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MEDICARE PRESCRIPTION DRUG CARDS AND ASSOCIATION HEALTH PLANS

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

SPECIAL HEARING

APRIL 2, 2004—NORRISTOWN, PA

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MEDICARE PRESCRIPTION DRUG CARDS AND ASSOCIATION HEALTH PLANS

FRIDAY, APRIL 2, 2004

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Norristown, PA.

The subcommittee met at 12:15 p.m., in Courtroom "C" of the Montgomery County Courthouse, Norristown, PA, Hon. Arlen Specter (chairman) presiding.

Present: Senator Specter.

OPENING STATEMENT OF SENATOR ARLEN SPECTER

Senator SPECTER. Good afternoon, ladies and gentlemen. The field hearing of the Appropriations Subcommittee on Labor, Health and Human Services, and Education will now proceed.

I am joined today by State Senator Stewart Greenleaf and State Representative John Fichter. This hearing was suggested by Senator Greenleaf, who contacted me a few weeks ago and said that there was a lot of interest in the Medicare prescription-drug bill, a lot of information needed to be conveyed to the people in Pennsylvania in his State Senate District. And I compliment Senator Greenleaf for taking the initiative to undertake the hearing.

When we decided to schedule the hearing, it was decided to expand the hearing to include association health plans, as well, because small-businessmen and -women are facing tremendous problems on having adequate healthcare. It's very, very costly for small-businessmen and small-businesswomen to insure employees, and there has been a legislative proposal which would authorize the formation of association health plans, which would enable small-business people or individual employers to band together and get lower rates, and we thought that would be a good adjunct to this hearing.

It's not often that you have a hearing on the multi levels, but there's no reason why we couldn't do that. And so here we are.

Let me yield, at this point, to Senator Greenleaf.

STATEMENT OF HON. STEWART GREENLEAF, STATE SENATOR FROM PENNSYLVANIA

Senator GREENLEAF. Thank you very much, Senator Specter, for being here. And you've always been concerned—I know you almost live in Montgomery County, and you're from our area.

Senator SPECTER. Right across City Line Avenue is Montgomery County. A lot of advantages. You don't get to pay the city wage taxes.

Senator GREENLEAF. But, anyway, we're happy you're here in our courthouse and in the center of our town. I know you're concerned about both healthcare for small-business people, and also for prescription drugs, drugs for the elderly. And we know you're very busy and have a lot of things, and the ranking members of many, many committees, and we appreciate you taking the time to be here, and being here in this county and talk about an issue that not only affects us, but the rest of the State, as well.

We, in Pennsylvania, passed a program recently to increase the benefits for elderly citizens in Pennsylvania, increasing the PACENET by, I think, over $31,000 a year for married couples. And with Representative Fichter, in the House, and myself, in the Senate, both parties and both bodies worked very hard to have that passed. We have one of the best prescription plans in the Nation. But now the Congress, with Senator Specter's leadership, is able to have a drug-discount program passed, and it's now pending, and it will start in the very near future, for about a year and a half, and then go into a permanent program. So we're hopeful we can combine the two, combine the Pennsylvania program, which is funded by our lottery funds, and then the Federal program. And I think we will be very, very encouraged by that, the savings that Pennsylvania will have in regard to the Federal program. We can then take those monies and put them into additional benefits and raise the income levels even higher.

In the suburbs, it's hard for people to qualify on their income levels for the PACENET program. The program that the Senator and others in Washington have been instrumental in getting passed will add millions of dollars to our program, so we can then increase the income limits for our constituents so even more can qualify under the PACENET program. About 125,000 additional people will qualify for the new program. And we hope, with additional monies, both in the indirect aid to Pennsylvania and the additional people who qualify for the Federal program, we should have the best program in the Nation.

So thank you for inviting me to be here today. Thank you very much.

Senator SPECTER. Thank you very much, Senator Greenleaf.

I would turn now to distinguished State Representative, Mr. John Fichter.

STATEMENT OF HON. JOHN FICHTER, STATE REPRESENTATIVE FROM PENNSYLVANIA

Rep. FICHTER. Thank you, Senator Specter, Senator Greenleaf. Obviously being junior to both of these gentlemen in seniority, and specifically being a member of the House of Representatives, and not the Senate—anyway, following Senator Greenleaf—he just about said it all, but I do want to thank Senator Specter for coming to Norristown to highlight Medicare.

We've come a long way from July 1, 1965, when the President signed the Medicare law. I remember that Part A was free, and Part B was $3 a month. So now Part A, I think, is still free, but

Part B is $44 a month. But there's been a lot of improvements to the program over the years, and basically for the good of our senior citizens. And Arlen Specter has always had a soft spot in his heart for the senior citizens. And, Senator, just keep up the good work down there.

Thank you very much.

Senator SPECTER. Thank you very much, Representative Fichter.

One note before we begin. I want to thank the Montgomery County Court of Common Pleas and the Montgomery County commissioners for permitting us to have the hearing in this elegant courtroom. I am tempted to move across the street into the county and run for judge with surroundings like these.

I note a little definition here of "bodily injury" and "deadly weapon," the ingredients of a crime which apparently had to be charged to the jury. It reminds me of the good old days, when I used to be an assistant district attorney and I handled these matters.

STATEMENT OF HON. MICHAEL McMULLAN, DEPUTY DIRECTOR, CENTER FOR BENEFICIARY CHOICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Senator SPECTER. Let us turn now to our first witness. With the first facet of our hearing today being on the Medicare prescription drug plans, our first witness is Ms. McMullan, Ms. Michael McMullan, Deputy Director for Beneficiary Education at the Centers for Medicare and Medicaid Services. She led the formation of the Center for Beneficiary Services, and helped design the national Medicare program, Medicare & You. She received her B.A. in economics from Washington College, and a master's in business administration from Loyola.

Thank you, Ms. McMullan, for coming from Washington, and we look forward to your testimony. We will introduce Ms. Uhler in just a moment.

We have set the time at 4 minutes for opening statements from members of the panel, and 4 minutes for the witnesses. That is set to allow the maximum amount of time for questions and answers.

We had a memorial service for Ambassador Walter Annenberg at the Academy of Music. And among the guest speakers were former President Gerald Ford, Secretary of State Colin Powell, and Governor Rendell, and I was one of the guest speakers, and we were allowed 3 minutes. So I want you to know what a generous allocation 4 minutes is.

Ms. McMullan, the floor is yours.

Ms. MCMULLAN. Senator Specter, thank you for inviting me here today to discuss the Medicare Drug Discount Program. This is a voluntary program that will provide immediate relief.

Senator SPECTER. Would you pull the microphone right under you. Senator Thurmond, when he chaired, said, "Bring the machine closer."

Ms. MCMULLAN. Many seniors will reduce the cost of prescription drugs today. Today, people with Medicare who do not have coverage for prescription drugs pay, on average, 20 percent more for their prescription drugs. The Medicare-approved drug discount card is meant for this population; to help them reduce their out-of-pocket costs for outpatient prescription drugs. Very importantly, those

people with the greatest need, the low-income portion of the population, will also qualify for a $600 credit. Enrollment in these programs will begin as early as May 2004, and discounts will begin as early as June 2004. These discount cards are administered by private-sector organizations, and there will be at least two choices in every State. There are more than that number of choices in Pennsylvania.

Enrollment fees cannot exceed $30, and that's an annual enrollment fee. The transitional assistance that we've talked about, the $600 credit, is available in both 2004 and 2005 to people who are at 135 percent of poverty. For an individual, that is $12,569 and for a couple, that is $16,862. And if they qualify for the transitional assistance, the enrollment fee is waived.

They can enroll at any time. But once they are enrolled, they are locked into the drug card that they select. There is an open-enrollment period, November 15 through December 31. And the reason for the lock-in is that the way the drug discount card works is to collect as many covered lives as possible to negotiate the best price possible from the pharmaceutical manufacturer, as well as the pharmacy. This way the individuals with the card get the best price at the pharmacy.

To help people with Medicare understand what their options are, we have created on our web site, medicare.gov, an interactive database that will include information about all of the drug cards that are available, that an individual will enter his or her eligibility information, information about themselves, their income, and other information and their zip code. If they have a favorite pharmacy, they can enter the name of the pharmacy. If they just want to know how many pharmacies are within 5 miles of their location, they can also enter that, and we will narrow down their options and present that information to them.

People who aren't able to use the Internet themselves can call 1–800–MEDICARE, and a customer-service representative will walk them through this process, and we will mail them the information that has been tailored to them.

Additionally, at the end of April, we will mail to every Medicare beneficiary household a short, two-page description of the drug cards, so everyone will get this in their hands. And the Social Security Administration will also be mailing, to people who will potentially qualify for the $600 credit, a letter explaining the importance of taking advantage of the $600 credit.

I also want to note that we have a guide to choosing a Medicare-approved drug-discount card that will be available either by calling 1–800–MEDICARE or by going on the web site and downloading it. This goes into extensive information about the opportunity for the drug-discount card, how to enroll, the types of questions people need to be prepared to answer. And we'll be sharing this information, as well as additional aids like tip sheets, and a CD–ROM explaining the web site, with community-based organizations, including the State Health-Insurance Assistance Programs and other community-based organizations.

Our regional offices will be working with community-based organizations to reach out to individuals in the greatest need, those who have access barriers to information such as language, location,

literacy, and culture so that that population will also get an additional amount of information and attention to make sure that they know the opportunity exists both with the drug-discount card for those that do not already have outpatient prescription drug coverage and the $600 credit.

PREPARED STATEMENT

Just one last note. The card is not available to people who have Medicaid coverage for outpatient prescription drugs, but it is available to all other people with Medicare that are enrolled in either Part A or B.

[The statement follows:]

PREPARED STATEMENT OF MICHAEL MCMULLAN

Chairman Specter, Senator Harkin, distinguished Committee members, thank you for inviting me here to Norristown, Pennsylvania, to discuss the Medicare Prescription Drug Discount Card and the Transitional Assistance Program, which were enacted into law on December 8, 2003, as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). In May 2004, as an important first step towards comprehensive Medicare prescription drug coverage, Medicare beneficiaries will be able to enroll in a Medicare-approved drug card program that will offer discounts on their prescription drugs. This voluntary drug card program will give immediate relief to seniors and persons with disabilities covered under Medicare to reduce their costs for prescription drugs. In addition to the expected savings from the drug discount card, certain low-income beneficiaries will qualify for additional assistance in the form of a $600 annual credit. CMS is very proud to have a significant role in this important first step towards a comprehensive Medicare prescription drug benefit, which is slated to begin on January 1, 2006. CMS is working diligently to meet the aggressive deadline to implement the drug card and transitional assistance program. To this end, the Secretary last week announced the approval of 28 general and special cards, and 43 exclusive cards. We are confident drug card sponsors will begin marketing and enrollment efforts on May 3, 2004, with beneficiaries beginning to see discounts beginning June 1, as scheduled. We are also launching aggressive education campaigns to help beneficiaries choose the best card to fit their needs, and are planning strict monitoring efforts to ensure that card sponsors are not changing prices for unwarranted reasons.

BACKGROUND

Currently, Medicare beneficiaries who lack outpatient drug coverage pay among the highest prices for prescription drugs, as much as 20 percent higher than people with drug coverage according to a study of drug pricing prepared by the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation. Under the Medicare Prescription Drug Discount Card Program, we expect beneficiaries to save an estimated 10 to 15 percent off the retail price on their overall prescription drug costs, and up to 25 percent on some drugs. The drug card will pass savings on to beneficiaries in the form of price concessions. While not a drug benefit, the voluntary drug card program is an important first step in providing Medicare beneficiaries with the tools they need to better afford the cost of prescription drugs.

SPONSOR SOLICITATION

CMS has already begun implementation of the drug card program. We received 106 applications by the January 30, 2004, deadline. Five applications were withdrawn or merged by the applicants, leaving a total of 101. To be considered for the program, organizations were required to complete a detailed application concerning their qualifications and the design of their proposed drug discount card program. Applicants that did not receive our approval have a right to request a reconsideration within 15 days from the notice of initial determination. Any reconsideration determination will be final and binding on the parties and not subject to judicial review.

CMS solicited applications by potential drug discount card sponsoring organizations on December 15, 2003, and applicants were due back on January 30. We evaluated each application against the requirements to operate a drug card program,

and the sufficiently complete and correct applications were approved. A number of the applications were disapproved if, for example, they did not fulfill entirely a key requirement, such as providing a contract or letter of agreement (signed by both parties) when the sponsor indicated a plan to contract out a key function such as administering the $600 credit. Because of the short timeframe to implementation, we are providing such applicants with a two-week window to correct such deficiencies, and we will review this information on a rolling basis to determine if these applications can be approved.

We have approved 28 general card applications (of the 55 general applications considered). As approved sponsors can offer more than one card program, this results in 28 national approved programs and 19 regional approved programs. Twenty-seven potential sponsors were rejected based on failing to completely satisfy fundamental requirements of the solicitations, including liabilities exceeding assets and the failure to demonstrate the capacity to manage transitional assistance. CMS also approved 43 (of 44) exclusive card applications, associated with 84 Medicare managed care organizations, to provide the drug card as an integrated part of the Medicare Advantage benefit package available to beneficiaries enrolled in those plans. The recommended approvals allow for a manageable number of cards from which people with Medicare will select, and reflects the high standards attributed to the use of the Medicare name. The 28 general card applicants represent card programs that would be administered by insurers, pharmacy chains, and pharmacy benefit managers. We expect that beneficiaries can begin to enroll in these card plans in May and begin using their drug cards in June 2004.

