JOINT ECONOMIC COMMITTEE DEMOCRATS

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ECONOMIC POLICY BRIEF FEBRUARY 2006

ASSOCIATION HEALTH PLANS: THE WRONG MEDICINE FOR SMALL BUSINESSES' HEALTH INSURANCE ILLS AND NO HELP FOR THE UNINSURED

Many small businesses argue that they are at a disadvantage in providing health insurance coverage to their employees because they do not have the same opportunities as large businesses to pool risks or bargain for lower rates. In response, the Administration's FY 2007 Budget proposes once again to create association health plans (AHPs) that would allow trade and professional associations to pool together employees from member businesses to acquire health insurance within a larger purchasing group.

The following analysis shows, however, that the cost savings for small businesses joining AHPs are likely to be modest and that AHPs are unlikely to make much of a dent in the number of Americans without health insurance. Worse, AHPs may have negative side effects, such as the creation of market segmentation in the small group health insurance market leading to higher premiums for those who are not in AHPs; the weakening of state insurance mandates and regulations that provide valued consumer protection; and increased risk that plans will become insolvent, leaving employers and employees unprotected.

Health Insurance Problems of Small Businesses and Their Employees

The number of Americans without health insurance reached 45.8 million in 2004, and millions more lacked coverage for part of the year. Over 21 million people working full-time were uninsured, and only 59.8 percent of workers had employer-sponsored coverage, the lowest percentage since 1993.[1]

The rising costs of health care and health insurance affect large and small companies alike. According to the Kaiser Family Foundation and Health Research and Education Trust (Kaiser/HRET), health insurance premiums for employer-sponsored coverage have increased by at least 9.2 percent in each of the last five years, with no major slowdown in sight.

However, small business health insurance costs have grown faster than those of large employers recently. In 2005, health insurance costs rose by 9.8 percent for employers with fewer than 200 employees compared with 8.9 percent for those with more than 200 workers. For employers with fewer than 25 employees, the average increase was 11.8 percent.[1] In addition, deductibles are nearly twice as large on average for small firms as they are for larger firms and the administrative costs facing small businesses are disproportionately large, because they cannot be spread over a large number of employees.

With a smaller pool of employees to balance risk, small businesses whose premiums are based on the health experience of their employees can face greater fluctuations and possibly higher average premiums than those faced by larger companies. For small businesses, a single costly illness can drastically affect the cost of health coverage.

Small businesses are much less likely to offer health insurance coverage than larger businesses. In 2005, the Kaiser/HRET survey found that only 59 percent of firms with fewer than 200 employees offered coverage to their workers, down from 68 percent in 2000. In contrast, 98 percent of large firms offer coverage to their employees. This discrepancy leaves a higher percentage of uninsured workers in small firms.

When they are offered coverage, employees in small businesses are almost as likely as those in large businesses

to take up that coverage. In 2005, only about 20 percent of workers in firms with fewer than 200 employees declined coverage when offered compared with 16 percent of employees in large firms. The similarity of take-up rates among employees of large and small businesses suggests that increasing the availability of health insurance for workers in small businesses could contribute to reducing the number of Americans without health insurance.

The Republican AHP Plan

Republicans in the House of Representatives have consistently pushed association health plans as a way to relieve some of the health insurance burdens on small businesses. The House, supported by the Bush Administration, has passed AHP legislation several times, most recently in July of 2005. The House-passed legislation provides a guide to how AHPs would differ from health plans currently available to small businesses.[3]

Employers are currently allowed to band together into purchasing groups, either informally or as part of an association, in order to buy health insurance. Such groups are still regulated at the state level, however, and, in most cases, must comply with state mandates and regulations in each member firm's state.[4] Small business leaders argue that it can be administratively costly to set up plans satisfying multiple and disparate state regulations, putting them at a disadvantage compared with large employers, who can self-insure and are therefore regulated only at the federal level.

Unlike current small-business health insurance plans in the state-regulated market, AHPs following the House model would not be required to comply with most state benefit mandates, except regulations requiring a minimum hospital stay for newborn deliveries or rules mandating that a particular disease receive coverage. Self-insuring AHPs, like self-insuring large employers, would be subject only to federal Employee Retirement Income Security Act (ERISA) regulations administered by the Department of Labor (DOL). Fully insured AHPs, those associations obtaining coverage through a third-party insurer, would be subject to the premium-setting regulations of their insurers' domicile state. Opponents of the legislation believe that this provision would encourage associations to seek out third-party insurers from states with few regulations or consumer protections as a way to lower the cost of coverage.

