Ideas for Making Health Insurance More Affordable for Small Businesses
Alliance for Health Reform
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ED HOWARD: I want to welcome you on behalf of Senator Rockefeller and Senator Frist and the rest of this board of the Alliance for Health Reform that's designed to take a look at how to make health insurance more affordable and accessible to small businesses and the people who work for them and the people in their families. We know that only about half of the smallest firms in the country offer coverage to their workers mostly because of the cost of insurance. And we know that a big share of the uninsured on the other hand, that is to say the principle interest of the Alliance for Health Reform work in small firms or are in the family of somebody who does. So this is a program that both Senator Frist and Senator Rockefeller quite independently asked us to try to put together on relatively short notice. Most of you know that legislation on this topic is scheduled to hit the senate floor some time next week, Cover the Uninsured week appropriately enough. So this is one of the most timely programs that the Alliance has offered you. And it focuses on, I think, one of the most contentious issues that we've ever done a briefing on. You read through these materials that Ann Montgomery [misspelled?] and the staff that the Alliance put together and that are in your packets, and I don't know about you but I was reminded of Ra shaman [misspelled?]. The same situation described by several

different people in very different terms. So I'm looking forward to today's discussion. In the interest of full disclosure I should say that the Alliance for Health Reform offers health insurance to its employees through what is in effect an association health plan. The Center for Non-Profit Advancement is the name of it. The center offers its members, non-profits in the DC area, a choice of half a dozen health plans offered through three different carriers, and it's worked very well for us over the years. We're able to share the risk with hundreds of other non-profits in the DC area so with that as context I just want to say that our task today is to help you sort out some of the facts and some of the arguments about the competing bills that are going to hit the floor next week and the bills that have already passed the house in that case so that you can understand the issue better for yourselves. We're pleased to acknowledge the support that we've received for this briefing, both from the National Association of Realtors, whose members generally favor the bill reported by the senate health committee last month, and from a consortium of not-for-profit health plans and women's and labor and advocacy groups who generally don't favor that legislation. The list of both groups, proponents and opponents of these bills are in your materials. So thanks to all of those who were willing to provide support and the unusually good lunch that you are enjoying and

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allowing this conversation to take place in what we are very hopeful will be a balanced and fair forum.

A few quick logistical items that most of you have had before but I want to emphasize them for those you who haven't. In your packets, maybe in your pockets by now, are bunch of materials that are relevant to this topic. Incidentally we have posted those materials and a number of other pieces that were either too long or too recently received to be put into the packets on our Web site at allhealth.org. If you have colleagues who aren't able to be with us here today and can access it through the internet you can have them take a look at the materials by going to our Web site. Also by tomorrow morning a web cast of this briefing will be available on kaisernetwork.org and later in the week there will be a transcript so you can hold them to everything they said and not say you were misquoting. At the appropriate time you'll find in your packets both a green card on which to write a questions, microphones that some of you will be able to squeeze your way through to ask a question orally which I recommend if you can possibly do it and a blue evaluation form so that we can try to improve these briefings as we go to make them even better for you. We have a busy schedule over the next couple of months and we'd love to have your suggestions about topics and speakers and approaches.

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And we have a truly excellent line up of speakers today to help us understand these complicated and contentious issues and as usual we reserved a lot of time for your questions. I suspect that there will be a lot of them. So let's get started. We're going to lead off with Jean Hearne. Jean is a specialist in social legislation for the Congressional Research Service, where she's been for seven years. Prior to that she put in a stint at the Congressional Budget Office and at the Institute for Health Policy Solutions, a group we at the Alliance have had a close relationship with for more than a decade. Jean has literally written the book, well the monogram on small business health plans. You'll find that in your packets along with earlier versions written both by Jean and by Bernadette Fernandez [misspelled?] and Jean's task today is probably the most difficult one that is explaining in a very non-partisan way this complicated topic and the complicated bills that address it. So we're going to give her a little extra time to do that. Jean thanks for coming by today.

JEAN HEARNE: Thank you Ed. And also thanks for holding this session. I think this is a really important issue and a technically complicated set of issues too. So it's great to have the alliance putting together theses kind of sessions to get everybody thinking about this and we may really be able to get to where we can make some good changes

for some small employers who want to offer health insurance and have trouble doing so today. I have no small task to explain the provisions of three fairly complicated bills and also the similarities and differences. So as you can imagine I'm going to be staying to some very broad brushstroke type descriptions but you all know where to find me if you want to follow up and ask further questions.

Just very quickly a little bit of background to kind of get a sense of what it is that some of these bills are intending to address. The problems that small employers face in offering health plans, we know this based on lots of surveys and lots of research, primarily the affordability and tend to be more expensive for small employers. There are other barriers as well. There are administrative barriers that small employers face. They often don't have benefit offices or administrators that work for them that are able to do this kind of plan comparison and figure out the best options and they simply don't have the manpower. In addition to that though, they don't get to take advantage of kind of the economies of scale that some of the larger employers have available to them. If you think about it from an insurers perspective, it's a lot easier to seek out, to advertise, to enroll, a single employer with 500 employees than perhaps to do so for 200 smaller employers with a handful of employees each. Those administrative inefficiencies are taken into

consideration in the rates that small employers have access to. There are other labor market features as well, it's a lower wage workforce on the average than for larger employers so that it makes this decision about benefits versus salary more sensitive. More employee turn over so it's harder to offer kind of continuous plans and continuous coverage. And that last bullet, it says competition for workforce but what I really mean to say there is that small employers compete between firms. So within the same line of business if Joe's Bike Shop is the only bike shop offering health insurance, a fairly expensive benefit for their employees, they may be at a bit of a disadvantage relative to the other bike shops that don't do it because they have to pass these costs off to their consumers. So they really kind of all kind of settle in the same offer not offer kind of decision.

What are some of the factors behind the affordability issue? Well you know the big one of course again is the high cost of medical care but for the small groups again there are some particular inefficiencies. We've already talked about the economies of scale thing. But small groups don't spread risk as efficiently as larger groups when they're buying insurance on their own. Again think about that single employer with 500 employees. The risk that say two of those employees get a really expensive, a really debilitating kind of disease ends up being fairly well balanced among all of

the employee because there are 498 of them that are relatively healthy and they're all premiums into this balance as well. So there's good actuarial balance whereas the smaller groups really don't have that. That higher risk is again reflected in the rates that they would have to pay for insurance. And of course small employers don't have the kind of bargaining power with the carriers on rates that maybe larger employers may have. Two other factors that are implicated in the cost of the plans for small employers that some of these bills in particular are attempting to address and the cost associated with any other state regulations.

So what are the solutions that have been offered in this congress to deal with these questions? Three bills; I've been asked to talk about – this is not a comprehensive list there are some other bills, but these are three we're going to address today; S1955 introduced by Senator Enzi and recently passed out of the Senate Health Committee, S2510 introduced by Senator Durbin in early April although there have been a number of versions of this bill introduced and there's a house companion bill as well introduced in the house by Representative Kyne [misspelled?], and finally HR525 introduced Representative Johnson and passed by the full house last summer. This is kind of the way I think about the approaches that each of these bills uses to address this issue, all three bills include provisions that are intended

to help small employers pull their risk together and buy insurance together as a bigger group. Then one bill, S1955 has additional provisions in it that are intended to do regulatory reform market wide the purpose of which is to reduce the cost of those plans with less regulation that would apply to them. And S2510 has some subsidies in the form of tax credit and another reinsurance fund that addresses kind of the affordability issue head on.

So I'll start by describing generally how these bills pool risk. Two of them, S1955 and HR525, both use an association based approach whereas 2510 has a somewhat different approach it would construct a FEHBP-like program. FEHBP is Federal Employee Health Benefits Program, many of us might even have coverage under that program. I'm going to go ahead and discuss the pooling features of these bills first and then I'll go on to describe the regulatory reform provisions in S1955. But just kind of taking one step back, what you want to consider in bills that attempt to pool risk and what you really want to try to avoid when constructing something that allows employers to pool risk the goal is to have an actuarially balanced group, a larger group, and you want to get some of the features that large employer plans have access to like maybe better ability to negotiate and some of those administrative economies of scale that we talked about. What you don't want to do is you don't want to

create a situation where by the addition of the new pools in the market you create instability outside of the market and the other thing you don’t want to do is you don’t want to create pools in and of themselves are unstable. So that when people are buying these plans they actually have something there when they go to use the services. And those are kind of the discussion, I think, that you’ll probably hear with the other discussants. Where the pluses and the minuses of the various approaches are.