We also awarded a "special approval" to: three applicants to provide access to the $600 credit through long-term care pharmacies; two applicants to provide discounts to residents of the territories; and one applicant to service Federally recognized Indian tribe and tribal organization pharmacies. The MMA requires CMS to have one additional contractor for the tribal pharmacies. We have re-issued a solicitation to receive additional applications to meet this requirement, and several organizations have responded with a notice of intent to submit a proposal.

All applications of contractors that currently administer State pharmacy assistance programs will receive a Medicare approval, covering: IA, IL, KS, MA, MD, MI, NH, NY, OH, OR, PA, RI, SC, VT, and WV. States have the ability to exclusively contract with a Medicare approved card program. If a State's current contractor did not apply for an approval, the State may work with another (approved) card sponsor.

To ensure that beneficiaries have convenient access to their neighborhood pharmacies, card sponsors will not be permitted to limit their services to mail-order programs. Instead, all approved cards must include an extensive national or regional network of retail pharmacies, which must meet minimum requirements. For example, in urban areas, at least 90 percent of Medicare beneficiaries must live within two miles of a participating pharmacy. In suburban areas, 90 percent of Medicare beneficiaries must live within five miles, and in rural areas, 70 percent of beneficiaries must live within 15 miles of a participating pharmacy.

Drug card sponsors will be required to provide information to beneficiaries on the program's enrollment fee, which cannot exceed $30 per year, and to publish discounted prices available through their cards. In addition, Medicare will ensure that beneficiaries have at least two choices of approved general cards in each State, with the State being the smallest service area permitted under this program. If a card sponsor's service area includes additional States, the entire additional State must be included. Medicare will also provide reliable, easy-to-compare information that will show beneficiaries which programs are in their area, and allow beneficiaries to choose the discount card program that best meets their needs. Medicare will also inform enrollees that prescription drug card sponsors must protect personal and medical information consistent with the privacy requirements of the Health Insurance Portability and Accountability Act.

BENEFICIARY ELIGIBILITY

To qualify for the drug discount card, Medicare beneficiaries must be entitled to or enrolled under Part A and/or enrolled under Part B, but may not be receiving outpatient drug benefits through Medicaid, including 1,115 waivers. In addition to receiving discounts through the drug card, beneficiaries with incomes that do not exceed 135 percent of the federal poverty level ($12,569 for individuals, $16,862 for couples for 2004) will get a Federal credit of up to $600 per year to purchase their prescription drugs. The Federal government will also pay the full annual enrollment fee, which is not to exceed $30, for these cardholders with low incomes.

To enroll, beneficiaries will submit basic information to the selected approved discount card sponsor of their choosing about their Medicare and Medicaid status. Those beneficiaries requesting the $600 credit also must submit income and other information about retirement and other health benefits to the card sponsor, and attest to truthfulness of the information. CMS will verify this information and notify the approved discount card program of the beneficiary's eligibility and enrollment outcome. If a beneficiary is found to be ineligible for a drug card, the card sponsor will send written notice to the beneficiary explaining why he or she was found to be ineligible. For beneficiaries who are eligible, sponsors will send a welcome package, including their new drug card, so that they can begin obtaining discounts and, if receiving the $600 credit, using these funds to purchase prescription drugs, upon receiving their cards. Individuals found to be ineligible for either the discount card or the $600 credit may request reconsideration if they still believe they qualify.

An eligible beneficiary can enroll in an approved discount card program at any time. After the initial election in 2004, beneficiaries will have the option, for 2005, of choosing a different card program during the second election period between November 15 and December 31, 2004. In addition, a beneficiary may change cards under certain circumstances if, for example, the beneficiary enters a long-term care facility, moves outside of the area served by the beneficiary's approved program, or enrolls in or drops a Medicare managed care plan that is also providing an exclusive drug discount card program in which the beneficiary was enrolled.

TRANSITIONAL ASSISTANCE PROGRAM

In addition to providing a discount off the price of prescription drugs, MMA creates the Transitional Assistance program, which provides up to $600 in an annual credit for Medicare beneficiaries whose incomes do not exceed 135 percent of the federal poverty level ($12,569 for individuals, $16,862 for couples for 2004). When applying the $600 toward prescription drug purchases, beneficiaries at or below 100 percent of poverty will pay 5 percent coinsurance, and beneficiaries between 100 and 135 percent of poverty will pay a 10 percent coinsurance. The credit, in conjunction with the discount card, will give these most vulnerable beneficiaries immediate assistance in purchasing prescription drugs they otherwise may not be able to afford. For example, Medicare beneficiaries without prescription drug insurance on average would pay about $1,300 for prescription drugs in 2004. The expected savings of approximately 10 to 15 percent translates to $140 to $210. This savings added to the $600 credit will be of substantial help to those who need it most.

EDUCATION

To help explain the drug discount card to beneficiaries and help them navigate among cards to choose the card that best fits their needs, CMS has a number of education and outreach efforts underway. Print, radio, and television advertisements will highlight the upcoming changes to the Medicare program, including the addition of the drug discount card. The advertising campaign—presented in both English and Spanish—also includes Internet-banner ads and a 10-minute pre-recorded informational radio interview to educate beneficiaries about the upcoming drug discount cards.

These advertisements will direct beneficiaries to 1–800–MEDICARE and Medicare's website, www.medicare.gov, for more information. CMS is working to ensure that customer service representatives at 1–800–MEDICARE have up-to-date information on the drug card, as well as other CMS programs. Based on our analysis, we estimate 1–800–MEDICARE will receive 12.8 million calls in fiscal year 2004. This compares to an fiscal year 2003 call volume of approximately 5.6 million calls. The 12.8 million calls include an estimated increase of 5.5 million calls as a result of the new Medicare law and 7.3 million calls for routine 1–800–MEDICARE call topics. We plan to increase our CSR level at 1–800–MEDICARE in May 2004 to handle the expected increase in call volume.

An additional feature of the website will be a new price comparison tool, Medicare Price Comparison. Under the drug card program, card sponsors will negotiate drug discounts with both pharmacies and drug manufacturers. The new comparison tool will give beneficiaries, or their representatives, the capacity to find the sponsor-negotiated price for each drug or all their drugs at pharmacies in their area. Pricing information will be available for brand name, generic, and mail-order prescriptions offered through each card sponsor's program. Drug card sponsors will be able to update the drug pricing information on a weekly basis. Starting in late April, beneficiaries will be able to use the comparison tool by going to www.medicare.gov or by calling 1–800–MEDICARE. Customer service representatives at 1–800–MEDICARE also will be able to answer questions about the program, help them compare

drug cards on price and network pharmacies, and refer callers to other appropriate resources. They will also mail the results of the comparison to seniors.

CMS also has a number of beneficiary publications planned for 2004 to explain changes in the Medicare program. For example, HHS has prepared a detailed "Guide to Choosing a Medicare-Approved Drug Discount Card" for beneficiaries that explains the program, including eligibility and enrollment information, and provides step-by-step guidance for comparing discount cards and choosing one. The booklet currently is posted at www.medicare.gov, and printed copies will be available for free through 1–800–MEDICARE. CMS also will publish a small pamphlet with an overview of the drug card program and an introduction to the discount cards and the $600 low-income credit. In addition, a brief document that introduces beneficiaries to the discount cards and the Medicare-approved seal will be mailed directly to beneficiary households. This mailing, which will correspond with the television information campaign, is scheduled for late April 2004. Also, as required by MMA, CMS will work with its partners at the Social Security Administration to facilitate a mailing targeted toward low-income Medicare beneficiaries detailing the drug card and transitional assistance program.

To assist in beneficiary education and outreach, CMS increased funding to State Health Insurance Assistance Programs' (SHIPs) grants and REACH from $12.5 million last year to about $21.1 million for fiscal year 2004—a 69 percent increase above the fiscal year 2003 total. In addition, HHS' budget plan for fiscal year 2005 allocates $31.7 million to SHIPs—more than double the amount awarded in fiscal year 2003. With the new funding, SHIPs will be able to expand their efforts to work with and reach even more Medicare beneficiaries and increase and enhance their volunteer staff through additional training and resources.

To educate providers and pharmacists, as well as the States and other stakeholders, CMS will sponsor conferences and conduct a number of teleconferences to make the information available nationwide. For example, in-person training will take place at the CMS-sponsored drug card conference, which is scheduled for April 7–8. CMS staff will be available to provide technical assistance and support as the program begins.

COVERAGE

The discount card and $600 in transitional assistance can be used to purchase nearly all prescription drugs available at retail pharmacies. Syringes and medical supplies associated with the injection of insulin, such as needles, alcohol, and gauze, are also included. It is anticipated that many approved programs will use formularies to obtain deeper discounts on prescription drugs. If an approved discount card program uses a formulary then the drugs most commonly needed by Medicare beneficiaries must be included. At a minimum, each program must offer a discount on at least one drug in each of the 209 therapeutic categories of prescription drugs. However, even if a prescription drug is not on the sponsor's formulary, the $600 must still be applied to all the covered prescription drugs available at the pharmacy if the beneficiary uses the discount card toward the purchase. Drug card sponsors also may choose to offer discounts on over-the-counter (OTC) drugs, but the $600 cannot be used toward the purchase of OTC drugs. CMS made public on April 1, 2004 the enrollment fee for each drug card on the PDAP website, and the discounted prices will be posted at the end of April.

Medicare approved drug discount card sponsors will negotiate with manufacturers and pharmacies for rebates and discounts off the average wholesale price (AWP) for drugs covered under the drug card program. In order to get the most competitive savings to beneficiaries, some cards will use formularies, which can improve the negotiating leverage sponsors have with pharmaceutical manufacturers.

Beneficiaries will be guaranteed a percentage savings (or discount) on each purchase they make with their card. Individual prices may change, as AWP moves up and down, but the discount rate to which the card entitles them will not move, unless the sponsoring organization can satisfactorily report to CMS a good cause for such a move. The attached chart outlines how this process works. CMS expects to receive detailed information from program sponsors concerning specific discounts in the near future.

It is true that drug prices under the drug card may change. But this is not different from the way drug pricing works in the market place today. In typical industry practice, a pharmacy benefits manager guarantees, by contract, a certain discount off of the average wholesale price (AWP) to its payers. Within the universe of the thousands of prescription drugs on the market, there are changes in AWP in response to price shifts in labor and raw ingredients, as well as to supply and

demand. However, taken individually, the AWP for the vast majority of drugs either does not change or changes several times a year by a modest amount.

Once a card is selected, beneficiaries are committed to their card for the calendar year (with a few exceptions). This is a key program design feature to improve the discounts to beneficiaries under a drug discount card. Historically, drug discount cards have not included discounts from manufacturers because sponsors could not guarantee market share. By having committed beneficiaries, Medicare approved sponsors are able to guarantee a certain patient population. This guarantee increases their negotiating leverage with manufacturers and improves their ability to secure discounts and rebates, which are passed on to the beneficiaries. Because approved programs will be competing for Medicare beneficiaries to be able to increase their negotiating power, the programs will have an incentive to pass negotiated savings along to the beneficiaries in the form of the lowest possible drug prices.

While approved discount card programs may update their prices and lists of offered drugs on a weekly basis, CMS will monitor drug price changes to ensure that prices do not deviate from expected market changes, such as those in average wholesale price. While we do not anticipate that sponsors will be changing prices for unwarranted reasons, CMS will nonetheless closely monitor changes in prices over time for each drug that a card sponsor offers:

—If a card sponsor's drug prices change in an amount that is not consistent with the expected change due to AWP, then the sponsor must report it and provide a rationale.

—Also, CMS will routinely check for price changes from week to week compared to what is expected, based on changes in AWP. Price changes that are not expected will be flagged and evaluated.

—If the price change is not due to legitimate changes in their operating environment, such as losing a manufacturer contract, or unexpected costs of operating the call center, then a card sponsor could be sanctioned by CMS.

—Sanctions could include prohibiting further marketing and enrollment, monetary penalties, and terminating the card program.

FRAUD

Although the drug discount card program has not yet been implemented, some Medicare beneficiaries have already received calls as well as in-person solicitations from individuals/companies posing as Medicare officials attempting to gain personal information from beneficiaries for identify theft.

A beneficiary should NEVER share personal information such as their bank account number, social security number or health insurance card number (or Medicare number) with any individual who calls or comes to the door claiming to sell ANY Medicare related product.

Beneficiaries who are contacted by these false card companies should remember that Medicare-approved cards will not be available until May. The names of approved card sponsors have been made public and the companies will begin to market their cards through commercial advertising and direct mail beginning this month. Medicare-approved card sponsors will not market their cards door-to-door or over the phone.

In response to these complaints, CMS is coordinating information with customer service representatives at 1–800–MEDICARE, the call centers at the Medicare contractors and the State Health Insurance Assistance Programs (SHIPs). CMS has already informed the public through a press release about how to protect themselves from fraud. OIG referrals have been made for two complaints where we had specific enough information to make a fraud referral.

