

United States of Representatives
Small Business Committee
Hearing:
March 5, 2003
The Honorable Don Manzullo, Chair

Written Testimony of the
Detroit Regional Chamber

Purpose of Detroit Regional Chamber's Comments

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

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

Background of Detroit Regional Chamber

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

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

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

- Helping small firms choose the most appropriate coverage for their individual circumstances
- Processing membership changes and updates within the BCBSM operating system
- Assisting with claims questions and resolving claims issues
- Helping members adjust their coverage in response to changing circumstances or escalating premiums
- Referring members to other insurance companies when Blue Cross coverages do not fit their needs.

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

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

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

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

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

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

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

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

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

Association Health Plans Will Lead to Large Pools of Uninsured

In many states, AHPs already exist, subject to the requirements of those states. In Michigan, for example, 136 associations and chambers of commerce sponsor small group health programs underwritten by Blue Cross and Blue Shield of Michigan. In January, 2003, those programs covered:

- 52,079 businesses
- 305,266 employees

- 674,893 lives

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

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

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

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

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

Can National Standards be Effective?

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

On the other hand, could the federal government adequately assess and address health care needs within the individual states? And once a set of federal standards would be in place, would the legislative and executive branches have the will, the resources, and the desire, to ensure compliance and keep up to date? What about the already-clogged judicial branch? Isn't that a form of national health care so many have railed against?

Some proponents of AHPs have argued that HIPAA and ERISA requirements will provide adequate protection against the tendency of insurers to avoid risk. We disagree.

HIPAA left untouched the ultimate protection against risk – price. Only the individual states regulate price, within the HIPAA framework - - forty-seven of them utilizing some variation of the model act developed throughout the ‘90s by the National Association of Insurance Commissioners. Nor can we identify any ERISA regulations that will prevent adverse selection in small group health insurance markets.

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

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

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

Conclusion

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

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

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

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

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