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HEARING ON
HEALTH CARE FOR SMALL BUSINESSES

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Introduction

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

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

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

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

1. Small Group Reform

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

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

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

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

2. Purchasing Pools

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

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

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

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

B. Specific Concerns About H.R. 660

1. H.R. 660 Would Undermine State Reforms

Before state small group market reforms were implemented, the small group market was fragmented into various pools based on risk. If a small employer had healthy employees in a relatively safe working environment the employer could easily find coverage at a good rate. However, if one of the employees became sick, the employer would be shifted to a higher risk pool and often priced out of coverage. Those who started with sicker or higher risk employees were often priced out of the market from the beginning.

State small group market reforms forced insurers to treat all small employers as part of a single pool and allow only modest, and in some states no, variations in premiums based on risk. This spreading of risk has brought some fairness to the market. H.R. 660 would undermine state reforms and once again fragment the market.

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

2. H.R. 660 Would Undermine HIPAA Reforms

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

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

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

Proponents of AHP legislation claim that the Department of Labor already has sufficient resources to oversee the new plans and will be able to prevent any insolvencies or instances of fraud. This simply is not the case. The Department of Labor has neither the resources nor the expertise to regulate insurance products. The states have invested more than 125 years in regulating the insurance industry. State insurance departments nationwide employ over 10,000 highly skilled people, and the combined budgets of state insurance departments total more than \$700 million. The AHP legislation, H.R. 660, provides no new resources for regulating these plans.

While we acknowledge adequate regulation costs, it exists to protect consumers. Insurance is a complicated business, involving billions of dollars, with ample opportunity for unscrupulous or financially unsophisticated entities to harm millions of consumers. Unless oversight is diligent, consumers will be harmed.

This is not just speculation, but fact borne of years of experience with Multiple Employer Welfare Arrangements (MEWAs), multi-state association plans, out-of-state trusts, and other schemes to avoid or limit state regulation. Within the last year, 16 states have shut down 48 AHP-like plans that had been operating illegally in the state, many through bona fide associations. Association plans in several states have gone bankrupt because they did not have the same regulatory oversight as state-regulated plans, leaving millions of dollars in provider bills unpaid.

Each time oversight has been limited the result has been the same – increased fraud, increased plan failures, decreased coverage for consumers, and piles of unpaid claims. Specifically, the NAIC believes the following issues must be addressed:

a. Solvency Standards Must Be Increased

While the solvency standards in the AHP legislation have been increased over the years, they are still woefully inadequate. In particular, the capital reserve requirement for any and all AHPs is capped at \$2 million -- no matter the size of the plan. Almost all states require the capital surpluses to grow as the plan grows, with no cap or a far higher cap than that in the federal legislation. If a nationwide AHP were offered to a large association, a capital surplus of only \$2 million would result in disaster.

b. AHP Finances Must Receive Greater Oversight

Even if the solvency standards were increased, oversight is almost nonexistent in the bill. Under H.R. 660 the AHP would work with an actuary chosen by the association to set the reserve levels with little or no government oversight to ensure the levels are sufficient or maintained. Also, the AHP would be required to “self-report” any financial problems. As we have seen over the past year, relying on a company-picked accountant or actuary to alert the government of any problems can have dire consequences for consumers who expect to have protection under their health plan.

State regulators comb over financial reports and continually check investment ratings to ensure that any potential problems are identified and rectified quickly. AHP plans must be held to the same standard.

Simply limiting participation in AHPs to “bona fide trade and professional associations” and providing limited Department of Labor oversight of self-reported problems will not prevent fraud and mismanagement. Strict oversight is required and this will only occur if all health plans delivered through associations are licensed and regulated at the state level.

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

Included in H.R. 660 is the broad preemption of consumer protection laws. Proponents of AHPs will argue that state mandated benefit laws must be preempted so that AHPs do not have to provide coverage for expensive benefits. However, states have a complex regulatory structure in place for insurers. Not only will mandated benefit laws be preempted, but other laws protecting patient rights and ensuring the integrity of the insurers would be preempted as well. A small sample of these laws and actions follows:

- ◆ Background review of officers.
- ◆ Investment regulations to ensure that carriers only make solid investments instead of taking on risky investments such as junk bonds.
- ◆ Unfair claims settlement practices laws.
- ◆ Advertising regulation to prevent misleading or fraudulent claims.
- ◆ Policy form reviews to prevent unfair or misleading language.
- ◆ Rate reviews. Insurance departments may review rates to make sure the premiums charged are fair and reasonable in relation to the benefits received.
- ◆ Network requirements including provider credentialing and network adequacy, to ensure that plans offer a provider network that is capable of delivering covered services.
- ◆ Utilization review requirements to ensure that plans have acceptable processes and standards in place to determine medical necessity and to make coverage determinations.
- ◆ Internal and external appeals processes.

While some of these protections may be offered by AHPs as a service to their association members, there would be no requirement that they do so, and no entity to complain to if a patients' rights are violated by the plan. State insurance regulators act on millions of consumer complaints every year and work hard to protect the rights of patients. AHP participants should have access to the same protections and complaint process.

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

While H.R. 660 would allow states to impose premium taxes on AHP plans – to the extent they are imposed on other insurance plans – it preempts other state assessments. States often use health insurance assessments to fund such important entities as high risk pools (which provide coverage to the uninsurable) and guaranty funds (which help cover claims if a plan is insolvent.) Such programs are vital to the stability of the small group and individual markets and to the protection of consumers – they must not be undercut by federal preemption.

Conclusion

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

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

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