CMS is continuing to explore methods to limit the scope of these scams and develop a process to work with the appropriate law enforcement agencies to avoid further spread of this type of activity. CMS' office of Program Integrity is hosting a law enforcement fraud and abuse meeting this month. The primary participants will include the Department of Justice, Federal Bureau of Investigation, and the DHHS' Office of the Inspector General. Participants from other agencies that have dealt with issues of Prescription Drug fraud will also be invited. The primary topic of this meeting will be the discussion of the drug discount card program and how to prevent and deter fraud, waste and abuse in this area.

CONCLUSION

Thank you again for the opportunity to testify today about this new important transition toward a prescription drug benefit for Medicare beneficiaries. This voluntary drug discount card program will provide immediate assistance in lowering prescription drug costs for Medicare beneficiaries until the new Medicare drug ben-

efit takes effect on January 1, 2006. We recognize the importance of the discount cards and the low-income credit to Medicare beneficiaries, who, for too long, have gone without outpatient prescription drug coverage. We at CMS are dedicated to meeting the deadlines set out in the historic Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and are working expeditiously to satisfy the May 3 and June 1, 2004, effective dates for enrollment and implementation, respectively. Thank you again for this opportunity, and I look forward to answering any questions you might have.

Senator SPECTER. Well, thank you very much, Ms. McMullan.

STATEMENT OF DONNA UHLER, COORDINATOR, APPRISE PROGRAM, PENNSYLVANIA DEPARTMENT OF AGING

Senator SPECTER. We will defer questions until after we've heard from Ms. Uhler.

We now turn to Ms. Donna Uhler, the Apprise Coordinator in Montgomery County. Through their Montgomery County Agency on Aging, the Apprise Program provides seniors and their families in the country with information about Medicare and healthcare options. She has an MBA from St. Joseph's University in Philadelphia, a bachelor's degree from Millersville University.

We thank you for joining us, Ms. Uhler, and we look forward to your testimony.

Ms. UHLER. Thank you for inviting me today.

The Apprise Program is the State health-insurance assistance program, and subcontractor to the Retired Senior Volunteer Program here in Montgomery County. We have 12 counselors who are specifically trained, receiving update training twice a year by the State, 15 sites throughout the county. We, as stated by Senator Greenleaf, are very lucky to have the PACENET program here, which handles a good number of the folks needing prescription assistance.

The drug-discount cards names the approved companies that has been announced in the city papers, but I've not particularly seen it in the local papers. We've had limited individual calls at this time. We have received a number of requests for presentations. Many times, they're asking for the explanation of the whole modernization act. We've given at least six so far, and have five scheduled in just the next 2 weeks, and I'm sure more to come. Most of the individual calls come from two groups, those first turning 65 and those needing prescription assistance. We handle about 1,200 calls a year, plus those present at our presentations. The majority are of the middle-income bracket, around the $25,000 limit, with drug costs someplace in the $1,500 a year to $2,000 range.

We have one HMO here in Montgomery County, and that same company provides a PPO. Those folks will get their card through that company, and the company handling PACE has approved—has been approved as a card sponsor, and they will automatically assist members who are eligible for the $600 credit if they decide to go with that drug-discount card company. The government PPO type is provided by a company that has also been approved as a card sponsor.

Questions are coming from the long-term care facilities, which Senator Greenleaf is very familiar with since we were requested to do a presentation, and their confusion is as to how their long-term pharmacy groups are dealing with the discount card; not the long-term care residents, but the assisted-livings that are more inde-

pendent, or the independent residents living the long-term care setup, with one of the issues being that part of their agreement, when they go into these long-term cares, is some of their drug costs may be covered by the admission agreement.

Most of the seniors we talk to have heard about the change, but, quite honestly, they're not terribly trustworthy of the change. You often hear, "I know it's going to cost me more money," and we don't get the money to cover the cost. We will be providing presentations, doing health-fair participation, news articles, news letter articles, and, most important, handling the phone calls or meeting with the individuals. People always appreciate the human voice and feel more confident if someone looks at their choices.

The counselors we have are very dedicated and experienced, and they're even doing some of their counseling in the evening. We will be recruiting more counselors before the modernization act in 2005 and 2006.

Thank you.

Senator SPECTER. Well, thank you very much, Ms. Uhler.

This is, I think, a very important step in acquainting the seniors with the availability of this program. The statistics are that some 2,100,000 Medicare beneficiaries in Pennsylvania will have access to their prescription-drug benefit under the new Medicare law. And it was a matter of familiarizing the potential—the Medicare recipients with it. It is important to note that the beneficiaries can keep the current plan if they want to. It doesn't begin until the year 2006. Is that correct?

Ms. UHLER. Yes.

Senator SPECTER. But they have the option of going to the HMOs, where the thought is, with competition, that there may be a lowering of the cost of Medicare by giving physical examinations to having significant emphasis on preventive medicine, and making the availability of prescription drugs where we will have the opportunity to keep seniors healthier longer before it gets there, that we will be able to hold down the costs.

There's been a lot of controversy, as we all know, about what the program will cost. Congress has budgeted $400 billion over 10 years. There have been some comments that the real costs were concealed, that it would cost $150 billion more. Nobody knows precisely what it will cost. We are investigating to see if there was any material withheld, but the real determination of the costs will depend upon how it works with respect to the examinations, with respect to preventative care and competition.

Let me ask you this, Mr. Uhler and Ms. McMullan, what is the best way to get information to the seniors now about these drug cards? Are those brochures that you held up, Ms. McMullan, going to be mailed out to seniors?

Ms. MCMULLAN. There are several things happening in late April. We will mail, to every beneficiary household, a short description of the drug card, and refer them to 1–800–MEDICARE and to the web site for those people who use that, or whose children or other caregivers use it on their behalf. In addition, there's the Social Security mailing. We will be having ads on television, advertising both the $600 transitional system and the drug card, and leading people to 1–800–MEDICARE. We will be doing other out-

reach events through pharmacies, physicians, and healthcare providers.

Senator SPECTER. Is there a number which the senior citizen can call to get the information?

Ms. MCMULLAN. 1–800–MEDICARE.

Senator SPECTER. What's the number?

Ms. MCMULLAN. It's 1–800–633–4227.

Senator GREENLEAF. 1–800–MEDICARE.

Ms. MCMULLAN. 1–800–MEDICARE.

Senator SPECTER. It's very hard to spell "Medicare" on my phone. Translate the number for the media who are here. To list the number in any publication which goes out will be very, very helpful.

Ms. MCMULLAN. 1–800–633–4227.

Senator SPECTER. Ms. Uhler, how much will the reductions be by using these Medicare cards?

Ms. UHLER. The anticipated reduction is total overall of someplace between 10 to 15 percent, I believe, but there maybe an individual drug that, itself, may be 25 percent off.

Senator SPECTER. Well, my red light went on, and I like to observe the red light, so I'd yield now to Senator Greenleaf.

Senator GREENLEAF. Thank you, Senator.

On the State level, in regard to the Federal program—and you're going to be, obviously, involved in this very closely—it would be very important if you could let us know, as you get involved in these—in the two programs, to see how we can best interface the two and to supplement each other, and to help to increase the benefits that they now have to the maximum. And so it would be really important, with your practical experience of how to run it, and the practical changes we might be able to make in Pennsylvania that could help to include additional seniors in receiving the benefits; rather than have two separate programs, having a little more working together.

I've heard some proposals where that $600 could be reimbursed to the State, and then we would use that $600 to increase our benefits. That is what I was referring to, things like that might be helpful in helping Pennsylvania's seniors.

Ms. MCMULLAN. There are discussions going on with the State pharmacy assistance programs in order to figure out how best to integrate the transitional assistance into the State pharmacy assistance programs. We are dealing with each State individually, and working through the issues on how best to do that. But, indeed, those benefits and programs can be coordinated. There's lots of opportunity to integrate the drug card transition assistance into the State pharmacy assistance programs.

Ms. UHLER. The people in the Montgomery County can call the Montgomery County Apprise number, which is 610–834–1040, extension 20. A counselor checks that line daily, and we will get back to whoever calls.

Senator GREENLEAF. Thank you.

Senator SPECTER. Thank you very much, Senator Greenleaf.

We turn now to Rep. John Fichter.

Rep. FICHTER. Thank you, Senator.

Ms. McMullan, you talked about the enrollment period. Is there any penalty if I missed signing up during the stated enrollment period?

Ms. MCMULLAN. An individual can sign up at any time. Once they sign up, they are in for the year, and then they can sign up during the November 15 to December 31 enrollment period for another card in 2005. But you can sign up at any time, and there is no penalty for late enrollment.

Rep. FICHTER. It seems that every time the State starts a program or gets involved in a State-run program, we always have a problem finding everybody who's eligible for it. And I heard your testimony, where you're sending things out, you're going to do ads on TV, and various and sundry other things. How about the lady or gentleman up in Tioga County, where there is no TV, or the individual down on the Ozark Mountains, down in Kentucky? In case they miss, is there any followup to contact those people?

Ms. MCMULLAN. What we're doing, in addition to the mailing, which should go out to all of those individuals, because the mail service reaches into rural communities, is ask our regional office staff to make sure that they target those individuals in the outreach, particularly low-income individuals and people who have access barriers, to make sure that we get the information out. We're also partnering with as many organizations as possible in community-based organizations, as well as pharmacies. And as an example of one of those partnerships, Wal-Mart is going to have information available to tell people about the prescription drug—Medicare-approved prescription-drugs cards, and where to call to get information. So in places like local pharmacies and other local organizations, additional information will be out there. We are trying to find every mechanism possible to get the information into the community, into the grassroots, to the people in the low-income groups that are most benefitted by the prescription-drug card.

Rep. FICHTER. Thanks very much.

Thank you, Senator.

Senator SPECTER. Thank you very much, Rep. Fichter.

Well, thank you very much, Ms. McMullan and Ms. Uhler. I think that the presentation you have made here today is a very important one.

This program will go into effect so that people can start getting the discounts, estimated between 10 and 25 percent, as of May of this year. And the cards cost no more than $30 for the low-income brackets, and they may be obtained free. Depending on the income level, the individuals may have a $600 credit for the first $600 of prescription drugs which are purchased. And then in the year 2006, the major plans will come into effect, where seniors can either stay with traditional Medicare or exercise the option and go into an HMO.

There's been a lot of misinformation about the plan. There's been a great deal of politicization of it with people arguing whether it is good or bad—I think, fairly stated, in an effort to gain political points.

What we want to do is to acquaint the seniors with what the plan is, let the seniors be informed so they know what their rights and opportunities are. Then they can make their choices. They can

take it if they wish to. They're not obligated to take it. And then we will see how the plan works, emphasizing, again, that seniors can retain the current coverage they have. They don't have to go into the new plan, but they can do it if they want to. And there are very substantial sums being budgeted by the Congress to provide this prescription-drug help at a time when prescription drugs are enormously expensive.

So we thank you very much for coming, and we expect your telephones to be ringing more frequently now that there will be greater awareness by the seniors on what the programs are.

We now turn to our second panel on the issue of association health plans, and we would ask, at this time, that you to come forward—Ms. Alexis Barbieri, Mr. Paul Zieger, Mr. Ray Carroll, Ms. Mary Beth Senkewicz.

The issue on association health plans has been the subject of legislation which has been produced in both the House and the Senate. On March 6 of last year, Senator Snowe introduced S. 545, the Small Business Health Fairness Act of 2003, which would establish a regulatory framework and certification process for associated health plans. Associated health plans will allow small employers and self-employed to band together to voluntarily form multiple-employer groups to enable small business to offer health insurance to their employees.

We have Mr. Campbell, who has also joined us. Mr. Campbell, you're on the top of the page.

STATEMENT OF BRADFORD P. CAMPBELL, DEPUTY ASSISTANT SECRETARY, EMPLOYEE BENEFITS SECURITY ADMINISTRATION, DEPARTMENT OF LABOR

Senator SPECTER. Our first witness will be Mr. Bradford Campbell, who is the Deputy Assistant Secretary for Employee Benefits Security Administration in the U.S. Department of Labor.

Thank you very much for joining us, Secretary Campbell, and we look forward to your testimony.

Mr. CAMPBELL. Thank you very much, Mr. Chairman.

Good afternoon. My name is Bradford Campbell. I'm the Deputy Assistant Secretary of the Employee Benefits Security Administration.

I would like to ask that my full statement be submitted for the record.

Senator SPECTER. Without objection, your full statement will be made a part of the record.

Mr. CAMPBELL. I would like to thank you for inviting me to Norristown today to discuss the Administration's support for the bill you referenced, S. 545, the Small Business Health Fairness Act. On behalf of the administration, I would like to thank you for your cosponsorship of this legislation, which will offer working Pennsylvanians and their families improved access to affordable quality health benefits by establishing association health plans, or AHPs.

This bill is a central element of the President's plan to give workers better options in purchasing or securing affordable health benefits through their employers. In his State of the Union Address in January, President Bush called on Congress to pass this legislation, and we, at EBSA, are committed to working with you to enact this much-needed legislation.

Despite being growth engines for the economy, creating two out of every three new jobs, small businesses face significant hurdles in providing health benefits to their employees. The reality is that 85 percent of Americans without health insurance are in working families. And of that, 60 percent are affiliated with small business. While 98 percent of large businesses offer health benefits, less than half of small employers can afford to do so. These facts illustrate the problem, but they also suggest a solution. If we can level the playing field for small businesses, we will have gone a long way toward solving un-insurance in America.

