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Small Employer Health Insurance: First, Do No Harm, Then, Do the Right Things

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[1] I am grateful to Mary Beth Senkewicz and Mila Kofman for elucidation of some of the finer points of the NAIC Model Law of 1993, and to Preethi Guniganti for research assistance.

My name is Len M. Nichols and I am the Director of the Health Policy Program at the New America Foundation, a non-partisan, non-profit public policy research institute with offices in Washington, DC and Sacramento, California. I am honored to have been invited to offer my thoughts as you consider how to make health insurance more affordable for more small employers and their workers, a goal I know every member of this committee shares.

Our health care system is in crisis today, primarily because health care cost growth is pushing health insurance and access to timely health services out of reach for more and more working families. One statistic sums up the trajectory we are on: In 1987, the ratio of family premium to median family income was 7.7%.[2] Today, to purchase a family premium requires a sacrifice of 18% of median family income.[3] Simply put, an increasing fraction of our workforce cannot afford health insurance and access to health care as middle class Americans have come to expect it. This dynamic is neither economically nor politically sustainable, but few are willing to talk about this openly, and I applaud this committee and you in particular, Mr. Chairman, for taking up the challenge of looking for real solutions to the very real problems before us, and in a manner consistent with the time-honored, bi-partisan tradition of the Senate Finance Committee.

The cost problem is particularly acute for small employers, who face three disadvantages relative to large firms: (1) neither they nor the insurers serving them can achieve the administrative economies of scale associated with larger employer groups; (2) they cannot easily spread and pool the costs of high risk workers or family members over a large number of healthy workers; and (3) they have virtually no bargaining power vs. insurers and health providers. Given these disadvantages, and somewhat lower wages on average, it is not surprising that small firms are less likely to offer health insurance, and, as a consequence, workers in small firms are less likely to have access to employer sponsored health insurance, the primary source of coverage in our American system. According to the most recent data from the Medical Expenditure Panel Survey, which is carefully conducted annually by the Agency for Healthcare Research and Quality, only 43% of private establishments with fewer than 50 workers offered health insurance, and only 61.6% of workers in small establishments work for firms that offer health insurance as part of their compensation package. These rates compare with 95% of large establishments and 97% of workers in large firms, respectively.[4]

Since the advantages of group size for purchasing health insurance are so compelling, it is only natural for small firms to seek ways to join together to create opportunities to achieve similar efficiencies for themselves. We have before us two competing visions of how policy can facilitate this achievement; S. 1955 (Enzi-Nelson) and S. 637 (Durbin-Lincoln). These bills both represent significant improvements over the recently and often passed approach popular among the majority in the House (H.R. 525), which would

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[2] In combined employer and employee premium payments. I include the employer share since most economists agree that most employer payments are paid for in reduced wages in the long run.

[3] Author's calculations using Kaiser Family Foundation premium data and median income data from the Census Bureau.

[4] MEPS-IC data tables, downloaded April 1, 2006.

create self-insured Association Health Plans that would be exempt from the many state laws and consumer protections which hold the fragile small group market together. So S. 1955 and S. 637 share similar goals, and while not polar opposites, their key differences do merit serious analysis before final decisions are made.

Much has been written on the general subject of association health plans and subsidized broader purchasing pools, for policy research has long focused on how to enable the small group market to work better for more participants.[5] My testimony today draws upon my own research in this area over the last 13 years, that of others that has been published in the professional literature, and my own interviews and conversations with small group market participants, including my two older brothers who are both small businessmen in Arkansas and Texas, respectively, and who struggle to provide health insurance for their workers like virtually every other small businessperson in America today. I will focus on the implications of key features of S. 1955 and S. 647 that seek to address the three main sources of size advantage in purchasing health insurance: administrative economies of scale, risk pooling, and purchasing power.

