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AHPs: Are Association Health Plans a Remedy or a Pending Disaster?

Track: Health

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Summary: Amendments to ERISA have been proposed in Congress to allow federally certified associations to sponsor health plans for small employer groups. These associations would be exempt from complying with state benefit mandates and multistate rating and underwriting regulations. In 2003 the House passed the bill, but the Senate did not bring it to the floor because of other priorities. This year, an election year, the debate has intensified over the merits of this proposed legislation.

MR. JAMES O'CONNOR: Our presenters today are two gentlemen who are very familiar with the topic. Don Dressler is now a risk management consultant dealing with workers' compensation and employee benefit issues for entrepreneurial companies.

Kris Haltmeyer is the director of policy with Blue Cross/Blue Shield Association in Washington. He's responsible for policy development on Medicare, insurance reform and managed care legislation.

I'm Jim O'Connor. I'm a consulting actuary with Milliman and specialize in small group and individual health insurance. I will introduce the topic with a few facts

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Note: The chart(s) referred to in the text can be found at the end of the manuscript.

about the legislation itself. It's the Small Business Health Fairness Act of 2004, and this act has been passed a number of times by the House of Representatives, the latest one as of last week. However, it has not gotten to or through the Senate in either of its attempts. One of the things that we will address today is what is the likelihood that the Senate will act on this bill? The bill amends ERISA to extend certain features to the small employer groups. The idea is to help the small player groups whose members are most of the uninsured and underinsured, and it allows federally certified associations to sponsor health plans for these small employer groups. The key is that it introduces certain exemptions to sponsored health plans from complying with certain state laws and regulations, and we'll talk about more about that.

Table 1 demonstrates the distribution of firms within group size. It shows that the percentage with no plan is extremely high for those under 10, which probably will come as no surprise to everybody in this room. It goes down with the 50 or more having a high percentage of firms offering insurance program. That's a percent of no plan is firms offering health insurance programs.

Table 1

Census Category	Under 10	10-24	25-49	50 or more
Total Groups	3,594	752	308	1,490
% With no Plan	61.4%	32.6%	19.9%	3.1%
Total Employees	14,262	9,746	7,833	82,648
% Not Offered Plan	51.9%	27.5%	15.6%	1.8%

The bottom half of the chart shows the total number of employees in thousands, those who are not offered plans, so in the under-10 group, 52 percent of employees are not offered a plan. What we don't look at here is of those who are offering a plan, what percent do not take that plan for one reason or another? That sets the stage for why proponents of this legislation thought that some relief was needed for small group business.

Let's talk about the requirements to be a qualified association health plan (AHP). It's got to be a certified plan, sponsored by a bona fide trade business or professional association. I think we'll hear a few more comments from our speakers on what that might mean. The association has to exist for purposes other than just health insurance. Finally, health status cannot be a condition of membership dues or benefit coverage health status, nor can membership dues be conditional on participation in a sponsored plan.

Some of the features are exempt from state-mandated benefits, and that's a key feature of the law to help reduce premium rates. Another controversial point is it's subject only to the insurance laws of its state of domicile, and our speakers will discuss that. It's subject to HIPAA guaranteed issue, guaranteed renewability, portability and prohibition against treating members in a group differently because

of health status.

States were concerned about losing premium tax revenues, so included in this legislation is a requirement that they will have to pay premium taxes and other assessments to states. The association plans will be regulated by the Department of Labor with certain states retaining jurisdiction over certain aspects of the program. We'll talk about that.

AHPs can offer fully insured coverage through health insurance carriers. They can self-insure all their benefits if they choose, or they can use a combination of both. What they choose can lead to certain questions related to concerns over the stability of the health plans and visits to history. The legislation does call for reserves for the self-funded portions of the AHPs to be certified by an accredited actuary, so that means the people in this room would need to get involved in accrediting or certifying the reserves of these plans if the legislation ever passed. If the plan is fully insured, then the reserves fall upon the insurance carrier, and that carrier will be subject to the laws governing its fully insured plans today.

There have been a number of studies on the impact of AHPs. It's mixed and debatable, and that's why we're here today. Our two speakers are passionate about their involvement in being for or against passage of this legislation. About a year ago, the Congressional Budget Office (CBO) projected net new coverage of about 630,000 people only. An older CBO report projected premium reductions in state regulated plan rates would increase only about up to 2 percent. However, a report done for the National Small Business Association indicated opposite results—a 23 percent increase versus 2 percent. That wasn't an apples-to-apples comparison, but it certainly gets at the point of the debatable issues for this plan. That study indicated that uninsureds would increase, not decrease.

The impact is likely to vary by state, and that is because AHPs would be subject to the state of domicile. Depending on where the state is domiciled, it will have a different impact. State small group laws also will affect the impact. A community-rated state would likely be impacted much more than a typical NAIC-regulated state. With that, I shall bring up our first speaker, Don Dressler.

MR. DON DRESSLER: I spent my entire career until I retired a year ago working for nonprofit associations, and I believe they have a tremendous value for our country.

I want to talk about why associations are important to health care. I'll also talk a little about the legislation and little bit about our opposition. I was a president for a number of years and then legislative chairman of the Association Healthcare Coalition (TAHC). This is a group that started as a result of farm equipment dealers in the Midwest, who were able to have health benefit plans, and the first association health care plan bill was carried by a Congressman from Minnesota. We have had this collaboration of associations for many years. In fact, the early years of our

efforts were what I would call paid and professional organizations as opposed to general business industry associations in our nonprofit world.

We think of groups like the Chambers of Commerce and the National Federation of Independent Business (NFIB) as general business associations, and farm equipment dealers, chemical dealers and actuaries as trade and professional groups. Historically, up until about 15 years ago, 70 percent of the associations in the United States sponsored employee health plans for their members.

We think associations are critical because one of the things we find and observers have said is that you've got to have buying power. There's no mystery—you've seen the statistics that the rate of inflation for small employers is higher than for large employers. There's no mystery that 75 percent of the employers that have over 100 employees are ERISA self-funded plans, and the small-employer community has trouble accessing that structure and getting bargaining power if the businesses don't join together.

