SMALL BUSINESS ACCESS AND ALTERNATIVES TO HEALTH CARE

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HOUSE OF REPRESENTATIVES

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CONTENTS

WITNESSES

	Page
Talent, The Hon. Jim, U.S. Senate	4
Fletcher, Hon. Ernie, U.S. House of Representatives	6
Chao, The Hon. Elaine, Secretary, U.S. Department of Labor	8
Barreto, The Hon. Hector, Administrator, Small Business Administration	23
Trotter, Skip, National Federation of Independent Business	31
Hartnedy, John, Arkansas Department of Insurance	33
Hughes, Robert, National Association of the Self-Employed	35
Appel, Steve, American Farm Bureau	37
Kerrigan, Karen, Small Business Survival Committee	38
Alford, Harry C., National Black Chamber of Commerce	40

APPENDIX

Opening statements:	
Manzullo, Hon. Donald A.	47
Velazquez, Hon. Nydia M.	50
Prepared statements:	
Talent, Hon. Jim	53
Fletcher, Hon. Ernie	58
Chao, Hon. Elaine	60
Baretto, Hon. Hector	75
Trotter, Skip	80
Hartnedy, John	86
Hughes, Robert	91
Appel, Steve	99
Kerrigan, Karen	103
Alford, Harry C.	111
Women Impacting Public Policy	115
National Restaurant Association	120
U.S. Chamber of Commerce	123
Snowe, Hon. Olympia	128
King, Hon. Steve	133
National Small Business United	135
Small Business Association of Michigan	144
Ashmus, Keith	155

SMALL BUSINESS ACCESS AND ALTERNATIVES TO HEALTH CARE

WEDNESDAY, MARCH 5, 2003

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Washington, D.C.

The Committee met, pursuant to call, at 2:20 p.m., in Room 2360, Rayburn House Office Building, Hon. Donald A. Manzullo [chair of the Committee] presiding. Present: Representatives Manzullo, Bartlett, Graves, Schrock, Akin, Capito, Franks, Beauprez, Chocola, Velazquez, Udall, Ballance, Faleomavaega, Christensen, Case and Bordallo.

Chairman MANZULLO. Good afternoon. It is my pleasure to welcome everyone to today's Small Business Committee hearing, the critical issue of small business access and alternatives to health care. I am pleased to have our colleague Dr. Fletcher discuss this bill, H.R. 660, before our committee. Additionally, we want to extend a very warm welcome to the former chairman of this Committee who now resides in the other place, Senator Jim Talent. It is a great privilege to have Secretary Chao before this committee. I always look forward to hearing from our SB Administrator Hector Barreto, as well as our other witnesses.

Improving access and affordability to health care is one of the priorities for this committee. Year after year small business owners rate access and affordability of health care as the most important issue facing them. Of the 43 million Americans with no health insurance, 60 percent are small entrepreneurs, their families and their employees.

Affordability is always the major concern for small employers and the self-employed. High health care costs are one of the biggest expenses small businesses and the self-employed incur as they struggle to provide coverage for their employees.

As Congress continues to examine our Nation's health care problems, we need to remember that 60 percent of the estimated 43 million uninsured are small business owners, their employees and families.

Small business owners are unable to absorb spiralling health care costs and find themselves priced out of the health insurance market. Many owners are faced with the choice of staying in business or providing their employees with insurance. My brother was nearly driven to close the doors of our family restaurant because of exorbitant costs of health care insurance.

Our current health care system does not provide equal access to affordability and quality of health care for small businesses. One

of the reasons small businesses cannot afford health coverage for their employees is they are unable to achieve the economies of scale and purchasing power of larger corporations and unions. Small businesses suffer from unequal treatment. What they want most is a level playing field when it comes to health care. Large corporations use the purchasing power of thousands of employees to offer affordable health insurance to their workers. Small business owners, on the other hand, have to find their insurance on an individual basis, making it very difficult and expensive to find affordable health coverage.

I was heartened to see President Bush's plan for helping small businesses prosper in our community. The President is well aware of health care access and affordability problems facing small businesses, and his plan includes concrete steps to increase health security for employees of small businesses. His agenda calls for association health plans, AHPs, to be available for associations that want to provide health coverage for their members.

I look forward to the testimony of the witnesses here this afternoon, and on cue Senator Talent walked in, but first we want to have an opening statement from my colleague, the Ranking Member Ms. Velazquez from New York.

Ms. VELAZQUEZ. Thank you, Mr. Chairman.

Today we are facing a health care crisis. It is outstanding that in the United States, the only remaining superpower, the country with the largest GNP and the world's economic driver, there are 44 million Americans who cannot afford health care. That is outrageous. Nowhere is this health care gap more striking than in our Nation's small businesses. More than 60 percent of the 33 million adults and 11 million children without health insurance are small business owners, their employees or their families.

Small businesses bear the brunt of the health insurance crisis because of the two Cs, choice and cost. These are the two things that keep affordable quality health care out of reach for small businesses. Small employers face few options when it comes to health insurers and benefits. The market has become so skewed that in many parts of the country, small businesses have only one or two providers to choose from when trying to meet the health care needs of themselves and their employees. In fact, a recent report by the SBA's Office of Advocacy revealed insurers of small health plans have a higher administrative burden than those that insure large companies. These high administrative costs drive down the number of small health plan insurers, narrowing the field even more and giving small business less choice than they already have.

Cost is another barrier. Many small businesses are simply unable to afford health insurance. Those that can, the premiums increased 15 percent in 2002. Year after year, we see double-digit spikes in insurance costs, causing small firms to drop coverage. For example, coverage rates for firms with fewer than 50 employees are below 50 percent, while coverage rates for large employers are almost 90 percent. Once again, it is big business that wins and small business that loses. Small businesses that can afford health care pay as much as 30 percent more for policies similar to those offered by large corporations. While corporate giants can marshal accounts worth thousands of new customers and can negotiate health pre-

miums on their own terms, small businesses are left with a take-it-or-leave-it attitude from insurers.

As the state of health care for small business reaches a critical stage, President Bush should be paying attention to it, but he isn't. The President certainly knows how to talk the talk. Health care was on his small business agenda released a year ago this month, but today we have seen no real action.

One solution that could go a long way is allowing small businesses to band together through association health plans. AHPs will enable small businesses to harness the purchasing power while bringing equity to the insurance market. This is what we allow corporate America to do, and if it is good enough for corporate America, then it should be good enough for small businesses.

While it is important to help small businesses, it is critical that the price we pay is not with diminished employees' health care. That is why for AHPs to work we must have strong solvency requirements, adequate enforcement dollars and a system that does not discriminate based on health care needs. These protections, coupled with increased access and cost savings, will begin to turn the tide for the small business uninsured.

I want to take a moment to commend former House Small Business Committee Chairman, Senator Jim Talent for his leadership on this issue. Mr. Dooley, Mr. Fletcher and Mr. Johnson, working together we recently introduced AHP legislation, H.R. 660, the Small Business Health Fairness Act, which will go a long way in helping small businesses.

Small businesses, like health plans, come in all sizes and span industry sectors. There are private and self-insurance plans, State-sponsored imperatives and now AHPs. AHPs alone will not solve all the health care dilemmas of small business, but in combination with other alternatives, they can provide small businesses with two things they have not had before, more choice and lower costs.

Nowadays when I talk to small businesses, their top concern is health care. We need to stop talking about the health care crisis facing small businesses and start doing something about it. Large corporations shed jobs and wreak havoc during times of recession, yet they have access to quality affordable health care. On the other hand, small businesses are the backbone of our economy. They create 75 percent of all new jobs and make up a large percentage of individuals in the United States who do not have health coverage. Something is wrong with this picture. It is backwards, and I want to do something about it. I look forward to working with you all. Thank you.

Chairman MANZULLO. Thank you very much.

You notice the bipartisan endorsement of the AHPs.

Our first witness is—it is Senator Jim Talent. I guess your first name is still the same. You guys are pointing at each other. We are done voting in the House, so I will let the Senate go first. How does that sound?

Senator TALENT. Mr. Chairman, it is certainly up to you, and I would be more than happy to go first.

Chairman MANZULLO. Anyway. Senator Talent is the former Chair of this committee. He got AHPs through the House 2 years ago, and during the course of your testifying, Senator Talent, if you

could discuss why BlueCross/BlueShield and other insurance companies have opposed AHP legislation, I would appreciate that.

Senator TALENT. Okay. Sure.

Chairman MANZULLO. I look forward to your testimony.

STATEMENT OF HON. JIM TALENT, A UNITED STATES SENATOR FROM THE STATE OF MISSOURI

Senator TALENT. I usually cover that point at some point, Mr. Chairman. I am happy to go first, and I want to recognize my friend and colleague Mr. Fletcher whose actions on this bill have been no less heroic for several years now, and certainly one of the best things on working on this bill now is the opportunity to work with him and with you, Mr. Chairman, and also my old friend and colleague on the committee, Ms. Velazquez, whose just courage and vision in fighting for small business continues to amaze me. And I am grateful to you, Mr. Chairman, and to her for giving me a few minutes just to testify about this idea, which a whole lot of us, including many on this committee, have worked on for so long, because it makes such common sense, and it will have such an impact on the people who run small businesses and the people who work for small businesses, and that is what this committee is about.

You know, I said about this recently that it is not a revolutionary idea philosophically, but its impact is going to be revolutionary on small business, and the way to think of it is simply to allow small business people to get health insurance on the same terms as the big companies already can. So, in effect, the people that are concerned about how this is going to operate can just look at the models of how it is operating among the Fortune 500 companies. That is how this is going to operate. They are going to—people are going to get health insurance through their trade and professional associations, and with all the advantages, the economies of scale, the purchasing power, the diminished administrative costs, all of that, the increased competition, that will reduce the cost of health insurance, and so it will mean more people are insured.

And you all know that—well, the estimates vary, but about two-thirds of the people who are uninsured in the country are people who work for small business or are dependents of somebody who work for small business, in some cases people who own the small business, and everybody on this committee has visited people in this situation. I did a tour last year of small businesses, and it was interesting, the number one issue over and over and over and over again is the rising cost of health care. It is hurting them. It is hurting their employees. It is hurting their ability to retain good employees. It is taking money away that they want to put into wage increases. It is taking money away that they want to put into expanding the businesses, and because it is so unpredictable, it is demoralizing them as well. They don't know what the costs are going to be a year from now or 2 years from now or whether they will be able to get it if somebody in the business has a health care episode and, heaven forbid, has to use the health insurance for some major problem. And association health plans are the answer to that.

So the way it would work if we pass this enabling legislation is that big trade associations, you know, could be the Chamber of Commerce, it could be the Farm Bureau, whomever, would sponsor—would have a human—or a health benefit side, an employee benefit side like a big company does, and they would contract with big insurance companies or networks and probably have a self-insured side as well.

The bill has, as you know, Mr. Chairman, very strict solvency requirements, reserve requirements. The Ranking Member mentioned this and how important it is. We have worked on this over the years. They will to have set aside substantial reserves, have specific stop loss insurance for specific claims and aggregate stop loss insurance for aggregate claims. The Department of Labor is going to be given authority to regulate and can increase those if they believe that it is necessary.

And then if you join the trade association, the trade association has to offer you the health insurance, and on the same terms in which they offer any other group. They must offer, must carry. And you would be able to get health insurance like you were a little division of a big company. It would be just like a big company came in and bought you out.

So my brother runs a tavern. Many of you on the committee know that because I always talk about it. It would be like he was bought out by some national chain of taverns, and he would be able to get health insurance, and it would cut his costs by 10 to 20 percent. This wouldn't cost the taxpayers anything, which is kind of important right now when we are dealing with this deficit.

So why are people opposed to it? Mr. Chairman, I like to give people the benefit of the doubt. I don't think, though, that we have to turn a blind eye to the fact that BlueCross/BlueShield is a player in the small group market now, and in many cases they don't have any competition. And, of course, one can believe that they are here because they have some neutral interest in good health care policy, and it is not going to affect them at all one way or the other. But I think they are going to lose business if we pass association health plans. I have said for years the fact that BlueCross/BlueShield is so strongly opposed to this is one of the strongest signs that it is going to work. I mean, if they thought nobody is going to join these things, that it wouldn't offer lower cost health insurance and at better quality to people, why would they care?

So that is I think what is at the bottom—now, other people have raised concerns which we have tried to address over the years. The reserve requirement, the solvency requirements that the Ranking Member mentioned are a chief one, and I for my part—and we have the bill sponsor—I am willing to continue to work with people provided that they are acting in good faith, as long as what they are trying not to do is make the thing so burdensome that no one can actually set one up. That far I won't go.

So I appreciate the chance to be here. I am optimistic about our ability to pass this bill this year. You all have done yeoman's work in the House and on a bipartisan basis, and I am continuing to talk with Senators on both sides of the aisle and look forward to getting something done for small business. And I thank you, Mr. Chairman.

[Senator Talent's statement may be found in the appendix.]

Chairman MANZULLO. Thank you very much.

Maybe we could have a field hearing in your brother's tavern sometime. People won't remember what happened, and they won't care either.

Our next witness is Doctor, Congressman Ernie Fletcher, a good friend of mine, a tremendous Congressman, has done a great job for the people that he represents, a yeoman's job for the Nation in spearheading the efforts in the House on AHPs, and we look forward to your testimony.

STATEMENT OF HON. ERNIE FLETCHER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KENTUCKY

Mr. FLETCHER. Well, thank you, Mr. Chairman. I want to thank you and the Ranking Member for holding this hearing on this very important piece of legislation. Certainly I want to thank Senator Talent, who passed this baton to me when he left the House as an effort that has been ongoing for a number of years.

Chairman, one of the greatest assets to our American economy is the growth and expansion of small business. In many instances they are an economic engine for this Nation and the first to feel the effects of rising health care costs. One of the highest costs for any small business is providing health care benefits to their employees.

It is sad in a Nation of such innovation and prosperity, so many small business owners and their employers are left without the comfort and security of affordable, accessible quality health care. Currently 41 million Americans lack health insurance; 85 percent of those are from working families. However, the health care crisis for small businesses and their employees is even more bleak. Consider that 98 percent of large businesses, those employing over 100 employees, offer health insurance, while less than half of small businesses are able to offer this important benefit.

The best patient protection is access to affordable health care and health benefit options. However, affordable health care coverage is becoming a larger burden and financial strain for most small business owners in America.

As a family physician and former health care executive, I understand the pressures small businesses face. I have introduced H.R. 660, the Small Business Health Fairness Act of 2003, to ensure the basic right of health care security is extended to all workers, whether you work for an international conglomerate or the local hardware store.

H.R. 660 can reduce the high cost of health insurance for small businesses and the self-employed. An essential part of the solution is to allow small businesses across the country to pull together and access health insurance through a membership with bona fide trade or professional associations.

Only through AHPs operating under a uniform set of rules can small business workers obtain the same economies of scale, bargaining power and benefit design choices now available to workers in large corporations and labor unions. The Small Business Health Fairness Act will decrease the number of uninsured Americans, reduce health insurance costs by 15 to 30 percent, provide new cov-

erage options for self-employed like farmers and small business workers across there Nation, put forth tough new solvency standards to protect patients' rights and ensure benefits are paid, promote greater competition and choice in the health insurance markets.

AHP legislation will offer employer and employees more options in health care benefits as well as expanding access and choice for working families employed in small businesses. Experts estimate that up to 8.5 million uninsured small business workers could gain health insurance if AHP legislation is enacted.

Established trade and professional associations are uniquely structured to serve small employers and their workers by providing health benefits that meet their members' needs. In addition, AHPs will strengthen health insurance markets by creating greater competition, which is severely lacking in the current marketplace. A recent GAO report shows that the 5 largest insurance companies combined have 75 percent or more of the market share in 19 of 34 States supplying information, and more than 90 percent in 7 of those States. Greater competition will benefit the consumers by bringing premiums down and expanding access to coverage.

Opponents of this legislation will continue to proclaim that the U.S. Department of Labor is unable—or unprepared to handle such a program. Such statements are baseless and contradictory to the record of facts. The DOL currently administers protection covering 2.5 million private job-based health plans. Those programs serve 131 million workers, retirees and their families; 67 million individuals are in the self-insured plans that are monitored exclusively under DOL oversight. The facts clearly show that DOL has the expertise, the personnel and the vision to incorporate AHP legislation into the health insurance system immediately.

President Bush recently commented that AHPs are a critically important component to guarantee retirement and health security for all Americans. Congress and President Bush have an opportunity to make health insurance affordable for millions of small business workers by enacting legislation to bring Fortune 500 health benefits to the Nation's small business workers on Main Street through association health plans this year.

The President is ready for AHPs. The Department of Labor is ready. Small businesses, farmers and the self-employed are ready for AHPs. Uninsured Americans have already waited far too long for this basic right. Passing association health plan legislation will help to address this inequity and provide more Americans access to affordable, accessible quality health care through associations and small businesses.

I want to thank the Small Business Committee's leadership in moving this important legislation through Committee and to the House floor in an expeditious fashion. We hope that you are able to do that.

[Representative Fletcher's statement may be found in the appendix.]

Chairman MANZULLO. Thank you very much.

We have been advised that Secretary Chao has arrived, and I hope it is okay with the Members here that we forego the questions to the Congressman and the Senator in order to accommodate her

schedule. We want to thank you for your testimony. We will work—Jim, you got it through the House when you were here. So we believe we have the votes this time, and now we have to count on you to get it through the Senate.

Senator TALENT. Mr. Chairman, I thank you so much for that, but I do want to say that it was a very strong bipartisan effort, and I think we can all—and this committee—emanating largely out of this committee is what got it done, and I am hopeful of replicating the same thing in the Senate.

Chairman MANZULLO. That is great. Thank you for testifying.

The next witness will be the Secretary of Labor, who herself can answer those questions, when people say can a Secretary of Labor administer AHPs. And the order we are going to take because of her pretty difficult schedule is the Secretary will testify, Members will have an opportunity to ask questions, and then Administrator Barreto will testify. Okay?

Secretary, we look forward to your testimony, and thank you for coming today

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

Secretary CHAO. Not at all. Thank you, Mr. Chairman, and Ranking Member Velazquez and members of the committee. I have a formal statement which I would like to submit for the record.

Chairman MANZULLO. All the statements will be admitted for the record. And, Madam Secretary, could you pull the mike a little bit closer to you? Thank you.

Secretary CHAO. Thank you very much for providing this opportunity to discuss the President's agenda for giving Americans more access to quality affordable health care, specifically through the association health plans. As you know, more than 41 million working Americans—41 million Americans lack health insurance, and 85 percent of the uninsured are in working families. The President has proposed a comprehensive solution to the problems of high health care costs and lack of access. These proposals include making medical savings accounts more widely available, medical malpractice reform, individual tax credits and association health plans, also known, as you all know, as AHPs.

In my view the Small Business Committee is an ideal forum to discuss these issues and how to expand health care coverage. The sector that represents the ripest opportunities for making a real difference is small business, because right now those who work in small business with fewer than 100 employees make up 60 percent of the working uninsured.

Many small employers tell us that they want to provide health care insurance for their employees. Cost is a major factor, but there are also legal barriers, market barriers and the threat of fraud. All these hurdles prevent many small employers from being able to take care of their workers the way they would like, and rising health care insurance costs are also a significant barrier for employers to hire workers and keep their businesses afloat.

According to a recent Conference Board poll, health insurance costs were the greatest impediments to adding workers in the past 2 years. Soaring health insurance premiums are a different threat

to our efforts to expand the economy. As I said, cost is not the only hurdle, but it is probably the most significant. Small company premiums are about 20 to 30 percent higher than those of large, self-insured companies. That is because small businesses have got to take on the significant administrative overhead costs when they decide to offer health coverage and bear the cost of insurance company marketing and also underwriting expenses.

State benefit Band-Aids also make coverage more costly for the small group market, and small businesses are especially vulnerable to insurance fraud, which drives up the cost for everyone and robs the small employers of the funds that they could otherwise use to pay for stable, reliable coverage.

How AHPs help small business extend health coverage is the subject of our hearing today, especially to uninsured workers. According to CBO, the average savings on health insurance premiums would be at least 9 percent and could be as much as 25 percent per employer. As a result, CBO estimates that as many as 2 million additional American workers and their families could obtain health insurance through AHPs.

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

Under AHPs, small businesses would enjoy greater bargaining power, economies of scale, administrative efficiencies, as well as the benefits of a uniform Federal regulatory structure. By banding together, AHPs could give small employers many of the economic and legal advantages currently enjoyed by only the very largest of employers and union plants.

In order for AHPs to cover as many small businesses and their workers as possible, strong rules must be in place. To ensure coverage of all workers regardless of health status, insurance will be affordable for all workers if AHPs include individuals with a broad range of risks.

The AHP legislation contains numerous provisions to prevent cherry-picking, including a prohibition against excluding high-risk individuals or employers from participation. The Department will work with the committee to make sure that this bill has tough and effective provisions against cherry-picking.

To combat fraud AHPs will have to meet Federal certification standards and comply with the Department's ongoing oversight. These requirements will give small businesses, employers and employees confidence that we have carefully vetted AHP providers so that they have some assurance that they are not at the mercy of some fly-by-night operator. AHPs will also give small businesses the benefit of a uniform oversight system instead of having to comply with 50 different sets of State regulations.

Like other health benefit plans, AHPs must abide by the stripped fiduciary requirements of ERISA which the Department of Labor administers. Further, they will have to provide the full range of benefits in a number of Federal health care statutes such as HIPAA. AHPs have got to also comply with COBRA, mental health

parity, Women's Health and Cancer Rights Act, Newborns' and Mothers' Health Protection Act.

Workers with AHP health benefits would enjoy both Federal and State consumer protections. For AHPs that offer fully insured coverage, State insurance commissioners will be responsible for the solvency of the insurance company issuing the policy, just as they are responsible for insurance policies issued to fully insured group plans today.

AHPs that offer self-insured coverage will be subject to a single Federal oversight system in which standards of certification, solvency and ongoing oversight would be set and administered by the Department of Labor.

Many people may be interested to know that the Department of Labor currently administers ERISA protections for approximately 2.5 million private job-based health plans, which cover 131 million workers, retirees and their families. Of these, 67 million individuals are in self-insured plans that are subject exclusively to the Department's oversight.

In addition, the Department also protects exclusively an additional 5 million workers who are in union-sponsored multiemployer plans. In fact, employer-provided health insurance pays for more health care in America than Medicare and Medicaid combined.

At the Department of Labor we are engaged in aggressive efforts to combat health insurance fraud. Despite jurisdictional uncertainty, the Department, in conjunction with the State insurance commissioners, has been reasonably effective by shutting down scam artists who offer false health care plans and recover money for victimized workers.

In addition to enforcement—and I will end up soon—we provide a great deal of information to employers to help them manage their health plans. Recently we released a new Website containing warning signs for small businesses to watch out for coverage that seems too good to be true.

Finally, the Department recently announced a new compliance assistance program to help employers and health plans successfully implement Federal health care laws.

These are a few of the examples of the efforts that this Department commits to ensuring effective regulation, implementation and enforcement of Federal health laws.

I will be happy to answer any of the committee's questions and look forward to working with you on this very important issue.

[Secretary Chao's statement may be found in the appendix.]

Chairman MANZULLO. Thank you, Madam Secretary, for your testimony.

Ms. Velazquez. We are going to keep the 5-minute clock.

Ms. VELAZQUEZ. Thank you, Mr. Chairman.

Before I proceed, I would like to introduce our newest Member, the gentleman from American Samoa, Mr. Faleomavaega. Welcome.

Secretary Chao, thank you for coming before this committee today in such an important issue for small businesses. I am glad to hear that the administration is supporting AHPs, and I am sure that you are aware the President—he ran and included this issue when he campaigned for President to support such legislation on behalf of small businesses, and he also included this a year ago this

month in his small business agenda, but we haven't seen much action. A year later we have not enacted this legislation. I would like to know what steps the administration is prepared to take to help move this legislation forward.

Secretary CHAO. Congresswoman, I am delighted to hear that this committee is interested in this issue. I want to thank you for your leadership on supporting association health plans as well.

We would be willing to implement this law if it were enacted last year, and so we are very anxious that this bill move forward. We agree very much in principle with what this bill puts forward, and as I mentioned before, I am more than willing, as is the rest of my Department, to work with this committee and others on making association health plans a reality.

Ms. VELAZQUEZ. Do you think the President will meet with a bipartisan group of senior members from the Education and Labor Committee and with both Republican and Democratic Senators?

Secretary CHAO. I can promise for myself I will be more than willing to meet with both of——.

Ms. VELAZQUEZ. Would you talk to him and tell him that this is an important issue for small businesses?

Secretary CHAO. He is very much in support of it, and I think it is important to point out that Congress plays a very large role in this, of course, and we hope that Congress will act quickly on this.

Ms. VELAZQUEZ. It is important. I know that we are the one who vote on legislation, but if the President is totally behind it, and he approached and asked and sent a message here to the leadership, I am sure that we will bring it to the floor for a vote and will not include it in any type of legislation that is controversial, and that then it will be the end of the legislation.

Secretary CHAO. Well, we look forward to your leadership on that, too.

Ms. VELAZQUEZ. Thank you.

I am glad to hear you mentioned enforcement in your testimony, because in order for AHPs to work, it will take stringent oversight on the part of the Department of Labor.

In your testimony, you state that the DOL will devote significant resources for enforcement. How much is in your fiscal year 2004 budget request for enforcement, and how does that compare to the last 3 years?

Secretary CHAO. Well, as I mentioned, we already administer ERISA, which taken by itself oversees more health care plans than Medicaid and Medicare combined. So ERISA is a huge oversight responsibility. It is a law that was passed in 1974, and it oversees all employer-based health plans and benefits.

We currently, as I mentioned, have approximately oversight over 1.2 million plans and 67—over 125 million workers, including 67 private plans. We have the resources, and I am confident that if we do not, we will get the necessary resources.

Ms. VELAZQUEZ. Well, the reason I asked is that one of the big factors that the last administration emphasized in expressing their concerns about AHPs was that the Department of Labor will only be able to oversee each AHP plan once every 300 years. Now, how did we go from the last administration claiming they could not pro-

vide adequate oversight to your assurance that the Department of Labor can produce adequate oversight, and what has changed that would allow this oversight, or what was the last administration missing?

Secretary CHAO. Well, I respectfully disagree with the previous administration's assessment of their need. The new agency, the agency that used to be called Pension Welfare Benefits Administration, has a new name. It is called Employee Benefits Security Administration. Their budget has been increased 10 percent in the fiscal year 2004, and a great deal of it goes to enforcement. And as I mentioned, I do not anticipate that we will have any problems enforcing this added responsibility.

Chairman MANZULLO. Thank you, Ms. Velazquez.

Mrs. Capito.

Mrs. CAPITO. Thank you, Mr. Chairman. Thank you, Madam Secretary. I represent the State of West Virginia, and over 90 percent of our business is small business. And you mentioned—or it is mentioned in some of the statements firms of 100 and more and firms of 100 and lower. A lot of our firms, a lot of our small businesses are under the 50 threshold, into the 10- and 8-employee region, and time after time in visiting small businesses in West Virginia, their premiums are going up 30 and 40 percent.

You know, my question is what, in your view, is the largest stumbling block to seeing that this legislation goes through? And is there any kind of standards that have been set that would show what kind of association health plan insurer—what kind of standards would be set? Would you handle that through the Department of Labor, to ensure that those really small firms can get the accessibility that they really need?

Secretary CHAO. I think we are very close. I think in the past year legislation was introduced, there was a lot of miscommunication and misperception of what the issues are. I think there has been an effort on both sides to try to address the real health care crisis that is facing small business workers and employers, and so I think the issue of cherry-picking, for example, has been taken care of in the legislation. I think there is agreement that we cannot allow healthy people—only healthy people to be included in these plans, and that there must not be any discrimination.

The second point about regulations, I believe, has also been addressed in the reintroduced legislation as well. Right now a lot of small businesses are faced with a lot of very conflicting and difficult-to-comply standards, and so the Federal regulations would make it easier. As I have mentioned, the budget of EBSA will be increased 10 percent, and we will have enough resources.

The third point was—I forgot.

Mrs. CAPITO. Well, the quality assurance on the insurer.

Secretary CHAO. We want to be very sure also that the associations that are offering this plan are responsible, so we don't want to certify organizations that are set up solely for the purpose of offering this health care. We want organizations, associations to have a history, at least 3 years of history, and to have had some experience in providing services to their members that are different and

separate from health care so there will be rigorous verification standards, and we do that already.

Mrs. CAPITO. Well, I look forward to joining you and everyone in this effort.

I would like to point out as well in this day of State budgets that are having difficulty meeting their bottom line, a lot of the problem is the problem of the uninsured. The hospitals there, the level of free care, charitable care is rising every day, and I believe it is problematic, because it is indicative of the inability of small business to do what they want to do, which is to offer their employees good, solid health care. So thank you very much.

Chairman MANZULLO. Thank you.

Our next witness is Mr. Faleomavaega. You might note that I think the Small Business Committee is the only committee to have the Members from Guam, American Samoa, the Virgin Islands and Puerto Rico.

Mr. Faleomavaega.

Mr. FALEOMAVAEGA. Mr. Chairman, I offer my personal invitation to all the members of our committee to come to my district. I happen to have the largest tuna canning facility in the world, so I am going to make tunas out of you by the time we get through with you.

Mr. Chairman, I am very happy and pleased to be selected by our side of the aisle to be a member of this important committee. I certainly want to thank you and our Ranking Member, my good friend from New York, as leaders of our committee. And I want to personally welcome also Secretary Chao for her fine testimony and the important position that our President has now provided at least in support of AHPs. And I am really somewhat surprised, Mr. Chairman, as the most junior member of the committee, I have been asked to say a few questions. I thought maybe the pecking order of seniority goes in to those who are more senior than me.

