

POLICY ESSAY

SMALL BUSINESS HEALTH PLANS: A CRITICAL STEP IN SOLVING THE SMALL BUSINESS HEALTH CARE CRISIS

SENATOR OLYMPIA J. SNOWE*

In this Policy Essay, Senator Olympia J. Snowe argues that passage of Small Business Health Plan (SBHP) legislation will address the critical health insurance needs of small business employees by fueling a more competitive market for coverage. Senator Snowe highlights the legislation's provisions, debunks common criticisms of SBHPs, and recommends the enactment of SBHP legislation as a means to ameliorate the lack of affordable health insurance coverage for small business employees.

Across the country, the number one issue I hear, time and time again, is how soaring costs have moved health care far beyond the reach of the average American citizen. Issues like Supreme Court confirmations and the war against terrorism dominate headlines. But a far more pressing policy concern—one that has not received much attention by the mainstream media—is the rising number of uninsured Americans, in particular those who work for small businesses.

The American people have consistently and overwhelmingly told Congress that action is needed to address access to affordable health insurance and the explosive growth in premiums. In four of the past five years, health insurance costs have increased by double-digit percentages.¹ Health insurance costs are on pace to become the largest share of employers' total benefit packages, surpassing total retirement benefits.² According to a December 2004 study by the Employee Benefit Research Institute ("EBRI"), health care spending in 2004 constituted 43.2% of employers' total benefit spending, up from 36.3% in 1990.³

* Member, United States Senate (R-Me.). Senator Snowe serves as chair of the Senate Committee on Small Business & Entrepreneurship. Member, United States House of Representatives, 1978–94; Member, Maine State Legislature, 1973–78. I would like to thank Alexander N. Hecht, J.D., LL.M., Regulatory Counsel for the Senate Committee on Small Business & Entrepreneurship, for his research assistance on this Policy Essay.

¹ See Press Release, Kaiser Family Found., Survey Shows Private Health Insurance Premiums Rose 11.2% in 2004 (Sept. 9, 2004), available at <http://www.kff.org/insurance/chcm/090904nr.cfm>; see also KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS 2005 ANNUAL SURVEY 1 (2005), available at <http://www.kff.org/insurance/7315/upload/7315.pdf>.

² Michael W. Wyland, *Health Care Costs on Track to Become Largest Portion of Employer's Benefit Costs*, BNA DAILY REPORT FOR EXECUTIVES, Jan. 3, 2006, at A-6 (citing Ken McDonnell, *Finances of Employee Benefits: Health Costs Driving Changing Trends*, EBRI NOTES, Dec. 2005, at 2).

³ See *id.* at A-5.

Further compounding the problem, small businesses are trapped in dysfunctional small group insurance markets lacking meaningful competition, in which only a handful of larger insurers offer few coverage choices. Unfortunately, the United States Senate has failed to pass legislation to confront this deepening national crisis that continues to harm small businesses' ability to create jobs and compete in today's global economy.

One critical solution to the small business health care crisis is Small Business Health Plan ("SBHP") legislation. In February 2005, I introduced the Small Business Health Fairness Act of 2005,⁴ a bill that would allow small businesses to band together in SBHPs, offered through professional associations. These SBHPs would allow small businesses to offer quality health insurance to their employees across state lines with uniform benefits packages and at lower costs. Touted by President George W. Bush and supported by a coalition representing over twelve million employers and eighty million employees, SBHPs represent a fair, fiscally sound, and tested approach to reducing the number of uninsured Americans at nominal cost to the federal government.⁵

In this Policy Essay, I examine the plight of America's uninsured, with a specific focus on the deepening health insurance crisis that now confronts small businesses. I argue that the small group insurance market reforms in the Health Insurance Portability and Accountability Act ("HIPAA") of 1996⁶ have failed to produce meaningful competition among insurers and choices for small businesses. Finally, I advocate for SBHP legislation, a critical component to solving the small business health insurance crisis, and dispel myths and untruths about SBHPs that have persisted for the past decade.

I. REDUCING THE NUMBER OF UNINSURED AMERICANS

A. *Negative Coverage Trends for Small Business*

The plight of the uninsured continues to be one of America's most pressing domestic problems. According to the United States Census Bureau, there are now 45.8 million uninsured Americans.⁷ This number has

⁴ S. 406, 109th Cong. (2005).

⁵ In April 2005, the Congressional Budget Office ("CBO") issued a formal cost estimate of the House version of Senate Bill 406 (H.R. 525, 109th Cong. (2005)). The CBO estimated that Senate Bill 406 would cost \$4 million in 2006; \$55 million over the 2006–2010 period; and \$136 million from 2006 to 2015. They further predicted that the Department of Labor ("DOL") would need to hire 150 workers over the next three years to certify and regulate SBHPs. See CONG. BUDGET OFFICE, COST ESTIMATE, H.R. 525: SMALL BUSINESS HEALTH FAIRNESS ACT OF 2005 2 (2005), available at <http://www.cbo.gov/ftpdocs/62xx/doc6265/hrs2s.pdf>.

⁶ Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 29 U.S.C., 42 U.S.C., 18 U.S.C., and 26 U.S.C.).

⁷ See U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2004, 16 (2005).

risen dramatically this decade, increasing 800,000 since 2003⁸ and over 4,000,000 since 2001.⁹ In my home state of Maine, 130,000 people lacked health insurance in 2004.¹⁰ According to the Congressional Research Service (“CRS”), the number of uninsured has risen almost every year since 1989 and is expected to continue rising into the future.¹¹

The increasing number of uninsured Americans is just one in a series of alarming trends in our nation’s health care crisis. Approximately fifty-two percent of the nation’s 23.7 million uninsured citizens work for a small business with fewer than 100 employees or are dependent on someone who does.¹² According to an October 2005 study by EBRI, individuals without health insurance are more likely to be from families whose family head works for a small firm rather than a large one.¹³ Furthermore, individuals with a family head working in a firm with fewer than 10 workers have a 30.9% probability of being uninsured.¹⁴

Clearly, the size of an employer plays a pivotal role in whether that employer will offer health insurance as a workplace benefit. Small employers are far less likely than larger employers to provide health insurance to their workers.¹⁵ The 2005 Kaiser Family Foundation Survey of Employer Health Benefits found that only 59% of all small firms (defined as firms with 3 to 199 employees) provide health insurance.¹⁶ Insurance is provided in a meager 47% of companies with 3 to 9 employees; 72% of companies with 10 to 24 workers; 87% of companies with 25 to 49 workers; and 93% of companies with 50 to 199 employees.¹⁷ In contrast, health insurance is nearly universally offered as an employer-provided benefit in larger firms (200 or more employees), which offer insurance to 98% of their employees.¹⁸

Further compounding matters, these numbers are moving in the wrong direction. This is particularly true in my home state of Maine. The Maine Center for Economic Policy (“MECEP”) recently surveyed 1254 small

⁸ *See id.*

⁹ *See* U.S. CENSUS BUREAU, U.S. DEP’T OF COMMERCE, HEALTH INSURANCE COVERAGE: 2001, 1 (2002).

¹⁰ *See* CONG. RESEARCH SERV., HEALTH INSURANCE: UNINSURED BY STATE, 2004, 5 (2005).

¹¹ *See* CONG. RESEARCH SERV., ASSOCIATION HEALTH PLANS, HEALTH MARTS AND THE SMALL GROUP MARKET FOR HEALTH INSURANCE 1 (2005).

¹² *See* CONG. RESEARCH SERV., *supra* note 10, at 4.

¹³ *See* PAUL FRONTSTIN, EMPLOYEE BENEFIT RESEARCH INST., UNINSURED UNCHANGED IN 2004, BUT EMPLOYMENT-BASED HEALTH COVERAGE DECLINED, EBRI NOTES 3 (2005).

