ASSOCIATION HEALTH PLANS—PROMOTING HEALTH CARE ACCESSIBILITY

HEARING

BEFORE THE

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

WASHINGTON, DC

FEBRUARY 16, 2000

Serial No. 106–43

Printed for the use of the Committee on Small Business

U.S. GOVERNMENT PRINTING OFFICE

65–217 WASHINGTON : 2000

COMMITTEE ON SMALL BUSINESS

JAMES M. TALENT, Missouri, *Chairman*

LARRY COMBEST, Texas
JOEL HEFLEY, Colorado
DONALD A. MANZULLO, Illinois
ROSCOE G. BARTLETT, Maryland
FRANK A. LOBIONDO, New Jersey
SUE W. KELLY, New York
STEVEN J. CHABOT, Ohio
PHIL ENGLISH, Pennsylvania
DAVID M. MCINTOSH, Indiana
RICK HILL, Montana
JOSEPH R. PITTS, Pennsylvania
JOHN E. SWEENEY, New York
PATRICK J. TOOMEY, Pennsylvania
JIM DEMINT, South Carolina
EDWARD PEASE, Indiana
JOHN THUNE, South Dakota
MARY BONO, California

NYDIA M. VELAZQUEZ, New York
JUANITA MILLENDER-MCDONALD, California
DANNY K. DAVIS, Illinois
CAROLYN MCCARTHY, New York
BILL PASCRELL, New Jersey
RUBEN HINOJOSA, Texas
DONNA M. CHRISTIAN-CHRISTENSEN, Virgin Islands
ROBERT A. BRADY, Pennsylvania
TOM UDALL, New Mexico
DENNIS MOORE, Kansas
STEPHANIE TUBBS JONES, Ohio
CHARLES A. GONZALEZ, Texas
DAVID D. PHELPS, Illinois
GRACE F. NAPOLITANO, California
BRIAN BAIRD, Washington
MARK UDALL, Colorado
SHELLEY BERKLEY, Nevada

HARRY KATRICHIS, *Chief Counsel*
MICHAEL DAY, *Minority Staff Director*

CONTENTS

	Page
Hearing held on February 16, 2000:	01

WITNESSES

Wilson, Paul, Executive Director, North American Equipment Dealers Association Group Insurance Trust	05
Baumgardner, James R., Acting Deputy Assistant Director for Health Policy, Congressional Budget Office	07
Lehnhard, Mary Nell, Senior Vice President, Blue Cross Blue Shield Association	09
Joensen, Mark, Vice President and Director of Health Care Analysis, Consad Research Corporation	11
Kaplan, Arlene, CEO & Founder, Heart-to-Home	13
Gallo, Richard, Owner, The Office Outlet	15

APPENDIX

Opening statements:	
Talent, Hon. James	45
Christian-Christensen, Hon. Donna	48
Prepared statements:	
Wilson, Paul	49
Baumgardner, James R	56
Lehnhard, Mary Nell	60
Joensen, Mark	82
Kaplan, Arlene	86
Gallo, Richard	92
Additional material:	
CBO Papers, "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts", Congressional Budget Office	95

HEARING ON ASSOCIATION HEALTH PLANS

WEDNESDAY, FEBRUARY 16, 2000

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

The Committee met, pursuant to notice, at 10:00 a.m., in room 2360, Rayburn House Office Building, Hon. James M. Talent [chairman of the Committee] presiding.

Chairman TALENT [presiding]. I am going to go ahead and get the hearing going. I congratulate the Committee on its wonderful attendance.

As regular attendees of Small Business Committee hearings know, members come in as the hearing goes on, and I would hope we will have a good attendance before long.

Unless there is a problem, I will go ahead, and then when the Ranking Member comes, be happy to allow her to give her opening statement at that time.

Good morning ladies and gentlemen, and welcome. We meet today to continue our discussion on expanding access to health insurance for the small business community. The difficulty of purchasing quality, affordable health care continues to plague small business. In fact, small business owners, their employees, and their families represent over 60 percent of the 44 million uninsured in the United States.

I speak on a daily basis to small business owners who want to provide health benefits to their employees but cannot afford to do so. I hear from others who are able to offer insurance, but face the possibility of double-digit rate increases that would force them to cancel their plans. And still others complain that due to the high cost of their plan, they are forced to offer fewer benefits to their employees or raise their deductibles so high that many employees cannot afford to cover themselves and their families.

These small business people want and need to offer high quality, affordable health benefits. For example, a small "mom and pop" hardware store must compete with Home Depot to attract and retain quality employees. In our tight labor market, health benefit packages are essential. It is unfair that a small "Main Street" hardware store cannot access the same economies of scale, administrative efficiencies, and purchasing clout that Home Depot and other large businesses enjoy when purchasing health insurance. If such things are good for big business, why are they not good for small business?

To address these needs, Representative Harris Fawell introduced Association Health Plan legislation several years ago. AHPs em-

power small business owners, who cannot afford to offer health insurance to their employees, to access insurance through bona fide trade and professional associations. In other words, AHPs offer national trade and professional associations, from the National Restaurant Association, to the American Farm Bureau, to groups like the National Association of Women Business Owners, to respond to the needs of their membership and sponsor health care plans.

The small business owners and farmers who are members of these associations can buy into these plans for themselves, their employees, and their dependents. These Association Health Plans would cover very large groups, enjoy economies of scale, and have the option to offer self-funded plans which would not have to provide any margin for insurance company profits.

Since its inception, AHP language has been revised and improved to strengthen both solvency requirements and state enforcement provisions in response to concerns. I am confident that AHPs will allow associations the flexibility to design comprehensive, affordable benefit packages that meet the needs of their membership. They will promote health care accessibility for a segment of the population that is greatly underserved by our Nation's health care system—the small business community.

Today's hearing will continue a productive dialogue which began at a hearing we held back in June. Since that first hearing, we have seen some progress in Congress' quest to improve our Nation's health care system and reduce the number of uninsured. In early October, the House passed H.R. 2990, legislation which contained several access provisions, including AHPs. Later this month, a Conference Committee, of which I am a member, will meet to discuss the Senate and House versions of the bill. I am committed to insuring that AHPs are included in the final conference report.

Today we have assembled a knowledgeable panel of witnesses who will help us further explore the potential benefits of AHPs. We will hear testimony regarding recent data projecting the potential impact of Association Health Plans. Additionally, we will hear from an Association Health Plan administrator, a representative of the insurance industry, and two small business owners. I am looking forward to the testimony of all witnesses.

Now would be the point at which I would recognize Ms. Velazquez for her opening comments. Since we have a vote anyway and since she is not here to give those comments, I think what I will do is adjourn the meeting, go vote, and then come back, and see if Ms. Velazquez is here to give her comments. Otherwise, we will go ahead with the witnesses.

We are going to recess the meeting.

[Recess.]

Chairman TALENT. All right. We will reconvene the hearing, and I will recognize the gentlelady from New York for her opening comments.

Ms. VELAZQUEZ. Thank you, Mr. Chairman, for holding today's hearing on Association Health Plans.

I would like to commend you for your continued efforts to help small businesses provide health insurance coverage for their employees. I am happy to work with you on this issue, and last year

I was one of an original co-sponsor of your bill to provide an immediate 100 percent deduction for health care costs.

This is a critical issue not only for the small business community but for millions of uninsured Americans. I hope that today's hearing will provide us with a greater understanding of this problem and possible solutions.

Despite the booming economy and growth of the stock market, almost 43 million Americans are still without basic health insurance. Of these 43 million uninsured, almost 60 percent are either self-employed or have a family employed by a small business that does not provide health benefits. In 1997, workers in firms with fewer than 100 employees represented 32 percent of all workers age 18 to 64. Sixty percent of these, 42.6 million workers, obtained health insurance through their employer or their spouse's employer, but 28 percent are uninsured. These uninsured employees in small firms account for 49 percent of all uninsured workers.

Because many small employers are marginal firms that struggle to remain in business, they are often simply unable to afford health care. Additionally, those small businesses that do provide health insurance are especially vulnerable to increases in premiums. These factors make it more difficult for smaller firms to provide health insurance.

Earlier this year, this Committee looked at one solution to address the cost and access to help small business with health care. That solution was Association Health Plans. Employers have long been attracted to the idea of banding together to buy health insurance as well as to provide other benefits. AHPs will be small business purchasing entities that could benefit from economies of scales and greater purchasing power. AHPs will reduce the number of uninsured workers, although it is unknown by exactly how many.

Today, we continue that examination of AHPs as we hear from the Congressional Budget Office on a recent study it released. Despite the promise of reducing the number of uninsured, the CBO study paints a different picture and raises serious concerns on health plans that need to be addressed.

The CBO study found that AHPs will only have a slight effect on insurance coverage nationwide, increasing the number of people insured through small firms by 330,000 individuals. I am interested in hearing from CBO on its findings and rationale as to the drastic contrast and comparison it reached while conducting the study's research.

I also believe that the study brings up an important issue for this Committee to review. Concerns have been raised by a number of different groups that AHPs which seek out or attract employers with low-risk workers will weaken the equitable small business risk pools that States have spent years trying to build.

A result may be the firms with above average risks could find their insurance rates climbing steeply as low-risk, small firms join Association Health Plans. These are all issues that must be addressed in relation to Association Health Plans.

In closing, I would like to thank the chairman for holding today's hearing and reiterate my strong desire to help small businesses provide health care for their employees. I am looking forward to

hearing the testimony of the witnesses and learning more about Association Health Plans.

Thank you, Mr. Chairman.

Chairman TALENT. I thank the gentlelady, and the gentlelady and I have an agreement. We normally follow that she and I will make the opening statements. However, as members know, when a member of the Committee feels strongly and wants to make brief remarks, I will deviate from that as long as it doesn't get to the point where it really slows down the hearing.

And I understand Mr. Sweeney would like to make some brief opening statements.

Mr. SWEENEY. Yes. Thank you, Mr. Chairman.

Chairman TALENT. I would be happy to recognize him for that.

Mr. SWEENEY. Let me commend you for conducting this hearing. Let me say that I apologize, but I will have to step out and go to another Committee markup, and that is why I would like to at least have a statement submitted for the record and recognize that the numbers here are pretty overwhelming, as my colleague from New York pointed out, that over 44 million Americans are uninsured, and 60 percent of that 44 million are small business owners. And we know that small businesses and self-employers put their money and their assets into their business, and the price of insurance for small companies is astronomical. This oftentimes really puts a small business owner between a rock and a hard place, and this is a particular concern to me, because 90 percent of the employment in my district is derived from small businesses.

Let me finally just say that I strongly believe in a market-based system, and I look forward to the testimony of our witnesses to help us begin to look at opportunities to resolve this issue, and I again commend you and the ranking member for conducting this hearing.

Chairman TALENT. I thank the gentleman. We certainly understand. I have another hearing going on at the same time myself, a markup, and may have to step out for a few minutes from time to time.

All right. We will go right to the first witness who is Dr. Paul Wilson, and I am very pleased to welcome Paul, in part, because he is so knowledgeable and, in part, because he comes from my district in Missouri. Dr. Wilson is a Certified Employee Benefit Specialist and is currently the Executive Director of the Association Health Plan for the North American Equipment Dealers Association located in St. Louis.

And I just want to say for the members that Association Health Plans do operate sporadically on a State-by-State basis around the country, notwithstanding that there is no provision for them under Federal law. And Dr. Wilson is the executive director of such an association.

Dr. Wilson.

STATEMENT OF PAUL WILSON, EXECUTIVE DIRECTOR, NORTH AMERICAN EQUIPMENT DEALERS ASSOCIATION GROUP INSURANCE TRUST

Mr. WILSON. Thank you, Mr. Chairman.

I am Dr. Paul Wilson, and for the last 23 years I have served as executive director of the Association Health Plan for the North American Equipment Dealers Association, which has been located in St. Louis since the year 1900.

I am here today in my position as vice president of The Association Health Care Coalition—I will refer to that later as TAHC—which exists for the purpose of preserving the ability of bona fide trade and professional associations to provide high-quality health insurance coverage to American workers.

Today, I will briefly describe how Association Health Plans have been serving small business for the last 50 years and why the reforms of H.R. 2990 are so badly needed in order to protect the health coverage of workers. I will also comment on the recent report by the Congressional Budget Office.

I first want to commend you, Mr. Chairman, for your outstanding leadership on this issue of health insurance reform for small business. There is an immediate threat to bona fide association plans and their insured workers. NAEDA—that is the organization that I mentioned earlier, the North American Equipment Dealers—is representing TAHC today because of the immediacy of the circumstances which confront our Association Health Plan. These circumstances apply to many of TAHC's members.

NAEDA established an Association Health Plan in 1949 to provide farm and construction equipment dealers in mostly rural communities with affordable health benefits. This was necessary, because many insurance companies then seemed more interested in serving urban and suburban areas rather than rural communities.

We now face a very serious situation which jeopardizes the health insurance coverage of the workers covered by our plan. The proliferation of State regulations and mandates have made it likely that our association plan will end July 1, 2000. We have recently been informed by our insurance carrier, UniCare, that our association policy will not be renewed on that date as it applies to small group health coverage for employers with less than 50 employees. Rather, UniCare wants to transition our business now to small group lines of theirs which will reduce health plan options to our members in all but six States.

We have contacted more than 50 insurance carriers, but none want association business. They tell us it is just too costly to comply with regulations and mandates which differ in each State.

Assuming that our 50-year association plan comes to an end July 1, we are now faced with a very burdensome question: Will the employees and families currently served by our health plan be able to obtain similar high-quality coverage at rates their workers can afford by negotiating directly with the insurance companies, on their own, and without the assistance of an association plan and staff? My experience has shown that when insurance carriers underwrite new accounts, roughly 40 percent of the firms do not get the lowest quotation due to the health status of employees. In our situation, each of the carriers will likely rate-up or rate-down our members

based on new account underwriting case characteristics which often include individual employee health statements.

NAEDA strongly believes that our members would have more affordable coverage if we were able to continue as an AHP. Prompt enactment of H.R. 2990 is our only chance to continue as an AHP.

Many years of experience of TAHC's membership puts us in a good position to comment on the CBO report. We believe the CBO report dramatically underestimates the value of AHP's to small business, and therefore underestimates the number of uninsured people who could gain coverage if AHP reforms were enacted.

Attached to my written statement is a short peer review of the CBO study by Dr. Donald Westerfield, professor of Statistics and Economics at Webster University in St. Louis. Dr. Westerfield found that CBO did not account for wage differentials, health care package composition differentials, and premium contribution differentials between employers and employees, among other things, between large and—categories of large and small firms. Thus, CBO is comparing apples, oranges, and bananas. Dr. Westerfield concludes that a study normalizing the relevant data would much more effectively capture the cost savings that associations can provide to small business.

We believe the report does not recognize the fact that bona fide AHPs have a long track record of reducing health insurance costs for small businesses through operating efficiencies, such as economies of scale, greater bargaining power to negotiate discounts, and regulatory uniformity.

For example, at NAEDA, we know that we historically have provided savings of at least 8 percent of administrative expenses due to the economies of scale of our AHP. Associated Building and Contractors has a plan with administrative costs of about 13.5 percent compared with administrative costs of 20 to 30 percent for similar coverage purchased through an insurance company.

These are just two examples, and there are many others, but the CBO report simply does not acknowledge this reality, which we have seen demonstrated for 50 years.

Second, CBO's statistical analysis does not reflect the dynamics of the market when it assumes that AHPs will attract mostly low-risk populations. This ignores the reality in today's economy that small employers must offer competitive benefit packages in order to compete for quality employees, especially when they compete against large employers.

After working with small employers on a daily basis for the last 23 years, I can attest to the fact that they must offer high-quality benefit packages at the lowest possible cost out of economic necessity. AHPs that serve small businesses will be driven to offer affordable, attractive benefit options through operating efficiencies and offering innovative new products. Businesses with truly high-risk populations will be able to obtain savings on high-quality benefit packages due to the savings achieved. Again, the CBO report does not acknowledge this reality; rather, it assumes that small employers will always seek the smallest possible benefit package for their employees.

To summarize, TAHC believes that CBO substantially underestimated the benefits of association group purchasing and an injection of healthy competition into health insurance markets.

Finally, I must address comments by the Blue Cross Blue Shield Association in a statement released concerning the CBO report. They say that AHP legislation is merely a shell game. This is disingenuous coming from insurance companies which are engaged in their own shell games. Insurance carriers are actively target marketing to limited segments of the population while quietly avoiding the rest. Many other strategies practiced by insurance companies are described in my written report, and these amount to adverse selection against small business, and this is the real shell game going on today.

It is incumbent upon policymakers to establish policies which promote ways of getting health insurance to those people in communities that insurance companies are not interested in serving. AHPs are already filling this role and can do a much better job if given the proper tools and regulatory environment. TAHC strongly urges Congress to enact the AHP reforms in H.R. 2990 towards this end.

Thank you very much, Mr. Chairman.

[Mr. Wilson's statement may be found in appendix.]

Chairman TALENT. Thank you, Dr. Wilson.

Our next witness is Mr. James Baumgardner who is the Acting Deputy Assistant Director for Health Policy of the CBO.

STATEMENT OF JAMES R. BAUMGARDNER, ACTING DEPUTY ASSISTANT DIRECTOR FOR HEALTH POLICY, CONGRESSIONAL BUDGET OFFICE

Mr. BAUMGARDNER. Thank you, Mr. Chairman and members of the Committee. I am pleased to be here today to discuss the provision of employer-sponsored health insurance by small firms. The Congressional Budget Office recently completed a paper on that topic entitled "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts," and I ask that that report be included in the record.

My comments today will focus on three aspects of CBO's report: First, the circumstances that contribute to the relatively low rates of health insurance coverage through small firms; second, a summary of the rules that would apply to the proposed association health plans and HealthMarts, and finally, CBO's estimate of how the introduction of AHPs and HealthMarts would affect the number of people insured through small firms and the premiums they face.

Employees of small firms are less likely to have health insurance than are employees of large firms. For 1996, data from the Medical Expenditure Panel Survey indicate that about 40 percent of employees in small firms—those with fewer than 50 workers—obtained health insurance through their employer. In contrast, almost 70 percent of workers in firms of 100 or more employees obtained coverage through their job.

Several factors appear to play a role in the lower rate of insurance coverage through small employers. Workers in small firms, on average, have lower wages and lower family incomes than workers

in large firms. As a result, small-firm employees are less able to afford comprehensive health insurance, and less of a tax incentive exists for providing health insurance through their employer.

Small firms typically face higher costs for providing a given benefit package than do larger firms because of higher administrative expenses per enrollee and less purchasing power.

Small firms generally purchase insurance that is subject to State benefit mandates and other regulations, which tend to increase average premiums. Firms that self-insure—mostly large firms—are exempted from those State insurance rules by the Employee Retirement Income Security Act, ERISA.

Recent proposals would establish federally certified AHPs and HealthMarts, entities that would offer health plans to participating employers. Trade, industry, or professional associations that had been in existence for at least 3 years could sponsor an AHP, which would have to offer its insurance products to all member firms. HealthMarts, in contrast, would have to be available to all small firms in a specific geographic area rather than be offered in conjunction with an association.

To explore the effects of AHPs and HealthMarts, CBO constructed an analytical model using assumptions based on the relevant economics literature. We estimate that about 4.6 million small-firm employees and their dependents would receive coverage through the new insurance vehicles, but most of those individuals would have obtained insurance even if current law remained unchanged. On balance, about 330,000 more people would be covered through small-firm employment than would otherwise have been the case. That represents a 1.3 percent increase in coverage through small firms.

Because of lower premiums, some small firms would begin to offer their employees coverage through AHPs and HealthMarts, and others would shift from coverage obtained in the traditionally regulated market to the new entities. Firms that moved to the new plans would, on average, pay premiums that were about 13 percent lower than they would have faced in the traditional market under current regulations. They would be paying less money for less insurance, however, since some of those premium savings would be the result of a less generous benefit package.

Introducing AHPs and HealthMarts would be likely to lead to some selection. For plans that were fully State regulated, the proportion of firms with higher expected health costs would rise after the new AHPs and HealthMarts became established. Consequently, firms remaining in the traditional insurance market would see an average increase in premiums of about 2 percent.

The impact of AHPs and HealthMarts would vary from State to State, depending on the extent of State insurance regulation. In general, States that were more highly regulated would be riper markets for the new entities, as would areas with greater concentrations of small firms. The actual outcome of the proposed legislation would also depend on the activities of the regulatory authorities responsible for AHPs and HealthMarts.

That concludes my statement. I will be happy to answer any questions.

[Mr. Baumgardner's statement may be found in appendix.]

Chairman TALENT. And, without objection, your report will be entered into the record.

Our next witness is Mary Nell Lehnhard who is the senior vice president of Blue Cross and Blue Shield Association.

Ms. Lehnhard.

STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, BLUE CROSS BLUE SHIELD ASSOCIATION

Ms. LEHNHARD. Mr. Chairman, members of the Committee, I appreciate the opportunity to testify on this legislation.

Blue Cross and Blue Shield Plans share your commitment to small employers and their employees. We want to assure that small employers have coverage options that are as affordable as possible, of high quality, and responsive to the employer-employees' needs. We are actively supporting Federal legislation to make coverage more affordable for small employers through a system of tax credits.

I would like to make two points today. The first one is that States have enacted legislation to stop the most egregious and most destructive practice in the small group market—insurers reducing premiums by selecting or as they call it "cherry picking" the best risks and avoiding those employer groups who are sick. This practice was rampant in the eighties, and the States effectively stopped it with their small group reforms.

The bottom line then was that if your group had even one sick employer family member, your coverage was unaffordable, no one wanted your business. The States are now telling Congress that the AHP legislation would take us back to the days of competition based on risk selection and coverage for the sickest groups costing multiples of the coverage for the healthy groups.

I would like to submit for the record letters from the Republican Governors Association, the National Governors Association, the National Council of State Legislators, and the National Association of Insurance Commissioners, all urging the Congress not to enact this legislation.

My second point is that credible research reports what Blue Cross and Blue Shield Plans have been telling us and what the States are saying, that exempting some insurers or health plans, which is what AHPs are, from State law and oversight is bad public policy and will completely pull the rug out from under their success and stopping "cherry picking" at the State level. We have brought this research to you before from Barents and others confirming this, but I would highlight the key findings of the recent CBO report.

First, AHPs will not significantly affect the number of insured. Yes, for the 330,000 people that get coverage it is very significant, but the proponents have been alleging that AHPs would result in up to 8.5 million people receiving coverage that were previously uninsured. Again, CBO's estimate is 330,000.

Second point, CBO found that the slight increase in coverage would result from two things: AHPs selecting the better risks, for one, and this would happen in two ways: Self-funded AHPs would pull better risks out of the State insured market, the State regulated pool, and an insurer that offered an insured AHP product

would not have to pool that product with the rest of its business, which is what the States currently require. The other way they would reduce coverage is to drop the State-mandated benefits.

The third point from CBO is that AHPs would not reduce overhead costs. The CONSAD study states the benefit of State preemption would be found in administrative cost reductions. The CBO found, quote, "no substantial evidence," end quote, that joining a purchasing cooperative reduced insurance costs. And in fact a study by William M. Mercer Inc. found that administrative costs would in fact increase because of duplication and members having to pay membership fees.

Very important point: The States that have done the most to pool the risks in the small group market to make coverage more affordable for older, sicker groups would see the most damage. These are States like New York, Pennsylvania, most of the New England States, some of the large Midwestern States. "Cherry picking" in these States would be rampant because of the State reform laws, and the State laws would quickly become unworkable and meaningless. The Federal Government would then have to step in and redo what the States did in the eighties.

Fourth and most important point, CBO found that four out of five workers would be worse off. Twenty million workers would see a premium increase, only 4.6 would see a decrease, and this will vary tremendously by State. As I said, the States that have done the most to encourage cross-subsidization, which is what you want from insurance, will see the biggest premium swings. Finally, I would point out research by the Urban Institute that exempting AHPs from State reforms would actually reduce overall coverage.

We believe the warnings are clear, and we believe they are credible. The States knew what they were doing when they enacted these reforms. They live in these markets, and they understand these markets. Blue Cross and Blue Shield offers coverage in every State, urban, rural areas. We do no redlining, we are in every part of the State, and we, along with the States, ask Congress not to return to the days where there was no meaningful pooling of risks and thus no meaningful cross-subsidy in the small group market. We urge you not to enact these provisions.

[Ms. Lehnhard's statement may be found in appendix.]

Chairman TALENT. Thank you.

Our next witness is Dr. Mark Joensen who is the vice president and director of Health Care Analysis of CONSAD Research Corporation in Pittsburgh, Pennsylvania.

Dr. Joensen.

STATEMENT OF MARK JOENSEN, VICE PRESIDENT AND DIRECTOR OF HEALTH CARE ANALYSIS, CONSAD RESEARCH CORPORATION

Mr. JOENSEN. Good morning, Mr. Chairman and members of the Committee. I thank you for the opportunity to speak to you this morning about the effects of Association Health Plans on insurance coverage in the United States. I believe that some research that I have been involved with may be helpful to you as we deliberate these issues. I will keep my presentation short to leave ample time for questions later on.

My name is Mark Joensen. I am vice president of CONSAD Research and director of Health Care Analysis. CONSAD is a public policy research firm based in Pittsburgh. For nearly 40 years, we have provided Federal Government agencies, foundations, private enterprises, and others with impact analysis and other research designed to inform policy-making. We have performed numerous analyses of different health care reform proposals over the years.

In 1997, the National Federation of Independent Business Research Foundation commissioned a study from us to analyze the potential impacts of the proposed Expanded Portability and Health Insurance Coverage Act of 1997 on the number of Americans with insurance. This act included provisions to allow the creation of Association Health Plans. We completed that study in July 1998, and I have provided the Committee with copies of this report for your review.

Based on our analysis, we estimate that the creation of Association Health Plans would result in an increase in employer-sponsored insurance coverage of approximately 2.3 million workers employed with small firms. In addition, we estimate that an additional 2.2 million dependents would gain insurance coverage as a result of AHPs. In total, we estimate an increase of approximately 4.5 million newly insured workers and their families.

This estimate represents our best single point estimate of changes in insurance coverage. We also conducted sensitivity analyses of our results using ranges of assumptions for important model variables. This sensitivity analysis produced a range of estimates that vary from 2.1 million to 8.5 million newly insured individuals.

I am happy to answer any questions you may have about our research and results, but I would like to spend my remaining time comparing our analyses and results with those of the recently released CBO report. This CBO analysis projects that the creation of AHPs and HealthMarts would increase the number of people with insurance by 330,000 individuals—that would be both workers and dependents. The study gives a range of estimated increases that vary from 10,000 up to 2 million.

As is usual with projections of this kind, the results of the analyses depend highly on model assumptions and data. I believe that the different analytic frameworks used by CBO and CONSAD are quite similar. Based on my review of the CBO report, I believe that a large portion of the differences in estimates result from the selection of a single model parameter. The individuals from CBO may have a different view on where the main part of the differences are, but that is what I am going to talk about this morning.

This parameter, the price elasticity of demand for insurance of small firms, is a measure of how much small firms would react to changes in the price of insurance. If the price of insurance decreases, we expect more firms to offer insurance to their employees. The price elasticity of demand depicts the percentage change in insurance coverage that would result from a given percentage change in insurance prices.

The value of the price elasticities used by both CBO and CONSAD were taken from the economics literature. The CBO analysis uses a price elasticity equal to −1.1 to produce its estimates. For their sensitivity analysis, the CBO uses a range of −0.6 to −1.8. However, in the CBO report, other estimates of price elasticity of demand by small firms are presented, including estimates by Roger Feldman and others that would give a price elasticity ranging from −3.9 to −5.8.

In our analysis, we use a price elasticity equal to −2 to −3. This range of values is derived from the economics literature and are cited in our report. I believe that the larger value for the parameter explains the numerical differences between our results.

There are several reasons why I believe that it is appropriate to use the numbers that we did. First and most importantly, a majority of the pertinent studies in the literature support the values that CONSAD used. The additional reason I am going to present is a little bit more subtle. All of the available studies of price elasticities describe changes in insurance rates that result from price changes in the existing market for insurance. However, I believe that allowing for the creation of AHPs fundamentally changes a segment of the insurance market.

CONSAD's numerous studies of the insurance market indicate that a number of factors affect a small business' decision to offer insurance to employees. Price is obviously an important factor. But small businesses also face impediments to offering insurance that are due to a lack of trust between themselves and insurance brokers, incomplete access to information describing available health plans and the plan benefits, and a lack of resources to understand and manage the terms of available health plans.

AHPs will overcome these barriers to insurance coverage. AHPs will be administered by organizations in which small businesses already belong, and thus have existing relationships and communication links. Thus, even if there was no price reduction associated with the creation of AHPs, I believe that there would be an increases in insurance coverage, because they overcome some of these non-price barriers. And for any given change in insurance prices, I believe that an insurance market that includes AHPs would produce larger increases in coverage than the existing insurance market. There are several additional differences that we can discuss later.