Chairman MANZULLO. We start with American Samoa.

Mr. FALEOMAVAEGA. More and more I am beginning to like this committee more and more, Mr. Chairman. But I do thank you for this opportunity, and I do want to thank Secretary Chao for her presence here on our committee.

I just have a couple of questions for obvious reasons, and maybe I am pleading ignorance here. Secretary Chao, what seems to be the most important issue of why major health insurance companies are not supportive of this bill? Am I getting the wrong drift here? It is my understanding that Blue Health and Blue Cross is probably the strongest——.

Secretary CHAO. Well, I think you should ask them and others why they don't support it, because we have a real health care crisis in this country, and individual health care coverage is extremely high. If you are a——.

Mr. FALEOMAVAEGA. We understand that. I know my time is—but I want to say this. You have indicated that the administration does support the bill. Are there any——.

Secretary CHAO. Well, we support the principles of the bill, and we want to work with those others.

Mr. FALEOMAVAEGA. So in effect, you really do not support the bill? You support the principle, but not the provisions of the bill?

Secretary CHAO. I think it is going to evolve, and we want to make sure that we are working with the committee so that we can accommodate and work out some, perhaps, misunderstandings, some differences. I think we are so close, and paying attention to what the Congresswoman was saying, you know, we are so close, let us talk and let us work——.

Mr. FALEOMAVAEGA. Can you cite three specific areas that are really serious as far as the administration is concerned about the AHPs?

Secretary CHAO. I think the AHP bill is a strong bill, and as I mentioned, we strongly support the concept, and we want to see it go forward. But let us wait and see what the final bill looks like.

Mr. FALEOMAVAEGA. Can you share with us what exactly are those concerns in principle that the administration has?

Secretary CHAO. We support in principle. We support in principle. And as I mentioned, this is a good bill. We want to work with Members on it. We don't want to foreclose the opportunity to work with Members on it.

Mr. FALEOMAVAEGA. Thank you, Miss Secretary.

Thank you, Mr. Chairman.

Chairman MANZULLO. Thank you.

Mr. Beauprez.

Mr. BEAUPREZ. Madam Secretary, thank you for being with us today. A pleasure to have you in front of this committee.

Ninety-seven and a half percent of the businesses in my home State of Colorado are small businesses. It is our stock and trade, as it is in most States. I had not heard but was taken by your statistic. I believe you said 85 percent of the uninsured are in working families, and I am going to assume then that the vast majority of those are working for small businesses.

Secretary CHAO. Sixty-five percent, yes.

Mr. BEAUPREZ. And I know from personal experience what is happening to the cost of health care. Ours went up. At our business we give our employees two choices. One of those plans went up 72 percent last year, a dramatic increase. And not every business—at a time when the economy is doing what it is doing, business is basically getting squeezed from both directions, rising expense and declining revenue, and that is not a very nice combination. So a lot of businesses are struggling to either provide the benefit or have made the difficult decision that they have to pull it.

So I am very supportive of this. Other than perhaps eliminating the estate or death tax, this is the issue that is consistently and most fervently brought forward by small businesses that approach me.

My question is about—and I guess the concern of be careful what you ask for, you might get it, the concept sounds good to me, the principle sounds good to me. I have openly been supportive of this. But from your testimony, I think I heard you say, it does make regulation easier, more uniform. I think I wrote down that because it is consistent at a Federal level, it will make it easier to regulate and make sure that the end user, the worker, is getting good coverage. I would like you to explain exactly what you meant by that, and I am particularly concerned that we might actually be, God forbid, limiting competition and flexibility in choice in the market.

Is there any concern in your Department about that, that we might not have actually more choice? I am concerned that at the front end we may see a more affordable health care, but if we eliminate competition in the marketplace, it rises on us again, and we are back to the same problem. Could you address that?

Secretary CHAO. Let me address your question about regulation, because right now the regulatory structure is very confusing, especially if you have a small business that perhaps straddles two States or is over a regional area.

Basically self-insured association health plans would be solely regulated by the Department of Labor. A fully insured association health plan with the AHP purchases and insurance product from a health care health insurance company would be regulated by the Department of Labor and the States.

So regulation, there will still be adequate regulation. In fact, adequate is not the right word. We want to ensure that these association health plans are doing what they are supposed to be doing to protect workers, and we are confident that that will occur.

As for the issue about competition, I think the association health plan opens up competition, because right now if you are a single employee, employer, or if you are just a person opening up a shop, you have no options at this point, because the individual coverage—and it goes back to your question, Congressman, about why some people object. Individual coverage is prohibitively expensive. It is—you can buy it. It is purchasable, but it is prohibitively expensive for the majority of working Americans, and that is a problem.

Mr. BEAUPREZ. Thank you.

Chairman MANZULLO. Dr. Christian-Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and thank you—this is—this committee is one of the few that really is willing to take on some of these challenging issues. I am glad to be part of it.

Let me preface my question by just saying that I am signed on as a cosponsor of this bill. I think because I have made no bones about my strong commitment to universal coverage, my staff assumed that I would come on, but I am really not going to stay on unless I can be convinced that this is a good approach. So I have several questions. One, again, speaks to the fact that I am not convinced that the experience or the infrastructure is in place for what the Department of Labor is being asked to take on, and the question is an important part of the Department of Labor's responsibility in monitoring AHPs will be taking a proactive approach. In the past one of the problems was that DOL did not step in before the plans—other kinds of plans had gone bankrupt. That was the case with the MEWA plans.

Could you talk to us a bit about the auditing and the monitoring that the Department will be using to detect problems early on, and has the Department devised standards to determine when plans are in distress and how this will be monitored?

Secretary CHAO. We have been very concerned about MEWAs and the terrible plight that they leave employers and employees. They take advantage of the most vulnerable within our society, and employers and employees both suffer, because employers give their

premium to a company they presume is legitimate, and they think they are buying health care coverage for their employees, when in actuality these organizations are total shams.

So we have taken a very strong stand and embarked upon a three-prong strategy to attack this problem. One is obviously education and outreach. We need to let people know how best to look for affordable health care in the current market, and if a deal sounds too good, if the cost is like 90 percent below what the current market is, it is too good. So we have set up a Website. We have partnerships with the Hispanic Chamber of Commerce and with the African American Chamber of Commerce——.

Mrs. CHRISTENSEN. I hate to cut you off, because I know my Chairman is going to cut me off, but I have two questions, the auditing and the monitoring and any standards in place of when you will determine when the plan——.

Secretary CHAO. Well, MEWAs straddle States, so as they get bigger over a regional area, the regulatory regime is not adequate. And that is why, in fact, association health plans would actually help, in that right now we go—we recover, for example, $67 million. We have 181 cases pending. So we have a very active enforcement program going on.

Mrs. CHRISTENSEN. So some of the provisions are in place and just will be applied to AHPs, or there are provisions that will still have to be put in place? And if so, when——.

Secretary CHAO. We are pretty confident that we will be able to regulate the association health plans, certify it and conduct the audits. We already have the increased budget, but let me also say we currently administer the ERISA provisions, and that covers 2.5 million job-based health plans, covering 131 million workers. So this is not a major new activity for us. It will be an incremental increase.

Mrs. CHRISTENSEN. And it may be a large incremental increase that——.

Secretary CHAO. I don't think so either.

Mrs. CHRISTENSEN. I am sure I am going to have some follow-up questions that we would like to submit in the record.

Secretary CHAO. We would be more than glad to work with you to get them resolved.

Mrs. CHRISTENSEN. As I am speaking, you can see me looking through your testimony, because I saw somewhere—I couldn't find it in the written testimony—that coverage would be provided regardless of risk.

Secretary CHAO. Absolutely.

Mrs. CHRISTENSEN. Does that mean that coverage would be provided under these plans? I guess I should have asked——.

Secretary CHAO. What is happening now with small businesses is if they don't have health care coverage, they are losing out to big companies, and, in fact, the healthy workers are going to work for the big companies, and small companies can't find the workers that they need. That is a problem.

Mrs. CHRISTENSEN. But does that mean that preexisting—workers with preexisting conditions would be covered under this plan?

Secretary CHAO. Absolutely. That is under HIPAA already, which we administer and we have oversight responsibilities for.

Mrs. CHRISTENSEN. Okay. Let me ask one more question, and let me see if I can state this properly. But as I understand it, part of the reason for going in the direction of the association health plans is looking for—is because the State-mandated coverage is very strict, and supposedly small business have difficulty meeting the State standards. Now, Congress asked the Institute of Medicine to look at inequities in health care, and one of the things that they found was that there were different levels of coverage for different people, creating a two-tiered system of health care.

So if part of the reason why we are going in this direction is to avoid some of the State-mandated coverage of benefits that are found to be too strict, how do you convince me that we are not compromising the kind of health care that these plans are going to be providing by going to association health plans? Do you understand what I am asking?

Secretary CHAO. I do. State benefit mandates sound wonderful, but many times they have the unfortunate effect of driving up health care costs, because many cases they are Cadillac plans, which not everyone needs, and so, for example, State-mandated benefits increase premiums by about 13 percent. I am not against them. I am just saying that they are putting a different kind of plan for employers and employees who may not need that.

And so let us have a little flexibility, and quality affordable health care will be made available, because right now with the State-mandated benefits, what happens is a lot of employers just can't afford to pay for their employees, and they don't. To bring down the whole cost of health care, that will help, and timely health care, too.

Mrs. CHRISTENSEN. I am still not completely convinced, but I will keep reading and submit some questions, if I might.

Secretary CHAO. If I may offer——.

Chairman MANZULLO. You are a cosponsor of the bill, and you see the big picture.

Mr. Shuster.

Mr. SHUSTER. Thank you, Mr. Chairman, and thank you, Secretary Chao, for being here today. I don't really have a question, just a statement, a short one.

Before I came to Congress, I was a small business owner, employed between 30 and 35 employees, and this was always a struggle, health care, and in central and western Pennsylvania where I come from, there isn't much competition. So I think this is an extremely important bill for small business and across the Nation, especially in central and western Pennsylvania.

Also just an issue or point that Congresswoman Capito brought up, it is also going to benefit our small rural hospitals. One of the biggest expense lines in their budgets is for the uninsured, free health care, so it is important to small business, it is important to our small and rural hospitals. So anything I can do to work with you to get this piece of legislation passed and signed by the President, I certainly am committed to doing that.

Secretary CHAO. Thank you.

Mr. SHUSTER. Thank you again for being here.

Chairman MANZULLO. The new Member from Guam, could you help me pronounce your last name?

Ms. BORDALLO. Mr. Chairman, it is Bordallo. The double L is a Y. Just so you don't say bordello.

Chairman MANZULLO. That is why I deferred to you to pronounce your own name.

Ms. BORDALLO. Thank you, Mr. Chairman, for the opportunity. You know, when you hear from the two Territories, American Samoa and Virgin Islands, and Guam has to speak up as well, but I am very happy to be in this committee, Mr. Chairman, and our Ranking Member, and also to say that this is the only committee where I sit in the upper level. It may not be forever, but at least I am enjoying it now.

I want to say that I agree with our Ranking Member when she questioned the Secretary—Madam Secretary, about the support from the administration. You know, I see that it may be an exercise in futility if we go forward with this bill if there are provisions. You said in principle you support it, the administration supports it, but there are provisions?

Secretary CHAO. Well, I didn't say that.

Ms. BORDALLO. Could you repeat what you said?

Secretary CHAO. The administration is very much in support of association health plans, and we support with great enthusiasm the principles of this particular bill, but I think it is very unusual to come out and support any bill before it comes closer to final passage, because you just don't know what the bill would look like. So we have been spearheading this effort.

Ms. BORDALLO. Currently the way the bill is right now before us, is there anything in the provisions that you do not——.

Secretary CHAO. I don't think so, no.

Ms. BORDALLO. So what you are saying, then, is if it changes along the way, then you may not fully support——.

Secretary CHAO. No. I would view it as more of positive. I feel as if my concern is for those who have not signed on. We want to hold ourselves open to discussion and to dialogue, and we want to work with those, like Dr. Christensen and others, who may have lingering questions. I will be more than glad to make my staff available, myself available, to try to work to answer some of these concerns.

Ms. BORDALLO. So right now the way the bill is drafted, there is no objection? Is that what you are saying, now, without amendments or any changes?

Secretary CHAO. I believe so, yes.

Ms. BORDALLO. All right. One of the things that we must look at are the solvency requirements. Are the provisions there strong enough, in your mind?

Secretary CHAO. We think that it is important to have solvency requirements, because once again, we don't want to have fly-by-night operators. So we want to make sure that there is not too much of entrepreneurism at work here, but that organizations are established, that they have a financial history, that they are financially sturdy, and that their main mission is not for the purpose of being established to offer health care insurance. We want them to have some other mission of service to their members. That is all to ensure that the organization would be bona fide and that it is a sturdy organization.

Ms. BORDALLO. Would your Department, then, be willing to do an assessment of the solvency standards, or have you done that already? I am a new Member. So perhaps you have gone through this.

Secretary CHAO. I don't know the answer to that, but we will be more than glad to work with you on that.

Ms. BORDALLO. All right. Thank you, Mr. Chairman.

Chairman MANZULLO. Mr. Akin.

Mr. AKIN. Thank you, Mr. Chairman.

I don't know if this question was asked earlier, but one of the things that I had heard—and I was very strongly in favor of AHPs and all, but I had heard from an insurance company, and they were kind of whining that—they probably would object to the term ″whining,″ but they were saying it wasn't fair, because there were certain State mandates, and AHP would allow you to sidestep the State mandates. I am not necessarily sure that was good or bad, but is that true the way they are set up, somebody could set up a plan where you would not have to follow State mandates of an AHP? Would that be an advantage of an AHP? Am I right on that or not?

Secretary CHAO. A number of States have State benefit mandates, and as I mentioned, they sound wonderful, and we want to say that everyone should be able to have every single benefit available, but the reality also is that not everyone takes advantage—or needs the plethora of benefits that are being offered. But the increased number of benefits do jack up the cost of health care.

Mr. AKIN. I have been a legislator in the State of Missouri for 12 years, and we used to argue that all the time, so I am completely familiar with that, but the AHPs themselves, the way they are set up, would they require that you have to meet those State mandates or not, or could they be set up——.

Secretary CHAO. I don't believe so, no.

Mr. AKIN. You would not have to?

Secretary CHAO. Right.

Mr. AKIN. So from a competitive point of view, it was a legitimate complaint by an insurance company that it does have to meet those State standards?

Secretary CHAO. It would appear so, yes.

Mr. AKIN. Thank you very much.

Thank you, Mr. Chairman.

Chairman MANZULLO. Mr. Udall.

Mr. UDALL. Thank you. Thank you, Mr. Chairman.

Madam Secretary, I am just a little unclear on your support for the bill, supporting it in principle, and maybe asking this in a different way, are there any provisions in this bill that you do not support now?

Secretary CHAO. I don't think so, but let me also say, there is a——.

Mr. UDALL. And if we passed this bill and sent it to the President, you would then recommend to him that he sign this bill; is that correct?

Secretary CHAO. Well, the Senate has a say over this as well. So——.

Mr. UDALL. I am saying assuming the Senate—Mr. Talent was here, our former chairman, he assured us he is going to get it through the Senate, he is working hard. So under those circumstances, would you——

Secretary CHAO. We are very much in support——.

Mr. UDALL [continuing]. Support this bill in the current form with the provisions that are in it?

Secretary CHAO. I think I am pretty—I think I can say that. You will also hear from a second administration witness as well. There is a clearance process in the Federal Government in which different agencies will weigh in. So from our point of view, I think that is certainly——.

Mr. UDALL. Would you recommend to the President that he sign the bill in its current form, the bill you have testified about today that you have submitted this very lengthy testimony?

Secretary CHAO. Well, we are in support of the principles, as I mentioned. It will have to go through an administrationwide clearance process.

Mr. UDALL. I am asking for your recommendation. Would you support——.

Secretary CHAO. I have been a very strong supporter of association health plans.

Mr. UDALL. You would recommend to the President that he support the bill in the current form, yes or no?

Secretary CHAO. If it is in the current form and assuming nothing changes—and I am not trying to hedge you, but you know the legislative process better than I, but, again, I am very supportive of the principles in the current form.

Mr. UDALL. So in its current form, you could recommend that he support it?

Secretary CHAO. Right.

Mr. UDALL. Yes. Okay. Now, critics of the——.

Secretary CHAO. I wish I——.

Mr. UDALL. Critics of the AHP concept assert that two-thirds of the savings under AHPs would come from adverse selection, also known as cherry-picking. What is your response to that?

Secretary CHAO. Well, the legislation provides for provisions which would outlaw cherry-picking. This is a big issue year when this bill was introduced, and there was a great deal of discussion, and I think coming together in agreement that this must not occur. And so the legislation, even when it died last year, had prohibitions against cherry-picking.

Mr. UDALL. You mentioned in your testimony about MEWAs and how many of these were suspected of fraud, and you have the enforcement statistics in there that you have done. Could you explain for the committee how these two entities are different and why an AHP won't be a repeat of the MEWA experience?

Secretary CHAO. Well, under the current void, there is not the regulatory structure that we propose. So under association health plans, there would, in fact, be a stronger regulatory structure.

Mr. UDALL. And you are prepared to set that up under this bill.

Secretary CHAO. We already have that ability, as I mentioned. It is only an incremental increase.

Mr. UDALL. Now, one of the previous witnesses here testified that Blue Cross/Blue Shield basically had a monopoly in this small group area, and that that was the reason that we had such high prices and the reason the costs were so much higher. In addition to AHPs, outside the AHP issue, have you given any thought as to how we could bring additional competition into the small group market?

Secretary CHAO. AHP is a very——.

Mr. UDALL. Aside from AHPs, in addition.

Secretary CHAO. AHP is a very effective way to do so. Basically it is allowing small businesses the same advantages that a large business would have. They are able to pool their risk over a larger group of people, and in so doing would bring the risk down. So I think it is a very effective tool.

Mr. UDALL. But have you given any thought outside of AHPs how to bring competition into the small group market?

Secretary CHAO. Well, I think if you—there are other ways to decrease health care costs. You can have—as I mentioned before, the administration has a comprehensive proposal that includes expanding medical savings accounts, that includes tax credits, that includes medical malpractice reform, but I think the association health plan has a great deal of support right now from both sides of the aisle, and I would like to see it passed.

Mr. UDALL. When you talk about the monopoly, one of the suggestions always is antitrust enforcement. Have you given any thought in that area?

Secretary CHAO. Right now it is not a competitive situation. So AHPs would accomplish the dual goals of being able to cover—being able to offer coverage through a larger number of people and give individuals, employers and employees, more options.

Chairman MANZULLO. Thank you, Mr. Udall.

Mr. Case of Ohio.

Mr. CASE. Thank you, Mr. Chair, and as you note, the presence on the committee of the Members from Guam, the Virgin Islands and Samoa, you should know that there is an island conspiracy going on here. Clearly the balance of power on this committee belongs in the island bloc, which I am proud to be a part of.

Madam Secretary, in Hawaii we have a unique law—I believe it is still unique—among the 50 States of the Prepaid Health Care Act, which requires coverage of employees under an employer-provided prepaid health care statutory regime, which is actually a couple of decades old, which is one of the reasons why we have very low uninsured in Hawaii.

It is a pretty high cost. The problems you have alluded to in terms of statutory benefits being put in place are certainly true in Hawaii where the plan is beyond what many employees need and we operate under an ERISA exemption because of the scope of our law. That system has its very strong proponents and its very strong detractors and has led health care to be in Hawaii one of the top challenges facing small business. So it is not only a function of the cost of health care, but it is also a function of State law that requires fairly expensive coverage, universal coverage with some exemptions.

This is not the time for that debate or that discussion. I hope to have it at some point in the context of the ERISA exemption and what changes might be made in Hawaii's law to retain health care in terms of availability to workers there under what is a pretty good system in principle and to which direction many States have been creeping while making it more affordable.

Nonetheless, that is for another day. I guess the basic question I have for you today is, as you know it or understand it, or as I describe it to you, is there any reason why this bill would influence in a unique way the system we have in Hawaii? My impression is no. Because my impression is that you simply provided a Federal regime, and Hawaii can do whatever it wants within reason, and there is nothing inconsistent between what is being put forward in this bill and the Hawaii scheme. But I want to ask you the question to see whether there is anything that I am obviously missing in your mind or that you think I should be focusing on.

Secretary CHAO. I don't know. But I think you deserve an answer. Let me have my people get to work on what the impact would be.

Mr. CASE. Thank you, I appreciate that.

A little bit of a follow-up. When you talk about the AHPs—and if I missed it in your testimony, I apologize, but is there a projection as to those States who do not have a system like Hawaii's—if this bill was to be put into place roughly as expressed right now, what—is there any guesstimate of any kind as to the scope of coverage that would arise from the increased availability?

Secretary CHAO. Hopefully, it will give people more options. As we have seen in other health plans with groups of people, there will be an A plan, a B plan, a C plan, rather than just an A plan or a C plan.

Mr. CASE. Right. But are you projecting a level of coverage of workers as a result of this bill? Or are you aware any of projections as a result of this bill? We are all trying to increase the availability of health care to employees and their families. We are all trying to do it in an affordable way. Is there a projection anywhere, an estimate anywhere as to what level that would rise to?

Secretary CHAO. Health care plans are pretty complicated, and they vary according to different groups of people and who is in the plan. So I think my feeling is that it would be hard to come up with that, but we will look and see.

Mr. CASE. Do you believe that whatever increased coverage there might be arises because the health plans are picking up new employees that are not currently covered, or are they replacing the coverage of employees that are currently covered?

Secretary CHAO. Well, there are studies on that. In fact, the estimates are that, with the creation of the Association Health Plans, probably an average of increase of 2 million workers would be covered.

Mr. CASE. Increased?

Secretary CHAO. Yes, new workers. Those who would not have had access otherwise.

Mr. CASE. Thank you.

Chairman MANZULLO. Secretary, thank you for coming here. We promised you would be out at 3:30. We will start with Mr. Barreto

in just a minute. But I would like to meet you in the hallway and thank you personally for coming here.

Secretary CHAO. Thank you very much, and I extend an invitation to the Committee. We want to be helpful in all of this, and we want to work with you. Please call upon us and our staff.

Chairman MANZULLO. Appreciate that very much. Thank you.

[Recess.]

Chairman MANZULLO. Okay, I can pronounce this name. Hector Barreto is a great friend. He personally, I think, within the first month of becoming the Administrator of the SBA, visited Manzullo's Famous Restaurant in Rockford, Illinois, my brother's modest establishment, and talked to Frank and talked to many small businesspeople about the high cost of health care.

His background is that—your father had the insurance agency, Mr. Barreto?

Mr. BARRETO. No, I did.

Chairman MANZULLO. You did?

So we are just pleased to have you with us, Mr. Barreto, who knows the situation inside out; and thank you for your patience in accommodating Secretary Chao. We look forward to your testimony.

STATEMENT OF THE HONORABLE HECTOR BARRETO, JR., ADMINISTRATOR, SMALL BUSINESS ADMINISTRATION

Mr. BARRETO. Thank you, Mr. Chairman.

Good afternoon Chairman Manzullo, Ranking Member Velazquez and honored guests and distinguished members of the Committee. Thank you for inviting me to discuss how to increase access to affordable, quality health care for small businesses. We have had the opportunity on several occasions recently to talk about this issue. I am grateful for the continued attention to this most pressing issue facing small businesses, and I applaud you for having this hearing.

Small business owners tell me all the time that this is one of the most important issues they face and that the problem of access to affordable health insurance has grown considerably for them in recent years. I know you have heard the numbers—devastating, double-digit premium increases each year for small businesses. This steeply rising cost, added to a long list of other factors, have forced many small business owners to stop offering insurance coverage altogether. For some, the expense has meant that it has never really been an option. Is it any wonder that most of America's uninsured citizens either work for a small business or are self-employed or have a head of household or who works for a small business?

This impacts the ability of small businesses to compete for the skilled employees that they need to grow and prosper. The availability of quality health care benefits is often a deal breaker for employees when they are looking for a new job. Without action, this crisis will only grow. The urgency of this issue cannot be underestimated, nor can the opportunity to do something about it be ignored.

I have been witness to this problem throughout my life. I grew up in a small business; then I worked for a small business; I became a business owner myself; and, finally, I served as the head

of one of those small business associations that we talk about all the time. I have seen firsthand just how difficult it is for businesses to secure the health care they need for their employees, the coverage that their employees need and want.

As SBA Administrator, I have had the chance to visit with small business owners all over the country. At Manzullo's Restaurant and all across this country, wherever I go, they inevitably ask me what can Washington do to make health care more affordable for them?

My job as head of the SBA is to help small business owners and their employees. My agency is the government entity they look to when they are in need, and we are not able to help them when they ask about this, the issue that impacts their employees and their families so much.

The SBA ought to be able to provide small business owners with information when they call and ask about health care. We should be able to provide a credible referral to associations that they can join to purchase health insurance at a lower cost.

A key answer to the health insurance care question for small businesses is Association Health Plans. Given the staggering costs that are faced by all small businesses, President Bush has placed an increased access to affordable health care at the top of his comprehensive small business agenda.

Besides AHPs, the administration supports Medical Savings Accounts, tax credits for the purchase of individual coverage, greater access to State-based high-risk insurance pools, and medical malpractice reform to curb frivolous lawsuits that drive up the cost of insurance.

The President wants to make it easier for small employers to pull together to offer their employees the same sort of affordable health care coverage options that many large corporations and unions can currently provide. The President knows this can be achieved through AHPs.

Removing the legal barriers and allowing AHPs to flourish would bring cost savings to small businesses by reducing the daunting administrative cost and introducing the discounts that come with high volume purchasing. Ultimately, AHPs will mean the expansion of access to health care benefits for millions of uninsured Americans and more coverage choices for small firms.

Once Congress passes legislation enhancing AHPs, SBA will seek to connect small business owners with the best solution for providing health insurance to their employees while the Department of Labor will implement necessary programmatic structure.

I want to thank Secretary Chao for her leadership and the commitment that she has provided on this issue. I know that small business owners that have been struggling to make ends meet appreciate these and your efforts. I hope that the Secretary and I can work closely with you this year so that small businesses and the 57 million Americans who work for them can gain access to better, more affordable health coverage. Until we come up with a solution that crosses State lines, I don't think we can solve this problem. The time for Congress to act is now.

Thank you, again, for holding this hearing and for the support so many in this Committee for AHP legislation have offered. This

is truly a bipartisan effort, and I am happy to answer any questions you may have. Thank you.

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

Chairman MANZULLO. Thank you.

I do not have any questions myself, neither does Ms. Velazquez.

Anybody on the panel have any questions they want to ask of Mr. Barreto?

Mr. Faleomavaega, you have that look your face.

Mr. FALEOMAVAEGA. Why not?

I do want to thank Administrator Barreto for his testimony this afternoon. In line with some of the concerns some of the members have had with the proposed bill—I assume you have not had the opportunity to review the newly proposed bill which my understanding was passed in a previous Congress.

Mr. BARRETO. No, sir, I have not.

Mr. FALEOMAVAEGA. So I guess it is difficult for to you support it because you don't know what is in the provisions of the bill.

Mr. BARRETO. I know what the intention of the bill is to do. I mentioned some of that in my testimony. And I think this is a great start.

As you know, Congressman, this is not a new idea. This is not a new concept. But probably this is one of the first times that this level of attention has been paid to this issue in both the House Small Business Committee, the Senate Small Business Committee, the administration, trade groups across the country. There is definitely a focus and a real hope and expectation by all of those small business owners that we will finally be able to take care of this problem once and for all.

Mr. FALEOMAVAEGA. I want to thank you for your commitment and your offer of help on this important legislation.

Thank you, Mr. Chairman.

Ms. VELAZQUEZ. Mr. Barreto, for 6 years now I have been talking about this issue; and, like you, I have been, time and time again, meeting with trade associations, small businesses and it is the same issue: access to affordable health insurance.

So, look, this is a bipartisan effort legislation; and you and I know that if there is a strong commitment, this legislation will be brought up to the floor for a vote. But we need also strong commitment coming from the White House. If the President does not talk to the leadership in the House and in the Senate, this is going nowhere. So we need to have a strong message coming from the White House.

He included it as part of his campaign promises. He included it last year when he released his small business agenda. So the time to act is now. The President should come and meet with both the Senate and the House leaders.

Mr. BARRETO. You are absolutely right, Congresswoman; and I want to thank you very much for that history of the issue. As you said, you and many others have been on the front lines of this issue for a long time.

I can tell you, because I have been with him, that the President is committed and passionate about this issue. I have been with him already three times this year where we have done Small Business

Roundtables. I know the Chairman was with him not too long ago. This issue continuously comes up. The President is focused on it.

I can also tell you that members in the Senate Small Business Committee and members on this Committee are speaking with the President and do have his consideration and support, and that is why I think that this is a very unique and important opportunity for small business. I think that together we will be able to create a solution that will help many, many small businesses.

Chairman MANZULLO. Mr. Bartlett.

Mr. BARTLETT. Thank you very much. Thank you for your testimony.

It is very commendable that we and the administration are working to make health care coverage as available to small businesspeople as it is to those who work for large businesses. But once we have accomplished that, there still will remain enormous problems to be solved. Health care costs are rising at three and four times the rate of inflation. The only other large entity in our country where that is true is the Federal Government, and we need to curb the growth of both of these.