In that small group reform, we had an array of benefit plans canceled. When we went to our structured-tier grading and characteristics, uniform rating and guaranteed issue, we lost an enormous array of options. You could have this HMO or this PPO, and that's it. There may be three different co-pays, and that's it. It hurt us in terms of losses. I was able to sit down with employees and employers and ask what was important to them. For example, in California there are far more people who are Hispanic with large families. Our average family had over three children, and employers and employees were concerned about them.

We can tweak and design plans. I have noted that most insurers when they design plans have underwriters, maybe actuaries, maybe some salesmen and a few brokers. Few of them through the whole array of choices go out and sit down with the employers or the employees and say, "Let's build a plan that makes sense for you." Associations, at least the ones I've worked with, had the ability to do that. They were able to draw together thousands of employers.

There's a doctor in Firebaugh, Calif., who is a nice guy. There are no HMO coverages in Firebaugh. We had an association health care plan, and this doctor was a participating provider. We didn't use the big pharmacy cards because we wanted to be able to negotiate programs with neighborhood pharmacies where all people lived and worked. We were able to aggregate the people by getting the law of large numbers to work for us. We could get some stability, and of course self-funding became critical to us. We started self-funding because to be a small employer insured program usually involves brokerage commissions, and the commissions are averaging 10 percent or more. We had an association health-care plan, and the total service budget including marketing was 3 percent. We know that there can be some efficiencies.

One of the questions that I was always asked as a head of a trade association was,

"What have you done for me lately?" There's a real pressure to add value. We were removed from the marketplace. Talk about consumer-driven. There's nothing more like consumer-driven and being an association executive. The average life expectancy—meaning job expectancy of an association director—is about seven years. Think about having a new boss every year. As the volunteers go through the leadership role, instead of finding one person one year and another personality another in a year, I was fortunate and made it a lot longer than seven years. You've got to be in touch with your members, and you need to know their business. For example, we could talk about blood tests for organic phosphate chemicals being important as a treatment for farm workers, and maybe somebody in inner city L.A. didn't worry about that. We were interested in health plans that covered cholinesterase testing. We think we gave our members significant savings. I think we still do.

What was happening, and I think you who have been in the business know, as the legislature tried to help the employers by creating a whole group of small group health plans, we ended up with balkanization of health care, and every state had its own rules. You add every little medical specialty to pay makers in Minn., including podiatrists, acupuncturists, professional nurses and nurse practitioners, and everybody wants to drive to get his piece covered by the health plan. That's what's led to all these mandated benefits. It wasn't employers, and it wasn't even the employees. It was selfish associations of medical providers that lobbied to get their piece of the pie.

Along the way, we lost Metropolitan, Prudential, Aetna, Cal-Pharm, John Hancock and Pacific Mutual in the association and small group market to the point where now Blue Cross has a 70 percent market share in about 20 major metropolitan areas of the country. Almost everywhere in the country, the top five carriers have over an 80 percent market share. There isn't a lot of choice and competition for the small employer market.

We've seen the effects of that. Some of you may be familiar with an announcement that just came out—the Commonwealth study— that indicated that between '01 and '03, New Yorkers' health insurance costs went up 54 percent. While we were doing that, we weren't doing a good job of regulating the market. You're going to hear later that it's dangerous to have associations involved in health care because we're unreliable and unstable and therefore may be insolvent.

We don't have to get involved for there to be insolvency. In the past two years, more than 15,000 employers from 144 separate bogus health insurance plans cost people, or left unpaid, $252 million. That's how well the current system is working. I'm reminded a little bit about the temperance folks who said, "Let's keep prohibition in effect as it keeps people from drinking." It worked really well, except that we also created a gain in crime culture in America.

Let's face it. Congress was focusing on retirement and pension plans when ERISA

was passed. I was a young, new lawyer starting in my career when ERISA was passed. I learned about mass withdrawal and withdrawal liabilities from pension plans, and Congress did a halfway decent job writing funding standards for pensions. Therefore, we have always struggled under ERISA with an absence of solvency standards. That's the problem today, it's always been a problem, and it's going to be a problem until we fix it. We do have a solution, however. If you're ever going to study the uninsured in America, the highest percentage of Americans who were covered by health insurance was in 1973. I wonder what happened in '74. Small businesses are at a disadvantage. Association plans were canceled as our carriers left. Small businesses are paying more for coverage. You're seeing a large number of uninsured, and most of them are uninsured because they can't afford to be. Therein lies why we think we have some solutions.

ERISA must have done a good job for large employers because so many of them have taken advantage of it. They have been able to stay out of this mandated benefit fray, and of course we've had litigation at the New York Supreme Court from time to time about state preemption and how far ERISA goes, but it's a lot farther than the individual small employer is able to go. It also creates some uniformity and lets employers design what they want to design to do what they need to do. What we want to do is say what's good for the goose is good for the gander. If it's good for large employers, it should be good for small employers.

We also think we need competition. We desperately need competition in this country. Insurance agents and insurance company executives are going to organize most of those plans. Some guy who had an office and an ability to run bills thought he'd collect money on a positive scheme before people caught up with him.

We don't want those kinds of people in this business. We are after people who are at the core long-standing contributors and part of American society. What can we do? For one thing we think we can bargain together. We can get prescription plans that charge 12 percent below wholesale. We can get prescription plans for our members where 75 percent of the manufacturer's rebate comes back to reduced cost for the employer. We can get discounts now. We found a big partner, Blue Cross of California, and we're getting an average of 46 percent discounts on billed charges for our plan, and we are getting over 85 percent of our bills coming through the network.

The problem with Western Growers is it's the trade association of fruit and vegetable growers, and you can't grow lettuce in one place year-round in California, even though we have wonderful climate. You've got to be able to go to Colorado, New Mexico, Texas or Arizona to have a full, year-round crop, so we are a multi-state industry. Our people move, and we need to be able to handle differences in different jurisdictions.

What do employers want? They want lower premiums. You're in California, probably the only place in the country where I think you'll hear more complaints about

workers' compensation premiums than you will about health premiums. It's not that the health premiums are better here; it's just that the workers' compensation is so much worse. Next week, our insurance commissioner will announce his solution to that.

We want to get more access for small business and make sure that these plans are there. We cannot have here today, gone tomorrow. We're looking for a plan, and the interesting thing is that generally the insurance industry acknowledges the challenges that we're facing. I heard the Health Insurance Industry Association (before it changed its name, so now it's Health Insurance Plans) just last week, and its CEO said, "We have overlapping and duplicated state regulations that raise costs and raise the ranks of the uninsured." Amen. We agree with that. We say let's create an opportunity to sidestep that and welcome insurance companies to write insurance policies mandates through an association sponsored health plan.