Irrespective of the differences and the absolute values of the CBO and the CONSAD results, both analyses indicate that insurance coverage will be increased as a result of the creation of AHPs. Clearly the benefits associated with AHPs will outweigh potential costs. Although AHPs will not provide the complete solution to the problem of Americans without insurance, I believe that they are part of the solution.

This concludes my prepared testimony, and I invite any questions you might have for me after all the panelists present their remarks. Thank you.

[Mr. Joensen's statement may be found in appendix.]

Chairman TALENT. Thank you, Dr. Joensen.

Our next witness is Ms. Arlene Kaplan, CEO and founder of Heart-to-Home of Great Neck, New York. Thank you for coming here, Ms. Kaplan.

STATEMENT OF ARLENE KAPLAN, CEO AND FOUNDER, HEART-TO-HOME

Ms. KAPLAN. Good morning, Mr. Chairman, members of the Committee. Thank you for the opportunity to appear before you today to discuss Association Health Plans and their importance to women-owned businesses.

My name is Arlene Kaplan, and I have been in the health care field for over 40 years. I was once a laboratory technologist, working in some of New York's finest hospitals. Then for almost 20 years I worked with 1199, the Hospital Workers Union in New York, as an organizer and a vice president. In 1984, I opened my first company called Heart to Home, a New York State licensed home care agency. I also own a New York State licensed adult home, Heartland on the Bay, and Workplace CPR, a company that provides CPR training and first aid to corporations and the community.

In addition I am a past national officer of the National Association of Women Business Owners and have been a member since 1985. My principal focus for NAWBO has been in the health care and health insurance reform arena. My remarks today are on behalf of NAWBO. NAWBO is a non-profit organization representing the interests of over nine million women business owners. NAWBO has over 78 chapters across the United States.

While working with Local 1199, I was involved in the union's plans for a National Health Care Program. As part of my responsibilities, I testified in December of 1978 before the Senate Health Subcommittee regarding a comprehensive national health plan. I was also very lucky to be part of the union's wonderful health and disability plan. We were self-insured and could and did create our own programs. As a union that was predominately female, we provided benefits that did not exist with insurance companies. We provided maternity disability before it became law, and we provided prenatal and delivery benefits regardless of your marital status. We provided well-baby care long before insurance companies. To the best of my knowledge, the union's benefit plan always exceeded the State mandate of benefits.

I touch on this only to show what can be done when people with a community of interest come together and design programs that fit their needs. That doesn't mean that NAWBO would set up an Association Health Plan, but we would certainly like to explore the possibility. We believe that we have needs that could be best addressed if we were permitted, as the union was, to design plans that meet those needs.

That is what happened with my union. The union existed for the purpose of representing members in collective bargaining, and the establishment of our benefit plan was an outgrowth of those goals.

NAWBO exists for the purpose of representing the needs of and furthering the goals of women business owners. To be able to develop an Association Health Plan would be a step in the furthering those goals.

Small businesses are the backbone of the American economy. The majority of these businesses do not offer health care benefits to their employees, not because they don't want to, but cost, access, and the ability to remain with a carrier has been a detriment. For example, Wanda Goetz, a NAWBO member and owner of an information management consulting service in Florida, cannot afford to give her employees health insurance benefits, because most of them are older, 50 plus. The premium cost was estimated at $7,000 a month for small business. As someone who has benefited from the legislation that allowed the union to be self-insured, I think that as a woman business owner I should have the same rights.

NAWBO strongly believes that the Association Health Plans would benefit our membership. Any plan that we design we certainly would want to be superior. We have grown our businesses by being better and more efficient, and that is how we would treat our health plan.

Association Health Plans give small businesses and the self-employed the freedom to design more affordable health options and offer their workers access to health care coverage. NAWBO members believe that these new coverage options would promote greater competition, lower costs, and new choices in health insurance markets. By allowing individual and small employers to join together, AHP's promote the same economies of scale and purchasing clout that workers in large companies currently realize.

The Quality Care for the Uninsured Act, H.R. 2990, includes the language supported by virtually the entire small business community to expand Association Health Plans. We must reach those small business owners without health insurance, and AHP's are the market-oriented private sector solution to the small business problem. We believe that the language in the Quality Care for the Uninsured Act would provide the necessary protections.

I would like to share just one more story with you. Christine Bierman, owner of Colt-Safety in St. Louis, Missouri tells her own story. Quote, "I own a small fire and rescue distribution company in St Louis, Missouri. I founded the company in June of 1980. Through the years, we have had up to 25 employees at any given time. We currently have 15.

My mother worked for the company from 1987 till her death in 1994. In 1989, she was diagnosed with breast cancer and had a mastectomy. The cancer recurred in 1992. We were one of the lucky companies that did not have to fight their insurance company to cover bone marrow transplant. The unfortunate and most unfair situation was that for the next 6 years of my mother's life, the insurance company rates escalated between 15 and 25 percent each year. In about year 3, I began questioning about getting into another insurance company. We could go nowhere else due to my mother's preexisting condition.

The escalating costs came at a time when we were also losing market share due to integrated suppliers and mega-mergers in our industry. This is usually when a small company can show their entrepreneurial skills by cutting costs and moving quicker than the mega companies. We were forced to cut our 100 percent employee coverage to 80 percent, and now only cover 60 percent of employee benefits."

What we see happening if my association, NAWBO, is permitted to form an Association Health Plan is that our members in each State will be able to provide for their employees' health benefits so that all of our stories have a good ending not a sad one.

Thank you.

[Ms. Kaplan may be found in appendix.]

Chairman TALENT. I thank you, Ms. Kaplan.

What we will do is we will go to Mr. Gallo for his statement and then adjourn for the vote which is on a rule, and then come back. And I would urge members to return. This is the only panel, and we will go right to questioning, and then we do have to vote out our views and estimates of the SBA's budget submission for the Budget Committee.

Our next witness is Mr. Richard Gallo, owner of the Office Outlet of Indiana, Pennsylvania.

Mr. Gallo.

STATEMENT OF RICHARD GALLO, OWNER, THE OFFICE OUTLET

Mr. GALLO. Chairman Talent, members of the Committee, good morning, and thank you for giving me this opportunity to come to you today and give my testimony concerning health care reform and how it affects my small business and my family.

Just a little background about myself, first. I am from Indiana, Pennsylvania, the hometown of the late, great actor Jimmy Stewart. We have a very nice museum and a statue of Mr. Stewart, so please come and visit us. Centered in our community is a fine educational institution, Indiana University of Pennsylvania. We are also known as the "Christmas Tree Capitol of the World." But, we are not quite as famous as our neighboring town of Punxsutawney, PA which has the famous weather forecaster, Punxsutawney Phil, which reminds me, we have six more weeks of winter here.

I was born and raised in Indiana, Pennsylvania, population of 15,000. I have been married to my wife, Wendy Bechtel Gallo, for the last 16 years. We have 4 children, 6, 8, 10, and a 12–year old. My wife and I were blessed when we were able to purchase our first business, the Office Outlet, an office products store. We have owned the Office Outlet since 1995.

Previously, I had managed an office product store for over 16 years. I was employed there a total of 22 years. I found that being employed was very different than owning your own company. I had high hopes of being able to provide benefits, like health care insurance, to our employees. To my shock and surprise, I found out it would cost me over $40,000 per year for a small company to give every employee, including my family, health care insurance. This was looking at the lowest priced health care plans and group rates

around. For a small business, just starting out, meeting this figure would be impossible.

So for now, my wife and I go without health care insurance, and my employees must take care of their own by whichever means they can.

I recently had to see a specialist for health reasons. I had no idea what expense would be—what it would be or how I was going to come up with the extra cash for payment. With four children, a mortgage, bills, and other expenses, there is not much cash in the savings account. With all the tests and medicine it was quite expensive, and I may yet have to have surgery. This motivates me even more to travel to Washington, DC, and speak out concerning this very important issue before you—affordable and accessible health care insurance plans for small businesses.

I feel for the many others in my situation, and now I personally know the frustrations of not having health care insurance. This can become a financial nightmare. I was blessed to have a family member who helped me with the expenses, but a lot of others may not have someone to turn to for help.

I ask this Committee: Who are the people going to turn to for health care insurance? The Government cannot pay for everyone to have insurance. My answer: The only way that this can be resolved is that we, as employers, must have available affordable health care plans to give our employees or at least offer them as co-pay plans.

I was blessed to have worked for a company that paid my insurance for the 22 years I was employed there. I appreciated that benefit, and it is one of the reasons I remained with that company at that length of time. It gave me a sense of security and appreciation for my job. I would like to be able to offer that same benefit for my valuable employees. I strongly encourage this Committee to continue their efforts with AHPs. This will help small business employers like myself by giving us the same access and choice of affordable health care for our employees.

The Fortune 500 companies, like Ford, Chrysler, and Wal-Mart have the ability to offer health benefits to their employees under the one unified Federal statute, known as ERISA, the Employee Retirement Income Security Act. This saves the big guys from the cumbersome task of having to comply with the different rules, regulations the benefits mandates that exist in each 50 States. We, the small businesses, have no such opportunity. This is why Associated Health Plans are an absolute necessity.

I see that many small employers are faced with the same problem. We must make enough profit to be able to employ good workers and offer them benefits that will keep them with our companies. As employers, we need good workers that are going to stick with us, to help build our companies as well as their futures. Without benefits, they look elsewhere for jobs. In Pennsylvania, we have lost thousands of young people for this reason each year. Our fine representatives from Pennsylvania can attest to that.

AHP will allow us, as small business owners, the opportunity to band together across State lines through memberships and bona fide trade or professional associations, enabling us to purchase affordable health coverage for our families and our employees.

For example, many of us are members of national associations, such as the NFIB, the Chamber of Commerce, realtors, builders, and restaurant associations. If AHPs would become law, small business owners and employees will benefit from the same economics of scales, purchasing clout, and administrative efficiencies as our big business counterparts. This will result in lower health care costs and new coverage options for the working uninsured, like myself, who are currently faced with no options other than the high priced, overregulated plans that exist in our individual States.

I close with this summation and advice: Please work together as one Committee and come to a true assessment of what is needed. Work with the insurance companies to come up with reasonable legislation that is fair for all and enables the insurance companies to provide health care for the millions that need it at affordable rates.

I will end with a quote from Mark Twain, "Do the right thing, it will gratify some of the people and astonish the rest."

Thank you, Mr. Chairman and Committee members, may God be with you.

[Mr. Gallo's statement may be found in appendix.]

Chairman TALENT. Appreciate your testimony, Mr. Gallo.

We will adjourn—or recess the Committee, excuse me, while we vote and then come right back.

[Recess.]

Chairman TALENT. We will reconvene the hearing, if the witnesses will have a seat. If we can have order in the room. Thank you for not making me break my pledge never to use the gavel during my time as chairman.

Looks like the ping pong game will be over for awhile, so maybe we can all get our questions in.

Mr. Baumgardner—There were parts of your report that I agreed with, and I want to start with those. On page 4 of your report, you talked about the reasons why the cost of health insurance for small firms is generally greater than that for bigger firms. I just want to go over that for a minute, and I certainly agreed with what you were saying.

You mentioned that, first of all, a larger firm is likely to have more purchasing power, because they represent bigger groups. That is one reason, isn't it? And then another is they can spread their administrative costs out over more employees. So, if you have got $1 of administrative costs and you spread it over two employees, that is 50 cents a person, but over 100 employees that is 1 cent a person. That is another reason, right?

Mr. BAUMGARDNER. Right.

Chairman TALENT. And then also, I don't know if you mentioned this or not specifically, but a firm that is big enough to be able to self-fund has savings also, doesn't it, over firms that can't, because it doesn't have to pay the marketing costs of the insurance company or the profit margins of the insurance company. That is an advantage too, isn't it?

Mr. BAUMGARDNER. Yes.

Chairman TALENT. Okay. So, that much I agreed with.

I want to cut right to the chase and get to the part that I disagreed with and I think is really the crux of all the aspects of the

report that I didn't agree with. And that is—your assertion that AHPs, if they were formed, would in effect "cherry pick;" in other words that healthier groups would tend to go into AHPs. And as I understand it, you believe that because AHPs would be exempt from state benefit mandates and, therefore, would have the ability to offer employees less extensive coverage and so would offer employees less extensive coverage. Is that the sum and substance of your opinion?

Mr. BAUMGARDNER. Yes, sir. First of all, we never used a term as inflammatory as "cherry pick." I know others have used that. But there are really two reasons why we think there would still be some selection: One is the issue of the exemption from mandates—that is, by not offering certain mandated benefits, you would be relatively more attractive to groups that had a lower expected cost, because their employees would see themselves as less likely to want to use those benefits. So, that was one point.

I think the second reason we would expect some selection is what in economics we call the survivor principle. Basically, if you can offer lower prices, on average, you are going to get a bigger market share. And in the case of States, especially those that have had tighter premium compression regulations, the lower-cost firms are doing a lot more cross-subsidizing of the higher-cost firms.

In essence, the availability requirements on the AHPs would allow them to slice the market in a different direction. The AHPs have to make their coverage available to everyone in the association, whereas the State-regulated plans have to adhere to the Statewide availability rules. So, in essence, the plans that are going to survive in the longer run are the AHPs that are able to offer a better price break relative to plans in the regulated market. The groups doing the cross-subsidizing in the regulated market are these with lower expected costs. We think lower cost groups would gravitate toward the AHPs for that reason.

Chairman TALENT. But the second reason is really a function of the first, as I understand it. In other words, because AHPs offer less—in your theory, because they are exempt from state benefit mandates, would offer less extensive coverage, cost less, therefore draw in the healthier firms who would be attracted to the lower price. And the effect would then magnify, because as those healthy firms left the small group market, there would be fewer healthy firms to cross-subsidize the sicker firms in the small group market, so that insurance would go up, and the effect would tend to magnify for that reason.

Let me just read what you said: "Exempting AHPs and HealthMarts from offering mandated benefits might substantially affect selection. With the exemption, AHPs and HealthMarts could design benefit packages that had fewer benefits and were relatively unattractive to firms whose employees had costly health care needs. Those firms would want more extensive benefit packages and would probably maintain their enrollment in traditional, fully regulated plans. As a result, their high health care costs would not affect the premiums offered by AHPs and HealthMarts, which might allow those plans to lower their costs by more than the savings from the mandate's exemption alone.

Lower price plans with leaner benefit packages would appeal more to healthy firms, both those that offered no coverage to their employees and those that already offered insurance. In other words, the effect magnifies. The more they draw in the healthier firms, the better is their pool, the more competitive they are vis a vis the small group market, and therefore the more they draw in from the small group market, and the selective impact magnifies." That is what your report says.

Mr. BAUMGARDNER. Yes, that is basically correct.

Chairman TALENT. The crux of the whole thing is the assumption that firms that are exempt from state benefit mandates would, for that reason, offer less comprehensive health insurance, insurance that would be less attractive to firms that had sick employees.

Mr. BAUMGARDNER. That is a lot of it. I think that if AHPs had to face the same guaranteed availability statewide that the firms in the state-regulated market did, the guaranteed availability would play a role as well.

Chairman TALENT. Do you know of any other entities besides AHPs that currently are exempt under the law from State benefit mandates?

Mr. BAUMGARDNER. Well, of course, as I said in my testimony, a self-insured, single-employer firm is exempt.

Chairman TALENT. Big companies that can self-fund, right? Now, have we observed this effect in the big company market? I mean, would you say that self-funded, large corporate plans offer insurance that is lower quality than you can get on the small group market?

Mr. BAUMGARDNER. Well, I think there are two things—I think you raise a good point, and it is an interesting point.

Chairman TALENT. I agree. Maybe you would like to answer it. I mean, do big firms—this is important, Mr. Baumgardner. I have been working on this for a long time, and you come in here and say, on the basis of an assumption that I think is just unsound, that AHPs are going to adversely select, and they are going to take healthy firms out of the market, and I don't think they will.

See, they are made to operate very similarly to big corporation health insurance practices, including self-funded practices. So, tell me, do you think that big companies with self-funded plans, on balance, offer less comprehensive and less poor quality insurance than is available in the small group market? I can read you what you said in the report.

Mr. BAUMGARDNER. I would like not to be held to a yes-no on this.

Chairman TALENT. Well, I will be happy to give you an opportunity to explain. The premiums themselves do not differ consistently on the basis of firm size. That means big firms, small firms pay the same premium. But the benefit packages that large firms offer their employees are more generous than those offered by small firms. That is on page 4 of your report.

Mr. BAUMGARDNER. Right. And I totally agree with that statement. I think the important thing that also needs to be recognized is that, as we said in today's testimony, larger firms, on average, have higher paid workers, higher income folks who are going to tend to want a higher quality package.

I think it is also the case, as we mentioned, the tax exemption from employer-sponsored insurance that, in essence, lowers the price more when you have workers in a higher tax bracket. So, I think—and also the large firms facing lower administrative costs for a given benefit package, it is cheaper for them to provide it.

So, for reasons that their costs are lower, their workers tend to be higher income, their workers tend to get greater incentives through the current tax system, those are all reasons we would expect larger firms to be offering more generous benefit packages.

Chairman TALENT. Those are reasons why larger firms can save money on health insurance. They don't usually save money—they don't save the money by cutting the benefits. They put the money into increased benefits, and the reason is not the generosity of people like "Hacksaw" Jack Welch over at General Motors; it is because they want good employees. Now, don't you think small businesses will want good employees as much as big businesses want good employees?

Mr. BAUMGARDNER. Well, again, I think it is a function of the workforce in these different size firms. On the other side, let me take—go down to the small firms. Precisely because they have lower income workers, they probably would prefer a less generous package so as to have less of their earnings offset by the cost of that package to the employer. In fact, it is exactly in the small firm market that these mandates probably are certainly more binding since the group that—because of the interaction of ERISA with state law, the group that probably would want a less generous package, to some extent, can't get it because of the mandates, and in fact that is why we do estimate in the end some increase in coverage among small firms.

Chairman TALENT. I appreciate that. Did you talk to any small business people who told you their employees want the poorer quality health insurance?

Dr. Wilson, you run Association Health Plan, okay? Do your members and their employees want lower quality health insurance than the big companies?

Mr. WILSON. They want the same benefits. An example of that is a Virginia equipment dealer that I am quite familiar with just last month. His costs went up, he got a rate increase from his carrier, and he wanted to eliminate that little drug card that you take to your pharmacy with a co-pay. He said, "Well, I can't really afford the rate increase, so I will just remove that drug card from his plan." So, he announced it to his employees that in the effort to—and these are mostly garage mechanic type employees—told them that he was going to remove the drug card, and he had an uproar on his hands. In fact, his accounting manager called me up and said, "Paul, you are going to have to help my boss. He is in the doghouse with all the employees. He is taking their drug cards away."

So, this notion of small employers being able to change those benefit levels and have that be accepted by their employees, I have not witnessed that.

Chairman TALENT. Mr. Gallo, you used to work for a bigger firm, right, and you had health insurance.

Mr. GALLO. That is correct.

Chairman TALENT. And then you opened up your own small business.

Mr. GALLO. Yes, sir.

Chairman TALENT. Now, did your preferences for health insurance change? When you opened up your own small business, did you want poorer quality health insurance at that point?

Mr. GALLO. No, sir. In fact, I look at my employees as my company, and they are very important to me, and my employees deserve a good health care plan. I don't think dumping to down would be the answer.

Chairman TALENT. Plus you have to compete with the bigger firms, don't you?

Mr. GALLO. Right, that is correct.

Chairman TALENT. Kind of what I figured, and I emphasize this point to the Committee, because this whole analysis that attacks Association Health Plan rests on the assumption that because Association Health Plans would be exempt from state benefit mandates that therefore they would offer poorer quality health insurance to their people, which causes then—that supports the whole argument that they would "cherry pick" by drawing in healthier people.

As a matter fact, Dr. Wilson, you run an Association Health Plan. Do the members of your association with the healthier or the sicker people tend to go into your plan? Or does it make any difference?

Mr. WILSON. Well, we really don't—since HIPPA, we don't really select that out to that extent, but I do know this: Our association plan is a member of TAHC, and it has had 70 members since 1992, since it began, 70 bona fide association plan members—only bona fide association plan members.

Last night at dinner, I read some of the materials and wondered, are these people really using adverse selection? We went through our membership, and I brought our list with me, and last night we went through and we sorted by blue collar and white collar. And we came up with the fact that these bona fide trade associations, we are probably the best cross-section of them that exists, these 70. They are 90 percent blue collar. We have contractors, car dealers, equipment dealers, builders, telephone workers, bottlers, lumber growers all across what you consider the service sector in blue collar. We only had 10 percent—we did have 10 percent of our members who were in professional, what some people think are the low-cost associations.

Chairman TALENT. Just emphasize again to the Members, the point is to recreate for pools of small businesses the same economies and efficiencies of scale that big businesses have, so, Association Health Plans will operate an awful lot like the big corporate plans, which don't result in healthier people going to work for corporations. As a matter of fact, all of us know, as a matter of experience, that people who have a history of illness, if they can get a job with a big company that has good coverage generally tend to do it, because it is more secure. So, if anything, the Association Health Plans will draw in sicker people, not healthier ones.

I want to make one other point, Mr. Baumgardner. We talked before about the extra costs that small businesses have to pay rel-

ative to big firms in terms of buying of health insurance. Because big firms can spread the administrative costs over more employees, because they are larger purchasing pools, because they can self-fund, they don't have to pay as much for profit margins or marketing costs. And yet your report assumes that the cost savings arising from the group purchasing features of AHPs and HealthMarts would be negligible. Isn't that right?

Mr. BAUMGARDNER. Yes, that is correct.

Chairman TALENT. Now, that is an assumption; that is not a conclusion you make. It is an assumption, and notwithstanding the diseconomies for small firms, if they could join into an AHP and make one big purchasing group, they would not have cost savings arising from that feature. That is an assumption you make on page 22.

Now, as a basis for that assumption—you do drop a footnote here—a study by Stephen Long and Susan Marquis about pool purchasing?

Mr. BAUMGARDNER. Yes, that is correct, sir. They looked at—and that is one thing I would like to say is we are always careful about receiving selected data from folks who of course are going to let you know how much they were able to save costs within their particular plan.

To us, the Long and Marquis data had the advantage that it was a random sample of firms that were selected regardless of were they in the regular small group market or where they were purchasing, say, as an individual small group or were they purchasing from a cooperative arrangement of some sort? Some of those were alliances that were not AHPs. Others were Association Health Plans under current law.

And, essentially, the Long and Marquis paper came to the conclusion that they were not seeing any premium differences between the small firms purchasing as an individual firm versus people purchasing through the pools. What they did find is that the choice of plans was bigger if you were with an alliance or a cooperative, and there was also more information often conveyed to the employees comparing the health plans offered within the cooperative. But the premium differences they didn't find. So, that was the basis of the assumption we made there.

Chairman TALENT. Well, let me direct you. The staff should have given you a copy of that article. I agree it is a pretty good study. They reached some very interesting conclusions. I have marked it, handwritten different pages on it. So, if you will go to what I have marked as page 3, and I will be happy to provide this to members of the Committee if they want. If you look at the bottom of page 3 where it says, "We did not see evidence of differential risk selection in pool purchasing arrangements."

Mr. BAUMGARDNER. And that is under current law where States can regulate these plans, and they have to comply with benefit mandates.

Chairman TALENT. Yes, exactly. In other words, they weren't studying the kinds of Association Health Plans that the bill would create, were they? They were studying all different kinds of pooled arrangements, including state-sponsored, pools that the government had put together, right? It would not surprise me at all, Mr.

Baumgardner, if pools the government had put together did not achieve any economies or efficiencies of scale, the same kind of people who pay $500 for an ashtray over at the Department of Defense.

Now, if you will go back to the end of the article, page 7, because they allowed for the fact that they were looking at a whole lot of different kinds of pools and not specific ones. And here is what they say, this is the last paragraph, "Clearly, there is a need for more research beyond what this first descriptive study can do. The pool purchasing we examined comprised a broad range of agreements. We found some evidence that the outcomes may differ substantially under different forms. But further work is needed to desegregate the types of pooling and to do more carefully constructed studies within markets of the participants and non-participants."

So, actually, this study, which as far as I can tell is the sole support for your assumption that Association Health Plans would not have cost savings from premiums, stands for, if anything, the opposite proposition, because they say, "We found some evidence that the outcome may differ substantially under different forms." So, at best, we really don't know what would happen if somebody studied just Association Health Plans, do we?

Mr. BAUMGARDNER. I think that is fair, and certainly as research is updated we will look at those studies.

Chairman TALENT. Well, I appreciate your candor. I think that is fair too, and I will recognize the gentlelady from New York for any questions she may have.

Ms. VELAZQUEZ. Thank you, Mr. Chairman.

Mr. Baumgardner, the CBO analysis indicates that 20.3 million Americans will actually see rate increases for health coverage due to the passage a law creating AHPs and HealthMarts, does it not?

Mr. BAUMGARDNER. Ms. Velazquez, I would like to speak to that point, because I think perhaps it is taken slightly out of context in that basically that 20 million, we really can make—with our analysis, we really can only speak on average what is going to happen. So, within that pool that stays in the traditional regulated plans, we feel those firms, on average, are going to see a 2 percent increase.

I think it is going to depend on State law. There are a number of States that allow fairly wide ranges of premiums to be charged to different firms. You can see like 5 to 1, 2 to 1 as what is allowed. A lot of firms probably won't see any change in those less regulated States. So, it is really an on average statement of a 2 percent increase within that 20 million group that stays within the traditional regulated market.

Ms. VELAZQUEZ. One of the arguments used by the proponents of HealthMarts and AHPs is that this plan will enable small businesses to pool resources through group purchasing and obtain significant administrative cost savings through these new arrangements. What proportion, if you can tell us, of the premium reduction estimated by CBO is related to administrative savings?

Mr. BAUMGARDNER. Well, as the chairman pointed out, we assume zero for that. We assume 5 percent for the mandate exemption savings. So, the answer would be zero with the assumptions we use, as far as the administrative savings. And, again, that

was—the Long and Marquis study suggested and the Chair made reasonable points that there will be more research in the future, but based on what we could see now, we went with zero as the assumed savings there.

Again, I think a big coop still is not the same as one large firm. You don't control the benefits office. They don't work solely for you. They work for a lot of distributed small firms. Yegian and others in a study in California, for instance, found that the—and they are looking at a particular health purchasing alliance; yes, it is not an Association Health Plan. But they found that the premiums charged to these small firms through this cooperative arrangement those premiums were larger than what large firms saw. So, I think even small firms as a group are never going to have some of the economies that a large firm can have. Again, the benefits office and all the employees are yours in a large firm.

Ms. VELAZQUEZ. Are you telling us that the CBO study has to be revisited?

Mr. BAUMGARDNER. Well, when more research comes up—these studies often are slow in coming through the academic literature—there could be an update someday. I couldn't say I would foresee one any time soon, though.

Ms. VELAZQUEZ. Dr. Joensen, the CONSAD report implies that small employers will be better off under AHP legislation. However, the CBO report estimated that four out of five small businesses will face higher health insurance premiums if AHP legislation were enacted.

Please explain why the CONSAD analysis came to such a different conclusion regarding the value of this legislation for the average small employer.

Mr. JOENSEN. That is a good question. The purpose of our study was simply to estimate the increase in insurance coverage, and in fact we did not focus on the impact of the creation of Association Health Plans on the premiums of other firms. And in fact I think that the estimate provided by CBO of a 2 percent increase is probably a reasonable estimate.

What are we seeing? We are seeing that firms that have higher—the actuarial value of the health care services being used by those firms are higher than average, and in fact that 2 percent increase means they are going to be paying of their own health care costs. In exchange for that, these individuals who are able to join AHPs we believe will be seeing a decrease in costs, and as a result of that decrease——

Ms. VELAZQUEZ. Why so?

Mr. JOENSEN. Why? Because for a number a reasons, including the reasons that we heard from Mr. Baumgardner. They include the reduction in benefits because of mandates, the relaxation of mandates. We believe, in fact, that there will be a administrative savings due to the grouping independent of what the Long and Marquis study presents. It is just one study.

We believe that it is reasonable to expect savings, but it is important to note that our results estimate—the results that our study estimates are based on a 10 percent decrease in premiums for those small businesses that currently do not offer insurance. And I believe that the result presented by CBO is associated—they esti-

mate that there will be a 13 percent decrease, is that correct, for the firms that join the AHPs?

Mr. BAUMGARDNER. Right, for the firms joining the AHPs, on average.

Mr. JOENSEN. Right, right. So, I think we are talking about estimated reductions that are very similar.

Ms. VELAZQUEZ. Mr. Joensen—Dr. Joensen, a primary concern raised by the CBO's report is that AHPs will pool the healthy from the small group market, causing premiums to increase for the majority of small employers. Unlike the CBO report, the CONSAD analysis does not consider that AHP legislation will have on employers purchasing coverage in the traditional small employer insurance market. I would like you to explain why the effects on the traditional market were not considered in that analysis?

Mr. JOENSEN. Again—very good question—again, the focus of our study was simply to look at the pool of businesses that currently do not offer insurance, not the impact on those that currently do. I believe that, as I said before, that the CBO's analysis of those effects on those businesses that currently offer insurance is a reasonable one. They see a 2 percent increase, on average, in premiums and a decrease in insurance coverage for those people that is negligible compared to the uptake.