AHPs are squarely targeted to the health-coverage needs of small businesses, and they address the two main threats they face, cost and fraud.

First, cost. The fact of the matter is, small business pay 20 to 30 percent more than large businesses for similar benefits. The reason is because Federal law allows large employers and unions to pool their employees and members together across State lines, something small businesses are generally unable to do. The result is that small businesses are denied the benefits of administrative efficiencies, economies of scale, and greater bargaining power. By contrast, small businesses are effectively isolated, trying to buy coverage for 5 or 10 employees at a time, instead of 5 or 10 thousand.

Moreover, in many States the marketplace is consolidated, with one or two insurers coming to dominate the market. With less competition comes less choice and higher costs. This problem is exacerbated by the fact that each State has different requirements for plan design. The complexity of trying to craft an insurance policy that meets these different requirements adds considerably to the cost, making it very difficult to design an affordable insurance policy that can operate in multiple States.

AHP legislation remedies this disparity in Federal law, allowing small businesses to join together through their trade associations to purchase health benefits in a way similar to large employers and unions.

Second, fraud. In part because small businesses have fewer healthcare options, they're more vulnerable to scam artists, who try to prey on their need to have health coverage. This is a significant area of enforcement at the Department of Labor. And one of the key portions of our enforcement effort in preventing fraud is association health plans. Before an AHP can offer a benefit to a single employee, it will have to be certified in advance by the Department of Labor as meeting the requirements of the legislation that prevents this sort of fraudulent behavior from occurring.

To the critics who claim that EBSA will be unable to regulate these plans and protect consumers, I would like to point out, Mr. Chairman, that we have 30 years of experience in administering the Employee Retirement Income Security Act, or ERISA, which provides us regulatory authority over 131 million Americans in employer-provided health plans, of which 67 million Americans are in self-insured plans solely regulated by the Department of Labor. And you'll generally find, I think, both anecdotally and looking at the actual facts, that these are widely regarded as some of the best health benefits available in these plans that are regulated by the Department.

PREPARED STATEMENT

I would just like to conclude by saying that if you look at the report from the Congressional Budget Office, AHPs are estimated by them to provide new benefits to as many as two million workers, and reduce premiums by as much as 25 percent for small businesses.

With that, I would like to thank you for inviting me to testify today, and I look forward to answering any questions you may have.

[The statement follows:]

PREPARED STATEMENT OF HON. BRADFORD P. CAMPBELL

INTRODUCTORY REMARKS

Good afternoon, Chairman Specter. My name is Bradford Campbell, and I am the Deputy Assistant Secretary for Policy of the Employee Benefits Security Administration. Thank you for inviting me to Norristown today to discuss the Administration's staunch support for Association Health Plans (AHPs), a key element of the President's plan to increase access to quality, affordable health benefits for working Americans.

Mr. Chairman, I would like to thank you, on behalf of the Administration, for your cosponsorship of S. 545, the Small Business Health Fairness Act. S. 545 is the Senate version of the AHP legislation passed by the House of Representatives on a strong bipartisan basis. The President called on Congress to pass AHP legislation in his State of the Union Address, and we appreciate your support of the bill, which will give working Pennsylvanians more health insurance options in what is becoming an increasingly concentrated insurance marketplace.

I am testifying before you today on behalf of the Employee Benefits Security Administration, or EBSA. EBSA is the federal agency that will oversee AHPs. Our job is to protect the employer-provided health and retirement benefits of millions of Americans, and I can assure you, Mr. Chairman, that we are committed to working with the Congress to make sure that AHPs are a secure and well-regulated option for employers seeking to offer high quality and affordable health benefits. EBSA has firsthand experience dealing with group health plan regulation as well as combating insurance fraud. We administer the Employee Retirement Income Security Act (ERISA), protecting approximately 2.5 million private, job-based health plans and 131 million workers, retirees and dependents. Of these, 275,000 plans covering 67 million individuals are self-insured, and therefore are subject exclusively to EBSA oversight. These include large, self-insured multiemployer plans (established and operated jointly by a union and two or more employers), which cover more than 5 million participants, not counting their covered dependents.

SMALL BUSINESSES AND THE UNINSURED

Despite being the driving engine of our economy, small businesses face many obstacles, and finding affordable health insurance is one of the most significant. Secretary Chao has met with small business men and women around the country, including here in Pennsylvania, and they have consistently expressed to her their concerns about finding good health insurance at a reasonable price. The numbers behind the uninsured statistics highlight the need for AHPs—85 percent of Americans without health insurance are in working families, and approximately 60 percent of them work for small businesses with less than 100 employees.[1] That's why AHPs will be especially effective in getting more Americans insured—they are targeted squarely at small businesses who are trying to provide affordable health benefits.

Although most working Americans receive health insurance from their employers, firms with fewer than 100 employees find it particularly difficult to offer benefits. Just 49 percent of these small businesses offer insurance, compared with 98 percent of larger firms with 100 or more employees.

Many small employers want to offer health insurance, but circumstances make it difficult for them. Let me spend just a minute to discuss the barriers small employers face when it comes to health insurance. I will then describe how AHPs will help.

[1] Department of Labor estimates of working families' health insurance status, based on the Census Bureau's annual March Current Population Survey.

First, Cost.—For a variety of reasons, insurers typically charge small firms more per employee than large firms for comparable coverage. According to the General Accounting Office,[2] insurers incur higher marketing, underwriting and administrative costs when providing health care coverage to small employers than to large employers—and they pass those costs on to small firms. Small company premiums are 20 percent to 30 percent higher than those of large self-insured companies with similar claims experience.[3] And the cost of these policies continues to rise—small businesses recently have faced double digit premium increases from year to year.

Second, Overhead.—When a small firm decides to offer health insurance, it must take on administrative tasks, including identifying available insurance policies; comparing their prices, benefit packages and other features; assembling plan descriptions, enrollment materials and other forms; and educating and enrolling its workforce. This takes staff time and money.

Third, State Regulatory Burdens.—The States have been very aggressive in regulating small-group insurance markets, overseeing rates and imposing benefit mandates that leave employers without affordable options, and a very limited ability to design benefits that best suit their needs. Indeed, benefit mandates are responsible for one of every five small employer decisions not to offer coverage.[4] As a result of different benefit mandates and policy approval processes across the 50 States, small businesses generally are not able to join together across State lines. It is expensive and difficult to develop an insurance policy that meets the requirements of more than one State, and the resulting costs from this complexity tend to make such policies unaffordable.

Taken together, these factors put small employers at a big disadvantage in the insurance marketplace. And because the cost and complexity of offering coverage makes small employers eager to shop for bargains, there is one more factor that hits them hard—health insurance fraud.

HOW AHPS WOULD WORK

In an AHP, small businesses could join together across State lines through their trade and professional associations to purchase health benefits, reducing the market and financial barriers that they face. Small businesses would enjoy greater bargaining power, economies of scale, administrative efficiencies, and more uniform regulation, giving them more access to affordable coverage.

To ensure that unscrupulous promoters cannot operate AHPs, only bona fide trade or industry associations that have been in operation for at least three years for purposes other than providing health benefits will be allowed to sponsor these arrangements. Before an AHP can begin operating, EBSA will examine the plan sponsor and certify that they meet rigorous statutory eligibility standards, as well as the applicable tough solvency and membership requirements.

Bargaining Power and Economies Of Scale.—By grouping small employers together to purchase coverage, AHPs will be able to act more like large employers and offer lower cost coverage to employers, employees and their families. If the AHP chooses to purchase insurance, it will be in a better position to negotiate with insurers regarding the terms and costs of coverage than a small employer acting individually. AHPs will also enjoy economies of scale in the administration of plans. They will give insurers a vehicle to market and distribute policies to many small employers at once. By offering a well-selected and stable choice of policies to members, AHPs can help slow small employers' otherwise costly movements from one insurer to another.

Streamlined Regulation.—AHPs will allow small businesses to enjoy a more uniform regulatory system. Just as large employers and unions are able to offer the same health plan to their workers and members regardless of which State they live in, AHPs will allow small businesses to join together across State lines to purchase uniform health benefits. It is important to note, however, that the pending AHP legislation leaves in place major elements of State insurance regulation. Much as in

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[2] U.S. General Accounting Office, Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage, GAO–02–8; and Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market, GAO–02–536R. Insurers must market and distribute their policies to a very large number of unconnected employers. Insurers also must compensate agents for each small policy sold or renewed. Some costs, such as the cost of collecting detailed medical histories for purposes of medical underwriting, are layered on each time an employer changes insurers.

[3] Actuarial Research Corporation. Cost drivers include small businesses' administrative overhead, insurance company marketing and underwriting expenses, adverse selection, and State regulatory burdens.

[4] Gail A. Jensen and Jon Gabel, "State Mandated Benefits and the Small Firm's Decision to Offer Insurance," Journal of Regulatory Economics; 4:379–404 (1992).

the current group health marketplace, insurers selling policies to AHPs are regulated by the States. The AHP legislation passed by the House preserves important State consumer protections for these insurers, including solvency standards and prompt pay laws. AHPs that offer self-insured coverage will be subject to a single, effective, national certification and oversight process administered by EBSA. The legislation provides strict new solvency standards for these plans to protect consumers.

Pooling Risk.—AHPs will help ensure that small employers will not be denied insurance coverage or be priced out of the market due to the health of their employees. An employer with high claims experience would be offered the same coverage options as other employers within the sponsoring association. In fact, AHPs would generally be prohibited from setting premium rates based on health status, severely restricting AHPs' ability to engage in favorable risk selection, or so-called "cherry-picking."

Broader Choice of Coverage.—Associations will be able to fashion coverage options that best meet their members' needs. By offering broader choices, AHPs will encourage small business workers who are currently uninsured to purchase coverage and pay into the premium pool. Expanding health insurance coverage to include more of the uninsured not only improves their lives, but it reduces costs across the system by broadening the risk pool.

Cost Savings and Increased Coverage.—Small businesses obtaining insurance through AHPs could enjoy significant premium reductions. According to the Congressional Budget Office (CBO),[5] the average savings would be 13 percent and could be as much as 25 percent per employer. CBO further estimated that, because insurance will be more affordable, as many as 2 million Americans whose employers do not offer insurance today will be brought into the employment-based health insurance system.

Wide Availability and Greater Access.—Dozens of well-known small business groups are eager to offer coverage to their members, and support enactment of AHP legislation, including organizations such as the National Federation of Independent Business, the United States Black Chamber of Commerce, the United States Hispanic Chamber of Commerce, Women Impacting Public Policy, the American Farm Bureau, the Associated Builders and Contractors, and the National Restaurant Association, to name just a few.

PROTECTING WORKERS BY OFFERING BETTER OPTIONS

Because of the obstacles small businesses face in obtaining affordable health insurance, they are especially vulnerable to scams that promise low-cost health coverage but fail to deliver. Many of these arrangements turn out to be multiple employer welfare arrangements (MEWAs), although they are usually not marketed under that name. MEWA is the legal acronym for arrangements that provide health benefits to employees of two or more unrelated employers who are not parties to a collective bargaining agreement.

MEWAs are subject to a mix of State and Federal laws and regulations. While some MEWAs operate successfully and provide reliable benefits to participating employers and their workers, unscrupulous promoters have exploited complexities in their regulatory and oversight structure to operate Ponzi schemes that collect premiums but intentionally default on their obligations to pay claims.

Health insurance fraud artists take advantage of small employers by marketing generous coverage using slick brochures and promising cheap premiums. The scam artists delay State and Federal law enforcement authorities by raising jurisdictional issues while they collect premiums and sign up new customers. Sometimes these promoters present themselves not as MEWAs, but as other "ERISA plans," not subject to State oversight. Fraud increases the cost for everyone, and the fear of being taken in deters many small employers from offering coverage at all.

EBSA employs a three-pronged approach to fighting insurance fraud. First, we work hard to educate small employers about how to spot fraud in the marketplace to prevent people from falling victim to scams in the first instance. Second, we have a vigorous civil and criminal enforcement program, conducting active investigations and cooperating closely with State insurance regulators to find scam artists, shut them down, recover monies to pay benefits, and send criminal perpetrators to jail. Third, we support the enactment of Association Health Plan legislation, which will provide a secure, well-regulated, and affordable health coverage option for small businesses.

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[5] Congressional Budget Office, "Increasing Small-Firm Health Insurance Coverage through Association Health Plans and Healthmarts," January 2000.

Let me be clear that we regard health coverage scams as a top enforcement priority, and will continue to do so until these unscrupulous operators are stamped out. The President's proposed budget for fiscal year 2005 includes a request for 30 additional investigators, 10 of who will be criminal coordinators in our regional offices—their job will be to work with State and Federal prosecutors and law enforcement entities to make it harder for criminals like these to slip through the cracks.

In the end, however, the best way to protect the public from these scam artists is to change the environment in which they operate. Small employers are more vulnerable to fraud because they have few options for health insurance in most States. High cost and limited choice make employers more receptive to deals that are too good to be true. AHPs will change this environment by providing an attractive, cost-effective alternative to fraudulent health plans that is certified, regulated, and closely monitored by the Department of Labor. There will be no confusion over jurisdiction, and no question as to the Department's authority to shut down bad actors. And, for small employers, the Department's certification will serve as a "stamp of approval" signifying that an AHP will provide reliable, affordable health insurance coverage. By making these real choices possible, AHPs make it harder for scam artists to find people desperate enough to try anything to get the coverage they and their workers need.