Mr. BARRETO. Health care is growing faster.

Mr. BARTLETT. You are right.

There are two fundamental problems in health care. You mentioned one of them, and that was malpractice reform. Many estimate that that could account for as much as 25 percent of health care costs, considering the defensive medicine that is practiced. It is impossible to get a firm fix on that because you cannot get inside the doctor's head to know how much of what he prescribes and so much is related to defensive medicine but many estimate as much as 25 percent.

The other thing that drives health care costs is third-party payer. A reasonable analogy is that every time you go shopping for groceries, you know that when you go to the checkout counter you know that somebody else will be there with their credit card to pay for what you filled your basket with. Now, if you knew that, the average shopper would fill their basket with very different things than they fill it with when they know that they are going to have to pay for it. How are we going to address that problem? Until we address that problem, we are only nibbling at the margins of the fundamental problem in health care.

Thank you very much for that question, Mr. Vice Chairman. I think you have articulated the issue very, very well.

This is a first step. It is not the only step. Other things have been mentioned, and we need to tackle these problems one at a time. In fact, I don't think there is time to wait. I think we have to attack these all the time. I think you stated it very well.

I put it this way: I say that small businesses are always put in the place of giving the bad news to their employees. It is always, we are getting a double-digit increase; we have got to change plans; you have to change doctors; finally, I can't provide health care benefits.

It also affects the doctors. With those lawsuits going up, many of them, their insurance premiums go up on their medical malpractice, and they will maybe stop practicing in a certain area. There are many rural areas where they are losing their doctors.

They do not want to practice anymore because it is too expensive or they are afraid of getting sued.

So there are many problems. The problem that we are dealing with today, which is a very important problem, is access and cost; and Association Health Plans can take a big bite out of that problem if we finally do what we should have done a long time ago and give small businesses that option.

I think a lot of issues have been brought up, and there is no doubt in my mind, having been in the industry, that if we offer Association Health Plans to small businesses not only will competition increase but I think that the quality of health care and pricing all across this country will go down, which will have a dramatic impact on the lives of small businessmen and women across this country.

What you said is, of course, entirely true, that we have absolutely got to provide health care access. I was a small businessperson, one of 35 people in the Congress who belonged to NFIB, before I came here; and I know that many people in small business with the escalating cost of health care cannot provide it to their members. But once they are able to provide it on the same basis that it is available to large businesses, they still will have an enormous problem and that is that their cost of doing business, because of the escalating cost of health care, is going to threaten their survivability in a global marketplace.

I just want to make sure that once we have cleared this hurdle—and this is an absolute must; we should have done it a long time ago—that we remember that there are other major problems that we have got to face in health care.

Thank you very much for your testimony.

Chairman MANZULLO. Dr. Christensen.

Mrs. CHRISTENSEN. Thank you. I thank our chairman.

Mr. Bartlett also just mentioned some of the things—concerns that I had, because I have heard a lot about the rising cost of health care. But Association Health Plans are not going to fix all of that problem. It will not even be a big bite. The CBO says 2 million people perhaps, and that is if it works.

Mr. BARRETO. It is really not known, as the Secretary said. One of things we do not know is how many people will associate themselves with an organization, maybe for the very first time, simply because they will now be able to get access to affordable health care. There are other options as well. There is the self-insured options that have been discussed. So we really do not know.

What we do know is that the largest part of uninsured are probably working for small business. What we do know is that these people are worried every single day that something is going to happen to them, and if they do not have health insurance they could lose their business or their valued employee. So it just goes to reason that if you offer a solution that many small businesses—they have told us this over and over—will take advantage of it.

I agree, it is not the only solution or the full solution, but it is a big part of getting to the solution that we need to get to.

Mrs. CHRISTENSEN. There is apparently a report that the Office of Advocacy, they funded a study which reveals that small busi-

nesses who operate health care plans have high administrative costs; and there are some questions I have relating to that report.

But one question I want to ask before I ask two specific ones about the report, if I have time. Some States have already set up high-risk pools for small employers to purchase insurance collectively. How do you see this legislation affecting those pools?

Mr. BARRETO. Well, I think this is a much broader application. I know—I practiced—my employee benefits practice was in California, and I know that we had some of these high-risk pools. But they really touch very few small businesses. This is a much broader application. It is a nationwide application. So we think that it is going to help.

Also, remember that these plans are voluntary. If a small business felt like, you know what, it is not in my best interest—small businesspeople are very smart. They will shop around. They will not jump at the first solution. These Association Health Plans will have to compete for their business the way the large insurance carriers have to compete for their business right now. So if it is not a good deal, they will not select it.

Mrs. CHRISTENSEN. If we could have done something legislatively on the Federal level to support the forming of high-risk pools, would that be a reasonable alternative to this one?

Mr. BARRETO. Again, I go back to the fact that my experience with high-risk pools is that it is very limited and a very limited application of who can go into these high-risk pools. Usually, it is people with very, very serious medical conditions who cannot get insurance anyplace else. And, obviously, very expensive to provide benefits to those individuals. So I think it depends on the details and the actual options that are being described. What I think we are talking about is a much broader, much more easily accessible solution for small businesses.

Mrs. CHRISTENSEN. To go back to the report a minute, because it kind of goes to the question that was asked of Secretary Chao a few times to try to ascertain whether there was real support for this or was it just in principle. In the report—apparently, in that report it says, this is a quote: AHPs located in the States with less stringent laws could offer insurance at a lower cost to groups that are now forced to subsidize higher cost groups in those States that require community rating or narrow rate bands.

Isn't that another way of saying that AHPs would be a great deal for the healthy—the problem that we are trying to get away from with this—but cause premiums to increase for high-cost firms that community ratings were designed to help? And that is coming from the SBA report.

Mr. BARRETO. I would say to you that I actually spoke to the Chief Counsel of Advocacy before I came. I wanted to ask him about his report, and he told me that he is totally supportive of Association Health Plans. Some of those things were misconstrued, and some of those things were mentioned before.

I would tell you that the idea here is that when you allow associations to provide these kinds of benefits to their members, they want as many of their members as possible to benefit. They are not going to choose, well, we want these members over here because we

like them better or they are healthier to get the benefits. Any solution is going to be made available to all of their members.

As you know, there are already laws in place that prevent this kind of cherry-picking or adverse selection to go into effect. The Secretary of Labor has been very strong in her statement that they will not allow there to be any cherry-picking.

Because at the end of the day what it does is it actually—that is one of the reasons that when Association Health Plans have been tried in the past they have not worked. What happens is that everybody gets excited about it; they join the Association Health Plans; and, as the rates start going up, the healthy people leave. Guess what happens? You only have the unhealthy people in there. Rates go up for everybody, and the plans blows up. That will not happen in this case.

Mrs. CHRISTENSEN. Thank you.

Mr. Chairman, again, since I have several questions on the report, I would like to ask them to the Office of Advocacy and have them respond.

Chairman MANZULLO. Let's go to Mr. Schrock and then Mr. Ballance.

Mr. SCHROCK. Let me say I agree with what Mrs. Christian-Christensen and what Mrs. Velazquez said. Let me make two observations. You may or may not agree with me.

Number one, if we are going to truly get health care costs under control, we have to get a cap on suing being the national pastime in this country. Malpractice insurance is out of control. My wife's family, her parents, her aunts and uncles are all doctors; and the premiums they pay to practice are outrageous. They are not going to eat them. The patient is going to eat them. Unless we stop these frivolous lawsuits, that is one area we will not make any progress.

Number two, the cost of drugs for the American taxpayer is higher than any nation in the world. It is our companies that research, develop, and bring these drugs to market; and it is our population that gets stuck with the costs. And the answer I get is, well, we have trade agreements with other nations so they can get it cheaper. Baloney. It is time that we level the playing field so that everybody else pays the piper just like our people do. Why should our elderly go without drugs because they are expensive and somebody in Canada can get it for a fraction of the price? That makes no sense to me; and, unless that changes, it is impossible to get this under control. Agree or not?

Mr. BARRETO. We agree completely. Having been in that business and industry working with small businesses—and I also had doctors who were my clients. And doctors have to buy health insurance, too; and they complained about these things all of the time.

I think the fact that there is a focus on this, I think the fact that there is an interest and a commitment on your part, the part of this Committee, is going to help us make great strides, maybe for the first time in history, great strides to start solving these problems.

The first thing that we are tackling is the access and the initial cost of health insurance premiums. By providing these Association Health Plans we know that it is going to reduce the cost of health

care for small businesses in the short term. Long term, we have to deal with some of these issues.

Mr. SCHROCK. And if there are any lawyers in the room offended by my malpractice comment, too bad. Right?

Chairman MANZULLO. Mr. Ballance, are you an attorney?

Mr. Ballance is an attorney.

Mr. BALLANCE. I am a trial lawyer and proud of it. A former trial lawyer, because I can't practice anymore.

Mr. SCHROCK. There is one less lawyer practicing.

Mr. BALLANCE. I do not bash lawyers nor doctors. There is a better way to do it.

Mr. Barreto, I want to raise one issue. This bill addresses access to health care. What about the question of access to providers? In North Carolina, we have a rule that protects that if there is no provider within a reasonable distance, you can go outside of the plan.

Mr. BARRETO. It is my understanding that what is going to happen once this law passes is that the association will be able to negotiate with carriers. I know this from my own experience, one of the things that they ask for is, let me see your provider directory. I want to make sure that there are doctors in the community where I need them. I also want to make sure that there are doctors who are culturally sensitive. I also want to make sure that there are doctors that speak the languages that I need them to speak. If not, one of the deal breakers oftentimes is, until the insurance company can bring a provider directory that really reflects the needs of that population, no deal.

Insurance companies, as you know, can add those doctors when they need to. Oftentimes, they freeze those provider directories and say we have too many. We are not accepting any more doctors. But if they need to recruit more doctors to cover their clients, they definitely will.

So I think that the Association Health Plans may be a great way to actually expand provider directories all across this country. Obviously, you will have to take it on a case-by-case basis, because the needs of North Carolina may be different than the needs of California or New York or the Virgin Islands or anyplace else.

Mr. BALLANCE. Thank you.

Chairman MANZULLO. Thank you so much.

You know, you always impress me, Mr. Barreto, when you get to health care. You just shine on that.

Mr. BARRETO. Thank you, Mr. Chairman. I appreciate it.

Chairman MANZULLO. How long did you have that firm?

Mr. BARRETO. Fifteen years. Thank you very much, sir.

Chairman MANZULLO. Thank you very much. I appreciate your patience in accommodating the Secretary of Labor.

We will take a 10-minute break here and get a reconfiguration at the table. Thank you so much.

Mr. BARRETO. Thank you, Mr. Chairman. I look forward to working with you.

[Recess.]

Chairman MANZULLO. We will reconvene the meeting.

The first witness is Mr. Skip Trotter from Trotter Machine Incorporated of Rockford, Illinois, home of Trotter Machine Incorporated and Manzullo's famous restaurant. He is testifying on behalf of

himself and as a guest of the NFIB. We look forward to your testimony.

We have got lights up there. When it is green, it is okay. When it is yellow, start moving. When it is red, that is it. Okay?

Thank you for your patience in coming here and waiting to testify. We look forward to your testimony.

STATEMENT OF SKIP TROTTER, TROTTER MACHINE INC., NATIONAL FEDERATION OF INDEPENDENT BUSINESS

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

My name is Skip Trotter; and my father and I run Trotter Machine Incorporated, a manufacturing firm that produces hydraulic valve spools based in Rockford, Illinois. At Trotter Machine, my employees and I work together to produce valve spools which control the restriction and flow of high-pressure hydraulic oil in values. The unique part of our business is that there are only three of us in the world who manufacture valve spools.

Like many entrepreneurs, I learned early that if you want to remain competitive, I must offer an attractive benefit package. Since we started the company, we have provided comprehensive health care insurance.

Our company is able to offer a PPO, Preferred Provider Plan, to our 47 employees. My father and I want to provide a quality plan—medical, dental and vision coverage with a wide network of doctors—and every year that passes, I have to set our deductible higher and change our network of providers to keep our premiums affordable. I set an eligibility requirement of 90 days or, in some cases, on the first of the month after 60 days of employment. I offer an 80/20 employer-employee shared contribution rate. Every year, I have changed insurance companies because it is difficult to find an affordable plan.

However, the reality is that being insured is critical to our employees. Most them are more interested in the benefits we offer than in the wage they will be earning. Employees pay $80 per month for individual coverage and $120 per month for a family. Trotter Machine picks up the other 80 percent of the cost for our employees. In addition, we pay for full coverage of life and disability insurance, which is roughly $1,000 a month.

Annually, in February, my assistant and I go through the painstaking work of getting bids from other insurance carriers, since our average increase has been 28 percent every year over the last 4 years. This year, our increase was 40 percent; and what bothers me the most is that the coverage and service continues to get worse.

A particular frustration of mine is that insurance carriers move at one speed—their own. In past years, we have had to go an additional month with the old company to stay covered at the higher cost, waiting for the current insurance carrier to get underwriting and firm pricing back to us.

In addition to the hassle of just maintaining affordable coverage, my time is wasted spending countless hours on the health care renewal process. It takes two of us 3 days to fill out all the necessary forms for underwriting. This cuts into my employees' production time and other areas in which I would be producing a quality product for my customers. We are facing a crisis in manufacturing by losing jobs to China; Therefore, it is vital that I work to keep our firm competitive.

Knowing that providing health insurance is necessary to me for both business and personal reasons, and knowing that I cannot increase prices to my customers an extra 40 percent in order to absorb the cost, I continue to offer health insurance benefits despite the growing cost to the business. Our business has absorbed the cost every year. We have only passed a total of $5 a week on to our employees over the past 4 years. I am at a point where I might have to increase our employees' share or stop paying for their disability insurance. Thus, I take the risk of losing good employees and dramatically increasing my turnover rate.

While I continue to struggle to provide affordable coverage, some of the big insurance companies have announced record profits the last few quarters. Are they making money off the backs of hard-working small business owners? I support businesses being successful, but when I am faced with double-digit increases every year or when my colleagues cannot provide insurance to their workers, I feel that the insurance industry is more worried about their profits than my ability to afford health care for my employees. I have to compete, so why shouldn't insurance companies? Simply put, competition is needed in the small group market.

Those of us in the small business community who offer insurance are struggling each year to afford the cost of insurance premiums. It is for this reason that I support legislation endorsed by NFIB that would create Association Health Plans, AHPs. AHPs would allow small business owners to band together across State lines to purchase health insurance as part of a large group, thus ensuring greater bargaining power, lower administration costs, and freedom from costly State insurance mandates.

Fortune 500 companies and labor unions already have this right. AHPs will simply level the playing field and give small employers the same privileges as their counterparts in labor and big business. In addition, AHPs will introduce into the marketplace much-needed competition and diversity. Without the ability to shop for more affordable options, we are forced to shift costs to our employees and drop coverage. Association Health Plans would end the nightmare of health care purchasing for small businesses.

I also encourage——.

Chairman MANZULLO. You are out of time, Skip. It is red on there.

Mr. TROTTER. I can't see the light. I apologize.

Chairman MANZULLO. We appreciate that.

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

Chairman MANZULLO. I am going to skip to Mr. Hartnedy. You have a flight that leaves at 6?

Mr. HARTNEDY. Yes, Mr. Chairman.

Chairman MANZULLO. What I would suggest is this. I want you to testify, and then I want you to leave.

Mr. HARTNEDY. Yes, sir.

Chairman MANZULLO. So you have 5 minutes. If you go over that, you have a lot of traffic to get through. I look forward to your testimony, and then you will be excused.

Does anybody else have any flight problems going on here? Okay.

Please, Mr. Hartnedy, go ahead.

STATEMENT OF JOHN HARTNEDY, CHIEF DEPUTY COMMISSIONER, ARKANSAS DEPARTMENT OF INSURANCE

Mr. HARTNEDY. Thank you, Mr. Chairman.

My name is John Hartnedy. I am the Deputy Insurance Commissioner of the State of Arkansas, a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I have worked with a variety of health insurance committees, and I have over 41 years of experience. I am speaking for myself from Arkansas only, no other commissioners or no other States or no other organizations of regulators.

The uninsured are growing, as we know. I would suggest to you that one of the laws passed at the Federal level, HIPAA, in some ways didn't help, especially with guaranteed issue. That is one of the reasons that we believe in Arkansas—at least we are seeing the small group rate increases be much more significant than is happening even with individuals and certainly with large groups. So my suggestion to you is that we have to be careful with H.R. 660, that we do not do more harm than good.

The number one issue is cost. It is not access. We have a State risk pool. Anybody in the State can get insurance. The problem is they can't afford it.

I do not see how this law is going to provide very much help, but I want it to have the best chance to work so I am making some suggestions that I think will improve it. I say that from the point of view that, 2 years ago in Arkansas, we passed a law that looks very much like this one and in this session we are tweaking it to try and make it better. So it is not that we are not interested in trying to do this, but I am not sure at this point what it is going to accomplish.

We certainly need stability in the group. It should be an established group.

Cherry-picking keeps coming up, and I will give you one simple example. If you had an association of health club workers, they are going to be very healthy. You have an association. You don't bar anybody. They will get extremely low rates. They will come out of the normal small business market, so the rest of the small business market, obviously, the rates will go up because the healthy people are not there.

I heard the Secretary clearly speak that they have things in the law, and they do, to prevent cherry-picking. There is no way you can prevent it all, Mr. Chairman; and I just think the Committee needs to know that as they move ahead. There will definitely be cherry-picking of some limited kind.

Solvency is my next major issue, and we had the MEWAs that were originally under the DOL. They have—a lot of them have

gone bankrupt. I will just tell you, as far as the DOL handling, we found them good to work with. The primary work is being done in our department. We probably devote almost a full-time person to doing nothing but working on the MEWAs. That is not being regulated entirely or very much, bluntly, by DOL.

We have solvency requirements in the States. It is called risk-based capital. A simple example: If an AHP or an insurance company would buy treasuries, they do not have to increase their surplus. If they would invest in junk bonds, they are going to put 30 percent of the value of those bonds in surplus to cover their risk. The same things happen on the liability side.

What I do not understand is why the DOL wants to build a whole new thing when we have got it in place and you could just tell us to take care of it. It is already there.

State of domicile is an excellent idea. I think before somebody goes self-insured they ought to be in for 3 years and have 5,000 members. The reason for that is that I am an actuary. With 1,000 members, one $1 million claim puts them in extreme difficulty. You say they should have stop loss. You saw what happened on September 11th and the difficulty of getting reasonable reinsurance after that. If you have got a 5,000 life case, you can retain a whole lot more of the risk and you are not —excuse the expression —the victim of whatever is happening in the reinsurance market. I strongly recommend that you raise that number if you are going to do this.

The mandates—all the States have mandates. In my opinion, they have an awful lot of them. Some of them are not needed. For example, the one I get complaints about the most in Arkansas is in vitro fertilization. People would love to be without that.

You have included HIPAA. Great move. The cost savings, the providers have been squeezed about as far as they can be squeezed. We will not get much more out of that. Our small employers in our State buy into the same provider markets that anybody else can. The expenses, they will still have to bill each employer. Maybe there are some savings in commissions. The mandates would save, from what I have seen, 5 to 10 percent, less than the 13 the Secretary mentioned.

We are going to take our premium tax. That is one of our next moves, to take another 2½ percent out of it. I like the idea of disclosure and identifier information on the Web. The people need to know what they are buying. We had the market conduct examinations. The consumer protection law is already in place to protect them in that area.

If you do it, Mr. Chairman, I recommend that you throw a whole lot more of the burden on us. We are already equipped to do the job.

Thank you, Mr. Chairman.

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

Chairman MANZULLO. Thank you.

If it is okay with you, if we could submit some questions in writing. Mrs. Velazquez wanted to ask those.

Also, I would extend to you if there are any questions that you want answered as the Commissioner of Insurance of the State of Arkansas, and obviously as an affected person, if you would get

those questions to me, preferably to me on your letterhead, we will shop those questions around to Dr. Fletcher, to the Committee on Education and Labor, and bump it over to the Department of Labor. Because you have some tremendous things to add that could possibly perfect the language on it. Okay?

Now you can leave.

Mr. HARTNEDY. Thank you, Mr. Chairman, for letting me speak before you told me to leave. I appreciate it, sir.

Chairman MANZULLO. Our next witness is Mr. Hughes. We look forward to your testimony.

STATEMENT OF ROBERT HUGHES, PRESIDENT, NATIONAL ASSOCIATION OF THE SELF-EMPLOYED

Mr. HUGHES. Thank you, Mr. Chairman.

My name is Robert Hughes, and I am the President of the National Association for the Self-Employed. I am also a self-employed CPA in Dallas, Texas. I have been in micro-business since 1982.

This is a very important issue. We realize that when we talk about this issue here in this Committee hearing we are preaching to the choir.

The NASE currently has 250,000 member businesses around the country, representing about 600,000 employees, employers and self-employed individuals. Most of these are micro-businesses having fewer than 2.5 employees, including the owner and the owner's spouse.

The chief impediment that micro-businesses and the self-employed face as they try to stay afloat during this time of economic uncertainty is the ever-increasing cost of health coverage. The state of health care among the Nation's self-employed and micro-businesses is critical.

According to a study which we released in early 2002, 7 in 10 micro-businesses owners report that they do not provide any type of health care coverage to their employees, nor do they have coverage themselves. Costs are cited as the chief reason for this trend.

The NASE is in full support of H.R. 660, the Small Business Health Fairness Act introduced by Congressman Fletcher. The NASE believes that Association Health Plans would give the self-employed and micro-businesses owners access to lower rates through consolidated buying power as well as administrative efficiencies.

According to the NASE Affordability in Health Care study, the participants said they would be much more likely to purchase health insurance if the right incentives were in place; and we believe AHPs can offer those kinds of incentives.

However, my focus today is not on Association Health Plans, even though we support those, but my focus today is on a couple of other issues that we think would help the affordability of health coverage for micro-businesses, namely, a self-employment tax deduction for health insurance premiums and health care tax credits.

A core issue facing self-employed individuals, all 15 million of them in the country, is their inability to deduct their health insurance premiums for purposes of the self-employment tax.

The tax inequity faced by the self-employed when purchasing health insurance lies in the fact that Schedule C filers, sole propri-

etors, and schedule E filers, partners in partnerships with earned income, do not receive a business deduction for their health insurance premiums. The premiums are not deducted for purpose of the self-employment tax and, accordingly, these business owners pay self-employment tax at a rate of 15.3 percent on their insurance premiums. The self-employed are the only segment of business owners in the country that pay this extra tax on their health insurance premiums.

The self-employed are required to pay two types of taxes on their annual tax returns: the regular income tax which we all understand and the self-employment tax. So while 100 percent deductibility of health insurance was phased in this year, it does not solve the tax inequity. A 100 percent deductibility relates only to the income tax and not the self-employment tax.

To bring this to a personal level, let me ask you: How much did you or your employer pay for your health insurance coverage last year? Make a mental assessment. Multiply that amount by 15 percent, and then pull out your checkbook and write a check payable to the United States Treasury for that amount. That is what the self-employed and micro-businesses do every year because their insurance premiums are not deductible for self-employment tax purposes.

To achieve tax equity between all forms of business entities, the self-employed must receive exclusion of health insurance premiums from self-employment tax, regardless of the entity form under which they choose to operate. Health insurance premiums of the self-employed should be deductible on Schedule C or E as an ordinary and necessary business expense, rather than a deduction above the line on Form 1040. This issue is not only one of fairness but, in the current health care climate, the self-employed are disproportionately affected. Removing this extra tax on health insurance premiums would simply make coverage more affordable for the self-employed.

The NASE strongly supports tax credits and deductions as a viable solution to begin addressing the larger issue of the uninsured in our Nation. Nearly 80 percent of the respondents in our survey indicated they would likely purchase health insurance for their employees if they were give tax credits.

So, Mr. Chairman, we urge again that this Committee strongly consider not only Association Health Plans but creating some form of deductibility for health insurance premiums for the self-employed tax purposes.

[Mr. Hughes' statement may be found in the appendix.]

Chairman MANZULLO. Thank you for your testimony.

I am dubious about a farmer from Washington whose name is Appel. I raise beef cattle. Do you raise apples?

Mr. APPEL. No, Mr. Chairman, I do not raise apples, but you are not the first one to ask me that question.

Chairman MANZULLO. I bet you raise cattle and grow apples. Is that what it is? I am not sure what the term is. Is it apple or Appel?

Mr. APPEL. The correct pronunciation would be Appel. But most people say apple, and I answer to whatever name you want to call me.

Chairman MANZULLO. Steve, glad to have you here. Mr. Appel is testifying on behalf of the American Farm Bureau Federation, a member of the Washington State Farm Bureau and a farmer himself; and we look forward to your testimony.

STATEMENT OF STEVEN APPEL, VICE PRESIDENT, AMERICAN FARM BUREAU

Mr. APPEL. Thank you, Mr. Chairman.

My name is Steve Appel. I am a wheat and barley grower in Whitman County, Washington, to answer that question. I am the President of the Washington State Farm Bureau and am Vice President of the American Farm Bureau Federation.

Of all the small businesses in need of lower cost group health insurance, the American farmer is perhaps one of the ones that are most in need. Our members are the smallest of the small, for the most part themselves ineligible for small business group coverage.

Group underwriting standards have traditionally excluded companies where direct family members consist of more than one-half of the group's enrollment, and that is exactly the situation for our members. Farm and ranch businesses are also often excluded from the eligibility list of many insurance carriers.

Additionally, most farmers and ranchers are not large enough to enter the arena of self-insurance which through ERISA preemption allows larger employers to reduce their health costs through exemptions for mandates and community rating.

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

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

Farmers and ranchers should have options. The Washington Farm Bureau established its health plan 4 years ago. It has grown to the point where it now covers 30,000 subscribers and has over $50 million in annualized premiums. As a bona fide association, the plan offers guaranteed, issued coverage to all of its members, thus eliminating the cherry-picking issue.

Each farmer and ranching member is offered a preferred or standard rate with a maximum premium differential spread of 30 percent in our rates. Our health plan enjoys a 99.2 percent retention rate after 4 years of operation. Of those who join our plan, we have found that over 25 percent enter with no prior health insurance coverage. Even with its success, several State-mandated provisions which would not be required under an ERISA self-funded plan, have prevented additional flexibility and could further reduce the cost of the plan.

Other Farm Bureau organizations would like to participate in the Washington Farm Bureau plan or duplicate that plan for them-

selves, but because they cannot cross State lines or State laws prohibit this type of a plan or do not allow the latitude needed to provide such a plan they are unable to establish a program for their own members. Each State requires separate approval, making it impossible for multistate plans to be implemented. Also, increased administrative costs could be directly attributed to the multi-State jurisdictions. It can easily cost millions of dollars to obtain a license within each State and thousands of dollars to gain approval for each and every insurance policy offered within a State jurisdiction.

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

The American Farm Bureau would encourage additional consideration of some provisions of AHP legislation as embodied in H.R. 660. For instance, we believe that the state of domicile provisions need to be to be clarified: Plans should only need to meet the form filing requirements in the State where the plan is domiciled, and an admitted carrier in any State where they operate fully-insured plans should be used. The language also needs to better define the operation of fully-insured AHPs.

Size requirements of AHPs should be reviewed in the case of self-insured plans and ensure that qualified individuals will operate the plan. We feel there is a need to better define solvency requirements for self-insured plans by establishing a formula that take into account reasonable initial capital, surplus and reserves when establishing an AHP.

These concerns, however, are minor compared to the overall need to enact AHP legislation this year. Health insurance premiums have been skyrocketing, and it is having an increasingly adverse impact on the ability of our members to provide coverage for themselves and for their employees.

AHPs represent a major step that, if implemented correctly, can significantly improve the prospects of better insurance coverage for farmers and ranchers and millions of others across the Nation. We do strongly urge the adoption of AHP legislation and offer to help in molding the legislation.

Chairman MANZULLO. You have already helped with that testimony. Thank you so much.

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

Our next witness is Karen Kerrigan, founder and chairman of the Small Business Survival Committee. We look forward to your testimony. Thank you for your patience.

STATEMENT OF KAREN KERRIGAN, CHAIR AND FOUNDER, SMALL BUSINESS SURVIVAL COMMITTEE

Ms. KERRIGAN. Thanks go to you, Chairman Manzullo, for, first of all, having this very important hearing today. Your leadership has been extraordinary on this issue, and we congratulate you.

We also thank the ranking member, Congresswoman Velazquez, for her support, for her passion and her tenacity on this issue as well.

Again, my name is Karen Kerrigan. I am Chair of the Small Business Survival Committee. We are a national nonprofit small business advocacy organization with over 70,000 members Nationwide.

The issue of affordable health care, of competitive health insurance, of consumer-centered health care has been an issue since our founding in 1994. Obviously, the issue of cost has reached a different level over the past several years in terms of being a major impediment for our members to provide health insurance for their employees. It has become a hindrance to the growth of firms, to their ability to create jobs and to invest in their business. But we are very optimistic that something will be done this year in the Congress with the support of the administration in moving something through that will provide small businesses with some relief and get more people into the ranks of the uninsured.

Certainly, SBSC stands in support of Association Health Plans. It only makes sense that small businesses are allowed to purchase health insurance under the same regulatory framework and conditions as large businesses. It is equitable and will have a positive impact on the ability of all firms to afford health insurance, control costs and retain and attract quality employees.

One of the other issues that we have been focused on in our organization now since our founding is how to make the system more consumer centered. How do you put consumers back in control of the system? That is why we have supported Medical Savings Accounts for many years.

