Small Businesses and Health Insurance: Easing Costs and Expanding Access
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Topeka, KS
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Testimony

Good morning Mr. Chairman. My name is Sandy Praeger and I am testifying today on behalf of the National Association of Insurance Commissioners (NAIC). The NAIC represents the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. The primary objective of insurance regulators is to protect consumers and it is with this goal in mind that I comment today generally on the small business healthcare crisis, and in particular the proposal to create Association Health Plans (AHPs).

To begin I will emphasize the commissioners' recognition of how important it is to ensure affordable, available health coverage 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 fifteen years to stabilize and improve the small group market. States have required insurers to pool all of their small group risk by imposing rating bands or limitations, to further spread the risk of smaller, unhealthier businesses across a larger population. Many states have created purchasing pools and allowed associations to provide licensed, state-regulated insurance products to their members. States continue to experiment with reinsurance, tax credits, subsidies, basic health plans for small businesses, and programs to promote healthier lifestyles and manage diseases. As always, states are the laboratories for innovative ideas. It is critical that the federal government and the states work closely with healthcare providers, insurers and consumers to implement true reforms that will curb spending and make insurance more affordable to small businesses. Rehashing strategies that have failed, such as Association Health Plans, is not a step forward. It's time to move on to find effective solutions.

NAIC's Principles for Federal Reform

In their search for effective solutions, the nation's insurance regulators have identified seven basic principles by which federal health insurance reform legislation can be analyzed. These principles are intended to keep the focus on the needs of consumers and the true causes of the current crisis. These principles are:

Principle 1: The rights of all consumers must be protected. States already have patient protections, solvency standards, fraud prevention programs, and oversight mechanisms in place to protect consumers; unless new federal standards equal or exceed existing state standards and enforcement they should not be preempted. Any new insurance arrangement purporting to increase the number of people with health insurance will be a failure if the insurance arrangement is not solvent and cannot pay the claims of those who have placed their trust in it. Further, all new proposals must preserve access to sufficient grievance and appeals procedures, and also assure that benefits and provider networks are

adequate. Consumers must always be protected from fraud and misinformation.
Principle 2: Existing state reforms and assistance programs must be supported, not degraded. As you know, states have already enacted small group purchasing pools, high-risk pools, and other reforms to increase the availability and affordability of health insurance. Federal reforms must not erode these successful efforts by permitting good risk to be siphoned off through manipulation of benefit design or eligibility for benefit provisions.
Principle 3: Adequate consumer education must be provided. Federal reform will be complicated, creating new insurance choices for many Americans. The federal government must coordinate with existing state consumer education programs to ensure consumers are able to make informed choices.
Principle 4: The overarching issue of rising healthcare costs must be addressed. Federal efforts to increase access to insurance will not be successful over time unless the overriding issue of rapidly rising healthcare costs is also addressed. Insurance is a mechanism for paying for health care and has had only limited success in controlling costs, but insurance is not the cause of those skyrocketing costs. There are multiple drivers of healthcare costs, and they in turn are driving up the cost of health insurance. To bring long-term stability to the healthcare system efforts must include provisions to address cost drivers and control rising healthcare costs.
Principle 5. Current cost shifting must not be exacerbated. Inadequate reimbursement payments have led to cost shifting to the private sector. Unfunded federal mandates to states have shifted costs onto state governments. The cost of providing care to the uninsured is also shifted, driving up rates for insurance consumers. These actions have resulted in higher overall costs and decreased access for many consumers. Federal health insurance reform legislation must address cost shifting.
Principle 6: The position of less healthy individuals must be protected. Both state and the federal governments have begun the process of reforming tax structure and other financial policies to encourage individuals to be more responsible consumers of health care. Emerging industry trends reflect developments in benefit and plan designs that create incentives for responsible consumer behavior in health care purchasing decisions. Public policy decisions must assure that new designs do not shift costs to such an extent that insurance no longer offers meaningful protection to the sick or discourage appropriate care. Federal legislation should encourage appropriate usage of the health care system without inappropriately withholding needed health care services to the sicker patient.
Principle 7: Public policymakers should be wary of allowing the creation of insurance companies without appropriate oversight. Remember, legislation that allows alternative risk-bearing arrangements must acknowledge that it is allowing the creation of new insurance companies. A mere change in the name of the arrangement does not transform its essential insurance nature and function – the acceptance and spreading of risk. To allow such new insurance companies to be formed outside the existing regulatory structure will create an unlevel playing field that is unfair to existing insurers and potentially harmful to consumers. To do so without providing adequate additional federal resources to ensure sufficient oversight of new entities will be disastrous.

AHP Legislation Violates NAIC Principles

The AHP legislation that has been once again introduced in the House and the Senate violates almost all of the principles outlined above and, therefore, the NAIC must remain steadfast in its objections to the AHP bills. Specifically, the legislation would:

1. 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. Although the proponents claim AHPs are a vehicle for allowing small businesses to pool together, they would actually reduce the amount of pooling in the small group market. In fact, it is not pooling but "cherry picking" that would enable AHPs to offer lower-cost coverage in some cases. Such savings would come at the expense of all others in the small group market who are not part of AHPs. The AHP legislation in Congress would undermine state reforms and once again fragment the market.