CONCLUSION

Thank you, Senator Specter, for the opportunity to testify today. The Administration strongly supports AHPs, and stands ready to work with you to help pass and effectively implement legislation that expands access to affordable quality health insurance coverage for working Americans and their families.

Senator SPECTER. Thank you very much, Secretary Campbell.

STATEMENT OF ALEXIS L. BARBIERI, EXECUTIVE DEPUTY ATTORNEY GENERAL, COMMONWEALTH OF PENNSYLVANIA

Senator SPECTER. Our next witness is the executive deputy attorney general for the Commonwealth of Pennsylvania, Alexis Barbieri.

If I may add just a personal note, which I do on rare occasions when I see Ms. Barbieri, I note my longstanding friendship with her father, Judge Alex Barbieri. He and I were elected to the Committee of Censors of the Philadelphia Bar Association together in 1964, and Judge Barbieri then became a member of the Court of Common Pleas, Number 8, a very distinguished court, with Judge McDevitt and Judge Spaeth. And then Judge Barbieri became a Commonwealth Court judge and a Supreme Court justice.

I tried a murder case, when I was district attorney, before him, Frank Joseph Campbell—this is probably more than you want to know—and without telling you about the case, the defendant, Frank Joseph Mitchell, was victimized in a sheriff's van. And Judge Barbieri then asked me, as district attorney, to lend him a young assistant named Alan Davis, who was the special master, and conducted a very intensive investigation into abuses and prisons attacks on one prisoner against another. That was 1968, and that was the first such investigation ever conducted.

Since that time—this was a long time ago, 36 years ago—there have been many investigations, but that was a landmark investigation. And "60 Minutes" was in its first year in 1968. They came to the sheriff's cell block to interview those of us who were involved in that investigation.

So, Ms. Barbieri, you come from a very distinguished lineage. And having used up all your time, Ms. Barbieri we will now move on to the next witness.

Ms. BARBIERI. Thank you, Senator. I think I will paraphrase my testimony since my time is much more limited than I anticipated.

Senator SPECTER. You have your full time, Ms. Barbieri.

Ms. BARBIERI. Senator, in my capacity in the Attorney General's Office, I was in the Public Protection Division. And within that division is the healthcare section. The attorney general is the chief enforcer in the Commonwealth of the consumer-protection laws. And in the areas of consumer protection that implicate healthcare, the healthcare section investigates, mediates, and brings legal action against entities that engage in unfair or deceptive practices in the delivery of healthcare.

The pending legislation provides special exceptions for health-insurance coverage sponsored by professional business associations, known as association health plans. Health insurance sold through or sponsored by these associations is a coverage option available to the self-employed and small business and others. Currently, these association health plans must comply with all the applicable State insurance and consumer-protection laws. The proposed Federal legislation would allow them to escape State regulation and oversight, which protects consumers by ensuring that these plans are marketed in conformance with the consumer-protection laws.

State oversight and regulation is critical to protect consumers from unscrupulous operators that sell phony health insurance to unsuspecting businesses and individuals. The AHP legislation, which promotes affordability and access to coverage for small businesses and their employees, would exempt them, unfortunately, from that comprehensive State oversight and regulation that consumers have come to expect from their health-insurance coverage. And eliminating the consumer protection laws and State oversight will only harm the consumers. And for that reason, 42 attorneys general across the country have sent a letter in opposition to this legislation because they were concerned about their continuing ability to enforce State law. They know from past experience that exempting these plans from State law harms consumers.

In the 1970s, Congress experimented with providing exemptions for similar entities, multiple-employer benefit arrangement, and the result was widespread fraud and abuse, resulting in $123 million in unpaid medical claims and many uninsured. Congress restored the States' authority to fully regulate these entities in the 1980s, and the States have made tremendous strides in combating healthcare fraud.

These States have been aggressive to take action against unscrupulous operators, issuing 108 cease and desist orders against 41 unauthorized entrants, and imposing civil and criminal penalties. This legislation would not permit them to continue in this enforcement pursuit.

Reemption of State laws would also leave the States powerless to protect the plans that fail to deliver promised benefits or engage in deceptive practices. Under the Federal AHP legislation, protections that are taken for granted would be eliminated.

PREPARED STATEMENT

While the attorneys general strongly support efforts to increase access to affordable coverage for small businesses and their employees, we believe that this legislation would make the problem worse. Indeed, the U.S. Congressional Budget Office found that

AHPs would actually increase health insurance premiums for the vast majority of small firms at a time when businesses are experiencing double-digit increases in the health insurance.

[The statement follows:]

PREPARED STATEMENT OF ALEXIS L. BARBIERI

Good Afternoon. First, I want to thank Senator Arlen Specter—the senior Senator from Pennsylvania—for holding this field hearing on the important issue of health care reform. Senator Specter, you have long been a leader of efforts to improve our nation's health care system through increasing funding for medical research (including doubling funding for the National Institutes of Health); ensuring adequate funding for prevention and public health programs; and, improving access to high-quality, affordable health care.

My name is Alexis Barbieri, and I am an Executive Deputy Attorney General and the Director of the Public Protection Division in the Office of Attorney General for the Commonwealth of Pennsylvania. Within my Division is the Health Care Section. The Pennsylvania Attorney General serves as the principal enforcer of consumer protection laws throughout the Commonwealth of Pennsylvania. In matters pertaining to health care, the Health Care Section of the Attorney General's Office is responsible for protecting consumers through vigorous enforcement of patient protection laws including, but not limited to, the right to independent external review of denied medical claims. The Attorney General's Health Care Section investigates, mediates, and brings legal actions against entities that engage in unfair or deceptive practices in the delivery of health care. It also investigates and mediates consumer complaints of coverage denials and fraudulent practices.

My testimony will focus on the pending legislation before the U.S. Congress (H.R. 660/S. 545), Association Health Plan (AHP) legislation. This legislation provides special exemptions for health insurance coverage sponsored by professional and business associations, known as association health plans (AHPs). Health insurance coverage sold through or sponsored by associations is a coverage option currently available to the self-employed, small businesses, their employees and others. Currently, association health plans—which are engaged in the business of providing health insurance—must comply with all applicable State insurance and consumer protection laws. The proposed federal AHP legislation would allow AHPs to escape State regulation and oversight, which protects consumers by ensuring that these plans are financially sound, fairly priced and cover important health benefits.

State oversight and regulation is critical to protect consumers from unscrupulous operators that sell phony health insurance to unsuspecting businesses and individuals. Regrettably, the AHP legislation, under the guise of improving affordability and access to coverage for small firms and their employees, would exempt AHPs from the comprehensive State oversight and regulation that consumers have come to expect from their health insurance coverage. Eliminating consumer protection laws and State oversight will only harm consumers and, for that reason, 42 Attorneys General across the country, strongly oppose federal AHP legislation.

State oversight and regulation is the best way to ensure that health insurance plans remain financially solvent and that consumers are protected against fraud and abuse. We know from past experience that exempting these plans from State laws harms consumers. In the 1970s, Congress experimented with providing exemptions for similar entities—multiple employer welfare arrangements (MEWAs)—and the result was widespread fraud and abuse, resulting in millions of dollars in unpaid medical claims and more uninsured. Congress restored the States' authority to fully regulate MEWAs in the 1980s, and the States have made tremendous strides in combating health care fraud.

I am especially concerned about the prospect of federal preemption in light of a new wave of health insurance scams that have left over 200,000 individuals and families uninsured and saddled with over $252 million in unpaid medical claims. The States have been aggressive in taking action against unscrupulous operators—issuing 108 cease and desist orders against 41 unauthorized arrangements, as well as, imposing criminal and civil penalties. Regrettably, this legislation would prohibit States from helping consumers by usurping their authority and putting the U.S. Department of Labor (DOL) in charge of regulating these entities. DOL has neither the resources nor the expertise necessary to adequately protect consumers from health insurance scams. According to the U.S. General Accounting Office (GAO), DOL was only able to shut down 3 fraudulent entities out of 144 unauthorized entities identified by GAO over a three year period.

The AHP legislation would also put consumers at risk for unpaid medical claims because of the bill's inadequate solvency standards. Self-funded AHPs would be exempt from State solvency requirements and instead, would have to meet minimal federal standards (capped at $2 million). This standard is far less stringent than State solvency requirements and, thus, far less protective of consumers. Plan failures are a major problem for these types of entities, which have a long and troubled history of financial insolvency and even fraud. Indeed, the assets of the association sponsoring an AHP would not be at risk in the event of insolvency. Therefore, it is critical that the States be able to apply and enforce their stronger solvency standards. Otherwise, consumers would be victims of unpaid medical claims in the event of a plan failure or insolvency.

Also, preemption of State laws would leave States powerless to protect consumers from plans that failed to deliver promised benefits or engaged in deceptive practices. Under federal AHP legislation, protections that are taken for granted would be eliminated including; limits on how much and how often premiums can increase; the right to independent review of claim denials; coverage for important health services (e.g. maternity care, preventive care, child immunizations, cancer screenings, mental health services and treatment) and, consumer marketing protections. Preemption from State laws and oversight will ultimately do great harm to consumers by eliminating many of the consumer protections that Pennsylvanians have come to rely on.

While the Attorney General's Office strongly supports efforts to increase access to affordable coverage for small businesses and their employees, we believe this legislation would actually make the problem worse. Indeed, the U.S. Congressional Budget Office found that AHPs would actually increase health insurance premiums for the vast majority of small firms at a time when businesses are experiencing double digit increases in their health insurance premiums.

Senator SPECTER. Thank you very much, Ms. Barbieri.

For the record, it should be noted that Ms. Barbieri has a bachelor's degree from the University of Pennsylvania, a law degree from Widener University School of Law, and a career as a clerk to Superior Court Judge Vincent Cirillo, who used to be a Montgomery County Court judge.

Senator GREENLEAF. That was in this courtroom.

Senator SPECTER. I had a big case involving—with Frank Perdue, the chicken man, who drove onto the Pennsylvania Turnpike one night when it was under construction, and didn't know that it was one-way, and pulled out to pass and had a head-on collision with an oncoming car, and killed the other driver. And Frank Perdue came to me—I had finished my tour as district attorney and was a defense lawyer at that time—and rather than take the 20 minutes to tell you how I got him off, he was not guilty. It's not necessarily relevant to him getting off.

STATEMENT OF PAUL ZIEGER, ON BEHALF OF THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Senator SPECTER. Back to the hearing. Our next witness is Mr. Paul Zieger, whose family has been in the florist industry for almost a century, 80 employees, and had his health insurance premiums increase by more than 15 percent over the last 4 years. Mr. Zieger has a bachelor's degree in physics from Muhlenberg, and a certificate in business administration from the Wharton School.

Thank you for joining us, Mr. Zieger. We look forward to your testimony.

Mr. ZIEGER. My pleasure.

Good afternoon, Senator, members of the committee. Thank you for inviting me to talk this afternoon about the important issue of affordable and accessible health insurance, especially for those of us who are working and owning small businesses.

I'm here on behalf of the National Federation of Independent Business, the NFIB, which represents 600,000 members of small business people, like I, who face similar challenges. I've been a member of that organization for 30 years.

My name is Paul Zieger, and I own and run a company, Zieger & Sons, which is a wholesale florist. At Zieger & Sons, my employees and I work together to sell and distribute flowers—cut flowers, that is—to retail merchants over a five-State area.

My grandfather started Zieger's in 1910, when he purchased a greenhouse business in the Germantown section of Philadelphia. He restored the greenhouses and developed the business by growing a multitude of flowers and wholesaling them to the local trade. His sons, Herman and Wilbur, took over his dream, and the company grew from there.

As the company moved into the 21st century, the family members decided that it would be best for the success of both the growing and wholesaling divisions if they separated into two companies. Thus, in August 2002, the descendants of Herman Zieger opened Zieger Floral, Inc., for the growing division, leaving the descendants of Wilbur Zieger to operate Zieger & Sons as only wholesale. For those of you who are Montgomery County residents, Zieger owns the warehouse.

At Zieger & Sons, we now have 80 employees. I, along with most of the management team, have college degrees, while most of my employees have high-school diplomas. Our employees range anywhere from high-school graduates to late-50s. We have part-time and full-time workers, and our payroll is divided among hourly workers, commissioned salesmen, and management. Our company has a family atmosphere, with low turnover, which is why it is so important to me to be able to give my employees the benefits they deserve. We are just as dedicated to our employees as they are to us.

Like many entrepreneurs, I learned very early that if I want to remain competitive, I must offer an attractive benefits package. Since the early 1950s, our company has provided comprehensive health insurance for our employees. We have seen steady premium increases of at least 15 percent per year for the last 3 years, and these premiums now rose by more than 19 percent this year. We have been lucky not to have had excessive claims, which could have raised those premiums even more.

It has been an employee—I have an employee in Delaware who now has to be covered under a policy of just one, because I have no group coverage, since he is in another State. I have a similar problem for anyone I might hire from the State of New Jersey, because the insurance coverage is prohibitive. I will keep this employee, even though it is expensive to me, because he is important to me, and I certainly wouldn't want to discharge anybody just because he was difficult to insure.

We changed our plan in 1994 from a PPO to an HMO because of continually rising costs. We want to offer one plan to our employees. And if they want dependent coverage, we charge them. We used to pay 100 percent, but now the employees share 2 percent of that cost of the premium, and we're raising that to 3 percent as we move to try to control our continually rising cost.