¹⁴ *See id.*

¹⁵ *See* KAISER FAMILY FOUND. AND HEALTH RESEARCH AND EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2005 ANNUAL SURVEY 4 (2005) (reporting that only 47% of small businesses, with 3 to 9 employees, currently provide health insurance to their employees, down from 52% in 2004 and 58% in 2002).

¹⁶ *See id.*

¹⁷ *See id.*

¹⁸ *See id.*

business owners in Maine.¹⁹ Over the past five years, the rate of coverage offered by small businesses with 2 to 10 employees has dropped from 62% to 43%.²⁰ The MECEP survey reported that Maine small businesses have experienced an average annual premium increase of 15% over the past three years.²¹ To cope with this escalating health insurance inflation small business have done three things: 28% of Maine small businesses have reduced health benefits;²² at their last insurance renewal, over 25% have delayed pay raises to their employees in order to pay for health insurance;²³ and 8% have dropped health insurance coverage entirely.²⁴

With each passing year that Congress fails to address the small business health insurance crisis, fewer and fewer small businesses are able to offer health insurance as a workplace benefit. This is simply unconscionable. Access to affordable health insurance is the number one issue facing small businesses,²⁵ and it is one that my colleagues and I hear time and time again. Small businesses are the engine that drives America's economy, generating between 60% and 80% of net new jobs each year for the past decade.²⁶ And yet, when it comes to securing quality, affordable health insurance, small businesses are treated like the pariahs of the insurance market. Congress should consider and pass SBHP legislation this year to help resolve the burgeoning small business health insurance crisis.

B. Small Businesses Bear a Disproportionate Burden of Health Care Cost Increases

Escalating cost is the primary reason that small businesses do not offer health benefits. A study by the Small Business Administration's Office of Advocacy ("Office of Advocacy") found that "price is the major factor affecting small firms' ability to offer health insurance for [their] employees."²⁷ In four of the past five years, small businesses have experienced double-digit premium increases that far outpaced wage gains and inflation. Health insurance premiums increased by 10.9% in 2001, 12.9% in 2002,

¹⁹ See FRANK O'HARA & LISA POHLMANN, MAINE CENTER FOR ECONOMIC POLICY, MAINE SMALL BUSINESS HEALTH INSURANCE: A 2004 SURVEY 1 (2005).

²⁰ See *id.*

²¹ See *id.* at 12 (stating that even the "good news" of an 11% average premium increase in 2003–2004 "remains well over the general rate of inflation, and is a burden for small businesses").

²² See *id.* at 13.

²³ See *id.*

²⁴ See *id.* at 1.

²⁵ NATIONAL FEDERATION OF INDEPENDENT BUSINESS (NFIB), HEALTH CARE: COST VERSUS VALUE—CHOICE VERSUS CHANGE: SMALL BUSINESS OWNERS CONSIDER THE FUTURE OF HEALTH CARE 3 (2003), available at <http://ahps.ion.nfib.com/object/IO16330.html> ("Health care costs have been NFIB members' number one priority since 1986.").

²⁶ OFFICE OF ADVOCACY, SMALL BUS. ADMIN., Small Business Frequently Asked Questions, <http://www.app1.sba.gov/faqs/faqindex.cfm?areaID=24> (last visited Apr. 15, 2006).

²⁷ OFFICE OF ADVOCACY, SMALL BUS. ADMIN., STUDY OF ADMINISTRATIVE COSTS AND ACTUARIAL VALUES OF SMALL HEALTH PLANS 1 (2003).

13.9% in 2003, 11.2% in 2004, and 9.2% in 2005.²⁸ The smallest firms (three to twenty-four employees) saw their premiums increase by 13.6% in 2004.²⁹ Subsequently, a 2004 Kaiser survey questioned whether “smaller firms will continue to support family coverage for their employees as costs continue to rise.”³⁰

The Office of Advocacy has found that small businesses typically spend much more than larger businesses for the same benefits.³¹ According to an Office of Advocacy study, “administrative costs of some benefits are almost fourteen times more for the smallest firms than for their largest counterparts.”³² When small firms pay the same amount for coverage as larger firms pay, the coverage for these small firms is less generous than for larger businesses.³³

In addition, employees in smaller firms must absorb a greater portion of their plan’s administrative costs due to the smaller number of employees in their purchasing group. According to the Government Accountability Office (“GAO”), “[f]rom twenty to twenty-five percent of small employers’ premiums typically go toward expenses other than benefits, compared with about ten percent for large employers.”³⁴ The Office of Advocacy found that, “for the same claims per covered employee or enrollee, small group plans pay up to twenty to thirty percent more in total premiums than larger health plans. Administrative expenses for small group plans are three to seven times higher as a percentage of claims.”³⁵ Thus, small businesses generally bear a much higher cost burden than large businesses in providing health insurance for their employees.

C. HIPAA’s Small Group Market Reform Has Failed To Help Small Businesses

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) is a comprehensive federal statute addressing the portability of employer health plans and ensuring the privacy and security of patient

²⁸ See KAISER FAMILY FOUND. AND HEALTH RESEARCH AND EDUC. TRUST, *supra* note 15, at 1.

²⁹ See *id.* at 18.

³⁰ *Id.* at 8.

³¹ See OFFICE OF ADVOCACY, *supra* note 27, at 1 (“Small health plans have higher administrative expenses than larger employers in the form of higher broker commissions, underwriting expenses and other expenses related to operating a health plan.”).

³² OFFICE OF ADVOCACY, SMALL BUS. ADMIN., COST OF EMPLOYEE BENEFITS IN SMALL AND LARGE BUSINESSES 35 (2005).

³³ See OFFICE OF ADVOCACY, *supra* note 27, at 43 (“The largest firms, firms with union employees, and firms with higher percentage of workers with high wages had more generous health plans while the smallest firms and construction firms had less generous health plans.”).

³⁴ U.S. GEN. ACCOUNTING OFFICE, PRIVATE HEALTH INSURANCE: SMALL EMPLOYERS CONTINUE TO FACE CHALLENGES IN PROVIDING COVERAGE 3 (2001).

³⁵ OFFICE OF ADVOCACY, SMALL BUS. ADMIN., STUDY OF ADMINISTRATIVE COSTS AND ACTUARIAL VALUES OF SMALL HEALTH PLANS 31 (2003).

health information.³⁶ It was also created in part with the purpose of reforming the small employer, or small group, insurance market.³⁷ However, it has utterly failed to spur competition and choices in the small group market.

Before HIPAA provided a federal framework for employee health insurance, many states enacted regulations in the early 1990s to make health insurance easier to purchase when moving from job to job.³⁸ Many states also enforced similar provisions for small group market reform.³⁹ Thirty-eight states had varying guaranteed issue laws, which typically precluded health insurance companies from denying coverage to any individual who applied for insurance in the small group market.⁴⁰ Forty-three states had guaranteed renewal requirements, such as health insurance policies that once in place must be renewed at the request of the insured, may not be canceled so long as premiums are paid, and must be renewed without discrimination at the same rate.⁴¹ However, roughly half of the states with guaranteed issue laws prior to HIPAA's enactment applied them only to insurance plans with standardized benefits that were designed for higher risk subscribers.⁴²

The enactment of HIPAA in 1996 changed these inconsistencies by imposing a universal guaranteed issue requirement in state small group markets.⁴³ Each health insurance issuer that offers health insurance in the small group market must accept every small employer that applies for coverage, regardless of the employer's claim history or health status; must accept under such coverage every eligible individual who applies for enrollment; and may not place any restrictions inconsistent with these requirements on an employee being a participant or beneficiary.⁴⁴ By allow-

³⁶ Joy L. Pritts, *Altered States: State Health Privacy Laws and the Impact of the Federal Health Privacy Rule*, 2 YALE J. HEALTH POL'Y L. & ETHICS 325, 341 (2002).

