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## **Association Health Plans, Health Marts and the Small Group Market for Health Insurance**

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# Association Health Plans, Health Marts, and the Small Group Market for Health Insurance

## Summary

An estimated 41.2 million people were without health insurance in 2001. The number of uninsured has risen in almost every year since 1989 and is expected to continue its rise in 2002 and 2003. Most people in the U.S. who have health insurance obtain it through their own, or a family member's, employer as a workplace benefit. Small employers, however, are far less likely than larger employers to provide health insurance to their workers and almost half of the uninsured work for, or are family members of employees who work for, small employers.

Legislation under consideration by the 108<sup>th</sup> and earlier Congresses is intended to assist small employers in offering health insurance as a benefit to their workers. The Small Business Health Fairness Act of 2003 (H.R. 660/S. 545) and a number of bills from the earlier Congresses include provisions creating new groups for small firms to join or encouraging the growth of existing groups so that small employers can band together to offer coverage to their employees.

Association Health Plans (AHPs) and Health Marts (HMs) are two of the groups that would be established by these bills. Both types of entities would build on existing groups already available to some small employers; many trade and professional associations offer health insurance to their members, and health insurance purchasing cooperatives (HIPCs) established by a few state governments as well as other groups exist in a number of states and metropolitan areas.

The goals that are offered for establishing such groups include reducing the administrative challenges for small employers in seeking out, contracting with, and administering health benefits and providing them with the bargaining power that larger employers have in negotiating contracts with insurers. In addition, some of those groups may be able to offer reduced priced plans, thereby enabling more employers to afford to offer such coverage. Reducing the number of small firm workers without access to health insurance is another goal that has often been offered for pursuing expanded group purchasing options. Evidence based on existing group purchasing mechanisms suggests that some of these goals are more likely to be achieved by the proposals than others. Opponents of the legislation posit that unintended negative consequences would arise, negating the benefits that the new groups would create. This concern largely relates to fears that AHPs would increase risk segmentation in the small group market for insurance by covering mostly healthy groups, leading to increased instability and higher premiums for other small groups.

Still other groups have taken the position that the proposed small employer groups, while not undermining the small group market, would require additional features to significantly expand insurance coverage among the uninsured. New proposals recommend combining pooling mechanisms with cash subsidies or tax credits or providing seed money to states to improve the effectiveness of such entities in helping small employers access health insurance. This report will be updated periodically.

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# Association Health Plans, Health Marts, and the Small Group Market for Health Insurance

## Introduction

An estimated 41.2 million people were without health insurance in 2001.<sup>1</sup> The number of uninsured has risen in almost every year since 1989 and is expected to continue its rise in 2002 and 2003. Most people in the U.S. who have health insurance obtain it through their own, or a family member's, employer as a workplace benefit. Small employers, however, are far less likely than larger employers to provide health insurance to their workers and almost half of the uninsured work for, or are family members of employees who work for, small employers. For some small employers, especially those with young and transient workforces, providing health insurance may not be a high priority. Other small employers would like to offer employees health insurance, but face a number of difficulties. While the cost of insurance is cited as the primary reason for not offering the benefit, there are other significant reasons for not offering coverage, such as the complexity of offering insurance to a job force with high turnover, and the belief that coverage is not necessary to attract workers.<sup>2</sup>

Legislation considered by the 108<sup>th</sup> and earlier Congresses is intended to assist small employers in offering health insurance as a benefit to their workers. These bills include provisions creating new groups for small firms to join or encouraging the growth of existing groups so that small employers can band together to offer coverage to their employees. These groups are intended to reduce the administrative challenges for small employers in seeking out, contracting with, and administering health benefits and to provide them with the bargaining power that larger employers have in negotiating contracts with insurers. In addition, some of those groups may be able to offer reduced priced plans, thereby enabling more employers to afford to offer such coverage.

Association Health Plans (AHPs) and Health Marts (HMs)<sup>3</sup> are two of the groups that would be established by the bills that have been and are under

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<sup>1</sup> CRS Report 96-891 EPW, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2001*, by Chris L. Peterson, Jan. 7, 2003.

<sup>2</sup> *Kaiser Family Foundation: 1998 Health Benefits Survey of Small Employers, February, 1999*, by Jon Gabel, Kimberly Hurst, Heidi Whitmore, Samantha Hawkins, Catherine Hoffman, and Gail Jensen, Feb. 1999.

