Small Businesses and Health Insurance: Easing Costs and Expanding Access
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Testimony

Good morning, Mr. Chairman and members of the committee. I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national trade association representing nearly 1,300 private sector companies providing health insurance coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We would like to commend the committee for looking broadly at a wide range of options for meeting the health care needs of small employers and their employees. By widening the scope of this debate, you are opening the door to considering a comprehensive set of solutions that could improve choices for small businesses and help bring costs under control for all Americans. Our members are committed to working closely with you to identify workable strategies and to support your efforts.

My testimony today will focus on four issues:
• The challenge of confronting rising health care costs;
• A description of what health insurance plans are doing to control health costs, enhance choices, and improve quality;
• Recommendations for increasing the availability of affordable health care options; and
• An analysis of the potential unintended consequences associated with one of the options, association health plans (AHPs), that has been proposed to make health coverage more affordable for small businesses.

THE CHALLENGE OF CONFRONTING RISING HEALTH CARE COSTS

The committee is starting its work in the right place – by focusing on rising costs and the affordability of coverage – because when health care costs outpace growth in the overall economy, businesses large and small find it more difficult to provide or maintain coverage. While we are encouraged about what we can do in the private sector to continue to reduce growth in health care spending, we believe that all stakeholders – including the government – have a role to play in working together to accomplish this objective. Evidence also strongly suggests that attention needs to be drawn to the efficiency and effectiveness of health care services if purchasers are to be assured that they are receiving maximum value for their health care investment.

From 1994 through 1999, national health expenditures were in line with overall economic growth, because health insurance plans implemented a variety of tools to keep costs

under control. This had a direct impact on the ability of employers to purchase affordable coverage for their employees. Indeed, the Lewin Group estimated that up to 5 million people who otherwise would have been uninsured were able to receive coverage as a result of these costs being restrained.

As the policy debate shifted away from containing costs, legislative proposals at both the federal and state levels focused on rolling back the mechanisms that were keeping health care affordable. This led to a new cycle of accelerating health care costs that has had an impact on all purchasers, particularly small businesses. Recognizing this challenge, our members have developed a new generation of cost containment tools that already are having a positive impact and showing promise for the future. For example, the rates of increase in pharmaceutical expenditures have significantly declined as a result of our members' implementation of programs to encourage greater use of generic drugs and other measures that encourage case management of chronic conditions. This progress is reflected in the most recent data from the Department of Health and Human Services (HHS), which projects that national health care spending increased by an estimated 7.5 percent in 2004 – the lowest rate of increase since 2000. At the same time, health care costs still are growing faster than the overall economy.

The Center for Studying Health System Change has noted that hospital prices continue to be a major factor behind increased spending, accounting for almost half of the annual rate of increase in health care expenditures. At the same time, innovative drugs, devices and other therapies – while they can provide undeniable benefits in life expectancy and improved quality of life – are significant cost drivers. Without any organized way to assess the impact of this technology or compare the effectiveness of various therapies, employers and their employees are absorbing these higher costs without information about what works and the conditions under which certain therapies are effective. As the committee begins its work on the best methods to ensure post-marketing surveillance, we look forward to providing recommendations for your consideration. In addition, we support the efforts of Dr. Mark McClellan, administrator of the Centers for Medicare & Medicaid Services (CMS), who is working with the Institute of Medicine (IOM) to develop the information necessary to establish evidence-based coverage policies for Medicare. This effort will mark an important and needed transition.

As purchasers assess the impact of rising costs, they also are questioning whether they are getting the best value for their health care investment. Considering the Rand Corporation's finding that patients receive care in accordance with best practices only 55 percent of the time, more information about clinical effectiveness studies needs to be made available to physicians and other health care practitioners. As the committee reviews the work of the National Institutes of Health (NIH), we are prepared to offer recommendations for ensuring that information generated by this country's robust system of clinical trials is more quickly translated into everyday medical practice.