Most of the people who are in our coalition are insured and want to stay insured, and we want to have access to that. We think that it's a good thing for the insurance industry, but we haven't been able to persuade it. We also have an option for self-funding, and I'll tell you why we have an option for self-funding because I was the one who insisted on that.

Have you ever taken a knife to a gunfight? Have you ever tried to bargain with a big organization who counts its members in the millions and its revenue in the billions and then say, "I'm here to either take their price or take their price?" If you have the opportunity to self-fund and take part of the risk, you now have choices at the bargaining table. It doesn't mean that you want to do it. It doesn't mean that you will do it, but the ability to do it becomes important, and that's something that needs to be understood.

Who's against what we're talking about? Blue Cross/Blue Shield Association is because it has such an enormous market share and it likes the state-by-state rules because it came out of the state-by-state environment. There are dozens of Blue Crosses. Some states have multiple ones. In California you have Blue Cross and Blue Shield competing with each other, although that wasn't always the case. They have been able to set up a structure that they can handle with this balkanization of American health care.

Their problem is it's hard for them to compete for multinational or large national employers because it's hard for them to service people all across the country. But they've got great perquisites and are putting up a great fight. I will add because I was there seven years ago when we said, kind of quoting Rodney King, "Can't we all find a way to get along together?" What do you need out of legislation? What do you want, and how can we do it? Never does anyone from that side come out and say, "If you make these changes in the bill, we can live with it." Actuaries have, by the way.

I had the misfortune of being a native of Kansas sitting at a table in Washington and testifying about AHPs against the insurance commissioner of Kansas and chairman of the National Association of Independent Insurance Commissioners. She told us how wonderful it was that 7,000 people in this country work for the insurance departments and how much of a protection for the consumer they are. Of course, neither of them ever got anybody insured. They did such a great job that the fraud that we talked about earlier has been allowed to go on because it's like Alphonse and Gastone between the Department of Labor and the Department of Insurance: "You go first. No, you go first. No, you go first," which leads to this craziness of who has jurisdiction to enforce laws.

The governors are against it because their insurance commissioners told them to be and because they said you lose premium packs, and then there is a small group of people who want to see the payer government-run system, so they're against anything that would create options in a market-driven solution.

Why do they object? There are a lot of reasons. One is that they say we'll be cherry pickers. I always found that interesting because I worked for an organization where we actually covered cherry pickers. Do you know that unless they were covered by an AHP, Blue Cross of California, Blue Shield of California, Kaiser, Aetna and other companies would not cover these short-term seasonal people because cherries don't last long. You see the cherry blossoms in Washington. They come, they bloom, and later on we have fruit. We pick it and it goes. That's not the kind of person that a managed care organization wants to mess with. Do you know what? They're at great risk. They're saying, "We've got to pick the best risks." Who are these best risks that we're going to pick? They always say accountants.

Accountants seem to be a great risk. Nobody ever said an actuary is a great risk. Why are accountants a great risk? Because they didn't read your studies. When I started in this business, starting to work in the health insurance, I got out these long tomes of tables—this was before computers—to read probabilities of health care costs. Do you know what I found? As your income increases, your use of health care increases. As your education increases, your use of health care increases. Of course, as your age increases, your use of health care increases. How can you have adverse selection if you have guaranteed issue? If we cherry picked, our rates would be lower, so we'll have to take them. It just an argument made by actuaries and insurance underwriters, and nobody has any statistics. There are a few professors who have been hired by Washington lobbyists, but when you get the data there's not a single statistic, no proof that adverse selection occurs. Besides, what is choice worth?

Solvency issues are a big, legitimate problem—one that we've dealt with from the beginning. I've seen solvency issues locally. I've seen solvency issues in other states. We have a proposal that says to fix it, have an actuary put his name on the line. Do you think that the government and Department of Labor made pension plans run well the past 30 years? Didn't the annual actuarial evaluation have

something to do with that? When employers left multiemployer plans, who calculated the withdrawal liability? Who approved the investment assumptions? They have a self-policing enforcement because they count on the integrity and reliability of professionals. I think we can use those same skills dealing with solvency.

When it comes to federal oversight, I can tell you the state of California is not too great at oversight. Citrus growers went bankrupt. They stated this in their monthly financial plans, and nobody read them. We were saying it's interesting. We wrote a state law that said you had to file financial reports, but we didn't put in the law that the Department of Insurance had to read them. Go figure.

If you want this process and want options to occur in America, AHPs are one of the tools that don't require a dime of government subsidy that would inject options in our marketplace. The one thing I know about employees and health benefits is that no matter how generous an employer is, if the employee has choice, he's happier, even if he makes the same selections that his employer would have made. I think employers are the same way. If we can create a system that gives them choice, they're going to be happier, and we're all going to benefit from it.

MR. KRIS HALTMEYER: Don was correct that associations were the cornerstones of Blue Cross/Blue Shield's history, but this is not a debate about whether AHPs or associations should sponsor insurance products for their membership. It's a debate about the rules that should govern the insurance marketplace.

To put this legislation in context, I would argue that what we're debating here is the largest proposed change in the federal regulation of insurance. 30 years ago. This legislation would exempt AHPs in whole or in part for many of the rules that you all operate in state-regulated markets by today.

AHPs can structure themselves to avoid insurance reforms, consumer protections, solvency regulations at the state level, market conduct and even fair trade practices laws. I believe, and most people in the insurance industry believe, that the creation of this unlevel playing field would have a significant and negative impact on coverage in the small employer market and even in the individual and potentially large group markets.

I don't believe that this is a win-win-win scenario. Clearly, some national associations would benefit from this legislation, but there is a growing list of business groups that oppose this legislation. I also think that most insurers and the majority of small employers would be worse off if this legislation becomes active.

Now I'd like you to picture yourself as a congressional staffer on the Hill last week when the House voted on this legislation. These are some of the things you would have heard: AHPs could provide Fortune 500-style benefits for the small guy, and

they would provide administrative savings of up to 30 percent. You would have heard that economics applied to the health-care market, so these things will save money. It's cheaper to buy soda by the case than by the can. You would have heard that the requirements for these associations are stronger than what states require.

