Testimony by

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Expanding Access to Quality Health Care: Solutions for the Uninsured

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Mr. Chairman and Members of the Committee:

Thank you for inviting me to testify today. Families USA is the national organization for health care consumers. Our mission is to ensure that all Americans have access to high-quality, affordable health care.

In my testimony today I will begin by identifying the primary target population for the first steps that should be taken to expand health coverage for the uninsured. After that, I will turn to an examination of the merits of several proposed solutions designed to reach that population.

In doing so, I will first present the reasons why Families USA has determined that expansion of public programs—Medicaid and the State Children's Health Insurance Program (SCHIP)—is a better strategy than individual tax credits for decreasing the number of low-wage workers and their families without health insurance coverage. While individual tax credits may help some families cope with high health insurance premiums, the proposals before Congress do not provide a sufficient subsidy to allow low-wage workers and their families to purchase insurance, and will discriminate against workers who need health care the most.

Second, in recognition of the jurisdiction of this Committee, I would like to present the reasons why Families USA and other consumer groups oppose the current Association Health Plan (AHP) proposal (H.R. 2563). After extended and careful consideration, we find that the current AHP proposal poses a serious threat to our existing employer-based health insurance system and violates the important principle: do no harm.

The Target: Uninsured Low-Income Workers and Their Families

The uninsured are predominantly low-income working families: over half (58 percent) of the uninsured who are poor have at least one family member who works full- or part-time outside

the home. Eighty-five percent of the uninsured who are near-poor (below 200 percent of the federal poverty level or an annual income of a little more than $3o,000 for a family of three) come from families with at least one full-time worker.[1]

As you know from previous hearings, more than 60 percent of the U.S. population receives employer-based health insurance coverage. However, there are working Americans that fall through the cracks in employer-based health insurance—especially low-wage workers, part-time workers, and workers in personal services. In fact, eight out of ten of the uninsured are in working families. Most of these uninsured workers (70 percent) do not have an *offer* of employer-based coverage. This is especially true for low-wage workers. Nine out of 10 workers whose wages are $15 an hour or more are *offered* coverage by their employer, but only half of those whose wages are $7 an hour or less are *offered* coverage.[2]

Most workers participate in employer health plans when offered, but for low-wage workers affordability is an issue. For workers with an offer of coverage and whose family income is below the poverty line, 19 percent are uninsured (compared to 2 percent for workers with an offer and incomes above 300 percent of the poverty line).[3] As you heard at this Subcommittee's hearing on June 18th, the situation will only worsen for low-wage workers as employers pass on higher premiums and higher out-of-pocket costs to their employees.

Medicaid and SCHIP fill in only portions of the gaps left by employer-based coverage. While Medicaid reaches many people who need basic health care, millions of low-wage workers and their families are left behind. Today, more than four out of five low-income, uninsured adults are ineligible for Medicaid or other public health coverage. An analysis by Families USA of Census Bureau data show that, nationally, an estimated 81 percent of low-wage, uninsured

adults—more than 13 million people—have incomes that are considered "too high" to qualify for Medicaid coverage in their state.[4]

The holes in the Medicaid safety net are readily apparent. In 42 states, non-parent adults (childless couples or single adults) are ineligible for Medicaid—even if they are penniless—unless they are severely disabled.[5] For parents, the Medicaid eligibility levels are very low—below $15,000 in annual income for a family of three in almost three-quarters (37) of the states.

As I will describe, Families USA had determined that the best approach to help low-income people without health insurance is to build on the Medicaid and SCHIP programs, thereby fixing the holes in our already existing health care safety net.

Weighing Medicaid Expansion versus Individual Tax Credits

Families USA has identified two over-riding principles that guide us as we evaluate proposals to reduce the number of uninsured Americans. First, to be effective, any proposal directed at low-wage people and families must realistically make coverage affordable in light of their low-income status. Second, the proposal should extend help equally to all low-income uninsured regardless of health status.

These two principles clearly lead us to support Medicaid- and SCHIP-type expansions over individual tax credits. In a nutshell, federal dollars spent on Medicaid- and SCHIP-type expansions, unlike individual tax credits, provide a realistic subsidy for the cost of meaningful coverage. Further, unlike individual tax credits, Medicaid does not reject sick people or charge sick people very high premiums.

Principle #1:

Unlike pending tax credit proposals, Medicaid provides a realistic subsidy for the cost of meaningful coverage.