While the AHP bill does make some effort to reduce "cherry picking" the NAIC believes the provisions will be ineffective in stopping risk selection. Under the current bill, AHPs can still "cherry-pick" using four very basic methods:

a) Membership – S. 545 permits associations to offer coverage only to their members, allowing plans to seek memberships with better risk;

b) Rating – S. 545 eliminates state rating limits for most plans, allowing them to charge far more for higher risk persons, forcing them out of the pool;

c) Service area – S. 545 eliminates state service area and network requirements, allowing plans to "redline" and avoid more costly areas;

d) Benefit design – S. 545 eliminates all state benefit mandates, allowing plans to cut prices by denying consumers costlier treatments, driving employers whose workers need these treatments into the regulated market while siphoning off employers with healthier workforces.

If no cherry picking were possible, AHPs would attract a risk pool that, on average, was the same as the current small group market – which would take away a major advantage of forming AHPs. Assertions by proponents of this measure that this issue has been addressed are incorrect.

2. Lead to Increased Plan Failures and Fraud Due to Inadequate Oversight

Proponents of the AHP legislation claim that the Department of Labor has sufficient resources to oversee the new plans and insolvencies and fraud will be prevented. 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. The combined budgets of state insurance departments total more than $700 million. The AHP bill provides no new resources for regulating these plans.

While the NAIC acknowledges state regulation may cost slightly more initially, those costs are offset by the protections provided to our 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 those states, 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 and consumers liable for their payment.

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. The capital reserve requirement for any and all AHPs is capped at $2 million -- no matter the size of the plan. 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 merely $2 million would result in disaster.

b. AHP Finances Must Receive Greater Oversight

Even if the solvency standards are increased, oversight is almost nonexistent in the bill. Under the bill 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 is required to “self-report” any financial problems. As we have seen over the past few years, relying on a company-picked accountant or actuary to alert the government to 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.

3. Eliminate Important Consumer Protections

Included in the current AHP legislative proposals is the broad preemption of consumer protection laws. AHP proponents 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 multi-faceted regulatory structure in place for insurers. Not only are mandated benefit laws preempted, but other laws protecting patient rights and ensuring the integrity of the insurers are preempted as well. Here is a small sample of preempted consumer protections:

• Internal and external appeals processes.
• 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.
• Background review of officers.
• 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.

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 patient's rights are violated by the plan. State insurance regulators act on hundreds of thousands of consumer complaints every year and work hard to protect the rights of patients. AHP participants deserve access to the same protections and complaint process.

4. Cut Funds to State High-Risk Pools and Guaranty Funds

While the latest version of the AHP legislation allows states to impose premium taxes on AHP plans – to the extent they are imposed on other insurance plans – it preempts other state assessments. States 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.

Alternatives for Real Reform

If this hearing is truly about alternatives to our healthcare needs, then it is time to look at alternatives. As you know, states have been the laboratories for innovative ideas in this arena for some time. In Kansas, the Governor announced a $50 million HealthyKansas initiative to expand coverage for 40,000 children and 30,000 working parents; find ways to control costs through more risk sharing among small businesses; improve availability of generic drugs for low-income individuals; and increase awareness of obesity and other preventable chronic conditions. As part of this initiative, we are modeling reinsurance as part of a small group reinsurance feasibility study under a HRSA State Planning Grant. Four alternative reinsurance mechanisms will be modeled with varying assumptions to quantify the impact of each on premium cost and small employer take-up rates in the Kansas market. There are four reinsurance approaches that we will model, two prospective and two retrospective. The prospective approaches will follow NAIC small group reinsurance model and Connecticut designs and the retrospective will follow Healthy New York and a diagnosis-based design considered by Colorado. We then intend to select the most effective reinsurance approach that will control claim fluctuations and risk acceptance by carriers. Since we will be using our reinsurance system to process five years of actual Kansas claim data we will be able to project the amount of subsidy that

actually could be provided in future years given different levels of subsidy.
Other states have experimented with reinsurance, tax credits, subsidies, basic health plans for small businesses, public program expansion, and programs to promote healthier lifestyles and manage diseases. Many states utilize reinsurance mechanisms in the small group market, with various degrees of success. The most recent effort by the state of New York in its Healthy New York program has utilized a retrospective reinsurance mechanism, subsidized by state tax dollars, that has resulted in about 70,000 new insureds, all low wage workers in small businesses who were formerly uninsured.
As another example, in Maine, the state enacted the Dirigo Health Plan, intended to provide coverage for 180,000 state residents. The plan has two components: 1) expansion of Medicaid and SCHIP to parents with incomes up to 200% of the federal poverty line and to everyone earning less than 125% of the federal poverty line; and 2) establishment of a public/private plan to cover business with 2-50 employees, the self-employed, and unemployed and part-time workers. The plan is in its early stages of implementation, and state policymakers have high hopes for its success.

Conclusion

All of us recognize that it is very important to make health insurance available to small employers. The states have begun to address this problem, and will continue to do so. However, the problem is complex and does not lend itself to easy solutions.
The federal government and the states need to work with healthcare providers, insurers and consumers to implement true reforms that will curb spending and make insurance more affordable to small businesses. We stand ready to work with members of Congress to draft effective reforms that will address both the affordability and availability issues facing small businesses. Together, we are convinced, real solutions to this critical issue can be found.