Administrative economies of scale

S. 1955 would permit members of associations that have been in existence for 3 years to purchase insurance together through a fully insured Small Business Health Plan. The potential economies of scale, then, would result from similar firms in the same industry or belonging to the same association banding together to purchase insurance. However, as Rick Curtis and Ed Neuschler of the Institute for Health Policy Solutions have written after extensive study of the design and effects of joint purchasing vehicles, merely putting

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[5] A partial list of my publications on this subject include: A. Davidoff, L. Blumberg, and L. Nichols. "State Health Insurance Market Reforms and Access to Insurance for High Risk Employees," *Journal of Health Economics* 24 (2005); L. Nichols, "Improving State Insurance Market Reform: What's Left to Try?" in *State Health Insurance Market Reform: Toward Inclusive and Sustainable Health Insurance Markets.* Alan C. Monheit and Joel C. Cantor, eds. (Routledge Press: New York) 2004; J. Holahan, L. Nichols, L. Blumberg, and Y-C Shen, "A New Approach to Risk Spreading via Coverage-Expansion Subsidies," *American Economic Review* v. 93, #2 (May 2003); L. Blumberg, L. Nichols, and J. Banthin, "Worker Decisions to Purchase Health Insurance," *International Journal of Health Care Finance and Economics*," v. 1 # ¾ (September/December 2001); L. Blumberg and L. Nichols, "The Health Status of Workers Who Decline Employer-Sponsored Insurance," *Health Affairs* 20(6), 2001; L. Nichols, "Policy Options for Filling Gaps in the Health Insurance Coverage of Older Workers and Early Retirees," in *Ensuring Health and Income Security for an Aging Workforce.* P. Budetti, R. Burkhauser, J. Gregory, and H. Hunt, eds. Upjohn Institute: Kalamazoo, MI 2001; L. Nichols and L. Blumberg, "A Different Kind of New Federalism? The Health Insurance Portability and Accountability Act," *Health Affairs* v. 17 # 3 (May/June 1998); L. Nichols and L. Blumberg, "First, Do No Harm: Developing Health Insurance Market Reform Packages," *Health Affairs* v. 15 # 3 (Fall 1996).

firms together in the same plan may do little for the firms' own administrative efficiencies unless the *local* scale of the association's own SBHP enrollment is large enough that enrollment functions can be transferred from the individual firm to the new Plan.[6] SBHPs would likely lower selling costs per enrolled life for insurers offering the SBHP compared to selling to each member of the association individually, at least in the long run after the members understand the benefit package that will be exempt from current state law. These efficiencies could get passed along in lower premiums if enough insurers compete for SBHP business. CBO has, however, long concluded that both these sorts of efficiencies are likely to be non-existent or negligible within Association Health Plan/SBHP type arrangements, especially when compared to potential gains from avoiding state benefit mandate and premium variance restriction regulations,[7] a point I address in the next section on risk pooling.

The administrative scale economies that might ensue were S. 637 to become law are potentially much larger for 3 main reasons. First, the purchasing pool is not limited to members of a long-standing association, but would be open to all employers with fewer than 100 employees. This could easily exceed 40% of the private sector workforce in most locales. Second, the tax-credit subsidies for employers who provide coverage to lower wage workers would attract entry from firms that might otherwise remain indifferent, and this could swell the pool to a very large scale. Third, the S. 637 pool is to be administered by the federal Office of Personnel Management (OPM) which currently oversees the Federal Employees' Health Benefit Plan (FEHBP), and OPM already has in place a highly efficient enrollment, premium collection and health plan selection operation for employees with different agency employers in locations all over the country.

Thus, on the criteria of administrative economies of scale, S. 637 has much more potential and likely positive effects than S. 1955.

Risk Pooling

Two dimensions are most important here: benefit mandates and premium variance restrictions. I discuss each in turn.