Medicaid provides coverage for virtually the *full* cost of meaningful insurance that is precisely targeted to persons and families with limited incomes. By way of contrast, the size of currently proposed tax credits—even for young healthy non-smokers—buys inadequate coverage that often does not cover critical services and has high out-of-pocket deductibles and copayments that low-income people can't afford.

Research shows that those with low and modest incomes are unlikely to take advantage of subsidies that fall short of the costs of insurance and are unlikely to use care if they face large out-of-pocket costs.[6] Current individual tax credit proposals would force low-income people to pay from 20 to 50 percent of their annual incomes on top of the tax credit value for decent health insurance coverage. Not many low-wage working families can afford to do this.

President Bush has proposed a $1,000 individual tax credit. In a recent report, Families USA looked at the annual premium for a standard plan that is comparable to typical employer-based coverage and to the most popular plan in the Federal Employee Health Benefits Plan (FEHBP) program.[7] The average annual premium for a standard health plan was $4,934 for a healthy, non-smoking 55-year-old woman and $2,459 for a healthy, non-smoking 25-year-old woman.

Our recent report also found that no $1,000 policies were available to healthy, non-smoking 55-year-old women in 47 states. Even healthy, non-smoking 25-year-old women could not buy $1,000 policy in 19 states.

When $1,000 plans were available, they had limited coverage with high deductibles and out-of-pocket costs. Benefits—such as prescription drugs, emergency services, inpatient hospital services, and mental health—were not covered in some states and very limited in others. The plans that were available to 25-year-old women did not cover doctors' visits in 18 states and prescription drugs in 19 states. In the three states that did offer $1,000 plans to healthy, non-smoking 55-year-old women, the annual deductibles were $5,000.

Principle #2:

Unlike individual tax credit approaches that push people into the individual market, Medicaid does not reject sick people or charge sick people high premiums.

Government insurance programs do not underwrite on the basis of risk. Medicaid provides all eligible people with the same covered benefits and with the same protections against high out-of-pocket costs. The tax credit proposal, however, would result in discriminatory harm to people with health conditions or disabilities. This is because the tax credit approach pushes people into the individual market, and people with health conditions or disabilities face discriminatory denials of coverage or unaffordable high premiums from insurance companies. Although the value of the proposed individual tax credit would remain fixed, private health insurance premiums, copayments and other out-of-pocket costs are significantly higher for sick people, older people, and other people at risk of needing health care. Thus, the tax credit leaves the very people who most need health insurance with the highest out-of-pocket costs. And for some sick people, no individual health insurance would be available at any price.

A study by the Kaiser Family Foundation documents what happens to people in less-than-perfect health in the private individual insurance market.[8] The study had hypothetical consumers with varying health problems apply for coverage in diverse insurance markets: the applicants were

rejected for coverage 37 percent of the time. The Maryland Insurance Administration found health insurance applicant rejection rates comparable to those found in the Kaiser study: one Maryland plan rejected 32 percent of the 18,000 people who applied for individual coverage in 1998.[9]

For the hypothetical consumers in the Kaiser study who were offered coverage, only 10 percent of the offers were "clean"—that is, the plans were offered at the standard premium, with no limitations on covered benefits. The rest of the offers had significant limitations on benefits. For example, Frank, a 62-year-old retired salesman who smokes, is overweight, and has high blood pressure, was rejected on 55 percent of his applications and received only two clean offers. Three of the 27 offers he received included riders excluding coverage of his entire circulatory system.

People in less-than-perfect health also faced higher premiums for coverage. For example, one national carrier in the Kaiser study offered the same policy to Alice (a 24-year-old with hay fever) in Corning, Iowa for $1,471 per year and to Frank (a 62-year-old overweight smoker with high blood pressure) in Miami for just over $30,000 per year—more than a 20-fold difference in price. Thus, an individual tax credit would provide greatly varying levels of help based *not on need*, but rather on age, gender, health status, place of residence, occupation, and many other factors used to price or underwrite individual policies.

By way of contrast, Medicaid cannot discriminate by turning away sick or older people (or any other higher-risk people). Further, Medicaid provides reasonable limits on how much low-income people can be charged for health services regardless of their health status, age or other risk factors. Only public sector programs like Medicaid truly guarantee the availability of medically necessary care to people with serious health conditions and protects them from the high cost of their care.