As you know, Chairman Manzullo, MSAs were passed as part of the 1996 Health Insurance Portability Act. They were a pilot project that were enacted as part of that law. The program has been extended, I believe, now three times and is scheduled to expire at the end of this year unless Congress takes action.

The uncertainty in the program itself really has been a hindrance to MSAs reaching their full market potential in the marketplace. However, they are doing their job. According to the Internal Revenue Service, 73 percent of people who are buying MSAs are the previously uninsured. Over 70 percent are families. We think that, in order for them to have their full potential in the marketplace, that certain restrictions must be removed from Medical Savings Accounts.

Number one, they need to be made permanent so there is certainty, so the industry does market them to the full extent that they can, they put resources into it, that they be made permanent, I said, they be made universal, that all people have access to Medical Savings Accounts, regardless of the business or regardless of their employment status. Right now, it is limited in terms of who can purchase them.

We also believe that other restrictions like allowing both the employer and the employee to contribute to the Medical Savings Account will make it a very attractive—is another attractive feature that we believe will give it good standing as a product to compete in the marketplace.

So these reforms were passed, along with AHPs by the House last year, but nothing did happen in the Senate. We are encouraged by the administration's support of these reforms. It is in the

budget. And we are encouraged by the bipartisan support that MSA expansion and permanency has received both in the House and in the Senate.

Lastly, I would like to also putting a quick pitch for one other reform that really does recognize the fact that, even if all of these reforms were to take place, not all—there will be small businesses, some left, that still will not be able to afford health care. There will be a sector in the workforce, very highly mobile sector that will be very hard to insure. That is why we also support refundable tax credits for individuals. We think this recognizes the highly mobile nature of our workforce, the entrepreneurial nature of our workforce, and legislation has been reintroduced again in mid-February.

So these are the types of reforms that we hope will also be enacted along with AHPs to bring more people into the system to make it more accountable and responsive to all consumers. Thank you.

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

Chairman MANZULLO. Thank you very much.

Our next witness is Harry Alford. He is the President and CEO of the National Black Chamber of Commerce. We got to meet him about a year and a half, 2 years ago; and you have been a witness about two or three times since then.

Mr. ALFORD. Yes, sir.

Chairman MANZULLO. We should have met earlier than that. We like to have you testify here.

Mr. ALFORD. I love to testify.

Chairman MANZULLO. The way it works out, the minority asked that you testify; and I said, gosh, whose witness is this? So I will make sure for this hearing that you are a minority and a majority witness, because you speak for everybody.

Mr. ALFORD. The Honorable Nydia Velazquez and the National Black Chamber of Commerce have strong ties and go back a ways, so I am honored and flattered to be here.

Ms. VELAZQUEZ. It shows, Mr. Chairman, that I do not discriminate.

STATEMENT OF HARRY C. ALFORD, PRESIDENT/CEO, NATIONAL BLACK CHAMBER OF COMMERCE, INC.

Mr. ALFORD. Mr. Chairman, Ranking Member Velazquez, thank for having the National Black Chamber of Commerce here. As President and CEO I am proudly representing the 1 million businesses in this Nation that are owned and operated by African Americans.

Our businesses are the key to job creation and wealth building. Small business growth in the African American communities will lead to new jobs. The African American community comprises 25 percent of its total population living under the poverty level. The fastest and permanent way to lead people out of poverty, poor health care, substandard education, is a means for employment. Small business accounts for the vast majority of new employment in this Nation.

We want our segment of the population into the mainstream of the economy and off the dole. It is naive to carry on as if we can collateralize food stamps and turn public housing certificates into

assignable rights guaranteed to heirs. Employment that provides a decent living and suitable benefits is the key, and that is our charge via business development.

There is one problem with the above mission. With each job there should be health insurance. Unfortunately, there is not and, in fact, the possibility of health coverage for new employees is becoming more and more difficult. Even retention of current health care coverage is become overwhelmingly difficult.

Health care coverage at the NBCC national office has increased over 42 percent over the last 2 years. Two years ago, we had to cease offering health coverage to all new hires to our workforce. This has since become the top reason for attrition and has caused much difficulty in competing for the top echelon in the talent pool.

This is not unique, and our constituents complain about this problem constantly. It has become a national challenge and indeed a crisis.

The products of the civil rights movement have been many. The most important trend is a large mass of first generation college graduates who have subsequently gained valuable expertise training via employment with Fortune 500 companies and the officer ranks in the military. This group and their offspring are providing ready, willing and be able entrepreneurs.

I am a perfect example. My great-grandparents were slaves. My grandparents were Louisiana sharecroppers. My father was a truck driver who never made more than $15,000 a year. My mother was a domestic.

Through the success of the civil rights movement I was able to become a graduate of the University of Wisconsin, an officer in the U.S. Army, and a manager with three Fortune 100 corporations. This is not an unusual standard for my generation, and no nation on this Earth has provided such rocket speed access for a downtrodden segment of its society.

Responding to the great need for affordable health care, the NBCC has made many attempts to create a plan that could be offered to our constituents. We have failed every time, and it is mainly because of the decentralized oversight and regulation regarding insurance. We will not be able to adequately respond to the situation until there can be a way to provide a national plan.

The President and certain Members of Congress have proposed the use of Association Health Plans. We see this as the answer, a plan that can be offered to our constituents void of 50 different regulations, one for each State, and making coverage affordable.

The bottom line is too many of our small business owners cannot afford health care coverage for their employees. This can only be overcome by the inducement of incentives and the removal of barriers. Demanding that businesses provide insurance that they cannot afford will lead to job shrinkage and even business closings. Our economy cannot endure such a bad policy. What is needed is a comprehensive national plan such as H.R. 660, the Small Business Health Fairness Act of 2003, introduced by Representative Ernie Fletcher.

The National Black Chamber of Commerce, on behalf of 1 million black business owners who have the charge of economically stimulating low-income communities, will support such legislation. We

will actively participate in advocating such legislation and will fiercely promote it to our members.

Thank you, Mr. Chairman and Ranking Member Velazquez.

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

Chairman MANZULLO. I want to thank you all for your patience.

I have probably more comments than questions, but, as I sat here, Mr. Hughes, listening to your testimony, you could immediately reduce the cost of health insurance by 15 percent if we got rid of the FUTA tax for small business people and treated sole proprietors and partners in the same manner as corporations. Is that a correct assessment?

Mr. HUGHES. That is a correct assessment. We believe that it helps the health care issue substantially because it does provide a significant affordability benefit for all of those self-employed people. Greater than that, however, is the fairness and the equity. Our tax system simply discriminates against the self-employed on this issue.

Chairman MANZULLO. Mrs. Velazquez—or FICA. I am sorry. I get the AFL-CIO and FBI—I understand those.

Mr. HUGHES. It would do it for FUTA as well, although little—only $56 a year.

Chairman MANZULLO. Ms. Velazquez, we share some common traits. Neither of us have the gift of patience, but we both have the gift of persistence. I think that is one of the reasons—our patience has run out. If AHPs are so great, then why has it not been done? And her desire to move this as a solo bill so it gets through.

But one of the things that I would suggest if you are going to attach anything to it would be the very provision to which you testified. Because it makes so much sense and it brings equity among the little guys that simply cannot afford to go out.

I am just throwing that out. The folks from the SBA are here, and they are listening very intently. I tell you, it would be tremendous—just out of the box, boom, we are going to lower it by 15 percent and eliminate that and how easy. No new government. It takes one change in the tax law, and that is it. Automatically, it is reduced by 15 percent; right?

You like that, Richard? Mr. Spence back there with the congressional liaison does a great job for the SBA.

But these are the types of things that Members of Congress like because they are self-executing. It does not require the setting up of any new agencies or any new bureaucracy on it.

Mr. Appel, my question to you, and comment, is it appears that the State of Washington enacted legislation that is making AHPs work on the State level. Would that be——.

Mr. APPEL. That is a correct assessment, Congressman.

Chairman MANZULLO. Has it driven down the premiums of insurance?

Mr. APPEL. At this point in time over—our experience over the past 4 years with our particular group is that we have experienced less than 50 percent of the rate of increase that the rest of the industry in the State has experienced.

Chairman MANZULLO. Okay. One of the things that I would suggest, and this is really critical, is that the things to which you testified, there has to be a way to interface, perhaps, the Washington

program so that a national program does not wipe it out. Are you with me on that, and that is your concern?

Mr. APPEL. Actually, as we see the potential national program it would actually give us some other option. I would offer this as an example: We are a State that borders the State of Idaho, for example; and we have many growers—a State boundary is just a line on a map, and we have many growers with property on either side of that line. But if their residence is on the Idaho side of the line they cannot participate in our program, even though their operation is on our side of the line. If we have a national AHP language, we could then offer them coverage.

Mr. MANZULLO. So, in your opinion, can you have the two plans side by side?

Mr. APPEL. Yes, in my opinion, you can.

Chairman MANZULLO. That is extremely important. I think that should be in any legislation that even though there is a preemption—I am thinking out loud right now, but the question came up on competition; and in the drawing of this very delicate language, I would just stay very close. The Farm Bureau has always participated, but it is extremely important that that type of plan be able to, in my opinion, coexist with a Federal plan. Okay?

Mr. APPEL. We believe, actually, as we understand the Federal plan, that they are almost—never 100 percent—one and the same type of thing. It actually is a benefit to our plan, not a hindrance.

Chairman MANZULLO. And you have studied that professionally? You have come to that conclusion?

Mr. APPEL. I am not going to claim—I am a dirt farmer from Dusty. I always like to say that.

Chairman MANZULLO. You grow barley for the beer for Mr. Town's brother's tavern.

Mr. APPEL. Right. Exactly.

Chairman MANZULLO. Mr. Alford, with regard to if AHPs pass, do you conceive or perceive that perhaps the Black Chamber of Commerce could be placed in a role of administering an AHP plan or contracting out or being a part of this?

Mr. ALFORD. That would not be wise for us to have our own plan, based on the medical data of the African American male with diabetes. That would be a high-risk baby. But we would merge probably with either the U.S. Chamber or NFIB.

Chairman MANZULLO. So you would see that two or more organizations that could qualify could piece together——

Mr. ALFORD. Yes, sir.

Chairman MANZULLO [continuing]. And to contract or whatever it is to come up with your own plan?

Mr. ALFORD. That would be the logical approach for us.

Let me say also, time is of the essence. A solo bill makes a lot of sense in terms of time. And run it through the House, get it through the Senate, take it to the President's desk. Let's pull the trigger.

Chairman MANZULLO. Well, we do not have jurisdiction over the drafting of the legislation or putting it through, but I agree with that. Let's just get it moving. And I would be glad it work with you on that.

Ms. Velazquez.

Ms. VELAZQUEZ. Mr. Alford, recent studies show that there is a—25 percent of minorities that lack health insurance, while the national rate was near 15 percent. With this AHP legislation we hope to close this gap. Some studies estimate that AHPs could reduce the number of uninsured Americans working for small business by anywhere from 10 to 20 percent. Based on your membership, do you see similar reductions in the uninsured, or will AHPs have greater impact for minority businesses?

Mr. ALFORD. I think it would be a greater impact increasing the amount insured. Looking around metro D.C., you would not see that great of an impact, but in Kansas City, Wichita, Phoenix, you would see a tremendous impact on people having the ability to provide health insurance for their families.

Ms. VELAZQUEZ. Thank you, Mr. Chairman.

Chairman MANZULLO. Mr. Appel, you stated that when your plan came into effect people who were not insured before became insured. Do you remember making that statement?

Mr. APPEL. Yes, sir.

Chairman MANZULLO. Could you quantify that for us?

Mr. APPEL. The numbers—if you look at our entire plan and operation 4 years down the line, the 4-year experience is that 25 percent of those who joined our plan previously carried no insurance.

Chairman MANZULLO. That is astounding. Absolutely astounding.

Mr. APPEL. Rural America is looking for a way to cover themselves with health insurance. It has been a very difficult situation over time. My members, frankly, in my home State were screaming at me, saying, get us some kind of health insurance product. This is where we went, and it has worked out well for us.

Chairman MANZULLO. The final question is for my constituent over here. Skip, are you still with us? A little bit different experience than being back home and working in the shop, isn't it?

Mr. TROTTER. Most certainly.

Chairman MANZULLO. Are you enjoying yourself?

Mr. TROTTER. Oh, yes.

Chairman MANZULLO. Just think if the cameras were here. They are probably covering what happened to the animals at the zoo than showing up here today.

You had a 40 percent increase?

Mr. TROTTER. That is correct.

Chairman MANZULLO. Was there somebody—no one had a cancer or anything serious? It was just an overall 40 percent increase?

Mr. TROTTER. That is correct.

Chairman MANZULLO. I presume you shopped.

Mr. TROTTER. I shopped, and the lowest bid that we had was roughly 27 percent.

Chairman MANZULLO. One of the things that I have seen happen back home is that people have gone out and gotten a second insurance company to insure the deductible.

I would be glad to talk to you afterwards. There is a friend of ours that lives in McHenry County—we had a hearing in Rockford, remember that, a year ago on health insurance?

Mr. TROTTER. Yes, sir.

Chairman MANZULLO. And the gentleman from Woodstock who runs—Phil Bartman, who runs Cellular One, a telephone company,

portable telephones, testified that I think he had maybe 12 or 14 employees and that his insurance premium was going to go from $8,500 to $16,000. Sitting in the audience was a gentleman from Ringwood, Illinois, Scott Shalak, who is an insurance salesman. Scott went up to Phil afterwards; and he said, Phil, have you considered getting a second insurance company to insure your deductible; and Phil had never heard of that.

He did that, and his increase went from—instead of $8,500 to $16,000, it went from $8,500 to under $10,000. So it was a tremendous amount of shopping that can be done out there. This is not touting the constituent's name or something but just telling you this is what happens in the area out there when people get a little bit ingenious and try to use some different models.

I guess my final comment is, Mr. Alford, it just dawned on me that African American-owned small businesses that have a majority of African American population as their employees are really hit.

Mr. ALFORD. Yes, sir. It has a profound effect, and it is—basically, entrepreneurship, capitalism is the only way out. And African Americans people hire their own. So African American businesses tend to hire African Americans, Korean businesses tend to hire Koreans. So the ethnicity of the business activity in that neighborhood means a lot to the local economy, whether or not the dollars are circulating in that economy and the people are participating or if it is siphoning out.

Chairman MANZULLO. In the ratings, because African Americans have higher incidents of diabetes, heart disease—and there is one another?

Mr. ALFORD. High blood pressure. I have all three. Living testimony.

Chairman MANZULLO. Do insurance companies rate African Americans higher based upon those——.

Mr. ALFORD. I don't know of any studies.

Chairman MANZULLO. Do you have ratings statistics on it? Maybe it is not a fair question.

Mr. ALFORD. I would think if it was a wide pool—our insurance is with Aetna U.S. health care. I doubt if it is a wide risk. But if it is a tight pool somewhere.

Chairman MANZULLO. I imagine if it was a mom and pop operation, they would take a look at it.

Mr. ALFORD. It would depend on the insurance; and if it was Detroit versus Seattle, I bet it would be a significant difference.

Chairman MANZULLO. You guys have been very patient. Thank you for coming to Washington. You come from a long distance to add a tremendous amount of knowledge and wisdom.

Members of Congress rely upon your testimony, the things that you tell us. Even though our Committee will not write that health bill, there are a lot of things that you have said today.

Bob Hughes, with just a very simple statement there on automatically reducing health insurance premiums by 15 percent as an issue of parity, that is something that could be chewed upon immediately with very little hesitation.

And, Steve, your statement that in the AHP equivalent that your State passed that 25 percent of the participants had not had insur-

ance before, this really gives credence to the guidance to where we want to go with these plans.

So it is not a matter of theory, it is actually working in your State. So, again, thank you for coming.

The complete statements of the witnesses will be included in the record. Anybody that wants to add to the record, you can do so. Keep it under 2 pages of not less than 12-point type. We will go with 10-point Elite single spaced. We will leave the record up for 7 days for any additional statements that have to be made.

Chairman MANZULLO. This Committee is adjourned.

[Whereupon, at 5:00 p.m., the Committee was adjourned.]

House Committee on Small Business

"Small Business Access and Alternatives to Health Care"

March 5, 2003

Opening Statement of Chairman Donald Manzullo (IL-16), House Small Business Committee

Good Afternoon. It is my pleasure to welcome everyone to today's Small Business Committee hearing on the critical issue of small business access and alternatives to health care.

I am pleased to have our colleague Dr. Fletcher discuss his bill, HR 660 before our committee. Additionally, I would like to extend a very warm welcome to the former chairman of this committee, who now resides in the other chamber, Senator Jim Talent.

It is a great privilege to have Secretary Elaine Chao before this committee. And as always, I look forward to hearing from the SBA Administrator, Hector Barreto as well as of all of our witnesses.

Improving access and affordability to health care is one of my priorities for this committee.

Year after year, small business owners rate access and affordability of health care is the most important issue facing them.

Of the 43 million Americans with no health insurance, 60 percent are small entrepreneurs, their families and their employees.

Affordability is always the major concern for small employers and the self-employed.

Exorbitant health care costs are one of the biggest expenses small businesses and the self-employed incur as they struggle to provide coverage for their employees. As Congress continues to examine our nation's health care problems, we need to remember that 60 percent of the estimated 43 million uninsured are small business owners, their employees and families.

Small business owners are unable to absorb spiraling health care costs and find themselves priced out of the health insurance market. Many owners are faced with the choice of staying in business or providing their employees with insurance.

My own brother was nearly driven to close the doors on our family run business because of the exorbitant cost of health care insurance.

Our current health care system does not provide equal access to

affordable and quality healthcare for small businesses.

One of the reasons small businesses cannot afford health coverage for their employees is that they are unable to achieve the economies of scale and purchasing power of larger corporations and unions. Small businesses suffer from unequal treatment -- what they want most is a level playing field when it comes to health care.

Large corporations use the purchasing power of thousands of employees to offer affordable health insurance to their workers. Small business owners, on the other hand, have to find their insurance on an individual basis, making it very difficult and expensive to find affordable health coverage.

I was very heartened to see President Bush issue his plan for helping small businesses prosper in our economy. The President is aware of the health care access and affordability problems facing small business, and his plan includes concrete steps to increase health security for employees of small businesses.

His agenda calls for Association Health Plans or AHPs to be available for associations that want to provide health coverage for their members.

I am an original co-sponsor of Rep. Fletcher's bill HR 660, that will allow AHPs.

The President's agenda also calls for a permanent extension of Medical Savings Accounts, including a significant reduction in the required deductible for these health accounts.

Congress needs to ensure that there are many different health insurance options for small business owners to utilize. We need to help our businesses attract and keep employees, and nothing helps more than the ability to provide health insurance.

I look forward to the testimony of all the witnesses here this morning and I turn to my colleague, the Ranking Member for her opening statement.

Return to Hearing Summary

Return to Home Page of House Small Business Committee

The United States House of Representatives
Committee on Small Business

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House Committee on Small Business

"Small Business Access and Alternatives to Health Care"

March 5, 2003

Opening Statement of Ranking Member Nydia Velazquez (NY-12), U.S. House Small Business Committee

Thank you, Mr. Chairman.

Today, we are facing a health care crisis. It is astounding that in the U.S. – the only remaining superpower, the country with the largest GNP and the world's economic driver – there are 44 million Americans who cannot afford health care. That is outrageous.

Nowhere is this health care gap more striking than in our nation's small businesses. More than 60 percent of the 33 million adults and 11 million children without health insurance are small business owners, their employees or their families.

Small businesses bear the brunt of the health insurance crisis because of the two "c's" – choice and cost. These are the two things that keep affordable, quality health care out of reach for small businesses.

Small employers face few options when it comes to health insurers and benefits. The market has become so skewed that in many parts of the country, small businesses have only one or two providers to choose from when trying to meet the health care needs of themselves and their employees.

In fact, a recent report by the SBA's Office of Advocacy revealed insurers of small health plans have a higher administrative burden than those that insure large companies. These high administrative costs drive down the number of small health plan insurers, narrowing the field even more, and giving small business even less choice than they already have.

Cost is another barrier. Many small businesses are simply unable to afford health insurance. Those that can saw premiums increase 15 percent in 2002. Year after year, we see double-digit spikes in insurance costs causing small firms to drop coverage. For example, coverage rates for firms with fewer than 50 employees are below 50 percent, while coverage rates for large employers are almost 90 percent. Once again, it's big business that wins and small business that loses.

Small businesses that can afford health care pay as much as 30 percent more for policies similar to those offered by large corporations. While corporate giants can marshal accounts worth thousands of new

customers and can negotiate health premiums on their own terms, small businesses are left with a "take it or leave it" attitude from insurers.

As the state of health care for small business reaches a critical stage, President Bush should be paying attention to it. But he isn't. The president certainly knows how to talk the talk – health care was on his small business agenda, released a year ago this month. But to date, we have seen no real action.

One solution that could go a long way is allowing small businesses to band together through Association Health Plans. AHPs will enable small businesses to harness their purchasing power while bringing equity to the insurance market. This is what we allow Corporate America to do, and if it is good enough for Corporate America, then it should be good enough for small business.

While it is important to help small businesses, it is critical that the price we pay is not with diminished employee health care. That is why for AHPs to work, we must have strong solvency requirements, adequate enforcement dollars and a system that does not discriminate based on health care needs. These protections, coupled with increased access and cost savings, will begin to turn the tide for the small business uninsured.

I want to take a moment to commend former House Small Business Committee Chairman, Senator Jim Talent for his leadership on this issue, Mr. Dooley, Mr. Fletcher, and Mr. Johnson. Working together we recently introduced AHP legislation, H.R. 660, the Small Business Health Fairness Act, which will go a long way in helping many small businesses.

Small businesses, like health plans, come in all sizes and span industry sectors. There are private and self-insured plans, state sponsored cooperatives, and now AHPs. AHPs alone won't solve all the health care dilemmas of small business, but in combination with other alternatives, they can provide small businesses with two things they have not had before – more choice and lower costs.

Nowadays when I talk to small businesses, their top concern is health care. We need to stop talking about the health care crisis facing small business and start doing something about it. Large corporations shed jobs and wreak havoc during times of recession. Yet they have access to quality, affordable health care.

On the other hand, small businesses are the backbone of our economy, they create 75 percent of all new jobs, and make up a large percentage of individuals in the U.S. who don't have health coverage. Something is wrong with this picture. It's backwards, and I want to do something about it. I look forward to working with you all on this.

Thank you.

Return to Hearing Summary

Return to Home Page of House Small Business Committee

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U.S. House Committee on Small Business
" Small Business Access and Alternatives to Health Care"
March 5, 2003

Statement of Senator James M. Talent (R-MO)
"The Time to Act on AHPs is NOW"

Good morning. I would like to thank Chairman Manzullo and Ranking Member Velazquez for holding this important hearing, and for inviting me to testify about a subject that I feel strongly about: Association Health Plans.

I would like to begin my remarks by saying something we can all agree on: A major concern facing small business owners is access to quality, affordable health care. Of the 39 million Americans who lack health insurance,[1] more than 80% are workers and their families.[2] The lack of health insurance in America disproportionately affects workers in small businesses.[3] About 6 of every 10 uninsured Americans are in families headed by workers who are self-employed or who work at firms with fewer than 100 employees.[4] Workers at the smallest firms are far less likely to be covered on the job, and far more likely to be without insurance from any source.

Association Health Plans empower small business owners, who otherwise cannot afford health insurance, to offer "Fortune 500" company quality health insurance to their employees. AHPs allow national trade and professional associations, from the National Federation of Independent Business to the American Farm Bureau Federation, to respond to the needs of their membership and sponsor health care plans. In other words, AHPs are a solution to a problem that does not discriminate by locale – it helps the small business owner in cities and towns as well as the farmer and rancher. Any small business owner can buy into these plans for themselves, their employees, and their dependents.

Association Health Plans would cover large groups, enjoy large economies of scale, and have the option to offer self-funded plans that would not have to provide any profit margin for insurance company profits. Importantly, AHPs would expand health care coverage to millions of Americans at no cost to taxpayers.

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[1] Robert J. Mills, "Health Insurance Coverage: 2000," *Current Population Reports* P60-215, U.S. Bureau of the Census, September 2001.
[2] Ken McDonnell and Paul Fronstin, *EBRI Health Benefits Databook* (Washington, DC: EBRI, 1999).
[3] "Association Health Plans: Improving Access to Affordable Quality Health Care for Small Businesses," U.S. Department of Labor, released September 13, 2002, at 4.
[4] National Association for the Self-Employed, "Affordable Health Care: Conditions Critical for Self-Employed, Study Shows," Press Release, June 18, 2002.

Statement of Senator James M. Talent (R-MO)
"The Time to Act on AHPs is NOW"
U.S. House Committee on Small Business
March 5, 2003
Page 2

Background

Association Health Plan legislation was first introduced in the 104th Congress to give small businesses the same health care advantages of cost and efficiency as large single employers and unions. Since its inception, AHP legislation has been improved to strengthen solvency requirements and state enforcement provisions.

During and since my tenure as Chairman of the House Committee on Small Business, I have championed AHP legislation as a means to reduce the number of uninsured in Missouri and across the country. AHP legislation was included in the bipartisan Patients' Bill of Rights legislation that passed the House last Congress. I thank my former colleague Representative Ernie Fletcher for reintroducing this legislation (now H.R. 660) this Congress, and for championing its cause. I also thank Chairman Manzullo and Ranking Member Velazquez for supporting AHPs and for holding this hearing today to build a strong record upon which AHP legislation will pass the House on a bipartisan basis for a fourth time.

In the Senate, the new Chairwoman of the Small Business Committee, Senator Snowe, will be introducing the same AHP legislation in the very near future with Senators Christopher "Kit" Bond and me. The Senate legislation mirrors the House bill, and currently has the additional support of Senators John McCain, Elizabeth Dole, Kay Bailey Hutchinson and Norman Coleman. It also has the support of dozens and dozens of business and grassroots organizations from the National Black Chamber of Commerce to the National Association of Women Business Owners to the American Farm Bureau Federation.

Clearly, now is the time to enact AHP legislation. Not only does it have bipartisan support in the legislative branch of government and from important business and farming associations, but President Bush has voiced his strong support as well. Specifically, President Bush has stated:

> "I strongly support association health plans. That means that small businesses will be able to pool together and spread their risk across a larger employee base. It makes no sense, no sense in America, to isolate small businesses as little health care islands unto themselves. We must have association health plans."[5]

[5] "Women Entrepreneurship in the 21st Century Summit," March 19, 2002. U.S. Department of Labor, September 13, 2002.

Given the bipartisan, bicameral support in favor of AHP legislation to solve the health care crisis facing small business owners and their families, there is no reason not to act this Congress to make Association Health Plans a reality. AHP legislation will not only save small businesses money, it will save lives.

A Solution to the Health Care Crisis

There are approximately 600,000 uninsured Missourians.[6] Of these people, there are approximately 66,000 children who are uninsured. The number of uninsured in Missouri represents approximately 10% of my state's population – and this is unacceptable.

AHPs are a solution to help create access to health care. The Congressional Budget Office (CBO) has estimated that small businesses obtaining insurance through AHPs will enjoy premium reductions of 13% on average.[7] The average reduction amount ranges from 9% to as much as 25%.[8] Because insurance will be more affordable, more small firms will provide it to their employees and families.

According to the CBO, as many as 2 million American workers and their families would obtain health insurance through AHPs.[9] But these predictions may be too conservative. Among 600 small businesses responding to a recent survey, less than one-third currently offer insurance, but about three-fourths said they would be "very" or "somewhat likely" to participate in an AHP that offered lower prices, more choices, or less paperwork.[10] And, offering an alternative to red tape and reams of paperwork to provide insurance on an individual or a small group basis is another benefit of AHPs.

Breaking Insurance Monopolies

Perhaps it comes as no surprise that insurance companies like Blue Cross and Blue Shield (BCBS) do not like AHPs. One would guess that these insurers would welcome AHPs as an opportunity to make a lot of money by selling possibly tens of thousands more policies. However, that does not seem to be the case. And why not? Because insurers have a monopoly on health insurance through their ironclad grasp of market share. Insurers have no incentive to change the status quo and conduct business otherwise because they are exempt from antitrust laws. In other words, the largest

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[6] Census Bureau, 2002 Population Survey.
[7] "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts," CBO, January 2000.
[8] "Association Health Plans," at 5.
[9] "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts."
[10] "Affordability in Health Care Survey: Trends in American Micro-Business," a survey conducted for the National Association for the Self-Employed by Research USA, Inc., released June 2002.

insurers may choose to maintain their monopolies and resist change to the detriment of small businesses and their families.

I share the opinion of many of my colleagues that health insurers are motivated by profit, not consumer concern. The General Accounting Office has found that the five largest carriers, when combined, represent 75% or more of the market in 19 of the 34 states GAO reviewed, and they represented more than 90% in seven states.[11] Moreover, 25 of 37 states identified BCBS as the largest carrier offering health insurance in the small group market.[12] In addition, the median market share of all the BCBS carriers in the 34 states supplying information was about 34%.[13] In Missouri the five largest carriers have a 51.8% market share, and all BCBS carriers have a 32.2% market share.[14]

The CBO estimates that AHPs will offer health insurance premium reductions of between 9% and 25%.[15] That's about $450 to $1,250 per covered employee.[16] Clearly, these reductions are going to hurt the bottom line of insurance companies and reduce their stranglehold on small business purchasing options.

I believe in free market principles of competition, and health insurance companies appear unwilling to play by any rules except the ones they set. That's not the American way, but that's why health insurers like the status quo – to protect their monopolies.