So, yes, we could have increased the scope of our study and focused on the impacts on the currently insured. We chose not to do that. We believe that our estimate of the number of individuals that will receive insurance for the first time due to the AHPs is correct, and we should—we can change or we can add to our study to look at the decrease in those firms that currently offer insurance, but I believe it will also be a negligible number compared to——

Ms. VELAZQUEZ. Why?

Mr. JOENSEN. I am just basing that estimate on the results that CBO produced. They saw an increase of 340,000 in the firms that currently do not offer insurance and a decrease of only 10,000. So, I am saying that if we assume the same percentage of people losing insurance, it really is a small percentage.

Ms. VELAZQUEZ. Ms. Lehnhard, you state that the CONSAD report is not credible. Could you please elaborate on that?

Ms. LEHNHARD. Well, we commissioned the Barents group of KPMG to look at that study, and some of the things that they raised as concerns, for example, were, first, the universe of the population used was, in their terms, exaggerated. They used Medicare eligibles, for example, and Medicaid eligibles and some populations that don't belong in the base.

Secondly, they assume that for every 5 percent decrease in premiums, you have a 6.5 percent decrease in the number of uninsured, and that extraordinarily high by any of the literature. CBO won't even accept a 3 percent increase, I don't believe, for every 1 percent decrease in premiums.

They didn't look at the effect on the rest of the insurance markets, what would happen to people who weren't in AHPs, their premiums. Those are some of the kinds of concerns that we have.

Ms. VELAZQUEZ. Would you like to respond?

Mr. JOENSEN. Yes, I would, in fact. The issues that the representative of Blue Cross just mentioned were presented to me in February of 1999 in a letter that had been written by their consultant, I think it was the Barents Group, and they issued a number of criticisms after reading the report. I, unfortunately, didn't realize that we would be discussing those points today, but in response to those criticisms I produced a letter refuting each and every one of their criticisms, and I will make a copy of that letter available to the Committee, because I think it is quite important.

With regard to the two specific criticisms that we just heard they are both absolutely incorrect. The base of population that we used in our study was simply the currently uninsured. We did not look at people who are receiving Medicare, Medicaid insurance, insurance from other private sources, or insurance from the Federal Employment Benefit Plan. So, in fact, the base of individuals we used in our calculations was the currently uninsured.

In addition, this notion that we used an elasticity of 60 is—an elasticity of 6.5, we did not use an elasticity of 6.5. We used an elasticity of between two and three, which is, I believe, supported by results of literature, economics literature studies.

Ms. VELAZQUEZ. Yes, Ms. Lehnhard?

Ms. LEHNHARD. One other concern we had, and I think it was mentioned earlier today that they didn't take into account the income of workers for small employers, which CBO says is the largest single factor in their not taking up insurance.

But could I make one comment on the exchange, very quickly, we have heard between the two studies? With all due respect to the chairman, I think this whole debate has been about an exemption from State-mandated benefits so small firms could lower their costs by not offering State-mandated benefits.

Ms. VELAZQUEZ. What type of mandated benefits do you think would be most likely dropped?

Ms. LEHNHARD. The most expensive mandated benefits are mental health, substance abuse. The most numerous benefits are women's issues—breast mastectomy coverage, in vitro fertilization—those are the most numerous. But we work with small employers everyday, and they are desperate to get the costs down, and we have worked very successfully with State legislators to get streamlined packages. But we know they want—it is not a quality issue; it is a cost issue. Can we offer anything to our employees?

But I put that aside. The biggest issue is not mandated benefits——

Ms. VELAZQUEZ. Ms. Lehnhard, I just would like for Dr. Wilson to comment on those benefits that Ms. Lehnhard said will be dropped, will be most likely dropped. Are you providing those AHP that you are in——

Mr. WILSON. Yes, all of the mandates. But with all due respect, I think she is just guessing that. I don't know that there is any reason——

Ms. VELAZQUEZ. Do you provide your AHP those mandated benefits?

Mr. WILSON. Yes, ma'am. But I also know that the notion of bare bones plans has never worked for my association plan, no matter what the price was. Our dealers would be interested in a quote on

that. What if you gave me a plan that was really stripped down, had a high deductible, it had a high out-of-pocket maximum to where—and they get the quotation, and then they look at it, and it is a lot less. Bare bones plans are less.

And then they have to go back and convince their employees, because we can't overlook the fact that most small employers do not pay 100 percent of the cost for their plans. They do not have total control over these plans. The employees often pay 50 percent of the cost, and if the employer decides he is just going to arbitrarily go out and do a bare bones plan, he has almost got to take that to a vote to his employees or he could have a real disruption among his business. This can cause a very negative—and I think it is being overlooked, the fact that the employees do pay a whole lot of the cost, and they should have a lot to say about what the benefit levels are.

Ms. VELAZQUEZ. Would you like to comment?

Ms. LEHNHARD. The point I would make is that the biggest issue is not mandated benefits. That is a relatively small part of the cost. We do think that some employers, many employers will drop benefits. The biggest issue is who is going to crosssubsidize whom, and that is what the States have tried to address with the rating reform laws.

And, again, what the States are telling us is if groups can get out from having to cross-subsidize other groups in the State, if they are relatively healthy, they will do that. If they are not healthy, they will stay in the cross-subsidized pool. That is where the big premium swings will come, particularly in Northeastern States where they have really compressed the rates to achieve maximum cross-subsidies between older, sicker groups and younger, healthier groups. That is the big issue, and that is the big disruptive issue.

Ms. VELAZQUEZ. Mr. Baumgardner, based on your findings, how would the introduction of AHPs into a market like my home State of New York, a State that has very tight compressed premiums, and it is dependent on a strong and highly crossed subsidized market, be affected? Specifically, what will be the result on low-cost firms?

Mr. BAUMGARDNER. Well, we don't have specific results State-by-State and I think would hesitate to do that. But certainly based on our analysis and what drives the results, clearly, in States where you have got tighter rate compression, and I think New York is number one in that category, as well as a fair number of mandated benefits, I believe, we would expect more action in that State both ways.

The potential premium reduction to those firms who do take advantage of the AHPs is likely to be greater in New York than in other States. Proportionally to population, you would have more of a decrease in the uninsured in that State. By the same token, on the other hand, for the firms staying in the traditional regulated market, we would expect them to see a relatively higher premium increase in New York. So, all the effects one would expect would be more magnified in a more regulated State.

Ms. VELAZQUEZ. Dr. Joensen, would you like to comment?

Mr. JOENSEN. I agree with that analysis.

Ms. VELAZQUEZ. Thank you, Mr. Chairman.

Chairman TALENT. That analysis rests on the assumption, doesn't it, that healthier people would tend to go into the AHP? Because what I said before the whole chain of reasoning rests on your assumptions that AHPs "cherry pick," which rests on the assumption that if the smaller firms pool together as AHPs, had a resulting economies of scale or economies because they weren't subject to mandates, or whatever, that they would offer lower quality health insurance.

Now, I will ask you all again. Let us take the big firms, because they can function right now the way AHPs do. Do big firms tend to employ people who are relatively healthier than the rest of the market? Is there any data to suggest that?

Yes, Ms. Lehnhard.

Ms. LEHNHARD. Let me give you the answer this way: If the only issue in this bill were exemption from rating rules, your AHPs still had to provide mandated benefits, you would still have a horrendous problem. It is not the mandated benefit, it is the fact that they can get out from under a deliberate decision by the State to require some cross-subsidy in the market. It is really not a mandated benefit issue as much as a rating issue. And I think that is what CBO is saying, that two-thirds of their savings——

Chairman TALENT. Well, forgive me for thinking it was a mandated benefit issue given that the CBO report said exempting AHPs and HealthMarts from offering mandated benefits might substantially affect selection. You can see why I might have thought that exemptions from mandates might be part of what was driving this. We are now disavowing this?

Mr. Baumgardner.

Mr. BAUMGARDNER. I have not disavowed anything in the report, sir.

Chairman TALENT. I didn't think so.

Now, regardless of the reason why it costs a bigger firm or a pool of small employers less to buy health insurance, your whole case rests on the assumption that they will buy less insurance instead of using that margin to buy better insurance for their people. So, I will ask you again.

Ms. LEHNHARD. No.

Chairman TALENT. Big firms already operate that way. Now, do they buy poorer quality health insurance for their employees?

Ms. LEHNHARD. I am saying something very different. I am saying that if you neutralize the mandated benefit issue by requiring everybody in your world after AHPs are passed to provide mandated benefits, you are still going to get selection, because people who are healthier know they don't have to stay in a State pool and cross-subsidize sicker people. So, they will move to an environment where they don't have to cross-subsidize.

Chairman TALENT. But if the AHP, the cross-section of healthy and sick people in the AHP is roughly the same as in the small group market, then they are still cross-subsidizing if they go into the AHP, aren't they, and there is no incentive to do it. So, you have to show that AHPs will draw healthier people that will stay in the small group market.

So, I will ask you again: Do big firms, which can do everything that we want AHPs to do, tend to have healthier or sicker people working for them?

Either one of you want to answer? I mean, we all know anecdotally, because we probably all have friends who work for a big firm and don't want to leave, why? Because they have a history of illness or they have a child who has a history of illness, and they are afraid if they leave the big firm, they won't get as good a health insurance in the small group market. Anybody else here have friends like that?

Now, I didn't go through the study that CBO went through, but common sense tells me that sicker people will tend to go into larger pools, which an AHP is.

Dr. Wilson, do you want to make any comment?

Mr. WILSON. This is one of the items in the CBO report when you started talking about high-cost firms and low-cost firms. To a great degree here with small employers, we are talking about firms with maybe half a dozen or maybe two dozen employees, and I just wonder what a high-cost firm and low-cost firm is, what a sicker firm is versus a healthy firm?

Last—maybe today, we have a perfectly healthy firm ce—nobody has been in the hospital for 20 years, and now somebody has a serious auto accident. Does that immediately change that firm into a sicker firm or a healthy firm? I think not. I want to quibble a little bit with the rationale that the "cherry picking" is done, and there is resistant to changing these plans by employees who are paying——

Chairman TALENT. Now, I will just say that the bill we filed requires that the associations exist for purposes other than providing health insurance. You can't form just to offer health insurance. So, it has to be like the National Restaurant Association or the National Association of Women Business Owners or the Chamber of Commerce.

They have to accept any small employer into the association who is in that line of work. They can't, Ms. Lehnhard, say, "Oh, no, no. You have sick people working for you, so you can't join the association." They must offer health insurance to everybody in the association. I will tell my concern, Mary Nell, is that the things won't work, because the sick people will go into the AHPs. This is my concern.

Because my brother has—everybody who attends these Committee hearings regularly—if you attend them regularly, by the way, and you are not on the Committee or a staff member, okay, get a life. Never mind.

My brother is a tavern owner, okay? Right now, he buys it a bare bones plan in the small group market for himself. He can't offer it to his employees. Now, if my niece, his little girl, got sick, it would be a substantial incentive for my brother to join an Association Health Plan like the National Restaurant Association's plan, because he would be able to get better health care.

So, tell me why—what frustrates me—maybe I am doing this for Harris Fawell who carried this bill for six years and fought against this prejudice for six years—why do you think that sick people

would prefer to remain in the small group market rather than in a bigger pool? It is not rational, it is anti-intuitive in my mind.

Ms. LEHNHARD. I think what the States have done is maximize the pooling. In a Blue Cross and Blue Shield Plan, say, in Missouri, all of our small business is pooled. We have one pool. It used to be we could have 36 different categories and move people into different categories as they got sicker. And there are sick and healthy groups. I would say, for example, in the large group market, Microsoft has a very young, healthy population. The auto workers probably have an older, sicker population.

You are going to have the same variations in the small group market, and a lot of associations, you know, associations of young, high-tech manufacturers won't want to offer mental health benefits, substance abuse, and people will gravitate to that benefit package when they don't need those benefits.

I would counter that your brother, if their child got sick, wouldn't go into an AHP; they would go into the State-mandated benefit package and get as many benefits as they could. And HIPPA let—one more point—HIPPA lets you do that.

HIPPA is going to let people hop constantly from health plan to health plan based on the benefits they need. And we have worked very hard to have what is called a retention strategy, that you keep people in the plan, you keep them over time, you don't have disruption, you don't have churning, price war competition. It is very disruptive and confusing to people, and we think that is exactly what is going to happen, that people are going to hop when they see a better opportunity or their family members get sick.

Chairman TALENT. Well, Mary Nell, let us address the mandated thing. A little while ago you said even if you equalize the mandated issue it wouldn't make any difference.

Ms. LEHNHARD. No, it will make a difference. You will still have a problem.

Chairman TALENT. You will still have a problem, okay.

And the reason for that, isn't it, that mandates by their nature tend to affect pretty small sections of the population. In other words, if you take 10 people who are ill, okay, or 100 people who are ill, 95 of them have illnesses that are not affected by State mandates, because State mandates—and I used to be in the state legislature. You pass a State mandate, because there is a particular, discreet, usually small fraction of the population that has a serious problem. It is not big enough that the market would on its own provide insurance to that person. And, so the State has to come in and say, "Look, we know that not enough people need in vitro that is probably going to be offered in most plans, but we think it is so important that people have this, we are going to require that you have it."

So, this idea that mandates make a big difference to the average person who is sick making a decision about where they are going to go, because they are not—the treatment for their illness doesn't depend on a mandate. Mandates don't—they only cover illnesses that affect small fractions of the populations. I am not saying they are not important.

And if you want to say, "We don't want AHPs because we don't want more plans that are subject to state mandates, I understand

that argument. But don't say that affects "cherry picking," because the overwhelming majority of people who are sick don't need the mandates to get the coverage. They just need good, quality insurance.

Ms. LEHNHARD. But if you look at—any actuary will tell you that I think it is about 6 percent of the population, any population—this room, Washington, DC—generates about 20 percent of health care costs. Twenty percent of the population generates 80 percent of the health care costs. If you can avoid that 6 percent or part of that 6 percent, you make a bigger dent in your premium than the most aggressive cost management.

Chairman TALENT. If they are sick with emphysema or leukemia or diabetes or renal failure or cancer——

Ms. LEHNHARD. No, this is mental health, substance abuse, those are our big items.

Chairman TALENT. Yes, mental health is an expensive one, I will grant you that, okay? But most of the people that we are talking about aren't moving, and most of the States don't have, unlimited anyway, mental health or substance abuse mandates, do they?

Ms. LEHNHARD. Some States mandate special treatment for disabled and mentally ill children. It is extensive.

Chairman TALENT. I have looked at the mandates. The expensive ones are only in a few states. The ones that all the states tend to have are the ones for mammograms or in response to a special interest that wanted to get covered—the psychologists so you have to pay for the psychologist. I think this is mandate argument is a red herring.

I mean, you are in a lot of states, Blue Cross, right?

Ms. LEHNHARD. Every State.

Chairman TALENT. Yes, every state. And you were talking about the effect of small group reforms. Now, while the States have been doing all this compression, all these reforms, has the number of uninsured been going up or going down?

Ms. LEHNHARD. The number of overall workers with insurance has been going up. The number of workers in the small employer market with coverage has been going down. They are very price sensitive, and as premiums go up, very low-wage workers in the small group market they can't afford the coverage.

Chairman TALENT. Exactly. Now, you also mentioned the possibility of turbulence or ping ponging in and out of AHPs and back to them. And let us examine where you could go. Now, how many markets are you in where there is less than five competitors in the small group market?

Ms. LEHNHARD. Probably not very many.

Chairman TALENT. Well, how many are you in where you are the only one?

Ms. LEHNHARD. The only competitor?

Chairman TALENT. Yes. Quietly offering health insurance.

Ms. LEHNHARD. We are the only competitor in one State, and that is because they had small group reform and let the amoebas out, and everybody left the State.

Chairman TALENT. Okay. How many states are you one of, say, two?

Ms. LEHNHARD. I doubt anywhere.

Chairman TALENT. How many States—in how many states do you control, say, 50 percent of the market share?

Ms. LEHNHARD. I don't know. I would have to get back to you. We do have large market shares in some states.

Chairman TALENT. Yes, because, Mary Nell, I have to get to one thing. The ping-ponging is another way of looking at that, which is that Association Health Plans would be another pretty effective competitor in the market, wouldn't they?

Ms. LEHNHARD. Not at all. Our plans will not—they are not worried about that at all. First of all, an AHP can be an insured product, and we have got a lot of these—we have a tremendous—I think we have 60 percent of the association business now, and one of the AHP models is insured, we will be there with insurance. The other model is self-funded. We do a tremendous amount of third party administration for self-funded groups. They are not worried about the competition. They are worried about the public policy.

Chairman TALENT. I know you do a tremendous amount of third party administration for self-funded plans, but you don't insure those people, do you? You are hired as an administrator.

Ms. LEHNHARD. That is right.

Chairman TALENT. And if those people are currently employed in the market or insured in the small group market, markets, which let us say, Blue Cross has a very significant share in, and AHPs are created, and they do self-fund, and I would expect many of these national AHPs would self-fund. Anybody who goes into that self-funded plan is not going to be available for Blue Cross to insure.

Ms. LEHNHARD. But we might be there as a third party administrator.

Chairman TALENT. For a flat fee or something. I grant you—no, I take what you are saying on face value. I don't want to suggest otherwise.

Who is next here? Ms. Kelly.

Mrs. KELLY. Thank you.

Dr. Wilson, the CBO study assumes that the administrative costs generated by AHPs is going to really be negative. In the last hearing, we heard testimony that AHPs would generate considerable savings in administrative costs and marketing costs. Do you think that savings for your AHP, if this legislation was enacted, would be there and would stay there?

Mr. WILSON. Well, yes, I do, and primarily for one reason is that if this H.R. 2990 wording is included, it will keep the insurance companies involved with associations. I mentioned earlier that we went out to 50 insurance companies, including almost all of the Blue Cross' companies, and asked them if they wanted to work or even talk about working with our association, and not one responded.

Now, if this wording were to—my opinion is if this H.R. 2990 leveling the playing field for associations with large unions and large corporations were to occur, I believe you would see the insurance carriers then coming back into the AHP market and providing more competition.

Mrs. KELLY. Ms. Lehnhard, I am interested that you said when you were testifying earlier that your New York mandates are the

only reason Blue Cross—I think I got your words right—are New York's mandates the only reason that you said that Blue Cross and Blue Shield provide good insurance to New York? You implied that by what you said, and I wrote this down, because I wrote this down as a question to ask you. You said you are in the market in New York, and the mandates hold you to a certain level.

Basically, my question is, you know, you are out there, you are trying to insure those of us in New York, and we need you there, but I am wondering if our State mandates are the reason that you are doing as well as you are in New York or would you be doing this on your own?

Ms. LEHNHARD. I think without question what we would be doing in the absence of mandates is offering small employers the choice of those benefits, not requiring it for everyone. We have——

Mrs. KELLY. So, you would step in basically in the same way that this law would step in by offering choices, is that right?

Ms. LEHNHARD. We typically have a very broad choice of products for small employers.

Mrs. KELLY. What keeps you providing good coverage? What is it out there that is pushing you to keep good coverage on your people?

Ms. LEHNHARD. I think there are two levels of response, and let me respond for the industry, not Blue Cross and Blue Shield. The first level of response is the State insurance commissioner. The State insurance commissioner makes sure you have a decent lifetime limit, not $10,000; it is usually at least $1 million. They make sure you don't have co-insurance and deductibles in fine print that are misleading. That is not a mandated benefit; that is just oversight of the State that would be missing in a self-funded—nobody would be looking at that. There is nothing in the bill to that.

The other issue is mandated benefits, and we provide what our customers want. The customers drive our product.

Mrs. KELLY. In other words, you are saying that market forces are the things that are pushing you to provide what your customers want.

I want to go to you, Ms. Kaplan, because I think you brought that out in your testimony. You said that in your union, your mostly women union, you were offering better benefits at a lower price than you could purchase through any other way; is that correct?

Ms. KAPLAN. That is correct. We were a Taft-Hartley Fund. The money came from the employers, but the union essentially was designing the plan for the benefit of the people who were participating. And if I might, that is how our association sees it. The women business owners who belong to NAWBO would join the insurance part of it, because they are members, because they would be the people—we are a membership driven organization, so the members would be deciding the range of benefits that would be offered to all of our members across the country, and that would be the range of benefits that the members would buy into. It is not that some small group would decide within the organization that, "Well, we are only going to have 21 days of hospitalization and some doctor bills." That is not what members are looking for. They are looking for broad insurance, enough coverage so that they are

protecting their businesses by the business not having to foot bills for illnesses directly, which they may be doing now.

Mrs. KELLY. So, back to you, Ms. Lehnhard. What makes you think that the Association Health Plans wouldn't do the same thing? Why in the world wouldn't they at least meet their State mandates and go beyond them, as Ms. Kaplan just gave us an example of?

Ms. LEHNHARD. As I said, I think this whole debate, for the most part, has been about the cost of State-mandated benefits and the need to get out from under that cost. And if you go back to earlier——

Mrs. KELLY. She was in a situation where she wasn't involved with worrying about State-mandated benefits. She was just doing what she needed to do for her members, and it worked.

Ms. LEHNHARD. If you go back to the earlier testimony of the groups primarily supporting this, the debate has been about the cost of State-mandated benefits and how much cost that means for employers. With all due respect, I just can't imagine if it is not an issue, why push this to be passed?

Mrs. KELLY. What makes you think market forces wouldn't act to allow the Association Health Plans to—why wouldn't they act to allow the Association Health Plans to get better coverage at lower cost? As a matter of fact, on page 14 in the CBO study it says that there would—and I have got to read this here—"The firms that continue to purchase traditional health insurance plans would pay an additional $800 million in premiums. That increase would be more than offset by the $1.2 billion in net premium savings that would result because firms face lower premiums in AHP and HealthMart plans." What do you say to that? That is the CBO study.

Ms. LEHNHARD. Back to your question what small employers would do, CBO assumed a third of their savings, I believe, from dropping State-mandated benefits, but we live in the State markets. There is a reason, first of all, providers lobby for State-mandated benefits, and it is because the market is not providing them. And, secondly, if you look at the biggest opponents of State-mandated benefits, it is the small employers who don't want to have to provide those benefits.

Mrs. KELLY. Whose hide is the $1.2 billion coming out of?

Ms. LEHNHARD. I am sorry?

Mrs. KELLY. Whose hide is the $1.2 billion coming out of?

Ms. LEHNHARD. CBO is very clear on that. It is coming out of the sicker, older people who are paying higher premiums, because the younger, healthy people have left the insured market. It is a cost-shifting. It is a lack of cross-subsidy. You are asking older, sicker to pay more as the younger and healthier have lower premiums.

Mrs. KELLY. You are assuming that everybody in an AHP would be older and sicker? Is that what you are saying?

Ms. LEHNHARD. They won't join it unless they get a better price than they are getting in the State regulated market. That is an assumption that CBO makes. Why would they join it and pay more——

Mrs. KELLY. Well, you are assuming—wait, wait. You have been talking about—a lot about "cherry picking" here. You are assuming

that a—for instance, I am just going to use Ms. Kaplan, because she has got an example here that worked. You are assuming she is not going to include any of her younger people——

Ms. LEHNHARD. No.

Mrs. KELLY [continuing]. Younger members. I mean, I am sorry, maybe I just don't get it here, but why do you assume she is only going to take——

Ms. LEHNHARD. I think the States are assuming that the types of associations that will get out from under the cross-subsidies required by the States are the associations that have, by definition, younger, healthier people in them. That is what the States are worried about. They may not be worried about Ms. Kaplan's——

Mrs. KELLY. Well, I don't know if you have attended enough of these hearing to know, but I used to be a florist, and I had no way of insuring my employees, because I simply couldn't afford it. And I can tell you, had I had that opportunity—I had employees that were fully across the age range, and some of them were sicker, some of them were healthy. And I can tell you that if I had the opportunity to join an AHP, I would have done so, because my folks needed that. And I don't see why you would see that an AHP that is formed to cover people in a small business would decide they are only going to "cherry pick" with younger people. And who would then have to insure the older, sicker people? Are you worried that you would have to do that?

Ms. LEHNHARD. The question is not that the association would treat people differently. They would have to insure everybody in their association. It is the question of whether an association starts up in the first place. An association of older mine workers is not going to set up an AHP. They are going to stay in the State-insured market where they know they are fully cross-subsidized by younger, healthier people. They are just not going to start a union—I mean, an AHP, and that is what CBO says.

Mrs. KELLY. And CBO, from what I understand, I had a question about——

Chairman TALENT. Will the gentlelady yield?

Mrs. KELLY. Yes, sure.

Chairman TALENT. Where does CBO say that?

Mrs. KELLY. That is exactly what I was going——

Mr. BAUMGARDNER. I have lost which quote.

Chairman TALENT. Well, Mary Nell said that only associations that have healthier people will start AHPs, and that is why they will only have healthier people in there. Now, where do you say that in your report?

Mr. BAUMGARDNER. I doubt that we said that.

Chairman TALENT. Yes, you don't say that, do you? Mary Nell, you want to find a different source?

Ms. LEHNHARD. They don't say it like that. I can absolutely provide it for you. It is not that blunt. It is the question of who——

Chairman TALENT. Well, I don't want to be mistaken. Does staff know where that might be in the report, because as I recall, I read, I think, from page 8 where Mr. Baumgardner said, "No, no, the way that only the healthy people get in the AHPs is because they don't have to do the mandates," which we have disagreed about

whether the mandates are important or not. You notice, sometimes the mandates aren't important, sometimes they are important.

Mr. Baumgardner said on page 8—and I think I read this—"that exempting AHPs and HealthMarts from offering mandated benefits might substantially affect selection." Then he goes on to say, "It is because they won't be subject to the mandates. They will have lower costs. They will therefore buy less insurance. They will therefore attract the healthier people." It is not that they will start with healthier people.

You can take a minute. I thank the gentlelady for yielding. I will let her have her time back, and if you can find it——

Mrs. KELLY. I just have one question while we are waiting for a response from Ms. Lehnhard. I have the impression from reading your testimony and getting through as much as I looked at—I mean, I went through your report, but I perhaps didn't read it word for word, but I didn't get anything except that you based your CBO study on one study on the operating efficiencies of group purchasing arrangements. Did you use one study or did you use more?

Mr. BAUMGARDNER. Well, many studies went into——

Mrs. KELLY. Did you use one study or did you use more? Just yes or no.

Mr. BAUMGARDNER. In preparing this study?

Mrs. KELLY. In putting together this study.

Mr. BAUMGARDNER. Could you ask the question again, please. I want to get my yes or no right.

Chairman TALENT. If it is okay with the gentlelady, I like witnesses to be able to explain.

If you will maybe answer yes or no and then explain if you want to, how is that?

Mrs. KELLY. Okay, yes.

Mr. BAUMGARDNER. We used a number of studies——

Mrs. KELLY. You used one model, is that correct? One study, one model. A study based on one model. I will rephrase that, so I hope you understand what I am asking.

Mr. BAUMGARDNER. We constructed a model at CBO that, among other things, uses the results from a number of studies in determining what assumptions to keep——

Mrs. KELLY. Did you use just one model? It was your model.

Mr. BAUMGARDNER. Yes.

Mrs. KELLY. A theoretical model, correct?

Mr. BAUMGARDNER. It is a multi-equation, yes, but we used one model——

Mrs. KELLY. A multi-equation model is a theoretical model, isn't it?

Mr. BAUMGARDNER. Well, it uses parameters that—for the behavioral assumptions, one looks at various studies in the literature to decide what are reasonable assumptions and then feed into that.

Mrs. KELLY. Right. But it was your model.

Mr. BAUMGARDNER. Yes.

Mrs. KELLY. Thank you.

Chairman TALENT. Ms. Napolitano. Ms. Napolitano is next.

Ms. NAPOLITANO. Thank you, Mr. Chair.

Listening to a lot of the conversation, it is just befuddling to me being from California and the many small businesses that I know

that are unable to purchase insurance for their employees, especially the "Mom and Pops," and the hardships they go through when they are hit by catastrophic illnesses. But it just does not equate in my mind that given the large numbers of small business that there isn't something—there are some minor ones; they can purchase some insurance—but that there isn't an AHP that will be able to consolidate all the power that these numerous businesses can afford in being able to join together and have that purchasing power.

And I know there is diverse plans. I retired from Ford. I was initially covered 100 percent, and in time, by the time I retired, there was only, I think, 50 percent match. But needless to say, things change; that is accepted. You go through transitions, things change, costs change, et cetera. But why is it that we have to really fight every step of the way to get adequate coverage for the small business person who essentially is providing a great service?

And, certainly, they don't just go out and say, "I just want to employ young people because the coverage, if I may want to buy it, I don't have to pay a higher premium for the people, if I cost share of 50 percent it, whatever." You employ people who are going to get the job done, whether it is an elderly or retiree, whether it is a young one or a family member. You don't sometimes have that choice.

So, why does the insurance have the ability to red light—to me, it is a red light—when you say, "Well, sorry, but we don't really want you, because you have older employees that are going to be a drain on the pot, if you will." It is just inconceivable to me.