³⁷ Mark A. Hall, *The Competitive Impact of Small Group Health Insurance Reform Laws*, 32 U. MICH. J. L. REFORM 685, 691 (1999) (stating that all insurance policies offered in a state small group market must be "guaranteed issue," or made available to all small businesses in the state).

³⁸ See Timothy S. Jost, *Private or Public Approaches to Insuring the Uninsured: Lessons from International Experience with Private Insurance*, 76 N.Y.U. L. REV. 419, 465 (2001).

³⁹ See *id.*

⁴⁰ CONRAD F. MEIER, DESTROYING INSURANCE MARKETS: HOW GUARANTEED ISSUE AND COMMUNITY RATING DESTROYED THE INDIVIDUAL HEALTH INSURANCE MARKET IN EIGHT STATES 8 (2005).

⁴¹ See *id.* (citing GAIL A. JENSEN & MICHAEL A. MORRISEY, MANDATED BENEFIT LAWS AND EMPLOYER-SPONSORED HEALTH INSURANCE 4 (1999)); see also Mark A. Rothstein, *Genetic Privacy and Confidentiality: Why They Are So Hard To Protect?*, 26 J. L. MED. & ETHICS 198, 199 (1998).

⁴² See Mark A. Hall, *HIPAA's Small-Group Access Laws: Win, Loss, or Draw?*, 22 CATO J. 71 (2002).

⁴³ See Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 29 U.S.C., 42 U.S.C., 18 U.S.C., and 26 U.S.C.).

⁴⁴ See GRETA E. COWART, HIPAA NONDISCRIMINATION AND PORTABILITY UPDATED AND EXPANDED 4 (2005); see also Hall, *supra* note 37, at 691.

ing higher risk purchasers to choose any of an insurer's offerings in the small group market, HIPAA supporters argue that it "took what existed in most states and made it universal."⁴⁵

HIPAA defines the small group market as covering businesses that have employed an average of two to fifty employees during the preceding calendar year and have employed at least two employees on the first day of the plan year.⁴⁶ As discussed above, HIPAA's enactment marked a significant change in how insurance companies provide health insurance products in the small group markets.⁴⁷ Unlike the individual and large group markets, which are not subject to a federal guaranteed issue requirement, the small group market reform under HIPAA meant that any small business that fit the two to fifty employee definition under HIPAA would provide guaranteed access to whatever policies that insurance companies offered in the small group market.⁴⁸ The success of this policy goal, of course, relied on the assumption that insurance companies would in fact offer a range of affordable, quality coverage options after HIPAA's enactment.⁴⁹

Unfortunately, the HIPAA small group market reform has provided little assistance in helping small businesses that are seeking more affordable health insurance options.⁵⁰ Skeptics point out that HIPAA's small group market reform is fraught with hidden costs, including the foreclosure of market innovations and the creation of new administrative burdens on the state level.⁵¹ They also argue that HIPAA has actually driven health care costs up in the small group market, because it incentivizes healthy groups to wait until one of their employees becomes sick before buying insurance.⁵² This holds true because under HIPAA's guaranteed issue requirement, any small business with two to fifty employees would be automatically eligible to participate in any health insurance products offered in the small group market, regardless of how sick or old their employees may be.⁵³ Rather than offering health insurance to younger, healthier workers, small businesses could wait until these employees grow older or become sicker and thus increase the cost of providing insurance overall via insurance premium hikes.⁵⁴

⁴⁵ Hall, *supra* note 42, at 71.

⁴⁶ 42 U.S.C. § 300gg-11 (2000).

⁴⁷ See Hall, *supra* note 37, at 691.

⁴⁸ *Id.*

⁴⁹ See Hall, *supra* note 42, at 72.

⁵⁰ See Tom Miller, *The Health Insurance Portability and Accountability Act: More Than We Bargained for, and Less*, 22 CATO J. 1 (2002).

⁵¹ See Hall, *supra* note 42, at 72.

⁵² See generally MEIER, *supra* note 40 (detailing how guaranteed issue and community ratings have sometimes adversely affected private insurance markets in various states).

⁵³ Hall, *supra* note 37, at 691.

⁵⁴ See Ann Hilton Fisher, *Small Employers and the Health Insurance Needs of Employees with High Health Care Costs*, 8 EMPL. RTS. & EMPLOY. POL'Y J. 53, 53-55 (2004) (indicating that strong incentives exist to drop the insurance of those employees whose medi-

Further compounding this problem is a simple business reality: small businesses have limited resources and operating budgets.⁵⁵ In my experience as Chair of the Senate Committee on Small Business and Entrepreneurship, most small businesses desperately want to provide health insurance to their employees. Health insurance is a critically important component to attracting quality workers and remaining competitive with larger businesses.⁵⁶ And yet, rising costs have moved the accessibility of health care far beyond the reach of our nation's smallest businesses.⁵⁷ As a result, I have witnessed these "micro" small employers, especially those with fewer than ten employees, often wait until one of their employees needs coverage before obtaining it. When employers with healthy employees take their money out of the system and sit on the market sidelines, health insurance premiums increase, forcing other small employers to drop coverage. When small businesses finally decide to purchase health insurance, they find themselves trapped in dysfunctional state small group markets that are dominated by a small handful of larger insurers who offer very few affordable coverage options.⁵⁸

D. HIPAA's Guaranteed Issue Mandate Has Contributed to the Lack of Competition in the Small Group Insurance Market

HIPAA's guaranteed issue mandate has suppressed competition in the small group market. In addition, some states, including Maine, have enacted modified community rating laws that limit the factors by which an insurance company can modify health insurance premiums.⁵⁹ With their profit potential being threatened, many insurance companies have pulled

cal needs increase health care costs).

⁵⁵ Amy Bushaw, *Small Business, Local Culture and Global Society: Some Examples from the United States*, 5 J. SMALL & EMERGING BUS. L. 223, 223–25 (2001) (stating that due to economies of scale, small businesses face many financial challenges that larger businesses do not face).

⁵⁶ See Dayna Bowen Matthew, *Controlling the Reverse Agency Costs of Employment-Based Health Insurance: Of Markets, Courts, and a Regulatory Quagmire*, 31 WAKE FOREST L. REV. 1037, 1039 (1996); see also Jodie Snyder, *Small Business Juggles Health Plan Options* (Jan. 17, 2006), available at <http://www.azcentral.com/health/news/articles/0117HCR-cereus17.html>

⁵⁷ Ronald Wilson, *Federal Tax Policy: The Political Influence of American Small Business*, 37 S. TEX. L. REV. 15, 37 (1996) (indicating that a lack of affordable health plans is the most common reason why small businesses do not provide health insurance coverage for their employees).

⁵⁸ See U.S. GEN. ACCOUNTING OFFICE, PRIVATE HEALTH INSURANCE: NUMBER AND MARKET SHARE OF CARRIERS IN THE SMALL GROUP HEALTH INSURANCE MARKET, GAO-02-536Ra, at 2 (2002), <http://www.gao.gov/new.items/d02536r.pdf> (stating that five or fewer insurers control at least three-quarters of the small group market in most states, and this lack of competition contributes to double-digit rate increases for many small businesses).