Now is the Time to End the Crisis

Now is the time to end the health care crisis in this country by enacting AHP legislation. Health insurance costs are hitting companies' bottom lines. The situation is bleakest for the smallest companies, whose costs are highest and rising most quickly. Their premiums increased 16.5% on average in 2001.[17] And premiums are likely to grow more quickly this year than last.

AHPs will make more affordable insurance options available to small businesses. As mentioned, CBO has estimated that small businesses obtaining insurance through AHPs will enjoy premium cuts averaging between 9% and 25%. The smallest firms stand to save the most from AHPs since they face the highest administrative expenses and have little buying power and few affordable options. AHPs will give small firms

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[11] GAO letter to the Hon. Christopher S. Bond, "Private Health Insurance: Number and Market Share of Carriers in the Small Group Market," March 25, 2002.
[12] Id.
[13] Id.
[14] Id.
[15] "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts."
[16] Assumes premiums of $5,000 per employee. "Association Health Plans," at 6. Mercer Foster Higgins reports that health benefits cost $4,924 per employee on average in 2001. Id.
[17] "Association Health Plans," at 6.

administrative savings, more purchasing power, and new, more affordable choices. Importantly, passing AHP legislation would unburden small business owners from worrying about how to provide health care to their employees owners to doing what they do best – running their businesses.

Again, I thank Chairman Manzullo and Ranking Member Velazquez for holding this important hearing, and for allowing me the opportunity to share important arguments in favor of AHP legislation. Now we need to take the next step toward making this goal a reality for small businesses. I urge my colleagues to support efforts toward passing AHP legislation to make health care affordable for millions of uninsured Americans.

The Hon. Ernie Fletcher
Testimony Before the Small Business Committee
March 5, 2003

I would like to thank Chairman Manzullo for holding this hearing on this important piece of legislation and for inviting me to testify.

Chairman, one of the greatest assets to our American economy is the growth and expansion of small businesses. In many instances, they are an economic engine for this nation and the first to feel the effects of rising health care costs. One of the highest costs for any small business is providing health care benefits to their employees.

It is sad that in a nation of such innovation and prosperity so many small business owners and their employees are left without the comfort and security of affordable, accessible, quality health care. Currently, 41 million Americans lack health insurance - 85% of those are from working families. However, the health care crisis for small businesses and their employees is even more bleak. Consider that 98% of large businesses, those employing over 100 employees, offer health insurance, while less than half of small businesses are able to offer this important benefit.

The best patient protection is access to affordable health benefit options. However, affordable health care coverage is becoming a larger burden and financial strain for most small business owners in America. As a family physician and former health care executive, I understand the pressures small businesses face. I have introduced H.R. 600, the Small Business Health Fairness Act of 2003, to ensure the basic right of health care security is extended to all workers, whether you work for an international conglomerate or the local hardware store.

H.R. 660, can reduce the high cost of health insurance for small businesses and the self-employed. An essential part of the solution is to allow small businesses across the country to pool together and access health insurance through their membership with bona fide trade or professional associations. Only through AHPs operating under a uniform set of rules can small business workers obtain the same economies of scale, bargaining power, and benefit design choices now available to workers in large corporations and labor unions.

The Small Business Health Fairness Act will:

- ✓ Decrease the number of uninsured Americans
- ✓ Reduce health insurance costs by 15 - 30%
- ✓ Provide new coverage options for self-employed -- like farmers and small business workers across the nation

- ✓ Put forth tough new solvency standards to protect patients' rights and ensure benefits are paid
- ✓ Promote greater competition and choice in health insurance markets

AHP legislation will offer employers and employees more options in healthcare benefits, as well as expanding access and choice for working families employed in small businesses. Experts estimate that up to 8.5 million uninsured small business workers could gain coverage if AHP legislation is enacted. Established trade and professional associations are uniquely structured to serve small employers and their workers by providing health benefits that meet their members' needs.

In addition, AHPs will strengthen health insurance markets by creating greater competition, which is severely lacking in the current market place. A recent GAO Report shows that the five largest insurance carriers combined have 75% or more of the market share in 19 of 34 states supplying information, and more than 90% in seven of those states. Greater competition will benefit consumers by bringing premiums down and expanding access to coverage.

Opponents of this legislation will continue to proclaim that the U.S. Department of Labor (DOL) is unable or unprepared to handle such a program. Such statements are baseless and contradictory to the record of facts. The DOL currently administers protections covering 2.5 million private, job-based health plans – those programs serve 131 million workers, retirees and their families. Sixty-seven million individuals are in self-insured plans that are monitored exclusively under DOL oversight. The facts clearly show that DOL has the experience, the personnel, and the vision to incorporate AHP legislation into the health insurance system immediately.

President Bush recently commented that AHPs are a critically important component to guaranteeing retirement and health security for all Americans. Congress and President Bush have an opportunity to make health insurance affordable for millions of small business workers by enacting legislation to bring Fortune 500 health benefits to the nation's small business workers on Main Street through Association Health Plans this year.

The President is ready for AHPs, the Department of Labor is ready for AHPs, small businesses, farmers and the self-employed are ready for AHPs. Uninsured Americans have already waited far too long for this basic right. Passing Association Health Plan legislation will help to address this inequity and provide more Americans access to affordable, accessible, quality health care through associations and small businesses.

I respectfully request that the Small Business Committee lend its support in moving this important piece of legislation through committee and to the House floor in an expeditious fashion.

TESTIMONY OF ELAINE L. CHAO
SECRETARY OF LABOR
BEFORE THE
COMMITTEE ON SMALL BUSINESS
UNITED STATES HOUSE OF REPRESENTATIVES

March 5, 2003

Introductory Remarks

Good morning, Chairman Manzullo, Ranking Member Velazquez, and members of the Committee. Thank you for inviting me to discuss the Administration's initiatives to expand health insurance coverage, and specifically our support for Association Health Plans (AHPs) to increase coverage offered by small employers.

More than 41 million Americans lack health insurance, and fully 85 percent of the uninsured are in working families -- with most working at firms with fewer than 100 employees. In fact, workers in small firms and their families comprise 60 percent of the working uninsured.[1] To increase health insurance coverage, the President has proposed a comprehensive reform agenda that includes tax credits for the purchase of individual coverage, expansion of the availability of medical savings accounts (MSAs), greater access to state-based high-risk insurance pools, medical malpractice reform, and AHPs.

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

The Uninsured and Small Businesses

Although most working Americans receive health insurance from their employers, small firms with fewer than 100 employees find it particularly difficult to offer benefits. Just 49 percent of these small businesses offer insurance, compared with 98 percent of larger firms with 100 or more employees. The picture is especially troubling at "low-paying small firms" (defined in a study as firms with fewer than 100 employees where more than half of the employees earn less than $9.50 per hour) where only 34 percent offer insurance to their employees. [2]

The difficulties that small businesses face in trying to offer quality, affordable health insurance explain a significant part of America's uninsurance problem. Small firms employ 42 percent of all workers. Yet these workers and their families comprise 60 percent of the working uninsured.[3]

We know that small employers want to offer health insurance to their workers and their families. Among 600 small businesses responding to a recent survey, less than one-third currently offer insurance, but about three-fourths said they would be "very" or "somewhat likely" to participate in an AHP that offered lower prices, more choices, or less paperwork.[4] Small business employees also value health insurance. According to a recent survey, health insurance was ranked as "very important" by 89 percent of small business employees.[5] AHPs can help make coverage a reality for more small businesses - the challenge we face is how to make AHPs a reality.

While tax credits, MSA expansion and other policies will all help increase coverage, AHPs are aimed squarely at the gap in coverage among small businesses. In order to understand why AHPs are part of the solution to expanding coverage, it's important to

understand the barriers that prevent many small employers from offering coverage today, as well as the harm they have experienced because of health insurance fraud.

Small Firms Face Numerous Barriers to Coverage

Cost is clearly the biggest barrier for small employers that want to provide health insurance. For a variety of reasons, insurers typically charge small firms more per employee than large firms for comparable coverage. Small company premiums are 20 percent to 30 percent higher than those of large self-insured companies with similar claims per covered employee.[6] Cost drivers include small businesses' administrative overhead, insurance company marketing and underwriting expenses, adverse selection, state regulatory burdens, and vulnerability to insurance fraud. Small firms are likely to offer less generous benefits and more of their premiums are consumed by administrative costs.

In addition, small employers' costs are rising more rapidly than those of larger employers. Total costs per employee increased by 18.1 percent at firms with 10 to 500 employees in 2002, compared with 11.5 percent at larger firms.[7]

Employees in small businesses bear the brunt of these cost increases, according to a recent survey by the Blue Cross Blue Shield Association (BCBSA), the Employee Benefit Research Institute (EBRI), and the Consumer Health Education Council. Of the businesses that changed their health benefits, 65 percent increased workers' copayments and deductibles, 30 percent raised the percentage of premiums paid by employees, and 29 percent cut back on the package of benefits offered.[8]

Rising health insurance costs are a significant barrier for employers to hire workers and keep their businesses afloat. According to a recent Conference Board poll of 120 chief executives, health insurance costs were cited as the greatest impediment to adding workers in 2001 and 2002.[9] Almost 82 percent of 1,017 members surveyed by the Connecticut Business and Industry Association in 2002 said rising health insurance costs were "an important factor" in decisions about whether to add workers.[10] In April 2002, the Small Business Association of Michigan commissioned a poll on the impact of rising health care costs on small businesses. They found that nearly a quarter of all small business owners (and 40 percent of women and minority-owned businesses) fear the high cost of health insurance will force them out of business.[11]

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

Insurance Company Expenses: According to the General Accounting Office[12], insurers incur higher costs when providing health care coverage to small employers than to large employers. Insurers must market and distribute their policies to a very large number of unconnected employers. They typically must compensate agents for each small policy sold or renewed. Some costs, such as the cost of collecting detailed medical histories for purposes of medical underwriting, are layered on each time an employer changes insurers - and smaller employers generally tend to change insurers more frequently.

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

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

State Regulatory Burdens: Some state laws further impede small employer coverage. Because some states have been very aggressive in regulating small-group markets, many insurance carriers have withdrawn from those markets, leaving employers with little choice in plan design or cost options. Five or fewer insurers control at least three-quarters of the small-group market in most states. In some states, insurance for certain small firms is available only through a state-operated risk pool or from one insurance carrier.[13]

Additionally, small employers are sensitive to the cost of state benefit mandates (such as requiring coverage for hair transplants, or treatment provided by acupuncturists)

that drive up the cost of the small group coverage. Such mandates are responsible for one of every five small employer decisions not to offer coverage. [14] Another study reported that mandates raise premiums by four to 13 percent, and that up to one-quarter of uninsured Americans lack insurance because of state mandates.[15]

Vulnerability to Fraud: Small employers are also especially vulnerable to health insurance fraud – scams that promise low-cost health coverage, but fail to deliver. Many of these arrangements are multiple employer welfare arrangements (MEWAs). MEWAs are arrangements that provide health benefits to employees of two or more unrelated employers who are not parties to collective bargaining agreements. MEWAs are subject to a complex mix of state and federal laws and regulations. While many MEWAs operate successfully and provide reliable benefits, unscrupulous promoters have exploited MEWAs' complex regulatory and oversight structure to operate Ponzi schemes that collect premiums but intentionally default on benefit obligations. Fraud increases the cost for everyone, and the fear of being taken in deters many small employers from offering coverage at all. AHP legislation will help protect against this type of abuse.

Current Anti-Fraud Activities of the Department of Labor

Let me take this opportunity to focus on the Department's current efforts to combat health insurance fraud. AHP legislation will help address this serious problem by providing an attractive, cost-effective alternative to fraudulent health plans.

The Department combats health insurance fraud through both education and enforcement. By educating small employers, we can alert them to ways they can protect themselves and their employees from fraudulent health insurance schemes. The

Department also devotes significant resources to enforcement efforts. Our efforts have been effective in closing down fraudulent health plans and, in some cases, recovering money for their victims.

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

The Department provides guidance to small employers on how they can avoid purchasing health coverage from fraudulent MEWA operators. In an effort to educate small businesses about these risks, I recently wrote to over 80 business leaders and associations requesting them to distribute and follow simple tips drafted by EBSA, entitled "How to Protect Your Employees When Purchasing Health Insurance." These tips, which are also highlighted on EBSA's website, offer important warning signs for small businesses to consider about coverage that is "too good to be true." Checking simple information can alert small employers to fraudulent schemes. I encourage interested small employers and employees to visit the EBSA website at www.dol.gov/ebsa or call EBSA's toll-free hotline at 1-866-444-EBSA (1-866-444-3272) for further information about protecting themselves against fraud.

The Department also has published technical assistance materials for employers and service providers. Materials include a publication explaining current federal and state regulation of MEWAs, and guidance on what to do when health coverage offered by a MEWA is lost. EBSA has also issued numerous advisory opinions to assist state prosecutors and regulators in the enforcement of state insurance laws against MEWAs.

Enforcement: In addition to education efforts, the Department continues to devote significant resources to enforce existing health laws and to work with state insurance departments and the National Association of Insurance Commissioners (NAIC) to protect workers and their families. In particular, EBSA is actively investigating and litigating issues connected with abusive MEWAs. The Department's primary goals are to shut down such scam artists quickly, to appoint independent plan fiduciaries in order to protect plan assets, and to recover money for victimized workers.

To combat MEWA fraud and corruption, EBSA has implemented a two-pronged approach using both its civil and criminal enforcement authorities. Due to our enforcement efforts, almost $9 million was recovered in FY 2002 alone for innocent victims to assist them with unpaid medical bills. Most of the criminal MEWA investigations have been jointly conducted with other agencies including the Department's Office of the Inspector General, the FBI and the United States Postal Inspection Service. As of September 30, 2002, EBSA was pursuing 90 civil and 17 criminal investigations of fraudulent health plans.

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

unpaid medical providers' claims in order to protect the plan participants from being pursued by the health providers. Criminal sanctions are also being pursued.

The AHP Solution: Reduced Barriers and Fraud

Let me now turn back to our proposal to increase small employers' access to affordable health insurance through AHPs. In an AHP, the current market and financial barriers that face small businesses would be reduced or eliminated. Small businesses would enjoy greater bargaining power, economies of scale, administrative efficiencies, and the benefits of a uniform regulatory structure.

To combat fraud, federal certification demonstrating that legitimate and financially sound sponsors operate AHPs would provide small businesses with the assurance that the Department of Labor has determined that the organization offering coverage is not a "fly-by-night" operation. Certified AHPs would be subject to rigorous DOL oversight.

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

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

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

Streamlined Regulation: AHPs will allow small businesses to enjoy the benefits of a uniform regulatory system. For AHPs that offer fully insured coverage, state insurance commissioners would be responsible for the solvency of the insurance company issuing the policy, just as they are responsible for insurance policies issued to group health plans today.

AHPs that offer self-insured coverage will be subject to a single, effective, national certification, solvency and oversight process that will be administered by the Department of Labor. Strict standards would be met to ensure solvency and protect consumers and there would be no confusion or uncertainty over whether the states or the Department of Labor regulate certain aspects of the entity. Fully insured AHPs would purchase insurance products with solvency standards and consumer protections regulated by the states.

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

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

Expected Results of AHP Legislation

Cost Savings and Increased Coverage: Small businesses obtaining insurance through AHPs could enjoy significant premium reductions. According to the Congressional Budget Office (CBO),[16] the average savings would be at least 9 percent and could be as much as 25 percent per employer. CBO further estimates that, because insurance will be more affordable, as many as 2 million uninsured Americans will secure coverage. Indeed, CBO's predictions may be too conservative. A study by the CONSAD Research Corporation foresaw larger gains, estimating that up to 8.5 million uninsured workers and dependents could gain coverage from AHP legislation.

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

benefits, and more health plan choices, at affordable prices. " The American Society of Mechanical Engineers (ASME) looks to AHPs to help make health coverage more affordable for 19,000 of their members in nine states who have no access to the ASME group health plan due to the high cost of mandated benefits.

Ensuring That AHPs Keep Their Promises

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

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

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

Safeguards Against Insolvency: An AHP that offers self-insured coverage will be required to establish premium rates that are adequate to cover claims and maintain adequate reserves, as determined by a qualified actuary. Self-insured AHPs will also be required to keep additional funds on hand to cover unexpected losses. There will also be a funding mechanism in place to ensure that claims can be paid if an AHP becomes insolvent.

Insurance Market Safeguards: AHP legislation will include provisions to ensure that AHPs result in stable, reliable markets for health insurance. Spreading risk and costs across a large group of individuals is fundamental to effective health insurance. In the past, small group markets have sometimes been vulnerable to practices, such as adverse selection or "cherry picking," that segregate good risks from bad. Such practices can make insurance unaffordable or unavailable for small firms when employees or their families become seriously ill. To prevent cherry-picking, AHPs and participating employers will not be allowed selectively to direct their higher-cost employees to the individual insurance market. AHPs must offer all available health policy options to all of the membership's employers and individuals. Finally, legislation should also make clear that DOL has the authority to limit AHPs' ability to vary the premiums for their participating employers.

ERISA, HIPAA and Other Laws: Like other group health plans, AHPs will be subject to the fiduciary requirements of ERISA, which sets high standards of behavior for health plan sponsors. In particular, the Health Insurance Portability and Accountability Act (HIPAA) would apply to AHPs. Under HIPAA, group health plans are subject to portability, pre-existing condition, nondiscrimination, special enrollment, and renewability provisions. These provisions also will limit the opportunity for cherry-

picking. Other federal health insurance requirements that provide consumer protections such as COBRA, DOL's claims regulation, the Mental Health Parity Act (MHPA), the Women's Health and Cancer Rights Act (WHCRA), and the Newborn's and Mother's Health Protection Act (the Newborns' Act) would apply to AHPs.

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

Conclusion

Thank you for the opportunity to testify today. Small business employers and employees are in critical need of new ways to increase health insurance coverage, and Association Health Plans are a responsive solution to this problem. We at the Department of Labor stand ready to work with members of Congress and this Committee to help pass and administer legislation that expands health insurance coverage for working Americans.

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

Statement of Hector V. Barreto
Administrator
U.S. Small Business Administration
Access to Affordable Health Care
House Committee on Small Business
March 5, 2003

Chairman Manzullo, Ranking Member Velazquez, distinguished Members of the Committee and honored guests, thank you for inviting me to discuss how to provide greater access to affordable, quality health care for small businesses.

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

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

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

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

As Administrator of the SBA, I have had a chance to visit with small business owners throughout the country. During this time, I have visited some 26 states and have participated in numerous business roundtable discussions. No matter the topic of these discussions, small business owners inevitably ask me at these gatherings

what we can do in Washington to make health care more affordable for them. They tell me that their inability to find access to affordable, quality health care is their biggest concern.

The problem of providing access to affordable health insurance often forces small business owners into a cycle of delivering increasingly bad news to their employees. First they may inform their employees that their premiums will increase for the upcoming year. Then employees may be told that, despite the rise in premiums, their choices will be limited as they move from a PPO system to an HMO. But it may not end there. Many small business owners are ultimately forced to tell their employees that providing any health insurance is beyond their economic means and that all coverage is being dropped.

Studies bear witness to the truth of these anecdotes. Though businesses large and small have experienced rises in health insurance premiums disproportionate to inflation, small businesses have been particularly hard-hit. For instance, while premiums for the largest companies (5000+ employees) grew by 10.8% in 2001, premiums for companies with ten or fewer employees grew by an astounding 16.5% that year. Even before these increases, small businesses were already struggling to keep health care affordable for their employees.

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

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

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

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

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

I would like to address the problem as it affects Latinos since I have first-hand knowledge from my previous work experiences. Hispanics are now the largest minority group in the United States. They are also the least insured ethnic group. Approximately one-third of all Hispanics do not have any insurance at all, and another 15% to 20% are underinsured. Millions of Hispanics work for small businesses that are unable to provide them with the health insurance coverage they need.

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

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

President Bush is committed to creating an environment where small businesses can flourish. The President has made access to affordable health coverage a priority of his small business agenda, recognizing that these costs are prohibitive for many small businesses wanting to do the right thing. The Administration supports Association Health Plans (AHPs), tax credits for the purchase of individual coverage, expansion of the availability of medical savings accounts, greater access to state-based high-risk pools, and medical malpractice reform to curb frivolous lawsuits that drive up the costs of health insurance.

The President wants to make it easier for small business owners to pool together to offer their employees the same sort of affordable health coverage options that many large corporations and labor unions can currently offer. The President supports reducing the barriers current law places upon AHPs. Allowing AHPs to grow will expand access to health benefits to millions of uninsured Americans while providing more choices to small businesses that currently have only limited choices.

Enhancing AHPs will level the playing field for small businesses by enabling them to pool their resources across state lines, thereby benefiting from higher-volume purchasing and more coverage options. Small employers are often forced to seek health insurance for their workers as separate entities, making it more expensive or even impossible for them to purchase insurance coverage. AHPs would allow small businesses to join together, affording them the benefits of uniform federal regulation and greater economies of scale enjoyed by large employers and labor unions. Under current law, small businesses that choose to pool their resources must instead cope with the requirements and mandates of up to 50 different state insurance regulators that can prove to be so costly that forming AHPs is almost always cost-prohibitive.

Strengthening AHPs would make the option of pooling together with other small businesses and within associations to purchase health insurance much more cost-effective. As President Bush said last March at the Women's Entrepreneurship Summit, "I strongly support Association Health Plans. That means that small businesses will be able to pool together and spread their risk across a large employee base. It makes no sense, no sense in America, to isolate small businesses as little health care islands unto themselves. We must have Association Health Plans."

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

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

Once Congress passes legislation enhancing AHPs, SBA will seek to connect small business owners with the best solutions for providing health insurance to their employees. I want to thank Secretary Chao for the commitment and leadership she has shown on this issue and I look forward to working with her to help small business owners overcome their biggest hurdle. Until we come up with a solution that crosses state lines, I do not think we can solve this problem for small businesses. The time for Congress to act is now.

Thank you, Mr. Chairman and Congresswoman Velazquez, for the opportunity to discuss this issue. I am happy to answer any questions that you have.

Testimony of

Skip Trotter, Vice President of Operations
Trotter Machine Inc.

Before the

U.S. House Committee on Small Business

Small Business Access and Alternatives to Health Care

March 5, 2003

Testimony of
Skip Trotter, Vice President of Operations
Trotter Machine Inc.

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

My name is Skip Trotter, and my father and I run, Trotter Machine Inc., a manufacturing firm that produces hydraulic valve spools based in Rockford, Illinois. At Trotter Machine Inc, my employees and I work together to produce valve spools, which control the restriction and flow of high-pressure hydraulic oil in valves. The unique part of our business is that there are only three of us in the world who manufacture valve spools.

Trotter Machine Inc. was established in March 1999. My father, Earl Trotter, worked for K&M Screw Machine Inc. for 17 years prior to buying out K&M in 1999. We have manufactured valve spools since 1985 and currently have sales of around 6 million dollars. I am the Vice President of Operations and am responsible for the overall management of our company. My position involves various tasks; from the purchasing of tooling, hiring outside contractors, and dealing with customers on a daily basis, to managing the human resources activities and administrating our employees' benefit packages. At Trotter Machine Inc we have 47 employees. I, along with one other employee, have college degrees, while most of my employees have high school degrees.

They are typically in their early thirties, stay for about five years, and earn an hourly wage ranging from $9.00 up to $18.83.

Like many entrepreneurs, I learned early that, if I want to remain competitive I must offer an attractive benefit package. Since we started the company, we have provided comprehensive health care insurance to all employees. However, in recent years, one experience forced me to stop and think about health insurance and what role an employer should play.

One of my employees has a blood disorder. My firm was actually turned down by an insurance company and we were unable to get a policy. Imagine if this employee had to look for coverage as part of a smaller group or as an individual. Where would he go for coverage? With 47 employees, we are able to spread our health care risks a little, but they need to be spread over a larger group to keep down health care costs. It's interesting to me that as a businessman, I cannot discriminate when hiring, yet insurance companies can?

Our company is able to offer a Preferred Provider Plan (PPO) to our employees. My father and I want to provide a quality plan – medical, dental and vision coverage, with a wide network of doctors – and every year that passes, I have to set our deductible higher and change our network of providers to keep our premiums affordable. I set an eligibility requirement of 90 days in some cases or on the first of the month after 60 days of employment, and I offer an 80/20 employer-employee shared contribution rate. Every

year I have changed insurance companies because it is difficult to find an affordable plan. However, the reality is that being insured is critical to our employees. Most of them are more interested in the benefits we offer than in the wage they will be earning. Employees pay $80 per month for individual coverage and $120 per month for a family. Trotter Machine picks up the other 80% of the cost for our employees. In addition, we pay for full coverage on life and disability insurance, which is $1,000 a month.

Annually in February, my assistant and I go through the painstaking work of getting bids from other insurance carriers, since our average increase has been 28% every year over the last four years. This year, our increase is 40% and what bothers me the most is that the coverage and service gets worse! A particular frustration of mine is that insurance carriers move at one speed: their own. In past years, we have had to go an additional month with the old company to stay covered at higher cost, waiting for the current insurance carrier to get underwriting and firm pricing.

In addition to the hassle of just maintaining affordable coverage, my time is wasted spending countless hours on the health care renewal process. It takes two of us **three days** to fill out all the necessary forms for underwriting. This cuts into production time and other areas in which I could be producing a quality product for my customers. We are facing a crisis in manufacturing by losing jobs to China; therefore, it is vital that I work to keep our firm competitive.

Knowing that providing health insurance is necessary to me for both business and personal reasons, and knowing that I cannot increase prices to my customers an extra 40% in order to absorb the cost, I continue to offer health insurance benefits, despite the growing cost to the business. Our business has absorbed the cost every year. We have only passed a total of five dollars a week onto our employees over the last four years. I am at the point where I may have to increase our employees' share or stop paying for their disability insurance. Thus, I take the risk of losing good employees and dramatically increasing my turnover rate.

While I continue to struggle to provide affordable coverage, some of the big insurance companies have announced record profits the last few quarters. Are they making money off the backs of hard-working small business owners? I support businesses being successful but when I'm faced with double-digit increases every year or when my colleagues cannot provide insurance to their workers, I feel that the insurance industry is more worried about their profits than my ability to afford health care for my employees. I have to compete so why shouldn't insurance companies? Simply put, competition is needed in the small group market.

A recent actuarial study released by the U.S. Small Business Administration (SBA) shows that administrative expenses for health-insurance plans that cover small businesses are significantly higher than those that cover larger groups. Specifically, the SBA study reports that administrative costs for businesses, like mine, range from 33 to 37 percent of the cost of claims, as opposed to just 5 to 11 percent of the cost of

claims for large companies' self-insured plans. We must stay focused on the true crisis in health care -- and in the economy as a whole -- the skyrocketing cost of health insurance.

Those of us in the small business community who offer insurance are struggling each year to afford the cost of increasing premiums. It is for this reason that I support legislation endorsed by NFIB that would create Association Health Plans (AHPs). AHPs would allow small business owners to band together across state lines to purchase health insurance as part of a large group, thus ensuring greater bargaining power, lower administrative costs and freedom from costly state insurance mandates. Fortune 500 companies and labor unions already have this right. AHPs will simply level the playing field and give small employers the same privileges as their counterparts in labor and big business. In addition, AHPs will introduce into the market place much needed competition and diversity. Without the ability to shop for more affordable options, we are forced to shift costs to our employees or drop coverage. Association health plans would end the nightmare of health care purchasing for small businesses.

I also encourage the expansion of medical savings accounts—MSAs—and flexible spending accounts (FSAs). Eliminating the regulatory burden on medical savings accounts would benefit small business. MSAs, without the current restrictions, would provide positive benefits to employees. They give employees control over their own health care decisions. Making MSAs more workable by easing the regulatory burden on them will provide yet another affordable health care option to small business. NFIB also

supports allowing money leftover in a flexible spending account to be rolled over into the same account the following calendar year. I also support the concept of having a tax credit for the purchase of individual health insurance.

Like most small business owners, I talk to a lot of people every day. To be competitive on Main Street, you have to. I know from talking to other manufacturers that AHPs, MSAs, FSAs and tax credits would be great options for small business owners. Now, I'm a businessman, not a health policy expert, but I do know that there is a lot of debate about how to insure more Americans and how to help those currently insured continue to afford their coverage. AHPs, in particular, are a good, common sense solution to controlling the cost of quality health care.

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

U. S House of Representatives

Committee on Small Business

Testimony of John Hartnedy

Deputy Commissioner of Insurance

State of Arkansas

March 5, 2003

Mr. Chariman, Ranking Member and Members of the Committee on Small Business. My name is John Hartnedy; I'm the Deputy Commissioner of Insurance for the State of Arkansas. I have served within the Department for 6 years and been involved in the insurance risk industry for over 41 years. I'm an actuary by profession and a member of the American Academy of Actuaries and Fellow Society of Actuaries. I serve on the Health Insurance & Managed Care Committee, Health Insurance Task Force, Life and Health Actuary Task Force at the National Association of Insurance Commissioners on behalf of my Commissioner Mike Pickens, who is currently the President of the NAIC.

I want to thank your for considering my testimony today on health care access. I will make my comments brief, but ask that my entire statement be placed in the record. We all understand the growing problem of the uninsured. As you are all aware, the number is 40 million and growing, which means that 16% of Americans are uninsured. In my state of Arkansas, we have over 19% of the population under the age of 65 who do not have healthcare coverage.

I'm not here today to tell you that Association Health Plans will end the plight of the uninsured, but if implemented correctly, AHPs can offer a new, helpful, alternative in the market place. Remembering that 60% of the uninsured work for small businesses, AHPs can offer new opportunities for those segments of the market.