Cost shifting is another issue with significant implications for health care purchasers. The costs associated with uncompensated care – along with funding shortfalls in government health programs – are major causes of cost shifting. This translates into higher costs for

private sector payers, including small employers, and underscores the importance of ensuring adequate funding for Medicaid and other government health programs.

On the regulatory side, the existing patchwork quilt of regulations frequently prevents employers from designing benefit packages that they can afford and, as a result, sometimes forces them to make the decision not to provide health care benefits. We have been working with the National Association of Insurance Commissioners (NAIC), your colleagues in the Senate Banking, Housing and Urban Affairs Committee, and the House Financial Services Committee to assess the impact of the lack of uniformity in regulation, the administrative burdens associated with exploding compliance costs, and recommendations for improvement.

Similarly, the country is not well served by the current medical liability system. This system creates incentives for excessive litigation – thereby delaying the resolution of disputes, fostering a culture of blame, and forcing doctors to practice "defensive medicine" that diverts up to $100 billion annually and fails to reduce medical mistakes. Patients deserve an improved system that promotes quality; resolves disputes in a fair, fast and effective manner; and lifts the burden of defensive medicine from health care providers.

PRIVATE SECTOR COST CONTAINMENT AND QUALITY IMPROVEMENT INITIATIVES

In response to the latest cycle of rising health care spending, health insurance plans have been working aggressively to improve quality and control costs, while also meeting consumer demands for choice, through a variety of innovative strategies and initiatives.

Pharmacy Benefit Management

Health insurance plans use a wide range of pharmacy benefit management tools and techniques to reduce out-of-pocket costs for members and improve quality by reducing medication errors. These tools and techniques include:

• programs that encourage the use of generic drugs;

• step therapy programs that promote proven drug therapies before moving to newer, different treatments that are not necessarily better;

• negotiated discounts with pharmacies that participate in a plan's network;

• disease management techniques that include practice guidelines to encourage the use of the most appropriate medications; and

• appropriate use of mail-service pharmacies.

The success of these strategies is clearly evidenced by new data, released in December

2004 by the Center for Studying Health System Change, showing that growth in prescription drug spending has dropped from almost 20 percent in the second half of 1999 to 8.8 percent in the first half of 2004. A number of studies have reinforced that these tools and techniques are controlling costs in public programs:

• A 2003 study, conducted by Associates and Wilson on behalf of AHIP, found that the PACE program in Pennsylvania – the largest state pharmacy assistance program in the nation – could save up to 40 percent by adopting the full range of private sector pharmacy benefit management techniques.

• Another 2003 study, conducted by the Lewin Group for the Center for Health Care Strategies, found that Medicaid managed care plans reduced prescription drug costs by 15 percent below the level states would otherwise have experienced under Medicaid fee-for-service programs. Plans achieved these savings by performing drug utilization review, establishing pharmacy networks, and encouraging patients to take the most appropriate medications.

• The Government Accountability Office (GAO) reported in January 2003 that pharmacy benefit management techniques used by health plans in the Federal Employees Health Benefits Program (FEHBP) resulted in savings of 18 percent for brand-name drugs and 47 percent for generic drugs, compared to the average price customers would pay at retail pharmacies.

Our members also are taking steps to improve patient safety and reduce the risk of medication errors. Health insurance plans have created pharmacy information systems which, as a matter of standard practice, alert pharmacists when the combination of two or more of a patient's medications could lead to an adverse drug reaction. Software that plans use in their pharmacy networks is programmed to identify hundreds of potentially harmful drug interactions, including those that could occur due to the patient's age or gender. When the system recognizes a dangerous combination of drugs or contraindications, an on-screen alert is sent to the pharmacist who can then call the patient's doctor to find a safer alternative.

Transitioning to Evidence-Based Medicine

Health insurance plans are working aggressively to promote evidence-based medicine. This term refers to the widespread adoption in everyday clinical practice of treatments and therapies that are consistent with the latest scientific evidence on what works best and reduces the number of inappropriate services that have little or no value to patient outcomes.