⁵⁹ Ann Hilton Fisher, *Small Employers and the Health Insurance Needs of Employees with High Health Care Costs: A Need for Better Models*, 8 EMPL. RTS. & EMPLOY. POL'Y J. 53, 77–78 (2004) (stating that nineteen states have adopted some type of community rating including Maine, New York, New Jersey, Massachusetts, and Vermont).

out of the small group market.⁶⁰ Further exacerbating the problem, HIPAA contains an exclusion clause barring an insurer that has pulled out of the small group market from re-entering the market for six months.⁶¹

In May 2005, along with Senators Christopher “Kit” Bond (R-Mo.) and Jim Talent (R-Mo.), I requested that the GAO research the competitiveness of small group health insurance markets in every state.⁶² For each state, I requested that the GAO determine the total number of licensed health insurance carriers; the largest carrier and its market share; the combined market share of the five largest carriers; and the rank of the largest Blue Cross/Blue Shield (“BCBS”) carrier, as well as the combined market share of all BCBS carriers.⁶³

The GAO report, released in October 2005, revealed that a handful of large insurance carriers dominate the small group market, leaving small businesses with few, if any, choices when it comes to securing affordable, quality health insurance for their employees. More specifically, the GAO discovered that the median market share of the largest small group carrier was about 43% in 2005, compared to 33% in 2002; when combined, the five largest carriers in the small group market represent 75% or more of the market in 26 of the 34 states that supplied information, up from 19 states in 2002; and the median market share of all BCBS carriers was about 44%, up from 34% in 2002.⁶⁴

There are simply too few health insurance carriers competing in the small group market. This lack of competition has contributed to higher prices for the handful of products that do exist in the small group market.⁶⁵ According to a recent report jointly issued by the Federal Trade Commission and the Department of Justice, “competition generally results in lower prices and, thus, broader access to health care products and services Vigorous competition promotes the delivery of high-quality, cost-effective health care.”⁶⁶ Thus, the lack of competition amongst carriers

⁶⁰ Susan Adler Channick, *Come the Revolution: Are We Finally Ready for Universal Health Insurance?*, 39 CAL. W. L. REV. 303, 307–08 (2003) (arguing that to compete profitably, health plans “began experience rating their insurance pools, i.e., rating on the basis of risk experience, rather than using community rating”).

⁶¹ See 42 U.S.C. § 300gg-11(c)(2) (2000).

⁶² See Letter from Olympia J. Snowe, Christopher Bond & Jim Talent, U.S. Senators, to Kathryn G. Allen, Director, U.S. Gov. Accountability Office (May 9, 2005) (on file with author). This letter followed up on a prior request made in 2002 by Senator Bond. See U.S. GEN. ACCOUNTING OFFICE, *supra* note 58, at 1–2.

⁶³ See Letter from Olympia J. Snowe, Christopher Bond & Jim Talent to Kathryn Allen, *supra* note 62.

⁶⁴ See GOV. ACCOUNTABILITY OFFICE, PRIVATE HEALTH INSURANCE: NUMBER AND MARKET SHARE OF CARRIERS IN THE SMALL GROUP HEALTH INSURANCE MARKET IN 2004 2 (2005).

⁶⁵ Bushaw, *supra* note 55, at 223–25.

⁶⁶ FED. TRADE COMM’N & DEP’T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 4 (2004).

in the small group market has contributed to rising health care costs and has narrowed available options for employees.⁶⁷

In this way, small businesses are being trapped in stagnant, dysfunctional health insurance markets, in which prices are spiraling out of control and viable coverage options have moved far beyond their budgetary reach.⁶⁸ In Maine, BCBS now controls 63% of the small group market, while the five largest carriers dominate 98% of the market.⁶⁹ I recently met with representatives from the Maine Association of Realtors, who explained to me how the only “affordable” coverage option in their insurance market is “catastrophic coverage.” On top of already expensive premiums, the realtors pay deductibles ranging from \$5,000 to \$15,000 for policies that fail to offer basic health insurance coverage. This situation is unacceptable, and Congress must take immediate action to address the problem.

II. SOLUTION: SMALL BUSINESS HEALTH PLAN LEGISLATION

One effective solution that Congress could adopt is SBHP legislation. In February 2005, I introduced “The Small Business Health Fairness Act of 2005.”⁷⁰ My bill offers a fair, common-sense solution to the problem of rising health care costs. It unleashes the power of the competitive market to provide small businesses with more choices when it comes to securing affordable, quality insurance coverage. Just like larger businesses and unions, small businesses should have the option to purchase health plans across state lines with uniform benefits packages.

SBHPs were originally conceived in the mid 1990s as a response to the Clinton Administration’s effort to overhaul the nation’s health care system with a delivery/payment system to be run by the federal government.⁷¹ SBHPs allow small businesses to purchase cheaper employee health insurance by joining together, or “pooling,” in order to increase their bargaining power and reduce administrative costs. A recent Small Business Administration’s Office of Advocacy (“Office of Advocacy”) report validates the potential savings inherent in SBHPs: “Allowing small firms greater access to methods of pooling risk and administrative costs in both pension plans and health insurance may also encourage a wider offering of

⁶⁷ See *supra* note 58 and accompanying text.

⁶⁸ Jeffrey Ralph Pettit, *Help! We’ve Fallen and We Can’t Get Up: The Problems Families Face Because of Employment-Based Health Insurance*, 46 VAND. L. REV. 779, 799 (1993) (“Small businesses are unable to absorb rising insurance premiums that derive from astronomical increases in health care costs, and are forced to limit or to discontinue employee health benefit plans.”).

⁶⁹ Gov. ACCOUNTABILITY OFFICE, *supra* note 62, at 2.

⁷⁰ S. 406, 109th Cong. (2005).

⁷¹ Tiana Velez, *Small Business Insurance Groups Likely*, ARIZ. DAILY STAR, Apr. 3, 2006, available at <http://www.azstarnet.com/business/122750> (providing a detailed time line of the political path traveled by SBHP legislation, which dates back to 1995).

those benefits.”⁷² The National Federation of Independent Business further concluded that “[t]he administrative costs of SBHPs are lower, on average, than those achieved by other small health plans, for-profit Medicaid plans, and not-for-profit Medicaid plans.”⁷³

Thus, SBHP legislation would spur competition in stagnant insurance markets in which small businesses have few viable coverage choices. It would allow small businesses to shop for quality health insurance plans with much lower administrative costs, while at the same time shrinking the ranks of the nearly forty-six million uninsured Americans at virtually no cost to the federal government.

SBHPs have been widely supported both by President Bush as well as a coalition of more than 190 associations representing twelve million employers and eighty million employees.⁷⁴ In July 2005, the House of Representatives overwhelmingly passed SBHP legislation⁷⁵ for the eighth consecutive time.⁷⁶ In the Senate, SBHPs have received unprecedented attention. On April 20, 2005, I chaired a hearing in the Senate Committee on Small Business and Entrepreneurship, which focused on SBHPs.⁷⁷ On the following day, the Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing also focused on SBHPs.⁷⁸

⁷² OFFICE OF ADVOCACY, SMALL BUS. ADMIN., COST OF EMPLOYEE BENEFITS IN SMALL AND LARGE BUSINESSES 2 (2005).

⁷³ ANTHONY C. RUCKS, A STUDY OF THE ADMINISTRATIVE COSTS ACCRUING TO ASSOCIATION HEALTH PLANS 12 (2005) (asserting that the lower administrative costs of SBHPs have been achieved by lower marketing expenses; skillful outsourcing of administrative functions; and plan participants being the primary stakeholders of SBHPs).

⁷⁴ Trade associations strongly supporting Senate Bill 406 (S. 406, 109th Cong. (2005)) include the National Federation of Independent Business; the National Association of Realtors; the U.S. Chamber of Commerce; Associated Builders and Contractors; International Franchise Association; National Association of Home Builders; National Association of Manufacturers; National Retail Federation; the National Restaurant Association; and the National Association of Wholesaler-Distributors. See Coalition Supporting Access & Choice Through Small Business Health Plans, About Us, <http://www.SBHPsNow.com/page/SBHPsNowAboutUs> (last visited Mar. 17, 2006).