Some of the features in common between the association based plan in S1955 and HR525 the purpose of both of these bills would be to provide for alternate and potentially larger purchasing groups and that employers have access to now. And don’t forget just as an aside that associations actually, just like Ed said, today offer health insurance plans. What these bills do is just create some particular advantages for the associations that create plans that qualify under the provisions of these bills. Under both bills these plans would be sponsored by bona fide trade and professional associations and franchise networks. The health plans offered by the associations would be certified by the secretary of the department of labor and both of them include provisions that are intended to ease the regulatory burden, particularly over the associations that are selling plans in multiple states by preempting state laws. Although even

associations offering a plan in a single state would be able to take advantage of these preemption rules.

What are the differences between the association sponsored plans in these two bills? In the senate bill the plans must all be insured. That means there's an insurance carrier involved selling the plan through the association or an HMO or some kind of traditional issuer of group health insurance. In the house bill the plans offered by associations may self insure. The preemption of state law is very different between the two bills. In S1955 a handful of state laws are intended to be retained so the health plans offered through those associations will still be subject to some state regulatory authority. Where as in HR525 much broader preemption of state laws, where state authority in S1955 that bill would establish new federal standards so in that scheme a lot of state laws are retained and then where's preempted there are new federal standards for benefits and rating. Whereas in the house bill a large bulk of the states laws are preempted and the bill would establish federal standards only for solvency so the rest are just kind of gone. The bills are also different in terms of whether they create a level playing field or not. The senate bill, has, because of the regulatory reform provisions in titles two and three, all plans whether or offered through the associations or not would be subject to the state same kinds of

regulation. In the house bill it's very different. The associations would have one set of rules, as I just said, most state laws preempted and federal standards for solvency. And outside the associations all of these traditional state laws would continue to apply. The next slide I'm going to skip but essentially this was just me thinking out loud or on the slide. Some of these bills really create some new interactions between state authority and federal authority. Sometimes it's not exactly clear what those lines are between the two and how they overlap and it would be a good thing kind of to think about along the line about whether these regulatory kinds of schemes are going to be able to be operationalized [misspelled?].

Okay just to move on to the Durbin bill the pooling mechanism is an FEHBP like program where a federal administrator would negotiate with a set of plans to offer across the nation. They'd be available for firms between sizes one and 100. And that bill, as I've already said, would include tax credits for employers who contribute 60% or more toward the employee's premium and it would establish a reinsurance fund to help for some very high cost claims and that would provide incentives for insurers to participate. The biggest differences between the association approach and the FEHBP approach is that the FEHBP plans would be available to all small employers nationwide whereas the association

plans are going to be available when and where there is an association that sponsors those plans in your geographic area. The FEHBP approach is going to have a single government administrator or sponsor whereas the association based approaches are going to have multiple private plan sponsors, the associations and also in the FEHBP kind of system employers would not be segregated by their trade or profession whereas in some associations just because that's what they do they would be offered to just those people in the trades or professions that their membership comes from.

And I'll just finish up with a very brief discussion of the regulatory reforms that are in S1955. Titles two and three of that bill would establish a federal rating rules and federal benefits standards and then some other harmonized insurance standards and to get a list of what those writers were those thinking, what those harmonized standards would include, they're listed on the very last line. Under this approach states would be allowed to adopt these federal standards but if the states do not then the insurance carriers operating in the states would be able to choose to adopt the standards themselves. If they do the other state's laws would be preempted. The state's laws in those areas would be preempted. Rating just simply the federal standards in this bill are based on a national association of insurance commissioner's model act from the early '90s. The federal

standard for benefits would basically allow insurers, carriers to offer a plan that does not include one or more of the state's benefits requirements as long as they offer a second plan that reflects the covered services, providers, and benefits under a state employee plan in five of the most populist states; and those states are California, Texas, New York, Florida, and Illinois. So with that I think I'll turn it back over to Ed for further discussion of implications of these provisions.

ED HOWARD: Thanks very much Jean. Admirable job with a formidable task. Next we're going to hear from Mila Kofman who's an associate research professor at Georgetown's Health Policy Institute. She's been writing about and analyzing how small businesses can get coverage for their workers for a very long time. She's had a hand in regulating those relationships as a staff member at the Department of Labor. She's now a member, has been since 2002, of the Consumer Participation Board for the National Association of Insurance Commissioners. She's a lawyer by training but don't hold that against her some of my best friends are lawyers and we're very pleased to have Mila back with us today.

MILA KOFMAN: Thank you so much for that great introduction, both having worked on ARISSA [misspelled?] and being a lawyer, I know that puts me in a very, very, very bad

category in some of your minds already. Thank you, Ed, for hosting this very important event and I'd like to echo Jean's comments that the timing of this couldn't be better as our national policy makers are considering ways to reform the market and change the way things are regulated in the US. In addition to being involved with the NEIC and also co-editor of the *Journal of Insurance Regulation* and have studied the insurance markets from different perspectives for quite awhile, I would like to recognize one of my colleagues who is here with me today, Karen Pollitz [misspelled?] she is co-author of a paper that's in your packet on health insurance and the way health insurance is currently regulated. She's also a national expert in this area and I would encourage all of you to try to meet her as well.

As Jean said, S1955 would do a couple of things one it would allow associations to be federally licensed and that's just one small part of the legislation. The other two parts of the legislation are quite significant and quite big and the other two titles have nothing to do with associations and they have everything to do with the way health insurance, products, and health insurance companies are regulated in the US or will be regulated in the future so it's quite a fundamental change in how health insurance products and companies would be regulated. The legislation has

significant restrictions on states and what states can do to help their consumers.

I just want to highlight for you some of my first significant concerns with the first title of the bill and that's the title that would establish federally certified association health plans. I believe that this bill has some of the same problems as prior bills like HR525 that have been around congress for over a decade. Some of the same problems like market segmentation allowing cherry picking, hurting the most vulnerable populations and in my mind one of the most significant problems which is the potential increase for fraud, an open door for crooks come in and get federally licensed. This legislation doesn't require associations to buy health insurance from licensed companies but as we've seen in the last cycle of scams these crooks who operate phony coverage, they lie about buying real health insurance and they sell phony policies either through real or phony associations. That's how they do business. There's a provision in the legislation that will allow associations to be deemed certified if the Department of Labor doesn't act within 90 days and having worked for the federal government, in fact for the Department of Labor in the past I can tell you it is very difficult to do anything in 90 days. In fact sometimes it takes 90 days to get your mail [laughter].

One of my biggest concerns is that right now both states and the federal government have authority over associations and the phony ones. They can both shut them down. And in fact during the last cycle of scams the Department of Labor shut down three compared to 41 that were shut down by the states. This would change things and remove authority from the states and give that authority solely to the federal government and it would actually make it easy for phony associations to get certified and defraud small business.

Title II and Title III of this legislation will also have significant concerns on how health insurance products and companies are regulated in the US. First of all this bill would allow the type of discriminations that's currently prohibited by states. It would allow insurance companies to do things that they're not allowed to do now. The kinds of rating structure that this legislation would establish would allow rate differences to be at least 26:1; meaning I would pay $100.00 for coverage and you would pay $2,600.00 for the same coverage just because you happen to be older or work in a particular industry or work for a very small business. Right now most states limit variations and rates and in fact many states prohibit health based rating all together. The bill would allow unlimited rate ups for certain factors like small employer size, age of employees, genders, geography.

Industry is capped at by 15%, so you can only be rated up by 15% for the particular industry you're in and there is a cap on rating people up based on their health or claims needs to 200%. But when you add up all those factors, the best case scenario is 26:1 difference in price. In fact something like this has recently been tried in New Hampshire. New Hampshire used to prohibit insurance companies from using health in they way they established rates. That was repealed and rate bans were put in, the kind of structure that's envisioned by this bill. That resulted in many small businesses seeing rate increases of 7-8-900%, businesses with older workers in certain industries and they lost health coverage as a result. In fact in 2005 the newly elected governor in New Hampshire and some of the new policymakers put back the old system of adjusted community rating. So this has been tried before and most recently in New Hampshire, and it hasn't worked and it hurt many small businesses.

I'm also concerned about the bare bone policies that would allow to be sold under this legislation, mandate free policies. Essentially my biggest concern with this is that people would buy insurance that's not enough for them. They would be under insured or they would by insurance that leaves them completely uninsured for certain medical events like cancer or diabetes. The choice that Jean mentioned, the choice of two policies to me, is just illusory because one

your choice of two policies could be either mandate free policy or high deductible health plan which may be unsuitable for many people and even if insurance companies give a choice of a comprehensive benefit plan only sick people are going to buy that and eventually it will just disappear because only sick people sign up and not enough healthy people sign up. It will just be too expensive.

I'm being told that I have a few more minutes to wrap things up so I'll try to just highlight. I think I'm going to skip over this slide. If afterwards people have questions about the rating structure we can get back to it.