Can somebody tell me what can be done to be able to actually bring together the pool, whether it is by the organizations' efforts or whether it is anybody, just explain that anomaly.

Ms. LEHNHARD. I would make two quick points. There isn't a State in the country where we can refuse coverage for a small group no matter how sick they are. We have to take every small group. And in terms of pooling for purchasing powers, in California—California Blue Cross, California Blue Shield—a small employer gets the power of the arrangements that Blue Cross and Blue Shield has negotiated, not only with small employers behind them but all other big accounts. When we go out and negotiate an arrangement with a hospital or provider, we are representing the groups of 2 and the groups of 10,000. They have maximum purchasing power. You couldn't find a pool in California as big as our Blue Cross and Blue Shield plans.

Ms. NAPOLITANO. I understand that, and I have retired a couple times. I am covered by PERS, Public Employees Retirement System. Guess what? I used to have Blue Cross Blue Shield. I now only have Blue Cross. So, if I have medical necessities that would put me in the hospital, I am not covered, and yet this is a $127 billion entity in PERS.

Now, tell me about the purchasing power for the employees or the retirees.

Ms. LEHNHARD. I don't understand. You don't have hospitalization coverage?

Ms. NAPOLITANO. No, just Blue Cross.

Ms. LEHNHARD. Blue Cross is——

Ms. NAPOLITANO. Or Blue Shield. One or the other. I only have the medical. I do not have the hospitalization.

Ms. LEHNHARD. Blue Shield offers and hospital and——

Ms. NAPOLITANO. I know it offers, but the employer is not offering it to the employees, whether it is a cost-based decision or not. That, again, is something that affects employees.

Ms. LEHNHARD. That is the employer's decision.

Ms. NAPOLITANO. Right, but we don't have a choice is what I am trying to say. And, unfortunately, that happens more often than not.

My concern is the small business—if we are going to capitalize on the growth of the small business and the entrepreneurship and be able to afford then the ability to have employees maintain that economy, we need to be sure that we provide them with all the assistance we can. Part of it is the health coverage, and I would want to look into how we can work together to be able to provide the pooling of resources to be able to assist the employers in covering of their employees regardless of who they are.

Ms. LEHNHARD. One of things we have said is Congress needs to focus on the low-wage worker in the small-employer group with scarce resources. That is where to start.

Ms. NAPOLITANO. Most of the small businesses are low wage——

Ms. LEHNHARD. And we supported tax credits for that low-wage worker, not the employer but where they have a low-wage worker to help them pay for coverage and a decent cost-sharing arrangement with the employee. Even if that employee is buying coverage now, it is probably out of money that should be used for food or rent or something for their children. And we said just go ahead and provide the tax credit even if the employer is already providing it, if they are low-income.

Ms. VELAZQUEZ. Would the gentlelady from California yield for one second?

Ms. NAPOLITANO. Yes, certainly.

Ms. VELAZQUEZ. Ms. Kaplan, how would you view—and this is based on what Ms. Lehnhard just brought up—how would you view a Federal tax credit aimed at covering your employee in low-wage jobs?

Ms. KAPLAN. I would view any help that would enable the small business with low-wage employees—and you know, being from New York, we talk about health care workers doing home care. We are talking about low-wage workers, so that any time that they are asked to contribute to their own health care costs it is impossible. There is no way that an employee is going to make a choice between feeding their kids and paying a premium.

And the only way we are going to provide a company like mine for everybody is if the employees contribute so that anything that would help to get the both of us into a situation where we could buy the insurance, they could contribute in some way but getting tax credits or other things, anything would help.

Ms. VELAZQUEZ. You would support that.

Ms. KAPLAN. Absolutely.

Ms. VELAZQUEZ. Mr. Gallo?

Mr. GALLO. I think of a tax credit as kind of a temporary fix there, because the cost is still going to rise in the health care insur-

ance. So, that might help out that they have some credit there, but I don't think it is an answer to it.

Ms. VELAZQUEZ. What about if you could comment in terms of giving employees of businesses that are unable to provide health care the ability to deduct 100 percent?

Mr. GALLO. Well, that would be good for the business in helping the business out. I look at the, again, the employees where we are talking co-pays. They still have to—and I think it was the Doctor that made the comment about they want good benefits, and if they are partners in that program or that plan, that rise in cost is still going to be there, and they are going to be paying part of that.

Ms. VELAZQUEZ. Thank you.

Thank you, Ms. Napolitano.

Ms. NAPOLITANO. Thank you, Nydia.

One of the things that comes to mind is that a small—a low-wage earner without insurance but with a family would rather insure the children, because if they get sick, they need to have the child taken care of before anything else. And any plan, I don't care what plan it is, only offers the employee, spouse, and then family. Has any thought been given to be able to provide families with children coverage for children? Is has really—in my case, I had five children. I would have rather covered them than myself, because I knew I had to go to work, and I kept myself healthy or at least reasonably so. But if any of my children—I would go bananas, I'd be desperate.

Ms. LEHNHARD. I think this is what the CHIP Program is designed to do, and the States can take it to quite a high income level relative to the——

Ms. NAPOLITANO. But you have to have a certain income level.

Ms. LEHNHARD. But I think you are talking about——

Ms. NAPOLITANO. But many of them do not—not necessarily. You have two people working. Sometimes you will not be eligible. So, what happens to those families who have a husband and wife working, even at a minimal that are at that wage line?

Ms. LEHNHARD. I would have to check on it, but it may be that you are eligible even if both parents are working as long as you meet the income level. It is a tremendous program, and we are working with CHIP Program——

Ms. NAPOLITANO. I am well aware of the CHIP Program.

Ms. LEHNHARD [continuing]. To try to get coverage for children.

Ms. NAPOLITANO. Right. But it is still a small business owner that sometimes will be facing the absence of a mother if the child is sick. So, it costs the company in the long run.

Thank you, Madam Chair—Mr. Chair.

Chairman TALENT. I thank the gentlelady.

Ms. Lehnhard, I haven't found in the CBO report any statement that they think only the healthier associations will start Association Health Plans. Have you been able to find it or your staff?

Ms. LEHNHARD. It is a question of who is most apt to—if you are an association, are you going to look at your enrollment and say, "Am I going to be successful?"

Chairman TALENT. Right. I understand the point, but you said CBO relied on it, and I haven't been able to find it.

Ms. LEHNHARD. Page 10, "In the long run, one would expect the most successful AHPs to be sponsored by association whose members had lower than average health care costs."

Chairman TALENT. Okay, where is that?

Ms. LEHNHARD. The top of the page.

Chairman TALENT. That is a statement about which are likely to be successful in the long run, not which are likely to go in there.

Ms. LEHNHARD. And it is the premium relative to what you can get in the State-insured market. If you can't offer a cheaper premium, you are not successful.

Chairman TALENT. If you can't insure at less cost, you are not successful. In other words, you may charge the same premium and provide more insurance and provide a competitive advantage for that reason, right?

Ms. LEHNHARD. I think the point is risk selection. This is, I believe, in the context——

Chairman TALENT. No, we haven't gotten past the problem here with risk selection then. Unless you can show that the employers in the Association Health Plans will use any economies to save money and buy less insurance rather than provide better insurance, you haven't got your risk selection issue. And every time I have asked you guys about it, you kind of looked at me, and I haven't forced you to say yes or no, because I don't want to be mean. But, you haven't shown that yet.

Ms. LEHNHARD. I think I have said pretty clearly that I think this whole debate is about small employers wanting out from under State-mandated benefits and their costs when the choice is between basic primary care and hospitalization versus additional benefits.

Chairman TALENT. Okay. Let us go back then, Mary Nell. Big firms, right now, they are not subject to State mandates, right?

Ms. LEHNHARD. Big firms don't, on average, have low-income workers like the small groups.

Chairman TALENT. Okay. So, small firms do. Have you ever heard of the Western Growers Association?

Ms. LEHNHARD. They offer a very stripped down benefit.

Chairman TALENT. Who are their workers? They are migrant workers, right?

In comparison—this is testimony from our last hearing—the least expensive comparable health plan offered by the government-run Health Insurance Plan of California for the comparable age range is $273.75 per month. This is comparable plans. However, the HIPC Plan is only available in certain parts of the state. Western Growers Association's least expensive family health plan is $149 per month for employees of any age.

Ms. LEHNHARD. I think the point, though, is they have asked the State, and the State has agreed, they are out from under State-mandated benefits. They asked to be out, and they have a yearly cap of $20,000 a year on spending.

Chairman TALENT. Well, the question is not whether they are subject to state mandates or not.

Ms. LEHNHARD. They asked to be out from under them.

Chairman TALENT. You keep going back to that after you say it is not relevant. The question is however they save the money——

Ms. LEHNHARD. I said it is not as relevant as rating. It is about——

Chairman TALENT. Because big employers aren't subject to state mandates either, right? And big employers do not use those savings to offer poorer quality health insurance. We are agreed on that, aren't we? Big employers don't offer poorer quality health insurance than small employers. Are we agreed on that?

Ms. LEHNHARD. In general, I agree. They have richer benefits; they can afford it.

Chairman TALENT. Okay, good. So, that is no longer a question in the debate. So, now the only issue what your statement is that it is because they have healthier people working for big employers?

Ms. LEHNHARD. No, they have higher-income employees. That is the CBO's point. The employees can afford—when employees are paying 50 percent of the premium, they can—higher-income employees can afford that.

Chairman TALENT. I am trying to follow this.

Ms. LEHNHARD. The employees have to pay——

Chairman TALENT. Is there any data, Mr. Baumgardner? Do you have any data to support that?

Mr. BAUMGARDNER. Which part of the——

Chairman TALENT. The point that they have employees who want better health insurance as opposed to small businesses.

Ms. LEHNHARD. No, the employees can afford the coverage more than employers in small groups.

Chairman TALENT. All right. Do they have people who can afford it and who want it more? Do you have data to support that?

Mr. BAUMGARDNER. Certainly, there is evidence that with higher income people generally in a lot of markets choose a higher quality product.

Chairman TALENT. Dr. Wilson, do you have a point you wish to make.

Mr. WILSON. I didn't want to interrupt, but——

Chairman TALENT. Well, go ahead.

Mr. WILSON [continuing]. I would like to say, again, to emphasize Dr. Westerfield's view, which is included in my paper, and he is a statistician also, but I asked him to put this in English so that I could understand it. And I would ask that everybody look at that.

But he really—we are almost using the CBO study, because it is the only study we are talking about today as some kind of baseline where he feels that it did not, in their model, address wage differentials that you are talking about, in the model. There should be another line on that table 1 for wage differentials between the three different category of size of employers. He feels that there should be a line having to do with plan differentials—full-board plans or bare bones. And then the employer-employee contribution. We are not talking—the study doesn't address who is actually paying for these benefits and the differences between large and small employers.

I am a little—I am totally uncomfortable that we have a very valid report here at this moment.

Chairman TALENT. Well, Ms. Kaplan testified that when she was in a union, which was, of course, exempt from mandates, that she felt she got better health care insurance.

Ms. KAPLAN. There was no question that we were and still are—the union is still a majority of women, and so the benefits that the union was dealing with were geared towards the population that was covered under the plan. We were providing maternity benefits for single women before those benefits were available, because the insurance companies sold programs that said you had to be a family to get maternity benefits. We provided maternity disability before it became a mandate. We provided well baby care, because that is what was necessary for the people who participated in that plan. Now, that was on top of whatever other general benefits there were.

And that is how NAWBO perceives that it would create a plan based on the needs of the small women business owners. So, the women business owners of our organization, would look at what are their needs, what are they looking for, and create a plan that would, for the most part, be concerned with the kinds of benefits these women want. I am going to say, right off the bat, it is going to be—have to include coverage for mammographies, for routine pap smears, for mastectomies, for child care, for maternity benefits where—we are not going to create a plan that says you can go in the hospital, have your baby, and you are going to leave today. We have experienced it. We are not going to do that to ourselves, at least I don't think so. We never have in the past. We are going to look out for us.

Chairman TALENT. I appreciate that very much. Here is what I am going to do. I am going to try and be fair here, because I have interrupted a few times. I feel strongly about this. So, I am going to state the case as I see it, and then I will let Ms. Lehnhard or Mr. Baumgardner have the last word, how is that? So, you all get to trump me this time.

I am going to quote from the written testimony of Joe Rossman, with the ABC, and they have an association plan, and this was from the last hearing on this: "The ABC plan has total expenses of 13.5 cents for every dollar of premium. These costs include all marketing, administration, and insurance company risk claim payment expenses and premium taxes. Alternatively, small employers who purchase coverage directly from any insurance company can experience total expenses of 30 cents for every dollar of premium or more."

As CBO indicated in its report—I don't think there is any question that if small employers pool; they get economies of scale. They have higher purchasing power; they have lower administrative costs; they can spread the administrative costs among more employees; they don't have to pay—if they can self-fund, they don't have to pay the insurance companies profit margin; they don't have to pay the insurance companies marketing costs, because they are not trying to make a profit on the plan. They may be using it as a recruiting tool to get people in the association, but they are not trying to make a profit. And they don't have any marketing costs, because they simply send the flyer out to their members. Therefore, they are able to buy insurance and provide insurance at less cost.

Because they are able to provide insurance at less cost, more small employers will be able to afford insurance, and we will have fewer people who are uninsured, and more people who currently

are insured but only have a few choices will have more choices, because there will be more money to buy them insurance with.

Now, the alternative argument, it seems to me, to the extent it is still standing here, that somehow Association Health Plans will only attract healthier people, and that therefore this will have a negative impact on the small group market. I don't see it. I think it will tend to attract sicker people. I don't think people who work for small employers are necessarily healthier. I think the tendency may be for them to be sicker. I don't think they have any less need or desire for health insurance if they are sick than people who work for big employers. And I don't see any reason why it wouldn't operate very similarly to the way big companies' self-funded plans or big company plans do.

So, now I will let you two offer the response.

Mr. BAUMGARDNER. I would like to touch a couple points. One is the issue of mandates. There is some evidence from the Journal of Public Economics paper by Gruber. Looking at small firms, comparing States that had a mandate and States that didn't, roughly they found about a 5 percent less offering of drug abuse treatment in the States without the mandates, 8 to 9 percent less offering of out-patient mental illness coverage, about 6 percent less offering of in-patient mental illness coverage. So, we believe there is some binding effect for some plans of these State mandate benefit restrictions. And, again, to the extent the legislation exempts one from complying with those mandates, we think some plans are going to take advantage of it.

Let me also point out they are clearly not going to take advantage of all mandated benefits. GAO did a study, looked at the actuarial cost—that is sort of the claims cost—of per paid claims for the areas where there were mandated benefits. They found estimates in the range of, say, 5.4 to I believe it was 22 percent as the actuarial cost of those mandated benefits. One of the reasons we in fact assumed only a 5 percent mandate savings was a recognition that not all these benefits are going to be dropped simply because you have an exemption.

And in fact that leads to why is the coverage result relatively small? It is small, in part, because there doesn't appear to be a big advantage taken of being exempt from the mandates. A lot of those benefits would stay in the package. We are just saying, on average, there would be fewer benefits in these packages.

And then on this other point, on selection, a couple observations. One is that there is some evidence, and we would be happy to look for that for your staff, on packages and selection. The ones I am aware of, Medigap, people who choose the benefit that has prescription drug coverage do tend to be sicker. There have been some studies of university health plans where the more generous package started to attract the older workers in those plans. So, there is some evidence of that out there.

Again, a final point on the—that kind of covers both: I think what are the key elements in the legislation that these new plans don't have to comply with that plans under current law do? Basically, it is the State-mandated benefits and the availability rules, not complying with State availability rules but just availability within the association. So, those are really the two things that are

different, and in fact they are the source of the effects that we have calculated.

Again, on this selection thing, it need not even be active selection. I think the point is, again, I call it economic selection—I referred to the survivor principle earlier. If you are in a situation where you are allowed to price lower for the same thing, you are going to tend to do better, and given the premium compression rules that are State regulations, the associations that do end up with an average risk that is lower than the average in the State pool will indeed be able to offer lower premiums on that count, and we would expect them to survive.

Again, we are not making any judgment on are the State rules a good idea, are these rules a good idea? I am really just trying to explain sort of the source of the effects within our study.

Thank you.

Ms. LEHNHARD. I don't want to be redundant to what he said, so I will focus on a different point: The non-selection savings. You mentioned that 13 percent administrative cost is about what our Blue Cross and Blue Shield administrative cost is for small group coverage. And I would just point out that when you have an Association Health Plan, you will have some marketing costs. You have got to tell them about the product; you have got to send out enrollment forms; you have got to follow-up.

But the biggest cost difference between a large employer and a small group market is enrollment. It is very expensive to enroll a plan, get people's names, addresses, social security numbers, their family members, do the family members have other coverage, is anybody on COBRA? It is a very expensive process to enroll, and when you enroll a big company, you have the economy of scale of dealing with that one company. When you enroll 50 companies, you don't have economies of scale on enrollment, and that is the major marketing cost.

Putting all that aside, though, I don't want to leave the impression that Association Health Plans are bad or, as I said, it is active "cherry picking." I think it would be inadvertent selection. We do a lot with Association Health Plans, and you do get a lot from it. You get the trust, the communication, all of those things that you mentioned, but they are regulated by the State. You can do that and keep that without changing the law, and that would be my final point.

Chairman TALENT. Do you have anything else?

Ms. VELAZQUEZ. No.

Chairman TALENT. Okay. Appreciate you all being here. We have a little more business in the Committee to conduct, but I will adjourn the hearing, and I do appreciate everybody's input. I think it has been a very useful hearing.

Thank you very much.

Without objection, we will leave the hearing record open for 10 days for any additional written questions from the members.

The hearing is adjourned.

[Whereupon, at 1:08 p.m., the Committee was adjourned.]

COMMITTEE ON SMALL BUSINESS
CHAIRMAN JIM TALENT- OPENING STATEMENT

Association Health Plans- Promoting Health Care Accessibility
February 16, 2000

Good morning Ladies and Gentlemen, and welcome. We meet today to continue our discussion on expanding access to health insurance for the small business community. The difficulty of purchasing quality, affordable health care continues to plague small business. In fact, small business owners, their employees and their families represent over 60% of the 44 million uninsured in the United States.

I speak on a daily basis to small business owners who want to provide health benefits to their employees, but cannot afford to do so. I hear from others who are able to offer insurance, but face the possibility of double digit rate increases that would force them to cancel their plans. And still others lament that, due to the high cost of their plan, they are forced to offer fewer benefits to their employees, or raise their deductibles so high that many employees cannot afford to cover themselves and their families. These small business people want and need to offer high quality, affordable health benefits. For example, a small "mom and pop" hardware store must compete with Home Depot to attract and retain quality employees. In our tight labor market, health benefit packages are essential. It is unfair that a small "Main Street" hardware store cannot access the same economies of scale, administrative

efficiencies, and purchasing clout that Home Depot and other large business enjoy when purchasing health insurance. If this is good for big business, why is it not good for small business?

To address the needs of the small business community, Representative Harris Fawell introduced Association Health Plan legislation several years ago. AHPs empower small business owners, who cannot afford to offer health insurance to their employees, to access insurance through bona fide trade and professional associations. In other words, AHPs allow national trade and professional associations, from the National Restaurant Association to the American Farm Bureau, to respond to the needs of their membership and sponsor health care plans. The small business owners and farmers who are members of these associations can buy into these plans for themselves, their employees, and their dependents. These association health plans would cover very large groups, enjoy large economies of scale, and have the option to offer self-funded plans which would not have to provide any margin for insurance company profits.

Since its inception, AHP language has been revised and improved to strengthen both solvency requirements and state enforcement provisions in response to concerns raised by certain groups. I am confident that AHPs will allow associations the flexibility to design comprehensive, affordable benefit packages that meet the needs of their membership. They will promote health care

accessibility for a segment of the population that is greatly under-served by our nation's health care system- the small business community.

Today's hearing will continue a productive dialogue which began at a hearing we held back in June. Since that first hearing, we have seen some progress in Congress' quest to improve our nation's health care system and reduce the number of uninsured. In early October, the House passed H.R. 2990, legislation containing several access provisions, including AHPs. Later this month a Conference Committee, of which I am a member, will meet to discuss the Senate and House versions of the bill. I am committed to insuring that AHPs are included in the final conference report.

Today we have assembled a knowledgeable panel of witnesses who will help us further explore the potential benefits of AHPs. We will hear testimony regarding recent data projecting the potential impact of association health plans. Additionally, we will hear from an association health plan administrator, a representative of the insurance industry, and two small business owners. I look forward to the testimony of all witnesses.

I now turn to my distinguished colleague, Ms. Velazquez, for any opening comments she would like to make.

DONNA M. CHRISTIAN-CHRISTENSEN
DELEGATE, VIRGIN ISLANDS

COMMITTEE ON RESOURCES
MEMBER, SUBCOMMITTEE ON NATIONAL PARKS AND PUBLIC LANDS
MEMBER, SUBCOMMITTEE ON WATER AND POWER

COMMITTEE ON SMALL BUSINESS
RANKING MEMBER, SUBCOMMITTEE ON RURAL ENTERPRISES

MEMBER, CONGRESSIONAL BLACK CAUCUS
MEMBER, CONGRESSIONAL CAUCUS FOR WOMEN'S ISSUES
MEMBER, CONGRESSIONAL TRAVEL AND TOURISM CAUCUS

Congress of the United States
House of Representatives
Washington, DC 20515–5501

PLEASE RESPOND TO:

WASHINGTON OFFICE
☐ 1711 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-1790
FAX (202) 225-5517

DISTRICT OFFICES
☐ VITRACO MALL, BLDG. 2—SUITE 3
ST. THOMAS, VIRGIN ISLANDS 00802
(340) 774-4408
FAX (340) 774-8033

☐ SUNNY ISLE SHOPPING CENTER
SUITE #3 MINI MALL
P.O. BOX 5980
ST. CROIX, VIRGIN ISLANDS 00823
(340) 778-5900
FAX (340) 778-5111

☐ 109 ENIGHED CONTANT
OLD HILLTOP BUILDING
ST. JOHN, VIRGIN ISLANDS 00831
(340) 776-6209

OPENING STATEMENT
COMMITTEE ON SMALL BUSINESS
HEARING ON ASSOCIATION HEALTH PLANS

FEBRUARY 16, 2000

THANK YOU MR. CHAIRMAN TALENT AND RANKING MEMBER VELAZQUEZ FOR SCHEDULING A HEARING ON ISSUE OF EXPANDING ACCESS TO EMPLOYER-BASED HEALTH INSURANCE SO IT BETTER SERVES BUSINESS OWNERS THEIR EMPLOYEES AND THEIR DEPENDENTS. I WOULD ALSO LIKE TO WELCOME OUR PANEL OF WITNESSES.

AS A MEMBER OF THIS COMMITTEE, A PHYSICIAN, AND FORMER SMALL BUSINESS OWNER, THE ISSUE OF MEETING THE HEALTH CARE NEEDS OF THE SMALL BUSINESS COMMUNITY IS A PRIORITY, NOT ONLY BECAUSE IT HELPS SMALL BUSINESS, BUT ALSO BECAUSE IT CAN HELP TO CLOSE THE GAP OF THE UNINSURED.

I AM PARTICULARLY ALARMED BY REPORTS THAT THE SMALL BUSINESS COMMUNITY REPRESENTS 60 PERCENT OF THE 44 MILLION UNINSURED INDIVIDUALS IN THE UNITED STATES. THIS IS AN ALARMINGLY HIGH RATE AND REFLECTS THE FACT THAT WITHOUT OUR HELP, MANY SMALL BUSINESS EMPLOYERS WILL NOT BE ABLE TO AFFORD TO PROVIDE HEALTH CARE TO THEIR EMPLOYEES. IN ADDITION, THOSE SMALL BUSINESSES THAT CAN AFFORD TO PROVIDE HEALTH INSURANCE COVERAGE ARE SUBJECT TO HIGH OR INCREASING INSURANCE PREMIUMS BECAUSE OF VARIED REASONS AND/OR BY THE MERE FACT THAT THEY ARE A SMALL BUSINESS.

THIS MAKES TODAYS HEARING WHICH IS THE SECOND ON THIS ISSUE FOR THIS COMMITTEE AN IMPORTANT ONE. IT IS IMPORTANT TO WEIGH THE PROs AND CONs F AHPs AND TO CONTINUE TO EXPLORE HOW AHPs MIGHT BE ABLE TO HELP TO MAKE HEALTHCARE MORE ACCESSIBLE AND AFFORDABLE TO THOSE WHO WORK FOR AND THOSE WHO OWN A SMALL BUSINESS.

ALTHOUGH AHPs OFFER THE POSSIBLITY OF MAKING ACCESS TO HEALTH CARE AFFORDABLE TO SMALL BUSINESSES, THERE ARE MANY QUESTIONS TO BE ANSWERED, SUCH AS WHETHER AHPs WOULD REDUCE THE COST OF HEALTH INSURANCE ENOUGH TO MAKE COVERAGE AFFORDABLE TO SMALL BUSINESSES; WHETHER THEY WOULD BE SUBJECT TO STATE AND LOCAL LAW; WHETHER AHPs WOULD PROVIDE AN ADEQUATE BENEFIT PACKAGE; HOW IT WOULD AFFECT THE REST OF THE INSURANCE MARKET; AND HOW MANY ADDITIONAL PEOPLE WOULD BE COVERED. I AM LOOKING FORWARD TO HEARING THE TESTIMONY OF THE WITNESSES WHICH SHOULD HELP US TO ANSWER SOME OF THESE QUESTIONS.

THANK YOU.

PRINTED ON RECYCLED PAPER

Washington Office
Duane L. Musser
Executive Director
Schramm, Williams & Associates, Inc.
517 C Street, NE
Washington, DC 20002-5809
Ph: (202) 543-4455
Fax: (202) 543-4586
Email: MusserSWA@aol.com

The Association Healthcare Coalition

St. Louis Office
Dr. Paul Wilson
CPCU, CEBS
12537 Barrett Parkway Dr.
Suite 325
St. Louis, MO 63021-5866
Ph: (314) 821-1515
Fax: (314) 821-7468
Email: trust@mvp.net

THE HEALTH ORGANIZATION FOR BONA FIDE TRADE AND PROFESSIONAL ASSOCIATIONS

Statement of Dr. Paul Wilson
North American Equipment Dealers Association
on behalf of
The Association Healthcare Coalition

House Committee on Small Business

February 16, 2000

Thank you, Mr. Chairman. I am Dr. Paul Wilson, and for the last 23 years I have served as Executive Director of a bona fide Association Health Plan (AHP) for the North American Equipment Dealers Association and its nationwide regional affiliates. I am an adjunct professor of employee benefits at Webster University Graduate School in St. Louis, Missouri. I also serve as Vice President of The Association Healthcare Coalition (TAHC), an organization which NAEDA helped form in 1992. TAHC's purpose is to preserve the ability of bona fide trade and professional associations to provide high quality health insurance coverage to American employers and workers.

I would like to emphasize that TAHC represents only bona fide associations which were formed for substantial purposes other than offering health insurance, and which provide a wide array of services to small and medium-sized businesses.

I am pleased to be here today to describe how bona fide Association Health Plans have been serving small and medium-sized businesses for the past 50 years, and also how association plans will be able to serve American workers and their families if Congress enacts the badly needed reforms (H.R. 2990) to our health insurance laws to protect and strengthen AHPs. I will discuss these issues in reference to a recent report on proposed AHP legislation by the Congressional Budget Office (CBO).

I first want to commend Chairman Talent for his outstanding leadership on the issue of health insurance reform for associations and small business. I also want to thank Representatives Jim Moran (D-VA), John Shadegg (R-AZ) and Cal Dooley (D-CA) for their leadership on AHP legislation.

The Immediate Threat to Bona Fide Association Plans and Insured Workers

NAEDA is representing TAHC today because of the immediacy of the circumstances which confront our group insurance trust. However, these general circumstances apply to many of TAHC's members. First, a brief background on NAEDA's Association Health Plan.

NAEDA established an Association Health Plan in 1949 in order to provide farm and construction equipment dealer businesses in mostly rural communities with affordable health benefits. This was necessary because many insurance companies then seemed more interested in serving urban and suburban areas rather than rural and agricultural communities. Our trust also provides group dental, life and disability coverages, and NAEDA has provided many other non-insurance services to our members since 1900. NAEDA members' employees are typically repair shop, retail sales or office workers.

NAEDA and its regional affiliated association membership encompasses almost all of the equipment dealers in the country including John Deere, CaseIH, New Holland, AGCO and other equipment lines. NAEDA Trust has provided availability of a bona fide association health plan to equipment dealers since 1949. The program serves the needs of more than 10,000 dealer-members, employees and their dependents. Since the beginning, the program has been fully insured. However, it is self-administered by trust employees who are interested and experienced in this industry. Our mission statement is to provide an experienced, flexible, competitive and service-oriented association member service.