Next Steps to Improve Medicaid and Cover More Low-Income Working Families

The holes in the Medicaid safety net leave a large number of low-income adults without health coverage. In effect, these programs divide low-income populations into three groups—children, parents of children, and childless adults—and treat each group very differently. This categorization and differential treatment is an unfortunate vestige of the 16th-century Elizabethan Poor Laws that formed the basis of our nation's welfare system and, starting in 1965, the Medicaid program as well.

Children, who in recent years have aroused the greatest political sympathy, are accorded better coverage than the two adult groups. Most states now consider children eligible for public-sector coverage if they live in families with incomes below 200 percent of the federal poverty level ($30,040 for a family of three).

Low-income parents receive considerably less coverage protection than their children do. States have near-total discretion to establish the Medicaid income eligibility standards for parents—and most states have established standards that are very low. In more than half (26) of the states, a parent in a three-person family working at the minimum wage ($5.15 per hour) is considered to have "too much income" to qualify for Medicaid if that parent works full time. As a result, there are 6.5 million low-income uninsured parents and approximately two-thirds of them—4.3 million—are ineligible for Medicaid coverage.[10]

Single adults or childless couples—even if they have no income at all—are excluded from Medicaid coverage in 42 of the 50 states. But even in the states that provide some coverage, the income eligibility standards are meager: in five of the eight states, income eligibility standards are below $9,000 of annual income. As a result, among the 9.8 million low-income, non-parent adults

who are uninsured today, approximately 91 percent—or more than 8.9 million people—are ineligible for Medicaid or Medicaid-like coverage.[11]

It is time for the Medicaid program to be modernized. And it is time to recognize that work does not always move a family out of poverty. As first steps, we have three recommended improvements to the Medicaid and SCHIP programs.

First, we recommend that the historical ties to categories of eligibility be undone once and for all. States should be allowed to cover low-income adults—regardless of their parental status—without a waiver of federal law.

Second, to encourage states in these tough fiscal times to provide expanded health insurance coverage to parents of children eligible for Medicaid and SCHIP, we recommend that states be given an enhanced matching rate for parents. Ideally, parents should be served by the same program—Medicaid or SCHIP—that serves the children. Thus, this enhanced matching rate would be provided both through the Medicaid program and through additional funding in the SCHIP allotments.

Third, states must be given the flexibility to cover legal immigrant children, parents, and pregnant women in their Medicaid and SCHIP programs. Without preventive and basic care, uninsured parents' and children's minor health problems can become life-threatening and require treatment in hospital emergency rooms—and *then* Medicaid covers the more expensive care required. Likewise, without access to prenatal care, pregnant legal immigrant women are four times more likely to deliver low-birth weight infants and seven times more likely to deliver premature infants than women with prenatal care. These infants, born citizens, *then* qualify for Medicaid and SCHIP to cover the expensive complications created by the lack of prenatal care.[12]

Thus, the prohibition against Medicaid and SCHIP coverage of legal immigrant parents, children and pregnant women is penny-wise and pound-foolish.

Additional Help to the Recently Unemployed: COBRA Subsidy

In addition to building on the existing Medicaid and SCHIP programs, Families USA supports a COBRA subsidy to help recently unemployed families afford the cost of continuing their employer-based coverage.

Certainly, for many recently unemployed families, the cost of COBRA coverage is a very real barrier. Newly unemployed workers must pay 102 percent of the employer's cost—the full premium, including the portion that the employer previously paid, plus a 2 percent administrative fee. It is estimated that only one out of five unemployed workers who are eligible for COBRA coverage took advantage of the opportunity. A major reason for the low COBRA take-up rate is the high cost of premiums for employer-based coverage.[13] The 2001 cost of COBRA continuation coverage through the average employer plan was $7,194 for family coverage and $2,705 for a single worker.[14]

A COBRA subsidy allows people to retain their group health insurance coverage rather than face the severe limitations of the individual market—especially important for any person who is not young or who is in less-than-perfect health. From an employer's standpoint, however, the high cost of COBRA coverage creates a problem of adverse risk selection—sicker and older former employees are more likely to stay in the employer's insurance pool and healthier and younger former employees move into the individual market. This segmentation of the insurance pool drives up the cost of employer-based health insurance coverage. By subsidizing COBRA premiums, this problem is greatly ameliorated because young and healthy former employees will

find the cost of subsidized COBRA coverage to compare favorably to the cost of unsubsidized coverage in the individual market.