I will focus my testimony today on the structure of the bill and changes that can be made in H.R. 660 that will in my view improve the prospects for success of AHPs. I speak for no insurance department other than Arkansas, but feel you will find more acceptances by other commissioners if changes are undertaken in the bill.

The premises of AHPs are admirable. In fact, pooling individuals is the primary concept of insurance risk. AHPs can effectively pool segments of the market without disturbing the current overall market if done correctly. The primary challenge is keeping membership in the group if and when the cost of health care coverage rises. Unlike in the case of a large employer where the cost of health coverage does not in most cases directly affect the employment of an employee, when you have association members who are not bound to stay within the association, it is often the case that healthier members will leave once the rates begin to exceed the open market premiums.

This scenario has happened time and time again in the fully-insured market. You will see this most often in the case of associations specifically formed to sell insurance, but it could happen to any group or pool where insurance coverage is the primary reason for membership. On the other hand, when you have a loyal association member, such as a business trade alliance, where the primary reason for membership is not the insurance coverage, you will find a more stable pool similar to that of a large employer.

For this reason, you may want to qualify the types of associations that are allowed to offer self-insured plans. This can easily be accomplished as part of the certification process. I would also recommend that if a board of trustees terminates an AHP, some period of time be required to pass before allowing the plan to begin again or undertake a new plan. When a carrier exits a state's market, you will find that the state usually requires five years before the carrier can reenter. This insures that a plan does not terminate just because of spiraling rate increases.

In reviewing H.R. 660, I see that solvency requirements have been included, but I also see that those provisions fail to provide for growth in the surplus reserve set aside if the plan is successful and adds new members. In my world, with all the precautions we take, we still have too many health plans fail because of insolvency due to under-capitalization. For this reason, I would encourage the Members to address this aspect of the bill very carefully.

When you have beneficiaries in a plan, there will be claims. To insure that those claims are paid, the plan should be required to begin operation with capital, surplus and reserves that will be sufficient for the first year. In addition, there should be a formula which increases the capital, surplus and reserves as the risk increases. The cap of $2 million provide for in H.R. 660 is insufficient. In fact, the $2 million cap is less than the initial minimum required for a new health carrier applying for admission in many states.

For this reason, I strongly recommend that the National Association of Insurance Commissioners' Risk Bask Capital for Health Organizations Model Act (RBC) be adopted as the basis for minimum solvency standards. The NAIC spent three

years debating among the states and carriers various formulas before reaching agreement on the RBC. The RBC formula is used in some form in every state and offers flexibility based on the type of risk. Although these standards are just minimum requirements, it is a reasonable basis to judge the financial risk of plan. We do not want a situation to develop where AHPs successfully penetrate the market but end up with members having unpaid claims due to insolvency. Even reinsurance does not prevent unpaid claims.

It is my estimation that if AHPs are enacted, most association plans would use admitted carriers and have fully-insured plans. For this reason, I endorse the 'State of Domicile" aspect of the bill. By having a responsible regulator involved, such as a state commissioner, you will find adequate protection for the public and enough flexibility for the plan. I do not see any particular challenge having a plan cross state lines into different jurisdictions if the plan uses an admitted carrier within the different states.

Once the filed forms are approved by the State of Domicile, the plan would be free to offer its program in other states' jurisdictions. I would recommend that the plan be required to do a courtesy filing prior to selling and that an admitted carrier be required to be used in each state it does business in. This allows the State of Domicile's commissioner to have overall jurisdiction of the plan regardless of where it is doing business, and by using an admitted carrier in each state, there will be a comfort for the insured in having a local carrier that is regulated by their commissioner. They will still have all the advantages afforded an AHP plan participant.

I agree with the suggestion that a plan should be required to have three years experience of coverage under a fully-insured arrangement prior to being allowed to apply for certification as a self-insured plan. I would also endorse idea that a plan has at least 5,000 member insureds (certificate holders) before establishing the self-insured plan. These items are prudent risk management.

Although the bill requires the Department of Labor to regulate self-insured plans, I would suggest that, allthing being equal, state insurance departments would do a better job of regulating such plans, even under the same rules proposed if regulated by the DOL. The fact is that when insureds have problems, they call the state insurance department. Although this is not critical to the success of the AHP plans, it would be favorable to the insureds.

I would next like to address the issue of state mandates. This is often a point of contention between state required mandates for fully-insured plans and lack of such for self-insured ERISA plans. Under the bill, AHPs would not be required to include such mandates. Often, state legislatures are heavily lobbied by special interest groups to include such mandates. There is no doubt that there is a cost to any mandate, but I find that most ERISA plans do in fact include many of the mandated benefits because they are benefits that insureds want. It is my guess

that many AHPs would have several of these mandates within their plans, partly to satisfy their membership and to insure that they have competitive plans.

Flexibility for the AHP in this regard could help plans offer some savings to the membership. In the State of Arkansas, we require invitro fertilization as a state mandate. This important procedure for those who require it is not a basic health care requirement, but I would guess many would choose to not to include it in their plans, which in my personal opinion would not detract from the over all comprehensiveness of a medical plan.

I was very pleased to see HIPAA compliance included in the bill this the time around. It will insure that there is no cherry-picking by the AHPs. Bonafide associations will be required to offer guaranteed coverage to their membership. In reviewing the Farm Bureau's recommendation, where the Bureau's Washington State plan offers a one-time, 30 percent differential at the time of entry, this can help insure a healthier block without great penalty to the insureds that are unhealthy. This is a reasonable risk adjustment method solution.

With regard to cost savings, there is a potential that AHPs could reduce some overhead, but I would guess it would not be more than 5 to 15 percent. Even though the AHP would be treated like a large group plan with its own rate experience, provider fees have already been negotiated to rock bottom levels by carriers and large employers. AHPs would receive those same savings, but should not expect any additional savings. AHPs would still need to send out billings to their members and have other administrative costs similar to insurance carriers. What I am saying is that I think we need to be realistic as to expectations. AHPs will likely provide some savings, and provide better policies from a cost and benefit standpoint than what many small businesses currently have available to them, but it will not be the kind of bonanza that some may be expecting.

Premium insurance taxes levied by state insurance departments generally go to the state's general fund, not the insurance department. The department's budget operates off a small, insignificant portion of the tax levied. If a premium tax is levied against AHPs, as is allowed in the bill, it should generate sufficient funds to allow for adequate regulatory supervision and have excess funds available to distribute a portion of the tax to the state risk pools. This may be needed because if an insured leaves a current carrier's plan and moves over to the AHP within the state, it would reduce the tax levied on the current carrier for the state pool.

One last item I would very much endorse the idea of a plan identifier be established to help insureds easily identify the AHP plan available to the insured. The identifier would show the consumer where the AHP is domiciled, who regulates the plan and if the AHP is insured or uninsured. This form of consumer protection or something similar should be implemented.

All of us recognize that new strides must be taken to help the uninsured. Although we should be careful when making changes to the system, this should not prevent us from looking for and implementing carefully thought-out ideas. Insurance itself was invented out of need. AHPs could be a valuable step in the right direction, but again I caution you. We have had years of experience with risk management. If associations are going to be in the insurance business, they need to pay heed to reasonable prudent and proven facts.

I therefore hope you will take the extra steps required to insure that AHPs, if enated, are responsible insuring entities. I look forward to any questions you may have of me and offer my assistance to help find solutions to the access challenges.

END

2/28/2003 1

The Nation's Leading Resource for the Self-Employed and Micro-Businesses

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Testimony of

Robert Hughes, President of
The National Association for the Self-Employed

House Small Business Committee
"Small Business Access and Alternatives to Health Care"

March 5, 2003

The National Association for the Self-Employed (NASE) would like to thank Chairman Manzullo and the Members of the House Small Business Committee for convening this hearing on a very important issue facing our nation's small business owners. The NASE is the nation's leading resource for the self-employed and micro-businesses, businesses with ten or less employees. We currently have 250,000 member businesses, representing over 600,000 employers, employees and self-employed individuals nationwide. Today, this vital segment of the small business population within our nation numbers more than 18 million. Micro-businesses are the drivers of America's economic engine, creating well over a third of all new jobs to the economy between 1998 and 1999. The last U.S. Census reported that these firms employ more than 12.3 million workers with a total annual payroll of more than $309 billion. Beyond these tangible contributions, it is also important to note that according to an August 2002 poll by USA Today, CNN and Gallup, Americans rate people who own and operate small businesses as the second most trustworthy group in the nation, right behind teachers.

The chief impediment that micro-businesses and the self-employed are facing as they try to stay afloat in this time of economic stagnation is the ever-increasing costs of health coverage. The

state of health care among the nation's self-employed and micro-businesses is critical. According to a June 2002 study released by the NASE entitled "Affordability in Health Care: Trends in American Micro-Business," seven in 10 micro-business owners report they do not provide any type of health care coverage to eligible employees nor have coverage for themselves. Costs are cited as the chief reason for this trend. Participants in the study say the situation is worsening as health insurance premiums for micro-businesses are increasing at double-digit rates while insurance benefits and plan choices are decreasing.

Access to affordable health care coverage for small firms – roughly half of all U.S. employer firms – is interwoven with the nation's broader health care crisis, affecting 53 percent of the private workforce. Census data indicates that among the estimated 41 million Americans without health insurance, 62 percent (24.5 million) are from families in which the head of household is self-employed or working for a company with fewer than 100 employees. A study released by the General Accounting Office (GAO) in April 2002 reported that the self-employed and small businesses have been hit hardest by the lack of competition in small-group health insurance, a situation that is contributing to strong and sudden increases in premiums for coverage.

According to the NASE "Affordability in Health Care" study, health care reform is at the top of the list of pressing issues micro-business owners would like the federal government to focus on in the months ahead. It also shows that the cost of health insurance premiums for micro-businesses increased by an average of almost 13 percent from 2001 to 2002. With this in mind, it may not be surprising that 96 percent of micro-business respondents believe the cost of insurance is unreasonable for their business. Nearly half (46 percent) say their employees cannot afford to share in the cost of health insurance premiums. Among those companies who offer insurance programs, one in three (33.5 percent) report their employees share in the cost of premiums.

In addition to costs, administrative burdens also make it difficult for micro-businesses to provide health insurance, the survey reports. Thirty-six percent of respondents say that acquiring insurance presents too much administrative burden for their small businesses.

The NASE feels that the following three proposals would greatly assist micro-businesses in gainin access to affordable health coverage:

Self-Employment Tax Deduction for Health Insurance Premiums

Association Health Plans

Health Care Tax Credits

Self-Employment Tax Deduction for Health Insurance Premiums

A core issue facing self-employed individuals is their inability to deduct their health insuranc premiums for the purposes of self-employment tax. All employees who receive compensation fron employers pay FICA taxes. FICA comprises Social Security (6.2 percent) and Medicare (1.45 percent taxes. Employers are required to withhold from gross compensation 7.65 percent for FICA. In additio to the FICA withheld from the employee, the employer is required to "match" the FICA withholding Therefore, the employee and employer contribution for FICA is 15.3 percent of compensation (subjec to applicable annual limits).

The self-employed also pay into the Social Security Fund at a rate equivalent to employees an employers. FICA tax for the self-employed is called "self-employment tax." The self-employment ta is computed at the same rates (15.3 percent) as employee/employer FICA and is subject to the sam annual limits.

The tax inequity faced by the self-employed when purchasing health insurance lies in the fact tha Schedule C filers (sole-proprietors) and Schedule E filers (partners in partnerships with earned incom and 2 percent owners in S Corporations) do not receive a "business deduction" for health insuranc premiums. The premiums are not deducted for purposes of the self-employment tax and, accordingl the sole proprietor(s), partners in partnerships and S corporation owners pay self-employment tax (15. percent on self-employment income up to $86,000) on the insurance premiums. **The self-employed ar the only segment of the business population that has to pay this extra tax on health insurance.**

C corporations, on the other hand, receive a deduction for health insurance premiums as an ordinar and necessary business expense for all employees including owners. Since the premiums paid fo

health insurance are not considered compensation to the employee or employee owner, they are not subject to FICA (Social Security and Medicare) taxes for either the employee or the employer.

The self-employed are required to pay two types of taxes on their annual tax returns: income tax and self-employment tax. So while 100 percent deductibility of health insurance premiums will be phased in this year, it does not solve the tax inequality. One hundred percent deductibility relates only to income tax and not self-employment tax. The self-employed still pay the 15.3 percent self-employment tax on their health insurance premiums.

To achieve tax equity between all forms of business entities, the self-employed must receive exclusion of health insurance premiums from self-employment tax regardless of the entity form under which they choose to operate. Health insurance premiums of the self-employed should be deductible on Schedule C or E as an ordinary and necessary business expense rather than the deduction above the line on Form 1040. This issue is not only one of fairness but, in the current health care climate, the self-employed are disproportionately affected. Removing this extra tax on health insurance premiums would make health coverage slightly more affordable.

Association Health Plans

The NASE feels that association health plans (AHPs) would give the self-employed and micro-business owners access to lower rates through consolidated buying power, as well as administrative efficiencies. On average, a worker in a firm with less than 10 employees pays 18 percent more for health insurance than a worker in a firm with 200 or more employees. Disturbingly, health insurance premiums for small businesses are again increasing at double-digit rates, while at the same time benefits and health plan choices are decreasing. AHPs can help remedy the severe lack of access to affordable health insurance for small businesses.

AHPs can reduce health insurance costs by 15 – 30 percent by allowing small businesses to join together to obtain the same economies of scale, purchasing clout, and administrative efficiencies now available to employees in large employer and union health plans. New coverage options for the self-employed and small business workers will promote greater competition and choice in health insurance markets. Tough new solvency standards protect patients' rights and ensure benefits are paid.

Employee enticement and retention within the small business community are also an indirect positive affect of association health plans. By making health coverage affordable to small employers, AHPs will assist small businesses in competing with larger employers with extensive benefit packages in acquiring and retaining qualified employees.

NASE "Affordability in Health Care" study participants said they would be much more likely to purchase health insurance if the right incentives were in place. Almost eight in 10 (78 percent) say they would participate in an AHP if they received group purchase price breaks. Three in four would be motivated to participate in such plans if they were able to have more choice in benefits, or if participation would lessen paperwork and administrative burden.

Health Care Tax Credits

The NASE also strongly supports tax credits and deductions as a viable solution to begin addressing the larger issue of the uninsured in our nation. Nearly 80 percent of the respondents to the NASE survey say they would be likely to purchase health insurance for their employees if they were given tax credits. The NASE supports the re-introduction and passage of the S.A.V.E. Act sponsored by Representatives Kay Granger and Albert Wynn.

Conclusion

The NASE feels that self-employment tax deductions for health insurance premiums, association health plans and health care tax incentives would go a long way to ease some of the burden of micro-business access to affordable health care and alleviate the growing ranks of the uninsured. Yet, there is no silver bullet that will cure the issues within our nation's health care system. Thus, the National Association for the Self-Employed strongly supports continued efforts to find proactive solutions, rather than reactive, to address the root causes of continual health insurance premium increases and lack of quality health coverage.

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Micro-Business Testimonials on Access to Health Coverage

"As with many people...the events of 9/11 changed my life. I worked in the Travel industry and was laid off after 14 years of service. I took this as an opportunity to do something with my life that I probably would have never done prior. I took advantage of a self-employment program offered by Pennsylvania for people laid off wanting to open their own business.

With their guidance and many long hours...Cook-A-Doodle-Doo Personal Chef Service was born. I invested many hours and much money into my business to get it off the ground. Soon after, I had my first MS attack and was diagnosed. Luckily for me I'm on Cobra and all of my medical bills and RX bills are covered. The bad news for me is when Cobra runs out in April. I am asking, how a sole proprietor, with a medical condition or without any conditions, can afford to make a premium payment. This will put me out of business and is outrageous. This is so unfair to the little guy.

Small business owners make our society what it is. It's the American Dream that is being taken away from me because I can't afford my medical bills. Congress must make some changes and help out the small business owners."

Allison Coia
Cook-A-Doodle-Doo Personal Chef Service
Aston, Pennsylvania

"I moved to Texas approximately two years ago. My wife are both psychologists and we opened a private practice. We were very excited about the prospect of being self-employed. However, we were not prepared for the difficulties associated with sequestering and maintaining health care. We pay exorbitant rates for very limited coverage. I am appalled by the lack of rights (as it relates to health insurance) for the self-employed in Texas."

Dr. Erick Gonzalez
Allen, Texas

"I just have to say that as a new small business owner, I find it very upsetting that health insurance for my family is so high. We are just struggling to make ends meet and make our dream come true and the cost of health insurance for the self-employed is OUTRAGEOUS! Just so I can pay exorbitant payroll taxes, I must let my coverage run out because I can't afford the premiums. I have two small children and I pray that we can make it through this time with no coverage."

Melinda Jenkins
Treydon's Bar & Grill
Easthampton, Massachusetts

"I was a self-employed business person. I am now an employed physician. The United States government has made what is an essentially unfair playing field for self-employed physicians."

Roy Blackburn M.D.
Elizabethtown, Kentucky

"The cost of securing health care coverage for my family has roughly doubled in the past five years; or just shy of a 20 percent annual increase. Neither our annual revenue nor our net income grows at a rate remotely near that neighborhood. Our premiums have increased in spite of the fact that you can count on one hand the number of times members of my family have in the past five years made a visit to a healthcare provider for anything other than routine dental and eye exams, and our policy doesn't include dental. Not one member of our family has a chronic condition more serious than adolescence. And you can count on the hand of a really careless woodshop teacher the number of times we have been to the emergency room over that period (that's zero).

Our family has maintained some remote semblance of affordability in healthcare coverage only because we have increased the size of our deductible to its current household limit of $15,000 annually. If rates continue to increase, we will be forced to increase that deductible to the maximum available limit of $24,000 per year.

Of course, a consequence of our high deductible policy is a benefit that is too rare in America's health care system: the incentive to carefully scrutinize each health care provider's bill. It is this kind of individual accountability for health care cost containment, which, I think, is an inescapable requirement for meaningful health care reform. I hope that making the health care consumer also the health care billing watchdog through the increased use of MSAs coupled with higher-deductible health plan options will characterize the future of the delivery of healthcare services in America. It seems to me that the competitive pressures unleashed by an increased availability of association health plans also certainly would aid in slowing the rapid rise of health care costs."

David Alders
Nacogdoches, Texas

Statement of the American Farm Bureau Federation

STATEMENT OF
THE AMERICAN FARM BUREAU FEDERATION
TO THE
HOUSE COMMITTEE ON SMALL BUSINESS
REGARDING AFFORDABLE HEALTHCARE ACCESS

Presented By
Steve Appel
Vice President, AFBF

March 5, 2003

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STATEMENT OF
THE AMERICAN FARM BUREAU FEDERATION
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March 5, 2003

Mr. Chairman, Ranking Member and Members of the Committee on Small Business. My name is Steve Appel. I'm a wheat and barley grower from Whitman County outside of Spokane, Washington. I'm the President of the Washington State Farm Bureau and Vice President of the American Farm Bureau Federation.

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

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

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

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

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

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

Farmers and ranchers should have options. Recognizing the need to help its membership, the Washington Farm Bureau established its health plan three and a half years ago. It has grown to the point where it now covers some 30,000 farmers and ranchers and has over $50 million in annual premiums. As a bona fide association, the plan offers guaranteed issue coverage to all its members, thus eliminating cherry-picking. Each farmer-rancher member is offered a preferred or standard rate with a maximum premium differential spread of 30 percent in rates. Our health plan enjoys a 99.2 percent retention rate after 3 1/2 years of operation. Of those who join our health plan, over 25 percent enter with no prior health coverage. Even with its success, several state-mandated provisions, which would not be required under an ERISA self-funded plan, have prevented additional flexibility that could further reduce the cost of the plan.

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

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

The American Farm Bureau Federation would encourage additional consideration of some provisions of the AHP legislation as embodied in H.R. 660. For instance, we believe that the state of domicile provisions need to be clarified: plans should only need to meet the form filing requirements in the state where the plan is domiciled and an admitted carrier in any state where they operate for fully-insured plans should be used. The language needs to better define fully-insured AHPs, as many associations will not reach enough members to self-insure.

Size requirements of the AHPs should be reviewed in the case of self-insured plans in order to ensure that qualified individuals operate the plan. We feel there is a need to better define solvency requirements for self-insured plans by establishing a formula that takes into account reasonable initial capital, surplus and reserves when establishing an AHP and reflects adequate increases as the risk of the plan grows.

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

Biography
Steve Appel
President
Washington Farm Bureau

Steve Appel is a family farmer from Whitman County in southeast Washington. He owns and operates a wheat and barley farm near Dusty.

Next to his family, Steve loves farming and the Farm Bureau. And like most farmers today, he realizes that if you want to farm, you have to invest time to protect the family farm from being plundered by a not so benevolent government.

That is why he is here today.

Steve has been active in Farm Bureau since 1974, serving as chair of the Whitman County Young Farmers and Ranchers Committee and later as President of the Whitman County Farm Bureau for three terms.

Mr. Appel was elected to the Washington Farm Bureau board in 1987 -- served as First and Second Vice Presidents -- and in 1994, was elected President – a position he holds today.

He was elected to the American Farm Bureau board of directors last month and sits on the Farm Bureau national bank board of directors.

For those of you who don't know, the Washington Farm Bureau represents family farmers and presently has more than 18,000 member families.

Join me in welcoming Steve Appel.

S:lh\appel-bio

Committee on Small Business

Witness Disclosure Requirement - "Truth in Testimony"
Required by House Rule XI, Clause 2(g)

Your Name: Steve Appel		
1. Are you testifying on behalf of a Federal, State, or Local Government entity?	Yes	(No)
2. Are you testifying on behalf of an entity other than a Government entity?	(Yes)	No
3. Please list any federal grants or contracts (including subgrants or subcontracts) which you have received since October 1, 1999: None		
4. Other than yourself, please list what entity or entities you are representing: American Farm Bureau Federation		
5. If your answer to question number 2 is yes, please list any offices or elected positions held or briefly describe your representational capacity with the entities disclosed in question number 4: Vice President, AFBF		
6. If your answer to question number 2 is yes, do any of the entities disclosed in question number 4 have parent organizations, subsidiaries, or partnerships whom you are not representing?	Yes	(No)
7. If the answer to question number 2 is yes, please list any federal grants or contracts (including subgrants or subcontracts) which were received by the entities listed under question 4 since October 1, 1999, which exceed 10% of the entities revenue in the year received, including the source and amount of each grant or contract to be listed: None		
Signature: S J Appel	Date: 3-3-03	

Small Business Access and Alternatives to Health Care

Testimony provided by:

Karen Kerrigan
Chair & Founder
Small Business Survival Committee

Before the:

Committee on Small Business
U.S. House of Representatives
Rep. Donald A. Manzullo, Chairman
March 5, 2003

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The issue of affordable, competitive and quality health care coverage has remained a central concern of the Small Business Survival Committee (SBSC) since our founding in 1994. Therefore, we are pleased that our organization has been provided the opportunity to be a part of this very important hearing today. On behalf of SBSC and its nationwide membership, we thank House Small Business Committee Chairman Don Manzullo and Ranking Minority member Nydia Velazquez for your leadership and determination on this serious issue facing the nation's small business and entrepreneurial sector.

My name is Karen Kerrigan, Chair and Founder of SBSC – a nonpartisan small business advocacy organization headquartered in Washington, D.C. Since 1994 we have been advocating reforms and solutions to help make health insurance coverage more affordable, flexible and competitive for small firms and individuals. The need for Congress to act could not come at a more critical time. As House Small Business Committee members are fully aware, the cost of health insurance is becoming increasingly out of reach for many small firms, their workforce and the self-employed.

The cost of health insurance has truly become a hindrance to the growth of small firms, diverting precious resources away from job creation and investment. An under-performing economy has not helped either. Quite simply, small businesses are in a vise -- a health insurance cost squeeze, if you will.

<u>Increased costs means more uninsured Americans</u>. According to U.S. Census Bureau figures released in October of 2002, the number of Americans without health insurance rose to 41 million last year. Unfortunately, the growing ranks of the uninsured are found in those working in, or owning small companies. Americans working for businesses with fewer than 25 employees were half as likely to have health insurance than those working for much larger firms, according to 2002 Census Bureau figures.

The pervasive increase in the cost of health insurance continues unabated. The Council for Affordable Health Insurance (CAHI) recently reported: "Health insurance premiums are rising about 15 percent on average, but many individuals and businesses are seeing increases of 30 percent to 40 percent." A December 2001 report from *Fortune Small Business* estimated that health insurance premiums rose 55% faster for small businesses compared to large firms during 2001. In my regular discussions with small business owners and entrepreneurs, premium increases are running even higher than these "official averages". It has become commonplace for business owner to cite increases as high as 60 percent or higher.

Unfortunately, higher costs have translated into a lower percentage of small businesses offering health benefits. The percentage of small firms offering health insurance dropped from 67 percent in 2000, to 65 percent in 2001 and 61 percent in 2002.

Increasing health care costs reduce access to quality care. For many businesses, large increases in the cost of health insurance coverage force a reduction or elimination of coverage for their employees. Such cost increases particularly place small businesses at a severe disadvantage in terms of both attracting good employees and competing against rivals in the marketplace. Participants at "Women Entrepreneurship in the 21st Century," a conference for women business owners hosted by the U.S. Department of Labor, the U.S. Small Business Administration and the Public Forum Institute in March 2002, found "cost" the biggest obstacle for 76% of attendees in their ability to provide health benefits for employees. "Lack of purchasing power" was cited by 21% of the women business owner attendees -- another issue that directly relates to cost.

An April 2002 national survey of small businesses by the Kaiser Family Foundation found that 56% of businesses with 3 to 9 workers offered health insurance coverage, while 72% of businesses with 10-24 employees did so. Of the small businesses not offering health insurance, 72% noted costs as a very important reason for not doing so. In addition, 67% of all small business executives surveyed said they were "very or somewhat dissatisfied" with the cost of health care and health insurance.

I believe I have exhausted my point on costs – health insurance costs are spiraling out of control and access to coverage has become unreachable for many small firms and self-employed individuals.

Who are the uninsured? According to the Galen Institute the uninsured are primarily "minorities, especially Hispanics; lower and lower-middle income Americans; young adults between ages 18 and 24; workers or dependents of workers who are not offered or cannot afford to purchase health insurance through the workplace; and workers who are between jobs." The Census Bureau reports that the uninsured are likely to be self-employed or employees of small firms, work in service-industry related jobs and are families with annual incomes of less that $25,000.

From our perspective it makes sense that Congress focus on health care reforms that target small business. In sum, the data and research strongly suggests that the largest percentage of the uninsured either work for a small business, are small business owners themselves, are starting a small business, or are in a family headed by someone who works in a small business.

Solutions. The problems and challenges facing our health care system are extraordinarily complex. However, SBSC believes that several reform initiatives will help small businesses cope with rising costs and help uninsured individuals purchase affordable, quality health coverage. In addition, the reforms we support will help increase choice, competition and consumer engagement in the health insurance market. In the end, bringing more consumers into the health care system by

targeting reforms that lead to more competition and price sensitivity will help make the system more accountable and responsive to all consumers.

Association Health Plans. SBSC strongly believes in giving individual consumers and small businesses increased market power and incentives to help lower costs and increase access to health coverage. Therefore, we support the creation of Association Health Plans (AHPs). One of the key issues underlying the distortion in health insurance costs is the fact that many groups get treated differently from a public policy perspective. If small businesses were given equitable treatment under federal law that larger businesses receive in purchasing health insurance, it will make a dramatic cost impact for small firms.

A U.S. Department of Labor report, "Association Health Plans: Improving Access to Affordable Quality Health Care for Small Businesses," underscores the above point. The September 13, 2002 report finds that:

- **"The Congressional Budget Office (CBO) has estimated that small businesses obtaining insurance through AHPs will enjoy premium reductions of 13% on average. The average reduction amount ranges from 9% to as much as 25%."**
- **"According to CBO, an additional 330,000 (and as many as two million) American workers and their families would obtain health insurance through AHPs."**
- **"A study by the CONSAD Research Corporation foresaw larger gains. It estimated that up to 8.5 million uninsured workers and dependents could gain coverage from AHP legislation. This study confirms that even small cost savings can result in large increases in purchasing power for small businesses, and thus can have a real impact for small business workers who make up over 60% of the uninsured."**

Why the benefits? The Department of Labor report notes: "Preemption of 50 state insurance regulatory regimes under federal ERISA law has allowed large employers and unions to provide cost-effective health benefits. A federal structure for small employers would bring stability, uniformity and lower costs for health care coverage." The report continues later: "One way AHPs will boost coverage is by relieving small businesses from costly state benefit mandates. Such mandates are responsible for one of every five small employer decisions not to offer coverage. Another study reported that mandates raise premiums by 4 to 13%, and that up to one-quarter of uninsured Americans lack insurance because of state mandates."

In addition to treating all businesses and individuals equitably under law to help alleviate distortion and improve access, government at all levels needs to construct policy that is in tune with our modern economy and workforce. The mobility of the workforce, and the entrepreneurial nature of the workforce command more flexibility and portability in workplace benefits.

That is why SBSC has supported the improvement and expansion of Medical Savings Accounts (MSAs) and refundable tax credits for the uninsured. Neither of these reforms is necessarily tied to the workplace (meaning if a person loses his or her job, or wishes to start a business, they lose their insurance.) But more importantly, both these measures will help to increase the number of insured in the U.S. by providing powerful, affordable incentives for people to purchase health coverage.