After serving small businesses in various states for 50 years, we face a very serious situation which jeopardizes the health insurance coverage of many of the workers who are now covered by our plan. The proliferation over the last decade of state regulations and mandated coverages have made it likely that our bona fide association plan will end July 1, 2000. We have recently been informed by our insurance carrier, UniCare, that our association group health policy will be not be renewed on that date as it applies to employer groups of 50 or fewer employees. Rather, they want to "transition" our business to their small group lines, which will reduce health plan options for our members in all but six states.

Now that UniCare, which is a division of WellPoint Health Networks, Inc., no longer wishes to include health coverage for small businesses in our master policy, we have contacted more than 50 other insurance carriers, but none want association master group business. I have letters from dozens of companies saying that they do not want the time and expense of helping associations comply with small group regulations and mandates which differ in each state. Five to ten years ago, they would have been lined up and competing fiercely for our association plan business, but not now.

Please recall that large self-insured corporate and large union plans are exempt from these state regulations. In many respects association plans are just as large as the big corporation and union plans, and are similarly designed and administered. But, these numerable state regulations and mandates apply only to small businesses with fewer than 50 employees. Small business unfairly pays more for health coverages than large companies, and self-insurance on the part of small business is not a practical option. The health cost playing field needs to be leveled so that it is not merely a function of state regulations and business size. It increasingly has become very difficult for AHPs like NAEDA Trust to serve our small business members under current conditions.

Assuming that our 50-year bona fide association plan comes to an end July 1, 2000, we are now faced with a very burdensome question. Will the employees and their families currently served by our health plan be able to obtain similar high quality coverage at rates their workers can afford by negotiating directly with insurance companies on their own, without the assistance of a bona fide association plan? My experience has shown that when the small group insurance carriers underwrite new accounts, roughly 40% of the firms do not get the lowest quotation due to health status of employees and other reasons. In our situation, each of the carriers will likely rate-up or rate-down our members based on new account underwriting "case characteristics" which often include individual employee health statements.

Despite this unfavorable situation, as a member service, NAEDA Trust has dedicated itself to facilitating the transition for our members by searching out the best alternative options available to them in the small group market. However, NAEDA believes strongly that our members overall would have more affordable coverage if they were able to continue as an AHP under the reforms in H.R. 2990.

The AHP reforms of H.R. 2990 are needed to protect the existing health insurance of workers who currently receive coverage through an AHP like NAEDA's. TAHC estimates that at least 4 million persons nationwide are covered by AHPs. These reforms will ensure that NAEDA Trust and other bona fide association plans are able to continue providing affordable coverage to the millions of workers who depend upon them for their health benefits. By removing the barriers to an expansion of AHPs, H.R. 2990 also will expand access to affordable coverage for small business workers who currently are uninsured due to increasing premiums. Failure to approve this legislation will deteriorate, or possibly end, all association plans, and will accelerate the trend toward declining access to affordable coverage for small businesses, thus increasing the number of uninsured Americans.

Comments on CBO Report

The Congressional Budget Office concluded in their study released in January of this year that the AHP legislation, which was approved by the House in 1999, would extend coverage to up to 2 million uninsured American workers, with no cost to the government. This was despite using very conservative and questionable assumptions in its methodology, which I will describe below. Nevertheless, the CBO report helps to demonstrate that AHP legislation will strengthen and expand access to affordable health coverage to hundreds of thousands, and potentially millions, of workers who currently cannot afford health insurance.

However, we believe the CBO report is fundamentally and statistically flawed in several respects, and therefore dramatically underestimates the value of AHPs in expanding access to affordable health coverage. First, CBO substantially underestimates the ability of AHPs to provide savings through operating efficiencies such as economies of scale, greater bargaining power to negotiate discounts, and regulatory uniformity. Second, CBO's static analysis and conclusion do not reflect the dynamics of the market when it assumes that AHPs will attract mostly lower risk populations.

I am attaching, for the hearing record, a short peer review of the CBO study by Donald L. Westerfield, Ph.D., professor of statistics and economics at Webster University in St. Louis. After reviewing the report, Dr. Westerfield found that the study was "statistically flawed and distorted," as he characterized it. The key problem that he found is that CBO did not account for wage differentials, health care package composition differentials, and premium differentials, among other things, between large and small firms. This is critical, he contends, because without a "normalization of the data," CBO is comparing apples, oranges and bananas. Dr. Westerfield concludes that a study normalizing the relevant data would more effectively capture the cost savings that associations can provide to small businesses, and therefore the number of uninsured workers who would be able to afford coverage. I urge you to review his comments on this study.

AHPs Have Demonstrated They Can Add Value for Small Business

In addition to Dr. Westerfield's observations, the many years of experience of TAHC's members put us in a good position to comment on the CBO report. We believe that the report does not recognize the fact that bona fide AHPs have a long track record of reducing health insurance costs for small businesses. Despite an increasingly difficult regulatory environment, AHPs are already providing high quality, yet affordable health coverage to our small group members, and have historically provided substantial savings compared with the cost of purchasing coverage directly from insurance carriers. Examples include the following:

- Associated Builders and Contractors (ABC), another TAHC member, has a plan with administrative costs of about 13.5%, compared with administrative costs of 20% to 30% for similar coverage purchased through an insurance company; the ABC members' employees are typically construction workers.

- Western Growers Association provides family health plans for $149 per month, compared with about $270 for a comparable plan offered by the California state purchasing cooperative. Western growers members' employees are typically farm workers in California and Arizona.

- NAEDA Group Insurance Trust, always fully-insured but self-administered, has had roughly 8% less administrative expense due to the economies of scale of the AHP.

The CBO report does not acknowledge this reality. CBO reaches the conclusion that savings from group purchasing through AHPs via operating efficiencies will be small based apparently on only one study which found that group purchasing arrangements established by state governments have been ineffective in making health coverage affordable for small businesses. We agree with CBO's contention that state government reforms have not helped expand affordable coverage to small businesses. But we strongly disagree that private sector entities, given the proper tools and regulatory environment, cannot do better.

It is terribly short-sighted to make the assumption that private-sector entities cannot do any better than government-planned efforts in expanding access to affordable insurance for small business workers. By extending to small businesses the same tools that large corporations and large unions now use to make health insurance affordable, AHPs can make a difference for small businesses and expand access to coverage for many currently uninsured workers. Again, AHPs have already demonstrated that they can produce substantial savings for small businesses through operating efficiencies.

Adverse Selection Claim Based on Flawed Assumptions

The second major problem with the CBO report is that its statistical analysis ignores the benefits of competition in the marketplace. This flaw, along with the failure to recognize the unique ability of bona fide associations to add value for small and medium-sized businesses, leads to the assumption that AHPs will only be utilized to offer scaled-down benefit packages to attract low risk populations. This ignores the reality that, in today's economy, small employers must offer competitive benefit packages in order to compete for quality employees, especially when they compete directly against large employers. For example, many small lumber dealers must compete directly against Home Depot for employees. Under current law, workers employed by Home Depot likely have the advantage of obtaining coverage under an ERISA exempt plan, while workers at a small lumber dealer generally do not. It is not fair, nor does it make sense, to impose more regulation and mandates on small businesses while exempting large corporations and unions.

Thus, market incentives, which I can attest to from 23 years of working with small employers, will drive small businesses to offer high quality benefit packages at the lowest possible cost out of economic necessity. AHPs that serve small businesses will be driven to offer affordable, attractive benefit options through operating efficiencies - economies of scale, bargaining power, and administrative uniformity. Businesses with truly high risk populations will be able to obtain savings on high quality benefit packages due to savings achieved through operating efficiencies.

The CBO report does not acknowledge this reality. Rather, it assumes that small employers will always seek the smallest possible benefit package for their employees. The experience of TAHC's members is that entrepreneurs must offer the highest benefit packages they can afford, and will do so regardless of the perceived health risks exhibited by their employees.

CBO also does not appear to factor in the benefits of increased competition that will result from an expansion of AHPs into its analysis. More competition will lead to greater innovation to create products and services which meet consumer needs at the most affordable price. An expansion of AHPs will significantly increase competition (which has been decreasing as more and more carriers leave state insurance markets), thus unleashing innovation that will benefit small business workers. Increased competition will drive down costs, and will expand health care options for all types of workers.

Bona fide associations welcome more healthy, vigorous competition in the market for

providing small businesses with high value health insurance packages. We do not see such competition in markets today. Greater competition will benefit our association members, and we exist to serve our members.

As such, we believe that CBO's assumptions regarding adverse selection do not factor in a number of very powerful forces that militate against adverse selection. However, CBO does make an interesting point regarding the possibility of adverse selection among AHPs. CBO noted that attempts to actively market health plan options only to low cost populations would tend to drive up administrative costs for the AHP. We would agree with this observation, which is another factor providing incentives against adverse selection.

To reiterate, TAHC believes strongly that CBO has recognized some benefits for AHPs in its analysis, but substantially underestimated the benefits of association group purchasing and an injection of healthy competition into health insurance markets.

Comments on Blue Cross and Blue Shield Association Reaction to CBO Study

I would also like to take this opportunity to address comments made by the Blue Cross Blue Shield Association in a statement released concerning the CBO report. BCBSA said that AHP legislation is analogous to a "shell game" because, they claim, AHPs can't add value for small business and can only be successful through adverse selection. This is more than a little disingenuous coming from insurance companies which are engaged in their own "shell game" today. For example, some insurance carriers, including Blue Cross Blue Shield plans and their affiliated companies, are actively target-marketing to segments of the population from which they can obtain the highest financial return, while quietly avoiding the rest.

Some of the practices which represent various forms of adverse selection by health insurance companies include the following:

- insurance carriers are constantly exiting some state markets and targeting others based on the current attractiveness of profit margins, which doesn't always coincide with the needs of healthcare consumers;

- insurance carrier agent or broker commission scales often provide disincentives to solicit and place health coverages for small businesses, especially those with less than 10 employees;

- individual health statements are often required of small businesses for rating by the insurance company's underwriters. This allows insurance companies to underwrite businesses based on the health status of workers, and more detailed questions about health status are sometimes asked of businesses with 15 or fewer employees;

- insurance companies are pursuing a strategy of standardizing benefit plans, thus greatly reducing choices in health plan options for small business workers and limiting the number of consumers who find health insurance affordable.

These and other activities of insurance companies are the real "shell game" going on today in small group markets.

I would not argue that insurance companies should not have the freedom to pursue a financial strategy that maximizes return for their shareholders. They too are having to deal with the very difficult state-by-state small group regulatory environment. However, it is outrageous and self-serving for them to claim that an expansion of bona fide AHPs will result in adverse selection. Insurance companies can now exit a market any time they like (and often do), forcing droves of small business to find alternative coverage. Bona fide associations, on the other hand, can be depended upon to act in the interest of their members, as long as they are fairly given the tools to do so.

It is incumbent upon policy makers to establish policies which promote ways of getting health insurance to those people and communities (i.e., the uninsured) that insurance companies are not interested in serving, for whatever reason. AHPs already are filling this role, and can do an even better job if promptly given the proper tools and regulatory environment.

Conclusion

Bona fide associations have an excellent track record of providing high quality, affordable health insurance to employers for over 50 years. Associations have not, and cannot, open and shut our doors, whereas insurance companies can enter and exit state markets at their choosing. We exist for the sole purpose of serving our members, and we are driven by market forces to add value for small employers and workers.

We do not claim to be able to cover all of the estimated 44 million uninsured - no one proposal can. But, AHPs can be expanded to cover hundreds of thousands, and possibly millions, of currently uninsured workers, without adverse selection, and with no cost to the U.S. taxpayer.

TAHC strongly urges Congress to enact the AHP reforms in H.R. 2990 as part of any comprehensive health reform effort. Thank you, Mr. Chairman, for this opportunity to provide TAHC's views to the committee.

CBO TESTIMONY

Statement of
James R. Baumgardner
Acting Deputy Assistant Director for Health Policy

Association Health Plans

before the
Committee on Small Business
U.S. House of Representatives

February 16, 2000

This statement is not available for public release until it is delivered at 10:00 a.m. (EST), Wednesday, February 16, 2000.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss the provision of employer-sponsored health insurance by small firms. The Congressional Budget Office (CBO) recently completed a paper on that topic entitled *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts*. I ask that it be included in the record.

My comments today will focus on three aspects of CBO's report: the circumstances that contribute to the relatively low rates of health insurance coverage through small firms, a summary of the rules that would apply to the proposed association health plans (AHPs) and HealthMarts, and CBO's estimate of how the introduction of AHPs and HealthMarts would affect the number of people insured through small firms and the premiums they face.

Factors Contributing to Lower Rates of Coverage Through Small Firms

Employees of small firms are less likely to have health insurance than are employees of large firms. For 1996, data from the Medical Expenditure Panel Survey indicate that about 40 percent of employees in small firms—those with fewer than 50 workers—obtained health insurance through their employer. In contrast, almost 70 percent of workers in firms of 100 or more employees obtained coverage through their job.

Several factors appear to play a role in the lower rate of insurance coverage through small employers:

- Workers in small firms, on average, have lower wages and lower family incomes than workers in large firms. As a result, small-firm employees are less

able to afford comprehensive health insurance, and less of a tax incentive exists for providing health insurance through their employer.

- Small firms typically face higher costs for providing a given benefit package than do larger firms because of higher administrative expenses per enrollee and less purchasing power.

- Small firms generally purchase insurance that is subject to state benefit mandates and other regulations, which tend to increase average premiums. Firms that self-insure—mostly large firms—are exempted from those state insurance rules by the Employee Retirement Income Security Act (ERISA).

Association Health Plans and HealthMarts

Recent proposals would establish federally certified AHPs and HealthMarts, entities that would offer health plans to participating employers. Those plans would be exempt from most state benefit mandates. Trade, industry, or professional associations that had been in existence for at least three years could sponsor an AHP, which would have to offer its insurance products to all member firms. HealthMarts, in contrast, would have to be available to all small firms in a specific geographic area rather than be offered in conjunction with an association.

Effects of AHPs and HealthMarts on Coverage and Premiums

To explore the effects of AHPs and HealthMarts, CBO constructed an analytical model using assumptions based on the relevant economics literature. We estimate that about

4.6 million small-firm employees and their dependents would receive coverage through the new insurance vehicles, but most of those individuals would have obtained insurance even if current law remained unchanged. On balance, about 330,000 more people would be covered through small-firm employment than would otherwise have been the case. That represents a 1.3 percent increase in coverage through small firms.

Because of lower premiums, some small firms would begin to offer their employees coverage through AHPs and HealthMarts, and others would shift from coverage obtained in the traditionally regulated market to the new entities. Firms that moved to the new plans would, on average, pay premiums that were about 13 percent lower than they would have faced in the traditional market under current regulations. They would be paying less money for less insurance, however, since some of those premium savings would be the result of a less generous benefit package.

Introducing AHPs and HealthMarts would be likely to lead to some selection. For plans that were fully state regulated, the proportion of firms with higher expected health costs would rise after the new AHPs and HealthMarts became established. Consequently, firms remaining in the traditional insurance market would see an average increase in premiums of about 2 percent.

The impact of AHPs and HealthMarts would vary from state to state, depending on the extent of state insurance regulation. In general, states that were more highly regulated would be riper markets for the new entities, as would areas with greater concentrations of small firms. The actual outcome of the proposed legislation would also depend on the activities of the regulatory authorities responsible for AHPs and HealthMarts.

BlueCross BlueShield Association

An Association of
Independent Blue Cross
and Blue Shield Plans

1310 G Street, N.W.
Washington, D.C. 20005
Telephone 202.626.4780
Fax 202.626.4833

TESTIMONY

Before the

THE COMMITTEE ON SMALL BUSINESS
U.S. HOUSE OF REPRESENTATIVES

on

IMPACT OF LEGISLATION TO EXEMPT ASSOCIATION HEALTH PLANS FROM STATE INSURANCE STANDARDS

Presented by:

MARY NELL LEHNHARD
SENIOR VICE PRESIDENT
POLICY AND REPRESENTATION

February 16, 2000

Mr. Chairman, I am Mary Nell Lehnhard, Senior Vice President of the Blue Cross and Blue Shield Association (BCBSA). I am pleased to present the views of the nation's 49 independent Blue Cross and Blue Shield Plans on the impact of exempting association health plans from state consumer protection and small group reform laws.

Collectively, Blue Cross and Blue Shield Plans are the nation's largest provider of insurance coverage to small employers. One-in-four small firms that offer health care coverage to their workers purchase their coverage from Blue Cross and Blue Shield Plans.

BCBSA recognizes the challenges faced by small firms in offering insurance to their employees. Blue Cross and Blue Shield Plans have been leaders in developing innovative health plans for small employers, including low-cost plans and special products for low-income workers.

BCBSA was one of the first groups to unveil a program designed to address the problem of the uninsured last year with a primary focus on tax reforms to make coverage more affordable for small firms and individuals. One innovative component of this proposal, as I will discuss, is a tax credit to address the high rates of uninsured among low-wage small employers.

We are pleased that Congress is studying ways to address the uninsured problem. Any workable solution for the uninsured, however, must build on a stable health insurance market. By undermining state laws, the association health plan (AHP) proposal would destabilize the insurance market and jeopardize efforts to expand coverage. The net result of this legislation will

be higher premiums for the majority of small firms and a return to a small group insurance market driven by aggressive selection of the best risks.

The focus of this hearing is the research on the effect of (AHP) legislation. The credible studies that have been done to date on this issue reaffirm BCBSA's concerns that AHPs would undermine the existing small employer health insurance market. Studies performed by the Congressional Budget Office, the Urban Institute and Actuarial Research Corporation each found that the majority of small employers would face higher premiums and other adverse consequences if AHP legislation were to be enacted.

In my remarks, I will make five points:

I. State have enacted legislation to address the access and affordability problems experienced by small firms, which would be undermined by AHP legislation;

II. The recent CBO report and other research indicate that AHPs would have a negligible effect on reducing the uninsured, while resulting in premium increases to the majority of small businesses, destabilizing the health insurance market;

III. The CONSAD Research Corporation report on AHP legislation is fundamentally flawed and should not be used as a basis for debate on AHP legislation;

IV. AHP legislation would have many adverse effects that have not been considered in analyses that focus solely on cost and coverage; and

V. Instead of AHPs, Congress should focus on real solutions to the access problem, such as the tax-based proposal released by BCBSA last year.

I. States Have Enacted Legislation To Address the Access And Affordability Problems Experienced By Small Firms Which Would Be Undermined By AHP Legislation

Before turning to analyses of the impact of AHP legislation, I would like to describe the history of regulation in the small employer health insurance market and how AHPs could be used as a vehicle to circumvent existing state laws. Over the past decade the states have enacted laws designed to assure the affordability and availability of health insurance coverage for small employers by putting a stop to issuers offering a low price by selecting the best risks. By exempting AHPs from state reforms that prohibit risk selection, AHP legislation would create a market where competition is characterized by aggressive selection of healthy groups and exclusion of sicker groups. A market driven by risk selection represents one of the greatest threats from AHP legislation, and in turn, drives many of the adverse consequences identified in most research on AHP legislation.

The Problem:

In the 1980s, small employers faced serious problems trying to obtain and retain health coverage. In some cases, health coverage was simply unavailable for businesses with less healthy workers at affordable rates. Small firms confronted three major obstacles to providing health coverage:

- ***Extreme variations in rates:*** Small businesses were faced with an insurance market where rates could be extremely low for healthy groups, but very high for groups with sick employees or dependents. Small firms routinely experienced steep premium increases if one of their employees became sick, forcing them to drop coverage for all of their workers. During this period, an employer with less healthy workers could face premiums that were 10 times those of employers with very healthy workers. Insurers had many "pools" of

employers, which resulted in fragmentation and meant that no meaningful cross-subsidies were provided.

- ***Lack of availability:*** Many small firms discovered that insurers refused to offer coverage if they had sick employees -- aggressive screening for existing medical problems was common. For these firms, coverage was not accessible even if they could afford to purchase it.

- ***Vulnerability to being dropped:*** Small employers who were able to buy coverage often found that their coverage was not renewed if their employees had filed high cost claims during the previous year. These employers were fortunate if they found another insurer willing to cover them; some were forced to go without coverage.

State officials recognized these problems and identified their root cause: a small employer health insurance market with competition based almost entirely on aggressive risk selection. When health care costs rose during the late 1980s, small employers with healthier employees began to resist the idea of subsidizing the cost of other small employers who had sick employees. They wanted their premiums to reflect only the costs of their own workers.

At the same time, many insurers realized that they could be much more competitive -- that is, offer lower initial premiums -- by screening applicants to select only the groups with healthier people, than through techniques to manage health care costs. As a result, most insurers rated groups aggressively and according to the health status of each group's employees. For small employers with healthy workers, premiums dropped. But for other small employers with less

healthy workers, this "risk-selection" meant much higher premiums.

In the late 1980s, states began responding to the problems faced by small firms by enacting reforms to make small group health coverage more accessible and affordable. These reforms were surprisingly consistent from state to state and included:

- ***Risk-spreading laws***, which set limits on what an insurer could charge its sickest group compared to its healthiest group and forced insurers to assure meaningful cross-subsidies for high cost small employers;
- ***Guaranteed issue laws***, which required insurers to accept all small firms, regardless of the health risk of the employees;
- ***Pre-existing condition laws***, which set limits on the length of waiting periods for coverage and required that credit be given to employees who had prior coverage; and
- ***Guaranteed renewal laws***, which prohibited insurers from terminating small businesses on the basis of their claims experience -- making health coverage more secure for small businesses and their employees.

These reforms successfully reversed aggressive competition based on risk selection, which was creating wide variations in premiums and left the sick without health coverage, by creating broad insurance pools for small employers. As a result, rates typically charged to less healthy small groups (relative to rates for low-cost small groups) declined significantly. These laws benefit all small employers because today's healthy group may be tomorrow's sick group.

AHP Legislation Would Reinvent Many of the Problems States Have Just Solved

As Congress moves forward regarding access issues for employees of small businesses, BCBSA urges you not to enact legislation that would undermine the progress that has already been made by the states. We recognize the good intentions behind the proposed AHP legislation -- expanded coverage for small employers. However, we believe this legislation would take us back to aggressive competition based on risk selection; it would let AHPs out from under the very state reforms designed to put an end to the practice of risk selection.

Exempting AHPs – including certain multiple employer welfare arrangements (MEWAs) -- from state law would undermine state risk spreading laws and increase premiums by creating opportunities for AHPs to select a population that is healthier than those in the state-regulated pools. Under current proposals there would be a number of opportunities for AHPs to risk select. For example, they could:

- avoid attracting less healthy groups by not covering the state-mandated benefits that less healthy people find desirable or by setting low lifetime limits;
- establish membership criteria that would essentially limit enrollees to healthier groups (rather than taking any small group that applies, as required by HIPAA);
- market association membership only in areas of the state with lower health costs and a younger, healthier population; or
- set rates based only on the claims experience of their group (i.e., they could avoid requirements to cross-subsidize less healthy groups that do not join the association).

By exempting AHPs/MEWAs from state law, the state-regulated market would be left with high-risk, high-cost individuals. Premiums in the state pools would then increase, triggering a spiral whereby other healthier groups leave the state pool, generating another round of premium increases. States would not be able to stabilize these escalating rates because a large portion of individuals would be outside of their authority.

The one sure way that federally certified AHPs could offer lower costs is by taking advantage of the unlevel playing field. AHPs could offer scaled-down benefits that attract healthier-than-average groups. It is important to recognize that **20% of the population accounts for 80% of health care costs in any given year**. By attracting low-cost populations, AHPs could offer significant price savings, at least initially. The state-regulated insurance market would take a double hit: It would be forced to carry the cost of mandated benefits and its healthier small firms would be cherry-picked by this new category of federally licensed insurers.

AHPs/MEWAs could offer lower rates initially, but when the cost of coverage rises they could disband and their members would be guaranteed access back into the insured small group market under HIPAA. As a result, the loss of coverage in the state-regulated market could compromise any potential gains in coverage in the new federally regulated AHP market.

II. The CBO Report and Other Studies Predict that AHPs will have a Negligible Effect on the Uninsured, While Making Coverage Less Affordable for Many Firms

The recent CBO report on AHPs validates many of the concerns regarding AHP legislation that I have just mentioned. In particular, this report reveals that AHP legislation would make coverage less affordable for the majority of small employers, while doing little to address the problem of the uninsured.

- **AHPs would not significantly reduce the number of uninsured:** Contrary to proponents' claims that AHPs could cover up to 8.5 million uninsured, the CBO estimated that coverage would increase by only 330,000 individuals. However, CBO also noted that the overall number of individuals insured would be lower, "because some of those who gained coverage through AHPs and HealthMarts would have otherwise obtained coverage in the individual market."

- **Four in five workers would be worse off under AHPs/HealthMarts:** According to the report, 20 million employees and dependents of small employers would experience a premium increase under AHP legislation, while only 4.6 million would see a rate reduction. In other words, the average small business would see its health insurance premiums rise under AHP legislation, not fall as proponents have claimed.

- **AHPs would save money primarily by "cherry picking":** The CBO estimated that nearly two-thirds of the cost savings for AHPs would result from attracting healthier members from the existing insurance pool, thereby increasing costs for those who remain in the non-AHP

market. The report states that, "In the long run, one would expect the most successful AHPs to be sponsored by associations whose members had lower-than-average health care costs." Moreover, the CBO estimated that 10,000 of the sickest individuals would lose coverage under AHP legislation.

- **AHPs would eliminate benefits to cut costs:** Contrary to proponents' claims that AHPs could offer generous benefits (e.g., comparable to those offered by Fortune 500 firms) while lowering insurance costs, the CBO found that dropping state mandated benefits would be the second major method that AHPs would use to reduce costs (after cherry picking). The CBO estimated that one-third of costs savings in AHPs would come from eliminating state-mandated benefits.

- **AHPs would not reduce overhead costs:** Contrary to claims that AHPs could reduce overhead by 30 percent, "...CBO assumed that cost savings arising from the group purchasing feature of AHPs and HealthMarts would be negligible." The CBO found "...no substantial evidence that joining a purchasing cooperative produced lower insurance costs for firms." Indeed, a recent analysis by William M. Mercer, Inc., found that AHPs would actually increase administrative costs for small firms by 1.5% to 5% of premiums, when additional costs such as royalties paid to the sponsoring association and membership dues were taken into account.

- **States with aggressive insurance reforms would see the most damage:** The report indicates that states with strict insurance reforms would be most attractive to AHPs. The

report concludes that "in states with more tightly compressed premiums – where the most cross-subsidization occurs – low-cost firms would face the greatest potential difference in price between traditional and AHP/HealthMart plans.'' In states such as Massachusetts, New Jersey, and New York, which have strict limits on the rating factors that insurers may use in setting premiums for small employers, the effect on premiums in the state-regulated small group market could be significantly worse than CBO's average estimates.

While the results of CBO's analysis are compelling, other studies have found that AHPs could have even more dire consequences. The results of an Urban Institute study indicate that AHP legislation would actually reduce overall health insurance coverage. The results of the study, which were outlined in testimony by Len Nichols, Ph.D. before the House Commerce Health Subcommittee, indicate that net small employer coverage would decline by one percent under AHP legislation – in other words, the ranks of the uninsured would swell by about 250,000 individuals.

Similar to the CBO analysis, the Urban Institute study predicts that AHPs will derive cost savings primarily from cherry picking. According to Nichols "AHPs will appeal to good risks since they can practice more segmented premium rating practices than the commercial insurance industry…." AHPs will be "…more attractive to the good risks and less attractive to high risks in search of more heterogeneous pools." In other words, AHPs will fragment the insurance market into smaller and smaller pools, rather than increasing pooling as proponents claim.

In his testimony, Nichols said net coverage is reduced because the commercial pools "...lose some of their best risks to the AHPs, and thus their pools deteriorate. Because of this risk pool deterioration, some firms drop coverage rather than pay the new higher prices that go with this deteriorating risk pool. These firms do not join the AHPs...because that risk pool is too segmented for their taste and risk profiles."

Another report authored by Jack Meyer, Ph.D. and Eliot Wicks, Ph.D. for the National Coalition on Health Care raised similar concerns with AHP legislation. The report states that AHPs could have a negative impact on state reforms and pull the healthy out of the state-regulated insurance market. The authors state that the proposed legislation could "...dilute the effect of state small group reforms by permitting small businesses with low-risk employees to group together, especially in Association Health Plans, to get cheaper coverage. To the extent that they do so, small firms with higher-risk employees would likely see their premiums climb."

Although this report did not quantify the effect of this legislation on coverage, the authors state that AHPs and other types of cooperative purchasing arrangements are not likely to solve the Nation's uninsured problem. The authors conclude that, "Association Health Plans are not likely to reduce health insurance premiums enough to entice most small businesses not now offering insurance to do so." Rather, the authors predict that most of the enrollees in AHPs will derive from employers who already purchase coverage in the state-regulated small employer insurance market.

I would like to mention one other study of association health plan legislation, which was performed by Actuarial Research Corporation. This 1996 analysis found that AHPs could have an even more negative effect on the state-regulated small employer health insurance market. The report found that premiums for small employers could increase by up to 16% in states with stringent insurance reforms, resulting in a reduction in coverage.