I don't think any of these things have a basis in fact on either the economics of the association marketplace or on the volume of public policy studies that have been done on this legislation. I'd like to walk you through those two things in the remainder of this presentation.

First, here's some information on the association marketplace. Many people in Washington think it's a novel thing that the associations doing this today think they are a fairly important piece of the health care market. Our best estimate, and this is conservative, is that 8 percent of the small group market purchases coverage through associations today. There's the medical expenditure panel survey according to an analysis that the Rand Corporation did, which indicates that perhaps one-third of small employers are purchasing coverage through some sort of group purchasing arrangement, including associations. That 8 percent may be conservative. As Don mentioned, those who are for and against this legislation are in the association marketplace today. Most of the major groups pushing this legislation are offering insurance plans today, and Blue Cross and many opposed to this legislation are also participating in the market.

Associations offer coverage. They can adopt a number of different models. By far, the most common model is an endorsement model. The association works with an insurance company to offer a fully insured state-regulated policy. This accounts for a little over two-thirds of the marketplace today. Some associations do attempt to do things internally, either by outsourcing with a third-party administrator or by performing functions in-house. Funding is more common in these types of arrangements, and that's where these guys have gotten into trouble. With regard to state small group reform, which was designed to reduce some of the fragmentation in the marketplace, and also with regard to more stringent solvency regulations at the state level, Don mentioned the plan that failed in California. There are a number of legitimate associations that have failed in the past few years, and states have responded by increasing the solvency standards for those arrangements.

Some people in Washington think that the associations have a cost structure that's comparable to that of large firms. I don't think this is the case for one simple reason. The cost structure of an employer with 5,000 employees is completely different from the cost structure of an AHP comprised of 1,000 employers with five workers, whereas the large employers administers a plan or several plans for their employees with an annual open enrollment period. The various functions that are near the small group market are performed on an employer-by-employer basis in the association market. Associations have to verify membership. They ensure that the associations have to do sales and marketing, and they have to do underwriting,

servicing, installment of groups and billings for each small employer.

One important distinction is that the employers in a large group, self-funded arrangement is paying claims out of their revenue. In this arrangement, the association is assuming risk on behalf of thousands of independent small employers and paying their claims. By any definition that I can think of, that means these guys are in the business of insurance when they sell funds, and that's an important distinction that I'd like you to remember.

Can the associations lower administrative costs? I'm not sure they can for a couple of reasons. Chart 1 consists of a composite of interviews we've done with associations over the years, and it illustrates the different types of revenue sources that associations get from sponsoring this product. The vast majority of associations do sponsor products as a revenue-producing benefit. Almost all charge either a royalty or some other servicing fee when they offer coverage. Royalties typically run 1 percent to 3 percent of premium. When associations perform some of the administrative functions for an insurer, they also incur servicing fees.

If they use an outside administrator, they have to pay that administrator, and one interesting thing we found about agent commissions, which Don mentioned some groups don't use, is that a number of associations do use agents to distribute their products, and some of those that don't capture the agent's commission when they sell that coverage directly. That's an important source of revenue. When you add all these things together, I don't think there is much potential for administrative savings. I think we will find some unique plans out there that can give you administrative savings, but by and large, there's not much potential here.

In the end, AHPs are collections of small employers and individuals, and the costs that they represent will have more to do with the composition of those employers that are members than any economies of scale.

There isn't a lot of data on this marketplace, but the government's medical expenditure panel survey did ask a question about whether employers participated in a group purchasing arrangement or purchased coverage directly, and according to the Rand analysis that I mentioned, group purchasing arrangements are higher than direct purchase insurance coverage by about 2 percent.

Moving on to the public policy issues, this is first and foremost a debate about the rules, as I mentioned, and insurers are concerned that there will be a different set of rules. Using this small group market as an example, in almost every state there are rating bands that apply to health status. In a number of states there are rating bands that apply to other factors: age, area, geography, gender and group size. There also is the full range of benefit mandates, which as Don mentioned are costly. Prompt-pay laws, solvency requirements, external review and other mandates apply to insurers. Self-funded associations are completely exempt from these standards, with the exception of one minor change that limits the abilities to

contributional rates for participating employers based on health status and based on the allowable rating range for bona fide associations in the state. It's not what small group market allows; it's bona fide associations.

On the insured side, this legislation allows an association to get a policy approved in one state and market that coverage nationwide without complying with other states' laws. The only exceptions to that are state prompt-pay laws and solvency laws, which were accepted in the latest version of the legislation. There's also a question about who regulates. Under traditionally insured plans, the states primarily regulate. There's some minimal oversight not by the Department of Labor, but by the Department of Health & Human Services, related to HIPPA standards. Self-funded AHPs are completely exempt from state regulation and will be regulated by the Department of Labor. For multistate insured, I think it's a question mark. Does the state insurance commissioner have the authority to enforce rules in another state? I don't know.

Don mentioned that there is no concern about adverse selection here, but I would argue that for a number of factors, there is a serious concern about adverse selection. Even the basic structure of an association can raise particular potential for adverse selection. Carriers in the small group market must guarantee issues of all small employers, regardless of their characteristics. AHPs are allowed to limit the participation only to groups that meet their membership criteria. If you have an association that is healthier on average than the traditional small group market, it'll be more likely to form if you have an association that's worse off, a costly association, and there's probably no benefit to creating an AHP.

Under the rating rules of most states, carriers are required to pool all small group experience. There are limitations on a number of blocks of business, and some are in a relationship between the index rates for those blocks of business. That doesn't apply to AHPs. They're weighted only on the experience of their membership with no relationship to other coverage.

AHPs can vary rates by more than allowed under state law, so they can charge a healthy firm a lower amount than would be allowed in state law. They can charge a sicker firm more. State-regulated plans have to comply with all benefit mandates. Maybe AHPs will not offer bare bone plans, but they could exempt some mandates that can drive selection. Mental health and maternity may be a couple of those. The insured plans have to abide by all market conduct rules. There used to be a requirement for AHPs to actively market to all members. That requirement was dropped out, which I believe could allow for selective marketing. Indeed, what this legislation primarily relies on is self-policing by associations.