However, if unemployed workers are given the "choice" to go into the individual market with their subsidy, the problem of adverse risk selection will be *worse* for employers. As I have already described, older workers and workers with any kind of health conditions will not be able to find coverage (or it will be significantly more expensive and less comprehensive) in the individual market and will remain in the employer insurance pool. These workers don't really have a "choice" to buy coverage in the individual market. However, younger and healthier workers, who are often willing to settle for less coverage to save money, will remain likely to purchase coverage in the individual market because they won't forfeit their subsidy. As this adverse risk selection continues, premiums also will continue to rise as employer plans do not gain any ability to cross-subsidize premiums among *all* former workers.

Some laid-off workers are not eligible for federal COBRA continuation coverage even though their employer provided health insurance benefits: workers who had jobs in firms with fewer than 20 employees. However, 38 states have enacted COBRA-like laws that supplement the federal law and help workers laid off from firms with fewer than 20 employees.[15] Thus, it is very important that a subsidy be available for the purchase of continuation coverage guaranteed by *both* federal *and state* laws. The combination of both federal and supplemental state laws provides continuation coverage to almost three-quarters of laid-off workers.

Why Families USA Opposes Current AHP Proposals

The current Association Health Plans (AHPs) legislative proposal (H.R. 2563) is intended to help smaller employers and self-employed individuals come together to purchase health

insurance coverage at lower cost. While the concept sounds reasonable—allowing small employers to come together to achieve cost-savings through greater bargaining clout and efficiencies of scale[16]—the current legislation has the potential to cause significant harm to the existing small employer insurance market.

In fact, small employers can come together under existing law to purchase health insurance. Nothing in current federal or state law *prohibits* small employers from forming associations.[17] In fact, one in four of all private employers and one in three of all small employers (nine or fewer employees) purchase insurance through group purchasing arrangements.[18]

Generally, any time more than one small employer comes together it is considered a Multiple Employer Welfare Arrangement (MEWA) under ERISA law and must comply with certain DoL registration requirements and basic fiduciary duties. In addition, both fully-insured and self-insured MEWAs also are under state regulation. MEWAs must comply with state laws, including: solvency standards to protect against plan financial failures and state consumer protection laws, as well as rating, underwriting laws, and benefits mandates that protect against adverse risk selection and segmentation in the small group market.[19]

If small employers currently are able to band together to purchase health insurance, then what does AHP legislation accomplish? The key change is that AHPs will be able to operate outside of state insurance laws.

The proposed federal AHP legislation would federalize the regulation of Association Health Plans by eliminating state authority to regulate these arrangements.[20] H.R. 2563 would create two types of AHPs. For *insured* AHPs, the insurance company would be required to comply with state laws regarding solvency requirements in the state where it is licensed, as under current law. However, the *plans* offered by insurance companies to AHP members would have to comply

with the state consumer protection laws in *only one state* in which the plan is offered—even if it is offered in more than one state. Currently plans must comply with the laws in *each* state where the plan is offered. Logically, insurance companies would select states with the fewest consumer protections. Further, insured AHPs would *not* have to comply with state rating laws, limits on medical underwriting, and benefits mandates.

Even more problematic, *self-funded* AHPs would be exempt from *all* state laws and oversight—including solvency requirements and all consumer protections as well as premium rating laws, limits on medical underwriting and benefits mandates.

After careful consideration, Families USA does not find evidence that exempting AHPs from state regulation will improve the situation for small employers. Rather, we find that the current AHP proposal would not lower average premiums for small employers but would actually *increase* premiums for many small employers. In fact, costs for some employers that now offer health insurance benefits would increase so significantly that they would be forced to drop coverage. In addition, an exemption from state oversight will place consumers at a great risk for enrollment in insolvent plans—whether the financial failure is due to deliberate fraud or poor management.