III. The CONSAD Report on AHP Legislation is Fundamentally Flawed and Should Not be Used as a Basis for Debate on AHP Legislation

The study performed by CONSAD Research Corporation for the National Federation of Independent Business (NFIB) is an aberration in the research on association health plan legislation. While all other analyses indicate that AHPs would not make a significant dent in the uninsured, this report concludes that up to 8.5 million uninsured individuals could gain coverage. In our opinion, which is supported by an analysis by the respected health economics firm of Barents Group/KPMG, the CONSAD report suffers from serious deficiencies that wholly undermine its credibility.

The Barents Group's review of the CONSAD analysis found, "...a number of problems that raise serious concerns regarding the accuracy of the estimates." Barents concluded that "...the report fails to provide an adequate justification for the assertion that coverage would increase under the proposed association health plan (AHP) legislation." Flaws identified include:

- **No Consideration of the Adverse Effect of AHPs on the Existing Small Group Market.** The CONSAD study neglects to take into account the primary problem with this proposal: that it would result in adverse selection and premium increases for employers remaining in the state-regulated insurance market. Other analyses of this legislation, including the analysis by the CBO and Urban Institute, have projected that AHPs would obtain cost savings primarily by siphoning off healthy groups from the state regulated market. As a result, premiums would increase for small employers who stay in the traditional small group market, causing some of these groups to drop coverage. By failing to factor this dynamic into their estimates, CONSAD provides an overly optimistic assessment of the effect of this legislation.

- **Unsubstantiated claims of savings:** The projected increase in coverage is based on assumed savings for AHPs of 5 to 20 percent. According to Barents, "...these assumptions...are not based on any evidence that such savings would actually exist. In fact, other studies have shown that AHPs would increase costs for many small firms by skimming off employers with healthy workers and undermining state reforms." As the Barents analysis points out, "...if AHPs are successful in reducing costs by attracting a healthier risk-pool, any increase in coverage could be offset by reductions in coverage for the rest of the small group market."

- **Unrealistic assumptions:** Barents found the results of the NFIB study to be "...implausible because they are inconsistent with the existing body of literature on worker health insurance coverage." For example, the study inflates the estimates by assuming that people are three to six times more likely to buy coverage than one would expect based on the economic literature.

Simply correcting for these erroneous price sensitivity assumptions would reduce CONSAD's estimate of the number of people who would gain coverage by three- to six-fold.

- **Use of inflated numbers:** The base population used for the estimate is "inflated, which results in overestimation of the number of people who would obtain coverage." For example, it appears that individuals covered by Medicare, Medicaid and other public programs were included in this base, despite the fact that they would typically not participate in AHPs.

- **Neglecting the effects of income on the decision to purchase insurance:** The report failed to account for the fact that low-wage workers would be less likely to purchase coverage than high wage workers. This omission is likely to have a major effect on the estimates, given that small firms that do not currently offer insurance are more likely to employ low-wage workers. "The net effect of not accounting for affordability is to overestimate the number of workers that would obtain coverage," according to Barents.

In light of these deficiencies, we believe that the CONSAD report should be viewed with the utmost skepticism. Because this report lacks credibility, the results should not be interpreted as an upper bound estimate for more credible analyses.

IV. AHP Legislation Would Have Many Adverse Effects That Have Not Been Considered in Analyses That Focus Solely on Cost and Coverage

Although estimates of the cost and coverage effects of this legislation are important to consider, there are a number of significant policy issues that are not contemplated in the studies that are the primary focus of this hearing. We believe that Congress must consider the full range of adverse effects of this legislation, including:

- ***Creation of a large, unresponsive regulatory infrastructure.*** AHPs would operate as federally certified insurance companies that market coverage to small firms and individuals. As such, the federal government would need to reproduce regulatory processes and functions already performed by state insurance regulators, such as:
    - Licensing/certification of health plans;
    - Monitoring market conduct (e.g., preventing deceptive marketing practices);
    - Assuring that rates are reasonable in relationship to benefits offered;
    - Performing financial examinations to assure that plans remain solvent; and
    - Assuring that consumers are protected in the event that an AHP fails (including administering a federal guarantee fund for AHPs.)

  Transferring regulatory authority from the states to the federal government would require the creation of a large federal infrastructure to monitor these new federally regulated insurance companies. **The Labor Department has testified that it currently has the resources to review each ERISA plan only once every 300 years.** This level of regulation would not be adequate for federally certified AHPs, which operate more like insurance plans than large

employers. Regulation of AHPs would require DoL to hire new staff and build the capacity to regulate insurance functions, such as solvency, that are already regulated by the states.

Proponents of this legislation claim that provisions that allow the Secretary to delegate some regulatory responsibilities to the states will ease the regulatory burden. However, once this legislation preempts existing state small group reforms some states are likely to refuse to regulate AHPs. Moreover, the federal government would have to build the infrastructure to regulate AHPs (such as federal solvency guarantees), regardless of the degree to which states are delegated such authority. **The regulatory cost to maintain this dual system would reach as high as $3.2 billion over seven years, according to a recent estimate by William Custer, Ph.D. and Martin Grace, Ph.D. of Georgia State University.**

- ***Unpaid medical bills for consumers and providers:*** Exempting AHPs from state law could leave consumers and providers with large unpaid medical bills. MEWAs -- a type of AHP -- have a history of bankruptcy problems. Unfortunately, the proposed solvency standards for self-funded AHPs remain inadequate. The solvency standards are undermined completely by inadequate liquidity standards and the allowance of stop-loss coverage to substitute for reserves. As the American Academy of Actuaries has pointed out previously, the capital requirements in AHP proposals are inadequate for AHPs with 5,000 to 10,000 members. In addition, the $5,000 assessment on AHPs for the federal insolvency fund provides inadequate up-front funding to protect against AHP failures. The National Association of Insurance Commissioners, representing the state officials who work to assure health plan solvency,

testified last year that the solvency standards and regulatory framework of current AHP proposals remains inadequate to protect consumers.

In lieu of state solvency standards, the federal AHP legislation substitutes an elaborate scheme of stop-loss and indemnity insurance coverage in an attempt to provide protection for consumers when AHPs fail. However, these provisions are not an adequate substitute for strong capital standards, local oversight and early intervention, or the full arsenal of tools available to state insurance commissioners when a health plan threatens to become insolvent.

Moreover, under the federal guidelines dealing with plans that file for bankruptcy, AHP participants are given the same status as other creditors in ensuing court proceedings. By contrast, state regulators can place insolvent plans into receivership and seize the assets to pay the claims of plan participants. Under the AHP proposal, the state insurance commissioner could no longer seize assets of the plan to keep them in the state to pay claims for participants in the event of bankruptcy.

- ***Reduced funding for state access programs***: A majority of states have created high-risk pools to provide affordable coverage in the individual market for those with existing medical conditions. These risk pools are primarily funded by assessments on health insurance premiums. Only certain AHPs would be required to contribute to these pools or other state programs; any AHP in existence before the passage of this legislation would be exempt from paying state premium taxes. As a result, state assessments on insured small groups would have

to increase in order to compensate for non-contributing AHPs.

- ***Consumer Confusion:*** Exempting AHPs from state law would create consumer confusion about whether state or federal protections would apply to their coverage. Most consumers are currently accustomed to calling their state insurance commissioner when they have a problem with their small group coverage. **Under AHP legislation, they would likely have to call the Labor Department.** States have passed numerous laws regarding fair marketing practices, rating limits, financial standards and access and quality safeguards. These protections would not apply to consumers enrolled in AHPs that are exempt from state law.

V. Instead of AHPs, Congress Should Focus on Real Solutions to the Access Problem, Such as the Tax-Based Proposal Released by BCBSA Last Year

BCBSA believes that improving access to health insurance among small employers should be a priority for policymakers. While recent statistics show that the number of non-elderly Americans with employer-based health coverage has increased after years of decline, a new report funded by the Kaiser Family Foundation illustrates that small employers have not been a part of this trend. The most serious gap in the uninsured exists for small firms with low-wage workers.

The lower the company's wage structure, the less likely it is to offer insurance. According to the Kaiser Foundation report, companies with a high proportion of low-wage workers were half as likely to offer health benefits as high-wage companies. Research indicates that low-wage

workers are interested in coverage, but are either not offered coverage or are not able to afford coverage.

In February of last year, BCBSA unveiled a two-part program to address the problem of the uninsured that focuses on the unique problems of small employers. First, BCBSA urges Congress to adopt a new litmus test to assure that no legislation is enacted that will increase the number of the uninsured. Approximately 300,000 Americans lose their health insurance coverage for every one percent increase in private health insurance costs, according to estimates by the Barents Group/KPMG and the Lewin Group.

Second, BCBSA recommends that Congress enact targeted solutions that address significant gaps in insurance coverage. Specifically, Congress should enact:

- **Tax Credits For Low-wage Workers in Small Firms.** A disproportionately high share of workers in small firms are uninsured. In firms with less than 10 employees, the uninsured rate is 35 percent. One reason for this higher uninsured rate is that nearly one-third of all workers in small firms earn less than 200 percent of the poverty level. Tax credits for workers in low-wage firms are needed to make health coverage more affordable for small employers and their low-income employees.

- **Full Tax Deductibility For The Self-Employed.** Those who are self-employed should be allowed to deduct the full cost of their health insurance, just like larger employers can today. Congress has already moved in this direction by approving legislation that will phase in full

deductibility for the self-employed. Congress should accelerate this phase in of full-deductibility for the self-employed.

- **Full Tax Deductibility For Individuals Without Employer-Sponsored Coverage.** The current tax system disadvantages individuals who do not have access to employer coverage. These individuals should be allowed to deduct the cost of purchasing their coverage.

- **Federal Seed Grants For Targeted Initiatives.** Targeted federal grants could be used to help other segments of the uninsured. These grants could be used to provide funding for private initiatives, community health centers and state high-risk pools.

CONCLUSION

In summary, as you consider federal legislation that exempts groups from state law, we urge you to consider the serious, unintended consequences on a highly complex market. **First and foremost, Congress should recognize that states have laid the foundation for successful reform by guaranteeing access and creating cross subsidies.** If federal legislation is proposed, it should build on state reforms by addressing affordability through the tax system and take care not to unintentionally undermine existing state reforms.

If Congress enacts AHP legislation or any other legislation that undermines state reforms, it will be left with a market that is built upon aggressive risk selection and fragmented insurance pools – factors that will prevent the effectiveness of federal intervention to help the uninsured. The

federal government will need to do exactly what the states have done, but will not have the infrastructure to regulate the market with the same responsiveness to consumer protection.

Thank you for the opportunity to speak to you on this important issue. BCBSA looks forward to working with Congress to address the access and affordability needs of small employers in a manner that truly help small business.

Analysis of the Projected Impacts of Association Health Plans on Health Insurance Coverage

Oral testimony of
Mark A. Joensen, Ph.D.

To the
House Committee on Small Business

16 February 2000

CONSAD Research Corporation
121 North Highland Avenue
Pittsburgh, Pennsylvania 15206
Telephone: 412.363.5500
Internet: http://www.CONSAD.com

Mr. Chairman and members of the Committee, good morning, and thank you for the opportunity to speak to you about the effects of association health plans on insurance coverage in the U.S. I believe that some research that I have been involved with is helpful to you as you deliberate these issues. I will keep my presentation short in order to leave ample time for any questions you may have.

My name is Mark Joensen. I am Vice President and Director of Health Care Analysis at CONSAD Research Corporation, a public policy research firm based in Pittsburgh, Pennsylvania. For nearly forty years, CONSAD has provided federal government agencies, foundations, private enterprises, and trade associations with impact analysis and other research designed to inform policy decision-making. We have performed numerous analysis of proposed changes to the U.S. health insurance market, including analyses of national health care reform proposals such as the Health Security Act.

In 1997, the National Federation of Independent Business Research Foundation commissioned a study from us to analyze the potential impacts of the proposed Expanded Portability and Health Insurance Coverage Act of 1997 on the number of Americans with insurance. This Act included provisions to allow the creation of Association Health Plans. We completed that study in July 1998. I have provided the committee with copies of this report for your review.

Based on our analysis, we estimate that the creation of Association Health Plans would result in an increase in employer-sponsored insurance coverage of approximately 2.3 million workers employed with small firms. In addition, we estimate that an additional 2.2 million dependents would gain insurance coverage as a result of the creation of AHPs. In total, we estimate an increase of approximately 4.5 million newly insured workers and their families.

These estimates represent our best single point estimates of changes in insurance coverage. We also conducted sensitivity analyses of our results using ranges of assumptions for important model parameters. This sensitivity analysis produces a range of estimates that varies from 2.1 million newly insured individuals to 8.5 million newly insured individuals.

Our analysis was based on traditional microeconomic theory, and used data from established government databases, and other parameters taken from the economics literature.

I am happy to answer questions you may have about our research and results, but I would like to spend my remaining time comparing our analysis and results with those of a recently released Congressional Budget Office analysis presented in the report entitled *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts*. This CBO analysis projects that the creation of association health plans and healthmarts would increase the number of people with insurance by 330,000 individuals (workers and dependents). The study gives a range of estimated increases that vary from 10,000 to 2 million.

As is usual with projections of this kind, the results of any analysis depend highly on model assumptions and data. I believe that the different analytic frameworks used by CBO and CONSAD are quite similar. Based on my review of the CBO report, it is my view that the a large portion of the differences in estimates between the two studies result from the selection of the value used for a single model parameter. This parameter, the price elasticity of demand for insurance for small firms, is a measure of how small firms would react to changes in the price of insurance. If the price of insurance decreases, we expect more firms to offer insurance to their employees. The price elasticity of demand depicts the percentage change in insurance coverage that would result from a given percentage change in insurance prices.

The values of the price elasticities used by both CBO and CONSAD were taken from the economics literature. The CBO analysis uses a price elasticity equal to –1.1 to produce its point estimate of an increase of 330,000. This assumption means that a decrease in the price of insurance of 10 percent would result in a 11 percent increase in the number of firms offering insurance. For their sensitivity analysis, the CBO used a range of –0.6 to –1.8. However, in the CBO report, other estimates of the price elasticity of demand for insurance by small firms are presented, included estimates by Roger Feldman and others of a range of –3.9 to –5.8.

In CONSAD's analysis, we use a price elasticity of demand for insurance of –2.0 to –3.0. This range of values is derived from sources in the economics literature that we cite in our report. Our use of a larger value for this parameter explains, in part, the numerical differences in the CBO and CONSAD results.

There are several why I believe that it is appropriate to base our projections on price elasticities in the range of –2.0 to –3.0. First and most importantly, a majority of pertinent studies in the economics literature support values in this range. An additional reason is more subtle. All of the

available studies of price elasticities describe changes in insurance rates resulting from price changes in the current market for insurance. However, I believe that allowing for the creation of AHPs fundamentally changes a segment of the insurance market. CONSAD's numerous studies of the insurance market indicate that a number of factors affect a small firm's decision to offer insurance to employees. Price is obviously an important factor. But small businesses also face impediments to offering insurance that are due to lack of trust between themselves and insurance brokers, incomplete access to information describing available health plans and plan benefits, and a lack of resources to understand and manage the terms of available health plans. Association Health Plans will help overcome these barriers to insurance coverage. AHPs will be administered by organizations to which small businesses already belong, and thus have existing relationships and communication links. Thus, even if there were no price reduction associated with the creation of AHPs, I believe that they would result in increases in insurance coverage because they overcome some of these non-price barriers. And for any given change in insurance prices, I believe that an insurance market that includes AHPs would produce larger increases in coverage than the existing insurance market.

One other noticeable difference between the CONSAD analysis and the CBO analysis is the categories of firm sizes that are expected to be affected by the creation of AHPs. The CBO analysis includes only firms with 50 or few employees. The CONSAD analysis includes firms with 100 or fewer employees.

There are several additional differences that can be discussed, but the two that I have mentioned account for the vast majority of the differences in results between the CBO and CONSAD studies.

Irrespective of the difference in the absolute values of the CBO and CONSAD model results, both analyses indicate that insurance coverage will be increased as a result of the creation of Association Health Plans. Clearly the benefits associated with Association Health Plans will outweigh potential costs. Although AHPs will not provide the complete solution to the problem of Americans without health insurance, I believe that they are part of the solution.

This concludes my prepared testimony. I invite any questions that you may want to ask.

TESTIMONY OF

ARLENE KAPLAN

CEO & FOUNDER, HEART TO HOME, INC.

ON BEHALF OF

THE NATIONAL ASSOCIATION OF WOMEN BUSINESS OWNERS

BEFORE THE

U.S. HOUSE COMMITTEE ON SMALL BUSINESS

ON ASSOCIATION HEALTH PLANS

FEBRUARY 16, 2000

Good morning Mr. Chairman and members of the committee. Thank you for the opportunity to appear before you today to discuss Association Health Plans and their importance to women-owned businesses.

My name is Arlene Kaplan and I have been in the health care field for over 40 years. I was once a laboratory technologist, working in some of New York's finest hospitals. Then for almost 20 years I worked with 1199 the Hospital Workers Union in New York as an Organizer and Vice President. In 1984 I opened my first business called Heart to Home, Inc. a New York State Licensed Home Care Agency. I also own a New York State Licensed Adult Home, Heartland on the Bay, Inc. and Workplace CPR, a company that provides CPR training and First Aid to corporations and the community.

In addition I am a past National Officer of the National Association of Women business owners and have been a member since 1985. My principal focus for NAWBO has been in the health Care and Health Insurance reform arena. My remarks today are on behalf of NAWBO. NAWBO is s non-profit organizations representing the interests of over 9 million women business owners. NAWBO has over 78 chapters across the United States.

While working with 1199 I was involved in the Union's plans for a National Health Care Program. As part of my responsibilities I testified in December of 1978 before the Senate Health Sub-Committee regarding a comprehensive national health plan. I was also very lucky to be part of the Union's wonderful health and disability plan. We were self-insured and could and did create our own programs. As a Union that was predominately female we provided benefits that did not exist in insurance companies. We provided maternity disability before it became law and we provided prenatal and delivery benefits regardless of your marital status. We provided well-baby care long before insurance companies. To the best of my knowledge the Union's Benefit Plan always exceeded the state mandate of benefits.

I touch on this only to show what can be done when people with a community of interest come together and design programs that fit their needs. That doesn't mean that NAWBO would set up an Association Health Plan, but we would certainly like to explore the possibility. We believe we have needs that could be best addressed if we were permitted, as the Union was, to design plans that meet those needs

That is what happened with my Union. The Union existed for the purposes of representing members in collective bargaining and the establishment of our Benefit Plan was an out-growth of those goals.

NAWBO exists for the purpose of representing the needs of and furthering the goals of women business owners. To be able to develop an Association Health Plan would be a step in the furthering those goals.

Small businesses are the backbone of the America Economy. The majority of these businesses do not offer health care benefits to their employees not because they don't want to, but cost, access and the ability to remain with a carrier has been a deterrent. For example, Wanda Goetz, NAWBO member and owner of an information management consulting service in Florida, cannot afford to give her employees health insurance because most of them are older, 50 plus, and the premium cost was $7000.00 per month. As someone who has benefited from the legislation that allowed my Union to be self-insured, I think that as a woman business owner I should have the same rights.

NAWBO strongly believes Association Health Plans would benefit our membership. Any plan that we would design we certainly would want to be superior. We have grown our businesses by being better and more efficient. And that is how we will treat our Health Plan.

Association Health Plans give small businesses and the self-employed the freedom to design more affordable benefits options and offer their workers access to health care coverage. NAWBO members believe these new coverage options promote greater competition, lower costs and new choices in health insurance markets. By allowing individual and small employers to join together, AHP's promote the same economies of scale and purchasing clout that workers in large companies currently realize.

The Quality Care for the Uninsured Act, H.R. 2990 includes the language supported by virtually the entire small business community to expand Association Health Plans. We must reach those small business owners without health insurance, and AHP's are a market oriented private sector solution to a small business problem.

We believe that the language in the Quality Care for the Uninsured Act will provide the necessary protection.

I would like to share just one more story with you.

Christine Bierman, owner of Colt-Safety in St. Louis, Missouri tells her own story.,

"I own a small safety, fire and rescue distribution company in St Louis, Mo. I founded the company in June of 1980. Through the years we have had up to 25 employees at any given time. We currently have 15 employees.

My mother worked for my company from 1987 till her death in 1994. In 1989 when was diagnosed with breast cancer and had a mastectomy. The cancer recurred in 1992. We were one of the lucky ones who did not have to fight their insurance company to cover the controversial bone marrow transplant. The unfortunate and most unfair situation was that for the next 6 years of my mother's life, our company's insurance rates escalated between 15 and 25 % each year. In about year 3 I began questioning our operations manager on the pricing. I asked her to shop other insurance e companies only to find out we could go nowhere else due to my mother's pre-existing conditions.

The escalating costs come at a time when we ere also losing market share due to integrated suppliers and mega-mergers in our industry. This usually when a small company can show their entrepreneurial skills by cutting costs and moving quicker that the mega companies. We were forced to cut our 100% employee coverage to 80% and now only cover 60% of employee benefits."

What we see happening if my association, NAWBO, is permitted to form an Association Health Plan is that our members in each state will be able to provide for their employees health care benefits so that all our stories have a good ending not a sad one.

Richard G. Gallo
President
Gallo Office Products, Inc.
DBA / The Office Outlet
2128 Oakland Avenue
Indiana, Pennsylvania 15701

TESTIMONY FOR
Congress of the United States
U.S. House of Representatives
106th Congress
Committee on Small Business
Healthcare Accessibility

Wednesday February 16, 2000 10:00AM
Washington, DC

Richard G. Gallo
Gallo Office Products, Inc.
DBA – The Office Outlet
2128 Oakland Avenue
Indiana, Pennsylvania 15701

Congress of the United States
House of Representatives – 106th Congress
Committee on Small Business
2361 Rayburn House Office Building
Washington, DC 20515-6315

Tuesday, February 16, 2000

Testimony

Chairman Talent and Congressmen,

Good morning and thank you for giving me this opportunity to come before you today and give my testimony concerning healthcare reform and how it affects my small business and my family.

Just a little background about myself, first:

I am from Indiana, Pennsylvania, the hometown of the late, great actor Jimmy Stewart. We have a very nice museum and statue of Mr. Stewart, please come and visit us. Centered in our community is a fine educational institution, Indiana University of Pennsylvania. We are also known as the "Christmas Tree Capitol of the World". But, we are not quite as famous as our neighboring town of Punxsutawney, PA which has the famous weather forecaster, Punxsutawney Phil.

I was born and raised in Indiana, PA – population approximately 15,000. I have been married to my wife Wendy Bechtel Gallo, for the last 16 years. We have four children, 6, 8, 10, and 12 years old. My wife and I were blessed when we were able to purchase our first business, the Office Outlet, an office products store. We have owned the Office Outlet since 1995.

Previously, I had managed an office product store for over 16 years, I was employed there a total of 22 years. I found that being employed was very different than owning your own company. I had high hopes of being able to provide benefits, like health care insurance to our employees. To my shock and surprise, I found out that it would cost me over $40,000 per year for my small company to give everyone including my family, healthcare insurance. This was looking at the lowest priced healthcare plans and group rates around. For a small business, just starting out, meeting this figure would be impossible.

So for now, my wife and I go without health insurance and my employees must take care of their own by whatever means they can.

I recently had to see a specialist for health reasons. I had no idea what the expense would be or how I was going to come up with the extra cash for payment. With four young children, a mortgage, bills and other expenses, there is not much cash in the savings account. With all the tests and medicine it was quite expensive and I may yet have to have surgery. This motivates me even more to travel all the way to Washington, DC, and speak out concerning this very important issue before you, affordable and accessible healthcare insurance plans for small businesses.

I feel for the many others, in my situation, and now I know personally the frustration of not having healthcare insurance. This can become a financial nightmare. I was blessed by a family member, who helped me with the expenses, but alot of others may not have someone to turn to for help.

I ask this committee: Who are the people going to turn to for healthcare insurance? The government can not pay for everyone to have insurance. My answer: The only way that this can be resolved is that we, as employers, must have available affordable healthcare plans to give our employees or at least offer them as co-pay plans. I was blessed to work for a company that paid my insurance for me all 22 years of my employment. I appreciated that benefit, and it is one of the reasons I remained with one employer for that length of time. It gave me a sense of security and appreciation for my job. I would like to be able to offer the same benefit for my valuable employees.

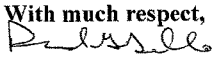
I see that many small employers are faced with the same problem. We must make enough profit to be able to employ good workers and offer them benefits that will help keep them with our companies. As employers, we need good workers that are going to stick with us, to help build our companies as well as their futures. Without benefits, they look elsewhere for jobs. In Pennsylvania, we have lose thousands of young people for this reason each year. Our fine Representatives from Pennsylvania; Representative English and Representative Pitts can attest to this.

I close with this summation and advise, please work together as one committee and come to a true assessment of what is needed. Work with the insurance companies to come up with reasonable legislation that is fair for all and enables the insurance companies to provide healthcare for the millions that need it at an affordable rate.

I will end with a quote from Mark Twain, "Do the right thing, it will gratify some people and astonish the rest."

Thank you, Mr. Chairman and committee members, may God be with you.

With much respect,



Richard G. Gallo,
President/Owner
Gallo Office Products, Inc.

CBO PAPER

INCREASING SMALL-FIRM HEALTH
INSURANCE COVERAGE
THROUGH ASSOCIATION HEALTH
PLANS AND HEALTHMARTS

January 2000

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

NOTES

Numbers in the text and tables of this paper may not add up to totals because of rounding.

All dollar values are expressed as 1999 dollars.

PREFACE

The large and growing number of uninsured people in the United States, particularly uninsured workers in small firms, continues to be a concern to policymakers. In the 105th Congress and again in the 106th, the House passed legislation that would create two new vehicles, association health plans (AHPs) and HealthMarts, to facilitate the sale of health insurance coverage to employees of small firms. The effects of AHPs and HealthMarts on premiums and coverage in the small-group health insurance market are the subject of this Congressional Budget Office (CBO) paper.

James Baumgardner and Stuart Hagen of CBO's Health and Human Resources Division prepared the paper under the direction of Joseph Antos and Linda Bilheimer. Michelle Jewett checked the paper for accuracy. A number of people at CBO offered helpful comments and suggestions, including Nabeel Alsalam, Tom Bradley, Jennifer Bullard, Steve Lieberman, Karuna Patel, David Torregrosa, Bruce Vavrichek and Greg Waring. Additional assistance was provided by Thomas Buchmueller, Cathi Callahan of the Actuarial Research Corporation, Matthew Eichner, and Gail Jensen.

Leah Mazade edited the paper, and Chris Spoor proofread it. Sharon Corbin-Jallow prepared the report for publication. Laurie Brown prepared the electronic versions for CBO's World Wide Web site (www.cbo.gov).

Dan L. Crippen
Director

January 2000

CONTENTS

SUMMARY AND INTRODUCTION 1

THE HEALTH INSURANCE MARKET FOR SMALL GROUPS 3

ASSOCIATION HEALTH PLANS AND HEALTHMARTS 6

Association Health Plans 6
HealthMarts 7

HOW AHPs AND HEALTHMARTS WOULD AFFECT PREMIUMS AND COVERAGE 7

Premiums in the AHP/HealthMart Market 8
Premiums for Traditional Insurance Plans 11
Coverage 12

ESTIMATING THE EFFECTS OF AHPs AND HEALTHMARTS ON PREMIUMS AND COVERAGE 14

Main Findings 14
Findings Under Alternative Assumptions 17

CONCLUSIONS 18

APPENDIX: MODELING THE EFFECTS OF AHPs AND HEALTHMARTS 20

TABLES

1.	Health Insurance Coverage by Size of Firm	2
2.	Estimated Effects of Association Health Plans and HealthMarts on Coverage in the Small-Group Health Insurance Market	15
3.	Estimated Annual Effects of Association Health Plans and HealthMarts on Total Premiums in the Small-Group Health Insurance Market	16
4.	Estimated Effects of Association Health Plans and HealthMarts on Average Premiums in the Small-Group Health Insurance Market	17
A-1.	Estimated Lower and Upper Bounds of Effects of Association Health Plans and HealthMarts on Coverage in the Small-Group Health Insurance Market	29
A-2.	Estimated Lower and Upper Bounds of Annual Effects of Association Health Plans and HealthMarts on Total Premiums in the Small-Group Health Insurance Market	30
A-3.	Estimated Lower and Upper Bounds of Effects of Association Health Plans and HealthMarts on Average Premiums in the Small-Group Health Insurance Market	31

BOX

1.	Health Insurance Purchasing Cooperatives	9

SUMMARY AND INTRODUCTION

The rising number of people who lack health insurance continues to be a major concern to policymakers. According to the Census Bureau's Current Population Survey, about 43 million people under age 65 were uninsured in 1997. That estimate represents about 18 percent of the nonelderly population, compared with less than 15 percent who were uninsured a decade earlier.[1]

Given that the primary source of private health insurance coverage in the United States is employment, one might reasonably assume that people who lack insurance also lack jobs. Yet most uninsured people are members of families with at least one full-time worker. Uninsured workers are usually employees of small firms (those with fewer than 50 employees), and small firms typically face higher costs for health insurance than do larger firms, which may make small firms less likely to offer it. In 1996, 42 percent of small-firm establishments offered health insurance to their employees (see Table 1). (An establishment is a single geographic location of a firm.)[2] By contrast, more than 95 percent of establishments in firms with 100 or more employees offered insurance. Another reason for lower rates of health insurance coverage for workers in small firms is lower take-up rates when insurance is offered. In 1996, about 81 percent of employees in small firms accepted insurance coverage when it was offered by their employers, compared with 87 percent of employees in firms with at least 100 employees.[3]

Concerns about low rates of coverage for employees of small firms have led to a number of initiatives at both the state and federal levels as well as in the private sector. One example is the formation of group purchasing cooperatives, some private and some sponsored by state or local governments, in which firms join together to purchase insurance in larger volumes at more affordable prices. By one estimate, almost a third of small firms purchase their health insurance through some form of cooperative purchasing arrangement.[4] Even so, concerns persist about the affordability of insurance coverage and the lack of sufficient alternatives for reducing its cost. Recently, the House passed H.R. 2990, the Quality Care for the Uninsured Act of 1999, which among other things calls for establishing association health plans (AHPs) and HealthMarts, two new vehicles for offering health insurance coverage

---

1. Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1998 Current Population Survey*, Issue Brief 204 (Washington, D.C.: Employee Benefits Research Institute, 1998), pp. 1 and 4.