As far as the notion that associations will do the best for their membership, based on some of the experience with association plans, you may have seen the *Wall Street Journal* articles that profiled a couple of association plans. One of these is a big supporter of this legislation and is reunderwriting people multiple times in a

given year. I think you need rules to prevent that type of abuse. You can't simply leave it to a business association.

What about the impact on the small group market? As Jim mentioned, the CBO study indicated that the majority of small firms would get a rate increase under this legislation—about 75 percent. While people enrolling in AHPs would get a rate reduction, the aggregate cost for the small employer market was basically unchanged. They were pulling healthier members from the traditional market and allowing them to offer a lower rate in the marketplace.

CBO assumed that only 5 percent of the savings for AHPs came from elimination of benefit mandates. The rest, 8 percent or so, came from adverse selection or favorable selection. The Mercer study that Jim mentioned is unique because it's the only study that's taken into account cumulative anti-selection theory and looked at the impact on the small group market over a four-year period. That study found that, as Jim mentioned, rates would go up by 23 percent in the state-regulated market at the end of that four-year period.

What about the uninsured? There have been five different analyses done of this legislation over the past few years, and almost all of them indicate that this will have a negligible impact or a negative impact on the uninsured. The Mercer study estimated a -1 million change in the uninsured; the CBO estimated a +600,000 change in the uninsured. All of those credible studies by Mercer, Urban Institute, California Healthcare Foundation and CBO would indicate that the range of changes is within a +2 percent in terms of the uninsured or -4 percent.

There isn't a huge impact on the uninsured from all of these recent analyses. The only study that has found that AHPs would result in a significant increase in the uninsured at 8.5 million was a study commissioned by the NFIB, which failed to even look at the impact on the small group market and included the elasticity of demands that was six times what I think you could realistically use based on the literature.

What about solvency? I think the key issue is that the capital and surplus requirements are not risk-based in this instance. They are, in fact, capped at $2 million regardless of the size of the AHP. There are also some other factors, such as the ability for AHPs to substitute stop-loss for adequate capital and reliance almost entirely on a self-reporting system if an AHP gets into trouble. These guys are not subject to stay guarantee funds, either. There also are not clear protections from consumers ending up in bankruptcy court with no preference over general predators. What this relies on is essentially a system of creating a new AHP fund at the federal level that wouldn't be available for the payment of claims. It would go only for the continued payment of stop-loss and indemnification coverage, and I would question whether that indemnification coverage will even be there given the risk inherent in these plans.

The Academy has looked at this legislation. It determined that all of these factors were inadequate for an AHP with only five to 10,000 members. This is an analysis that we commissioned from Mercer that also looked at the failure rate for AHPs compared to insurers operating under risk-based capital. At 25,000 lives, you would see the failure rate for AHPs has being over 15 percent versus a failure rate of under 2 percent for entities operating under risk-based capital. This is a risky area. Don also mentioned the GAO report that found that there were 144 fraudulent or unlicensed plans that defrauded consumers of $252 million. One-third of those, by the way, were association plans, whether legitimate or illegitimate.

Is ERISA an appropriate structure for regulating health insurance? I don't think so. This is a quote from the Department of Labor during the Clinton administration: "Currently, my program has 625 people to enforce ERISA requirements for 750,000 pension plans and 2.5 million health plans. Based on our investigative experience, we could review each pension plan in 170 years and, if you include health plans, once every 300 years. An infrastructure necessary to handle the new responsibilities, replicating the functions of 50 state insurance commissioners, simply does not exist."

Olena Berg, the assistant secretary who is in charge of pension and welfare benefit loss, said that DOL has the capacity to review each health and welfare plan only once every 300 years. The DOL is not an active regulator. It gets involved only with welfare plans when there is a pattern of abuse. It does not investigate individual complaints from consumers, and it does not have the capacity. I think it's important to realize that DOL has never regulated insurance products, which is what I would argue these things are. It has never regulated rates. It has never regulated insurer solvency. It has never done enforcement for these types of arrangements and is precluded from doing so under federal law today.

What about the opposition to this? It's often said that we are the only group opposing this legislation, but in fact there are 1,075 organizations opposing this, including most state organizations, the NAIC and the attorneys general. I think they are simply not concerned about preserving their turf in the marketplace but also are concerned about consumers and what impact this could have on them. There are also, as I mentioned, a growing number of business associations that are opposing this legislation. There are over 60 groups now including the National Small Business Association, 28 metropolitan chambers of commerce and a number of farm bureaus. Last, there are a number of insurance groups. The Americas Health Insurance Plans, despite its concern over state mandates, is opposed to this legislation because it thinks it'll have a negative impact on this marketplace.

In conclusion, I don't think this legislation has ever been enacted. I think this legislation has never been enacted because some people in Washington do care about public policy. There is substantial risk inherent in this legislation for questionable gain, both in terms of reductions in insurance premiums or expanded coverage of the uninsured. There's been a horrific track record with Multiple

Employer Welfare Associations (MEWS), which were originally exempt from state regulation. Because of problems, Congress put them back under state jurisdiction in '83, and there are larger public policy issues raised by this legislation.

Who should regulate the health insurance market? I don't think we've come to a consensus under this proposal, but clearly it would be taking regulation away from the states or a large segment of the market and putting it under federal control. What are the long-term consequences of federal involvement? Someone I know from large employer association in Washington made some errors. If we pass this, a few years down the road, we're going to have to rebuild all of the state regulations at the federal level as part of ERISA, and that could compromise the viability of ERISA itself for large employers.

What's the real framework for addressing the uninsured? This does not sit well within the framework that either conservatives or liberals have advanced for addressing the nonusers. Conservatives want individual-based tax credits. These people can't sell to the individuals unless they're self-employed. They don't fit within the framework that Kerry and others have addressed or put forth for pooling, which is largely a Federal Employees Health Benefit Program (FEHBP) style system.

This has proven to be extremely politically and ideologically divisive, as well. The Senate Republican task force on the uninsured deliberated this proposal at some length this year and eventually could not come to agreement, but there should be a consensus position. This should happen in part because you have a number of important senators that feel that this is against states' rights and that this has a lot of potential for creating consumer problems in the long run.

MR. O'CONNOR: Don, can you comment on the prospects for enactment of the legislation this year? As I mentioned, that the House passed the bill last week. The Senate hasn't acted on it. We know that the Bush administration has been supportive of this bill and maybe as corollary to this same question is, given that this is a national election, if Kerry becomes president, what's the likelihood of passage if it doesn't pass this year?