I looked at the states in the US with the highest percentage of uninsured rates. And what I found was that in all of those states the small group market is exactly like this bill envisions. You have rate bans, and except for one of the states, nine out of the ten states you have mandate free or bare bone policies. So this experiment has been tried before and it hasn't worked. In fact there's going to be a [inaudible] study coming out some time later this week or next week and they've gone back and they've looked at offer rates among small business. They found that in states with the most consumer protections, the most tightly regulated markets with adjusted committee rating you have the highest offer rates among small businesses so I encourage you to look at that study.

I just want to say a couple of things about restrictions on state based authority to regulate health insurance companies. This bill essentially guts state enforcement authority at the front end to protect consumers and certainly at the back end to correct problems and it creates a regulatory black hole in terms of oversight. There is no enforcement authority that would be given to HHS to enforce these federal standards if states choose not to adopt these standards there won't be a federal regulator to enforce them and small businesses who choose to buy these products if there's a problem, they're not given authority to go to federal court to challenge insurance companies for violating these federal standards. So essentially you're creating a system where there is no oversight and in fact insurance companies are given authority to take states to federal court to sue them and actually recover attorney's fees. In fact insurance companies get more rights under this bill than all of us have in this room. The bill is really relying on hoping and praying that insurance companies will do the right thing but when you think about the industry it's for profit and they exist to minimize their risk and make money. And without oversight that's their incentive to avoid risk, to avoid covering sick people. And without real oversight consumers of insurance will be left without real insurance. I just want to close by saying, reminding all of us about

public policy and what we're trying to achieve. We finance medical care in this country through private health insurance, so good insurance has to do two things for you. One it has to give it access to medical care when you need it and two it has to keep you out of bankruptcy. And so sure selling mandate free policies that only work for young and healthy people, those policies will be cheaper but it's just like a car without engine. It will be a cheaper but it won't work. And we need health insurance that works today for us if we're sick and health insurance that works tomorrow for us when we get sick. This bill just doesn't accomplish those goals.

ED HOWARD: Thank you Mila. Our final speaker is Joe ROSSMANN. He's the Vice President of Fringe Benefits at Associated Builders and Contractors. He's been dealing with association health and welfare programs for almost three decade and if you've been following the debate about small business health plans, you know Joe ROSSMANN because he's been one of the most active and visible advocates of the Enzi-Nelson bill that came out of the Health Committee and we're very please to have you with us today Joe.

JOSEPH ROSSMANN: Thank you very much Ed. I really appreciate the opportunity to be here today to talk about the benefits of the legislation and how it's going to help small business, their employees, and their families. I'd kind of

like to approach the discussion today from a practical standpoint to talk about how it impacts small business and at the same time give you a little background at ABC and our association and how we provide insurance benefits and options to our members and their families and small employers throughout the country.

I've been involved with ABC for 18 years as a Vice President for Fringe Benefits. I've also worked for trade associations exclusively with their health insurance programs for almost 29 years and I can tell you from experience that health insurance plans are a viable source of comprehensive coverage for small employers. ABC established its insurance trust back in 1957 by five contractors who couldn't buy insurance coverage on their own because they were just too small. Since then we've enjoyed a 48 year history of providing health and other welfare benefits to other contractor members and their employees. During the first 43 years ABC's insurance trust only had two different insurance carriers. That speaks very highly of the stability of the program and the confidence that the insurance companies had in ABC and our plan. ABC is also a perfect example of the savings that are available to small employers through an association plan. The total costs for the ABC health program varied from 13.5-16% of premiums and those numbers included all the insurance company expenses. On the other hand the

sales, administration expense, and profits of insurance carriers, selling in the small group market from one of the largest insurance providers is targeted at 35%. The difference between their number and ours is 19-22.5% in premium savings which goes directly to the benefit of the small employers this year and in future years.

In addition to the administrative savings inherent in small business plans there's also the experience rating margins or profits that stay in the plan for the benefit of the participants rather than going to the bottom of larger insurance companies. Experience rating is a industry standard for large employers and small businesses could have the same advantages through this legislation. It goes without saying that small employers have their backs against a wall; struggling to maintain a business while at the same time being able to afford and provide quality health care coverage for themselves and their families. The problem's exacerbated by the fact that they must mitigate the effects of annual double digit health insurance rate increases that have hit them over the past five to six years. At the same time we've seen major insurance companies consolidating for what they've called increased efficiencies in economies of scale; telling us that the bigger insurance companies would have more clout to negotiate lower prices from hospitals, doctors, and drug companies.

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And according to an article in the *Washington Post* that just hasn't happened. Instead our reward seems to be the creation of local or national oligopolies characterized by less competition, less choice, higher prices, and higher returns to insurance company stockholders. The *Post* went to report that James Robinson [misspelled?] a professor in health economics calculates that the top three insurance companies controls two-thirds or more of the business in all but 14 states. Robinson juxtaposes those numbers with the 2000-2003 results from the five top national carriers and he shows a decline in the percent of each premium dollar that goes to pay medical cost, along with a strong trend towards higher premiums, higher profits, and higher stock prices. This appears to have been accomplished on the backs of small employers who have borne the brunt of these double digit rate increases for the past five years.

The bottom line to me seems to be that we need to create more competition in the health insurance market place in providing more options for small employers not fewer. In 1999 ABC's insurance carrier came to us and said they no longer want to stay in the business of providing a group health insurance plan for us because of the complexity and inconsistency of state law. That statement was very understandable to me because over the six years previous to that we saw our program carved to pieces as the insurance

company pulled out of one state after another because of the state small group legislative activity; pulling out of states like New York, Kentucky, and Colorado because it became almost impossible for them to comply with the new states laws and continue to provide the master policy approach for ABC's insurance trust. ABC had a strong and viable program which was gradually dismantled piece by piece by well intentioned insurance reform. We talked to over 50 different insurance carriers to take over the ABC's insurance program which at that point in time was about $44,000,000.00 in business and there were no takers. No insurance company wanted to be involved with our program with all the state insurance requirements as they exist today. They're just too inconsistent and too piecemeal. ABC even looked at the concept of going self-insured but we determined that the expense involved in complying with each and every state's filing requirement would have cost more in the long run than what we could have saved our members.

ABC's story is almost like a poster child for small business health plans. We succeeded as a health insurance plan for our members but we were legislated out of serving our members. Based on our history we look forward to the passage of S1955 to bring new options back for our members because it fosters competition and it's a model that works and it's a model that doesn't have its hand out for a

government subsidy. S1955 is a bill that's been negotiated in good faith by representatives in the insurance industry, the NEIC, the business community and our coalition. It provides for fully insured plans and state oversight of insurance companies with ongoing patient protection. 1955 includes three fundamentally important concepts. It provides for the ability to pool all small employers together for experience rating purposes, providing economies of scale and reduced administrative cost. It also provides for the common rating techniques which are consistent across state lines, a set of rating techniques actually developed by NEICA which are currently in use in the majority of states. Sixty-one percent of the states use rating rules that are either identical or closely approaching those specified in the bill. And third it provides for consistency in benefits in plan design, where small employers can select a high option or Cadillac style plan plus have lower cost alternatives available all based on actuarially developed rates taking into consideration only the plan differences. And all the plans are then pulled together under the small business health plan for rating purposes and future rate development. ABC's insurance trust offered a fully insured program for over 43 years. We offered 14 different medical plans for our members to select from. The plans were comprehensive in that they covered all licensed providers, plus any required

benefits from our home state of Virginia. These same plans were provided to all members in all other states even if the state had lower requirements. Under this legislation ABC trust would take a similar approach, the insurance trustees working with the carrier would make sure that ABC provided coverage options stressing preventative care and cost effective treatment of medical conditions. The goal is to provide comprehensive affordable health insurance to members and their employers. Small employers must compete with large employers for their workforce and because of this small employers want to offer the same high quality comprehensive benefits that large employers offer. And also small employers provide those same benefits to their own families under the same plans. The ABC small business health plan would be on a level playing field with other health insurance companies. We'd simply be another health care option for our members to choose from. We need to earn our member's business by providing high quality coverage at a reasonable cost.

The last title of the bill provides for harmonization of insurance standards. It's intended to greater uniformity in the administrative processes and the current state health insurance regulation and by creating greater consistency and uniformity it should reduce administrative cost to the insurers and ultimately provide savings to the insurers.

Since this legislation only allows for fully insured plans the responsibility for oversight and management of the insurance market remains with the states. States will continue to have oversight of the insurance carriers and be able to enforce patient protections. I'm very excited about S1955 and the choices it can make available to ABC members and it address a vital issue of importance to our members and to the entire small business community. Thank you very much.

ED HOWARD: Thank you very Joe, it's very good to get some tangible firsthand experience laid on the table. And now we get to the point where you can ask your questions. For the Q&A part of our program, we're going to supplement our panel. We're going to be joined, I hope, by two bona fide legislative experts, Steve Northrup and Krista Donohue whom if we can, we're going to ask them to come up. I've arbitrarily put them the other way but we can change the signs as easily. That's Steve going from right to left, Krista going from left to right. I'm not sure about that symbolism.

