



A not-for-profit health and tax policy research organization

Health Issues

A WALK THROUGH THE WOODS OF ASSOCIATION HEALTH PLANS - SEPARATING THE FOREST FROM THE TREES

BY GREG SCANDLEN

The idea of Association Health Plans (AHPs) has become surprisingly contentious in Washington. The concept is simple on the face of it: Allow professional and business associations to offer health coverage to their members – individuals or small and medium-sized companies – so they can achieve some of the savings that large employers enjoy when they provide health insurance to their workers.

Large employers are exempt from state laws that regulate health insurance due to ERISA (the Employee Retirement Income Security Act of 1974), which allows employers to craft their own benefit plans for their own workers without having to comply with fifty different sets of state regulations. This is known as self-

funding” or “self-insurance” because the companies set up their own programs without buying them from insurance companies.

However, insurance companies selling health policies to customers in the open market receive no such relief from state laws. They must offer insurance that complies with all the mandates, taxes, and other regulations the states have enacted. Over the years, the states have enacted a huge number of such regulations, which have added dramatically to the cost of coverage. Small employers often find they can no longer afford to pay these costs and may stop offering coverage altogether.

These small employers look longingly at the

large employers who are free of these onerous regulations and wish they could enjoy those advantages as well. So, they have proposed joining into associations that would be able to self-fund benefits much as large employers currently do.

Of course, insurance companies fear losing the bulk of their remaining business if small companies can self-insure. And state government officials don't want to lose their authority over the small group market. So they have come to oppose releasing small employers from the regulated market.

Both sides overstate their case, with proponents arguing AHPs will dramatically lower costs and reduce the numbers of uninsured, and opponents countering that AHPs will destroy the small group market and deprive workers of important "consumer protections."

As usual in Washington, there is some truth to both sides, but the case is overstated for political effect. The hyperbole hardens positions and makes it difficult to find a compromise that could work for both sides. But in this case, a compromise is within reach and could help straighten out the current crisis in small group coverage.

The Disaster in the Small Group Market

That is the context for this debate: There is indeed a crisis in small group coverage. Premiums are rising in some cases by 40 to 50 percent a year. Even 20 or 25 percent hikes are considered modest these days.

At the same time, general inflation is nearly non-existent. Deflation is more of a concern than inflation in today's economy. Very few small businesses can afford to raise prices to meet rising health care costs without losing

customers to competitors. Most operate on small margins, so they can't take the added costs out of profits. Wages are already cut to the bone in many cases. Dropping coverage, scaling back benefits, or passing more costs on to workers seem to be about the only remaining alternatives for many employers.

(There is another alternative we discuss later, which is substituting a "Health Reimbursement Account" for an insurance policy. But few employers have caught on to this approach to date.)

Small Group Reforms Backfire

Much of the cause of the crisis lies at the feet of the misguided "small group reforms" and other insurance regulations enacted over the past 15 years by the states and federal government. These reforms were intended to "stabilize" the market and reduce what was seen as an overly competitive, volatile industry. Most states focused on restricting the range of allowable premiums, including in some cases, requiring strict "community rating," which means that all policies offered to a "community" of residents must charge equal premiums for all subscribers – old and young, sick and healthy.

The states were also busy mandating the precise benefits that must be included in health insurance contracts. The fifty states have enacted some 1,500 mandates for small employers, often including requirements for coverage of such things as in vitro fertilization, chiropractic care, or counseling with social workers.

At the same time, the states enacted a host of arcane requirements on insurance companies such as market conduct rules, prompt payment requirements, any-willing-provider laws, list-billing prohibitions, and others too numerous to count.

The market is now collapsing under the weight of all these regulations, and employers are increasingly desperate for relief.

The Case for Risk-Based Rating

Some of these mandates and regulations were actually supported by the business community — community rating and other restrictions on risk-based rating, for instance. Many associations of small businesses supported these initiatives in the mistaken belief they would lower costs. Even today, these groups want relief from mandated benefits, but want to retain these rating restrictions. Deference to state premium restrictions appears to be built into some of the AHP proposals now before Congress.

This is unfortunate because the impact of community rating on the small business market dwarfs the impact of mandated benefits. Mandates may add from 10 to 20 percent to premiums, but community rating knocks costs out of the ballpark.

Imagine, for instance, that a carrier under normal circumstances would have a three-to-one spread of premiums. That is, the absolute healthiest group would be charged \$100/mo for coverage per person, while the very sickest group would pay \$300/mo. Community rating sets the rate at \$200/mo for everyone. That means the healthy group is paying double what it should be paying, and the sicker group gets a 50% decrease in premium.

But the process doesn't stop there. The healthy groups decide the coverage isn't worth the cost, so they drop out. While the sicker groups decide they are getting a bargain and come into the market for the first time. That changes the risk profile of the entire population and raises rates well above the previous average

of \$200. Now the average premium is something like \$250/mo, causing yet more healthy groups to drop out.

This “death spiral” is the primary result of the “reforms” the states enacted in the early 1990s, and the primary cause of the extraordinary premium increases we are seeing today.