To distinguish AHPs from loose associations and perhaps to prevent fly-by-night organizations from being formed, the House AHP legislation requires that AHPs must be at least three years old and have a Board of Trustees. The Association would need to have over 1,000 participating individuals, and all employees of member firms would have to be offered coverage.

The Limited Benefits of AHPs

Proponents of AHPs argue that their creation would accomplish three things: lower the cost of insurance in the small-employer market; allow more small employers to offer health insurance benefits; and reduce the number of Americans without health insurance. However, analysis by the Congressional Budget Office (CBO) suggests that reductions in premiums for AHP members could be partly offset by increases in premiums for small businesses that remain in the traditional state-regulated market. Moreover, AHPs are unlikely to have much of an impact on the number of Americans without health insurance.

Cost Savings from AHPs. CBO generally agrees with AHP advocates that some premium savings are possible for member businesses in a participating association. CBO estimates that the introduction of AHPs would produce an average savings of 13 percent compared with premiums in the state-regulated market, thanks largely to a bigger, perhaps healthier risk pool and the exemption from most state mandates.

For small businesses that chose not to participate or do not have access to an association offering an AHP, CBO estimates that premiums will, on average, increase by two percent. These small businesses would likely have a less-healthy risk pool and need to comply with state mandates.[5]

CBO estimates that less than a quarter of small-business workers would obtain health insurance through AHPs, leaving the vast majority in the state-regulated market. The more than 20 million Americans left in the small-group market would likely face somewhat higher health insurance premiums.

Covering the Uninsured. AHP supporters suggest that the plans could substantially increase coverage among the

uninsured. CBO estimates, however, that AHPs when fully implemented would only reduce the number of uninsured by 620,000. That figure represents less than 10 percent of the 8.5 million Americans that CBO expects will be getting their coverage through an AHP[6] **(Chart 1)**. In other words, AHP participants would most likely be businesses that currently provide coverage to their employees. Coverage for businesses not in an association and their employees could, in fact, become more expensive, potentially reducing offer rates and number of employees purchasing insurance.

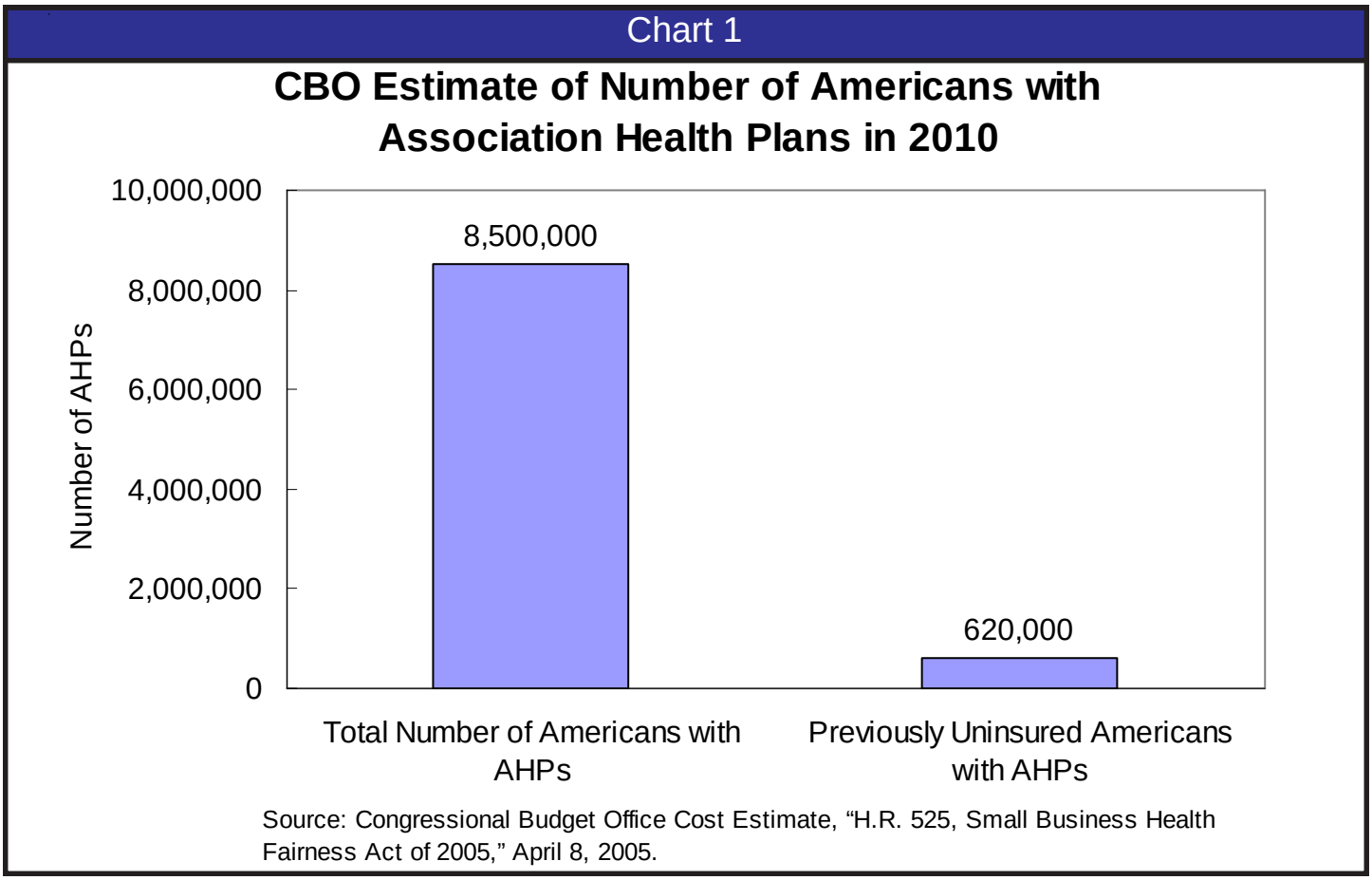
AHPs Could Cause Market Segmentation in the Small Business Health Insurance Market