As part of this effort, our members are working with physician groups to increase the use of quality technology assessment and clinical practice guidelines that help clinicians make decisions about the most appropriate course of treatment for patients with a specific disease or symptoms. Furthermore, AHIP has collaborated with the Agency for Healthcare Research and Quality (AHRQ) and the American Medical Association to

establish a National Guideline Clearinghouse – www.guideline.gov – which is a web-based resource that gives patients and providers access to the latest medical evidence on effective treatments and technologies. The National Guideline Clearinghouse provides access to both summaries and the full text of clinical practice guidelines, an electronic forum for exchanging information on best practices, and a tool that allows users to generate side-by-side comparisons for any combination of two or more guidelines.

Disease Management

Virtually all health insurance plans have implemented disease management programs to improve the coordination and quality of care for patients with diabetes, asthma, congestive heart failure, and other chronic diseases. These programs improve patient outcomes and satisfaction – and help control costs – by ensuring that these patients receive effective care on an ongoing basis so that they can avoid emergencies and unnecessary hospitalizations. A number of research studies have demonstrated that these programs are effective.

A study published in Medical Care evaluated the impact of a heart disease management program on hospital service utilization, as well as the potential costs savings over and above the cost of delivering the program. This randomized controlled study included 443 women aged 60 or older with diagnosed cardiac disease who were seen by a physician approximately every six months. The results demonstrated that hospital cost savings exceeded program costs by a ratio of nearly 5 to 1. Moreover, program participants experienced 46 percent fewer inpatient days and 49 percent lower inpatient costs than the control group, while no significant differences between the two groups were reported in emergency room utilization.

Another study, published in the journal Disease Management , examined the cost savings associated with a disease management program for three conditions (asthma, diabetes, and coronary artery disease). The preliminary results of this study show that the program produced a return on investment of $2.84 for each $1.00 invested.

Yet another study, published in Managed Care , examined a large health management program for 120,000 individuals having, or being at high risk for, one or more of 17 chronic conditions or diseases. Findings for the first year indicate:

• a return of at least $2.90 for every dollar invested in the program;

• average overall savings of $41 per program member per month;

• 14 percent fewer hospital admissions;

• 18 percent fewer emergency room visits;

• significant improvement in diabetics’ HbA1c levels; and

• absenteeism from work or school was reduced significantly (7-11 percent) among members participating in the program.

Health Information Technology

By implementing health information technology, our members are helping consumers make well-informed decisions about their health care, while also achieving greater efficiencies and cost savings throughout the health care system.

Health insurance plans have developed a wide range of health information technology initiatives, including secure websites that allow their members to quickly locate information about their benefits, check the status of claims, contact member services, or learn about preventive care, drug interactions, disease management, and other health issues. Other plans have created on-line pharmacies that allow enrollees to refill their prescriptions and access information about their medications. Another strategy implemented by a number of companies provides opportunities for members to receive health information from doctors and nurses through websites and e-mail.

Our members also are implementing information technology to improve claims processing, offer better customer service, decrease administrative costs, and enhance their overall efficiency. An October 2003 report by the GAO noted that health information technology allowed health insurance plans to reduce claims processing costs, improve the quality of claims data, improve staff productivity, and increase provider and customer satisfaction.

The GAO study also noted that plans' implementation of health information technology has resulted in improved clinical care for members. For example, one plan reported that diabetic retinal exams increased from 71 percent to 93 percent and the rate of adolescents receiving a flu vaccination increased from 29 percent to 43 percent due to information technology that generated reminders for health screenings.

AHIP and its members are committed to developing an interconnected health care system that improves personal health and the delivery of care, enhances health care quality, and increases productivity. We are committed to working with all stakeholders and the Office of the National Coordinator for Health Information Technology to develop uniform interoperability standards and business rules.