AHPs that eliminate mandates might whittle 10 or 20 percent off the premium, but that is small potatoes compared to the impact of community rating. In fact, for most small companies, it is less than the annual increase they are seeing in their bills this year.

There is a further inequity to these rate restrictions. Older, sicker people place a much higher value on health coverage than younger healthy people do, so they are willing to pay more for it. They know the importance of being able to receive timely care, while younger people feel they are immortal and don't get the point of spending a lot of money on health insurance. To keep them covered, it is essential that they be asked to pay an appropriate premium.

It is the younger population that is most in need of health coverage today. Eighty percent of the uninsured are under the age of 45, and 62% are under age 35. We need to lower the cost of coverage for younger people, and the best way to do that is get rid of rate restrictions that forbid consideration of their lower use of services. A useful AHP law would do just that.

Cherry Picking

Opponents have raised concerns about selection. They say associations will attract all the good risks, leaving only high-risk individuals and groups behind in the state-regulated market. It is hard to find much validity in this concern, for several reasons:

- The federal HIPAA (Health Insurance Portability and Accountability Act of 1996) law requires “guaranteed issue” of all small group products. That means no one may be denied coverage based on their health. This applies to all employers and all group insurance plans.
- There is no reason to believe broad-based associations would attract only healthy people. In fact, they are usually defined by some common quality having nothing to do with health condition – print shops, auto dealers, dentists. Even if there were some category of people who are uniquely unhealthy, they too would be able to form an association and gain the benefit of joint purchasing.
- It is every bit as likely that an association would attract the worst risks, not the best ones. Every member of an association remains free to shop for coverage outside of the association if it can find a better deal. That leaves the association covering only those people who cannot get a better deal in the private market.

Funding High-Risk Pools

AHP legislation has been criticized for removing AHP members from the base of support for subsidizing state high risk pools that provide “last resort” coverage for individuals seen as uninsurable. These pools are typically subsidized through a premium tax on insurance companies, typically of two percent.

In fact, the primary AHP bills before Congress include a provision to tax AHP coverage at a rate similar to a premium tax for the express purpose of helping to subsidize these pools.

This is unfortunate. Premium taxes are a very poor source of subsidy for the risk pools. It means only those people who pay premiums help in financing the pools. It adds yet another cost to the coverage that already costs too much and it helps keep people from affording coverage and becoming insured. Only the individual and small group markets are affected by this tax – not the uninsured, not the large self-insured employers, not people on Medicare. It would be better for the states to come up with a more equitable and progressive source of support for the pools.

The False Distinction Between Insured and Self-Insured Plans

Those who buy coverage through AHPs would also benefit from being exempt from all of the other nit-picky regulations the states have enacted if the association they join were able to self-fund its benefits the way large corporations do. But the insurance industry doesn’t understand why it should be subject to state mandates and regulations if associations become exempt under the AHP legislation. They argue that AHPs will only compound the problems created by ERISA, which left the individual and small group markets highly regulated while exempting larger self-insured employers. Some but not all insurers say, “Give us the regulatory relief and we’ll provide the lower-cost coverage.”

It’s a good point. As a practical matter, there is no distinction between “fully-insured” and a “self-funded” employer benefit plan. Both rely on the employer to pay the cost and make the coverage decisions. Both use the same provider networks, claims processing systems, enrollment forms, and even employee identification cards. Employees themselves have no idea whether their coverage is insured or self-funded. Self-funded employers almost always have limited risk exposure because

they purchase stop-loss reinsurance. Very large employers may be “insured,” and fairly small employers may be “self-insured.” The only difference is that one group is exempt from state laws and the other buys insurance products that are subject to these laws.

This dual track for regulating health insurance is an enormous problem. Part of the reason the states have been able to enact so many onerous laws is because the larger employers in the states have been exempt from them and indifferent as to whether they passed. The only parties affected have been insurance companies and small employers, and they don’t have enough political clout to hold back the tide.

State or Federal Regulation?

AHPs are an effort to extend to smaller employers some of the same protections from excessive state regulation larger self-funded employers enjoy. No one seems to be willing to address the problem of excessive regulation directly. Congress could, for instance, simply pre-empt some or all of the state regulations on health insurance.

Such preemption would not be as radical as it seems. The Constitution reserves the regulation of Interstate Commerce to the federal government, and there is hardly an industry that is more “interstate” than insurance. In 1946, Congress delegated its responsibility for insurance regulation to the states when it passed the McCarran-Ferguson Act. Congress is perfectly free to take back its authority if it decides the states have done a poor job. It did that in 1974 when it enacted ERISA, removing the right of the states to regulate “employee welfare benefits plans,” including pensions and health benefits.

On the other hand, Congress could repeal the portions of ERISA that include health insurance programs. If the states are the best source of regulation, they should be the best source of regulation for large as well as smaller employers. The primary argument against repealing ERISA has been that multi-state employers need to provide consistent benefits across state lines. But ERISA is not confined to multi-state employers — any employer willing to do so may self-fund its benefits and be free to avoid state regulations. Further, multi-state employers manage to comply with other varying state regulations, such as different wage and hour laws, occupational safety rules, environmental regulations, business permits, and so on.