STEVE NORTHRUP: We've been trying to find the center all along Ed [laughter].

ED HOWARD: Touche. Most of you know Steve is the health policy director for the Senator Health Committee that's chaired by Senator Mike Enzi. He's been analyzing and shaping health policy for many years from a variety of

positions both in and out of government. Krista Donohue is the legislative assistant for, among other things, health care for Senator Dick Durbin, the assistant Democratic leader in the senate. Senator Durbin offered the principal Democratic alternative to the Enzi-Nelson bill that Jean was describing. Krista holds a Masters from the Kennedy School at Harvard. She's also been a main contributor to some of the liveliest discussions that the Alliance has held on topics like medical malpractice and patient safety. So we're looking forward to a lively discussion today.

As I said we have the opportunity for you to ask questions both the microphones and in green cards. If you will hold them up people will come by and pick them up. And let me start if I can while people are getting to that stage. You found in your packets descriptions of the NIAC model law from 1993 and the NAIC model law from 2001. The Enzi bill adopts the 1993 NAIC model as the standard, regardless of why that decision was made maybe somebody can explain to me the difference between the two because I've read them several times and believe me I can't understand them. Steve you want to try? Or Jean? Go ahead Steve.

STEVE NORTHRUP: I'll try to be as brief as I can. The '93 model act and actually the '95 model act that NAIC promulgated but they then updated in 2000, the main difference between the two is that the '93 model act is based

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

on the concept of rate bans that allow health status and a variety of other characteristics to be used in setting premiums. Most states use some form of that act with respect to rate bans. Some states have different limitations here and there, but the concept of rate bans is what most states use. The 95 model act that NAIC updated in 2000 is based on a concept of adjusted community rating and what that model act suggests is that rates can vary only based on age within a certain range and then with respect to geography and family composition. Those are the only three characteristics that you can use. There are about a dozen or states that use some form of community rating or adjusted community rating.

ED HOWARD: Mila, you want to add something?

MILA KOFMAN: Yeah I would just like to add a couple of points to that. Of the states that adopted the only NAIC model only four actually adopted the model verbatim without making some changes to it. Many of those states that have the old model further restrict the kinds of factors that could be used so you don't end up with a 26:1 rate variation. In addition to that the old NAIC model does not carve out associations. In fact it pools the experience of associations with the rest of the small group market. That's the major difference between S1955 and the old NAIC model. In S1955 essentially associations are given a separate experience, a separate class of business, and that class does

not have to be pooled with the rest of the small group market. So if the insurance companies itself or associations are very good at cherry picking and the bill gives them lots of ways to do it, the rest of the small group market, the prices in that market could be quite high.

KRISTA DONOHUE: Can I?

STEVE NORTHRUP: Go ahead, then I want to clarify.

ED HOWARD: Krista then Steve.

KRISTA DONOHUE: I just want to expand on want Mila said. When NAIC put out their model they had nine classes of business that were allowed under their model. The reason why, and a class of business is basically insurance speak for pool. They limited it because the more classes of business you have, the more market segmentation happens and you can charge sicker, older people more money than healthier people. So when you condense it to nine classes, you're saying there really can only be nine pools and you get more of an average cost because you have sick and healthy people pushed together. In the Enzi Bill when Mila is saying that they're carved out, it means that an association can be its own class of business. It can be its own pool. It creates an incentive for them then to want a healthy risk pool. So they can take to make their benefit packages and marketing guidelines to favor healthier people and leave the rest of

the folks in one of those nine classes of business whose rates might increase.

JOSEPH ROSSMANN: If I could just follow up on that. The reason you have the extra classes for the association market is the fact that we want association small business plans to be treated like a large employer. We don't these associations to be forced into one of the nine classes that an insurance company has today. That's the whole concept behind the pooling for associations is to get them to look like large employers. I would also say that the legislation for years and years has had requirements in there that as an association you cannot condition membership upon health status. So any member that's qualified to be in your association would be in there without health status. You cannot refuse participation to any member according to health status and you can't refuse any individual within a firm according to health status. So the association wants to take all comers we're not looking to have the individuals who are unhealthy or sick be in somebody else's pool rather than being in the ABC pool. We're looking to bring all of our members into the pool because we feel that there economies of scale and there are dollars that the insurance companies are keeping today that the association should be able to return to those small employers.

ED HOWARD: Steve?

STEVE NORTHRUP: I just want to point out and I'm not sure what version, Mila, of the bill that you're looking at but the version that I'm looking at which was on that was reported out of committee says pretty clearly in section 29 11B that the index rate for any class of business shall not exceed the index rate for any other class of business by more than 20%. So yes you can have a separate class of business for an association outside of the up to nine that you already have but it's not separate and distinct from the rest of the associations, from the rest of that carrier's business. In that class of business the index rate for it can vary so if it is tied to that carriers experience across the board. It is not only separate and distinct.

MILA KOFMAN: Right that's true but if you look at Title I of the bills which is the one that establishes certified associations at the federal level, there's an exemption from the section that you read from tying the index rate to all of your classes of business. So whether you intended to carve out the association business or not the way the bill is drafted currently at best it's ambiguous and I actually think the explicit exemption is pretty clear that the association business is not tied.

STEVE NORTHRUP: So if we address that issue that would address one of your problems with the bill?

MILA KOFMAN: One of many, yes.

STEVE NORTHRUP: Okay see we're making progress already [laughter].

ED HOWARD: Yes go ahead, if you want to identify yourself.

JILL WEXLER: I'm Jill Wexler [misspelled?] with *Managed Health Care Executive* magazine. I'm curious what the position of the insurers and health plans on the Enzi Bill. They've been sort of quiet. They didn't like the previous legislation because of the unleveled playing field in the insured versus self insured part and I'm wondering if a change in that is enough to build their support of if the regulatory reforms in the other two titles are of particular attractiveness.

ED HOWARD: And if there are people from any of those organizations in the audience we would be delighted to have you respond to that, otherwise or in addition to that any of the panelists who would like to take that up, feel free?

MALE SPEAKER: I think the main concern that the insurance industry had with the association health plan bills as I understood it, was the idea that association health plans would be operating on a different playing field. In other words association health plans would be self insured, regulated, to a limited extent by the Department of Labor operated under very different benefit rating rules, solvency standards than "traditional" insurance companies that are in

the state's small group markets. So the concept of a separate set of rules and the likelihood of adverse selection as a result of that healthier groups migrating towards those organizations operating under separate and restrictive set rules, that was the main concern that I understood the insurance companies had with the association health plan bill as passed by the house.

ED HOWARD: Yes go ahead.

DAVID KLEIN: I'm Chief Executive Officer Exalis [misspelled?] Blue Cross Blue Shield in upstate New York. My name is David Klein [misspelled?] and allow me to respond to your question Jill. There are many, many insurance markets in the United States and some work well and some don't. New York State is one which works very, very well. We have good programs. We have in most of our counties very low uninsured rates. We make use of peer community rating. There are high satisfaction levels, there's good access to care. The preemption of rating, the preemption of consumer protections as we looked at would increase the uninsured rate, would not help with the underlying question which is one of affordability. I think that type of position is held by many insurance companies and in both associations because of the split of positions you can't get a position either favoring or against the bill.

ED HOWARD: Go ahead, Mila, quick comment?

MILA KOFMAN: In terms of some of the larger insurance companies this is really like a Christmas tree for them. It insulates them from real accountability. There isn't real oversight. No federal oversight and states can choose not to deregulate their markets so there wouldn't be any state based oversight and insurance companies are given the right to go federal court to sue states, in fact sue their regulator and even recover attorney's fees. So for the insurance industry there are many perks in this legislation and that's while you'll find some in the industry who really appreciate this bill. And when folks talk about a level playing field you just have to understand that the level playing field is really no rules, almost no consumer protections and so it's like the Wild, Wild West of health insurance.

ED HOWARD: Joe?

JOSEPH ROSSMANN: I would just like to say in regards to New York our ABC members of New York are having a hard time with the cost and that's really one of the big issues for them and it's always been a big issue. And I think New York provides for association plans if I'm not mistaken or legislation, the only problem is you got to have 10,000 employees in the pool to be rated separately as an association plan and for many state based associations like

that it's a difficult number to achieve I'd guess you say. We're looking to do it on a national basis on their behalf.

ED HOWARD: I've got a question that's addressed either to Jean or to Steve and anybody else who would like to chime in would be fine. It reads as follows; according to section 102 of the Enzi Bill the Secretary of Labor is to consult with states regarding enforcement requirements for certification of small business health plans. Also would insure that only one state is recognized as the domicile state for such a plan. What complications with enforcement do you foresee with requiring states – this is what 101 does, 102? Is Texas going to like Delaware telling them how to manage SBHPs and it is reasonable to expect states to undertake this responsibility?