⁷⁵ H.R. 525, 109th Cong. (2005). On July 26, 2005, SBHP legislation passed in the House of Representatives by a vote of 263-165. See 103 Cong. Rec. H6478-84 (daily ed. July 26, 2005).

⁷⁶ In the 104th Congress, Representative Harris Fawell (R-Ill.) introduced the ERISA Targeted Health Insurance Reform Act of 1996. H.R. 995, 104th Cong. The bill was included in the House version of HIPAA, but was subsequently stripped out of the final version of the bill in conference committee. Since that initial bill, SBHP legislation has successfully passed the House on eight consecutive votes. See H.R. 4279, 108th Cong. (2004); Small Business Health Fairness Act of 2004, H.R. 4281, 108th Cong. (2004); Small Business Health Fairness Act of 2003, H.R. 660, 108th Cong. (2003); H. Amdt. 302, 107th Cong. (2001); Patient's Bill of Rights Plus Act, H.R. 2990, 106th Cong. (1999); H.R. Res. 348, 106th Cong. (1999); H.R. Res. 323, 106th Cong. (1999); Health Care Consumer Empowerment Act of 1998, H.R. 4250, 105th Cong. § 2201 (1998).

⁷⁷ *Solving the Small Business Health Care Crisis: Alternatives for Lowering Costs and Covering the Uninsured: Hearing on S. 406 Before the S. Comm. on Small Bus. and Entrepreneurship*, 109th Cong. (2005) [hereinafter *Senate Hearing on the Uninsured*].

⁷⁸ *Small Businesses and Health Insurance: Easing Costs and Expanding Access: Hearing Before the S. Comm. on Health, Educ., Labor and Pensions*, 109th Cong. (2005).

Senate Majority Leader Bill Frist (R-Tenn.) recently stated that he intends to bring SBHP legislation to the Senate floor “in the near future.”⁷⁹ If the Senate fails to pass SBHP legislation, the national small business health insurance crisis will only worsen, and more people will join the ranks of the uninsured.

A. *Specific Provisions of SBHP Legislation*

Below is a summary of the provisions included in the Small Business Health Fairness Act of 2005.

1. *Eligibility Requirements*

SBHP legislation would amend the Employee Retirement and Income Security Act (ERISA)⁸⁰ to include sections on the certification and regulation of SBHPs. The legislation would expand ERISA to allow small businesses, via bona fide trade, industry, and professional associations, to operate health plans under uniform rules similar to those governing plans sponsored by large corporations and unions.⁸¹ In order to be eligible, these associations must have been established for substantial purposes other than providing health insurance for at least three years.⁸² Sponsoring associations may not condition membership plan coverage on employee and dependent health status or related factors.⁸³ These provisions are designed to ensure that only legitimate, pre-existing member-driven associations offer SBHPs as opposed to opening the flood gates to potentially fraudulent entities that spring up solely to provide “insurance.”

SBHP legislation defines an “association health plan” as a group health plan that offers fully insured and/or self-insured medical benefits, has been certified, and is operated by a board of trustees with complete fiscal control and responsibility for all SBHP operations.⁸⁴ To be certified, a “self-insured” SBHP must have at least 1000 participants or beneficiaries.⁸⁵ This minimum “covered lives” requirement, coupled with the solvency and surplus requirements in the bill, would help to ensure the viability of self-insured SBHPs and to prevent fraud. One way for self-insured SBHPs to

⁷⁹ Press Release, Bill Frist, *Frist Praises HELP Committee Action to Protect Working Families' Access to Health Care* (Mar. 15, 2006), http://frist.senate.gov/index.cfm?useAction=PressReleases.Detail&PressRelease_id=2304.

⁸⁰ 29 U.S.C. §§ 1001–1461 (2000).

⁸¹ See S. 406, 109th Cong. § 801(b)(1) (2005). Senate Bill 406 contains most of its substantive provisions within Section Two of the bill. To be more informative, the author has cited the bill, which adds a new part to subtitle B of title I of ERISA, by referring directly to the new part's provisions.

⁸² See *id.* §§ 801(b)(1), 803(a).

⁸³ See *id.* § 803(b)(3).

⁸⁴ See *id.* § 803(b).

⁸⁵ See *id.* § 805(a)(3).

be certified is if coverage is available on the date of enactment.⁸⁶ Self-insured SBHPs already in existence on the date of S. 406's enactment would be "grandfathered" in and would not have to satisfy all of the bill's certification requirements.⁸⁷ Another means of certification is if the SBHP represents a broad cross-section of trades, typically by being a "federation" type of an association, such as a chamber of commerce with a membership that is open to many different types of businesses.⁸⁸ The third and final means of certification is if the SBHP represents one or more trades with average or above average health insurance risk.⁸⁹

2. Participation and Coverage Requirements

SBHP legislation requires that all employers participating in the SBHP must be members or affiliated members of the sponsor.⁹⁰ All individuals under the plan must be active or retired employees, owners, officers, directors, partners, or their beneficiaries.⁹¹ SBHP legislation prohibits discrimination by requiring that all employers who are association members be eligible for participation; all geographically available coverage options are made available upon request to eligible employers; eligible individuals cannot be excluded from enrolling because of health status; and premium contribution rates for any particular small employer cannot be based on the health status or claims experience of plan participants or beneficiaries, or on the type of business or industry in which the employer is engaged.⁹² Finally, state-licensed health insurance agents must be used to distribute health insurance coverage provided to small employers under a fully insured SBHP.⁹³

⁸⁶ See S. 406, 109th Cong. § 802(f)(1) (2005).

⁸⁷ See *id.*

⁸⁸ See *id.* § 802(f)(2).

⁸⁹ See *id.* § 802(f)(3). The bill specifically lists a number of industries with average or above average risk, including agriculture; equipment and automobile dealerships; barbering and cosmetology; certified public accounting practices; child care; construction; dance, theatrical, and orchestra productions; disinfecting and pest control; financial services; fishing; food-service establishments; hospitals; mining; medical laboratories; professional consulting; sanitary services; transportation; warehousing; and wholesaling/distributing. See *id.* § 802(f)(3). Furthermore, the bill would cover any industry not specifically listed that has been indicated as having average or above average risk or health claims experience through state rate filings, denials of coverage, proposed premium rate levels, or other demonstrated means. The intent of this provision is to serve as a broad "catch all" that would encompass the overwhelming majority of small businesses. See *id.* § 802(f)(3).

⁹⁰ See *id.* § 804(a)(1).

⁹¹ See *id.* § 802(a)(2).

⁹² See S. 406, 109th Cong. § 805(a)(2) (2005).

⁹³ See *id.* § 805(a)(4)(A).