<sup>3</sup> At least one bill (H.R. 2563 considered during the 107<sup>th</sup> Congress) called these entities Qualified Health Benefits Purchasing Cooperatives (HBPCs).

consideration. Both types of entities would build on existing groups that are already available to some small employers today. Many trade and professional associations offer health insurance to their members, and health insurance purchasing cooperatives (HIPCs) established by a few state governments as well as other groups exist in a number of states and metropolitan areas. Based on the most recent data available, about one-third of small firms are believed to purchase health insurance through such pooled arrangements.<sup>4</sup> This report examines the track record of the existing pooled purchasing arrangements that are most parallel to AHPs and HMs; evaluates the potential impact of AHPs and HMs, as defined in bills considered during the 108<sup>th</sup> and earlier Congresses, on small employers' access to health insurance; identifies the stakeholders in the small group market for insurance that could be impacted by such legislation; and discusses alternative approaches that some analysts believe would improve the potential impact of AHPs and HMs in reducing the number of uninsured.

The reader may find the following definitions helpful.

**Association-Sponsored Plans** — This phrase is used to describe the universe of plans sponsored by trade and professional associations, and business coalitions. A bill being considered by the 108<sup>th</sup> Congress (H.R. 660, the Small Business Health Fairness Act of 2003) would establish incentives for new association-sponsored plans and create some market advantages for new and existing association-sponsored plans that become certified under a process described in the bill. Such plans would be called *Association Health Plans (AHPs)*. Not all association-sponsored plans would qualify as AHPs as defined in H.R. 660. A more detailed description of H.R. 660 and the differences between proposed AHPs and existing association plans is below.

Under current law, association-sponsored plans are regulated by states, even when those associations self-fund the health coverage. This authority to regulate such plans was clarified in 1983 by the “MEWA” (multiple employer welfare arrangement) amendment to federal pension and benefits statute. (See definition below.)

**Health Insurance Purchasing Cooperatives (HIPC)** — This denotes a second broad category of purchasing groups for small employers that currently exist in a number of states. Often established by states or Chambers of Commerce, these groups allow small employers within a geographic area to purchase health insurance through the group. The HIPC negotiates with insurers to specify the features of the plans to be offered through the HIPC and the prices of those plans. Unlike most association-sponsored plans, small employers of any trade may purchase coverage through HIPCs. Bills considered during the 106<sup>th</sup> Congress would have established incentives for the formation of new HIPCs, and would have required these entities to have certain characteristics. Those entities were to be certified as *Health Martts*.

Under current law, states regulate the health plans offered by HIPCs.

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<sup>4</sup> S.H. Long, and S.M. Marquis, *Pooled Purchasing: Who Are the Players?*, Health Affairs, July/Aug. 1999, vol. 18, no. 4. (Hereafter cited as Long and Marquis, *Pooled Purchasing: Who Are the Players?*)

Sometimes the distinction between HIPCs and association-sponsored plans is blurred, under both current law and the proposed bills. The insurance marketplace is diverse and dynamic, making perfect categorization of types of plans sometimes difficult. For example, sometimes local chambers of commerce offer health coverage to small employers within a geographic area. Health coverage offered by that group may look very similar to that which is offered by HIPCs. A primary difference between association-sponsored plans and HIPCs under current law is that HIPCs offer *only* insured plans, never funding their own risk while associations often offer coverage to its members that is self-insured.

**Multiple Employer Welfare Arrangement (MEWA)** — This is a legal term established in 1983 within the Employee Retirement and Income Security Act of 1974 (ERISA)<sup>5</sup> for all group purchasing arrangements through which employers purchase insurance or benefits together. The purpose of the ERISA provision is to clarify that states have regulatory authority over such plans, whether the coverage offered by those groups of employers consists of insurance products or self-funded health plans (see definition below.) Under current law, association-sponsored plans *and* HIPCs are considered MEWAs and thus, may be subject to state regulatory authority.