Benefit mandates

All states have some mandates; some states have many, and, while controversial, they are also hard to repeal. This last fact implies that there is a substantial constituency that prefers certain kinds of protections and is presumably willing to bear what they see as the relatively small cost these protections impose for the coverage they or their loved ones might need some day. Differences of opinion about the marginal cost imposed on all and

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[6] R. Curtis and E. Neuschler, "Insurance Markets: What Health Insurance Pools Can and Can't Do," Institute for Policy Solutions, for the California Health Care Foundation, November 2005, downloaded from the CHCF website, April 1, 2006.
[7] CBO cost estimate for HR 660, 7/11/2003.

about the likelihood of personally needing certain coverage lead to disagreements about which mandates are most important.

Except for the national plan that would be offered in every state, S. 637 would not change state-specific benefit mandates in or outside the new pool. Thus workers in each state would continue to have products available that reflect their own legislature's judgment about which mandates are "worth it" in their state. The national plan would be selected by OPM as it does now for FEHBP, and thus would likely have a benefit package that was broadly comparable to the benefit packages mandated by most states and competing for business around the country within the national pool. National plan enrollment in FEHBP is driven far more by premium level comparisons with local competitors rather than benefit package differences, which are kept to a manageable minimum actuarial value variation (less than 6%) by OPM's oversight. Presumably OPM would do the same for the national plan in the SEHBP program.

S. 1955 would exempt SBHPs from all state benefit mandates, a long-standing goal of mandate opponents. While this might lower premiums for SBHPs on average roughly 5% from the actuarial value reduction,[8] the larger potential short-run benefit to SBHP premiums would be from favorable selection. In effect, SBHP benefit packages could be reduced in generosity in order to draw association members out of the mandated packages that were previously required to be sold outside the SBHP. This is a well-known and well-documented recipe for favorable selection within the SBHP and adverse selection against more generous packages. This will surely drive premiums down inside the SBHP, at least in the short run, and it will correspondingly drive up premiums for those who try to maintain the old levels of coverage. The market dynamic unleashed could easily result in a race to bare bones benefit packages, since all more generous packages would risk extreme adverse selection and could likely not survive in a competitive marketplace. This may be a goal of the legislation, or an unwelcome surprise an unintended consequence, but much logic and experience would suggest this effect is very likely to occur, and relatively quickly.

S. 1955 has a novel feature that is designed to address concerns about adverse selection outside the SBHPs, and that is a requirement that insurers who offer SBHPs without mandated benefits also offer plans that include all the benefits in at least one plan offered to state employees in one of the five largest states. While the provision is well-intentioned, offering this second product will do nothing to change the selection dynamics that will make the SBHP product more attractive to healthy groups. This "enhanced product" then will prove to be a shadow promise that cannot sustain itself in the face of withering selection effects. In short, it can and will be priced to attract no buyers, and thus will evaporate in practical fact if not in literal truth, since "offering" it is a requirement of remaining in the SEHBP business.

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[8]Congressional Budget Office, "Increasing Small Firm Health Insurance Coverage Through Association Health Plans and Health Marts," January 2000; L. Blumberg, L. Nichols, and D. Liska, "Choosing Employment-Based Health Insurance Arrangements: An Application of the Health Insurance Reform Simulation Model," Final Report, 06571-001-00, Department of Labor, Pension and Welfare Benefits Administration, March 1999; Texas Department of Insurance, www.dti.tx.gov, downloaded 2/1/03.

The continued focus on exemption from benefit mandates is curious, given the amount of scholarship devoted to this issue (see note 7 and the references in those references cited therein), and given the consistency of the analytic literature's conclusion that benefit mandates do not add much to the cost of major medical/comprehensive health insurance policies. Perhaps the methodological arguments and studies about the precise effects of mandates on premiums are too technical to be believed, since the academic research seems to contradict apparent common sense. I understand that reaction. So consider the following. If mandates that increased cost substantially were being added year after year in most states, employer offer rates would be falling over time. The following table shows the best and most precise time series data we have on small employers' offers, and their workers' eligibility and coverage.