Medical Savings Accounts (MSAs). MSAs combine a traditional high-deductible, catastrophic insurance policy and a tax-exempt savings account for out-of-pocket medical expenses. Consumers use the funds deposited tax free in their MSA to pay for routine medical care. If they have a year with high medical expenses or catastrophic illness, or use all the funds in the MSA account and reach their deductible on the insurance policy, the high deductible insurance policy kicks in to pay remaining medical bills. If they have a year with minimal medical bills, MSA policyholders keep the funds leftover in the account and the interest earned.

There are enormous benefits to MSAs. *In their most recent report on MSAs, the Internal Revenue Service (IRS) found that 73 percent of people buying MSAs are previously uninsured.* A report by the American Medical Association (AMA) entitled "Medical Savings Accounts the Health Care Coverage of Dependents and Children," found that the majority of MSA purchasers (70 percent) are families. Though restricted in who can buy them, and how many can be sold, still, MSAs are helping to provide individuals and small businesses with affordable access to quality health care.

The AMA report also finds:

- **"...MSAs have demonstrated potential to expand coverage to considerable numbers of uninsured, including children. Remarkably, about half of all MSAs policies are issued to families with children..."**

- **"...a survey of MSA experience in the U.S. and abroad turned up no evidence of MSAs restricting utilization of preventive care."**

- **"Researchers from the RAND Corporation found that MSAs would not disproportionately attract younger, healthier individuals (Goldman, et al. Health Services Research, April 2000)."**

- **"Similarly the Archer MSA Coalition reports that nearly 95% of MSA policyholders are over the age of 30 and approximately a third are over age 50..."**

- **"Available data suggests that the great majority of MSA enrollees do not reach their deductibles in a given year, and up to 80% have unspent MSA account balances at the end of the year (Bunce, 2001: Bond, et al., Benefits Quarterly, 1996)."**

▪ "The Council on Medical Services anticipates increased demand for MSAs as health insurance costs and premiums continue to rise and as employees pay greater shares of premiums. The Council believes that it is critically important to eliminate many of the restrictions facing MSAs, including temporary demonstration status, in order to permit the natural rise in both demand and supply of MSAs. The Council further notes that in the event of the death of the policyholder, MSA account balances can be inherited, enhancing their ability to secure health expense coverage for spouses and children."

Why are more uninsured Americans turning to MSAs? Quite simply, they're more affordable. For some uninsured Americans, the MSA product has been something they stumbled upon as a last resort for getting health coverage. (For many others, unfortunately, they are restricted by law from purchasing an MSA, but more on this later). MSAs are helping to lower costs for several reasons.

Primarily, the third-party payer issue is redressed. With MSAs, the traditional buyer-seller relationship in the marketplace is re-established. Unlike the detached nature of the third party system, consumers and health care providers become concerned about costs with MSAs. When its "their money", consumers are simply more inclined to check prices and bills, work to keep costs down and shop for best value.

Other benefits of MSAs include:

▪ Patient choice of doctors and specialists.

▪ Individuals and their doctors make health care decisions, not some distant bureaucrat.

▪Given that individuals make their own health care decisions, have the ability to build up savings through MSAs, and can spend MSA monies on IRS-approved medical expenses, there is greater incentive to obtain preventive care.

▪ The money left over in an MSA each year could be rolled into an IRA, allowing savings to be built up over a lifetime for health care expenditures in later years.

Unfortunately when tax-free MSAs were first established as a pilot program in 1996 as part of the "Health Insurance Portability and Accountability Act," many restrictions were imposed, which limited who could buy them. In addition, the year-to-year extension of MSAs has not provided the insurance industry with the certainty it needs to put maximum resources into marketing the product.

Other restriction include:

▪ The capping on the number of accounts sold at 750,000.

▪ MSAs were only made available to the self-employed or to businesses with 50 or fewer employees. Uninsured people who work for a small business cannot purchase a MSA.

▪ Either the employee or employer could contribute to the MSA, not both.

▪ Deductibles must be between $1,500 and $2,250 for individuals and $3,000 and $4,500 for families.

▪ Tax-free deposits into MSAs were limited to 65 percent of the deductible for individuals, and 75 percent for families.

▪ The program was set to expire on December 31, 2000. This pilot program has been extended through 2003.

Such restraints have had a severe dampening effect on MSAs in the marketplace. The temporary and inflexible nature of the pilot program has been a deterrent to both suppliers and consumers, *yet* MSAs are still offering consumers an affordable choice in health coverage *despite* these restrictions.

The current restrictions need to be abandoned, so that consumers have more choices in the health care marketplace. SBSC is pleased that improving and expanding MSAs has the support of President Bush and bipartisan support in the Congress. MSAs need to be made permanent and universal with all "caps" removed. MSAs should be made fully available to all health care consumers, including individuals, as well as to all employers and employees at all types and sizes of businesses. These reforms passed the U.S. House last year as part of the "Patients Bill of Rights" legislation.

In addition, the following improvements were also a part of the House-passed legislation: the lowering of deductibles; tax-free deposits into MSAs would cover any share of the deductibles for the accompanying catastrophic insurance plans; and employees and employers would both be allowed to contribute to MSAs.

There will be expanded use of MSAs and more insured Americans if current restrictions are lifted. In the end, businesses that choose the MSA option would experience lower health care costs for their employees. And, most importantly, health care consumers would have access to the physicians of their choice and would truly control their personal health care decisions.

<u>Tax Fairness for Individuals</u>. Earlier in my testimony I wrote of the need for public policy to treat all individuals equitably. Fortunately, a bipartisan group of House members feels very strongly about fairness when it comes to tax treatment in purchasing health insurance. The Fair Care for the Uninsured Act of 2003 (H.R. 583) was recently re-introduced by U.S. Reps. Mark Kennedy (R-Minn.), Harold Ford, Jr. (D-Tenn.), Bill Lipinski (D-Ill.) and Edolphus Towns (D-N.Y.) It offers a

refundable tax credit to individuals and families that purchase health insurance. Specifically, the legislation provides a $1,000 credit for individuals; $2,000 for couples; and $3,000 for a family to purchase health coverage. From our perspective, Fair Care provides individuals with a long overdue option in purchasing health coverage when none is provided in the workplace. Fair Care corrects inequities in the tax code that give unlimited tax benefits to those who purchase health insurance through their employer, but little, if any, to the individual purchaser.

Several studies demonstrate that tax credits could dramatically boost the number of insured. In testimony before Congress, eHealthinsurance.com Chairman and Founder Vip Patel showed that there is widespread availability of plans nationwide that the population targeted for tax credits would have access to. "No one solution will solve the entire problem of eliminating the uninsured in this country, but a tax credit can help a large segment of the uninsured population who are looking to buy individual coverage," notes Mr. Patel.

According to the Galen Institute, Wharton economist Mark Pauly found that a refundable tax credit would provide a powerful incentive for the uninsured to purchase health coverage. "One study showed that 48 to 66 percent of the uninsured would buy coverage if they received a subsidy worth half of the value of the policy. And the uptake rate increases as the subsidy rises: 74 percent of the uninsured would buy a policy if they received a credit worth 75 percent of the premium cost," writes Galen Institute President Grace-Marie Turner.

With 13 million workers changing employment status each month (U.S. Bureau of Labor Statistics) allowing tax credits for health coverage would provide some stability to workers who are highly mobile. After all, the health coverage they purchase through a tax credit is theirs to keep – they own the policy.

<u>Conclusion:</u> The implementation of each of these reform measures will collectively help to address the growing crises in the uninsured, and the cost crisis that so many small businesses are currently facing in health coverage. The reforms are targeted to address the population that is in most need of affordable health insurance. Flexibility is also central to these reforms recognizing that individuals and small firms must have choices and options in order to maintain coverage and to make the best health care decisions.

Thank you again Chairman Manzullo and members of the Committee for hosting this very important and timely hearing. SBSC stands ready to assist you in finding solutions to all challenges facing our nation's small business and entrepreneurial sector, and we are encouraged that the current Congress will address the long-term cost issue that small firms are facing in providing affordable, quality health coverage for our families and workforce.

I look forward to your questions.

Small Business Access and Alternatives to Health Care

March 5, 2003

Testimony Presented To:

Honorable Donald A. Manzullo
Chair
Committee on Small Business
United States House of Representatives

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

The National Black Chamber of Commerce, Inc. was founded in May, 1993, with 14 affiliated chapters. It has grown to be the largest business association dedicated to entrepreneurial development and economic empowerment within African American communities throughout the nation. We have over 191 affiliated chapters located in 40 states and eight nations. While we represent the interests of over 1 million Black owned businesses we have direct reach to over 90,000 entrepreneurs. Black owned firms are made up of C corporations (5.2%), Subchapter S corporations (3.6%), Individual Proprietorships (89.5%) and Partnerships (1.7%). In terms of sales there are three categories: Services (54.7%), Retail Trade (29.1%) and Construction (16.3%).

Our businesses are the key to job creation and wealth building. Small business growth in African American communities will lead to new jobs. The African American community is comprised of 25% of its total population living under the poverty level. The fastest and permanent way to lead people out of poverty, poor healthcare and substandard education is a means for employment. Small business accounts for the vast majority of new employment in this nation. We want our segment of the population into the mainstream of the economy and off the dole. It is naïve to carry on as if we can collateralize food stamps and turn public housing certificates into assignable rights guaranteed to heirs. Employment that provides a decent living with suitable benefits is the key and that is our charge via business development.

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

The products of the Civil Rights Movement have been many. The most important trend is the large mass of first generation college graduates who have subsequently gained valuable expertise and training via employment within the Fortune 500 and the Officer Ranks of our military. This group and their offspring are providing ready, willing and

able entrepreneurs. I am a perfect example. My great-grandparents were slaves. My grandparents were Louisiana sharecroppers. My father was a truck driver who never made more than $15,000 in any year. My mother was a domestic. Through the success of the Civil Rights Movement, I was able to become a graduate of the University of Wisconsin, an officer in the US Army and a manager with 3 Fortune 100 corporations. This is not an unusual standard for my generation and no nation on this earth has provided such rocket speed access for a downtrodden segment of its society.

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

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

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

The bottom line is too many of our small business owners cannot afford healthcare coverage for their employees. This can only be overcome by the inducement of incentives and the removal of barriers. Demanding that businesses provide insurance that

they cannot afford will lead to job shrinkage and even business closings. Our economy cannot endure such bad policy. What is needed is a comprehensive national plan such as HR 660, the Small Business Health Fairness Act of 2003, introduced by Representative Ernie Fletcher. The National Black Chamber of Commerce, Inc., on behalf of 1 million Black business owners who have the charge of economically stimulating low income communities, will support such legislation. We will actively participate in advocating such legislation and will fiercely promote it to our members.

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

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

Testimony Submitted Before

U.S. House Committee on Small Business and Entrepreneurship

On

"The Small Business Health Care Crisis: Possible Solutions"

March 5, 2003

Women Impacting Public Policy
www.WIPP.org

Good morning Mister Chairman and members of the Committee. My name is Terry Neese, President of Women Impacting Public Policy representing over 430,000 women business owners nationwide. We represent women and minority (African Americans, Hispanics, Native Americans, Alaskan Natives, Pan Asians) business owners and they support this testimony. I am also CEO of Terry Neese Personnel Services, with headquarters in Oklahoma City, Oklahoma.

Because WIPP is a small business association and the majority of its members are women and minority-owned businesses, we are uniquely qualified to speak on the devastating impact the lack of affordable health care has on its member businesses, on the working people of this nation, and on our economy. Over 22 million small businesses in America drive our economy, create nearly three quarters of the net new jobs and employ more than 50 percent of the workforce. Women Business owners number 9.1 million and employ 27.5 million according to the Center for Women's Business Research. Congressman John Boehner of Ohio, raised the alarm in citing the following appalling statistics: "Nearly 130 million Americans - almost 80 percent of all workers, get their coverage through their workplace. Another 43 million have no health coverage at all." Why is this appalling? Because premium rates for small plans, 3 to 9 employees, increase 12 -16 percent per year according to the Kaiser Family Foundation with some small businesses experiencing up to a 50 percent increase. WIPP members are experiencing anywhere from 12 – 72 percent increases in their premiums this year. For example, Terry Neese Personnel Services just received a 12 percent increase in our premiums. A WIPP member in Virginia, Dot Wood President and CEO of J D & W Inc., just received a 72 percent increase in her insurance premiums. Many small businesses can no longer afford to provide this vital benefit.

Another WIPP member, Dr. Karen McGraw from Marietta, Georgia told us the lack of reasonable health insurance costs has been the major barrier to her growth and ability to hire

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

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

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

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

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

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

The states have not been able to solve the health insurance crisis surrounding the small business marketplace. Current AHPs under labor unions and Fortune 500 companies operate under ERISA regulations, so why can't small businesses have the same access, the same options, and the same opportunity? Indeed, in recently speaking with the Oklahoma Insurance Commissioner, he supports Association Health Plans because of the lack of solutions coming from the states. He boldly endorsed AHPs Thursday February 27, 2003 before the National Women's Business Council hearing held in the House Small Business Committee Room.

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

The momentum for AHPs has picked up dramatically and WIPP is hopeful that the 108th Congress will enact AHP legislation immediately.

Statement
of the
National Restaurant Association
for a hearing on
Small Business Access and Alternatives to Health Care
before the
House Small Business Committee
March 5, 2003

One of the greatest challenges facing restaurants and other small businesses today is accessibility to affordable, quality health care. The National Restaurant Association is committed to increasing health care access for the uninsured—60% of who reside in a family employed by a small business. We believe that Association Health Plan (AHP) legislation (H.R. 660) offers a viable way to provide quality health care coverage to more individuals. We commend Chairman Manzullo for holding this important hearing and for his support of AHP's.

There are over 870,000 restaurant locations in the United States. The vast majority of these restaurants are small, single-unit operations, and seven out of 10 have less than 20 employees. The restaurant industry is also one of the largest employers in the country - employing an estimated 11.7 million people - making it the largest employer outside of government.

One of the primary obstacles to providing better coverage to more people is cost. Restaurateurs from around the country are reporting the same staggering premium

increases facing other small employers. For each of the last two years, the average premium increase for a tableservice restaurant was 23%. Many of our members tell us of increases in the 40-50% range. And unfortunately, analysts project similar increases for the foreseeable future.

Employees of smaller companies also pay more to offer health care than those of large employers. On average, a worker in a firm with less than 10 employees pays 18% more for health insurance than a worker in a firm with 200 or more employees.

The costs encountered in today's small group health insurance market not only makes it difficult for our employers to find affordable coverage, it is forcing those who wish to continue offering coverage to make difficult decisions. Many employers are either having to reduce coverage, pass on a higher percentage of the cost to their employees, or have to discontinue offering coverage altogether.

Another challenge facing employers is a lack of choices when they are shopping for a health plan. In many states, the small group health care market only offers employers a small handful of choices. It is clear to us that additional competition is necessary.

If enacted, Association Health Plans would decrease costs and provide needed competition. By allowing employers to consider the health plan of a bona-fide trade association of their choice – whether that be a National Restaurant Association plan or a Chamber of Commerce plan - employers would have more health plan options from which to choose. AHP's would also allow small businesses to take advantage of the same uniform regulatory status, economies of scale, purchasing clout, and administrative efficiencies that corporate and labor unions currently enjoy.

In addition, Association Health Plans would provide quality and reliable health coverage. Like corporate and labor union plans, AHP's would be fully regulated by the Department of Labor. In September, 2002, Secretary Elaine Chao issued a comprehensive report detailing DOL's readiness for assuming oversight of AHP's. Also in this report, Secretary Chao emphasized the numerous safeguards in the AHP legislation that are designed to protect consumers.

The National Restaurant Association believes Association Health Plans provide a great way to increase access to the uninsured. By removing some of the cost barriers and by instilling additional competition into the small group market, AHP legislation provides employers - particularly small employers - the tools they need to provide quality health care to more people.

Statement of the U.S. Chamber of Commerce

STATEMENT OF THE
U.S. CHAMBER OF COMMERCE

BEFORE THE
UNITED STATES HOUSE OF REPRESENTATIVES
SMALL BUSINESS COMMITTEE

March 5, 2003

Small Business Access and Alternatives to Health Care

The Chamber's mission is to advance human progress through an economic, political and social system based on individual freedom, incentive, initiative, opportunity and responsibility.

The U.S. Chamber of Commerce is pleased to submit the following statement at today's hearing on the issue of small business and health coverage. The Chamber is the world's largest business organization representing employers of every size, sector and region.

Small Business's Place in the Economy

It is important to understand why public policy that affects small business must be a high priority for lawmakers – and that is because small business is the engine that drives our nation's economy. According to 2000 U.S. Census Bureau records, just over 89 percent of the firms in this country are businesses that employ less than 20 people. Nearly one out of five employees in this country (18 percent) works for a company with fewer than 20 people, and 36 percent work for a firm with fewer than 100 people. When lawmakers in Washington pass legislation that impacts small business owners, those laws and regulations affect a lot of working American families.

Why Small Employers Offer Health Coverage

Small employers who offer health coverage do so because it is good business practice and because doing so helps them compete for workers. The fact that the tax code favors employer-provided coverage is also important. According to a 2002 survey by the Employee Benefits Research Institute/Consumer Health Education Campaign and the Blue Cross Blue Shield Association ("EBRI/CHEC-BCBSA"), 92 percent of employers said they offered coverage because it is the right thing to do.

Other important reasons for offering coverage are increased productivity because employees are healthy (64 percent) and reduced absenteeism (58 percent). Seventy-five percent of small employers said offering health coverage helps with employee recruitment as well as increasing loyalty and decreasing turnover (78 percent). More than half (57 percent) say they offer coverage because their competitors offer it or because employees demand or expect it (62 percent). However, employers do step up to the plate when required: nearly one-third of employers (30 percent) cited employee medical need for coverage as the reason why they offered benefits.

Why Small Employers DON'T Offer Coverage

Cost is clearly a barrier to small businesses being able to offer health coverage to their employees. In a separate study of small employers *(Kaiser Family Foundation-Health Research Education Trust 2002 Employer Survey, "KFF-HRET")*, 84 percent of employers cited high premiums as an important reason why they did not offer coverage. Not being able to qualify for group rates (45 percent) and administrative hassles (39 percent) were also cited as important reasons.

Similarly, the EBRI/CHEC-BCBSA 2002 survey found that 79 percent of employers stated that their business could not afford coverage as the reason they did not offer coverage. Finally, concern about revenue being too uncertain to be able to commit to a plan was also a reason (68 percent) for not offering coverage. This is an important factor

to keep in mind as the economy continues to struggle and as health plans' own commitment to the small business marketplace wavers.

Just because an employer doesn't offer coverage to its workers doesn't mean those employees – or the business owner – goes uninsured. Many (61 percent) employers said that because their employees were covered elsewhere, they did not need to offer coverage. When those circumstances change, or when the business owner himself needs coverage, small employers will seek out a group policy.

Small Business Employees and the Uninsured

During the late 1990s, more and more small businesses offered health coverage. From 1998 through 2000 – a time of strong economic growth – small employers (3 through 199 employees) increasingly offered coverage, from about 54 percent in 1998 to 67 percent in 2000 *(KFF-HRET 2000)*. This trend reversed, however, over the last three years, declining to 65 percent in 2001 and 61 percent in 2002 (*KFF-HRET 2002)*.

Uninsured individuals are overwhelmingly concentrated in smaller companies. More than one-third (34 percent) of employees at firms with less than 10 employees were uninsured in 2001, and 27 percent of employees in firms with 10 to 24 employees were uninsured. Along with coverage being harder to access and to afford, employees at small firms tend to earn less than their peers at larger companies, and larger employers often are able to pay a larger share of health plan premiums.

An alarming recent trend is the practice of employees electing to be uninsured – that is, declining their employer's offer of health benefits while not having another source of health coverage (through a spouse or parent or through a public program such as Medicare, Medicaid or the State Children's Health Insurance Program "SCHIP"). About one in six employees turn down the coverage offered them at work, mostly (61 percent) because they were covered by another plan. However, 20 percent said the coverage was too expensive to participate in the plan. Unfortunately, nearly one out of four (26 percent) of those employees who decline coverage go uninsured *(EBRI)*. This is a missed opportunity to improve the health and well-being of American working families, and one the Congress can easily remedy.

Small Businesses and Health Plan Costs

Health coverage also tends to more expensive on a per capita basis for smaller firms. Last year the average cost for employee-only health coverage was $3,060 but for small businesses (3 to 9 employees), the cost of employee-only coverage was $3,522 *(KFF-HRET 2002)* – a difference of 15 percent.

Some of the reasons for this cost difference include more state mandates and regulatory requirements on insured health plans (which most small businesses purchase because they cannot self-insure); a smaller pool over which to spread risk; and higher per capita administrative and marketing costs. And not surprisingly, recent cost increases are hitting smaller enterprises harder, too. Premiums increased an average of 12.5 percent in 2002 for employers with more than 200 employees, but 13.2 percent for employers with

less than 200 employees. Being able to self-insure health care costs helps to moderate those rate increases: rates increased 14.2 percent for fully insured health plans with conventional plan designs, but only 12.0 percent among self-insured conventional plans.

When asked how they would respond to a rate increase of 15 percent, 54 percent of small employers said they would change their coverage, and an additional 15 percent said they would drop their plans. If costs were to increase 25 percent, three out of five (59 percent) said they would change their health coverage but nearly one-quarter – 22 percent – said they would drop coverage *(EBRI/CHEC-BCBSA)*. This is significant because health plan costs are expected to rise 18 to 20 percent for small businesses over the coming year.

Furthermore, well-intentioned but costly proposals mandating coverage for mental health services, contraception, cancer screenings and a long list of requirements on health plans that has been offered in recent years as part of so-called "patients' rights" legislation will further drive up the cost of health coverage and put many small businesses within the danger zone of ceasing coverage altogether.

Recommendations

In some cases, small employers have been forced to get a new health plan because their insurer has left the marketplace, or employers have found that they have no other plan in their area to call for a rate quote when their current plan premiums skyrocket. State mandates on health plans have taken away health plans' ability to differentiate themselves in the marketplace and compete for customers by offering benefits tailored to meet their needs. When they leave the market, they leave businesses with one less place to go.

Unlike large businesses, small employers do not have the resources to self-insure under federal ERISA laws. Furthermore, more and more small businesses have employees in two or more states, and they have to arrange health coverage for their employees in each of those states. Under legislation like the "Small Business Health Care Fairness Act," small businesses could purchase coverage through associations and other organizations that meet federal requirements. No longer would small businesses be subject to state mandates and regulatory requirements that drive up costs, and small multi-state employers would enjoy a much simplified health care benefits program by being able to offer the same coverage to all their employees – just like larger businesses with whom they compete.

In addition to legislation permitting association health plans under ERISA, some other ways Congress can help small businesses and working families with their health plan costs include:

- Permitting insurance carriers to offer health plans free of state benefit mandates;
- Modifying the medical savings account program to allow both policyholders and employers to make contributions, lower the deductible thresholds, and permit full Medical Savings Account funding of the deductible;

- Modifying S-CHIP to make it easier for states to allow workers to use public program funds to cover dependent children in employer health plans instead of forcing them into a public program that is different from that of their parent(s);

- Permitting individuals who pay their health insurance premiums without employer assistance to take a full tax deduction for those costs; and

- Establishing a refundable tax credit for low-to-moderate-income individuals and families for the purchase of private health coverage, including a partial tax credit that can be applied to workplace coverage.

Cautions

What Congress should NOT do is:

- NOT expand medical liability to include employers who sponsor health plans;

- NOT impose even higher costs on those with health coverage by mandating coverage for costly services and benefits;

- NOT establish small business tax incentives for health coverage that are restricted to employers who previously had not offered a health plan (which penalizes employers who have struggled to offer coverage);

- NOT bias small business tax incentives to certain health plan purchasing arrangements.

Conclusion

Small business is the backbone of our nation and has driven much of the economic boom of the 1990s and suffered its share of the "bust." When small employers are confronted with health plan rate increases of first 20 percent and then 30 percent, they need to make adjustments to their overall business plan to compensate. Most small business's bottom lines just aren't growing at the same rate as their health plan increases.

Health coverage helps ensure access to care when you need it, and economic security for working families. Congress needs to make access to affordable health coverage for small business a priority for the health of working families families, and for the health of our economy.

Statement for the Record
Senator Olympia J. Snowe
House Committee on Small Business Hearing
"Small Business Access and Alternatives to Health Care"
March 5, 2003

One month ago, I convened my first hearing as Chair of the Committee on Small Business and Entrepreneurship to explore the crisis small businesses are currently facing in their attempts to find affordable health care for their employees. The reason I made this my first hearing was that whenever I spoke to small businesses this is the number one issue they wanted to discuss. Small businesses in my state are literally desperate for more health insurance options; some business owners even say this is keeping them awake at night.

At the hearing, small businesses from my home state of Maine made it clear that they have only one choice for their health care. Even when they band together in local purchasing pools, they are unable to attract any other insurance carriers to provide them with less expensive and more flexible options. Even though they have cut back on the coverage and increased the costs to the employees, they are still finding it almost impossible to provide health insurance to their employees. And as the costs to the employees increases, many employees find this too much to absorb, which leaves them uncovered and, therefore, increases the ranks of the employed but uninsured.

Indeed, the *Washington Post* reported on February 28 that worries about rising health care costs registered higher in a poll conducted by the Kaiser Family Foundation than even concerns over the stock market or terrorist attacks. Thirty eight percent of the respondents were "very worried" that the cost of their health care or health insurance would increase compared to 22 percent who were "very worried" about losing their savings in the stock market, or 19 percent who were "very worried" about being a victim of a terrorist attack.

With small businesses creating up to 75 percent of net new jobs in America and with a shocking 56 percent of the 41.2 million uninsured in this country *already* either working a full-time, full-year job *or* depending on one who does, we have an *obligation* to ensure that *more* of these individuals can receive insurance *through their employers*. So when the Kaiser 2002 Employer Health

Benefits Survey reports that only 61 percent of *all* small businesses are offering health benefits – and that's *down* from 67 percent just three years ago – is there any question that we're headed in exactly the *wrong* direction?

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

The fact is, with more than two-thirds of all Americans relying on their employer for health insurance, we can't afford to continue the disturbing trend identified by the Kaiser Family Foundation, where monthly premiums for employer-sponsored health insurance on average rose 11 percent from 2000 to 2001, and then *12.7* percent from 2001 to 2002 – the *second straight year* of *double digit* increases. As a result, *22 percent* of all firms increased employee deductibles in 2002, and *32 percent* told Kaiser they are likely to do so this year.

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

The result of all this isn't hard to predict. Businesses can and clearly *are* dropping health benefits. Others struggle onward in providing coverage, but only at the cost of the growth of the business, or offering packages with higher premiums, or a combination of both.

If we can do something that will help more small businesses provide health insurance to their employees, then we can significantly reduce the number of those who are without health insurance in this country. This is why I will soon be introducing the Small Business Health Fairness Act of 2003, the Senate companion to H.R. 660.

The Small Business Health Fairness Act of 2003 will improve access to affordable health care for small businesses by giving them the same advantages

currently enjoyed by large employers and unions. The bill employs a very basic principle – that volume purchasing of insurance by small businesses will work as it does for any other commodity and for any large business or union that purchases health insurance coverage – it will help reduce the cost. As President Bush has said, "It makes no sense in America to isolate small businesses as little health care islands unto themselves. We must have association health plans."

The Act will allow small businesses to pool together nationally, under the auspices of their bona fide associations, and either purchase their insurance from a provider, or self-insure in the same way that large employers and unions currently do. These association health plans (AHPs) would be monitored and regulated by the Department of Labor's Employee Benefits Security Administration in the same way that more than 275,000 plans offered by large employers and unions are currently regulated.

This agency is currently overseeing plans that cover 72 million people. The Department of Labor released a report last week that reveals high rates of compliance by group health plans with health care laws enacted under the Employee Retirement Income Security Act (ERISA). More importantly, the report, and the compliance project that is the subject of the report, are further evidence of the Labor Department's commitment and proven success in effectively monitoring health plans. The report establishes that the Department is prepared to oversee association health plans.

Studies by the Small Business Administration, the General Accounting Office, and the Congressional Budget Office have all found that these types of plans operate with between 13 and 30 percent lower administrative costs. These lower costs can then be translated into reducing costs to subscribers or providing more benefits.

Another reason AHPs will be able to offer less expensive plans, and also greater flexibility, is because they will be exempt from the myriad state benefit regulations. Associations will be able to design their plans to meet the needs of their members and their employees. By administering one national plan, it will further reduce the administrative costs instead of trying to administer a plan subject to the mandates of each state.

Even though the benefit mandates will not be in effect, associations will need to design their plans so that enough members participate in them to attract the necessary employees to make them work. By extension, this means they will provide a full range of benefits similar to what many states currently require. Indeed, in many cases, the plans offered by large employers and unions, which are also exempt from the state benefit mandates, are the most generous plans available. People often stay in those jobs specifically to keep their health care coverage.

The Act would also provide extensive new protections to ensure that the health care coverage was there when employees need it. Associations sponsoring these plans would need to be established for at least three years for purposes other than providing health insurance – this is intended to prevent the current epidemic of fraud and abuse that is occurring through sham associations who take money from unsuspecting small businesses and then cease to exist when some files a claim.

In addition, association health plans would be required to have sufficient funds in reserve, specific stop-loss insurances, indemnification insurance, and other funding and certification requirements to make sure the insurance coverage would be available when needed. None of these requirements apply to any of the plans currently regulated by the Department of Labor, either the large employer plans under the Employee Retirement Income Security Act (ERISA), or the union plans under the Taft-Hartley Act.