**Self-Insurance/Self-Funding** — A health care benefit offered by an employer or group of employers (an association or trade group) is “self-insured” or “self-funded” when that employer or group of employers sets aside funds to cover the cost of health benefits for their employees instead of purchasing an insurance plan from a traditional insurance company or a health maintenance organization (HMO). Sometimes the employer directly establishes contracts with providers and administers the plan but most often it is handled through an administration service-only agreement with an insurance carrier or a third-party administrator. Many self-insured employers or associations purchase stop-loss insurance that covers expenditures above a certain aggregate claim level and/or catastrophic illness or injury when individual claims reach a certain dollar threshold.<sup>6</sup>

## Employer Purchasing Groups

The concept of employers coming together to purchase health insurance is not new. Many health insurance purchasing groups for employers, both large and small, exist today and have a wide range of features. There are publicly sponsored purchasing groups and private purchasing groups; some that self-insure and others that bargain with carriers to offer a single or multiple insured products. There are a number of possible advantages for employers that purchase insurance through a well-designed group. By pooling their insurance risks together, the employers in the group may be able to increase their bargaining power with carriers and share administrative functions, theoretically resulting in lower premium costs. Further,

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<sup>5</sup> P.L. 93-406, Sec. 514(b)(6).

<sup>6</sup> Derived, in part, from *Glossary of Terms Commonly Used in Health Care*, Alpha Center.

employees of those firms may be able to select from a larger number of plans than if their employers were to obtain insurance independently.

Two types of purchasing groups, association-sponsored plans and HIPCs have been the subject of a great deal of bipartisan interest. Many hope that these purchasing groups, with the right legislative encouragement, could further reduce, for small employers, the administrative costs and burden of providing health insurance as a workplace benefit. If very effective, some hope that the group purchasing arrangements could even reduce the number of uninsured workers by raising small firms' coverage overall or by making the choices available through small firms more attractive to workers. Advocates also propose that such groups could, if enough small firms in a geographic area were to join, provide a portable form of health insurance coverage for workers who switch jobs.

In 1997, about 26% of all businesses participated in some form of pooled purchasing. For smaller firms, as many as one-third purchased through a pooled arrangement, but this percentage drops to about 14% for firms with 500 or more employees.<sup>7</sup> The distribution of firms and employees between association-sponsored plans versus other types of pooled arrangements is not available.

**Association-Sponsored Plans.** Under current state law, many trade and business associations offer health insurance plans for their members to purchase. Associations usually offer one health plan to their membership and often self-fund those plans.<sup>8</sup> While the primary purpose of most association-sponsored plans is to create economies of scale for small firms that band together, for those groups with below-average risk, another important goal is to buy lower-priced coverage reflecting their groups' lower risk.

Since 1983<sup>9</sup>, states have the authority to regulate health coverage sold by associations even when the coverage is self-funded. For associations with members in multiple states, this sometimes means that the benefits offered must comply with the insurance laws and regulations in all of the states in which their plans are sold, including solvency and funding requirements and consumer protections.

Little information exists on the variety and types of coverage offered through associations or on consumer satisfaction with that coverage. It is reasonable to

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<sup>7</sup> Long and Marquis, *Pooled Purchasing: Who Are the Players?*, 1999.

<sup>8</sup> Long and Marquis found that 80% of businesses participating in a purchasing coalition had a choice of two or more plans, while only 15% of businesses participating in other purchasing groups had a choice of plans.

<sup>9</sup> Before the 1983 addition of the MEWA provision to ERISA, self-funded association-sponsored plans were exempt from state regulation of insurance. The MEWA provision clarified states' regulatory authority over association-sponsored plans, even when the coverage offered is self-funded. This ERISA modification was Congress's response to a large number of highly publicized association plan failures. Many states responded to the ERISA change by establishing laws to regulate such plans, and by requiring those plans to abide by insurance laws already on the books including solvency and funding standards. Some states even prohibited the ability of association-sponsored plans to self-insure.

assume, based on the large numbers of people enrolled in such plans, that associations are an important contributor to the insurance coverage of the population. Associations, on the other hand, suffer from a bad reputation, based on a number of highly publicized plan failures, failures that drove the 1983 statutory change clarifying states' rights to regulate such plans.