STEVE NORTHRUP: I think there are a couple separate issues here, first of all the small business health plan, that is essentially the association, the structure it creates for offering the health benefit to its members. That has to be certified by the Department of Labor. But the insurance company that is going to be offering coverage through the small business health plan has to be licensed in each and every state in which it is doing business and that's an important point and on Mila's point on there being some sort of regulatory black hole. If you look in your packet there's a letter in there from the National Association of Insurance

Commissioners and I would say that the National Insurance Commissioners Association letter pretty clearly states that they get and they appreciate the fact that this bill in every way possible tries to preserve the state as the focal point for regulatory enforcement and that's a key thing to remember about this bill, is that the small business health plan, the insurer that's offering those policies has to be licensed in each and every state in which its doing business so if somebody in Texas has a problem with the policy they got through the small business health plan, not the Delaware commissioner and God forbid the Department of Labor.

ED HOWARD: Question addressed to Joe ROSSMANN here. You cited increasing concentration of health insurance market share as one of the factors in your insurance trust problems. Some of the increased concentration is attributable to Unite Health Care which has purchased a number of other insurance companies in other years. United also happens to be one of the strongest supporters of the Enzi Bill. Shouldn't that make small employers nervous about how they will fare if the Enzi bill becomes law.

JOSEPH ROSSMANN: I don't think so. I think what we've seen is all insurance companies seem to have become much larger as time goes on and we have seen fewer and fewer health insurance companies. And the ones that have been national in the past, if they haven't been purchased and

bought up they're retracted a little bit and become regional in scope. What we're looking to do is get more competition into the market and we'd love to have the UACs of the world negotiate with small business health plans to give a better deal to all these various associations and chambers of commerce around the country.

ED HOWARD: Anybody else?

STEVE NORTHRUP: If United Healthcare supposed this bill that letter must have gotten by the process up here because I haven't seen it.

ED HOWARD: Anybody here from United who would like to speak [laughter]? We'll accept communications for posting to our Web site if anybody would like to have done so. Go ahead Mila.

MILA KOFMAN: I would just like to say something about competition and the term competition has been thrown around a lot. The insurance industry is not competitive in the sense like when you go to the grocery store, when you go to buy a car, they compete for your business. The insurance industry is just the opposite, they really don't want to compete over unhealthy people. They're not looking to insure people with medical needs. They're only competing for the healthiest of the healthy that's out there. So if you have a 100 companies for the one person who's healthy in this room or if you have five it's not going to matter. What really

matters is fair rules that make health insurance accessible to everyone regardless of your health needs. And sure it's great to have a dozen companies to choose from but that's not the reality in the for profit industry. So when you eliminate the existing rules that are there to protect the healthy and the unhealthy alike you really create a system where only people who are healthy today and tomorrow they really won't have real coverage that they need.

JOSEPH ROSSMANN: Mila I would tend to agree with you on a lot of those points. I look at it over the fact that the even though there's fewer and fewer insurance companies they seem to be making more and more money. What we're trying to do is to interject the association or the chamber of commerce or the franchise group in the middle so that they can negotiate a better price for those small employers that's the whole idea behind this because what we've done over the last five to ten years in any state you're still seeing the insurance companies growing bigger, getting stronger, and making more and more profits. And the small employers are paying more and more for health insurance coverage and quite frankly a lot of small employers are eliminating coverage. I think five to ten years ago we had 70% of the small employers providing coverage now we're down closer to 60%. We need to stop this trend and continue to have small employers provide coverage to the employees and their families.

MILA KOFMAN: Joe I completely agree with you. I think it's absurd that the CEO of United last year banked over a billion dollars in bonus and stock options while small business workers and owners are suffering and not having the kind of access to affordable health insurance that they deserve. I think it's outrageous that we let 18,000 people each year die in this country because they can't get health coverage because they're uninsured. That is not acceptable. It's un-American. And I completely agree with you. What I disagree with you on is how we get there. I think keeping existing rules that states have enacted to protect everyone in their market place is important and building on those rules through tax credits, through other things that make health insurance more affordable and accessible is the way to go. I think when you negotiate with insurance companies you should start from a high level instead of no level of benefits. I think if you have to negotiate over maternity and mental health that means you negotiate less over something else, so why would you want to lose the existing baseline of benefits and protections? You should want to retain them and ask for more.

JOSEPH ROSSMANN: Under the bill there's no loss of benefits because as we said earlier you've got to offer one plan that mirrors one of the five most populist state plans, which means if you have a Cadillac plan that you're going to

be able to offer to your members and their employees. If they want that type of plan they can have it. If they want more cost effective plans they can choose that. But the benefit and I think one of the things we need to keep taking into consideration is the fact that no matter which plan an ABC member selects at the end of the year the experience of all those plans are going to be pooled together so that the increase if it's 5% or whatever it's across the board for every plan, not just for the high cost plan or the low cost plan, it goes equally. And that's the pooling aspect that we're trying to achieve with association.

ED HOWARD: Krista?

KRISTA DONOHUE: I think that pooling and negotiation with insurers is something that everybody agrees is part of the solution to this problem but the details really matter. And I think what you were saying about that benefits won't be lost is quite debatable. There's no affordability requirements for the high option plan. They could charge an enormous amount of money for the high option plan and you wouldn't be able to afford it and all you could choose is the low option plan. It could also be, who knows, an HSA? I mean Florida's state plan has an HSA available. So under the bill as currently written an HSA would qualify as a high option plan. Also, there was something that I was going to

say about negotiations with insurers but I forgot so I'll save it until I think of it.

ED HOWARD: Steve?

STEVE NORTHRUP: If I could just jump in with a point here. I think the issue is not – I see Mila's concern and Krista's concern, if you say in the legislation well we're going to give small business health plans the complete freedom to develop benefit packages that make sense for their members, I think the history of Joe's organization ABC, they clearly offered and you can look at their benefit package if you want to, what they used to offer until they couldn't find a carrier to offer it anymore. They offered generous benefits across state lines and also benefits that just didn't meet the minimum standards in a particular state. I mean they went above and beyond in a number of states what the state required. The issue is being able to offer a uniform benefit package across state lines which is why you don't see multistate associations anymore frankly offering coverage across state lines. If we can agree on diabetes or cancer screenings or what have you, these are important things that ought to be covered the problem is with respect to any one of those mandates, you could have some sort of mandated in 45 different states but each state mandates it in a slightly different way. So you can imagine the nightmare of trying to put together a marketing brochure to market that

your members if you have 45 different iterations of one particular mandate and the challenge inherent in administering that. I think we can all agree that we all want to see in the insurance packages that we have, the insurance coverage that we have. The challenge for a small business health plan, in an administratively simple and a minimally costly way as possible offer something uniform across state lines, so that you can have one uniform benefit package or several uniform benefit packages and not have to deal with the slightly different permutations of a particular mandate in any state and maybe that's another area we can find some common ground on.

ED HOWARD: Let me let Krista jump in and then I want to ask a follow up question to Joe.

KRISTA DONOHUE: The small group reform happened in states in the 90s for a reason. Insurance companies are in the business of reducing risk and exposure which is fine, they're for profit companies. But they were excluding certain benefits that were very expensive for example insurance companies aren't wild about covering babies in their first three weeks of life because you have to go into a neonatal unit it's very expensive so the states came in and said this is a market failure and these are certain benefits that must be covered. And when you Mr. Rosten [ph] is a great negotiator I'm sure but I'm sure there are other

associations that are not going to be as protective of their members and again there is a built in incentive to have a nice risk profile in your association pool. And so you may not want to offer prostate screening because what if, God forbid, somebody got prostate cancer and you have to pay for it and your rates for everybody go up. So these protections were put in place for a reason because insurers were acting like insurers and OPM does negotiation. Our bill is based on the FEHBP model and OPM, there's a federal pool of 8,000,000 people. They've been able to negotiate with insurers and keep rates consistently lower than the increases that have been in the private sector. A good example is 2005 last year, OPM sent Aetna back to the drawing board. Aetna covered at the time 250,000 employees this is not a good enough package, go back and try again. I mean OPM can do these kinds of negotiations because if you have one big national pool no one is going to want to stay of it.

ED HOWARD: And let me just follow up on something that Steve raised because a questioner has asked on the card addressed to Joe ROSSMANN if a bill like 1955 was enacted what kind of package would ABC offer and do you have an estimate in your head anyway of what that might cost and how does that compare to members current health insurance choices?