AHPs: Leave Many Small Employers Behind with Higher Premiums

States enact premium rating and underwriting laws to actually require insurers to "pool" all their small employers in setting premiums. With exemptions from these state laws, AHPs will divide small employers into high-cost and low-cost groups ("segment the market"). AHPs will be able to skim low-risk employers (employers with a young, healthy workforce) from the existing state-regulated small group market by attracting them with cheaper premiums. At the same time, high-risk employers will be left behind with much *higher* premiums because they will no longer

have the benefit of cross-subsidization of costs between high- and low-risk employers. The capacity of AHPs to significantly lower premiums is very much dependent on their ability to successfully "cherry-pick" healthy members—to "rob Peter to pay Paul." *In fact, the CBO estimates that nearly two-thirds of the cost savings from AHPs would result from attracting healthier members from the pool of existing insured workers.* Without state limits, many small employers with sicker or older workers will simply be driven out of the small group health insurance market by higher premiums. The CBO estimates that 80 percent of workers would be worse off under AHPs: 20 million employees and dependents of small employers would experience a rate *increase*.[21]

Proponents of AHPs also argue that small employers should be able to offer less generous benefits packages in order to bring down the cost of coverage. And, indeed, dropping state mandated benefits would be a major method that AHPs could use to reduce costs. The CBO estimated that one-third of cost savings in AHPs would come from eliminating state benefits mandates. However, the issue goes beyond simply weighing the social and political merits of guaranteeing certain benefits against the cost of those benefits. It is not simply a question of "some coverage is better than no coverage" for workers. It is critical to examine how exempting AHPs from state benefit mandates again will allow AHPs to cherry-pick healthy people and segment the small employer insurance pool.

An exemption from key benefit mandates would allow AHPs to offer benefit packages that save money by excluding prescription drugs, mental health services, and maternity coverage, for example. But these cheaper, less comprehensive packages will attract healthy people with lower premiums because they feel confident that they won't need the missing benefits. But this financial calculation also makes the AHP plan coverage less attractive for individuals who know that they

will need these benefits—older workers, women, disabled and chronically ill individuals. Thus, the AHP can manipulate the benefits package to attract people who are young and healthy, and to discourage other people. Once again, this "adverse risk selection" ultimately leads to increased costs for the small employers and workers who are left behind to insure through the traditional, non-AHP market.

It is critical to understand that state rating laws, underwriting laws, and benefit and provider mandate laws are all designed to make coverage affordable and accessible for *all* small employers and their employees. We are willing to work with proponents of AHPs to design structures that would address some of the cost concerns of small employers. For example, a productive discussion might examine what benefits mandates are critical to prevent adverse risk selection and market segmentation. And there are some promising ideas about how small employers might be helped with the cost of insurance through a small employer tax credit. *But we are opposed to any design or structure that will lower the cost of premiums for a few lucky healthy workers at the cost of the majority of workers that are in less-than-perfect health*.

AHPs: Solvency Protections and Active Oversight Essential

In addition to our concerns about market segmentation, we are extremely concerned about protecting consumers from plan failures that leave consumers with unpaid medical claims. For self-funded AHPs, the proposed (H.R. 2563) would preempt states from continuing their traditional role of regulating such matters as solvency and consumer protections and place self-funded AHPs under the jurisdiction of the U.S. Department of Labor (DoL).

Proponents of AHPs argue that their proposal would allow pools of small employers to operate under the same rules as large self-funded employers that are governed by ERISA. While this may sound reasonable at first glance, a large self-funded employer is a very different entity

from an AHP. When a large employer self-funds, the large employer has considerable assets, revenue flow and resources to handle fluctuations in the number of claims. Further, large employers tend to be more stable entities and to have a more stable workforce so that the level of claims is predictable.

An AHP is only a shell or skeletal structure created by an association of small employers and comprised of a board of directors. The assets of the small employers who are members are available to pay medical claims if the small employers sign a promissory note to put up their business assets against future unpaid claims. However, this places employers at very serious risk of financial ruin and bankruptcy. This is because it will be very hard to predict the claims that an AHP will experience: the average small employer's workforce is much less stable—the mix of healthy, sick, young, and old is changing—and small firms are more likely to come and go. If the actual claims level exceeds what was predicted, small employers have very little cash flow or liquid assets to make up the shortfall. Thus, a self-funded AHP must operate more like an insurance company to adequately protect its members—it must offer protection against unpredicted claims fluctuations—than is true of a self-funded large employer. These new "AHP insurance companies" for small employers would be created without any of the state laws and oversight that govern the solvency of other insurance companies. The only solvency protections that will exist are those that are required by the proposed AHP legislation.