The approach of the bill I will introduce is, I believe, a good one – but I also consider it a starting point. In that light, I intend to work with all groups and interested parties *that are committed to passing the bill* so that we can improve the legislation and finally provide small businesses with more health insurance options at lower costs. The current situation is simply unacceptable. Those who oppose this bill and believe the status quo only needs to be modified slightly are not paying attention – they are not listening to the millions of small businesses who are desperate for more choices, or the small employers who are unable to get health insurance at any cost.

The time for stalling on providing relief for small businesses unable to get affordable health insurance is over. We must act now, and we must pass the

Small Business Health Fairness Act of 2003 I will introduce to bring small businesses more choices and use the power of competition to bring them better options.

Statement by Rep. Steve King to the
Committee on Small Business
March 5, 2003

Mr. Chairman, health care costs are escalating, and there are few options for small business owners to choose from when selecting insurance coverage for their employees. In order to keep and attract talented workers, sourcing affordable, quality health insurance is a top concern of small business owners and farmers. As an owner/operator of a small construction business for over 28 years, I am well aware that the largest challenges are access and cost. Even though small business is the backbone of our American economy, over 60 percent of the estimated 41 million people without healthcare are small business owners, their dependents or their employees and dependents.

Association Health Plans (AHPs) can help reduce the number of uninsured and ease the burden on small businesses by giving them the same accessibility, affordability, and choice in the health care marketplace that big business now enjoys. AHPs will allow small business owners to band together across state lines through their membership in a bona fide trade association to purchase health coverage for their families and employees. Through AHPs small business owners and employees would benefit from the same economies of scale, purchasing clout, and administrative efficiencies that their big business counterparts already enjoy. This would result in lower health care costs and new coverage options for the working uninsured, whose only current choices are the high-priced, over-regulated plans that may exist in their individual states.

Mr. Chairman, I appreciate the Committee's consideration of H.R. 660 which will improve access and choice for health plans purchased by small businesses. As a cosponsor of this important legislation, I hope to work with Rep. Fletcher and others to bring improved access to care for small businesses. I, too, am outraged to know that small businesses are being held hostage with annual increases, sometimes as high as 40 percent, for less coverage and poorer services. My small business would have never survived such poor attention to our customers, and I find it outrageous that insurance companies hold our valued employees in the balance.

President Bush's Fiscal Year 2004 Budget permits **Flexible Spending Accounts (FSAs) to** allow up to $500(pre-tax) to be used for medical expenses such as co-pays, deductibles and services not covered under the base insurance plan. However, if these funds are not used by the end of the year, the money is returned. There is no rollover provision to allow individuals to keep the money for future expenses or for the funds to be distributed to the individual after taxes have been paid on the remaining funds. These limitations need to be changed to allow workers to take control of health care costs and prepare for the future. FSAs promote the taxpayer's willingness to participate in an FSA since unused balances at the end of the year will not be lost, thus permitting participant to use balances wisely. In general FSAs do not restrict patients from choosing their doctors. For this reason, FSAs are more attractive than managed care.

Medical Savings Accounts (MSAs) allow workers a low-cost, high-deductible private health insurance policy coupled with a tax-preferred personal medical savings account for out-of-pocket expenses. In fact, one-third of all MSA purchasers previously had no health insurance (IRS).

Again, the employer or sole proprietor has the incentive to keep health care costs down. From my view, the MSAs portability is a major reason to expand the eligibility and contribution limitations. Under current law, MSAs have too many restrictions and families cannot rely on them for their future health care needs. Therefore, we need to expand MSAs and extend pilot programs.

Additionally I support healthcare savings accounts that are fully portable and can be used with any healthcare plan.

Again Chairman Manzullo and Ranking Member Velazquez, I appreciate your holding this hearing. I believe that AHPs, MSAs, FSAs and tax credits are common sense solutions to attempt to harness galloping health care costs.

Steve King

Rep. Steve King
Member of Congress

PREPARED STATEMENT TO THE HOUSE SMALL BUSINESS COMMITTEE

NATIONAL SMALL BUSINESS UNITED

High Cost of Healthcare for Small Business

March 5, 2003

Honorable Chairman and Ranking Member:

Thank you for allowing National Small Business United to submit this written testimony to you regarding the high cost of healthcare for small businesses. On behalf of our more than 65,000 small businesses in all fifty states, as well as local, state and regional small business associations across the country, NSBU works with elected and administrative officials in Washington to improve the economic climate for small business growth and expansion.

Health care reform is extremely important to NSBU and its affiliates. In fact, health care reform is at the top of our priority issues for the 108th Congress and has been a priority issue for our organization for the last fifteen years. We are committed to working with the House Small Business Committee to see that this issue is addressed for small business.

I. How We Got Here

There was a time, not so many years ago, when health care reform was clearly the number one small business issue. Costs were escalating at double digits every year, small business health policies faced close health underwriting, many employees were saddled with significant pre-existing condition exclusions, some small businesses couldn't find coverage at any price, and millions could not afford the prices they were charged. Layered on top of these problems, we were looking down the barrel of proposals for having universal coverage mandated on all employers. Our health care "system" was facing crisis.

But several key events interacted to relieve the pressure of those times, without resorting to a fundamental reform of the system. First, the states (and later the federal government) reformed the small group insurance market to make it more fair (though no less expensive). Second, managed health care began to kick-in, forcing cost

discipline on providers and relieving the incessant upward push on premiums. Finally, Congress decisively defeated the employer mandates proposed by the Clinton Administration. The national upset over the issue helped pave the way for the Republicans to take over Congress.

But after several years of relative stability on the health care front, the patch-work of 1990s reforms have begun to fray and come apart. Small employers are once again facing enormous year-over-year premium increases, the cost, control, and quality improvement promises of managed care give every appearance of having run their course, and Congress is once again considering legislation that will make the situation far worse. To compound matters, the current recessionary environment is likely to further swell the ranks of the uninsured, which already number over 40 million.

In short, health care reform is once again the most pressing issue facing small business, and the most pressing domestic issue facing the nation. It is time to coalesce around a proactive agenda for reforming the health care system. These reforms should bring long-term stability, keep costs in check, be fair to all small businesses and their employees, and maintain the best health care in the world. Our national challenge is this: real solutions to these real problems will not always be easy, and they will not always be popular.

As we approach this challenge, however, let us keep in mind that every substantial reform that Congress has enacted on health care during the last decade has only driven up health care costs and insurance premiums. Medicare reforms, insurance market reforms, mental health parity revisions—all have responded to some real problem, but they have all piled on new costs or shifted costs to the private sector. And these changes have contributed significantly to health care coverage costs that have put insurance out of financial reach for tens of millions and threatened tens of millions more with loss of health care benefits.

II. Needed Small Business Reforms

NSBU recommends that the states and Congress enact a series of health care reforms that could immediately reduce the health cost pressures that small firms and their employees face, improve health care access for individuals who would otherwise be uninsured, and increase the range of choices available to the underserved small business market.

Pool Small Businesses Locally. Encourage the development of local employer health care coalitions that would assist small employers in obtaining lower rates for coverage through group purchasing. Such coalitions would also assist small employers in learning about existing local health insurance plan options, how to be a wise health

insurance purchaser, the issues of health care costs, health care quality and the availability of health care providers within their communities. Such local employer health care coalitions would continue to be subject to their respective state laws and therefore there would continue to be a level playing field for all employers providing insurance in the small employer market. Such local employer coalitions already exist, providing choice and savings for their members every day. Many of these organizations are part of NSBU.

Fix the Medical Savings Account Law. As currently structured, Medical Savings Accounts (MSAs) are confusing, restrictive, and largely unworkable for most Americans. Yet the promise of these plans is greater than ever. More and more health plans are moving toward higher deductibles, even though most out-of-pocket health care expenses do not qualify for any tax preference. MSAs respond to this unfairness in our tax policy, and they also generate a level of "consumer behavior" that can provide a significant component of an over-all market-based cost containment strategy. In addition, even in their limited use, MSAs have shown a powerful ability to cover the previously uninsured. About 40% of participants those who signed-up for MSAs during their first year were newly insured. To make them meaningfully effective for the future, though, we need the following changes:

- Allow both employers and employees to contribute to MSAs. Right now either may contribute, but not both. This restriction greatly inhibits the ability of individuals to collect sufficient funds into their MSA.

- Lower the minimum required deductible and out-of-pocket limits. Currently, participation in MSAs requires an insurance policy with a "deductible" amount of at least $1,700 for individuals and $3,350 for families. Lower minimum deductibles would make MSAs more attractive for many workers and ameliorate potential risk selection issues by making them more appealing to older and sicker individuals. Once individuals have a chance to "build up" their MSA funds, they will then be much more willing to have even higher deductibles.

- Remove the restriction that all family members who would be covered must be covered only by high deductible plans.

- Modify the current HMO Act to enable HMOs to offer high out-of-pocket plans. A large segment of the provider community is taken off the table by this provision and can make MSAs much less attractive.

- Remove the cap on the number of participants. Right now, only 750,000 individuals are allowed to participate in MSAs. With the other changes listed above, this cap would quickly be reached and MSAs would be unavailable to most small business employees.

Recently, the Administration highlighted Health Reimbursement Accounts (HRAs) which are similar to MSAs, but can only accept employer contributions, and employees cannot keep their excess funds. The objectives of MSAs could also be met by reforming the HRA structure: allowing employees to contribute, allowing employees to roll excess funds into retirement plans, and, most importantly, ***allowing small business owners to participate***. Like so-called cafeteria plans, HRAs specifically exclude owners of non-C Corporations from participating. This is a major obstacle that must be overcome if small companies are ever to take advantage of the potential of these plans.

On the subject of cafeteria plans (Section 125 plans), it should be noted that reforms of these plans could also be an important factor in increasing the ability of small business employees to fund various kinds of unreimbursed care. Two major roadblocks are in the way. First, small business owners generally cannot participate in cafeteria plans. Second, these plans have annual "use-it-or-lose-it" provisions, which cause some to spend money that did not need to be spent, but cause many more to never contribute to the plan in the first place. Fixing these two mistakes would be a real benefit to small business employees struggling to meet their out-of-pocket medical bills.

Create Health Insurance Tax Equity. After sixteen years of struggle and unfairness, the dawning of 2003 has finally brought small business owners the ability to deduct all of their health insurance expenses against their income taxes. Great thanks is owed to the many members of this committee who labored to make this change a reality.

We are still only part way to real health insurance tax equity for small business. Except for business owners, workers are allowed to treat their contributions to health insurance premiums as "pre-tax." This distinction means that those premium payments are subject neither to income taxes, nor to FICA taxes. While the owner of a non-C Corporation can now deduct the full premium against income taxes, that entire premium is paid after FICA taxes. Compounding matters, these business owners pay both halves of the FICA taxes on their own income for a total FICA fax burden of 15.3 percent.

Right here in Washington, D.C., the cost of a Blue Cross/Blue Shield family policy in a small group plan has topped $12,000 per year. A business owner who makes $60,000 and purchases this plan for his or her family pays $2,000 in taxes on that policy. A worker who makes $60,000 and has the same plan pays nothing in taxes on that policy. By treating this business owner the same way that everyone else in this country is treated, we can give him or her a 15 percent discount on health insurance premiums—probably a greater savings for some than any other policy change we will discuss today.

Reform the Medical Liability System. The enormous costs of medical liability and the attending malpractice insurance premiums are a significant factor pushing health care costs higher and restricting choice and competition for consumers of health care. Triple digit increases in malpractice premiums over the last five years have been common in many states and specialties.

These costs have a distorting effect on the health care system by causing physicians to retire early, change their practices to serve lower-risk patients, move to states with reformed malpractice laws, and concentrate their practice in high-profit centers, making quality health in rural areas and smaller towns increasingly difficult to come by. All of these changes restrict competition and the ability of employers to negotiate lower reimbursement rates. But the most profound affect of the liability system is the "defensive medicine" that is practiced by many risk-averse providers. Unnecessary, purely defensive procedures, cost the health care system untold billions each year and drive up premiums for all of us.

Protect the Small Employer Health Insurance Market from "Gamesmanship." The Health Insurance Portability and Accountability Act (HIPAA) of 1996 ensured that small groups could not be denied coverage by any insurer offering small group coverage in their state. The federal law, however, does not ensure that this coverage would be affordable, though states generally have implemented "rate bands" that provide some upper limit on rate increases for particular groups.

The individual market, however, is generally free of the guaranteed issue requirements enacted by HIPAA. Only those who had other insurance within the previous six months would be free of exclusion. This difference in rules between the individual market and the small group market means that premiums for younger and healthier individuals are almost always lower in the individual market than in the small group market. The opposite is generally true for older and less healthy individuals: their premiums are less in the small group market than in the individual market. This dynamic understandably leads some employers to purchase less expensive individual coverage on behalf of their employees, when they can qualify for low rates. When significant illness occurs, the individual premium escalates sharply, and the business will often switch to a small group plan, where they must be accepted and where the premiums will be much lower.

While this entire process is perfectly rational from the employer's perspective, it forces small group premiums to be higher than they otherwise would be. We believe that premiums would be lower and overall access to health insurance higher if this practice were discouraged, perhaps through a surcharge when the business re-enters the small group market (much like the penalty for early withdrawal of IRAs). Another way would be to clarify that employer-paid premiums in the individual market are taxable to the employee.

Help the Uninsured through Tax Credits and Current Programs. Much of the question of adequate health insurance coverage is really a question of affordability. There is probably no more efficient way to provide public subsidies for health insurance than through a system of tax credits, scaled to income, and targeted at individuals, such as those proposals that the President has put on the table. Further expansions of Medicaid and SCHIP programs to serve uninsured populations should also be considered.

There is certainly the potential to provide tax credits to small employers, as well, but we should be aware that such action is a potentially slippery slope. Which businesses would we subsidize? Do we subsidize businesses that don't currently provide health insurance? Tell that to the business that has been providing coverage for years. Do we subsidize businesses with low average wages? Plenty of them are highly profitable. We do not close the door to the possibility that an appropriate mechanism could be established to help smaller companies, but the potential problems, distortions, and inequities in doing so are manifold.

III. What Not to Do

Any new "improvement" to the private health insurance system that seeks to extend new benefits, provide new protections, or create new liabilities—no matter how well intentioned—should be carefully weighed against its cost. The worst case scenario is not no action, it is new federal action that increases expenses. All of these changes only pile more and more costs on a private system already tottering under the weight of its current load. We ask that the Committee members do all they can to educate themselves and their colleagues about this very complex situation.

There have also been calls from many of our brethren in the small business community to create a new form of federalized small business purchasing pools, run by associations. These Association Health Plans (AHPs) are a reaction to the very dire circumstances small businesses currently face in the health insurance arena: huge premium increases, a lack of control and clout, the costly tangle of state and federal regulations, and fewer funding, carrier, and plan selection options than their larger counterparts.

However, despite those good intentions, we are concerned that AHPs threaten to greatly worsen the market segmentation and risk-aversion that currently characterize the small group health insurance market, and which are at the root of the health care crisis uniquely faced by smaller firms. AHPs might be good for national small business associations (like NSBU) who want to run them, but NSBU believes they will not be good for the small business community at large, whose interests we are bound to represent.

Bigger is Better? One of the fundamental precepts that underpins the arguments of those advocating for AHPs is the idea that big pools will equal bargaining clout. In almost every market in the world, the larger the quantity you buy of something, the lower its per unit price will be. In the health insurance market, however, the make-up and location of that pool are both far more important factors in establishing a price than size alone.

A pool of 1,000 people with an average age of 40 could demand (and receive) a much better rate than a pool of 50,000 people with an average age of 55. Those are simply the actuarial facts of the matter. Moreover, when a plan is negotiating reimbursement with providers, a local hospital or physician will be driven by how many patients the plan will bring them. A local plan with a total of 100,000 lives will be able to drive a much better deal than a big national plan with 5 million lives, only 15,000 of which are local.

So, the risk profile of the group and their geographic concentration are the two most important factors in negotiating rates for small business health insurance. Unfortunately, AHPs would present us with problems on both fronts.

Risk Selection. The insurance industry competes based largely upon each company's ability to attract better (i.e. more profitable) risks. AHPs are likely to function in the same way. While AHPs could not exclude any specific qualified association member, risk selection is a much more subtle and powerful phenomenon than such blatant discrimination alone. In fact, such selection would be the crux of AHPs' competitive advantage.

By carefully designing benefit packages that will be relatively unattractive to older and less healthy populations, AHPs will be able to simultaneously attract a higher proportion of younger and healthier individuals in their pools, thereby driving down their expected claims costs and, thus, their premiums.

Currently, the rates that can be charged in the small group market are regulated by the states. Most states have "rate bands" of varying degrees that define the window in which rates can fluctuate and on what basis they can fluctuate. Other states have a form of community rating in which rates are essentially the same for all participants. Fully insured AHPs would only be subject to the rate bands in their state of domicile and would use those rules in all other states in which they operate. If an AHP were to sell into a community-rated state (such as Maine, to pick one at random) with varying rates, the consumer choices would be stark. The AHP rates for younger, healthier groups are likely to be significantly less than for other groups, while AHP rates for older, less healthy groups are likely to be higher than the average rate in a community-rated state. It is easy to see what will

happen: younger, healthier groups will join AHPs, and the rest will not. Moreover, the out-of-state AHP is likely to be able to take into account all sorts of risk factors in setting their rates.

Since apportionment of health risk is ultimately a zero sum game, lower premiums for those participating in AHPs will mean higher premiums elsewhere. These increases will drive more healthy people away from the traditional pools and into AHPs. Those AHPs that attract significantly better risks can be highly profitable. But AHPs that refuse to engage in this sort of risk selection, as well as traditional plans that are forbidden by state law from doing so, will fall into what is known as a "death spiral," where higher premiums chase away better risks, which leads to still higher premiums. The end result will be the destruction of the traditional insurance market for small firms and the displacement of millions of currently insured individuals.

Proponents of AHPs say that associations will act in their members' best interests and avoid these practices. But, to serve their members and to attract new members, AHPs will want to keep premiums as low as possible. The most effective way for such a pool to achieve lower premiums is to attract better risks. To deny that such will occur is to deny the effect of market forces.

Two types of associations seem most likely to offer AHPs: national vertical trade associations (representing a specific industry, e.g. banking, restaurants) and national general small business groups (such as NSBU or NFIB). A vertical trade group that believes that its trade population is relatively young and healthy is likely to start an AHP, and expect it to be successful. Similarly, a vertical trade group that believes its trade population is relatively old and unhealthy is unlikely to be able to sustain an AHP. In other words, affected trade associations and their health insurer partners would behave predictably and according to their organizations' financial interests. Risk selection would be part of AHPs from the very beginning. To believe otherwise is to refuse to acknowledge the way small group insurance markets function now, in spite of heavy state regulation. To disbelieve is literally "head-in-the-sand."

It is also likely that there would be a number of national general small business AHPs. These associations would market nationally to potential members, largely on the basis of premium. Given that these groups would all have the same regulatory advantages, they would succeed or fail almost entirely on their ability to attract and maintain a healthier population.

Cost and Access. Proponents claim that AHPs will save their members significant amounts of money. In fact, a Congressional Budget Office (CBO) paper estimated that businesses switching from an existing state-regulated pool to an AHP would see their premiums decline by 13 percent, a fairly substantial savings. However, most

(almost two-thirds) of those savings come from the risk selection described above. According to the CBO paper, AHPs would achieve cost savings by draining away healthier individuals from the state-regulated pools, thereby forcing premiums to go yet higher for the majority of the market. The CBO estimates costs will decline for the 20 percent of businesses that join AHPs, but will, therefore, go up for everyone else.

Proponents of AHPs hope that premium savings will cause new individuals to be insured. However, the CBO paper cited above clearly shows that the overwhelming number of participants in AHPs will be those who switched from a traditionally insured plan to an AHP. CBO believes that these switchers would outnumber the newly insured by nearly 14-to-1. We also must point out that the higher premiums for non-AHPs could lead to greater numbers of uninsured individuals, exactly the opposite of the outcome desired by proponents

The AHP Forecast. Despite the rosy picture painted by proponents of AHPs, we fear AHPs would only serve to dig the small business health market even deeper into a hole of adverse selection, further distorting an already perverted market. Those who have the least need for health care services will be able to buy health insurance cheaply (and insurers and AHPs will find this business very profitable). But those who are at greatest risk of illness will be least able to afford coverage, and insurers will be at ever-increasing pains not to sell coverage even to those who can scrape up a monthly premium payment that will soon surpass an average monthly mortgage payment.

AHPs may cause a number of currently uninsured Americans to get coverage. However, we believe that it will, over time, cause even more small business owners and employees to reduce and give up coverage due to cost increases.

If this hastened train-wreck is what occurs from AHPs, matters will not be politically or economically sustainable unless Congress embarks on exactly the kind of national mandate-setting and market regulation that all 50 states are struggling with right now (and which AHPs are a rebellion against). Some might think that would be a good thing, but one suspects that it would be very difficult to generate a majority for AHPs if it was understood this kind of additional federal intervention would be necessary in a few years.

We thank you for the opportunity to submit our remarks. NSBU welcomes any questions or comments you may have, please feel free to contact us at (202) 293-8830 or via e-mail at mbrogan@nsbu.org.

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Supplement to testimony of the Small Business Association of Michigan (SBAM) submitted March 5, 2003 by Barry Cargill, Vice President for Government Relations, Small Business Association of Michigan (SBAM).

Association Health Plans
Not the Right Answer for Small Business

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

Objectives of Association Health Plan Legislation:

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

MEWAs – A Historical Perspective

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

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

Department of Labor Oversight

One of the fundamental arguments for the formation of Association Health Plans is that their regulation would be transferred from the individual states back to the Department of Labor and, therefore can be established under a single set of rules by which they will be governed. The proponents of Association Health Plans believe these changes will encourage the establishment of many new AHPs by freeing them from compliance with different regulations in each of the 50 states, and allow them to deliver less expensive health care benefits by avoiding state mandates. This may or may

not happen, and the potential for state regulation "shopping" - finding the state with loose or favorable regulations - and expanded fragmentation of the small group market is a very real possibility.

Administrative Costs and Association Health Plans

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

AHPs also propose to lower costs by eliminating many state mandated benefits. While state mandated benefits differ from state to state, many cover essentially the same medical condition, and it is unlikely that these mandates generate 10% of the cost of a medical plan. Further, just because a benefit is no longer mandated does not mean that it would no longer be desired or offered. For example, it is hard to believe that a health plan that did not include coverage for maternity care would be attractive to the general marketplace. Unless they were trying to "skim" the market, most association health plans, as large businesses do today, would still provide a high level of coverage independent of the mandate. It is hard to imagine the elimination of mandated benefits being worth more than a 2% - 5% reduction in plan cost. Further, as the SBA study rightfully points out, "The National Association of Insurance Commissioners, The National Governors' Association, and the National Conference of Legislators oppose association health plans that are exempt from state mandates because they would "threaten the stability of the small group market... According to their analysis, small firms with healthier employees would enroll in the new AHP, increasing premiums for the groups

left in the small group market". This market segmentation is a very real outcome of association health plans that avoid state regulation and rate setting requirements. For the market to work effectively there must be a level playing field for all participants including those companies enrolled in an AHP and those buying coverage in the open market.

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

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

In the last 10 –15 years, much has changed in the world of health care and health care delivery. Managed care has come and, in some cases, gone and commercial insurers now see their market as any local group. As premiums have increased and the number of large businesses has stabilized or declined, large health insurers and many brokers have redefined their market, and now try to build market share by actively pursuing companies that they have traditionally ignored. Put differently, growth in market share for insurers, or growth in commission revenue for brokers, is now dependent upon growing their share of the small group marketplace. Therefore, association sponsored MEWAs are under increased pressure from their members to find new solutions to rising costs, while remaining competitive and finding answers to

the basic question of membership. Many programs face declining membership and serious questions regarding their long-term viability. Successful MEWAs must keep pace with the marketplace they serve. One way to do so is through the geographic concentration of membership, gaining mass, developing an acute understanding of its membership and the health care environment in which it operates, and expanding on the products and services they offer. This argues for local plans – like chambers or statewide group purchasers - and against national MEWAs that cannot hope to gain enough mass or knowledge of the member or marketplace to make a significant difference.

Association Health Plan Sponsors and Reserve Levels

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

It is proposed that the regulation for AHPs include certain financial requirements. While these requirement levels are unclear, AHPs would be required to maintain reserves for unearned contributions, incurred and future liabilities, administrative costs, errors and other obligations. Additionally, AHPs would be required to maintain a surplus reserve of $500,000 - $2,000,000, and have a qualified actuary determine reserve levels for claims. Setting reserve levels is critical to the future ability of an AHP to meet its obligations and this is precisely where the regulations of MEWAs in years past failed to protect the small business owner from fraudulent operators. If regulation reverts back to DOL, there does not appear to be a plan to prevent this from occurring in the future. In fact, the DOL has no history of regulating health insurance, something that the states have been

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

Conclusion

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

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

Surging Health Care Costs for Small Business.

House Small Business Committee
March 5, 2003.

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Small Business Association of Michigan
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Dear Members:

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

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

Scope of the Problem in Michigan

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

Michigan small businesses.

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

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

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

The Michigan Market.

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

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

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

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

Association Health Plans Spell Trouble for the Michigan Market.

AHPs are intended by their supporters to address the very dire circumstances small businesses currently face in the health insurance arena: huge premium increases, a lack of control and clout, the costly tangle of state and federal regulations, and fewer funding, carrier, and plan selection options than their larger counterparts. However, despite those good intentions, AHPs stand to greatly worsen the market segmentation and risk-aversion that currently characterize the small group health insurance market, and which are at the root of the health care crisis uniquely faced by smaller firms.

By carefully designing benefit packages that will be relatively unattractive to older and less healthy populations, AHPs will simultaneously attract a higher proportion of younger and healthier individuals for their insurance pools, driving down expected claims costs and, thus, their premiums. Since apportionment of health risk is mostly a zero sum game, lower premiums for AHPs will mean higher premiums elsewhere. These increases will drive healthier people away from the traditional state insurance pools and into AHPs. Those AHPs that attract significantly better risks can be highly profitable. But AHPs that refuse to engage in this sort of risk selection, as well as traditional plans that are forbidden by state law from doing so (such as Blue Cross Blue Shield of Michigan), will fall into what is known as a "death spiral," where higher premiums chase away better risks, which leads to still higher premiums.

The end result will be the destruction of traditional state-based insurance pools for small firms and the displacement of millions of currently insured individuals. To serve and attract members, AHPs will want to keep premiums as low as possible. The most effective way for such a pool to achieve lower premiums is to attract better risks. To deny that such will occur is to deny the effect of market forces.

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

Rating Reform in Michigan

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

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

From an insurance standpoint, this trend, if left unchecked, establishes the potential for

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

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

Individual Responsibility

Asking employees to finance a greater share of their health care cost is but one means of returning a sense of individual responsibility for persons seeking health care services. Whenever individuals are empowered to manage their own out-of-pocket expenses, they will become true consumers of their health care services and will help in containing the overall cost of health care. For example, if an individual has the choice of a brand name drug with a $30 co-pay or a generic equivalent with only a $10 co-pay, they are likely to accept generic, thus lowering the cost to themselves and their insurer.

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

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

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

Conclusion

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

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

Testimony presented to the House Small Business Committee

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

March 5, 2003

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

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

COSE is also a longstanding member of National Small Business United, the nation's oldest bipartisan advocacy association for small business, representing over 65,000 small businesses in all fifty states. Cliff Shannon has submitted testimony to you on behalf of

NSBU. COSE concurs with his statements; however, given our unique position in the marketplace, we felt the need to submit comments of our own.

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

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

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

While well intentioned, we believe AHPs may threaten the stability of the health insurance marketplace and ultimately harm those they are intended to help. From our 30 years of experience with group purchasing, we can see that AHPs will segment the marketplace through risk selection. If AHPs become law, associations that sponsor them could theoretically design their own benefit packages that would be more attractive (and less expensive) to a young, healthy population. This leaves the unhealthy to higher premiums and further segmentation of the market. We concur with the following statement from NSBU's testimony: "Proponents claim that AHPs will save their members significant amounts of money. In fact, a Congressional Budget Office (CBO)

paper estimated that businesses switching from an existing state-regulated pool to an AHP would see their premiums decline by 13 percent, a fairly substantial savings. However, most (almost two-thirds) of those savings come from the risk selection described above. According to the CBO paper, AHPs would achieve cost savings by draining away healthier individuals from the state-regulated pools, thereby forcing premiums to go yet higher for the majority of the market. The CBO estimates costs will decline for the 20 percent of businesses that join AHPs, but will, therefore, go up for everyone else."

Proponents of AHPs hope that premium savings will cause new individuals to be insured. However, the CBO paper cited above clearly shows that the overwhelming number of participants in AHPs would be those who switched from a traditionally insured plan to an AHP. CBO believes that these switchers would outnumber the newly insured by nearly 14-to-1. We also must point out that the higher premiums for non-AHP programs could lead to greater numbers of uninsured individuals, exactly the opposite of the outcome desired by proponents.

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

We at COSE are also very concerned about the prospects for AHP programs to fail, leaving small employers and their workers and families without coverage. Ohio has strong protections in the form of insurance reserve requirements. AHPs will be able to avoid those requirements in a number of ways. We have watched as several Multiple

Employer Welfare Arrangements (MEWAs) have failed, despite being regulated by the Labor Deparment. We cannot play risky games with the health insurance of our small businesses across the country who will be unable to analyze the true financial soundness of AHP programs. When the inevitable failures occur, the consequences for faith in our market system will be severe.

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

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

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