

**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  
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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.

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submitted March 5, 2003 by Barry Cargill, Vice President for Government Relations,  
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## **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 downright 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.