MR. DRESSLER: We passed the bill for six consecutive calendar years in the House of Representatives, so I think the House of Representatives has indicated, and we've been able to build a relatively good bipartisan approach. Fortunately, we have some reasonable Democrats from California, and we're in the legislative district of one congresswoman, Loretta Sanchez, who's a bright star for the future. She may not be as well-known as Nancy Pelosi, but she's a pretty nice person.

The problem has been in the Senate, and the problem has been Senators Don Nickels from Oklahoma, who is a well-funded candidate by Blue Cross, etc., and Judd Gregg from New Hampshire. Blue Cross was the third largest donor to his campaign, and it's true that it's the states' rights issue for those people. They're not interested in trying to advance any kind of government solution to health care and

therefore this is some dealing with government issues. I don't think you can say anything of past U.S. Senate this year.

The Senate can't pass a transportation funding bill. Its members can't do much of anything because everybody makes everything a political issue. The good news is we have Senator Jim Talent from Missouri, who carried the bill in the House and who is now in the U.S. Senate; Senators Kit Bond from Missouri and Olympia Snowe from Maine, who didn't come to this easily; and Senator Robert Byrd from West Virginia announcing support. It's going to be a tough battle. If I had to guess, it would be optimistic to call it a 50/50 chance of passage.

MR. HALTMEYER: I would say this legislation is dead for this year. I think the proposal didn't have a chance this year. They could have worked with the Senate Republication task force to modify the legislation to address some of the concerns and may have been able to move it forward, but they chose not to. I think this is largely an issue of positioning for next year. Don mentioned there is a significant effort on both sides to make sure that the senators keep their current positions. They don't have the votes to pass this in the Senate by, I think, a comfortable margin at this point, but it's largely a question of whether that can be switched or whether the senators can be moved as we move into next year.

If Kerry does win the presidency, I think this legislation is going to have a difficult time. I rate the chances well under 20 percent because Kerry is no fan of AHPs. I do expect this to be a fairly interesting debate if this legislation is brought up because from a sound bite perspective, I think he's got some great things to say about favoritism toward the well-monied associations that are behind this legislation. We'll just have to see how that's going to play out this year.

MR. O'CONNOR: Do you think that states will revise their rating, underwriting restrictions and response to AHP rules if the bill does pass? If so, how?

MR. DRESSLER: I think this legislation will have a detrimental effect in states that have community rating legislation or tight rate bounds, such as California, with a ±10 percent rate bound on health status. It may cause some state legislatures to reexamine that legislation, but I think this was the wrong way to go about modifying state small group reforms. What we're essentially saying is we're going to cause turmoil in the marketplace. We're going to cause a lot of small employers to see their rates go up as a way of forcing the hand of state government, and I don't think that's the right approach.

The Blue Cross/Blue Shield Association does an annual survey of state laws, and one thing we've seen over the past three years is a trend away from community rating laws. In '00, there were 17 states that had small group community rating laws, and today there are 10 states. I think there's an opportunity here for carriers, associations and others to work with states to revise those laws absent this big bang strategy of trying to blow up the reforms and resegmenting the marketplace.

MR. HALTMEYER: I would add that when I was in law school, one of my senior projects in my third year was to analyze the regulation of banking institutions and the competition between the comptroller of currency and state banking commissions. What we had was competition to be a favorable regulator to encourage entities to be either a state bank or a federal national bank. Wouldn't it be wonderful if we had regulators in the United States trying to make it easy to do business, attract new ventures and promote competition?

I would hope that there would be change in this process, which, by the way, we don't object to. I lived through the advent of small group underwriting in California. We made those rules and abide by them, and I don't think we'd have a nickel's worth of a problem with most states. We don't like New York, but it's interesting in New York that two-thirds of all the workers' compensation in that state is association self-insured pools. They found something that works in the voluntary market in New York; it's just not in the health insurance arena.

FROM THE FLOOR: The federal tool now is getting a lot of discussion. Kris, I hear the real bottom line is the anti-selection, which will affect the rates.

MR. HALTMEYER: That's a core issue for us.

FROM THE FLOOR: I don't know that there is that much else, but with the federal tools issue, do you see any possibility that there could be a general rule set at the federal level of some kind that would allow the states to use their staffs to do the consumer stuff to market regulation? What I'm really asking you is, since there seems to be at least a discussion going that way in federal tools, do you see a way that maybe there could be a compromise on AHPs? I'd sure like to hear what you and Don have to say.

MR. HALTMEYER: That's a relevant question right now. The Senate Republican task force that was addressing the uninsured issue looked at two different options for market reform. It looked at AHP legislation and at a new framework, which would essentially say that you'd have to offer insured coverage, but you could offer it under the same rules across the country. It put together a panel that would look at the state rules and state what's reasonable from a rating standpoint, what's reasonable from a consumer protection standpoint and what's reasonable from a benefit standpoint. Both associations and insurers could offer that coverage on a nationwide basis. I think that's a valid type of approach. I'm not sure whether it could ever pass Congress.

Even in this environment, you have Senator Ted Kennedy threatening to filibuster any health legislation, and I think anything that overturns state mandates that is less protective than state law would raise a real question mark for Democrats. We're operating in an environment where we have federal floors, and states can always go beyond them, whether it's HIPAA or the new mental health law that was likely to be stated in the coming weeks and in the Senate. That's usually the modus

operandi. It's not that you establish a federal preemption; it's that you establish a federal floor, so I'm not sure we'll ever get to a federal preemption.

MR. DRESSLER: I'll add that we like an idea that never got off the ground. The agreement of the Oklahoma Department of Insurance would allow the Oklahoma Department to enforce rules against MEWAs, and I think we were the first MEWA in Oklahoma, and we would be willing to have and I think encourage this. The other part of the bill, which happened to talk about it, is the stealth associations that show up and take money and run.

In one of our processes, the first thing you have to do is tell the insurance commissioners where you are and that you're there. "Hey, I'm here. Pay attention to me. Beware that I'm here." That has never happened before. That's an important step. It's a little piece of the bill, but it's part of it. We'd welcome the opportunity to have a uniform approach. I would say in terms of the consumer support of it, I think the marketplace is going to produce better consumer service than a Department of Insurance.