3. Reserve Requirements and New Provisions for Solvency

SBHP legislation also contains new solvency provisions that will increase consumer protections for small businesses who purchase insurance through a “self-insuring” SBHP that chooses to bear its own risk in providing health insurance rather than purchasing insurance through a traditional insurance company. These new provisions require claims reserves certified by a qualified actuary,⁹⁴ minimum surplus reserves,⁹⁵ both specific and aggregate stop-loss insurance,⁹⁶ and indemnification insurance to ensure that all claims are paid.⁹⁷

Self-insured SBHPs must be sufficiently funded for unearned contributions, benefit liabilities, administrative costs, or any other obligations.⁹⁸ Self-insured SBHPs must also make annual payments to a Small Business Health Plan Fund to guarantee that indemnification insurance is always available.⁹⁹ Issuers of stop-loss and indemnification insurance for self-insured SBHPs must notify the Secretary of Labor if the SBHP fails to make a payment that would result in the cancellation of the insurance policy.¹⁰⁰

4. Preemption from Mandated State Benefits

One of the primary purposes of SBHP legislation is to provide small businesses with relief from the confusing and complex web of state insurance regulations. Over the past twenty years, we have seen a significant increase in the number of mandated benefits at the state level.¹⁰¹ Under current law, insurance companies offering fully insured SBHPs must comply with the mandated benefit laws in each and every state in which their plans operate, even though the laws cover the same benefit at widely varying eligibility levels.¹⁰² The administrative cost of complying with these state regulations consumes a far greater percentage of the premium dollar

⁹⁴ See *id.* § 806(a)(2)(A).

⁹⁵ See *id.* § 806(b). A self-insuring SBHP must maintain reserves between \$500,000 and \$2 million, depending on the level of stop-loss coverage and other factors. See *id.* § 806(b)(1).

⁹⁶ See *id.* § 806(a)(2)(B).

⁹⁷ See *id.* § 806(a)(2)(B)(iii). The Secretary of Labor may require additional indemnification insurance for SBHPs when he or she deems it necessary. See *id.* § 806(c).

⁹⁸ See S. 406, 109th Cong. § 806(a)(2)(A)(i)–(iv) (2005).

⁹⁹ See *id.* § 806(f).

¹⁰⁰ See *id.* § 806(a).

¹⁰¹ *Senate Hearing on the Uninsured*, *supra* note 77, at 110 (statement of Tom Haynes, Executive Director, Coca-Cola Bottlers' Association (CCBA)) (asserting that the CCBA offered an SBHP to its members for ninety years until it was forced to disband in 2000 due to the overwhelming complexity of state small group reform laws and regulations).

¹⁰² See *id.* at 110 (“These well-meaning but counter-productive laws eliminated virtually all insurance companies from participating in multi-state arrangements due to their reluctance to navigate the myriad individual state premium and coverage requirements for small employers.”).

for small businesses than for larger ones, a major reason why most SBHPs have been forced to shut down in recent years.¹⁰³

SBHP legislation seeks to level the playing field between small and large businesses by preempting varying and duplicative state benefit mandates.¹⁰⁴ Certified fully insured SBHPs would be exempt from state health insurance laws and regulations in the state where the SBHP insurance policy is filed and approved, except those that prohibit the exclusion of specific diseases.¹⁰⁵ Self-insuring SBHPs would fall under the regulatory purview of the Employee Retirement and Income Security Act (ERISA), which currently preempts any state laws related to regulation of insurance for employers who choose to self-insure.¹⁰⁶ In either case, SBHPs would be able to offer uniform benefit plans across state lines with lower administrative costs.

SBHP legislation is ultimately a matter of fairness: small businesses ought to receive the same advantages under the law as larger businesses. Small businesses should be able to provide their hard working employees with the same type of quality insurance that employees at larger businesses receive. SBHP legislation would enable us to do this at virtually no cost to the American taxpayer.

5. Strong Enforcement

Finally, SBHP legislation does not require a new bureaucracy to ensure that existing and new SBHPs are properly regulated. The Department of Labor (“DOL”) would regulate self-insured SBHPs in the same manner it regulates over 300,000 self-insured health plans covering seventy-eight million people.¹⁰⁷ Within one year of enactment of SBHP legislation, DOL would promulgate implementing regulation detailing how the agency would conduct certification and oversight, safeguard the public against insolvency, and provide strong enforcement against potential fraudulent actors.¹⁰⁸ To discourage any corrupt exploitation of SBHPs, SBHP legislation provides for criminal penalties for employers that willfully misrepresent themselves as exempt SBHPs¹⁰⁹ and establishes a procedure for the

¹⁰³ See *id.* at 112 (“Many associations have had to close down their health plans because health insurance companies cannot afford the cost of compliance in multiple states.”).

¹⁰⁴ See *id.* at 38 (statement of Elaine L. Chao, Secretary, U.S. Department of Labor) (stating that fully insured SBHPs “will be able to offer a uniform benefits package nationwide, making it possible for employees to receive the same benefits regardless of where they live”).

¹⁰⁵ See S. 406, 109th Cong. § 812(b)(3)(c)(iii) (2005).

¹⁰⁶ See *Senate Hearing on the Uninsured*, *supra* note 77, at 38 (statement of Elaine L. Chao, Secretary, U.S. Department of Labor).

¹⁰⁷ See *id.* at 30–31.

¹⁰⁸ See S. 406, § 6(a); *Senate Hearing on the Uninsured*, *supra* note 77, at 40–43 (statement of Elaine L. Chao, Secretary, U.S. Department of Labor).

¹⁰⁹ See S. 406, § 4(a).

Secretary of Labor to petition a U.S. District Court for a cease activity order against fraudulent health plans.¹¹⁰

B. Myths and Realities About SBHPs

As SBHP legislation has meandered through Congress over the past decade, a number of myths have been perpetuated. These myths were generated by critics vigorously opposed to SBHP legislation, including those who comprise the BCBS,¹¹¹ the National Governors Association,¹¹² and the National Association of Insurance Commissioners.¹¹³

While each of these groups has substantive objections, at the heart of their opposition is a threat to their competitive standing. As discussed in Part II.C, the GAO report that I requested reveals the powerful market lock BCBS and a handful of other large insurers possess over the small group market. When no competition exists, larger insurers have no incentive to offer a range of insurance plans with varying benefit levels at reduced cost. Similarly, governors and insurance commissioners are resistant to ceding regulatory control to the federal government and thereby losing any associated tax revenues.¹¹⁴ Below, I discuss the myths and realities that have persisted about SBHP legislation. By examining the provisions of the legislation, the erroneous nature of the myths regarding cherrypicking, stripped benefits, consumer vulnerability, and potential for fraud will be unveiled. SBHPs will not only guard against these unwanted consequences but also reduce the size of the uninsured population, as well as reduce administrative costs.

One prevalent myth about SBHPs is that they will encourage risk selection and reduce risk pooling through “cherry picking.” Opponents contend that SBHPs would design benefit packages that will be relatively unattractive to older and less-healthy populations and that SBHPs would be able to “simultaneously attract a higher proportion of younger and healthier individuals in their pools, thereby driving down their expected claims costs, and thus their premiums.”¹¹⁵

¹¹⁰ See *id.* § 4(b).

¹¹¹ See Press Release, Blue Cross Blue Shield Association, Federal AHPs Would Eliminate Critical State Laws and Oversight That Protect Consumers (May 12, 2005), http://www.carefirst.com/media/InTheNewsDetails/InTheNewsDetails_20050512.html (last visited Mar. 20, 2006).

¹¹² See Press Release, National Governors Association, NGA Opposes Association Health Plans (Apr. 1, 2004), available at <http://www.nga.org> (follow “News Releases”).

¹¹³ See National Association of Insurance Commissioners (NAIC), Consumer Alert: Association Health Plans are Bad for Consumers, http://www.naic.org/documents/consumer_alert_ahps.pdf (last visited Apr. 15, 2006).

¹¹⁴ Susan Randall, *Insurance Regulation in the United States: Regulatory Federalism and the National Association of Insurance Commissioners*, 26 FLA. ST. U. L. REV. 625, 634 (1999) (acknowledging that states enjoy tax authority over the insurance industry).

¹¹⁵ *Senate Hearing on the Uninsured*, *supra* note 77, at 145 (statement of William N. Lindsay, former Chair, National Small Business Association).