Every year, of course, we had to get together and decide what plan we were going to offer to keep our cost under control. We've already heard that our increases have been more than 15 percent per year, and so we need association health plans to help us do that. And we have always absorbed those costs and looked to the future for Congress to help us to help keep those benefits available to us. The bottom line is, I take the risk of losing employees and dramatically increasing my turnover costs as I struggle to deal with this.

I support businesses being successful, but when I'm faced with double-digit increases every year, or when other small businesses cannot provide health insurance to their workers, I feel that the insurance industry is more worried about their profits than our ability to afford healthcare. I have to compete, so why shouldn't insurance companies? Simply put, competition is needed in the small market.

It is for this reason I support the legislation endorsed by the NFIB for the association health plans. And we've already heard the testimony about how they would allow us the same benefits that big companies and labor unions have.

Mr. Chairman, thank you for supporting this legislation and for allowing me to share my experiences.

[The statement follows:]

PREPARED STATEMENT OF PAUL ZIEGER

Good afternoon Mr. Chairman and Members of the Committee. Thank you for inviting me to talk about the important issue of affordable, accessible health insurance, especially for those owning or working for small businesses. I am pleased to be here on behalf of the National Federation of Independent Business (NFIB), representing 600,000 members who face a similar challenge. I have been a member of NFIB for 30 years.

My name is Paul Zieger, and I own and run Zieger & Sons, Inc., a wholesale florist. At Zieger & Sons, Inc., my employees and I work together to sell and distribute flowers to retail merchants over a five-State area.

Ernst Zieger started Zieger & Sons, Inc. in 1910 when he purchased a greenhouse business in the Germantown section of Philadelphia. He restored the greenhouses and developed his business by growing a multitude of flower varieties and wholesaling them to the local retail trade. His sons Herman and Wilbur took over his dream, and Zieger & Sons prospered. As the company moved into the 21st century, the family members decided that it would be best for the success of both the growing and wholesaling divisions if they separated into two separate companies. Thus in August 2002, the descendants of Herman Zieger opened Zieger Floral Inc., for the growing division, leaving the descendants of Wilbur Zieger to operate Zieger & Sons as only wholesale.

At Zieger & Sons Inc., we now have 80 employees. I, along with most of the management team, have college degrees, while most of my employees have high school diplomas. The ages of our employees range anywhere from just out of high school to late fifties. We have part-time and full-time workers, and payroll is divided among hourly workers, commission sales, and management. It is a family atmosphere with low turnover, which is why it is so important to me to be able to give my employees the benefits they deserve. We are just as dedicated to our employees as they are to us.

Like many entrepreneurs, I learned early that, if I want to remain competitive I must offer an attractive benefits package. Since the early 1950's, we have provided comprehensive health care insurance to our employees. We have seen steady premium increases of at least 15 percent per year for the last 3 years, and this year premiums rose by 19 percent. We have been lucky not to have had any catastrophic claims or I am sure they would be much higher.

One of my employees lives in Delaware. He has been an employee for six years and a very valuable one at that. Unfortunately, I pay quite a bit more for his health benefits since he resides in another State. Currently, there is no way to offer insur-

ance across State lines; therefore I have to pay for an individual policy. I will continue to do that because he is an excellent employee, and it is worth it to me to have him on staff. With 80 total employees, we are able to spread our health risks a little, but they need to be spread over a larger group to keep the costs down. I would like my employee from Delaware to be included in the same pool, as well as any other employees I might hire in the future from surrounding States.

We currently offer a Health Maintenance Organization Plan (HMO) to our employees. We changed plans in 1994 from a Preferred Provider Plan (PPO) to an HMO since many of the physicians were dropping out of the PPO network and costs were continually going up. We offer one plan to our employees and if they want dependent coverage they must pay for it themselves. We used to pay 100 percent of their premium, but each year we have had to ask the employees to pay more to allow us to continue to offer health care coverage. New employees must wait 90 days before becoming eligible, but after that period, the plan is offered to all workers including part-time workers who work over 30 hours per week.

Every year I, along with our human resources person, research different options for affordable health care for our workers. In February each year, my benefits consultant and I go through the painstaking work of getting bids from other insurance carriers or researching different options to bring down the cost. For the past three years, our health care costs have increased by 15 percent, and this year they rose by 19.4 percent. Currently, we pay 98 percent of the premium with the employee paying 2 percent. This year we will increase the employee pay share to 3 percent and raise our co-pays to bring our premium increase down to 14 percent. Seems to me that insurance companies continue to subsidize their costs by raising our rates. How is it that these companies have such high paid executives yet claiming they must raise rates to survive?

Knowing that providing health insurance is necessary to me for both business and personal reasons, and knowing that I cannot increase prices to my customers an extra 20 percent in order to absorb the cost, I continue to offer health insurance benefits, despite the growing cost to the business. Our business has absorbed the added cost every year. This company has run like a family operation for years, and I cannot imagine denying my employees health coverage, but unfortunately we are extremely worried about how the increases will look next year. The bottom line is I take the risk of losing good employees and dramatically increasing my turnover rate if we are forced to lower coverage and increase employee contribution.

While I continue to struggle to provide affordable coverage, some of the big insurance companies have announced record profits the last few quarters. Are they making money off the backs of hard-working small business owners? I support businesses being successful but when I'm faced with double-digit increases every year or when other small businesses cannot provide health insurance to their workers, I feel that the insurance industry is more worried about their profits than my ability to afford health care for my employees, which tells me the system is broken. I have to compete so why shouldn't insurance companies? Simply put, competition is needed in the small group market.

It is for this reason that I support legislation endorsed by NFIB that would create Association Health Plans (AHPs). AHPs would allow small business owners to band together across State lines to purchase health insurance as part of a large group, thus ensuring greater bargaining power, lowering administrative costs and easing the burden of having to comply with 50 different sets of costly State insurance mandates. Fortune 500 companies and labor unions already have this right. AHPs will simply level the playing field and give small employers the same privileges as their counterparts in labor and big business.

Mr. Chairman, thank you for your support of the legislation and for allowing me to share my experience with you and the Members of the Committee. I look forward to the relief that will come from Congress by enacting AHPs and I am happy to answer any questions that the Committee may have.

Senator SPECTER. Thank you, Mr. Zieger. I compliment you on your statement. I compliment you on handling all of those papers. I've seen a lot of witnesses at a lot of hearings, and I compliment you on doing an outstanding job. That's very effective.

STATEMENT OF RAY CARROLL, ON BEHALF OF THE PENNSYLVANIA RESTAURANT ASSOCIATION

Senator SPECTER. Our next witness is Mr. Ray Carroll, owner of Ray's Restaurant & Malt Shop, located in East Norriton, Pennsyl-

vania. Mr. Carroll is a graduate of Florida International University, with a bachelor of science and hotel/restaurant management.

Thank you for joining us today, Mr. Carroll, and we look forward to your testimony.

Mr. CARROLL. Thank you for having me today, Senator Specter and other members of the Committee.

One of the greatest challenges facing restaurants and other small businesses today is the accessibility to affordable, quality healthcare.

My name is Ray Carroll, and I am representing the Pennsylvania Restaurant Association as a member of the board of directors of the Philadelphia/Delaware Valley Chapter. I'm involved in our community through my restaurant, which touches over 100 nonprofit organizations in Montgomery County and the Philadelphia area. As you know, I own Ray's Restaurant & Malt Shop, since 1986, and employ 40 individuals.

There are over 870,000 restaurant locations in the United States. The vast majority of these restaurants are small, single-unit operations. And 7 out of 10 have less than 20 employees. The restaurant industry is also one of the largest employers in the country, employing an estimated 11.7 million people, making it the largest employer outside of government.

One of our primary obstacles to providing improved coverage to more people is cost. Restauranteurs from around the country are reporting that same staggering increases facing other small employers. For each of the last 2 years, the average premium increase for a table-service restaurant was 23 percent. Unfortunately, analysts project similar increases for the foreseeable future.

Employees of smaller companies also pay more to offer healthcare than those of large employers. On average, a worker in a firm with less than 10 employees pays 18 percent more for health insurance than a worker in a firm with 200 or more employees. Obviously, small businesses cannot pass on their retail costs or menu prices of 18 to 20 percent every year, or else we would be all out of business.

The cost encountered in today's small group health-insurance market not only makes it difficult for employers to find affordable coverage, it is forcing those who wish to continue offering coverage to make difficult decisions. Many employers are either having to reduce coverage, pass on a higher percentage of their cost to their employees, or have to discontinue offering coverage altogether.

Another challenge facing employers is the lack of choices when shopping for a health plan. In many States, the small group healthcare market only offers employers a small handful of choices. It is clear to us that additional competition is necessary.

If enacted, association health plans would decrease costs and provided needed competition. But allowing employers to consider the health plan of a bona fide trade association of their choice, whether that be the Pennsylvania Restaurant Association plan or a Chamber of Commerce plan, employers would have more health plan options from which to choose. AHPs would allow small businesses to take advantage of the same uniform regulatory status, economies of scale, purchasing clout, and administrative efficiencies that corporate and labor unions current enjoy.

In addition, association health plans would provide quality and reliable health coverage. Like corporate and labor unions, AHPs would be fully regulated by the Department of Labor.

In September 2002, Secretary Elaine Chao issued a comprehensive report detailing the Department of Labor's readiness for assuming oversight of AHPs. Also in this report, Secretary Chao emphasized the numerous safeguards in the AHP legislation that are designed to protect consumers.

PREPARED STATEMENT

The Pennsylvania Restaurant Association and I, as a small business owner, believe association health plans provide a great way to increase access to the uninsured. By removing some of the cost barriers and by instilling additional competition into the small-group market, AHP legislation provides employers, particularly small employers, the tools they need to provide quality healthcare to more people.

Thank you for inviting me today to give my testimony.

[The statement follows:]

PREPARED STATEMENT OF RAY CARROLL

One of the greatest challenges facing restaurants and other small businesses today is accessibility to affordable, quality health care. Senator Specter and members of the committee, thank you for the opportunity to present testimony today on the Association Health Plan legislation which will provide quality health care coverage to more individuals.

My name is Ray Carroll, and I am representing the Pennsylvania Restaurant Association as a member of the board of directors of the Philadelphia Delaware Valley Chapter. I am involved in my community through my restaurant which touches over 100 non-profit organizations in Montgomery County and the Philadelphia area. As you know, I have owned Ray's Restaurant and Malt Shop since 1986 and employ 40 individuals.

There are over 870,000 restaurant locations in the United States. The vast majority of these restaurants are small, single-unit operations, and 7 out of 10 have less than 20 employees. The restaurant industry is also one of the largest employers in the country—employing an estimated 11.7 million people—making it the largest employer outside of government.

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If enacted, Association Health Plans would decrease costs and provide needed competition. By allowing employers to consider the health plan of a bona-fide trade association of their choice—whether that be the Pennsylvania Restaurant Association plan or a Chamber of Commerce plan—employers would have more health plan options from which to choose. AHPs would allow small businesses to take advantage of the same uniform regulatory status, economies of scale, purchasing clout, and administrative efficiencies that corporate and labor unions currently enjoy.

In addition, Association Health Plans would provide quality and reliable health coverage. Like corporate and labor union plans, AHPs would be fully regulated by the Department of Labor. In September 2002, Secretary Elaine Chao issued a comprehensive report detailing the Department of Labor's readiness for assuming oversight of AHPs. Also in this report, Secretary Chao emphasized the numerous safeguards in the AHP legislation that are designed to protect consumers.

The Pennsylvania Restaurant Association and I as a small business owner believe Association Health Plans provide a great way to increase access to the uninsured. By removing some of the cost barriers and by instilling additional competition into the small group market, AHP legislation provides employers—particularly small employers—the tools they need to provide quality health care to more people.

Senator SPECTER. Thank you, Mr. Carroll.

STATEMENT OF MARY BETH SENKEWICZ, SENIOR COUNSEL FOR HEALTH POLICY, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Senator SPECTER. Our final witness on this panel is Ms. Mary Beth Senkewicz, senior counsel for Health Policy of the National Association of Insurance Commissioners. Prior to joining the association, she supervised the Consumer Affairs Division of the Wyoming Insurance Department. A JD from St. John's University, and a bachelor's degree in English and philosophy from Cabrini College, right around the corner—are you a native of this area, Ms. Senkewicz?

Ms. SENKEWICZ. I'm not, Senator. I was born in New York City, but I went to Mother Cabrini High School and then to Cabrini College.

Senator SPECTER. That makes you an adopted native.

Ms. SENKEWICZ. Thank you. And I'm on the board now. Thank you.

Senator SPECTER. Thank you for joining us. We welcome your testimony.

Ms. SENKEWICZ. Thank you, Senator.

I'm testifying this afternoon on behalf of the NAIC, which represents insurance regulators in all 50 States, the District of Columbia, and four U.S. territories, the National Association of Insurance Commissioners. The primary objective of insurance regulators is to protect consumers. And it is with this role in mind that I comment today on the AHP legislation.

At the start, I would like to emphasize that the States recognize the importance of insuring that health coverage is affordable and available for small businesses. And we offer the full support of the NAIC in developing legislation that will reach those goals.