JOSEPH ROSSMANN: It would be kind of difficult for me to just pull a package or price out of the air on a package of benefits but I can tell you from our history, we'd offer a comprehensive plan of benefits and we'd probably have anywhere from 10-15 different medical plants because what members want in the Northeast is totally different from what members want down in Texas, or Louisiana, or Mississippi so you have variances in your benefit packages but they'd all be all comprehensive benefit packages covering wellness benefits and those types of things. As far as price goes, again, I couldn't pull a number of the air right now but I can tell you from our experience, we know that we can negotiate or we have in the pass at lower expense factors to provide the coverage to employer members and their families than what we're doing today or what the insurance companies are doing today on a direct basis. We feel that the savings is anywhere from 15-20% from where they're at today.

ED HOWARD: Go ahead.

ALAN BLASS: Yeah Alan Blass [misspelled?] with Senator Biden, question for Mr. ROSSMANN can you be specific about what it is that you don't like about Senator Durbin's bill? It seems to me like it's a giant pooling group, much bigger than ABC group, has a lot of negotiating clout, it has national standards for the national plans, which is what you

just mentioned local standards for the local plans. Don't you think that would be a good deal for your members?

JOSEPH ROSSMANN: I think one of the concerns I have is the fact that it would be an open pool for small employers to select from but insurance companies would still be able to market directly in the states the way they're marketing today. So I think there's potential adverse selection for that particular pool the way it's set up. The sick and unhealthy would go to those pools where healthier ones would like for prices on the outside directly on the open market. I think there's potential there for selection number one.

KRISTA DONOHUE: I'll talk about the four ways that we prevent adverse selection in the Durbin bill. First of all we have a subsidy, there are two ways to really avoid adverse selection when you're creating new pools; you either put in place one set of rules that is across all markets which is what the Enzi bill attempts to do, unfortunately we don't feel like those rules protect enough people. And then there's another way which is to add a subsidy, so our bill only effects the SEHBP pool of people. It doesn't touch the large or small group markets. The way that we avoid having just people who are sick come into our pool is that we offer a subsidy so that healthy and unhealthy employers will want to come into the pool to get this subsidy. Second we have an open enrollment period so you can only sign up, just like in

the FEHBP you can't sign up just when you're sick. Employers cannot offer any other major medical coverage other than the FEHBP program. So you couldn't tell your healthy employers to go out into the individual market because it's cheaper for them, and we also have a six-month preexisting condition waiting period, it's reduced by the amount of creditable coverage you've had before. And again we have one class of business which will spread risk evenly, and we think make it affordable so that all employers will want to come into our plan.

STEVE NORTHRUP: Frankly Krista saying that your bill is based on the FEHBP is like me saying I'm based on George Clooney. I mean I'm a man, so is George Clooney and that's kind of about where it ends. The similarity is that both your program and the FEHBP are run by the Office of Personnel Management, but what we're trying to do is give small employers the ability to do what the Office of Personnel Management does on behalf of the large self-funded employer that is the federal government. I mean that's what OPM does for the FEHBP. The federal government acts like a large self insured employer, they go out and negotiate. We're trying to give small business associations the same ability to aggregate their members to do what the federal government does. I think that's one of the key differences. And to your point, sir, about the national plans having national

standards that's not in the fourth version of Senator Durbin's bill. They actually took that out. So the national plans will still have to meet all state benefit mandates in each and every state, which is different from FEHBP. FEHBP allows the national plans, Blue Cross Blue Shield, Standard Option, and the others to offer one uniform set of benefit packages across state lines, which is again what we are trying to allow to happen in the Enzi bill. So that's different in the fourth version of the Durbin bill is there is not the freedom for national plans. So really what we're talking about is just aggregating again a bunch of state small group markets together, because no insurance company is going to offer a national plan that has to meet all of the state benefit mandates. We've seen it happen before and Mr. Rossmann's a perfect example of that, his association.

ED HOWARD: Krista a quick comment.

KRISTA DONOHUE: The OPM requires the state benefit mandates be adhered to in the local plans, and they set up a list of benefits for the national plans which include all of the most expensive health benefit mandates that are in the states currently like mental health parity, organ transplantation. It's a very rich package and by requiring that the national plans in FEHBP adhere to the benefit mandates in every state we're not actually increasing the

price of the package that much. And I think we're going on your third version of Enzi's so.

STEVE NORTHRUP: Actually it's the workability, it's not so much the cost of the mandates, it's the workability. You can't offer a national plan and still have to meet 50 different state requirements. Yeah mental health is one thing, but hair transplants and athletic trainers and pastoral counseling. States have a lot of one off and two off mandates that they require and those are the things that are also going to be offered by a national plan under your pool. That's why I think it's very unlikely that you'll see any national plans under your pools.

KRISTA DONOHUE: I think if you aggregated small business together and we got 10,000,000 in a pool with the subsidy I bet you that insurers would come.

ED HOWARD: And what's wrong with hair transplants [laughter]? Yes here and then there's someone in the back too.

MARY AGNES CARRY: I'm Mary Agnes Cary [misspelled?]with *Congressional Quarterly* this is for Steve and Krista. Some health analysts believe this is the closest it's been in awhile for this type of legislation to pass the senate. Steve I wonder if you could talk about to try to do to reach out to opponents, traditional members who

traditionally opposed this bill particularly Democrats and Krista what you're trying to do to counter balance that.

STEVE NORTHRUP: Anybody who has seen Senator Enzi operate in his time in the congress knows that his style is to try to reach across the aisle. I think you've seen that in the chairmanship of the health committee. There have been a lot of things that he and Senator Kennedy have worked on together. And there are some things that they can't work on together. Maybe this is one of them I don't know all I can tell you is the chairman is continuing to reach out to Republicans and to Democrats to try to build a consensus for this bill. If there are Democratic staff out there who have concerns about this legislation come and talk to us. We've been trying to talk to everybody who's willing to talk to us, or have your boss talk to the chairman. That's all I can say. The chairman said build a coalition and that's what we've been trying to do and are continuing to try to do. So I guess the time is now if you want to come talk to us I'll free my schedule tomorrow for anybody who wants to come and talk about their concerns about the bill – staff that is, not all the rest of you guys [laughter]. I've heard enough from you.

ED HOWARD: Krista how's your schedule?

KRISTA DONOHUE: I'm not allowed to be quoted so you have to refer to me as a senate staffer or something.

STEVE NORTHRUP: Same goes for me.

KRISTA DONOHUE: If you want an official Durbin staffer comment you'll have to call our office but I can tell you off the record that Senator Durbin his bill for three years now and have spoken to many, many Republican offices. Would loved to have made our bill bipartisan. We don't think it's you know a liberal tax and spend bill. It's based on the private market. It's based on a proven effective program today. We did try to make our effort bipartisan. I think we have some commonalties with Enzi and that's that we like pooling and negotiation but that's where it stops and we're worried that his bill will make many, many people worse off and so we're obviously opposing it.

HERB CHAPMAN: Herb Chapman [misspelled?]I work for Bloomberg Radio. Mr. Rossmann earlier in this meeting there were a Howitzer load of criticism of what this bill that you support would do. That is it would allow for some of your members to be charged 26 times what other members would be charged. It would allow for a low common denominator approach which many would regard as affordable but which would be like, if I remember right, a car without an engine and so on. Would you address the criticisms that you heard? And also to ask Ms. Kofman if insurers won't insure this huge association under these circumstances what's the point?

JOSEPH ROSSMANN: Trying to take from the top. The rating mechanism in the bill is one that was selected I think because it's the most prevalent in the states. The comment was made earlier that the rating for that particular model could go from one up to 26.4 times that for a given rate which means that if you have a 19 year old group of employees and they're all 19 years old and nobody's sick at all they cost $1.00. And then if you've got everybody in another employer plan and they're 64 years old and they're sick as the devil and they're in the highest cost area, they cost $2,640.00. That was the analogy there. This morning I took the opportunity to take a look and say, what did ABC's plan do before the health insurance portion of it went away? And our numbers came up and this is utilizing age rating, the health status rating that's in the bill. It's also utilizing cost areas, gender, et cetera, et cetera and we came up with a differential of 1:9.4. I can tell you that an association in ABC would not have these huge swings in rates that are mentioned earlier. Also we would be providing comprehensive coverage. And you say, I forgot the last part of your question, other than the fact that you were saying low-ball plans I think. We couldn't offer low ball plans to our members because our members would go directly to UHC or to Aetna or somebody else to buy quality comprehensive benefits. We've got to offer them the kind of benefits that they need

to have to actually generate new employees for them because they're trying to get their employees from large corporation, so you've got to provide quality comprehensive benefits. I can tell you also the people that oversee these plans, ABC specifically, they're trustees. They're individual contractors who actually participate in the programs, and they buy the health insurance for themselves and their employees just like they have the oversight for other members of ABC. So they have a vested interest in it to try and do the right thing for their employees plus the other members of the association.