2. A firm may have many establishments; however, most small firms have only one.

3. This paper considers only private-sector for-profit and not-for-profit firms.

4. Stephen H. Long and M. Susan Marquis, "Pooled Purchasing: Who Are the Players?" *Health Affairs*, vol. 18, no. 4 (July/August 1999), pp. 105-111.

TABLE 1. HEALTH INSURANCE COVERAGE BY SIZE OF FIRM

	All Firms[a]	Firm Size (Number of Employees) 1 to 49	50 to 99	100 or More
Number of Private Establishments (Thousands)	5,999	4,708	213	1,078
Percentage Offering Health Insurance	53	42	85	95
Percentage Offering a Self-Insured Plan[b]	28	11	20	63
Number of Employees (Millions)	104	31	8	65
Percentage Offered Health Insurance	70	50	73	80
Percentage Who Take Up Health Insurance When Offered	85	81	83	87

SOURCE: Congressional Budget Office calculations using data from the insurance component of the 1996 Medical Expenditure Panel Survey, Agency for Health Care Policy and Research (available at http://www.meps.ahcpr.gov/data.htm).

NOTE: An establishment is a single geographic location of a firm. Most small firms (less than 50 employees) have only one establishment.

a. Specifically, private-sector for-profit and not-for-profit firms.

b. As a share of establishments offering health insurance. Under self-insured plans, firms bear the financial risks of their employees' health care costs themselves rather than purchase coverage from a health insurer or health plan.

to small employers. (The House passed similar legislation—H.R. 4250—in the 105th Congress, but the bill was never considered by the Senate.) Several other proposals for AHPs and HealthMarts have also been introduced in the House.[5]

This paper considers how the introduction of AHPs and HealthMarts would affect premiums and coverage in the small-group health insurance market.[6] (Although entities known as association health plans already exist, all of the legislative proposals would create federally certified AHPs operating under a different set of rules.) The

5. See H.R. 448, H.R. 1136, H.R. 1496, H.R. 1687, and H.R. 2926.

6. At least one of the bills would create individual membership associations, or IMAs, that would face some regulatory rules similar to those for AHPs and HealthMarts. Unlike those proposed insurance arrangements, however, IMAs would not be sold as part of an employee benefit plan. This paper focuses on the market for employer-sponsored health insurance available through small firms and does not consider IMAs.

new entities would be exempt from some state insurance regulations that apply to insurance plans offered in the small-group market. Such regulations tend to increase premiums for those traditional plans.

Currently, about 48 million people either work for a small firm or are a dependent of someone who does. Under the most likely scenario for AHPs and HealthMarts, the Congressional Budget Office (CBO) estimates that approximately 4.6 million of those people might obtain their coverage through the proposed new insurance arrangements. But overall enrollment in employer-sponsored health insurance would increase by only about 330,000 people, because most firms purchasing coverage through an AHP or HealthMart would be switching from traditional insurance coverage—that is, insurance plans subject to the full array of state insurance regulations.[7] On average, premiums paid by small firms that purchased health insurance through an AHP or HealthMart would be about 13 percent lower than the premiums they would otherwise pay under current law. With AHPs and HealthMarts in place, the firms that continued to purchase traditional coverage would face an average increase in premiums of about 2 percent.

THE HEALTH INSURANCE MARKET FOR SMALL GROUPS

As noted earlier, small firms are less likely than large employers to offer health insurance coverage to their employees, and small-firm employees are less likely to take up coverage when it is offered. Factors contributing to those lower rates of coverage include the characteristics of workers in small firms, firms' costs for providing insurance benefits, and state insurance regulations.

The earnings of employees in small firms are one of the chief reasons for lower rates of health insurance coverage among small employers. Compared with employees in large firms, those in small firms tend to be paid lower wages and have lower family income, although some employees are members of households with higher-paid workers. Given their lower income, employees of small firms may be unwilling to accept the even lower wages that would result if their employer sponsored a health benefits plan. Furthermore, because lower-income workers probably have fewer assets to protect in the event of a large medical expense, they may place less value on having insurance. Their lower wages also mean that small-firm employees have less of a tax incentive to purchase insurance than do higher-paid workers. (Because employees are not taxed on their employer's contribution for

7. Of nonelderly people in families headed by someone working for a small firm, CBO estimates that almost 26 million are currently insured through a small employer, a further 13 million are uninsured, about 3.5 million purchase coverage in the individual market, and the remainder obtain coverage from other sources.

health insurance, workers in higher tax brackets gain a larger subsidy for health insurance than do workers in lower tax brackets.)[8]

The cost of health insurance for small firms may be another factor in their lower rates of coverage. Health insurance premiums for equivalent benefit packages are higher for small firms than for large ones. The premiums themselves do not differ consistently on the basis of firm size, but the benefit packages that large firms offer their employees are more generous than those offered by small firms.[9] In addition, the administrative costs included in the premium are higher for small firms because they have fewer employees among whom to spread the fixed costs of a health benefits plan, including costs for marketing and enrollment. Premiums are also likely to be higher for small firms because they do not have as much purchasing power as large firms, which limits their ability to bargain for lower rates from providers and insurers.

State insurance regulations may also contribute to higher premiums for small firms. For example, premium compression regulations, although reducing premiums for some firms, have raised premiums for others. Because of their size, small firms may experience much greater variation than large firms in their expenses for health benefits. One employee's serious illness can dramatically boost a small firm's health expenses, and in the absence of regulatory intervention, the firm's health insurance premiums could also rise substantially (since, in general, premiums are set to reflect those expenses).[10] Such significant rate variation, and even cancellation of policies, characterized the small-group market during the late 1980s.[11] In response, many states imposed new regulations that guaranteed availability and renewability of insurance and limited the degree to which premiums could vary among small firms.[12] In California, for example, the highest premium that an insurer may charge for a particular policy can be no more than 20 percent above its lowest premium for that policy. To comply with that kind of regulation, known as premium (or rate)

---

8. For an extended discussion of this issue, see Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance* (March 1994). The average employee in a small firm has a relatively low income and therefore receives little benefit from the tax subsidy. However, the tax advantage is significant for employees in those small firms, such as law firms or other professional groups, that usually pay higher salaries.

9. See Len Nichols and others, *Small Employers: Their Diversity and Health Insurance* (Washington, D.C.: Urban Institute, June 1997).

10. That issue is discussed in Rick Curtis and others, "Health Insurance Reform in the Small-Group Market," *Health Affairs*, vol. 18, no. 3 (May/June 1999), p. 1.

11. Elliot K. Wicks and Jack A. Meyer, "Small Employer Health Insurance Purchasing Arrangements: Can They Expand Coverage?" *New Directions for Policy*, National Coalition on Health Care (May 1999) (available at http://www.americashealth.org/releases/stevesedit.html).

12. Federal law—specifically, the Health Insurance Portability and Accountability Act of 1996—also incorporates guaranteed availability and renewability of health insurance.

compression, the insurer must increase the premiums it charges its lowest-cost, or healthiest, firms and reduce the premiums it charges its highest-cost firms. The result is cross-subsidization—the increased premiums paid by the healthiest firms are used to help pay for the expenses of less healthy firms, whose premiums are no longer high enough to cover their expected costs.

Another way in which state regulations may have boosted premiums for small firms is by mandating the inclusion of certain benefits in all health insurance plans. (In a number of states, those mandates cover treatment for alcoholism, drug abuse, and mental illness as well as chiropractic care and bone marrow transplants.) If such regulations force insurers in the small-group market to provide benefits that firms would not otherwise purchase, the mandates will, in effect, push up premiums by more than the additional coverage's value to employees. Mandates may also discourage some small employers from offering coverage, particularly firms with employees who are relatively healthy and who—given the choice—would probably forgo at least some of the mandated benefits to obtain lower premiums. Another way in which state regulations may increase premiums is through premium taxes, which are paid by insurers. In 1996, such taxes ranged from less than 1 percent to as much as 4 percent of premiums.[13]

Although, in principle, mandates and premium taxes affect the premiums of any firm (regardless of size) that purchases insurance from a licensed insurer, they frequently have a greater impact on small firms. The reason is that larger firms can avoid such regulations by self-insuring—that is, by bearing the financial risks of their employees' health care costs themselves rather than purchasing coverage from a health insurer or health plan. The federal Employee Retirement Income Security Act (ERISA) exempts firms' self-insured health plans from most state insurance regulations. However, small firms are less likely than large firms to self-insure because they have fewer potential enrollees (employees and their dependents) among whom to spread expenditures and as a result are vulnerable to greater financial risk (see Table 1 on page 2). Small firms that offer coverage are much more likely to purchase it from a health insurer and must therefore bear the full cost of state insurance regulation.[14]

---

13. General Accounting Office, *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance*, GAO/HEHS-96-161 (August 1996), pp. 26-27.

14. Some small firms have chosen to partially self-insure by combining a self-insured plan with stop-loss insurance (an insurance policy that covers catastrophic health care expenditures). Partially self-insuring limits a firm's exposure to the risk of excessive health care expenditures—a critical consideration for a small firm—yet allows the firm to benefit from the advantages of self-insuring. Depending on the regulations of their state, firms that partially self-insure may avoid providing mandated benefits and paying premium taxes. However, states may limit the attractiveness of this option by effectively restricting the amount of stop-loss coverage that firms may purchase.

ASSOCIATION HEALTH PLANS AND HEALTHMARTS

AHPs and HealthMarts are intended to reduce the cost of health insurance for small employers. Like group purchasing cooperatives, they could enhance the purchasing power of their members, and they might reduce some administrative costs. But AHPs and HealthMarts would have two additional advantages compared with cooperatives: they would be exempt from most state benefit mandates, and they could avoid the full effect of state regulation of insurance premiums.

Association Health Plans

AHPs would operate subject to several important requirements. Trade, industry, or professional associations that had been in existence for at least three years could sponsor an AHP, which would have to offer its insurance products to all member firms. Those products could constitute a full range of health plans, including a self-insured plan, under certain conditions: generally, the AHP would have to offer at least one fully insured plan (purchased from a licensed health insurer), and the sponsoring association would have to meet other qualifying criteria designed to limit favorable selection (attracting enrollees that are healthier than average) and the risk of financial insolvency. Both the AHP's self-insured and fully insured plans would be exempt from state benefit mandates, but they would not be exempt from state premium taxes.[15]

Because of their structure, AHPs would be subject in only a limited way to state laws that regulate premiums in the small-group health insurance market. In general, AHPs would have to abide by the premium-setting regulations of each state for their enrollees who resided in that state. Some states require insurers that offer small-group policies to community-rate their premiums (a practice in which the price for a given health policy must be the same for all purchasers despite variations in those purchasers' expected costs per enrollee). Other states limit the degree to which premiums for a particular policy can vary among firms. AHPs would have to follow the state's rating rules, but the premiums they offered would be based on the average expected costs per enrollee of only the association's member firms—not on the costs of the broader (and potentially more expensive) groups that insurers offering traditional coverage serve. As a result, AHP premiums are likely to be lower than they would be if they reflected the availability rules applying to traditional (fully regulated) plans.

---

15. Under some proposals, including H.R. 2990, states could charge premium taxes on self-insured AHP plans commencing operations after enactment of the legislation.

HealthMarts

In many respects, HealthMarts would be similar to AHPs, but certain features—in particular, eligibility based on geographic location rather than association membership—would set them apart. HealthMarts would be nonprofit organizations that offered health insurance products to all small firms within their geographic service area, which would have to cover at least one county or an area of equivalent size. All of the health benefits plans that a HealthMart offered would be available to any small employer within its service area. Employers who chose to participate would have to agree to purchase health insurance only from the HealthMart. (That is, participating employers could not offer their employees plans from the traditional market in addition to HealthMart plans.)

Like AHPs, health plans offered through HealthMarts would be exempt from most state benefit mandates but would have to pay state premium taxes. HealthMarts would also be subject to state premium regulations that applied within their service area.[16] Unlike AHPs, however, HealthMarts could offer only fully insured plans from insurance issuers licensed in the state; self-insurance would not be an option.

HOW AHPs AND HEALTHMARTS WOULD AFFECT PREMIUMS AND COVERAGE

The effects of AHPs and HealthMarts on the premiums of and number of people enrolled in traditional plans would depend on the response of small firms to health insurance policies comprising fewer benefits coupled with lower premiums. Coverage might increase if AHPs and HealthMarts could offer plans with premiums that were lower than those for traditional coverage. Firms that do not currently offer insurance to their employees might choose to do so if the price was lower, even if the benefits were not as comprehensive as in some plans. Yet that response is only part of the coverage picture. Firms that already purchase traditional coverage might instead seek lower-cost coverage through an AHP or HealthMart. If the firms that dropped traditional coverage had healthier-than-average employees, and thus lower costs for insurance, fewer of those so-called low-cost firms would remain to subsidize the premiums of higher-cost firms. As a result, premiums for at least some firms purchasing traditional plans would have to rise, which could lead those firms to drop coverage.

16. Depending on the specific proposal, a HealthMart might be required to charge the same premium to every participating employer.

Premiums in the AHP/HealthMart Market

AHPs and HealthMarts could offer premiums that were lower than those for traditional coverage to the extent that they were exempt from state benefit mandates and could avoid some of the effects of state premium-setting regulations. Group purchasing of health insurance through AHPs and HealthMarts could also lower the cost of health insurance for small firms if it reduced administrative costs or increased firms' purchasing power. AHP premiums might undergo further paring depending on whether a particular AHP could achieve savings through self-insurance.

Avoiding State Regulation. According to their advocates, reducing the cost of state regulation is one of the principal attractions of AHPs and HealthMarts. Unlike the purchasing cooperatives that can now be found in many states, AHPs and HealthMarts would not be subject to state benefit mandates and might also avoid some restrictions on premiums. (Box 1 briefly discusses several kinds of purchasing cooperatives.) For example, small firms could obtain lower premiums if AHPs and HealthMarts dropped some of the benefits that states required insurers to cover and offered less generous benefit packages than were available in traditional plans. The extent of such savings and their effect on premiums would depend on whether employees of small firms still desired some of those mandated benefits. Firms take into account the preferences of their employees in designing their benefit packages and will not necessarily sponsor policies that omit all mandated benefits. (One study of self-insured employers found that many of those firms offered mandated benefits despite their exemption from state regulations under ERISA.)[17]

Exempting AHPs and HealthMarts from offering mandated benefits might substantially affect selection. With the exemption, AHPs and HealthMarts could design benefit packages that had fewer benefits and were relatively unattractive to firms whose employees had costly health care needs. Those firms would want more extensive benefit packages and would probably maintain their enrollment in traditional (fully regulated) plans. As a result, their high health care costs would not affect the premiums offered by AHPs and HealthMarts, which might allow those plans to lower their costs by more than the savings from the mandates exemption alone. Lower-priced plans with leaner benefit packages would appeal more to healthy firms (with lower-than-average expected health care costs)—both those that offered no coverage at all to their employees and those that already offered insurance. Some firms with higher-than-average expected health costs might also be attracted by the lower premiums, but they would be less likely to participate because of the leaner benefits.

---

17. Jonathan Gruber, "State-Mandated Benefits and Employer-Provided Health Insurance," *Journal of Public Economics,* vol. 55 (1994), pp. 433-464.

BOX 1.
HEALTH INSURANCE PURCHASING COOPERATIVES

Health insurance purchasing cooperatives are relatively popular among small firms. A recent study estimated that 33 percent of establishments in firms with fewer than 10 employees and 28 percent of establishments in firms with 10 to 49 employees purchase health insurance through some type of group purchasing cooperative.[1] Such group purchasing arrangements can be divided into three broad categories: state-sponsored health insurance purchasing alliances, multiple-employer welfare arrangements (MEWAs), and multiemployer union-sponsored plans (also known as Taft-Hartley plans).

To encourage small firms to purchase health insurance, a handful of states sponsored health insurance purchasing alliances beginning in the early 1990s.[2] (An example is California's Health Insurance Purchasing Cooperative.) Typically, state alliances offer a variety of plans, including one or more managed care options, to any qualifying employer who wishes to purchase insurance through the alliance, and employees then enroll in the plan of their choice. The health plans that alliances offer are subject to normal state insurance regulations, including premium-setting rules and benefit mandates, although a few states exempt alliance plans from some of those requirements.

MEWAs can take many different forms including privately sponsored alliances, which function like the state-sponsored type, and association health plans, which can offer coverage only to members of their sponsoring association. (Those existing association health plans should not be confused with the proposed association health plans that are the focus of this paper.) The association-sponsored plans are employee benefit plans as defined by the Employee Retirement Income Security Act, or ERISA. They are more likely than purchasing alliances to offer a limited selection of health insurance options, and they can self-insure if they choose. In general, both fully insured and self-insured MEWAs are subject to state insurance regulations, including benefit mandates and premium-setting rules.

Union-sponsored plans are the only type of purchasing cooperative that does not have to adhere to state insurance regulations. Even though Taft-Hartley plans may involve many employers, ERISA classifies them separately from MEWAs and exempts them from state regulations such as benefit mandates and premium-setting rules.

There is little direct evidence about the effect of cooperatives on premiums. According to a study of a major purchasing alliance in California, the premiums that participating insurers offered to qualifying small employers were not as low as those offered to large firms.[3] Long and Marquis's analysis of a national survey of small firms found that premiums for cooperatives were roughly the same as those offered by traditional plans. The advantages of alliances appear to be primarily choice and information. For about the same premium, firms purchasing their coverage through a cooperative are more likely than other small firms to offer a choice of health plans to their employees. They also have better access to information about those plans, such as the benefits offered and the quality of care provided.

---

1. Stephen H. Long and M. Susan Marquis, "Pooled Purchasing: Who Are The Players?" *Health Affairs*, vol. 18, no. 4 (July/August 1999), pp. 105-111.

2. Susan S. Landicina and others, *State Legislative Health Care and Insurance Issues: 1996 Survey of Plans* (Chicago, Ill.: Blue Cross/Blue Shield Association, 1996).

3. Jill Yegian and others, *Health Insurance Purchasing Alliances for Small Firms: Lessons from the California Experience* (Oakland, Calif.: California HealthCare Foundation, May 1998).

In the long run, one would expect the most successful AHPs to be sponsored by associations whose members had lower-than-average health care costs. Similarly, the most successful HealthMarts would probably be located in lower-cost areas of the country or areas where the costs of regulation and mandates were high.

Group Purchasing. To a limited extent, the advantages offered by group purchasing might enable AHPs and HealthMarts to offer premiums that were lower than those for traditional coverage. Like other group purchasing arrangements, AHPs and HealthMarts would probably have more negotiating power with health insurers than would small employers negotiating on their own. The larger the number of potential enrollees, the more willing health insurers and provider networks would be to discount their rates to attract business. Another advantage of group purchasing that might be reflected in lower premiums would be lower administrative costs—with group purchasing, some fixed costs would be shared among a larger number of enrollees.

Savings from group purchasing, however, are unlikely to induce many small firms to add coverage, because the group purchasing option, with its associated advantages, is already available to them through purchasing cooperatives. One exception may be AHPs and HealthMarts in states that have not been particularly supportive of cooperative purchasing arrangements.

Self-Insuring Through AHPs. Although AHPs would be able to offer self-insured plans, several factors would limit the attractiveness of that option. For example, all plans offered by AHPs, whether self-insured or fully insured, would be exempt from benefit mandates and would have to pay premium taxes. As a result, self-insured AHP plans would offer no advantage in those areas over fully insured AHP plans.[18] Other advantages of self-insuring might also go unrealized. For example, firms that self-insure can retain and earn interest on the money that they would ordinarily pay in premiums to a health insurer until the money is needed to pay medical claims.[19] But small firms enrolling in an AHP's self-insured plan would still have to pay premiums to a third party—the AHP. Moreover, to curb favorable-selection practices, some of the proposals being considered would restrict the self-insurance option to AHPs sponsored by associations whose member firms had higher-than-average health expenditures or represented a broad cross-section of industries (such as a chamber of commerce).

---

18. Some association-sponsored plans in existence on the date of enactment of an AHP/HealthMart proposal might be able to claim an exemption from premium taxes.

19. See Martha Patterson and Derek Liston, *Analysis of the Number of Workers Covered by Self-Insured Health Plans Under the Employee Retirement Income Security Act of 1974: 1993 and 1995* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, August 1996).

The option to self-insure jointly with other firms is not new. ERISA already allows small firms to self-insure by joining together with other firms in so-called multiple-employer welfare arrangements (MEWAs). However, MEWAs might not be as attractive a vehicle for self-insuring as AHPs would be. Unlike AHPs, MEWAs must comply with some state regulations, including benefit mandates. In addition, some small firms may consider participation in a MEWA to be too risky. Overlapping state and federal laws have made regulating MEWAs a complicated and difficult task. According to the General Accounting Office, "MEWAs have proven to be a source of regulatory confusion, enforcement problems, and, in some instances, fraud."[20] As of December 1998, the Department of Labor had initiated 358 civil and 70 criminal investigations of MEWAs that affected over 1.2 million enrollees and involved monetary violations of more than $83.6 million.[21]

To bypass such problems, all of the AHP proposals include requirements to facilitate effective regulation of small firms that self-insure collectively. AHPs that offered self-insured plans would be subject to federal solvency standards, including requirements to set aside adequate reserves and to purchase stop-loss and indemnification insurance. Stop-loss insurance, which insures against the risk of unusually high claims, would apply to claims for a specific enrollee as well as aggregate claims for the plan as a whole. Indemnification insurance would pay outstanding claims if the plan was unable to meet its obligations. Thus, although self-insured AHP plans might not offer many advantages over their fully insured counterparts, they might still be more attractive to small firms than self-insuring through a MEWA.

Premiums for Traditional Insurance Plans

If firms with healthier-than-average employees switched from traditional insurance to AHPs and HealthMarts, premiums for some firms' traditional policies would rise. Moreover, that selection effect could be exacerbated by recently enacted federal requirements regarding the portability of insurance coverage. The Health Insurance Portability and Accountability Act of 1996 limits exclusions for preexisting conditions when purchasers of insurance switch from one policy to another. That provision could lead to the sorting of "healthy" and "sick" firms into AHP/HealthMart and traditional plans, respectively. For example, a firm with healthy employees (and thus relatively low expected health costs) might purchase a relatively inexpensive policy (covering few mandated benefits) in the AHP/HealthMart market. If one or

---

20. General Accounting Office, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*, GAO/HRD-92-40 (March 1992), p. 2.

21. Department of Labor, Pension and Welfare Benefits Administration, Office of Public Affairs, "Fact Sheet on MEWA Enforcement" (December 1998).

more of its employees subsequently developed a serious illness, the firm could switch back to a traditional plan to obtain a more comprehensive policy, and its employees would face no exclusion (or only a limited exclusion) for preexisting conditions.[22]

To discourage favorable-selection practices, the proposals covering AHPs and HealthMarts generally include requirements that would limit their ability to attract healthier-than-average groups. For example, AHPs would have to offer their plans to any small firm that qualified for membership in the sponsoring association. Similarly, HealthMarts would have to make their plans available to any small firm located in their designated geographic area. A further factor tempering favorable-selection efforts may be that increasingly aggressive attempts by AHPs and HealthMarts to attract low-cost firms would add to administrative costs. Moreover, premium-setting regulations would still apply.

Even if AHPs and HealthMarts were successful in attracting primarily low-cost firms, the resulting premium increases for traditional plans would be relatively small. High-cost firms would be a small minority of those firms retaining traditional coverage, even though some lower-cost firms would switch to less costly AHP or HealthMart options. The low-cost firms that continued to purchase traditional health insurance would cross-subsidize the higher-cost firms, just as they do now.

Coverage

How AHPs and HealthMarts affected coverage would depend on how small firms responded to changes in premiums and benefits and, more specifically, on the differential responses by low-cost and high-cost firms. The effect on coverage of reforms in the small-group market that were enacted by many states in the early 1990s—reforms that AHPs and HealthMarts would weaken—may provide some insight into the potential impact of the proposed new insurance vehicles. Although the reforms may have stabilized premiums and made health insurance more available in the small-group market, they may also have led to reduced coverage: between 1987 and 1996, enrollment of small-firm employees in employer-sponsored health insurance declined by about 3 to 4 percentage points.[23]

---

22. For a limited set of categories, federal portability regulations allow plans to impose limitations on coverage of preexisting conditions if a person's previous plan did not cover those conditions. The coverage categories are mental health, substance abuse treatment, prescription drugs, dental care, and vision care.

23. See Philip Cooper and Barbara Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, vol. 16, no. 6 (November/December 1997), p. 14.

New insurance laws—including benefit mandates and premium compression requirements—that raised premiums for low-cost firms in the small-group market probably contributed to that loss of coverage. Benefit mandates may have caused firms to pay for benefits that their employees did not value highly. When those mandates resulted in higher-priced insurance policies, some losses in coverage probably occurred. Premium compression requirements, which lead to low-cost firms cross-subsidizing the coverage of higher-cost firms, raise the cost of insurance for firms with healthier employees and lower it for firms with less healthy employees.[24] Some empirical studies suggest that because low-cost firms and their employees have less immediate need for health insurance, they may be more sensitive to price changes than high-cost firms and their employees (see the appendix). Consequently, the studies show that the number of employees in low-cost firms who dropped coverage when their premiums rose was greater than the number of employees in high-cost firms who gained coverage when their premiums fell.

The differential responses to changes in premiums by firms with different expected health care costs is key to understanding the net effect of AHPs and HealthMarts on coverage. AHPs and HealthMarts would weaken some of the effects of state premium reforms; as a result, some low-cost firms would gain access to lower premiums, but some high-cost firms would see their premiums rise.[25] If, indeed, high-cost firms respond less to price changes than do low-cost firms, the resulting net coverage loss among high-cost firms would probably be less than the net coverage gain among low-cost firms, so overall coverage levels would probably increase. In addition, the mandates exemption of the AHPs and HealthMarts would allow them to offer plans with fewer benefits and at a lower price than the traditional plans can offer. The new plans are likely to be particularly attractive to low-cost firms, which would encourage some firms and workers to add coverage.

---

24. Because premium compression requirements also effectively impose an upper limit on the price of policies sold to higher-cost groups, insurers may have responded by not aggressively marketing their plans to as many firms with relatively less healthy employees as they would have if they had been allowed to charge higher rates.

25. That statement would be true only in general. A number of low-cost firms might remain enrolled in traditional plans, even though some of them would face increased premiums as other low-cost firms switched to AHPs and HealthMarts. In addition, some high-cost firms might obtain access to an AHP or HealthMart with predominantly healthy firms, enabling the high-cost firms to pay lower premiums than they would have paid if they had purchased traditional coverage.

ESTIMATING THE EFFECTS OF AHPs AND HEALTHMARTS ON PREMIUMS AND COVERAGE

CBO constructed an analytical model to project how small firms and their employees would respond to the introduction of AHPs and HealthMarts. Two measures of the potential impact of those proposed new insurance arrangements are the net increase in the number of people covered by insurance and the increase in total premiums paid to insurers. The latter measure reflects both the additional people covered by insurance and the net overall changes in the value of benefits offered to people with coverage. Changes in coverage might accompany either an increase or decrease in the total premiums paid. The estimates reported here indicate the long-term changes in premiums and coverage that would occur after the market had fully adjusted to the introduction of AHPs and HealthMarts.