While proponents of AHPs maintain that H.R. 2564 "fixed" the solvency protection problems of past AHP proposals, we find that *the solvency requirements for self-funded AHPs are clearly not adequate.* Without elaborating on the details, provisions in the bill regarding minimum surplus, minimum reserve, and individual and aggregate stop-loss insurance must be enhanced to protect workers. Even if these solvency requirements were appropriately strengthened, in order to

provide workers in AHPs real protection, the federal government must establish a true guarantee fund sufficient in size to pay the unpaid claims of insured workers. The so-called "guarantee fund" in the AHP bill only pays the premiums for stop-loss and "indemnification insurance."[22] A true guarantee fund will require significant federal funding support from general revenues; fees or assessments from AHPs will not be adequate to create this guarantee fund.

In addition to the cost of a federal guarantee fund, we should not underestimate the cost to provide the Department of Labor with the enforcement tools, staff, and resources necessary to oversee these many new "AHP insurance companies" removed from state jurisdiction. The AHP proposal would, in effect, re-create a national insurance department to replicate the function of 50 state insurance departments. The DoL has testified that they lack the funding and manpower to take on this enormous responsibility and estimate that they could review each AHP only once every 300 years.[23] A recent GAO report found that it would take DoL's current investigative staff 90 years to do a baseline assessment of noncompliance for pension plans alone.[24]

Are opponents of AHP legislation over-reacting to the potential for fraud, abuse and insolvency? History and recent events would indicate not.

In 1974, Multiple Employer Welfare Arrangements were exempted from state regulation and placed under the authority of the Department of Labor. The members of this Committee are aware of the disastrous results: MEWA failures in the four years from 1988 to 1991 left at least 398,000 consumers with over $123 million in unpaid claims, according to a 1992 General Accounting Office report. Through hearings and review of the situation, Congress decided that MEWA regulation had to be returned to the states. We do not want to repeat this mistake by leaving AHPs exempt from state solvency and consumer protection laws.

The regulation of MEWAs or association-type health plans for small employers is an enormous task. Recent media reports have documented the failure of self-funded association-type health plans for small employers over the last six months. These failures have hurt more than 50,000 workers and their families by leaving them with millions of dollars in unpaid medical bills. By contrast, that is more than twice the number of people hurt by the ENRON benefits plan failure.[25] State and federal regulators indicate that in the last two years, the number and magnitude of association health plans' abuses have grown and that such "illegal operations are rapidly growing and spreading around the country."[26] While some of the failed health plans were clearly fraudulent criminal schemes, others were sponsored by business groups that likely could have obtained certification as AHPs under the proposed legislation.

AHPs would also be exempt from state consumer protection laws that ensure that HMOs and other insurers do not wrongfully deny health care. The recent Supreme Court decision in *Rush Prudential HMO, Inc. v. Moran* provided a victory for patients by upholding the Illinois external appeal process that gives patients a right to have impartial health experts review the denial. This right would be meaningless for any worker receiving health coverage through an AHP. Nothing in the AHP legislation would replace that right to a fair and independent review that consumer advocates, policymakers and regulators in 42 states have deemed to be essential to balance the power between consumers and health insurers.

States have passed many other health insurance consumer protection laws that would be immediately wiped out for any worker covered under an AHP. These laws protect access to specialists, continuity of care, the autonomy of the patient-physician relationship, the right to emergency care, the right to full and fair disclosure of information about coverage, and the availability and timeliness of internal appeals of denials of treatment, to name just a few key

protections. The policy decisions and best judgment of 50 state legislative bodies—reflecting the experiences and problems of people in their states as well as the political weighing of the costs and benefits of these protections—would be usurped.

In closing, we share the concern of proponents of AHP about the growing number of uninsured and, in particular, share the recognition that the rising cost of health insurance is a major barrier to small employers who want to offer coverage to their workers. We are ready and willing to work with Congress to help craft solutions to help more small employers provide health insurance coverage. But we must be sure that what we design does not deliver more harm than help to workers and owners of small firms.