MR. ROB LYNCH: I hope this question is taken not as an attempt to bite the hand that feeds people but is taken in the vein that actuaries try to be fair. I have a little bit of a problem with the issue of adverse selection because in my experience, the conventional wisdom is that association plans suffer from adverse selection and a loosely regulated environment. Getting into an adverse selection spiral and getting out of control is a good way to lose money, whereas, now I'm hearing from Mr. Haltmeyer that Blue Cross/Blue Shield Association's position is that under AHP, these associations will benefit from the selection. What am I missing?

MR. HALTMEYER: That's a fair question. I think most actuaries that I talk to believe that the association market is a risky marketplace. It has to be managed carefully or else you do have selection problems. Some actuaries tell me you have about a three-year life before things start to deteriorate if you don't manage participation and associations and do effective underwriting. I think what we're talking about is association plans having more latitude in the way that they can pick small employers, the benefits they offer, the rating practices they use and the rules they have to abide by. I think that's why we're concerned about this legislation when we aren't concerned about association health plans existing under state rules where there is a level playing field between what the associations can do and what carriers selling directly to small employers can do.

MR. DRESSLER: The interesting thing is there is this presumption that associations pick their members. That isn't how it happens at all. We come out of a common need and a common problem. The grange was formed because of railroad rates that were being handled in this country in the 1870s and '80s. The Farm Bureau was established because somebody had to communicate the research being done at land grant colleges to the people on the farms who were producing food and fiber. We have a wonderful productive agriculture because of that. We're able to take

knowledge from migrant colleges out to the field.

Motor car dealers got together because they have common problems. Who are the MEWAs out in California? They are farmers, auto dealers and printers. The boards of directors who set these rules are from that industry, and they don't just say, "Let's see if we can have these healthy people over here who have nothing to do with our industry and profession, and the IRS would have something to do about that, too—about the qualifications for tax-exempt status." I think that there is an idea that somehow we pick cherries, but I don't think you should think that we're going to pick them for health plans.

UNIDENTIFIED SPEAKER: The proponents of AHPs state that only legitimate associations will be allowed to sponsor an AHP. Associations refer to air breathers, who have for many years been active in the small employer and individual health insurance markets, even though states also have laws requiring legitimate associations. What's the likelihood that air-breather associations will be approved to sponsor AHPs, and is it likely that a proliferation of new associations will grow over time out of this legislation?

MR. DRESSLER: Let me say first we'd welcome anything that is an approach and talking about, for example, creating an association plan so you can get money. Our proposal is that these are ERISA plans. Our proposal is that prohibitive transactions apply. Any of you who have worked with ERISA plans know that you can't use ERISA money to market and promote because it's not exclusive except to the benefit of plan participants. We would like those good conduct rules to apply.

On the other hand I hope that we have thousands of new associations because the world is changing, and we can't keep doing things the way we used to do them. As new entrepreneurs, new technologies and new ways of doing business come together, it's essential that we are able to form and join together. Don't forget that this marketplace that we're picking on—the small employer market—is the place where jobs are coming in our society. This is the place where new ideas are coming. This is the place where Apple was born. This is the place where Nike was born. Now they would all become those.

We're talking about cutting-edge, creative job creation driving part of our economy, and it should be nurtured, supported and given as many tools as possible. There are two provisions of this legislation that would attempt to prevent air breathers from forming. The first is a requirement that the association be formed for a purpose other than offering insurance. I think if you look at most air breather associations today, they do have another purpose, whether it's representing taxpayers, the self-employed or some other broad-based group. I think they might be able to circumvent that. The second is a provision that says that the board of directors of these plans has to be controlled by its membership. There's one important little exception that was thrown in that says if you're an existing association health plan, an insurer can be on the board of directors, which is the

case of most air breathers. I think you would see some clever people in the marketplace today, and by the way, there's an interesting article about a man in Missouri from whom you can buy an association off the shelf if you're interested in getting in there before this passes.

I think Don's right that there are some legitimate players in this who are supporting this legislation and who have a real desire to do the best thing for their membership. I think there are some other players as well who will be as aggressive as they possibly can because that's the only way they can make it go. You know that it's a mix. That's why you need to have rules. If you don't, some of the well-meaning associations could be harmed. Take a look at the NFIB, one of the largest promoters of this legislation with 600,000 members. It's a broad-based organization representing all industries with an average group size of around three employees. Its members are helped by and large under small group reform. If it doesn't adopt the type of aggressive practices that some carriers could and some entities could in this marketplace, it'll be cherry picked to death.

Let's look at the kinds of people who have lost their health plans. The American Institute of Architects, Coca-Cola Bottlers Association and Hardware Dealers of Delaware & New Jersey are good, long-term, effective organizations that have lots of things to do for their members and that, because of the effect of this whipsaw state balkanization, saw their carriers leave the market and be dumped on the side of the road.

FROM THE FLOOR: First of all, let me say that I appreciate the format of the session, where you take some strong positions on either side. Having said that, it's also a bit frustrating to see your polarization. I'll tell you a couple of things I believe in and from my practice also see: The small group market is poor for serving the small employers. Many are dropping coverage—we saw the statistics—because they can't afford it, and we can't blame affordability on the imperfections of the health insurance market. I recognize that.

Having said that, I also have business with a couple of associations, if you want to call them that, that are pools of employers that are effective in providing stable, low-cost health insurance solutions. For example, one pool has 30,000 employees and 450 groups. You can tell the group size is under 100. Its administration marketing charge is something like 5 percent of the premium. It has had single-digit rate increases four out of the past five years for each of these 400 employers. There's virtually no turnover.

I work with a couple of pools like that. I won't recite the other one, but it's extraordinarily successful. I'm not taking one side or the other in this because I think the pooling of risk can be valuable for small employers. It doesn't work well in the small employer marketplace right now, but I guess having said all that, what could be done to get you together so something would be passed that would be an improvement and wouldn't run us into the problems that have been cited on one

side? What could be done to accommodate both of you?

MR. DRESSLER: From our standpoint, almost anything could be done to accommodate us because nothing in the bill is a do-or-die issue for us. The bill is dramatically different than it was seven years ago when we started the process, and every time that we could find an opportunity to gain support, we would take the position that adds to it. We're open to anything. The problem is it's like negotiations in the Middle East. If everybody wants to use AK47s, it's hard to build a new community. We're willing to lay down our grenade launchers and our AK47s, and even swallow things that we don't like. We want some progress and some options. I can just speak from the association community. We're committed to that.