Either approach – federal preemption of all state health insurance laws, or requiring all health plans to comply with such laws – would be more rational than what exists today. Today, some employers are exempt and others are not, depending solely on a fictional contrivance called “self-funding.”

AHPs are an attempt to finesse this problem by allowing professional and business associations of small companies to self-fund the benefits for their members. But if the association itself is exempt, it shouldn’t matter whether it is self-funded or fully-insured. We should discontinue the fiction of there being a difference between the two forms of coverage. Let the association apply to the Department of Labor for qualified status (proving it is a bona fide association and has the management and financial resources to supervise a program) and then choose whether to insure or self-insure. That way, insurance companies could continue to participate in the small group market on an equal footing, and virtually all firms could organize themselves

into associations to make the purchase of coverage more efficient and equitable.

Adequacy of Federal Oversight

One of the great red herrings in this dispute over AHPs is whether the Department of Labor is up to the task of regulating all the newly formed association health plans. Yet the DoL currently manages to oversee tens of thousands of employer-sponsored plans with very little problem. Even in a time of corporate scandals and bankruptcies, there has been little problem with these companies' health benefit plans. That is quite a sterling track record when compared to state insurance departments that regulate only a handful of health insurers and have been plagued with scandals and insolvencies in recent years.

Solvency Issues

Another bone of contention in AHP discussions is whether the solvency provisions are adequate. Solvency is the fundamental duty of insurance regulation. All insurance mechanisms are based on the idea that you pay money today so the company will pay you sometime in the future when an adverse event occurs.

The company is selling nothing more than a promise to pay. The purchaser cannot effectively determine whether the company is able to fulfill that promise. It is the perfect environment for Ponzi schemes. AHPs must include a rigorous standard for capitalization and cash reserves and an independent referee who is able to vouch for the future solvency of the plan. If current AHP legislation is inadequate in this area, it should be strengthened.

Economies of Scale

One of the arguments put forth in favor of AHPs is that smaller companies will be able to achieve lower costs through greater administrative efficiencies and economies of scale through mass purchasing. It would be wise to be skeptical of these claims.

Large employers have centralized payroll and data systems that make enrollment and disenrollment simple. They have centralized human resource departments that can answer employee questions. And they have an enrollment base that doesn't change from year-to-year outside of normal attrition.

An association of small employers has none of these advantages. Companies can come in and out of the association at will. They all have their own systems for tracking employees and dependents that may not be compatible. The quality of their HR functions is all over the board. The management of the association health plan may be an additional cost that didn't exist before. Distribution of literature and plan documents may be awkward and expensive. Marketing expenses may be no less since the association adds another layer of marketing effort and someone still has to be available to explain the program and the choices to individual employees. And an employer who can get a better deal outside of the association is free to do so.

On the other hand, the association should be able to provide a level of professional benefits management that few small firms could afford on their own, and they may have negotiating clout superior to the "take-it-or-leave-it" position small firms are in today.

It is impossible to predict whether there will

be a net gain or a net loss from all these factors. Only actual experience can provide the answers.

Conclusion

If ERISA had never been enacted we wouldn't need separate AHP legislation. Similarly, if the states had been more reticent in enacting regulations, there wouldn't be a great need. But these conditions cannot be wished away.

The fact is that the small group market is in a crisis. Small employers are on the verge of bailing out of health care in massive numbers and there is no short-term remedy in sight. A properly written AHP bill could help. But such a bill is not before Congress at this writing.

The bill would have to exempt AHPs from virtually all state regulations, not only mandated benefits. It would have to extend that exemption to all qualified associations, whether insured or self-funded. And it would have to include solvency provisions that are indisputably adequate.

With those conditions in place, AHPs could transform the small group market from one in which near-monopoly insurers dictate the terms of coverage to thousands of little purchasers, to one in which a much smaller number of organized associations can shop for coverage on an equal footing with the carriers. This would structure and rationalize the market for more stability.

A Final Thought

With the new IRS ruling on Health Reimbursement Arrangements (HRAs), small employers do have a third option other than a choice of paying huge rate increases, or dropping coverage altogether. They can now decide what they can afford to pay for

health coverage and make that money available to employees to help with their health care needs – all on a tax-favored basis.

If an employer has been paying \$100/mo for coverage per employee and is told the same coverage will now cost \$130/mo, the employer may choose to continue to pay the \$100/mo but place it in an HRA. The employee may then take that money and pay directly for services, or he may add his own funds and purchase individual coverage, or he may save that money for a rainy day and use it for health expenses when he is unemployed.

These stand-alone HRAs do not have to accompany any kind of insurance plan. The employer can get out of the business of buying insurance, and simply make the funds available to employees to spend on the health services they prefer.

Employers may also set up an HRA to go along with a low-cost “catastrophic” insurance plan that protects workers from the serious and expensive conditions they could never afford on their own. Such a plan would not cover every health care need a worker may have, but it would protect against bankruptcy for a very little cost. To the extent the employer can pay more, the money could go into an HRA to help for immediate needs.

Greg Scandlen is the director of the Center for Consumer Driven Health Care at the Galen Institute, a free market think tank based in Alexandria, VA.
Contact greg@galen.org