However, in reality, SBHPs are specifically prohibited from being able to cherry pick.¹¹⁶ First, the language of the SBHP bill clearly states that bona fide associations must provide all interested employers (regardless of employee health status, etc.) with information regarding all coverage options available under the plan.¹¹⁷ Second, under HIPAA, an employer cannot deny coverage based on a preexisting health status or claims experience.¹¹⁸ As “group health plans,” SBHPs would thus be subject to the preexisting condition, portability, nondiscrimination, special enrollment and renewability provisions established under HIPAA.¹¹⁹ Third, the SBHP legislation clearly stipulates that any member of an association who is eligible for membership benefits be furnished with information regarding all coverage options available under the plan and may not be excluded from enrolling in the plan because of health status.¹²⁰ Finally, SBHP legislation requires that the contribution rates for any particular employer be nondiscriminatory,¹²¹ meaning that contribution rates for employers cannot vary on the basis of any employee health status factors or on the type of business or industry in which the employer is engaged.¹²² This holds true unless the state in which that small employer is located would specifically allow such a variation and, in such a case, this variation remains limited.¹²³

A second myth about SBHPs is that, because they will be exempt from state benefit mandates, they will only offer stripped-down benefits intended to appeal solely to the young and healthy in order to increase their profit margins. Similar to the “cherry-picking” myth discussed above, opponents contend that SBHPs would offer low-cost health plans that fail to provide any meaningful health coverage.¹²⁴

However, in reality, professional associations are driven by their members. SBHPs must constantly justify their worth to dues-paying members.¹²⁵ It is simply not realistic to assume that SBHPs will offer access to a health insurance product that does not meet the needs and demands of its members. Small businesses will demand that their SBHPs offer generous benefits, because they have to compete with larger companies already offering generous benefits to their employees. Moreover, the increased flexibility that SBHPs gain from receiving preemption from mandated state benefits

¹¹⁶ See United States Chamber of Commerce, Myths vs. Facts Regarding SBHPs, http://www.uschamber.com/issues/index/health/0603_ahps_mythsvsfacts.htm (last visited Mar. 20, 2006).

¹¹⁷ See S. 406, 109th Cong. § 804(d)(1) (2005).

¹¹⁸ See Hall, *supra* note 42, at 71.

¹¹⁹ *Senate Hearing on the Uninsured*, *supra* note 77, at 42 (statement of Elaine L. Chao, Secretary, U.S. Department of Labor).

¹²⁰ See S. 406 § 804(d)(2).

¹²¹ *Id.* § 805(a)(2).

¹²² *Id.* § 805(a)(2)(A).

¹²³ *Id.* § 805(a)(2)(B)(ii).

¹²⁴ See United States Chamber of Commerce, *supra* note 116.

¹²⁵ ARLENE FARBER SIRKIN, KEEPING MEMBERS: THE MYTHS AND REALITIES: CEO STRATEGIES FOR 21ST CENTURY SUCCESS 13 (1995).

will allow associations to narrowly tailor their insurance plans to meet the specific needs of their members' employees.¹²⁶ The reduced administrative expenses resulting from having centralized requirements will allow more resources to be devoted to providing benefits.¹²⁷ Finally, the competition amongst the different associations for members will ensure that these plans offer competitive benefits at attractive rates.

A third myth about SBHP legislation is that it would preempt important consumer protections that are currently provided through state regulation of insurance. These protections include prompt pay requirements, external and internal review mechanisms, and rate form filings.¹²⁸

However, fully insured SBHPs must actually continue to meet consumer protections, such as third-party external reviews, as well as solvency requirements set forth by the states.¹²⁹ Because it operates in the interest of its members, an SBHP will readily cover benefits demonstrated to be cost-effective, such as childhood immunization, prenatal care, and cancer screenings.¹³⁰ However, the well-intentioned, yet excessive coverage mandates that drive up the cost of health coverage and leave small businesses unable to afford coverage will be eradicated.¹³¹

With respect to self-insured SBHPs, the SBHP legislation establishes strict and explicit solvency requirements.¹³² In self-insured SBHPs, trustees who are fiduciaries are responsible for both the financial and operational integrity of the plan and provide the necessary oversight.¹³³ This fiduciary duty of oversight of the SBHP on behalf of its members is a key factor in assuring and maintaining the solvency and credibility of SBHPs in the long-term. In addition to the solvency standards and requirements for self-insured SBHPs and the fiduciary obligation, the patient protections included in the SBHP legislation are also more stringent than those now required under ERISA for self-insured plans.¹³⁴

¹²⁶ *Senate Hearing on the Uninsured*, *supra* note 77, at 38–39 (statement of Elaine L. Chao, Secretary, U.S. Department of Labor).

¹²⁷ *Id.* at 51 (statement of Hector V. Barreto, Administrator, U.S. Small Business Administration).

¹²⁸ See William Hammond, *Prompt Pay: Getting Paid Gets Easier for Michigan's Health Care Providers*, 81 MICH. BAR J. 24, 24–25 (2002); see also Danielle F. Waterfield, *Insurers Jump on Train for Federal Insurance Regulation: Is It Really What They Want or Need?*, 9 CONN. INS. L.J. 283, 320 (2003).

¹²⁹ *Senate Hearing on the Uninsured*, *supra* note 77, at 41 (statement of Elaine L. Chao, Secretary, U.S. Department of Labor).

¹³⁰ See Sara Rosenbaum, *Rationing Without Justice: Children and the American Health System*, 140 U. PA. L. REV. 1859, 1865 (1992); see also E. Haavi Morreim, *Diverse and Perverse Incentives of Managed Care: Will the Last One out of the Artesian Well Please Put on the Lid*, 1 WIDENER L. SYMP. J. 89, 108 (1996).

¹³¹ *Senate Hearing on the Uninsured*, *supra* note 77, at 36 (detailing a study that reported that mandates raise premiums by 4% to 13% and that up to one-quarter of uninsured Americans lack health insurance due to state mandates).

¹³² See *id.* at 41 (statement of Elaine L. Chao, Secretary, U.S. Department of Labor).

¹³³ S. 406, 109th Cong. § 805(a)(1)(A) (2005).

¹³⁴ *Senate Hearing on the Uninsured*, *supra* note 77, at 339 (statement of Elaine L. Chao, Secretary, U.S. Department of Labor) (asserting that self-insured SBHPs “will be

A fourth myth about self-insured SBHPs is that they will lack adequate solvency protections because of a lack of state regulation. However, SBHP legislation actually contains extensive requirements for solvency. First, SBHPs will only be certified if they have been in business for more than three years for a reason other than selling health insurance.¹³⁵ SBHPs must establish and maintain reserves in the amount recommended by the qualified actuary that would be sufficient for unearned contributions; benefit liabilities that have been incurred but not satisfied and their expected administrative costs; any other obligations of the plan; and a margin of error and other fluctuations that take into account specific circumstances of the plan.¹³⁶ The SBHP must also secure aggregate excess stop loss insurance for the plan with an attachment point not greater than 125% of the expected gross annual claim as well as specific excess stop loss insurance for the plan with an attachment point at least equal to an amount recommended by the plan's qualified actuary.¹³⁷ Finally, the self-insured SBHP must secure indemnification insurance¹³⁸ and maintain claims reserves in an amount between \$500,000 and \$2,000,000.¹³⁹ These measures will work in concert to guard against potential insolvency.