MR. HALTMEYER: That's a difficult question. I've worked on this legislation for eight years now. For those same eight years, I, the NAIC and other groups have been making the same arguments and raising the exact same concerns, and this legislation has not changed much at least in the past five years to accommodate any of those concerns. In some ways, this has been made worse. Taking this requirement out to actively market to all small employers is just one example of that.

Ultimately, this is not my legislation. I do not control the members of Congress in the drafting of this bill, and it's not incumbent upon me to fix it. It's incumbent upon the people who are supporting the legislation and want to get it passed, and they aren't negotiating with us. They're negotiating with members of Congress, so if they want to take a step forward, they need to be the ones putting something on the table that addresses the concerns that I've mentioned today. We'd be glad to look at it. I'd be glad to take it to our member plans. I'm sure the other organizations that are opposed to this would be glad to take it to their members as well. It's incumbent upon them to come up with some real progress, and not us.

MR. DRESSLER: I don't think that's an accurate statement and need to put it right out there. I went to the office of Blue Cross/Blue Shield National Association and said, "What can we do?" I got no response. We went to the offices of the NAIC and said, "What can we do?" There's a different political structure. We went to an actual governor's association and asked, "What can we do?" We wanted to go anywhere at any time to see anybody, like Mr. Kerry. I went to see George Bush weekly, monthly or annually, but nobody has said to us, "If you can fix these three things, we can support you," and we'd love to be in that position.

MR. HALTMEYER: Let me respond to that. I wasn't at the meeting when you came over, but my understanding of that meeting and our discussions with the proposals of the legislation since then is that they want it on a level playing field. That's a core issue for us. We believe that all competitors in the marketplace need to be regulated under a comparable set of rules. We have never sensed that there is any willingness to compromise on rating. There may be some willingness to compromise on solvency, but on the major things that we've raised, we've never sensed any

willingness to compromise, and we've never seen any suggestions from them. They come to us and say, "What will you give us?" The appropriate thing is to say, "This is what we can put forward." We can probably go back and forth all day on that one.

MR. WILLIAM LANE: One of the circumstances that originally brought about small group reform in this country was the practice of insurance companies offering low rates to employers that had healthy employees, and then when one or more of the employees got ill, they would radically change the rates and increase them significantly. There still are a small handful of states that have no rate regulation for small group. What would prevent AHPs from setting up a plan in one of those states and then following the same practice that makes small group reform in the first place by which they would offer to their members low rates, guaranteed renewable, but as soon as someone within the small employer became significantly sick, the rates would go sky-high for that particular small employer. How would that help the small employers to lose those protections they have from their rate increases in small group reform?

MR. DRESSLER: First, this isn't going to happen because the associations want their members to stay in business, be there and continue to prosper. That's why we fight trade legislation. That's why we fight import duties. Our job is to help our members continue to succeed and be in business. We didn't invent and don't want durational underwriting. We do not want postclaim underwriting. We didn't start any of that. We have loved rating bands. We have loved guaranteed renewal. We have loved guaranteed issue. We have loved mandatory mental health coverage. We're not too keen on mandatory pregnancy prevention techniques because we have a lot of employees who are Catholic, and that conflicts with some of those things. People want to still have a job two years from now. We want this to be successful. We didn't gain from the system.

MR. HALTMEYER: I think in every marketplace you have good actors and bad actors, and I would love to believe Don could speak for the entire association community as well as all the insurers that may participate in this marketplace, but I'm not sure he can. I'll leave it at that. I think he raises a valid issue. It's something we've heard and considered, and unless the rules are tightened, it's a real possibility.

UNIDENTIFIED SPEAKER: Don, would you favor it if that allowed the legislation to pass, including the provision that you can't rate on health status?

MR. DRESSLER: Absolutely. We think it's in the bill now. We agree with you.

MR. HALTMEYER: Yes, let me say there are other people in Washington who would disagree with Don on that issue.

MR. DRESSLER: In the coalition that I worked with there were about 120

employers, which includes the NFIB and which is a latecomer to our party. None of us wants to help underwrite. We do think we should be able to rate on family size, age and geography, and we think there should be bands on age. It shouldn't just be willy-nilly.

MR. HALTMEYER: I wish they would. I would recommend that. I have read the law several times, and I agree with you. I'm not sure it reads as some of the others say, but that is a key issue with a lot of the risk takers out there. If you can rate willy-nilly in term of health status and others cannot, there will be significant anti-selection, as well as a big backlash.

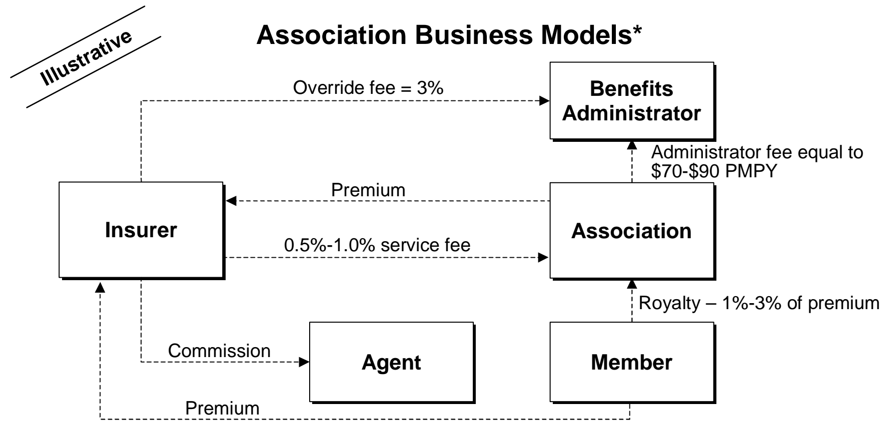
MR. DRESSLER: I can tell you that the people who sit down to draft the bill never wanted that.

MR. HALTMEYER: If you haven't looked at the Academy's letter on this legislation, I would encourage you to do it. It raises a lot of these concerns about anti-selection.

Chart 1

Association Economics: Additional Costs

Given additional layer of cost, limited pricing advantages exist for Associations offering health coverage



*Represents an aggregate of multiple Association business models; in other words, Association will incorporate various elements of the transactions shown above into their business model

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