Table 1. Small Employer Offer, Eligibility, and Worker Take-up Rates

	1996	**2003**
Percent of small establishments (fewer than 50 workers) that **offer** health insurance to at least some of their workers	41.7%	43.2%
Percent of **workers** in small firms **whose employers' offer** to some workers	62.3%	61.6%
Percent of workers in small firms who are **eligible**, given that their firm offers	82.2%	78.5%
Percent of workers in small firms who **take up** offer, given that they are eligible	81.1%	81.1%
Percent of workers in small firms who are **enrolled**, given that their establishment offers	66.7%	60.7%

Source: AHRQ, MEPS-IC data tables, various years, downloaded April 1, 2006.

These data support two conclusions: (1) small firms are not less likely to offer than they were in the mid-1990s; and (2) the primary reason workers in smaller firms are less likely to be insured by their employers than in 1996 is not a decline in offer OR in worker-take-up, but a reduction in the percentage of workers in offering firms who are eligible. The major point is not that adding benefit mandates does not matter, but that they cannot be the major driver of cost growth and declines in coverage that some advocates of their repeal would have us believe.

Premium variance restrictions

With the possible exception of benefit mandates, no area of insurance market regulation is more contentious and complex than premium rating rules, which vary considerably from state to state and essentially determine the range of premiums which insurers may charge different groups for the same product. This is where the proverbial rubber meets the road in insurance market regulation, because *all* restrictions on premium variance by definition force more risk pooling than an unfettered market would produce. The fundamental question is this: would you rather live in a society with no rules, loose rules, or tight rules on premium variance? Another way of asking this is, how much more than the healthy *should* the sick pay? *Should* questions involve value judgments, and are never easy to answer. There are inherent tradeoffs in any approach, since most of us are healthy most of the time, all of us will get sick and die, some of us will get really sick but survive with expensive chronic conditions for quite a while, and none of us know *a priori* when and with what we will be stricken. Not surprisingly, different people and state legislatures view these inherent tradeoffs differently, and that is why there is so much variation in state regulation of small group health insurance premiums. This variation in regulation reflects our federalist system allowing differences based on local preferences, a tradition as old as the original 13 colonies, and made possible by Congress' decision in 1945 with the McCarran-Ferguson Act to leave regulation of health insurance markets to the states.[9]

Quite a lot of scholarship has addressed these questions since states have provided a veritable laboratory for health insurance market reform experiments since 1991, and researchers love natural experiments as much as they love grant money (well, almost). An excellent set of summaries and syntheses of this literature can be found in the book edited by Alan C. Monheit and Joel Cantor, *State Health Insurance Market Reform: Toward Inclusive and Sustainable Health Insurance Markets.*[10] The bottom line consensus on small group reforms, as stated in my contribution to that volume,[11] is that their effect on overall coverage is statistically unobservable. This may surprise those who had hoped market reforms alone would expand coverage, and it may surprise those who feared that market reforms would ruin private insurance markets forever. But it does not surprise people who really understand and study market reforms, for it is increasingly clear that there were really three specific goals of health insurance market reforms: (1) to make health insurance premiums more stable; (2) to make health insurance markets stable and sustainable in the long run; and (3) to make health insurance more affordable for the sick.

The data in Table 1 above imply that reforms, specifically premium variance restrictions in conjunction with guaranteed issue laws, present in over 45 states prior to HIPAA, have indeed helped make small group health insurance markets more stable in the last seven years, as judged by the statistically identical percentages of firms that offer and workers that still take health insurance when they are eligible. However, nothing in insurance

[9] Nichols and Blumberg, 1998, op cit.
[10] Routledge Press, 2004.
[11] Nichols, 2004, op cit.

market reforms, nor in either one of these bills we are considering today, actually addresses the underlying sources of health care cost growth, and, thus, premium growth was not contained. Still, premium variance was surely dampened, since premium variance restrictions limit how much rates can vary across groups and over time.