[1] Catherine Hoffman and Mary Beth Pohl, *Health Insurance Coverage in America: 2000 Data Update* (Washington, D.C.: The Henry J. Kaiser Family Foundation, February 2002).
[2] Families USA, *Key Facts About the Uninsured* (Washington, D.C.: Families USA, April 2001).
[3] Peter J. Cunningham, Elizabeth Schaefer, and Christopher Hogan, *Who Declines Employer-Sponsored Health Insurance and Is Uninsured?* (Washington, D.C.: Center for Studying Health System Change, October 1999).
[4] Kathleen Stoll, *The Health Care Safety Net: Millions of Low-Income People Left Uninsured* (Washington, D.C.: Families USA, July 2001).
[5] The eight states which have expanded Medicaid to cover childless adults are: Arizona, Delaware, Hawaii, Massachusetts, New York, Oregon, Tennessee, and Vermont. Three states finance coverage to childless adults entirely with state funds: Minnesota, New Jersey, and Washington. However these three state funded programs are not entitlement programs.
[6] Kathleen Stoll, *Research Shows the Negative Impact of Out-of-Pocket Costs on Low-Income People* (Washington, D.C.: Families USA, August 2001); see also Families USA, "Increased Premiums and Cost-Sharing" in *Preserving Medicaid in Tough Times: An Action Kit for State Advocates* (Washington, D.C.: Families USA, April 2002).
[7] Kathleen Stoll and Erica Molliver, *A 10-Foot Rope for a 40-Foot Hole: Tax Credits for the Uninsured, 2002 Update* (Washington, D.C.: Families USA, May 2002).
[8] Karen Pollitz, Richard Sorian, and Kathy Thomas, *How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (Washington, D.C.: The Henry J. Kaiser Family Foundation, June 2001).
[9] Testimony of Steven B. Larsen, Insurance Commissioner, State of Maryland, before the Subcommittee on Health of the House Committee on Ways and Means, U.S. Congress, April 4, 2001.
[10] Kathleen Stoll, *The Health Care Safety Net: Millions of Low-Income People Left Uninsured* (Washington, D.C.: Families USA, July 2001).
[11] Ibid.
[12] The estimated average cost based on hospital claims data for postnatal car for women without prenatal care was $3,930, compared to a woman who had had prenatal care - $1,589. The average charge for a 35 week infant was 18 times, and a 36 week infant was five times more costly than a term (37 week) infant. That translates into $500,000 or more per baby for complicated births and follow-up care. See M.C. Lu, Y.G. Lin, N.M. Prietto, and T.J. Garite. "Elimination of public funding of prenatal car for undocumented immigrants in California: A cost/benefit analysis," *American Journal of Obstetrics and Gynecology*, *181*, no.1, January 2000. See also J.J. Fangman, P.M. Mark, L.P. Pratt, K.K. Conway, M.L. Healey, J.W. Oswald, and D.L. Uden, "Prematurity prevention programs: An analysis of successes and failures," *American Journal of Obstetrics and Gynecology*, *170*, no. 3, March 1993.
[13] Charles D. Spencer and Associates, *2000 COBRA Survey: One in Five Elect Coverage, Cost is 154% of Active Employees' Cost* (Chicago, IL: Spencer's Benefit Reports, 2000); see also Kathleen Stoll, *More Than 725,000 Laid-Off Workers Have Lost Health Coverage Since the Recession Began in March* (Washington, D.C.: Families USA, December 2001).
[14] Larry Levitt, Erin Holve, and Jain Wang, *Employer Health Benefits: 2001 Annual Survey* (Menlo Park, CA: The Henry J. Kaiser Family Foundation and the Health Research and Educational Trust, September 2001). Average premiums vary from state to state; for example, in Connecticut and New Jersey, a family would pay more than $8,000 annually.
[15] Kathleen Stoll, *More Than 725,000 Laid-Off Workers Have Lost Health Coverage Since the Recession Began in March* (Washington, D.C.: Families USA, December 2001).
[16] Proponents of AHP legislation maintain that group purchasing will achieve savings and Families USA does not challenge this assertion. However, when the bipartisan Congressional Budget Office examined this question, they found "…no substantial evidence that joining a purchasing cooperative produced lower insurance costs for firms." In fact, CBO points out that the minimal savings from group purchasing is unlikely to induce many small firms to add coverage *because the group purchasing option is already available to the vast majority of small employers*." (italics added). In addition to the CBO report, researchers examining data from 1993 and 1997 employer surveys found that the three largest statewide small-group purchasing alliances—in California, Connecticut, and Florida—did not increase coverage and did not reduce small group market health insurance premiums. Other noted researchers examining the issue have also concluded that AHPs "are not likely to produce a significant overall reduction in premiums or increase in coverage." William M. Mercer, Inc., a human resources business consulting firm, has stated that AHPs "…would provide no material opportunity for AHPs to reduce health insurance administrative costs for small businesses."