A fifth myth about self-insured SBHPs is that the DOL will not be able to effectively regulate them because they can provide their members with their own insurance as opposed to solely relying upon outside insurers. The DOL already effectively regulates 300,000 self-funded employer plans covering seventy-eight million people and can handle the additional workload from SBHPs.¹⁴⁰ DOL has a strong record of enforcement and protecting workers, retirees, and their families in health plans. As of December 2005, DOL has initiated 684 civil and 142 criminal investigations and has recovered over \$165 million in enforcement actions against fraudulent and failed multiple employer welfare arrangements (MEWAs).¹⁴¹

A sixth myth about SBHPs is that they will not significantly reduce the number of uninsured in this country due to their sole focus on providing health insurance for employees of small businesses. Yet the majority of the uninsured work for a small business or are dependent on someone who works for a small business.¹⁴² If we make it easier for small businesses to get health insurance for their employees, we will be able to substantially

required to meet strong solvency requirements that are not required of self-insured employer and union-sponsored group health plans today").

¹³⁵ See S. 406, § 803(a).

¹³⁶ See *id.* §§ 806(a)(2)(A)(i)–(iv).

¹³⁷ *Id.* § 806(a)(2)(B)(i)–(ii).

¹³⁸ *Id.* § 806(a)(2)(B)(iii).

¹³⁹ *Id.* § 806(b)(1)–(2).

¹⁴⁰ See *Senate Hearing on the Uninsured*, *supra* note 77, at 30–31.

¹⁴¹ See EMPLOYEE BENEFITS SECURITY ADMINISTRATION, U.S. DEP'T OF LABOR, FACT SHEET: MEWA ENFORCEMENT (2006), <http://www.dol.gov/ebsa/Newsroom/fsMEWAenforcement.html>.

¹⁴² CONG. RESEARCH SERV., *supra* note 10, at 4.

reduce the number of uninsured Americans. The Congressional Budget Office (“CBO”) has conservatively estimated that at least 620,000 uninsured individuals would become newly insured if SBHPs were passed,¹⁴³ and other studies have stated that as many as 8.5 million people may gain health insurance through SBHPs.¹⁴⁴

A seventh myth about SBHPs is that they would increase the incidence of insurance fraud occurring now under multiple employer welfare associations (MEWAs) because small business may confuse SBHPs with these MEWAs.

Small businesses are so desperate to find access to health care benefits that they are increasingly turning to organizations that are created overnight to purchase health coverage that is often insecure. These plans, called MEWAs, are supposed to be regulated by states.¹⁴⁵ Unfortunately, however, state insurance departments are often unable to prevent fraud and abuse by unscrupulous operators.¹⁴⁶ MEWAs are often “front” organizations for insurance companies or insurance agencies to sell insurance, leading to adverse selection and fraud.¹⁴⁷ Often, no certification process is required before MEWAs can begin providing health benefits to workers, and MEWAs have no federal solvency standards, which has led to further fraud and abuse.¹⁴⁸

SBHPs are fundamentally different from MEWAs.¹⁴⁹ Specifically, SBHP legislation provides that the sponsor of an SBHP must be a bona fide professional trade organization organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing annual meetings.¹⁵⁰ Furthermore, sponsors must be in existence for at least three years for purposes other than obtaining or providing health coverage.¹⁵¹ Sponsoring associations must set up a separate trust administered by trustees who become fiduciaries under the plan and are subject to the same ERISA responsibilities as fiduciaries of corporate and union health plans.¹⁵² These trustees must set up a financial and operational strategy for the trust and plan, assuring the active and ongoing involvement of

¹⁴³ See CONG. BUDGET OFFICE, *supra* note 5, at 4.

¹⁴⁴ CONSAD RESEARCH CORPORATION, THE PROJECTED IMPACTS OF THE EXPANDED PORTABILITY AND HEALTH INSURANCE COVERAGE ACT ON HEALTH INSURANCE COVERAGE 2 (1998), available at <http://www.consad.com/reports/healthinsport.pdf>

¹⁴⁵ See *Senate Hearing on the Uninsured*, *supra* note 77, at 36 (statement of Elaine L. Chao, Secretary, U.S. Department of Labor).

¹⁴⁶ See *id.*

¹⁴⁷ See *id.*

¹⁴⁸ See *id.*

¹⁴⁹ See *id.*

¹⁵⁰ See *Senate Hearing on the Uninsured*, *supra* note 77, at 36 (statement of Elaine L. Chao, Secretary, U.S. Department of Labor); S. 406, 109th Cong. § 801(a)(1) (2005).

¹⁵¹ See S. 406, § 803(a).

¹⁵² See *id.* § 805(a)(1)(A); see also *Senate Hearing on the Uninsured*, *supra* note 77, at 42 (statement of Elaine L. Chao, Secretary, U.S. Department of Labor).

the trustees in the plan's operation.¹⁵³ The SBHP must also file for certification with the DOL.¹⁵⁴ Finally, the continued oversight of the association on behalf of its members is a key factor in assuring and maintaining the solvency and credibility of SBHPs in the long term.¹⁵⁵ In order to be successful and retain participation in the plan, associations that offer SBHPs will have to offer benefits equal to or superior to traditionally regulated insurance plans in order to attract employers and their employees.¹⁵⁶ The regulation of these SBHPs will distinguish them from MEWAs. Small businesses will be able to safeguard themselves against fraud by looking toward these requirements and checking these entities for the appropriate DOL certification. Precluding small businesses from securing health insurance by deferring to the present status quo, which is void of affordable options, only exacerbates the likelihood that small businesses will experience fraud with MEWAs.

An eighth myth about SBHPs is that they will not succeed in reducing administrative expenses because it enlarges the infrastructure through which health insurance is provided.

In fact, uniformity provides for lower administrative costs. While smaller employers today are saddled with administrative costs that are typically 20% to 25% of their premium, self-funded large employers typically pay only 5% to 10% in administrative costs.¹⁵⁷

Several associations with experience offering SBHPs confirm the savings in administrative costs that SBHPs can achieve. For example, since 1965, the American Council of Engineering Companies ("ACEC") has offered a national SBHP that provides health benefits to over 1550 firms and 41,000 employees and their families.¹⁵⁸ ACEC's SBHP provides its participating members with approximately 100 different medical benefit plans with a wide range of deductibles—while efficiently delivering these benefits to small businesses, with administrative costs of only 9.5%.¹⁵⁹ However, ACEC contends that "[t]he proliferation of mandates and regulations imposed on a state-by-state basis is the greatest concern. These mandates have vastly increased the degree of complexity of administration and have resulted in a host of compliance and regulatory initiatives that have added a significant burden to the administration of the plan."¹⁶⁰

Thus, only practice can reveal the level of savings that SBHPs under the Small Business Health Fairness Act can deliver. Membership in an SBHP would be voluntary, and other insurance options currently available would

¹⁵³ See United States Chamber of Commerce, *supra* note 116.

¹⁵⁴ See S. 406, § 802; United States Chamber of Commerce, *supra* note 116.

¹⁵⁵ See United States Chamber of Commerce, *supra* note 116.

¹⁵⁶ See *id.*

¹⁵⁷ See OFFICE OF ADVOCACY, *supra* note 27, at 2; see also U.S. GEN. ACCOUNTING OFFICE, *supra* note 34, at 3.

¹⁵⁸ Senate Hearing on the Uninsured, *supra* note 77, at 203.

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

not be disturbed. Ultimately, if SBHPs cannot deliver significant savings, they will not gain traction in the market.

III. CONCLUSION

Small businesses desperately need relief from the crisis of sharply rising health care costs and the lack of coverage options in the small group market. I believe SBHP legislation is a critical solution to the small business health insurance crisis. SBHPs represent a common-sense, targeted approach to providing coverage to a sector of society that desperately needs it at nominal cost to the federal government, without inflicting a systemic shock to the health care system,. For far too long, Congress has failed to provide relief to small businesses. I will continue to work with my colleagues in the Senate and various stakeholders on both sides of the issue in order to move SBHP legislation to the Senate floor and achieve its passage.