MILA KOFMAN: That 9:1 is based on previous premium data?

JOSEPH ROSSMANN: Yes.

MILA KOFMAN: And you were regulated by state laws at that point?

JOSEPH ROSSMANN: Yes we're just taking a look at were the factors, using those same factors and we came out to be 9.47 one.

MILA KOFMAN: Joe I'm glad you mentioned that even within your association different businesses are going to have different rates because that's a myth out there that all members of the association would have the same rates. I'm glad to hear – although still want the difference between one and nine could be huge. The variation of 26:1 is based on

NAIC actuarial manual and that's a Safe Harbor. That's looking at the rating structure in senate bill 1955 and essentially using the Safe Harbor to come up with 26:1. The rates could be a lot greater, meaning they could vary on a much broader scale if an insurance company can justify the broader variations. I'm sorry I don't remember the second part of the question.

ED HOWARD: If the insurers won't write the policies what's the point?

MILA KOFMAN: That's what I've been asking myself when looking at this bill since November or earlier versions since November. We're all in this room because we care about health reform and consumer rights and health insurance that works. There's a reason why health insurance is expensive, medical benefits are expensive, hospital costs, provider costs, prescription drug costs and this legislation doesn't try to tackle the real reasons why health coverage is so expensive. You know GM adds $1,500.00 to the price of each of their cars just to pay for health benefits for their retirees and workers. This bill isn't going to make good health insurance cheaper for people it's just going to make health insurance cheaper, eliminating required essential benefits that mean life or death for people who are sick. It's going to mean that most vulnerable people who are currently insured are going to be forced to drop their health

insurance because it will become more expensive because all the sudden they'll pay 26 times more than me who is healthy or even 9 times best case scenario, in Joe's association, nine times more. That's what this is going to result in. It's not meaningful health reform. It's going to hurt the most vulnerable.

ED HOWARD: Can I just ask, a couple of times we've heard and Joe cited a figure of 19% or 22% of potential savings. There's a study in your packet that predicts a savings of about 12% or something like that. Is there agreement about the potential administrative savings as opposed to underwriting savings or knocking off benefits or keeping people out of the pool?

JOSEPH ROSSMANN: Well I would definitely say that there are administrative savings because I think I mentioned that earlier that ABCs program had administrative costs which included the insurance carrier's cost of 13.5 to 16 cents on the dollar. And we see large insurance companies, even for the largest employers have administrative and marketing and sales expenses and risk expenses 20% or more. We've seen companies in the small employer market target as high as 30-35%.

MILA KOFMAN: Can I just add something? For associations administrative savings, cost estimate I think is difficult to do because these are insured products. That

means there is some administrative functions that insurance companies have to retain in house. That also means that some of the administrative functions will be duplicated by the association. The association will have to recruit members, perhaps pay agent commissions, perhaps collect premiums to send over to the insurance company. Well the insurance company has to have systems in place to process those premiums, to process claims, so I'm not actually convinced that there will be substantial if any administrative savings. The cost savings with these products are going to come by cherry picking, by trying to attract the healthiest of healthy to enroll, ways that you can force out the sickest of the sick, and through benefit design. If you don't offer coverage that pays for prescription drugs well sick people aren't going to sign up for that coverage because they'll need prescription drugs. So I'm afraid that the cost savings are going to come from cherry picking and leaving the most vulnerable people out there without any private insurance and not from the administrative savings.

KRISTA DONOHUE: Can I just say one more thing? I'm sorry I know people are waiting. On the administrative cost, what goes into the administrative load on the premium is you know claims processing, marketing, agent commissions, things like that. Any kind of aggregation of people is going to bring down the marketing cost. And if I can put in another

plug for the Durbin bill; the Durbin bill aggregates everybody together so there's no marketing costs. But OPM would send out a booklet just like federal employees get that list the plans so the plans don't have to go out and seek out these small business, market to individual small businesses. Those savings would also be achieved, I think, in the Enzi bill on the administrative side but they would have to do it for multiple associations and each administration would have its own administrative structure and have to do its own marketing to its members. And in addition there's also administrative side costs on the employer's side which is they have to go out every year and see which is the best plan for my employees. Do I want to change? Sixty-two percent of employers last year looked for a new plan based on cost so that wouldn't be obviated by the Enzi bill. Under the Durbin bill basically we've taken the negotiation out of the employer's hands and given it to OPM.

STEVE NORTHRUP: That's one of the points that concerns us frankly is taking it out of the employer hands. We'd like to strengthen the employer's hands to get them to work together. And I think the idea that there won't be any marketing going on under the egis of the Durbin bill. I don't think insurance companies are going to want to participate in that pool if you could actually find something that would want to and just sit back and let the government

do their marketing for them. The reason OPM costs for marketing are non-existent essentially is because we're a captive audience, federal employees. We get our brochures every year at the same time. We're part of a closed pool and we all have a premium subsidy that we take and we use for that. Whereas the pool under your legislation is an open pool, open to all comers, they can choose to stay in the small group market, choose to join the pool. I think that suggesting that there aren't going to be any marketing and administrative costs that go with trying to convince small employers that it's a good deal for them, trying to essentially get their premium dollars as well. Again it's another area where just saying it's like the FEHBP doesn't mean it's like the FEHBP.

KRISTA DONOHUE: I'm not suggesting there would be no marketing costs. They would be reduced.

ED HOWARD: Okay you've been very patient.

EILEEN MARGULA: Eileen Margula [misspelled?] from Group Health Incorporated in New York. I'm here today with a group of health plans, we call ourselves the Coalition to Protect Access to Affordable Health Insurance and it's plan located in New York and around the country with a growing list joining us. In your materials there are some slides which describe our concerns about what the Enzi bill would do, especially in those states that have had those battles

and consumers have one the battles of having certain protections for them. Particularly the point I want to make now following up on a point Joe ROSSMANN made earlier and talking about small business is one of the slides in that packet points out I think a very significant fact and that's that there are 10 major states that have community pure or adjusted community rating. In nine out of ten of those states the access to health insurance by small business exceeds the national average. The point is going with community rating as opposed to the structures in the Enzi bill does have a positive impact on small business and the data shows it. I wanted to point that out.

STEVE NORTHRUP: Can I also point out that seven of the ten most expensive states for a family policy in the small group market are community rated states?

EILEEN MARGULA: But they are also in many cases the states with the tertiary care hospitals, with high costs of medical care for a variety of reasons. I can speak for my own plan 90 cents on the dollar goes to health care and 10 cents to goes to administration. So that had to do quite straight with the cost of care.

ED HOWARD: Before you walk away from the microphone, actually you touched on something as I was going through the materials in the packets, one of the slides shows that eight out of ten in the small group market, eight out of ten states

that are most expensive are not community rated states. On the other hand if you go to the handout that Life Underwriters have in the packets they say, although it's not restricted to small group that health insurance rates are much higher, as they put it in community rated states. Is there some common truth in that or is one of those more accurate than the other or how are we supposed to reconcile them?

EILEEN MARGULA: With an actuary? Our data that we've researched shows obviously what's in our slides but I'm not an actuary.

ED HOWARD: I didn't mean to put you on the spot but I thought you might have stumbled across that argument.

EILEEN MARGULA: It's okay, quite all right.

ED HOWARD: Mila? Mila's not an actuary but she plays one on TV.

MILA KOFMAN: Right I play one on TV. I'm an economist too. There are 12 states actually with adjusted or community rating. The two other states require their largest carriers, the Blues plans and HMOs to community rates, so I would say there are 12 states not 10 states where the impact of this legislation would be quite dramatic. In states with adjusted community rating where insurance companies can't charge rates based on one's medical needs, prices are going to be a little bit higher because you're covering sick

people. That's just a fact, you're covering sick people and if you are paying claims your prices are going to be higher if you're only covering healthy people you're going to have lower prices and that's what you see in a lot of these states with loose restrictions. You see lower prices for the very healthy, healthy groups and you see astronomical prices for people, for groups with medical needs. And when you compare rates for groups with medical needs in the community rated states versus loose regulation states it's much more affordable for businesses and their workers to live in New York or New Jersey or in one of the other 12 states that protect them.

ED HOWARD: We have maybe ten minutes and I want to as we go to this question, you've also been very patient, I want to remind those of you who are gathering up your things to gather up that blue evaluation form and make sure you fill it out before you leave. Yes sir go ahead.