Since the vast majority of states (48) have premium variance restrictions of some kind,[12] another way to think about the effect of premium variance restrictions is to see if current small firm offer rates are higher in states with "loose" rules than in states with "tight" rules. Precisely characterizing the totality of a given state's premium regulations as "loose" or "tight" is a very time consuming, state-specific exercise best not tried at home, but respected researchers like Rick Curtis and his colleagues at the Institute for Health Policy Solutions have been doing this for at least 10 years. They published a paper in 1999[13] in which they discussed the evolution of state reforms since 1991, discussed lessons states had learned, and provided examples of states doing various things. In that paper is a chart, Exhibit 2, on p. 153, in which 6 states are specifically labeled as having "loose" or "tight" premium rating rules. My Table 2 lists those states, along with AHRQ's estimate of the percentage of workers in small firms that offer, the key barometer, in most analysts' minds, of how the overall small group market is performing in any given state.

Table 2. Rating rules and percent of small firm workers in firms that offer, 2003

Rating rule regime and state	Percent of workers in small firms that offer
Loose	
Ohio	61.1%
North Dakota	54.8%
Tight	
California	61.3%
Connecticut	68.4%
Massachusetts	76.3%
New York	65.5%
US average	61.6%

Source: Curtis et al, *Health Affairs*, May/June 1999; AHRQ MEPS-IC tables, downloaded April 1, 2006.

Now I am well aware that the decision to offer health insurance is a complex outcome of many forces,[14] and I am certainly not trying to argue that this table proves that tight rating rules *caused* more workers to be offered health insurance by their small employers than would otherwise have been the case. But what Table 2 does show is that tight rating is at least consistent with offer rates that are at least as high as those observed in looser rating states, and that is the fundamental point. Insurers and employers adjust to the market

[12] Georgetown University, "Small Group Health Insurance Reforms: State-by-state Comparison" 2006.
[13] Curtis et al, "Health Insurance Reform in the Small Group Market, *Health Affairs*, May/June 1999.
[14] L. Nichols, L. Blumberg, P. Cooper, and J. Vistnes, "Employer Decisions to Offer Health Insurance: Evidence from the MEPS-IC Data," presented to American Economic Association, January 2001.

rules in place, insurers who do not like some rules leave those states, but offer rates remain as strong as they are likely to be in the small group markets, as data from these tightly regulated states show.

By and large, firms offer health insurance, if they do, because they must in order to attract the kind of labor force they want, or they do not offer because it is not necessary for them. All the rest is commentary, more or less. Specific rating rules, benefit mandates, etc., matter on the margin, but not much to the basic decision to offer a standard package in the locale where their workers live, because the total compensation package with health insurance included is more attractive to the workers they want than an equal additional amount of cash would be. The attractiveness of this package, in turn, hinges on the underlying demand for health insurance on the part of workers, which is of course, highly correlated with income and earnings.[15]

Recall that the third goal of small group health insurance reformers was to make health insurance more affordable for the sick. Research on this question lagged the overall coverage and market stability questions, for these latter questions were simpler to measure and answer, but in recently published work I and colleagues addressed the risk pool issue directly. We used National Health Interview Survey data with superior measures of chronic conditions and econometric analysis to control for other factors. Our results suggest that pre-HIPAA guaranteed issue plus premium rating reforms did indeed increase coverage a bit for small firm workers and their family members with chronic conditions.[16] The results also suggest that some low risk workers lost coverage as a result of the reforms, which is both evidence of the tradeoffs I mentioned earlier, and a partial explanation of why so many studies of the overall coverage impact of reforms found no net effect.

With this background, I now turn to the specific premium rating rules in each bill. The approaches could hardly be more different.