[17] Some states have "fictitious group laws" that prevent small employers from forming a group or association for the sole purpose of purchasing insurance. These laws require that the association have some other common legitimate purpose. These laws are designed to prevent the most blatant artificial segmentation of the small group insurance market and the higher premium consequences that it would have for the small employers who are not able to join the association.

[18] Stephen Long and Susan Marquis, "Pooled Purchasing: Who Are the Players?" *Health Affairs*, Vol. 18, no. 4, July/August 1999, p. 107. Group purchasing arrangements include Multiple Employer Welfare Arrangements (MEWAs), multiple employer trusts (METs), Health Insurance Purchasing Coalitions (HIPCs) professional and trade associations, employer coalitions, and alliances for their health insurance coverage.

[19] The DoL has made clear that state solvency laws are applicable to MEWAs and provide important protections against plan failure in addition to the protections provided by ERISA. However, there are problems with the definition of MEWAs in the ERISA law that allow some entities to assert an ERISA preemption shield that then requires states to go to court to assert state jurisdiction and regulate the entities (for example, in employee leasing company situations and certain other fraudulent underlying associations). This definitional confusion about the authority and scope of state jurisdiction over MEWAs has allowed some MEWAs to be poorly managed and also created opportunities for fraudulent association-type schemes. There is a definite need to provide some clarification and improvement in current MEWA law, but the proposed AHP legislation is not the best way to address flaws in the current MEWA laws.

[20] H.R. 2563's preemption provisions also create ambiguity under ERISA. The bill would preempt state laws that "may preclude" or merely have the "effect of precluding" entities from selling coverage to a federally licensed association (see § 421(b) amending ERISA § 514). These ambiguities make it easier for fraudulent scheme avoid state regulation.

[21] Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts*, (Washington, D.C.: Congressional Budget Office, January 2000).

[22] There are a number of problems with the reliance on stop-loss insurance and "indemnification insurance" in the current AHP proposal as mechanisms to make sure that individual workers are not left with unpaid medical claims. Five of the most important problems are: First, these mechanisms would provide payment directly to an AHP even if the AHP is mismanaged or fraudulent. There is no guarantee that the money would then go to pay workers' unpaid medical bills. Second, some risk is assumed by the AHP with stop-loss insurance and the protection of stop-loss insurance can leave a "gap" in unpaid claims before it provides help. The current AHP proposal allows AHPs to assume significant risk and leaves a significant gap because of a high attachment point. Third, stop-loss insurance may only pay a percentage of the claims when it does provide help, and may not pay claims for pre-existing conditions. Fourth, stop-loss insurance should help both when an individual claim is very high or the total of all claims is very high—individual and aggregate stop-loss. The AHP bill does not require both types of stop-loss insurance. Fifth, "indemnification insurance" as defined in the AHP bill does not currently exist. This product would need to be developed to fill in the gap left by stop-loss insurance when an AHP is mandatorily terminated. It is not clear why it would be a profitable endeavor to offer such a product.

[22] One of the primary reasons for these recent failures is the lack of clarity with regard to the states' ability to assert jurisdiction over these self-funded plans because of problems with the scope of the definition of MEWAs in ERISA. See footnote 19.

[23] Testimony of Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration, before the Senate Labor and Human Resources Committee, October 1, 1997, at pp. 9-11.

[24] U.S. General Accounting Office, *Pensions and Welfare Benefits Administration: Opportunities Exist for Improving Management of the Enforcement Program*, GAO-02-232, at p. 3 (March 15, 2002).

[25] One of the primary reasons for these recent failures is the lack of clarity with regard to the states' ability to assert jurisdiction over these self-funded plans because of problems with the scope of the definition of MEWAs in ERISA. See footnote 19. For a description of these failures, see Kofman, Mila, "Health Insurance Scams Promoted Through Associations: A Primer, Draft dated July 1, 2002 provided by the author and copy on file at Families USA. Submitted and expected publication in *The Insurance Receiver*, Vol.11, no. 3, Fall 2002. *The Insurance Receiver* is the quarterly journal of the International Association of Insurance Receivers.

[26] Ibid citing a telephone conversation with Fred Nepple, General Counsel for the Wisconsin Insurance Department, Chairperson of the National Association of Insurance Commissioners' ERISA Working Group (and a leading expert on association health plans and MEWAs) (April 24, 2002).