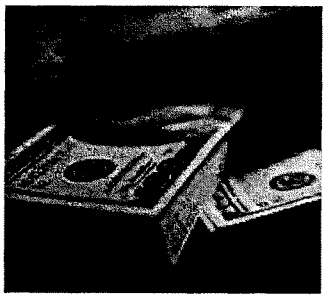
# AHPs Will Offer Relief from Surging Premiums

- Health insurance costs are hitting companies' bottom lines. The situation is bleakest for the smallest companies, whose costs are highest and rising most quickly. Their premiums increased 16.5% on average in 2001. And premiums are likely to grow more quickly this year than last.[1]



- AHPs will make more affordable insurance options available to small businesses. As mentioned, CBO has estimated that small businesses obtaining insurance through AHPs will enjoy premium cuts averageing between 9% and 25%.[2]

- The smallest firms stand to save the most from AHPs. They face the highest administrative expenses: 20 to 25% of premium at firms with fewer than 50 employees compared to 10% at larger firms. They have little buying power and few affordable options – five or fewer insurers control at least three quarters of the small group market in most states.[3] State mandates force small businesses to provide expensive benefits or none at all. AHPs will give small firms administrative savings, more purchasing power, and new, more affordable choices that are exempt from many state mandates.

[1] Paul B. Ginsburg, president, Center for Studying Health Systems Change, testimony to the House Education and the Workforce Subcommittee on Employer-Employee Relations, 6/18/02.
[2] Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts, CBO, January 2000.
[3] U.S. General Accounting Office, Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage, GAO-02-8; and Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market, GAO-02-536R.

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# AHP Safeguards Will Protect the Families that are Insured

Several requirements in the proposed AHP legislation will help ensure that the employees who are insured--and their families--will receive the health coverage that they and their employers pay for, including:

- **Reserve Requirements:** AHPs would maintain cash reserves for unearned contributions, benefit liabilities (incurred and future), administrative costs, obligations of the plan, and margin of error. In addition to reserves for claims, AHPs must maintain surplus reserves of $500,000 to $2,000,000, depending upon the AHP's size. The reserves provide a cushion against variations in claims experience.

- **Stop-loss Insurance:** AHPs would maintain both aggregate and specific stop-loss insurance coverage, with the levels of insurance determined by a qualified actuary. Stop-loss insurance provides essential protection against unexpectedly high claims that might otherwise exhaust reserves and surplus.

- **Indemnification Insurance:** AHPs would be required to purchase indemnification insurance to pay claims in the event that the AHP becomes insolvent and terminates.

- **Premium Rates:** Self-insured AHPs would establish premium rates that are adequate to cover claims and maintain required reserves, as determined by a qualified actuary. A statement of actuarial opinion must be provided to DOL as part of the certification process.

- **AHP Fund:** Self-insured AHPs would be required to pay assessments to an AHP fund prior to certification and annually thereafter ($5000 and supplemental payments, if needed). If an AHP became unable to satisfy its financial obligations, DOL could assume trusteeship over the AHP and pay premiums to a stop-loss and/or indemnification insurer to ensure that consumers' outstanding claims for health benefits are paid.

Taken together, these financial protections, along with the affirmative duties and prohibitions against conflicts of interest that apply to AHP management, will assure consumers that their claims for benefits will be covered.

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# MYTHS AND FACTS REGARDING ASSOCIATION HEALTH PLANS

Critics of the AHP legislation argue that AHPs will create the same risks for small employers as fraudulent multiple employer welfare arrangements (MEWAs) and "sham unions" (organizations posing as labor unions in order to preempt state law).

The following facts address the many myths propagated by opponents about AHP legislation.

**Myth:**

- AHPs will not reduce health insurance costs for small employers.

**Facts:**

- Insurers selling directly to small employers typically incur administrative costs of 20% to 25%. CBO has estimated that small businesses obtaining insurance through AHPs will enjoy premium savings of 13% on average.[1] Average savings could range from at least 9% to as much as 25%.

**Myth:**

- AHPs will not significantly reduce the number of uninsured Americans.

**Facts:**

- The number of working Americans that would gain health coverage through AHPs most likely will increase by 330,000, but could increase by 10,000 to 2 million lives, according to CBO.

- A study by the CONSAD Research Corporation foresaw larger gains.[2] It estimated that up to 8.5 million uninsured workers and dependents could gain coverage from AHP legislation. This study confirms that even small cost savings can result in large increases in purchasing power for small businesses, and thus can have a real impact for small business workers who make up over 60% of the uninsured.

- CONSAD identified an additional reason, beyond premium reductions, which will enable AHPs to expand access to health coverage for small businesses: "even if there were no price reduction associated with the creation of AHPs...they would result in increases in insurance coverage because they overcome ...non-price barriers," such as lack of information among small businesses.

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[1] "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts," CBO, January 2000.

[2] The Projected Impacts of the Expanded Portability and Health Insurance Coverage Act on Health Insurance Coverage, Pittsburgh: CONSAD Research Corporation, July 10, 1998.

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**Myth:**

- AHPs will engage in "cherry picking," and thus only benefit healthy people.

**Facts:**

- Only bona fide associations that are in existence for three years for purposes other than providing health insurance would be eligible to sponsor an AHP.
- A self-insured AHP must represent a broad cross-section of trades and businesses or industries. Alternatively it may represent one or more trades with average or above average health insurance risk or claims experience.
- AHPs and participating employers could not selectively direct their higher-cost employees to the individual insurance market.
- AHPs must offer coverage only to employers and individuals with specified, meaningful connections to the association.
- AHPs must offer all available options to all employers and individuals with the same specified, meaningful connections to the association.
- The legislation makes clear that AHPs will have to comply with the Health Insurance Portability and Accountability Act (HIPAA), prohibiting group health plans from excluding high-risk individuals or employers with high claims experience.
- The legislation limits AHPs' ability to vary the premiums of lower and higher-cost employers.