An important reason why CBO expects some of the cost savings achieved by those who join AHPs to be offset by increases for those who do not, is the probability that AHPs will encourage market segmentation. That segmentation could worsen over time if rising premiums in the remaining state-regulated market lead more small businesses with relatively healthy workers into AHPs, leaving those businesses with relatively less healthy workers facing the possibility of even higher premiums.

For some small businesses, joining an AHP will help lower their health care insurance costs compared with those in the state-regulated market. The potential savings will vary by association, depending largely on the plan design and the health status of participants. While associations cannot deny coverage to eligible businesses, they can tailor a plan to make it more attractive to firms with healthier employees by scaling back benefits and requiring additional beneficiary cost-sharing. Such a plan could prove untenable to a firm with high-risk employees or one or more employees in declining health. Since AHPs are not required to offer multiple options, firms whose workers have relatively low health risks could be attracted to join an AHP, while those whose employees are in relatively poor health remain in the state-regulated market because their employees need the comprehensive coverage available in that market.

Current AHP proposals are not blind to the dangers of market segmentation, but significant risks remain. Under the House legislation, AHPs would be prohibited from denying coverage to any employee of a member firm eligible for participation and they would not be able to exclude people based on health risk or status. Even so, the market

Chart 1



Source: Congressional Budget Office Cost Estimate, "H.R. 525, Small Business Health Fairness Act of 2005," April 8, 2005.

segmentation inherent in the creation of AHPs would raise costs for firms that decide not to enroll in an AHP because of the health status of their workforce or firms that do not have access to a plan. But there is also a danger that the entire traditional market for small business health insurance could further deteriorate as rising premium costs cause more firms to drop their coverage, reducing the scope for pooling and increasing premiums for firms that remained in the market.

AHPs Would Circumvent State Mandates

Most state insurance commissioners, governors, and consumer advocates have expressed opposition to AHPs.[7] States have been the traditional regulator of the insurance markets and the creation of AHPs would remove some small business health insurance coverage from state regulation. To the extent that residents of states with tighter regulations value those regulations and protections, the creation of AHPs would likely leave many Americans with less consumer protection.

For example, in the House legislation, AHPs would be exempt from state patients' bill of rights laws, which protect consumers in managed care plans by providing, among other things, recourse to appeal a denial of care resulting in injury to the insured. No such federal protection exists. Other non-federally protected mandates, such as mental health parity, would no longer be guaranteed.