Main Findings

The model's main findings rely on assumptions that were developed from the results of empirical studies about how firms and employees respond to changes in premiums and insurance regulations (see the appendix for details). Under those assumptions, the introduction of AHPs and HealthMarts would increase net coverage through small firms by about 1.3 percent, or 330,000 people, including employees and their dependents (see Table 2). The increase in the overall number of people with insurance, however, would be slightly lower, because some of those who gained employer-sponsored coverage through AHPs and HealthMarts would have otherwise obtained coverage through the individual market. The 330,000 figure represents a net increase of about 340,000 enrollees among low-cost firms that would be slightly offset by a net drop of 10,000 people among higher-cost firms. (For these estimates, low-cost firms are those with expected claims costs per enrollee in the lower 90 percent of the distribution for all small firms.) Altogether, CBO estimates that about 4.6 million people would be insured through AHPs and HealthMarts, with most of those people switching from the fully regulated market to the new plans.

Once AHPs and HealthMarts were in full operation, total premiums paid annually by small firms and their employees would be approximately $150 million more than they otherwise would be, which represents about a 0.3 percent increase in total spending for health insurance in the small-group market (see Table 3). Firms that continued to purchase traditional health insurance plans would pay an additional $800 million in premiums. That increase would be more than offset by the $1.2 billion in net premium savings that would result because firms faced lower premiums in AHP and HealthMart plans. In addition, the net increase in coverage among low-cost firms would add $600 million in premiums; among higher-cost

TABLE 2. ESTIMATED EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON COVERAGE IN THE SMALL-GROUP HEALTH INSURANCE MARKET

	Number of Enrollees[a]
Coverage Under Current Law (Millions)	24.6
Changes When AHPs and HealthMarts Are in Full Operation	
Low-cost firms[b]	340,000
High-cost firms[c]	- 10,000
Total	330,000
Coverage When AHPs and HealthMarts Are in Full Operation (Millions)	
AHP or HealthMart plans	4.6
Traditional plans[d]	20.3
Total	24.9

SOURCE: Congressional Budget Office.

NOTE: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

a. Workers and their insured dependents. However, these figures exclude an estimated 1.3 million people who participate in self-insured employer-sponsored plans under current law.

b. Firms with expected health costs in the lower 90 percent of the cost distribution.

c. Firms with expected health costs in the upper 10 percent of the cost distribution.

d. Subject to full state regulation.

TABLE 3. ESTIMATED ANNUAL EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON TOTAL PREMIUMS IN THE SMALL-GROUP HEALTH INSURANCE MARKET

	Millions of Dollars
Total Premiums Under Current Law	50,400
Changes When AHPs and HealthMarts Are in Full Operation	
Premium savings from net enrollee movement to AHPs and HealthMarts	-1,200
Increased premiums for firms covered under traditional plans[a]	800
Net increase in coverage among low-cost firms[b]	600
Net decrease in coverage among high-cost firms[c]	-50
Total	150
Total Premiums When AHPs and HealthMarts Are in Full Operation	50,550

SOURCE: Congressional Budget Office.

NOTES: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

The term "enrollee" includes insured workers and their insured dependents but excludes an estimated 1.3 million people who participate in self-insured employer-sponsored plans under current law.

a. Traditional plans are subject to full state regulation.

b. Firms with expected health costs in the lower 90 percent of the distribution.

c. Firms with expected health costs in the upper 10 percent of the distribution.

firms, the increase in the price of traditional plans would lead to a cut of about $50 million worth of coverage.

The price of a policy would be lower for some firms as a result of introducing AHPs and HealthMarts. On average, premiums paid by firms that participated in AHPs and HealthMarts would be about 13 percent lower than the premiums they would pay in the small-group market under current law (see Table 4). Five percentage points of that reduction come from the benefit mandate exemption and savings from group purchasing (see the appendix). The other 8 percentage points stem from the expected health costs of firms in the AHP and

TABLE 4. ESTIMATED EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON AVERAGE PREMIUMS IN THE SMALL-GROUP HEALTH INSURANCE MARKET

	Percentage
Change in the Average Premium Paid by Firms That Participate in AHPs or HealthMarts	-13
Change in the Average Premium Paid by Firms That Retain Traditional Coverage[a]	2

SOURCE: Congressional Budget Office.

NOTES: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

Changes are calculated relative to premiums under current law.

a. Traditional coverage is subject to full state regulation.

HealthMart market that are generally lower than average and that allow participating firms to avoid some of the premium-boosting effects of rate compression laws.

Once AHPs and HealthMarts became available, firms that continued to purchase traditional plans would, on average, see some increases in their premiums arising from the shift of some low-cost firms to the new insurance vehicles. CBO's projections indicate a net transfer of approximately 4.3 million enrollees in low-cost firms from fully regulated plans to an AHP or HealthMart plan. Those transfers would cause premiums offered to firms with traditional coverage to rise, on average, by 2 percent. The increase is relatively small because low-cost firms would continue to be a substantial part of the market for traditional plans.

Findings Under Alternative Assumptions

To determine a plausible range of possible outcomes once AHPs and HealthMarts were introduced, CBO varied its assumptions about the behavioral responses of firms and employees (see the appendix). At one extreme, the model estimated that coverage through small firms would increase by only 10,000 enrollees. That figure is associated with a negligible increase in premiums for small firms purchasing traditional insurance and a 9 percent reduction in premiums for participants in AHPs and HealthMarts. At the upper end of the range, the model estimated that coverage could increase by as many as 2 million people. The accompanying changes in

premiums would be an increase of 2 percent for firms retaining traditional coverage and a reduction of 25 percent for firms participating in AHPs and HealthMarts. Under those alternative scenarios, the total number of enrollees in AHPs and HealthMarts ranges from less than 1 million to 5.7 million.

CONCLUSIONS

CBO projects that the introduction of AHPs and HealthMarts would have only slight effects on insurance coverage nationwide, increasing the number of people insured through small firms by about 330,000. Although about 4.6 million people would enroll in the new plans, the net boost in the number of people insured through small firms would be far smaller because many enrollees in the new plans would otherwise have been insured through traditional plans and because the increase in enrollees from some firms (those that gained coverage through AHPs and HealthMarts) would be offset by the decrease in enrollees from others (those that dropped their traditional coverage). Although coverage among small firms would grow by about 1.3 percent, total spending for health insurance would actually rise by only 0.3 percent, for two reasons: some coverage would be less comprehensive—because AHPs and HealthMarts are exempt from most state-mandated benefit requirements—and the mix of low-cost and high-cost firms with coverage would change.

If low-cost firms moved to AHPs and HealthMarts, some firms with traditional coverage would see their premiums rise because fewer low-cost firms would remain to cross-subsidize the high-cost firms. In response, some firms and workers covered under traditional plans would drop coverage, but most would continue to be covered and pay slightly higher premiums. After summing the changes in enrollment in both AHP/HealthMart and traditional plans, CBO estimates that, on balance, high-cost firms would drop coverage and low-cost firms would add coverage. Consequently, among firms that have coverage, the proportion of low-cost firms would increase, and the share of high-cost firms would decrease.

Among the states, the impact of AHPs and HealthMarts would probably be uneven because states differ in the extent and intensity of their regulations. States that have imposed relatively strict premium compression rules would be likely to attract more of the new plans than states that allow insurers to charge a wider range of premiums. The reason is that in states with more tightly compressed premiums—where the most cross-subsidization occurs—low-cost firms would face the greatest potential difference in price between traditional and AHP/HealthMart plans. Similarly, states with benefit mandates that are more costly or that cover benefits perceived as having little value to the average employee would be riper markets for AHPs and HealthMarts, as would areas with greater concentrations of small firms.

In addition to considering who would gain and who would lose under these proposed new insurance arrangements, policymakers must address issues of regulatory authority and solvency standards. Much uncertainty attends the overlapping of federal and state jurisdiction over AHPs and HealthMarts. States, for example, would exercise considerable regulatory authority over HealthMart plans—which could only be fully insured products offered by state-licensed insurers. But the Department of Health and Human Services would also be given regulatory authority over HealthMarts. States would have some authority over AHPs but might rely on the Department of Labor to oversee those plans—especially since self-insured AHPs would have to comply with federal solvency standards. How great a role the federal government or the states played in regulating the new entities would depend, in part, on the resources that the two designated federal oversight agencies devoted to that function.

APPENDIX: MODELING THE EFFECTS OF AHPs AND HEALTHMARTS

In modeling the effects on the small-group market of introducing association health plans and HealthMarts, the Congressional Budget Office based its analysis on legislation recently introduced in the Congress, although the analysis may not reflect the specific provisions of any particular bill. CBO's model took into account how benefit mandates affect insurance costs and how firms respond to changes in premiums. Its estimates of premiums are based on the expected insurance costs of participants in the small-group market after factoring in state regulatory rules that restrict the range of premiums an insurer can charge.

The analysis considered two regulatory environments. In the first, which follows current law, small firms purchase traditional, or fully state regulated, insurance plans. In the second, firms may either purchase an AHP or HealthMart plan or obtain traditional coverage. By comparing the outcomes under the two sets of circumstances, the model estimated how AHPs and HealthMarts would affect coverage and premiums among small firms.

Assumptions

To choose assumptions to feed into the model, CBO reviewed studies of the health insurance market and tabulations from available data files. The major assumptions used in modeling the effects of AHPs and HealthMarts covered the following areas:

- Savings achieved through exemption from state benefit mandates;
- Savings from group purchasing arrangements;
- Coverage changes in response to a change in the price of insurance;
- Insured firms' willingness to switch to less expensive, less comprehensive plans;
- Differences in insurance costs between firms with healthy employees and those with sicker employees; and
- Premium reductions in the AHP/HealthMart market from avoiding rate compression.

Savings Achieved Through Exemption from State Benefit Mandates. The main findings reported earlier were based on the assumption that AHPs and HealthMarts

would save 5 percent of insurance costs because of their exemption from state benefit mandates. CBO developed that assumption after analyzing empirical studies whose results imply a wide range of costs imposed by such requirements.

Some firms and employees will drop coverage when the price of an insurance policy rises. Therefore, studies of how mandates affect coverage will also yield some insight into how they affect costs. Gruber studied how state mandates influenced insurance coverage in firms of less than 100 employees and found that they had a negative but not statistically significant effect.[1] He estimated that states passing all five of the mandates he designated as expensive (which included mental health services and drug abuse treatment) would see coverage drop by 1.2 percentage points, measured from a base of 46.5 percent of workers with employer-sponsored insurance in firms with less than 100 workers. He also found that a 1 percent increase in the actuarial costs of mandated benefits reduced coverage by 0.17 percentage points. (Actuarial costs are the costs of the claims paid for those benefits.) As Gruber recognized, a reason for the small effects he found was that his measure of costs overstated the actual additional costs that a mandate law imposes on insurance plans because many plans would have covered some benefits even in the absence of a legal mandate.

Summarizing studies that examined several states, the General Accounting Office found that the actuarial costs of mandated benefits ranged from 5.4 percent to 22.0 percent of total claims costs.[2] But the potential savings from the mandates exemption are smaller than the actuarial costs of the required benefits to the extent that health plans would have covered those benefits anyway. To adjust the results of studies that looked at actuarial costs, CBO used data on the frequency with which a health plan covered certain benefits (those that fell under the mandates Gruber designated as expensive) even though the state in which the plan operated did not require such coverage. Those calculations suggest a range of 0.28 percent to 1.15 percent as the effective marginal cost of state mandates.

Compared with the evidence noted above, the work of other researchers indicates that mandates impose greater costs and exert much larger and statistically significant effects on coverage. Such studies suggest that firms' and workers' decisions about coverage are more sensitive to premiums than is typically assumed. For example, Marsteller and others found that a mandate to cover alcoholism or drug abuse treatments significantly reduced private insurance coverage by about 2.5

---

1. Jonathan Gruber, "State-Mandated Benefits and Employer-Provided Health Insurance," *Journal of Public Economics*, vol. 55 (1994), pp. 433-464.

2. General Accounting Office, *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance*, GAO/HEHS-96-161 (August 1996).

percentage points.[3] And Jensen and Gabel's study of small firms indicated that about one-fifth to two-fifths of firms not offering coverage would do so if state mandates were eliminated.[4] Sloan and Conover analyzed individual-level data gathered from multiple states over time and concluded that removing the average number of benefit mandates would increase coverage by 4 percentage points—a figure suggesting that the lack of coverage for between one-fifth and one-fourth of the uninsured is attributable to benefit mandates.[5] The findings from Jensen and Gabel and Sloan and Conover are consistent with either or both of the following statements: firms' and workers' decisions about coverage are more sensitive to premiums than is generally assumed, and the marginal cost of mandates could be 10 percent or more.[6]

Savings from Group Purchasing Arrangements. As discussed earlier, CBO assumed that cost savings arising from the group purchasing feature of AHPs and HealthMarts would be negligible. The work of Long and Marquis supports that assumption; they found no substantial evidence that joining a purchasing cooperative produced lower insurance costs for firms.[7]

Coverage Changes in Response to a Change in the Price of Insurance. Elasticity of demand is a way of gauging responsiveness to price changes. For the estimates presented in the text, CBO assumed that the overall elasticity of demand for insurance through small firms is -1.1, meaning that an increase of 1 percent in the price of insurance will reduce coverage by 1.1 percent. That elasticity is larger than many researchers would typically use in evaluating the health insurance market in general. Nevertheless, studies focusing on the insurance-purchasing behavior of small firms suggest that an elasticity of that size is reasonable and that compared

---

3. Jill A. Marsteller and others, *Variations in the Uninsured: State and County Level Analyses* (Washington, D.C.: Urban Institute, June 1998).

4. Gail A. Jensen and Jon R. Gabel, "State Mandated Benefits and the Small Firm's Decision to Offer Insurance," *Journal of Regulatory Economics*, vol. 4 (1992), pp. 379-404.

5. Frank A. Sloan and Christopher J. Conover, "Effects of State Reforms on Health Insurance Coverage of Adults," *Inquiry*, vol. 35 (Fall 1998), pp. 280-293.

6. Selecting the most "reasonable" assumption from among a wide range of empirical findings is not always an easy task. Yet models require such choices to produce estimates of effects. Other researchers besides CBO analysts have also had to make assumptions about the savings achieved through the exemption from state benefit mandates. In a recent study, for example, Blumberg, Nichols, and Liska developed a microsimulation model that required such an assumption. Like CBO, they reviewed the literature and chose to assume that AHPs and HealthMarts would save 5 percent as a result of the exemption. See Linda J. Blumberg, Len M. Nichols, and David Liska, *Choosing Employment-Based Health Insurance Arrangements: An Application of the Health Insurance Reform Simulation Model* (Washington, D.C.: Urban Institute, March 1999).

7. Stephen H. Long and M. Susan Marquis, "Pooled Purchasing: Who Are the Players?" *Health Affairs*, vol. 18, no. 4 (July/August 1999), pp. 105-111.

with large firms, small firms are significantly more responsive to changes in the price of insurance.

For example, Feldman and others analyzed decisions about coverage made by small firms in Minnesota and found elasticities that ranged from -3.9 to -5.8.[8] Blumberg, Nichols, and Liska used a more representative data set covering firms in 10 states and found that the smaller the firm, the greater its sensitivity to price.[9] They calculated elasticities of about -1.5 for firms with fewer than 10 workers. Jensen and Gabel studied losses in coverage as a result of mandates. On the basis of their findings, CBO estimated that if the costs to a firm for mandated benefits are 15 percent of premiums, then the elasticity of demand for coverage by small firms is about -1.8.[10] If mandates cost a firm less than 15 percent, the implication is that small firms are even more responsive to price changes than a -1.8 elasticity would indicate.

Studies that have examined the demand for health insurance more generally—that is, not restricting the analysis to small firms—have for the most part found less responsiveness. That viewpoint is illustrated by CBO's 1993 survey, which adopted an elasticity of -0.6.[11]

Insured Firms' Willingness to Switch to Less Expensive, Less Comprehensive Plans. CBO's model also required assumptions about the willingness of otherwise insured employees and employers to switch to less expensive, less comprehensive health benefits plans. For its main findings, CBO thus assumed that more than 20 percent of otherwise insured people would switch to an AHP or HealthMart plan in exchange for a premium reduction of 13 percent. High-cost firms and their employees were assumed to be only one-fourth as willing as low-cost firms to switch to a lower-priced but less comprehensive plan.

CBO considered the results of several empirical studies in developing its assumptions about this factor. For example, Buchmueller and Feldstein, who examined the willingness of employees to switch health plans in response to changes in premiums, found that a $10 increase in the monthly premium would cause about 26 percent of enrollees to switch to a less expensive plan, whereas an increase of

---

8. Roger Feldman and others, "The Effect of Premiums on the Small Firm's Decision to Offer Health Insurance," *Journal of Human Resources,* vol. 32, no. 4 (Fall 1997), pp. 637-658.

9. Blumberg, Nichols, and Liska, *Choosing Employment-Based Health Insurance Arrangements.*

10. Jensen and Gabel, "State Mandated Benefits."

11. Congressional Budget Office, *Behavioral Assumptions for Estimating the Effects of Health Care Proposals*, CBO Memorandum (November 1993).

$20 per month would cause about 30 percent to switch.[12] Those findings are consistent with an assumption that a price discount of 15 percent relative to the price of a more comprehensive plan would cause about 26 percent of policyholders to switch, whereas a 30 percent discount would cause about 30 percent to switch. Morrisey and Jensen focused on small firms switching from fee-for-service plans to managed care plans in response to premium changes.[13] They found that a change of 10 percent in premiums would cause an increase of only about 3 percentage points in the fraction of firms switching plans. In its model, CBO used Buchmueller and Feldstein's results for its central assumption, but analysts reduced those results by their statistical margin of error to reflect the overall range of findings in the literature.

Differences in Costs for Low- and High-Cost Firms. CBO designated firms as either low or high cost depending on their average expected health expenses. For the main findings reported in the text, CBO defined low-cost firms as those with expected costs per enrollee in the lower 90 percent of the distribution of expected health costs among small firms; high-cost firms were those with costs in the highest 10 percent. CBO further assumed that low-cost and high-cost firms would be segregated in the AHP/HealthMart market because AHPs and HealthMarts face less sweeping availability requirements than those confronting insurers offering traditional plans. CBO chose to divide firms at the 90th percentile because of the skewed nature of expected health costs—relatively few firms have unusually high expected costs. Since small firms with high expected costs stand out in the distribution much more than do firms with low expected costs (which tend to cluster together toward the bottom), AHPs and HealthMarts could probably avoid enrolling those few least-healthy (high-cost) groups, but they would have difficulty limiting their enrollment only to the healthiest groups. Moreover, AHPs and HealthMarts would face association-wide or geographic availability requirements that would limit the degree of favorable selection they could achieve.

Direct data on the distribution of expected costs among small firms were not available, but since premiums reflect expected costs, CBO used data on premiums to estimate the distribution. CBO drew premium data for small firms from the late 1980s; its estimates are consistent with the results from Cutler's 1994 study of the small-group market, which was based on data from the early 1990s.[14] The advantage of using data from the late 1980s or early 1990s is that they predate the

---

12. Thomas C. Buchmueller and Paul J. Feldstein, "The Effect of Price on Switching Among Health Plans," *Journal of Health Economics,* vol. 16 (1997), pp. 231-247.

13. Michael A. Morrisey and Gail A. Jensen, "Switching to Managed Care in the Small Employer Market," *Inquiry,* vol. 34 (Fall 1997), pp. 237-248.

14. David M. Cutler, *Market Failure in Small Group Health Insurance*, Working Paper 4879 (Cambridge, Mass.: National Bureau of Economic Research, October 1994).

widespread introduction of premium compression laws by the states (which reduce the variation in premiums relative to the variation in expected costs). More recent data on premiums would have reflected the laws' effects and would therefore be less accurate in indicating how expected costs were dispersed among firms. Under CBO's definitions of low- and high-cost firms, the data indicate that average annual expected health costs per enrollee would be $1,810 for low-cost firms and $4,200 for high-cost firms.

Premium Reductions in the AHP/HealthMart Market from Avoiding Rate Compression. Under the proposed legislation, AHPs and HealthMarts would face different availability rules than those applying to insurers offering traditional plans. As a result, low-cost firms purchasing coverage through AHPs and HealthMarts could obtain lower premiums (in addition to the reduction stemming from the benefit mandates exemption) because state premium compression rules would exert less of an upward effect. Premium compression laws differ among the states. To simplify the analysis, CBO assumed that on average, the state rules allowed premiums to vary around a 20 percent band. It also assumed that low-cost firms switching to AHPs or HealthMarts would pay premiums that reflected only the expected costs of low-cost firms.

Several studies have found that overall, premium compression rules decrease coverage. Marsteller and others found a decrease in private coverage of 1 percentage point when premium compression laws were imposed on the small-group market.[15] CBO estimated that the drop in coverage reported in the Marsteller study would translate into a loss of approximately 2.3 million enrollees (in 1999 population figures). Simon's study of insurance coverage using a nationally representative sample and the microsimulation study by Buchanan and Marquis also support the finding of a significant loss in coverage as a result of premium compression laws.[16] In contrast, Sloan and Conover found no significant effect on coverage in the small-group market.[17] Buchmueller and DiNardo found no effect on coverage but noted a switch from fee-for-service plans to managed care plans in response to premium compression rules.[18]

---

15. Marsteller and others, *Variations in the Uninsured.*

16. Kosali I. Simon, "Did Small-Group Health Insurance Reforms Work? Evidence from the March Current Population Survey, 1992-1997" (draft, Department of Economics, University of Maryland, March 1999); and Joan L. Buchanan and M. Susan Marquis, "Who Gains and Who Loses with Community Rating for Small Business?" *Inquiry*, vol. 36 (Spring 1999), pp. 30-43.

17. Sloan and Conover, "Effects of State Reforms on Health Insurance Coverage of Adults."

18. Thomas Buchmueller and John DiNardo, *Did Community Rating Induce an Adverse Selection Death Spiral? Evidence from New York, Pennsylvania, and Connecticut*, Working Paper 6872 (Cambridge, Mass.: National Bureau of Economic Research, January 1999).

A decrease in coverage stemming from premium compression laws can occur if low-cost firms and their employees, in deciding to buy coverage, are more sensitive to changes in premiums than are high-cost firms. On the basis of the above studies, CBO assumed for its main estimates that low-cost and high-cost firms have different elasticities of demand for coverage and, as a result, that prevailing rate compression laws are responsible for 1.7 million fewer people having health insurance.

Sensitivity of the Estimates to Alternative Assumptions

As the preceding discussion suggests, the range of estimates in the economics literature for some of the key assumptions in CBO's model is quite large. The findings from the model that are reported in the text are based on assumptions that tend to fall near the middle of those ranges. To test the sensitivity of CBO's estimates to those assumptions, analysts reestimated the model using plausible upper and lower bounds. (The parameters used in the alternative assumptions fall short of the most extreme estimates in the literature when those extremes are clearly unreasonable.)

CBO used the following ranges of alternative assumptions in testing the model's sensitivity:

- Savings achieved through exemption from state benefit mandates—1 percent to 15 percent of premiums;

- Coverage changes in response to a change in the price of insurance —elasticities of -0.6 to -1.8;

- Insured firms' willingness to switch to less expensive, less comprehensive coverage:

  - For the lower bound, about 3 percent of otherwise insured employees would switch for a 10 percent reduction in price;

  - For the upper bound, about 28 percent would switch in response to a 25 percent savings in premiums; and

- Degree of favorable selection in the AHP/HealthMart market (which relates to cost differences between firms with healthy employees and sicker employees and to reductions in premiums from avoiding rate compression):

- For the lower bound, AHPs and HealthMarts would avoid enrolling firms with expected costs in the top 10 percent of the expected cost distribution of small firms (this is the assumption CBO used to generate the model's main findings, discussed earlier); and

- For the upper bound, AHPs and HealthMarts could avoid enrolling firms with expected costs in the top 20 percent of the cost distribution.

For all estimates, CBO maintained the assumption of no net savings arising from the economies of group purchasing.

Lower-Bound Estimates. Establishing AHPs and HealthMarts would have a minimal impact on coverage and premiums under the following conditions: the potential for mandate savings is small, AHPs and HealthMarts can achieve only modest favorable-selection effects, rate compression laws have no effect on coverage, and firms are minimally responsive to changes in premiums and unwilling for the most part to switch to less expensive, less comprehensive coverage. In those circumstances, the net increase in coverage among low-cost firms would be small (representing an increase of about 10,000 enrollees), and relatively few firms (representing 700,000 enrollees) would be covered through AHPs or HealthMarts, despite the somewhat lower premium costs (see Table A-1). Total premiums paid by small firms would decrease only slightly because the number of people covered by insurance would change very little (see Table A-2). For people who already had coverage, the net effect on total premiums would be only a slight drop because some people would switch to coverage that omitted some mandated benefits. Average premiums for firms that participated in the new AHP/HealthMart market would be only 9 percent lower than they would have been for traditional coverage in the absence of any regulatory changes (see Table A-3). Premiums for firms that retained traditional coverage would increase by less than 0.5 percent.

Upper-Bound Estimates. AHPs and HealthMarts would have the largest effects in the following circumstances: the potential for mandate savings is great, AHPs and HealthMarts are able to achieve a substantial degree of favorable selection, and firms respond strongly to changes in premiums and are more willing to switch to less expensive, less comprehensive coverage. Under those assumptions, coverage in the small-group market would increase by almost 8 percent (about 2 million people), with low-cost firms adding about 2.1 million people to coverage and high-cost firms reducing coverage by about 100,000. In that case, total premiums paid by small firms and their employees would increase by about $1.8 billion, or about 3.6 percent. That relatively large increase occurs because this scenario is based on assumptions that give an upper-bound increase in coverage. The almost $3.1 billion in total premiums paid for employees and their dependents who become covered by an

employer-sponsored plan exceeds the reductions that would occur as some high-cost groups dropped coverage and some firms and enrollees that were already covered switched to the new, lower-priced plans. The price of a policy for firms desiring traditional coverage would increase by 2 percent, and firms switching to the AHP/HealthMart market would pay premiums that were 25 percent lower than they would otherwise have been.

TABLE A-1. ESTIMATED LOWER AND UPPER BOUNDS OF EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON COVERAGE IN THE SMALL-GROUP HEALTH INSURANCE MARKET

	Number of Enrollees[a]	
	Lower-Bound Effect	Upper-Bound Effect
Coverage Under Current Law (Millions)	24.6	24.6
Changes When AHPs and HealthMarts Are in Full Operation		
Low-cost firms[b]	10,000	2,130,000
High-cost firms[c]	d	-100,000
Total	10,000	2,030,000
Coverage When AHPs and HealthMarts Are in Full Operation (Millions)		
AHP or HealthMart plans	0.7	5.7
Traditional plans[e]	23.9	20.9
Total	24.6	26.6

SOURCE: Congressional Budget Office.

NOTE: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

a. Workers and their insured dependents. However, these figures exclude an estimated 1.3 million people who participate in self-insured employer-sponsored plans under current law.

b. For the lower-bound effect, low-cost firms are those with expected health costs in the lower 90 percent of the cost distribution. For the upper-bound effect, low-cost firms are those in the lower 80 percent.

c. For the lower-bound effect, high-cost firms are those with expected health costs in the upper 10 percent of the cost distribution. For the upper-bound effect, high-cost firms are those in the upper 20 percent.

d. Decrease of less than 5,000.

e. Subject to full state regulation.

TABLE A-2. ESTIMATED LOWER AND UPPER BOUNDS OF ANNUAL EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON TOTAL PREMIUMS IN THE SMALL-GROUP HEALTH INSURANCE MARKET

	Millions of Dollars	
	Lower-Bound Effect	Upper-Bound Effect
Total Premiums Under Current Law	50,400	50,400
Changes When AHPs and HealthMarts Are in Full Operation		
Premium savings from net enrollee movement to AHPs and HealthMarts	-100	-1,900
Increased premiums for firms covered under traditional plans[a]	100	900
Net increase in coverage among low-cost firms[b]	c	3,050
Net decrease in coverage among high-cost firms[d]	e	-250
Total	e	1,800
Total Premiums When AHPs and HealthMarts Are in Full Operation	50,400	52,200

SOURCE: Congressional Budget Office.

NOTES: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

The term "enrollee" includes workers and their insured dependents but excludes an estimated 1.3 million people who participate in self-insured employer-sponsored plans under current law.

a. Traditional plans are subject to full state regulation.

b. For the lower-bound effect, low-cost firms are those with expected health costs in the lower 90 percent of the cost distribution. For the upper-bound effect, low-cost firms are those in the lower 80 percent.

c. Increase of less than $25 million.

d. For the lower-bound effect, high-cost firms are those with expected health costs in the upper 10 percent of the cost distribution. For the upper-bound effect, high-cost firms are those in the upper 20 percent.

e. Decrease of less than $25 million.

TABLE A-3. ESTIMATED LOWER AND UPPER BOUNDS OF EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON AVERAGE PREMIUMS IN THE SMALL-GROUP HEALTH INSURANCE MARKET

	Percentage	
	Lower-Bound Effect	Upper-Bound Effect
Change in the Average Premium Paid by Firms That Participate in AHPs or HealthMarts	-9	-25
Change in the Average Premium Paid by Firms That Retain Traditional Coverage[a]	b	2

SOURCE: Congressional Budget Office.

NOTES: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

Changes are calculated relative to premiums under current law.

a. Traditional coverage is subject to full state regulation.

b. Increase of less than 0.5 percent.