Redesigning Payment Models

Many health insurance plans are redesigning their payment models to reward health care providers for delivering high quality care. Paying for quality is a promising strategy for improving overall wellness and advancing evidence-based medicine, thereby reducing unnecessary follow up care and improving efficiency – which in turn will lead to better health outcomes and greater value. This is a significant change in a system that historically has paid providers the same amount, regardless of the quality of care they deliver.

Under these new payment models, many health insurance plans are offering financial awards to physicians in the form of increased per-member-per-month payments or non-financial rewards in the form of public recognition, preferential marketing or a reduction in administrative requirements. Additionally, some plans are beginning to tier provider networks and offer consumers reduced co-payments, deductibles, and/or premiums for using providers deemed to be of higher quality (based on select performance measures).

Let me briefly highlight two examples of the innovative programs our members are implementing:

• One health insurance plan has developed a program that includes: (1) an online PPO physician report card that allows physicians to benchmark their performance compared to their peers; (2) a physician recognition program that provides rewards for superior performance on clinical, administrative and pharmacy indicators, and (3) information resources provided to the PPO physician network to support quality improvement.

• Another of our members has developed an initiative to improve enrollee health through improved access/timeliness of care, preventive screening, and adherence to evidence-based guidelines for the treatment of chronic conditions. Under this initiative, a physician advisory group helps to develop "performance targets" in key areas, such as patient satisfaction, emergency room utilization/access, access/office visits, breast and colorectal screening, immunizations, and treatment for diabetes and asthma. Physicians then earn an award based on their level of performance: high, average and below average.

New Products: Bringing HSAs to Employers and Individuals

Besides using tools to promote quality and cost savings on an ongoing basis, health insurance plans are responding to the strong interest both employers and consumers have expressed in Health Savings Accounts (HSAs) as a new option for affordable health coverage.

This option allows beneficiaries to cover their health care expenses using a tax-free account in combination with a high-deductible health plan. Although this is a relatively new option that was authorized only 16 months ago by the Medicare Modernization Act of 2003 (MMA), more than 90 companies already offer high-deductible health plans that can be purchased in combination with HSAs. A wide variety of HSA products are available to consumers – including open access plans, preferred provider organizations (PPOs), and point-of-service (POS) plans. Health insurance plans that have contracts with providers can maximize the savings they deliver for employers and consumers.

Significantly, today's HSA products are more widely available and more popular than previous high-deductible options that Congress enacted in 1996. This is true for several reasons. First, the MMA allows any employer or individual to establish an HSA and make contributions to the account. Also, the product design for HSAs is much more flexible, particularly with respect to deductibles and out-of-pocket costs, and

expenditures for preventive care and certain disease management services do not count toward an individual's deductible. Although HSAs were authorized by Congress at the federal level, a number of states also have taken action to remove barriers to these new products.

Last year, an AHIP survey found that approximately 438,000 persons had established HSAs as of September 2004. This survey also indicated that among individuals who set up HSAs, 30 percent were previously uninsured and nearly half were over the age of 40. A more recent survey, which we will release soon, indicates that more than one million HSAs had been established as of March 2005. This reflects a more than two-fold increase in just six months. Additional findings from our survey will shed light on this dramatic growth in HSA products and their potential for extending affordable coverage to more Americans.

AHIP and the Small Business Administration (SBA) have jointly developed a website – HSADecisions.org – to serve as a clearinghouse and educational resource for consumer information on HSAs. This site hosts an online Learning Center that features a library and glossary to help consumers and small businesses better understand available HSA options. HSADecisions.org also provides a list of insurers that offer high deductible health plans that can be purchased in combination with HSAs. The site is updated on a regular basis to ensure that consumers have access to the most recent and most accurate information.

RECOMMENDATIONS FOR EXPANDING THE AVAILABILITY OF AFFORDABLE HEALTH CARE OPTIONS

As the committee looks at cost drivers, assesses what can be done to improve the effectiveness of the health care system, and reviews private sector strategies that are being developed to reduce costs and improve quality, our members would like to offer eight principles for your consideration.