**Myth:**

- AHP legislation will precipitate fraud and abuse problems like those experienced with MEWA health plans.

**Facts:**

- Under the legislation, AHPs will be fundamentally different from MEWAs. For example, MEWAs have been operated by a variety of entrepreneurs for the sole purpose of providing health insurance.
- The proposed AHP legislation includes strong solvency standards, including stop-loss and indemnification insurance, and strengthened sanctions, including criminal penalties, for violations of the AHP standards. No such federal consumer protections exist for participants in MEWAs.
- Under the legislation, an AHP would exist only upon a simple but meaningful certification by DOL, eliminating a fundamental problem associated with MEWAs. In the past, an entity providing health coverage to a group of employers might inform the state regulator that it was a group health plan, governed by DOL, effectively holding state regulators at bay. With AHP certification, there will be no confusion over regulatory jurisdiction.

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- The DOL regulatory structure for health and welfare plans is effective: ERISA requires the highest standards of conduct for employee benefit plan management.

**Myth:**

- DOL does not have the resources to regulate AHPs.

**Facts:**

- If AHP legislation is passed, DOL will allocate the resources necessary to effectively administer the AHP certification and oversight responsibilities, as well as provide effective, efficient and timely AHP regulation.

- DOL has gained valuable experience in recent years in response to the enactment of health legislation that gave DOL more responsibility and oversight over group health plans. For example, DOL has taken on significant new responsibilities as a result of the enactment of the Health Insurance Portability and Accountability Act of 1996, the Mental Health Parity Act of 1996, the Newborns' and Mothers' Health Protection Act of 1996, and the Women's Health and Cancer Rights Act of 1998.

- DOL's capabilities and commitment will ensure the integrity, financial soundness, and oversight of AHPs at the federal level, and will provide meaningful protections and safeguards for employers and plan participants.

- The bill also provides a role for state insurance departments to assist DOL in the regulation of AHPs.

**Myth:**

- Solvency standards for self-funded AHPs are inadequate and not as strong as similar state laws.

**Facts:**

- The bill requires 1) claim reserves, 2) stop-loss coverage (both specific and aggregate), 3) indemnification insurance in the event of plan termination, 4) additional surplus capital of up to $2 million, and 5) the establishment of a fund into which AHPs must contribute to cover any unpaid claims.

- These standards are similar or stronger than standards enacted by states for association plans.

- These new solvency standards go far beyond what is required of single employer and labor union plans under current law.

**Myth:**

- AHPs will drain resources from states because, like corporate and union plans, they will be exempt from state premium taxes.

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**Facts:**

- AHPs will not drain resources from state governments because the AHP legislation requires AHPs to pay a contribution tax to the states in which they operate that will address the loss in premium taxes.

**Myth:**

- AHP legislation will create a "loophole" in federal law that will put consumers at risk because AHPs will be granted the same exemption from state laws already granted to large companies and labor unions.

**Facts:**

- AHP legislation includes strong safeguards to protect workers against unpaid claims and imposes solvency standards on AHPs far beyond what is now required of single employer and labor union health plans.

- AHP legislation simply gives AHPs preemption rights under ERISA that are similar to those already given to corporations and unions.

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## SUPPORT FOR AHPS IS WIDESPREAD

Groups favoring AHP legislation include those that represent both employers and employees, such as the National Federation of Independent Businesses (NFIB), Hispanic Business Roundtable, and various engineering societies.

- AHPs are supported by the NFIB, representing 600,000 small and independent business owners. The majority of NFIB's membership (55%) has five employees or less; 72% have less than 10 employees.

- The National Association for the Self-Employed (NASE) completed a recent survey in which 78% of self-employed persons said they would be likely to participate in AHPs if it lowered costs, with 75% saying they would participate if AHPs offered more choices. NASE notes that more than 60% of the uninsured are from families that have someone employed by a small business.

- The American Society of Mechanical Engineers (ASME) notes that their health plan administrator cannot obtain affordable coverage in nine states due to the high cost of mandated benefits. In total, more than 19,000 ASME members have no access to the association's health plan.

**Other organizations supporting AHPs include:**

- American Association of Engineering Societies
- American Council of Engineering Companies
- American Farm Bureau Federation
- American Hotel and Motel Association
- American Institute of Chemical Engineers
- American Road and Transportation Builders
- American Society of Association Executives
- American Small Business Association
- American Veterinary Medical Association
- Associated Builders and Contractors
- Independent Insurance Agents of America
- Independent Office Products & Furniture Dealers Association
- Institute of Electrical and Electronics Engineers
- National Association of Home Builders
- National Association of Manufacturers
- National Association of Wholesaler-Distributors
- National Association of Women Business Owners
- National Automobile Dealers Association
- National Council of Agricultural Employers
- National Lumber and Building Material Dealers Association
- National Restaurant Association
- National Retail Federation
- National Roofing Contractors Association
- National Society of Professional Engineers
- North American Equipment Dealers Association
- The Professional Golfers Association of America
- Self-Insurance Institute of America
- Tire Association of North America
- U.S. Chamber of Commerce
- Western Growers Association
- Women Impacting Public Policy