Although small businesses believe that state regulations and benefit mandates are driving up the cost of health insurance premiums, the size of any such effect is probably modest. For instance, a 1998 study by the Texas Department of Insurance, using nine of the most used mandates in Texas as a measure, found that only about three percent of claims came from individuals accessing these mandates.[8] Other researchers, including those at CBO and the Urban Institute, have concluded that five percent is a reasonable estimate of the premium savings resulting from an exemption from state benefit mandates.[9]

The value of the benefits lost by the removal of state mandates and protections from AHPs has to be weighed against any cost savings. For example, AHPs may not offer certain medical procedures and care that are mandated in some state-regulated systems. If they were not so informed by their employer or the AHP, there is no guarantee that employees would even be aware of the loss of such benefits until they tried to claim them.

AHPs Would Have Inadequate Solvency Requirements

Solvency is an important concern of state insurance commissioners, who believe that self-funded plans with inadequate reserves would be at risk if even a few employees incurred catastrophic medical bills. Insurance companies typically have sufficient reserves to withstand an unusual surge of claims, and state solvency requirements are meant to get self-insurers to behave similarly. These reserve requirements typically are based on the number of people covered and typically are not capped at any particular dollar value.

Under the House plan, however, DOL would have the main oversight responsibility for fully insured AHPs and would be the only regulator of self-insured AHPs. Self-insured AHPs would be required to meet solvency standards of between $500,000 and $2 million of reserves as set by DOL, but would be exempt from state solvency standards for self-insured plans. The self-insured plans would be subject to ERISA rules as well as Health Insurance Portability and Accountability Act (HIPAA) protections.

Lack of state regulation could also reduce monitoring of plan solvency. DOL would be left to enforce solvency requirements and police failure to cover claims, but it is unclear whether DOL has the personnel and the enforcement capabilities to regulate the large number of plans that might emerge. State insurance departments often have substantial staffs devoted to ensuring compliance with consumer protection requirements and solvency standards. DOL would most likely need to add workers to provide adequate oversight and regulation of AHPs.

Conclusion

A large proportion of workers who lack health insurance work in small businesses, which are much less likely than large businesses to offer health insurance benefits. Many small businesses find it a financial strain to offer health insurance coverage and many employees find it a financial strain to pay large premiums.

The Republican response to the health insurance ills of small businesses and their employees is the creation of association health plans. However, the cost savings to small businesses from the creation of such plans are likely to be modest; small businesses that cannot or do not join AHPs may see their costs go up; state insurance and consumer protection regulation will be undermined; and the net effect of AHPs on the number of Americans without health insurance is likely to be small.

Proposals aimed at lowering the costs of health insurance to small businesses and their employees that do not try to mitigate the undesirable side effects associated with AHPs will simply shift the costs onto firms and employees that do not or cannot join an AHP. A cost-effective plan to increase health insurance coverage among small businesses would concentrate on providing incentives that would make health insurance more affordable for employees of modest means, who are the ones most likely to be deterred from purchasing health insurance because of the cost.

Endnotes

[1] U.S. Department of Commerce, *U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2004, August 2005*.

[2] Kaiser Family Foundation and Health Research and Education Trust, *2005 Annual Employer Health Benefits Survey, September 2005*.

[3] The "Small Business Health Fairness Act of 2005" passed the House of Representatives 263-165 on July 26, 2005.

[4] Prior to 1983, self-funded association plans were largely able to avoid state regulations and were covered under federal ERISA regulations. Many plans failed or were accused of mismanagement. A 1983 amendment to ERISA, creating Multiple Employer Welfare Arrangements (MEWA), allowed states to pass laws regulating these association plans.

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

[6] Congressional Budget Office Cost Estimate of H.R. 525, "Small Business Health Fairness Act of 2005," April 2005.

[7] The National Governor's Association, National Association of Insurance Commissioners, the National Conference of State Legislatures, and numerous consumer groups have all expressed opposition to AHPs.

[8] Texas Department of Insurance, *The Impact of Mandated Health Benefits, December 1998*.

[9] CBO developed the five percent estimate used in their 2000 study by analyzing several empirical studies with varying assumptions. A 1999 Urban Institute study by Linda J. Blumberg, Len M. Nichols, and David Liska, *Choosing Employment-Based Health Insurance Arrangements: An Application of the Health Insurance Reform Simulation Model, March 1999* also claimed five percent savings from state mandate exemptions.

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