BOB HINCKLEY: Thank you. My name is Bob Hinckley [ph] I'm with CDPHP, a member of the coalition that Eileen Margula mentioned and we also provide 90 cents on the dollar to medical costs and 10 cents to admin. I wanted to touch on a subject that wasn't touched on earlier and really address this to Steve. We see across the nation the states as incubators and innovators for health care ideas and whether it be the Durbin bill or the Enzi bill we all agree that this

only touches on a part of our health care issues in the countries. How would Enzi and most of these states address innovation through the regulatory process? How would Enzi effect the states as incubators? For instance Massachusetts which with a lot of fanfare introduced a new concept in providing universal health access, it's our understanding that in some of the plans of Massachusetts as well of the government is concerned about the impact of Enzi on that innovation. How would Enzi deal with that and don't you agree that it would dampen innovation in the states?

STEVE NORTHRUP: No I don't. In fact I think that Senator Enzi's bill with Senator Nelson has the potential to actually enhance what Massachusetts is trying to do. Remember what Massachusetts has done is to try to creat an individual mandate but that individual mandate depends on there being affordable products available and there's a lot of concern in Massachusetts right now about the regulations in the state with the respect to mandates and rating making it impossible for insurance companies to offer affordable products and then if there aren't affordable products available the individual mandate doesn't apply to people. So I guess that would be my concern. Under Senator Durbin's bill, I mean the testimony a couple weeks ago in the finance committee suggested that in order for Senator Durbin's bill to really achieve everything that he wants it to achieve that

national pool would end up becoming the de facto state small group market. So all of the state small group markets would have to go away. I mean if you're concerned about the states being laboratories of innovation there's not going to be a state small group market anymore under the Durbin bill if it actually works the way Senator Durbin thinks it would. What we've tried to do is identify things that have worked and things that haven't worked over the past 10 or 15 years in the states and apply some of that learning from the laboratory to try to make health care and health insurance more affordable across the country.

MILA KOFMAN: If I can just give you a different perspective on that. States as laboratories, states like New York with their healthy New York program, the most recent Massachusetts initiative, a bunch of states have a variety of initiatives for their small business. All of those programs rely on a market that works and on a market where insurance companies take some of the risk. This bill, senate bill 1955 would allow insurance companies to dump their risk and these state programs won't be able to continue to operate absent huge subsidies from tax payers. They'll essentially become dumping grounds that don't want to cover sick people or people with even minor medical needs. This will completely end any kind of innovations that states have been able to accomplish or future innovations in the state markets. It

will be devastating for state programs that are currently out there.

ED HOWARD: Yes go right ahead.

LAURA TRUMAN: My name is Laura Truman [misspelled?] and I head up a group called the Coalition for Affordable Health Coverage. I have to say right off the bat that our coalition has not taken a position on the Enzi bill. We have both ardent supporters with the US Chamber of Commerce and the National Association for the Self Employed who are very for it. Then we have other groups that have concerns, they haven't taken positions against, but they have some concerns. I want to ask and clarify something on the mandates. Obviously I think that we have a problem where some states and in fact many states have erred in the requirement of so many mandates that if you can't afford a Cadillac coverage you get none. We have a problem. We have increasing uninsured. And unlike the Bloomberg reporter who said it's a car without an engine, I think we're trying to offer a car without heated seats, navigation system, and a sun roof. We're trying to offer basic coverage and like or not, and I don't mean to mix apples and oranges, but Health Savings Accounts have taken off with huge response because they offered a kind of coverage that was less expensive. And so to the extent that people in these states will have two options, one if I'm a 58 year old woman I don't care if I

have infertility treatment or I don't care if I have newborn care. I want to be able to afford a policy and maybe right now I'm in a state where all those mandates are and I can have nothing. So they'd have two options, the 58 year old lady and the 22 year old lady could pick, they could say I need the one with infertility treatment and I need the one with newborn care. Or I need one that I can afford and I'm not hugely wealthy at Enron, I'm a small business owner and I don't need the infertility treatments, I'll pay for that one. So it's trying to move that balance back to where more people have something they can afford. I didn't mean to just give a speech.

ED HOWARD: There must be a question in there somewhere.

LAURA TRUMAN: There is a question and that is why, I guess I would say to Mila, why is it this just bringing balance and how do you feel about me saying that you know you're guaranteeing so many protections that you're pricing a lot of folks and the number of uninsured and the data on the age as many of them are very young, so they can't afford insurance but they're not big high risks.

MILA KOFMAN: First of all even an industry funded study estimates that the cost savings from not having mandates is only 5%. And as you know, in the last five years insurance premiums for small businesses have been increasing

the double digits. Some businesses have had 30-40-50% price increases every year. Even at best the 5% cost savings isn't going to make health coverage more affordable. And when you think about health insurance it's not like ala carte you go to get dinner and you pick what you want. You have no idea if you're going to have cancer tomorrow. You just don't know and if you do come see me afterwards I'd like know how you know that. We all need health insurance that works when we need it. We need health insurance that works for sick people and we need health insurance that works for healthy people who will get sick, who will age, who will have medical needs in the future. And making something cheaper by cutting out essential pricey conditions like cancer treatment, or diabetes, and other things that currently states require isn't going to be real health insurance. It's not really going to help anyone. At the end of the day you might be better off just putting the money aside and not buying a policy that's not going to protect you when you're sick. That's what we're talking about. We're not talking about a choice between a BMW and a Mercedes. We're talking about a choice between having something real, you know the old saying on the umbrella that melts in the rain, we don't want health insurance that melts in the rain. We want health insurance that covers us.

ED HOWARD: Joe?

JOSEPH ROSSMANN: I think from ABC's perspective our trustees would not be looking to go to the bottom of the cellar on coverage. They'd be looking to provide comprehensive quality benefits to all these employees and their families and what we're looking for really is consistency across state lines. It's so varied in each of the various states in what the mandates are or not. We need to have consistency in what the benefits that are offered. We still want to offer comprehensive coverages that takes care of the wellness programs and prevention and those times of things.

ED HOWARD: We have time for one more quick question and a quick response.

KAREN FOLETS: Karen Folets [misspelled?] from Georgetown, Mila's friend. I had a question about the provision in the Enzi bill that allows insurers to sue state regulators and why that's so important? Why nobody else has the right to sue to enforce their rights, consumers or small employers or providers? And what you envision the enforcement in the event that even one state decides not to enforce the federal rules under those circumstances?

STEVE NORTHRUP: The reason the legislation gives insurers the right to go to federal court is to basically insure that insurance commissioners cannot retaliate against them for offering polices that meet the federal standards

with respect to benefits, with respect to rating. Consumers, providers, others have all the remedies they have today under state law to go to state court and say insurance company X sold me this policy. They are not providing the benefit that they said they were going to provide under this policy and I'm going to take them to court to insure that they do offer. This bill doesn't touch any of those protections that are available under state law. What we're trying to do is avoid creating a federal regulator to come in and enforce these things and to try to encourage the state insurance commissioners to play fair, to allow plans to come in and rate under the federal rating standard, the optional standard, or offer benefits that adhere to the federal standard there. We don't want to create CMS having to have a major regulatory role as a federal fallback. So that's the approach that we've taken. But the bill does not sweep away any state consumer protections with respect to antifraud or the ability of a consumer to go to their state insurance commissioner and then go to federal court to say this benefit was promised to me. It hasn't been delivered. This company was operating under neither the state nor the federal standard with respect to benefit, so they're at fault.

ED HOWARD: Thirty seconds.

MILA KOFMAN: I just want to clarify a couple of things; one, injured consumers cannot go to federal court to

enforce their rights under this bill. There's not private cause of action. And two, even when states adopt these standards, the interpretation of the standards is only given to federal courts so it's very difficult for states, it would be very difficult to enforce any of this if any time they want it enforced they'll be dragged into federal court. The kind of mechanism and oversight that this creates is really unworkable if your goal is to protect the end user, the consumers of insurance, the small businesses who buy these federal standards or federal policies that are sold under these standards. There's no way to, if there's a problem in many situations, there won't be anyone to call, no federal regulator, no state, and if there's a real problem, you don't have the right to go federal court to enforce your rights under this bill.

ED HOWARD: I hate to cut this off, but we are at the end of our time. Before we finish up let me give Jean Hearne a chance to say something. She's been ducking from those Howitzer rounds the gentleman from Bloomberg was talking about, so if you'd like to make an observation feel free to do it at this point.

JEAN HEARNE: I will say despite the very polarizing positions that we have heard discussed for the last hour or so this debate represents a great deal of progress I think in this area of improving access for small employers. We've

seen the bills on association sponsored plans go from absolutely no state regulatory authority to some. And we're seeing FEHBP like approaches go from a wacky idea that nobody paid any attention to being a real proposal that people are trying to work through. I think this is a really great opportunity to get people from both sides working on this issue.

ED HOWARD: What a wonderful last word. Let me just say thanks to you for sticking with some really tough stuff for the last hour and forty five minutes. Let me once again thank the realtors for their support of this briefing along with the Coalition to Protect Access. And finally thank Jean and the other panelists for helping us go through this minefield with Howitzer's a blazing.

[END RECORDING]