1. Modernize and Maximize the Effectiveness of the Regulatory System.

• Encourage choice with uniform rules in the small group market: A common set of rules would encourage competition, enhance consumer choice, and provide greater predictability for employers. The solution is not to waive all requirements for particular groups, but to establish an appropriate and consistent framework for all participants to ensure that small employers have maximum options to meet their needs. This means that the federal and state governments need to work together to encourage "best practice" regulation. This process has begun with the development of draft legislation – known as the State Modernization and Regulatory Transparency (SMART) Act – that would promote uniformity in plan processes, particularly internal and external review of coverage disputes, speed-to-market and market conduct standards.

• Encourage prompt product approval and consistency in regulatory processes. Steps

should be taken to ensure that states adopt a mechanism by which health insurance plans can bring innovative products to the market in a timely manner. Ideally, the federal government should encourage states to be forthcoming regarding their standards for policy rate and form filing requirements and to abandon unwritten “desk-drawer rules.” This ultimately will create oversight mechanisms that allow companies to provide consumers with the products they need in a timely manner.

• Establish an independent advisory commission to evaluate the impact of mandates on health care costs and quality. Such a commission could advise policymakers on the safety and effectiveness of proposed and existing mandated health benefits, and assess whether proposed mandates result in improved care and value. The commission's findings also could inform public program coverage and decision-making to ensure that evidence-based standards are applied consistently in Medicare, Medicaid, and other public programs.

2. Pass S. 288, the “State High Risk Pool Funding Extension Act.” AHIP’s Board of Directors approved a statement in June 2004 indicating support for federal funding for state high-risk pools to cover individuals who have unusually high health care costs. This legislation fits within the parameters of what Congress is able to accomplish from a budgetary standpoint at this time. We applaud the committee for taking action earlier this year to approve S. 288. This proposal is one of the next steps Congress should take as part of a long-term strategy for strengthening our nation’s health care safety net.

3. Expand Tax Credits to Encourage the Purchase of Health Care Coverage. To address the needs of working Americans who are uninsured and ineligible for public programs, Congress can help make health coverage more affordable by expanding tax credits for low-income persons. This approach will be particularly helpful to Americans who do not have access to employer-sponsored coverage and to those who decline such coverage because of the high cost. Moreover, tax credits could prompt more small businesses to offer employee health benefits. The Employee Benefits Research Institute (EBRI) has reported that among small employers that do not offer employee health benefits, 71 percent would be more likely to seriously consider offering health benefits if the government provided assistance with premiums.

4. Develop a Framework for Evaluating Technologies for Effectiveness and Efficiency. To address the rapid development of new procedures, devices and other technologies, a public-private framework should be established to evaluate and compare the effectiveness and efficiency of these technologies. Moreover, new post-marketing surveillance models should be developed to assess the appropriate use and long-term value of certain breakthrough drugs, devices and biologicals.

5. Invest in Cost Effectiveness Research. While the federal government invests heavily in clinical research, it makes only modest investments in research that compares the relative effectiveness of existing versus new therapies that are designed to treat the same condition. The federal government should assign a high priority to this kind of research and, furthermore, create a National Center for Effective Practices to ensure that the

results are translated into usable information for providers and consumers.

6. Overhaul the Medical Liability System to Ensure Effective Dispute Resolution and Promote Safety and Value. The flaws in the current medical liability system should be addressed with reforms that place reasonable limits on health care litigation. Additionally, patient safety legislation is needed to establish legal protections for medical error information reported by health care providers, and to permit the aggregation of data that can be used to determine the causes of medical errors and develop strategies for improving patient safety. Also needed is a uniform, national administrative process to resolve malpractice disputes between patients and health care providers in a fair and efficient manner, thus avoiding the need for litigation as often as possible.