S. 637 would use modified community rating inside its SEHBP pool, allowing specified and limited variation in rates based only on age, family structure, and geography. Furthermore, the minimum sized geographic unit is the MSA, and as such it is not open to insurer self-definition, which could facilitate red-lining of specific areas suspected of having high cost enrollees. This rating approach expressly prohibits the use of health status or the presence of chronic conditions or claims experience to differentiate among groups, and thus is consistent with current NAIC model acts and research-based thinking on this subject.[17]

S. 637 then would impose tighter premium variance regulation than in some states' small group markets at the moment, since many states allow health status or claims to drive premiums within specified rate bands, and S. 637 would impose looser regulations than in other states with very tight age limitations, for example. This would not yield a purely

[15] Blumberg, Nichols, and Banthin, 2001, op cit.
[16] Davidoff et al, 2005, op cit.
[17] Curtis et al, 1999.op cit.

level playing field with the existing small market, and could cause selection against the new SEHBP pool. However, S. 637 includes a key safety valve preventing serious adverse selection against the SEHBP pool, and that is the availability of tax credit subsidies for firms that sponsor coverage for their low wage workers, i.e., those who make less than $25,000 per year. These subsidies indicate that this bill is intended to actually expand coverage, for the sponsors are willing to use resources to enable those who cannot afford coverage today to purchase it. These subsidies are at least 25% of employer premium costs, and rise with more expensive family structures and with higher employer shares of premiums. Importantly, these subsidies are available *only* if small employers – remember S. 637 defines small to be fewer than 100 employees – enter the SEHBP pool to purchase health insurance. Thus, the incentives would be very strong for all small firms with any low wage workers to join the SEHBP pool. Since the self-employed could also join the SEHBP pool and have access to tax credit subsidies if they are low income, and since their alternative is the non-group market, most of them would probably join the SEHBP pool as well. Rick Curtis, widely recognized as the country's foremost authority on how to make purchasing pools work, has written that one key to enabling pools to offer bargains to their participants is to subsidize the low income within the pools so that critical mass, economies of scale, and requisite bargaining power will result.[18] I will return to the bargaining power point, a portent of future reform possibilities, in the next sub-section.

S. 1955, by contrast, appears intent on taking a step back in time by basing its premium rating restrictions on NAIC's 1993 model act, which permitted the use of health status and claims within business classes, and also allowed specified variance across classes. Interestingly, the NAIC amended that 1993 act within 2 years, precisely in the period of the greatest state activity in passing market reform laws, and tightened its model variance recommendations over time, until today the model act specifies modified community rating, as employed in S. 637.

Now S. 1955 as currently drafted is certainly mindful of the fear of extreme rate variations, unlike HR 525, and seems on the one hand to protect against them. The bill provides that rates within a class cannot vary by more than +/-25% from the index rate, and among classes they cannot vary by more than +/- 20%. However, the rating variation rules (the same as those in the NAIC 1993 small group model law) are tied to a "base rate" and an "index rate." Those definitions are tied to "similar case characteristics" and "similar coverage." Allowable case characteristics include age, gender, group size, geography, and industry. For example, an older small employer group would not have a similar case characteristic as a younger small employer group. All of the apparent "within class" and "across class" restrictions on rating in the bill, therefore, can be eluded by the imposition of a higher "rating factor" to older groups, groups that are predominantly women, etc. This could be particularly devastating to older workers, as they have the greatest health needs in the workforce as they near retirement age. Individuals between 55-64 are over three times as likely to be in fair or poor health as individuals between 18-34.[19]

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[18] Curtis and Neuschler, 2005, op cit..

[19] MEPS HC data, downloaded April 1, 2006.