States have acted aggressively over the past 15 years to stabilize and improve the same-group market. More must be done, we agree. But unless the most basic underlying issue, the cost of healthcare, is directly addressed, all efforts will have limited results.

We would like to work with the Chair to develop legislation that would make insurance more affordable and provide small businesses with greater choices, but any legislation must meet the following criteria.

First, higher-risk employees must not be forced out of the market. Before State small-group market reforms were implemented, if an employee became sick, the employer was shifted to a higher-risk pool and often priced out of the market. State small-group market reforms forced insurers to treat all small employers as part of a

single pool, and allow only modest variations in premiums based on risk. This spreading of risk has brought fairness to the market, and must be preserved for the sake of higher-risk employers and their employees.

The AHP bill would dismantle the small-market reforms, allowing plans to cherry-pick risk, leaving higher-risk consumers with little or no coverage. The bill's proponents claim to have addressed this issue, but that is not the truth. AHPs would be encouraged to cherry-pick using four very basic methods: benefit package design, service area, membership, and rating. And the more underhanded plans could think of many more ways to improve their risk pool.

Second, consumers must be protected from plan failures and fraud. Over 10,000 State employees nationwide oversee the business of insurance to ensure that plans are able to pay claims. Through reporting requirements, States receive the information they need to identify problems and force corrective action. Yes, State regulation has a cost, but it has a cost because it provides real protections for consumers. Adequate Federal regulation would also have a cost.

Insurance is a complicated business involving billions of dollars, with ample opportunity for unscrupulous or financially unsophisticated entities to harm millions of consumers. The fact is, each time oversight has been limited in the past, the result has been the same: increased fraud, increased plan failures, decreased coverage for consumers, and piles of unpaid claims.

Crucial to the long-term viability of insurance plans is the maintenance of sufficient capital and reserves. In particular, the capital-reserve requirement in the bill for any and all AHPs is capped at no more than $2 million, no matter the size of the plan. States require the capital surpluses to grow as the plan grows.

More troubling, even if the solvency standards increased, oversight is nonexistent. State regulators comb over financial supports and continually check investment ratings to ensure that any potential problems are identified and rectified quickly. The AHP legislation would rely on self-reporting and an under-funded Department of Labor to identify and correct problems. The Department of Labor does not have the personnel, the funding, or the expertise to provide adequate oversight of the AHPs. The regulation of the self-funded ERISA plan is very different from regulating an insurance company, which is exactly what a self-funded AHP is. It is the creation of a Federal insurance company. This should be of particular concern to the committee.

PREPARED STATEMENT

Finally, patient rights must be preserved. The AHP bill will broadly preempt State consumer protections, since the AHP is self-insured, such as external appeals processes, policy and advertising reviews to prevent unfair or misleading language, networks, and utilization review standards, just to say a few. Furthermore, there would be no entity to complain to if the patient's rights are violated. States insurance regulators act on thousands of complaints every year and work hard to protect the rights of patients.

Mr. Chairman, thank you for inviting the NAIC to testify today. I ask that my full statement be made a part of the record.

[The statement follows:]

PREPARED STATEMENT OF MARY BETH SENKEWICZ

INTRODUCTION

Good morning Mr. Chairman. My name is Mary Beth Senkewicz and I am Senior Counsel for Health Policy for the National Association of Insurance Commissioners (NAIC). The NAIC represents the chief insurance regulators from the 50 States, the District of Columbia, and four U.S. territories. The primary objective of insurance regulators is to protect consumers and it is with this goal in mind that I comment today generally on the small business healthcare crisis, and in particular the proposal to create Association Health Plans (AHPs).

At the start, I would like to emphasize that the commissioners recognize the importance of ensuring that health coverage is affordable and available for small businesses and offer the full support of the NAIC in developing legislation that will reach these goals. States have acted aggressively over the past ten years to stabilize and improve the small group market. Many States have even implemented laws that allow associations to provide insurance to their members. However, the members of the NAIC remain strongly opposed to the AHP legislation that has been offered in Congress. More can and must be done to make health insurance more affordable for small business employees, but the AHP legislation, as currently drafted, would do more harm than good.

WHAT STATES AND THE NAIC HAVE ALREADY DONE TO ADDRESS THE PROBLEM

Throughout the 1990's, the States and the NAIC have devoted significant attention to the problem of making health insurance available to small employers. We have taken a variety of approaches in this effort.

Small Group Reform

One approach the States have taken is small group reform. Before the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 46 States had enacted some kind of small group reform based in varying degrees on NAIC models.

In 1992, the members of the NAIC adopted the Small Employer and Individual Health Insurance Availability Model Act. It required the guaranteed issue of a basic and standard health benefit plan by all health carriers doing business in a State's small group market. It also required guaranteed renewability, subject to certain exceptions, and established rating bands to assure consumers are not priced out of the market and risk is spread over a larger pool. In essence, the block of small group business is treated much like large groups for rating purposes.

In 1995, the NAIC refined this model. The 1995 version required guaranteed issue and guaranteed renewability of all products offered by a carrier in a State's small group market. It also required adjusted community rating with adjustments permitted only for geographic area, age, and family composition.

Today, our members are examining the impact of HIPAA and determining what further efforts are needed by States to assist small businesses in the provision of coverage.

Purchasing Pools

Allowing small businesses to form purchasing pools, sometimes called purchasing alliances, is another approach that States have taken to make health insurance more available to small groups. By joining together, small groups can somewhat reduce their administrative costs, provide their employees with more choice, and command better prices.

The NAIC has devoted considerable attention to health insurance purchasing pools. In 1995 the NAIC adopted three model acts allowing for the creation of purchasing alliances. These models represent the NAIC's complete agreement with the concept that small employers should have the opportunity to join together to purchase health insurance.

At least twenty-two States have either adopted legislation that creates some kind of purchasing pool or have allowed purchasing pools to operate without legislation. In 2000, Kansas passed legislation creating the Kansas Business Health Partnership, which allows for small groups to pool and establish their own set of benefits. It is not comprehensive insurance but it is a low cost alternative for businesses especially those with low wage workers.

Again, the NAIC agrees that more needs to be done to expand coverage to small businesses. Reforms should be broad, addressing both the affordability of insurance

(bringing down the cost of coverage to small businesses, possibly through financial incentives) and the availability of insurance (expanding choice and promoting competition). However, the AHP legislation is not the answer and would have the effect of reversing many of the gains that have been made over the last 10 years.

SPECIFIC CONCERNS ABOUT CURRENT AHP LEGISLATION

The AHP Legislation Would Undermine State Reforms

Before State small group market reforms were implemented, the small group market was fragmented into various pools based on risk. If a small employer had healthy employees in a relatively safe working environment the employer could easily find coverage at a good rate. However, if one of the employees became sick, the employer would be shifted to a higher risk pool and often priced out of coverage. Those who started with sicker or higher risk employees were often priced out of the market from the beginning.

State small group market reforms forced insurers to treat all small employers as part of a single pool and allow only modest, and in some States no, variations in premiums based on risk. This spreading of risk has brought some fairness to the market. The AHP legislation in Congress would undermine State reforms and once again fragment the market. AHPs would be encouraged to "cherry-pick" using four very basic methods:

(a) *Benefit design*.—S. 545 eliminates all State benefit mandates, allowing plans to deny consumers costlier treatments;

(b) *Service area*.—S. 545 eliminates State service area and network requirements, allowing plans to "redline" and avoid more costly areas;

(c) *Membership*.—S. 545 permits associations to offer coverage only to their members, allowing plans to seek memberships with better risk;

(d) *Rating*.—S. 545 eliminates State rating limits for most plans, allowing them to charge far more for higher risk persons, forcing them out of the pool.

While the AHP bill does make some effort to reduce "cherry picking" the NAIC believes the provisions would be woefully inadequate.

The AHP Legislation Would Lead to Increased Plan Failures and Fraud

Proponents of the AHP legislation claim that the Department of Labor already has sufficient resources to oversee the new plans and will be able to prevent any insolvencies or instances of fraud. This simply is not the case. The Department of Labor has neither the resources nor the expertise to regulate insurance products. The States have invested more than 125 years in regulating the insurance industry. State insurance departments nationwide employ over 10,000 highly skilled people, and the combined budgets of State insurance departments total more than $700 million. The AHP bill provides no new resources for regulating these plans.

While we acknowledge State regulation does increase costs, it exists to protect consumers. Insurance is a complicated business, involving billions of dollars, with ample opportunity for unscrupulous or financially unsophisticated entities to harm millions of consumers. Unless oversight is diligent, consumers will be harmed.

This is not just speculation, but fact borne of years of experience with Multiple Employer Welfare Arrangements (MEWAs), multi-State association plans, out-of-State trusts, and other schemes to avoid or limit State regulation. Within the last year, 16 States have shut down 48 AHP-like plans that had been operating illegally in the State, many through bona fide associations. Association plans in several States have gone bankrupt because they did not have the same regulatory oversight as State-regulated plans, leaving millions of dollars in provider bills unpaid.

Each time oversight has been limited the result has been the same—increased fraud, increased plan failures, decreased coverage for consumers, and piles of unpaid claims. Specifically, the NAIC believes the following issues must be addressed:

Solvency Standards Must Be Increased

While the solvency standards in the AHP legislation have been increased over the years, they are still woefully inadequate. In particular, the capital reserve requirement for any and all AHPs is capped at $2 million—no matter the size of the plan. Almost all States require the capital surpluses to grow as the plan grows, with no cap or a far higher cap than that in the federal legislation. If a nationwide AHP were offered to a large association, a capital surplus of only $2 million would result in disaster.

AHP Finances Must Receive Greater Oversight

Even if the solvency standards were increased, oversight is almost nonexistent in the bill. Under the bill the AHP would work with an actuary chosen by the association to set the reserve levels with little or no government oversight to ensure the

levels are sufficient or maintained. Also, the AHP would be required to "self-report" any financial problems. As we have seen over the past year, relying on a company-picked accountant or actuary to alert the government of any problems can have dire consequences for consumers who expect to have protection under their health plan.

State regulators comb over financial reports and continually check investment ratings to ensure that any potential problems are identified and rectified quickly. AHP plans must be held to the same standard.

Simply limiting participation in AHPs to "bona fide trade and professional associations" and providing limited Department of Labor oversight of self-reported problems will not prevent fraud and mismanagement. Strict oversight is required and this will only occur if all health plans delivered through associations are licensed and regulated at the State level.

The AHP Legislation Would Eliminate Important Patient Protections

Included in the current AHP legislative proposals is the broad preemption of consumer protection laws. Proponents of AHPs will argue that State mandated benefit laws must be preempted so that AHPs do not have to provide coverage for expensive benefits. However, States have a complex regulatory structure in place for insurers. Not only will mandated benefit laws be preempted, but other laws protecting patient rights and ensuring the integrity of the insurers would be preempted as well. A small sample of these laws and actions follows:

—Internal and external appeals processes.
—Investment regulations to ensure that carriers only make solid investments instead of taking on risky investments such as junk bonds.
—Unfair claims settlement practices laws.
—Advertising regulation to prevent misleading or fraudulent claims.
—Policy form reviews to prevent unfair or misleading language.
—Rate reviews. Insurance departments may review rates to make sure the premiums charged are fair and reasonable in relation to the benefits received.
—Background review of officers.
—Network requirements including provider credentialing and network adequacy, to ensure that plans offer a provider network that is capable of delivering covered services.
—Utilization review requirements to ensure that plans have acceptable processes and standards in place to determine medical necessity and to make coverage determinations.

While some of these protections may be offered by AHPs as a service to their association members, there would be no requirement that they do so, and no entity to complain to if a patients' rights are violated by the plan. State insurance regulators act on millions of consumer complaints every year and work hard to protect the rights of patients. AHP participants should have access to the same protections and complaint process.

The AHP Legislation Would Cut Funds to High Risk Pools and Guaranty Funds

While the latest version of the AHP legislation would allow States to impose premium taxes on AHP plans—to the extent they are imposed on other insurance plans—it preempts other State assessments. States often use health insurance assessments to fund such important entities as high risk pools (which provide coverage to the uninsurable) and guaranty funds (which help cover claims if a plan is insolvent.) Such programs are vital to the stability of the small group and individual markets and to the protection of consumers—they must not be undercut by federal preemption.

CONCLUSION

All of us recognize that it is very important to make health insurance available to small employers. The States have addressed this problem, and will continue to do so. However, the problem is complex and does not lend itself to easy solutions.

The AHP legislation proposed in Congress would put consumers at significant risk and disrupt the health insurance market. The illusion of federal regulation based on company self-reporting of problems will lead to extensive failures. The fragmentation of the small group market will leave many small businesses with higher premiums, or no coverage options at all.

The NAIC opposes AHP legislation as currently drafted and urges Congress not to adopt it. History has demonstrated that AHP-type entities have done more to harm rather than to help small businesses. The federal government and the States need to work with healthcare providers, insurers and consumers to implement true reforms that will curb spending and make insurance more affordable to small businesses. We stand ready to work with members of Congress to draft effective reforms

that will address both the affordability and availability issues facing small businesses. Together, we are convinced, real solutions to this critical issue can be found.

Senator SPECTER. Thank you, Ms. Senkewicz, for your comprehensive testimony. Your full statement will be made a part of the record.

Mr. Carroll, when you commented that small companies have to pay 18 percent more than the larger companies, if the smaller companies and restauranteurs, who you are speaking for, could have that 18 percent reduction, would that bring those policies within affordability for your restaurants?