7. Encourage a Uniform Approach for Quality Measurement and Reporting. The Institute of Medicine (IOM) has made a strong case that patients need more information to make decisions about their health care treatment; physicians, hospitals and other health care professionals need more information to improve the quality of care they provide; and purchasers need more information to ensure that they are receiving value for their investment in health care benefits. Unfortunately, the existence of multiple and sometimes conflicting efforts to measure performance and report data on quality and efficiency is causing unintended consequences, including confusion among consumers, burdens on providers faced with uncoordinated data requests, and a diversion away from key priorities to improve quality. Leaders of the key health care stakeholder communities need to reach consensus about what should be measured, and how to make data aggregation and reporting effective and efficient. One uniform approach would be far more cost effective and would minimize the growing confusion associated with numerous measurement and data collection efforts. Critically, it also will help address the key issue that underlies the IOM's Crossing the Quality Chasm report – closing the gap between what the science indicates is best practice and what practitioners actually do.

8. Encourage the Development of an Interconnected Health Care System and Uniform Standards. The delivery of health care in America is complex with individuals seeking care from a variety of physicians, hospitals, and specialists. The ultimate goal of modernizing the health care system is to improve personal health and the delivery of care by providing meaningful personalized information to consumers and providers in a usable form and in a timely manner. To achieve this aim, we need uniform, national standards that enable the exchange of health information by and between clinical electronic health record (EHR) systems and consumer-centric individual health records.

UNINTENDED CONSEQUENCES OF ASSOCIATION HEALTH PLANS

AHIP and our member companies have grave concerns about legislation, S. 406, that would establish special rules and exemptions for national and regional association health plans (AHPs). We strongly support the goal of developing affordable health care options for small businesses. This legislation, however, would not achieve this goal and, in fact, would further drive up health care costs and leave more Americans uninsured.

I would like to preface my comments on this issue by highlighting a number of "myths" about AHP legislation and then outlining the "reality" of how this legislation would harm small employers. I also will discuss a specific example of how the proposed AHP legislation would likely result in higher premiums for a typical employer.

Myth: AHPs would reduce health premium costs for most small businesses.

Reality: In fact, the Congressional Budget Office (CBO) has reported that AHPs would make health insurance less affordable for the vast majority of small businesses. According to CBO's analysis, 82 percent of small business employees would pay higher premiums under AHPs. This expected outcome is closely related to the fact that the proposed AHPs could set up headquarters in a state without laws that limit how much premiums can vary for small businesses based on differences in employee health status. AHPs also could choose to operate under federal rules that do not have these rate limits.

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Myth: AHPs would cover all populations equally.

Reality: Because AHPs could operate in the choice of environment most favorable to their bottom line, "cherry picking" of only the healthiest individuals would result. Although AHPs could not legally discriminate based upon health status, the absence of limitations on premium variations would ensure that quotes for small employers with a workforce in less than perfect health would be many times higher than for healthy groups. As a result, employers whose employees had incurred significant health care costs would be forced outside of the AHP. As soon as one or more employees of a small business experienced a serious illness, AHPs could drive up the group's rates and thus drive them out of the AHP. Ultimately, most small employers would be forced out of AHPs.

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Myth: AHPs would reduce the cost of administering health benefits.

Reality: Each AHP would administer claims for its members. However, AHPs would need to recoup their administrative expenses by charging membership dues or by building administrative costs into the premiums. While some nominal savings potentially could be achieved on administration, in fact, small businesses most likely would end up paying the same or even more for administration of health benefits through AHPs.

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Myth: AHPs will operate under strong oversight.

Reality: The legislation substitutes actuarial oversight with a self-policing actuarial certification and state solvency standard with a limited $2 million reserve. According to the GAO and the Department of Labor, staffing resources are completely inadequate to meet the challenge of the added regulatory responsibility. In addition, the American Academy of Actuaries concluded that the capital standards are inadequate for any AHP

larger than 5,000 insured.

Myth: AHPs would be better positioned to negotiate discounts with doctors and hospitals.