S. 1955 merely requires rating factors to be applied consistently. An insurer could consistently apply a higher rating factor based on age, an allowed case characteristic. Thus, the bill is likely to lead to higher premiums for older workers (and older dependents as well), groups dominated by women, very small groups, and groups from industries with higher expected claims costs, among others. There is no limit on how much rating factors for age and other factors can vary in S. 1955, and so this could be used to make sure firms with an older work force do not want to buy SBHPs. Actuaries from the Department of Insurance in New Hampshire believe that S. 1955 permits rates to vary among groups by as much as 25:1, if actuaries use conventional ranges on variable factors.[20] The danger then in S. 1955 is that with no limits on age, gender, geography (and geography can be defined by the insurer), family size and group size adjustment factors, premiums could vary far more than the bill sponsors intend or expect.

Now some associations may well want to effectively community rate their members, and may instruct their SBHPs to do so. In that case, they would be imposing rules more like the tightest state regulations do now, but over a much smaller pool than at present. In short, it is hard to argue that anyone would gain from SBHPs in the long run but young and healthy associations or members of associations with a commitment to community rating of their own members, a commitment that they do not exhibit now in their zeal to escape tighter premium variance restrictions in most small group markets.

Bargaining power

Part of the frustration of being a single small employer seeking health insurance is the absolute lack of control, the absence of ability to do anything but react on a take-it or leave-it basis to what insurers offer to them, as costs increase year after year. That understandable frustration is surely part of what is driving the movement to find a way to "act" more like large firms in purchasing health insurance, to be more demanding of insurers, and, in turn, of the providers who ultimately determine the real costs of care and the insurance which finances that care. What small employers may not know is that large employers are also extremely frustrated by continuing cost growth and low clinical value for dollar, but that is a larger point for another day.

Being more demanding is essentially about exercising more market power, more bargaining power. Simply put, the more bargaining power in the hands of employers, the more likely that health care cost growth will be brought under control in the long run, the absolute key to sustaining our systems ability to provide high quality care for all. So the last, simple, and most important long run question for the two bills before us today is: which type of structure, SBHPs or the SEHBP, is more likely to transfer more bargaining power to employers and the working families who depend upon them?

S. 637 is much more likely to create a larger pool, as we discussed in the Administrative Economies section. The fact that it is open to all with fewer than 100 workers, offers

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[20] Letter from New Hampshire Department of Insurance to Brian Webb of NAIC, March 13, 2006, commenting on S. 1955.

subsidies to those who pay at least 60% of the premium of low wage workers, and preserves existing benefit package mandates means that the SEHBP is likely to become the de facto small group and self-employed market in each state and, therefore, in the nation. This could lead to 40% of the workforce having access to the SEHBP, the fraction of workers in firms with fewer than 100 workers.[21]

Thus, in its totality, S. 637 not only creates a viable pool that will likely serve all participants in the small group market at least as well as they are served today, it sets the stage for the next steps towards a reformed health care system, one that can use bargaining power, information systems *and* consumer choice to achieve efficiencies in service and care delivery – through extensive use of pay for performance and comparative technology assessment -- that could make it possible for us to afford to cover all Americans someday and forever.

S. 1955, it must be said, exhibits less ambition about creating a pool with bargaining power that can help drive system-wide reform in the long run, and envisions instead a large number of much smaller pools that are expected to offer all existing association members a lower premium than they pay today. That is a reasonable outcome to desire, and I applaud the sponsors for trying to make it happen. But if all small firms do now or could join some association which could qualify to offer an SBHP, then the long run dream of S. 1955 could be realized only if all premiums are being artificially propped up today by unnecessary benefit mandates and misguided and counterproductive premium variance restrictions and other insurance market reforms. I believe a fair reading of the evidence of the health insurance market reform literature strongly contradicts this world view, but I must admit its proponents hold onto it with tenacity nevertheless. I fear the world view behind S. 1955 ignores or denies the inherent tradeoffs most students of the small group market see. In some ways I wish the world was that simple. I fear and believe it is not, and to act as if it is puts our already fragile small group markets in more jeopardy than they can likely withstand.

[21] AHRQ, MEPS-IC data, downloaded April 1, 2006.