Mr. CARROLL. Much more affordability. And that trickles down not only to offering employees that really enjoy the restaurant profession and industry, that really care, it trickles down to keeping those employees, retaining them, and being able to offer new employees that are out there an opportunity to work with you and to be a part of the community. So absolutely it would.

I mean, it's staggering what the insurance rates have gone up in our area. I would say sometimes it's been higher than 18 percent every year, so it's very difficult to manage.

Senator SPECTER. Mr. Zieger, you commented that, as I understood your testimony, you've raised the employees' share from 2 percent to 3 percent.

Mr. ZIEGER. Yes, we're just doing that, starting May 1.

Senator SPECTER. And that has been a considerable help to your company, enabling you to pay for the increasing cost?

Mr. ZIEGER. Oh, yes. We changed our deductibles, we increased our emergency-care co-pay from $50 to $100. We increased our specialist co-pay from $30 to $40.

Senator SPECTER. So you made those modifications of coverage, and you also increased the employees' share from 2 percent to 3 percent. Were your employees satisfied to see those modifications?

Mr. ZIEGER. Yes, they are, because they read the newspapers and see worse things out among their colleagues.

Senator SPECTER. It's interesting that they have been met receptively in your program.

Ms. Senkewicz and Ms. Barbieri, you both have raised a point about the issue of oversight. Ms. Barbieri, if the bill was modified to permit the State attorneys general to have oversight, would that solve a significant part of your objection to the bill?

Ms. BARBIERI. Yes, sir, definitely.

Senator SPECTER. Ms. Senkewicz, when you testified about sufficient capital reserves, capped at $3 million, what would you think the bill ought to provide to meet that very important objection that you have raised?

Ms. SENKEWICZ. In the State—Senator, at the State level, we use a concept that is called risk-based capital, which assesses the risk of the entire company. And there are different types of risk—insurance risk, business risk, investment risk, and some others that I'm forgetting. But in using the formula, then, you come up with an amount of money that the company needs to have in reserve, which is going to vary, then, according to the size of the plan.

Senator SPECTER. So you really think the Federal program ought to be modified to take those actuarial items into account. If we were able to do that, and exclude the higher-risk—eliminate the

cherry-picking, as you characterize it—well, you raise good objections to deal with the fraud issues and the patients' rights. Do you think the bill could be restructured to meet the objections which you and General Barbieri have raised, and allow small businesses to pool to get the benefits of larger purchaser participation?

Ms. SENKEWICZ. Senator, we definitely would like to work with the committee to look at restructuring of the bill. In fact, Senator Durbin and Senator Lincoln recently dropped a bill called the Small Employer Health Benefits bill that we are presently studying. That structure, which is different from an AHP structure because it uses insured plans only. Obviously greater pooling risk is something that the States are aware of and are working towards. States allow pooling now, but it is only usually within State lines. We'd be happy to work with you.

Senator SPECTER. Well, thank you for the invitation and the suggestions. And you raise important objections, and we need to deal with them.

Secretary Campbell, if this bill were enacted, two questions for you. How many people do you think could be covered among the now 40-million-plus Americans who are not covered by health insurance? And how much would cost be reduced?

Mr. CAMPBELL. There are several different studies that looked at that question. As I indicated, the Congressional Budget Office found that there would be up to 2 million Americans who previously had not had employer-provided insurance who would get it, and that the average premium savings would be up to 25 percent. There have been other studies, including by CONSAD, that estimate more on the order of 8 to 8½ million people with proportionately higher savings, as well.

I would like to point out one thing. I think the Senator has a very good point, which is, we can resolve the questions that folks are raising, the concerns they have with this legislation, through the legislative process. The question is not whether this is a good or a bad idea; the question is: How do we take this good idea and implement it to make it work even better? And that is something we're committed to working with you and the committee on, as well.

I would want to point out one important factor in this debate that's been a little bit blurred. Most AHPs would be purchasing insurance products from the State, and that insurance product would be regulated by the State, with a fairly narrow exception.

Senator SPECTER. So you're not going to cut out Ms. Barbieri?

Mr. CAMPBELL. No, sir. In fact, most of the consumer protections that we're talking about would continue to apply to insured products that an AHP is offering. But the narrow exception is to the benefit design, and the purpose of that is to allow uniformity so that benefits can be offered across State lines, much as they are for large employers and union plans. Our reading of the bill, and the reading of the bill by the House Education and Workforce Committee in their committee report, which I would certainly commend to the committee's attention, points out that external reviews, solvency standards, prompt pay laws, and a variety of other consumer protections not affiliated with benefit design are, in fact, preserved,

and the States do still have the regulatory authority under the legislation.

Senator SPECTER. Senator Greenleaf.

Senator GREENLEAF. Thank you.

Mr. Zieger, you grow roses, don't you?

Well, that was part of Zieger & Sons, prior to August 2002, but my cousin, David, under Zieger Florals company, does that.

Well, you've been an institution in the Willow Grove area. And there must be a lot of pressure on you, with all that land there, with the housing and commercial development there. It must be difficult to continue as a small business there, and I congratulate you on being able to do that. We all know that small businesses hire and create more jobs than any other type of business, and they hire more people than any other type of business, and it is important for us to make sure that you have a viable workforce, as well.

What are your costs in comparison to—and I guess this goes to Secretary Campbell, as well—what are your actual costs, as compared to other larger businesses? And what do they pay, as far as actual premiums for health insurance? Obviously, it's across the board, because it depends on what the benefits are, what deductibles are. Maybe you could give us some idea of what we're talking about as a comparison between those that are allowed to join together and those that are not.

Mr. CAMPBELL. The statistics that the Department of Labor has indicate that small employers pay roughly 20 to 30 percent more for similar benefits, and a large portion of that cost is due to the administrative overhead, the lack of negotiating ability. And all that's related to the inability to pool across State lines to get like-minded groups. When you're bidding for insurance for 5 or 10 people, and an insurer has to market that product to each of you separately, that increases cost and makes it much more difficult to provide the same benefits in a cost-effective manner.

Senator GREENLEAF. What about providing for oversight? Is the small business able to, unlike a larger one that maybe has thousands of employees, have a better oversight on what's being used? I mean, obviously, we've become so distant from our insurance that, you know, it's covered, it's paid; we don't really look at the bill very closely, we don't challenge it if it's wrong. Are there any things we could do to help that situation, to maybe give the employee, as well as the employer, a stake in the savings? Is that a factor in the cost of health insurance? And is a small employer capable of implementing this a little bit better than a larger one?

Mr. CAMPBELL. Well, to the question of other proposals that help get the actual consumer of the service, the employee, more involved in the decisions that are made, the administration has supported—in fact, the Congress has passed, in the Medicare legislation, health savings accounts, which are a way to allow persons to make those healthcare decisions with pre-tax dollars, and then use that in conjunction with a sort of major-medical insurance policy that has a lower premium. The result being a consumer making the choices up front and having money they can transfer from year to year and actually have ownership of while still having a lower cost, but important health benefits.

Senator GREENLEAF. The health savings account is where basically employers put up the savings account, and the employee gets the benefits. If they under-use it, they have the benefit of what's left over. What about just reversing that a little bit and getting employees even more involved in it by giving them the monies to take out to buy their insurance? There's a set amount, and then it's their responsibility, not the employer's, to go out and buy that insurance. Would that add more cost savings?

Mr. CAMPBELL. Two things. First of all, HSAs can be used by individuals as well as employers. It's really an individual tax benefit, so it goes in that direction that you're speaking of.

But as for the second point, employment provides a stable pooling device that generally offers better rates and better benefits than is available in the individual insurance market. Generally speaking, employer-provided coverage is cheaper and more comprehensive, which is one of the reasons that most Americans get their health coverage through their employer, as opposed to buying it on the insurance market for individuals.

Mr. ZIEGER. We were told by our consultant that the HSAs are possibly the wave of the future. And I suppose it would take the insurance factor out in many cases. That way, I would have a health savings account and use the funds in that account to just go pay a doctor for a visit or for my annual physical, and get rid of the insurance cost. You would only be insured for catastrophic illness, $2 or $5 thousand, whatever catastrophic kind of thing, and you'd just pay for service on a fee-for-service basis.

Senator GREENLEAF. It just seems to me the more we get the employee involved in the decisions, I think there will be cost savings there, as well. There's a little—there's now little involvement involving the employees. They're not the gatekeepers; they're not the ones looking at what the costs are. Then how we could save—whether there's double-billing or mistakes in the bill.

Thank you.

Senator SPECTER. Thank you very much, Senator Greenleaf.

Rep. Fichter.

Rep. FICHTER. Thank you, Senator.

Senator, before I ask questions, I just want to let you know that Ray's Diner has the best eggs benedict in Montgomery County.

Senator SPECTER. What time do you finish serving?

Mr. CARROLL. There's always an open invitation. We serve eggs benedict all day.

Rep. FICHTER. Thank you.

Mr. Campbell, you have me confused. Basically, when you say that when you have a large group or big corporations are going to pay one cost, and then the small firms, with the same level of benefits, are going to pay a higher cost than large corporations, I'm having a problem trying to figure out how that happens. Are you indicating that the small firms are subsidizing the large firms? Is that what you're saying?

Mr. CAMPBELL. No, sir. It goes to the nature of trying to offer products to them. First of all, the small firm is only, as I said before, 5 or 10 people. Clearly, when you have 5 or 10 people negotiating for any product, compared to 5 or 10 thousand, you're not going to get an economy of scale, you're not going to get some cost

savings associated with that. There are several reasons for that. One is, an insurer has to go out and find the small businesses, so there are marketing costs. There are administrative costs going through the rating processes for each of those businesses, which compound themselves, so that the cost for an insurance policy for that small business has a lot more overhead and those kinds of costs built into it. When you have a larger plan, say a union plan, and you're pooling them across these broad areas, you're able to more competitively bid that out. You have one contact point, which reduces your marketing cost, for example, and a variety of savings in those ways.

Rep. FICHTER. Well, taking it just one step further, if you have a group—let's say U.S. Steel, back in the 1970s, when they had thousands and thousands of employees, and they put a level of benefits in the benefit program, negotiated or not, and that having a group that large would spread the risk over that entire group. In other words, *x* number of people have heart attacks, *x* number of people have appendectomies in a given year, so that's going to generate an experience, and you're going to be experience rated on an annual basis.

Now, conversely, if you take the small firm, they don't have the number of employees to spread the risk that the large ones do, so that's basically why I'm having a problem with the statistics that you're saying, that they're going to pay a higher rate.

Mr. CAMPBELL. I think the example you used, if you had a firm, let's say, of five employees, versus U.S. Steel, if one of those five employees gets cancer, the proportionate effect on the rate for that group, depending on the State that they're in and to the extent the laws allow it, would much higher than it would be for U.S. Steel, as a whole. General speaking, the principle of insurance is the larger the group size, the more they're able to bear those kinds of risk and the less chance of statistical anomalies having such a disproportionate effect on the market. So that's another reason why small businesses have more difficulty; being rated as individual units when they have those sorts of events can dramatically affect their cost.

Rep. FICHTER. You see, that's the beauty of this legislation. It allows the small businesses to go from 10 to 20 to 30, across State lines. They can turn into thousands, also. So the bottom line is, they could spread their risk over many, many individual benefit programs.

Mr. CAMPBELL. Indeed, sir, that's one of the primary benefits.

Rep. FICHTER. Thank you very much.

Thanks, Senator.

Senator SPECTER. Thank you very much, Rep. Fichter.

I just have one additional question. Ms. Senkewicz, there was a famous football player from Georgia, Frank Senkewicz——

Ms. SENKEWICZ. No relation, unfortunately. I would have loved to have been his niece.

Senator SPECTER. I think he spelled his name differently.

Ms. SENKEWICZ. He had an extra "i" in his name.

Senator SPECTER. My father and my uncle spelled their names differently. My uncle spells his—my father spelled his name S-p-e-c-t-e-r, and my uncle spelled it S-p-e-c-t-o-r. They obviously

spelled it incorrectly. But when people spell my name with an "or," I can tell—I went to law school, I was followed by a fellow who spelled his name "or," and I'm certainly pleased that they misspell his name and started to spell his name like my name.

Well, that concludes the hearing. And I think it has been a very, very useful hearing. I think, on the Medicare program, there's been a good bit of information disseminated about prescription drugs and ways for seniors to find out how to utilize the program. And this panel, I think, has produced a lot of insight with small-businessmen here articulating the issue and identifying ways to cut costs through larger purchasing power. And the concerns raised by the attorneys general and by Ms. Senkewicz and Ms. Barbieri point the way to answering those issues.

We thank you for coming from Washington, Secretary Campbell, with an overview as to the administration's support for the bill and the way it can cut costs and increase the coverage.

My instinct is that we're a lot close to the 8-million mark, the small businesses, than the 2-million mark, among the 40-million-plus employees who are not covered. But healthcare is a major capital investment, and the Congress will be looking very, very closely at these issues as we proceed.

I, again, want to thank Senator Greenleaf for making the suggestion, and Representative Fichter for joining us. And I want to thank my staff for running another good hearing. We have a high level of professionals who keep the Senate in motion.

CONCLUSION OF HEARING

Thank you all very much for being here. That concludes our hearing.

[Whereupon, at 1:37 p.m., Friday, April 2, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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