Reality: Health insurance plans operating in the small group insurance market negotiate discounts from doctors and hospitals based not only on the small employer groups they cover, but rather, based on their entire block of business, including large employers as well as small groups. Because AHPs would represent small businesses only, it is unlikely that they could negotiate physician and hospital discounts that match or exceed those provided by health insurance plans covering both large and small employers.

Example of Premium Spike for Less Healthy Employer Groups

In order to fully understand the implications of the pending AHP legislation, it is important to focus on the fact that most states have adopted some variation of the National Association of Insurance Commissioners' (NAIC) model regulating rates in the small group market. The NAIC model limits rate variations – to no more than 25 percent above or below the average rate – for similar employer groups based on claims experience or health status. Moreover, this model limits annual rate increases for any one group to 15 percent on top of the rate increase applied to all groups.

The pending AHP legislation lacks this protection against wide rate fluctuations. That is, there is no limitation on what a group could be charged relative to similar groups based on health status or claims experience. The resulting rate swings would make small groups more vulnerable to catastrophic costs and make business planning less predictable.

Here is a rating example based on modeling done by the Hay Group: Peterson's Hardware Store applies for insurance under a state law that has adopted the NAIC's approach of limiting rate variations based on health status. Peterson's is quoted an annual premium of between $10,000 and $16,667 (based on the maximum variation based on health status allowed under current law in most states). If the AHP rules were put in place, it would be quoted a rate between $6,000 and $28,226 (based on no limit to the variation allowed). Only the healthiest groups would be quoted the lowest level of rates. The graph below shows this variation.

If we assume Peterson's Hardware were eligible for the lowest rate, but someone became extremely ill during the year, the rates for the next year could change as follows. Under current law in most states, the rate could go from $10,000 to $11,500 (but no more), plus the overall trend increase – because the NAIC model limits rate increases based on changes in health status. Under the AHP model, the rate could go from $6,000 to the very top tier rate of $28,226 (plus trend), because there is no protection against annual increases based on health status.

This example illustrates that while low rates initially may seem attractive to small

businesses with a healthy workforce, if one of their workers developed a significant illness, they would face a rate hike from the AHP the following year. Ultimately, the result would be a market in which a shrinking portion of healthy businesses would be covered by the AHP while businesses whose workers have significant health needs would be driven out of the AHP. This should be a major concern for all committee members.

We also urge the committee to consider the implications of allowing only certain entities – AHPs – to be exempted from state regulations. Congress should not create an unlevel playing field by granting special regulatory rules to specific entities that have little or no experience in the group and individual insurance markets. Federal legislative efforts should instead focus on creating consistent rules that address the affordability of health insurance coverage for all workers and their families.

Yet another serious concern is that preemption of state law for AHPs could repeat the problems of the late 1980s and early 1990s when Multiple Employer Welfare Arrangements (MEWAs) were exempted from state laws. The MEWA experience exposed thousands of individuals to unpaid medical bills and left them with no health insurance protection. Rather than repeat this history, we urge Congress to consider alternatives to AHP legislation.

Before closing, I want to briefly note that AHIP has launched a website – www.avoidfraud.org – which offers basic tips to help consumers avoid getting scammed by fraudulent, MEWA-like companies that claim to be health insurance plans. This site also provides consumers access to other relevant sources of information including the websites of their local state regulatory authorities.

Experience demonstrates that our industry can play a significant role in providing purchasers with coverage alternatives that are affordable and effective. To the extent that state legislation continues to be a barrier to fulfilling that goal, we urge you to consider a legislative approach that solves this problem broadly, rather than giving preference to an untested product based on a model that has had such unfortunate unintended consequences in the past.

CONCLUSION

AHIP and our member companies look forward to working with the committee to develop legislative solutions for meeting the health care needs of small employers and their workers. Our members have been working on creative strategies to make health coverage more affordable in the small-group market in a way that would avoid the many problems associated with AHPs. We are eager to share our ideas and contribute to a constructive debate on this issue.

Thank you again for providing AHIP the opportunity to testify on this important legislative priority.