Despite the 1983 statutory change providing states with regulatory authority over association plans, some of the problems with those plans continue to exist today as demonstrated by recent announcements of association-sponsored plan failures.<sup>10</sup>

These plans seem to have fallen through the regulatory cracks — some states' laws do not apply to out-of-state associations. Other association-sponsored plans suffer from fundamental instability, despite the states' regulations intended to strengthen those entities against such risk. Those plans that are unable to attract a large enrollment with a broad risk profile face a risk selection spiral — a phenomenon in which, year after year, annual premiums, which may begin at a low level, spiral upward. Once a few high cost claims are filed, premiums rise to reflect the cost of the now higher-risk group. The healthiest enrollees have an incentive to exit the group to seek lower premiums reflecting their healthy status. This prompts an additional increase in premiums due to the increasingly less healthy group left within the pool — which, in turn, triggers more exits among the healthier members left in the pool, and an increase in premiums, with the cycle repeating itself.

**Health Insurance Purchasing Cooperatives (HIPCs).** HIPCs are similar to association-sponsored plans in that small employers band together to purchase insurance in larger groups. But they are different from those plans in a number of important ways. HIPCs generally offer coverage to all small employers within a defined geographic area. The employers do not need to belong to a certain industry or be members of, or affiliated with, a professional association. Another difference between association-sponsored plans and HIPCs is that the cost of coverage offered by HIPCs is usually community-rated instead of at rates based on each individual employer's group (experience-rated). Finally, HIPCs tend to offer a choice of insured plans whereas associations usually offer one plan.

HIPCs are relatively uncommon. A number of HIPCs have been established privately by Chambers of Commerce or other similar entities. Others have been established by state or local governments. The largest of these is the California's Pacific Health Advantage (PacAdvantage) which, at last count, had enrollment of 11,000 small businesses through which almost 150,000 individuals received coverage.<sup>11</sup> It was established by the state but its authorizing legislation provided for its administration to be taken over by a private entity after 3 full years of operations. It is currently operated by the Pacific Business Group on Health, a coalition of large employers.

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<sup>10</sup> "More Patients Get Stuck with the Bills," *USA Today*, May 5, 2001; "Insurance Fraud Rises with Health-Care Costs," *Chicago Tribune*, Feb. 19, 2002; "Car Dealers' Health Insurance Trust Goes Under," *Newark Star Ledger*, Feb. 24, 2002.

<sup>11</sup> [<http://www.pacadvantage.org>]



As with association-sponsored plans, HIPCs have had a mixed history of success. Advocates hope that cooperatives, in addition to easing small firms' administrative burden, would also reduce the price that small employers face, and would enroll large enough numbers of employers to create a significant market presence. But reductions in the cost of plans sold through HIPCs have not been achieved.<sup>12</sup> Some HIPCs have encountered indifference on the part of health insurance brokers (most insurance sold in the small employer market is sold through insurance brokers) and insurers while others have had to close their doors for lack of enrollment.

Still others, like PacAdvantage, on the other hand, have stable enrollment and are considered to be a success. They have been able to provide small firm workers with a choice of plans and their advocates offer them as an efficient way to administer public subsidies — from existing programs like Medicaid and the State Children's Health Insurance Program (SCHIP) or proposed subsidies for employer-based health insurance coverage.

## Legislative Proposals for AHPs and Health Marts

The group purchasing provisions considered by the 108<sup>th</sup> and earlier Congresses have at their foundation a number of goals: to improve the ease with which small employers purchase insurance for their employees; to reduce the cost of health insurance plans offered in the small group market; to increase the number of workers in small firms who have health insurance; and sometimes, to increase the number of health coverage choices available to workers in small firms.

**AHPs.** H.R. 660, introduced by Representative Fletcher, was passed by the House of Representatives on June 19, 2003 and referred to the Senate Committee on Health, Education, Labor, and Pensions. Its companion bill, S. 545, was introduced in the Senate on March 6, 2003 by Senator Snowe. HR.660/S. 545 would establish Association Health Plans as generally defined above. Association-sponsored plans interested in attaining certification as AHPs as under this bill, would undergo a certification process to be established by the Department of Labor (DOL).

The bill would establish a number of features that plans must have to become certified as AHPs, and exempt such plans from state insurance law and regulatory oversight. The provision would remove AHPs from states' authority to apply a large body of insurance laws and regulations including consumer protections, solvency and fair marketing practices, grievance and appeals procedures, premium taxation and prohibitions on discrimination. Instead, the bill would establish the federal government as having the sole regulatory authority over these entities except in the

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<sup>12</sup> GAO/HEHS-00-40, *Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices*, Mar. 2000; J.M. Yegian, T.C. Buchmueller, J.C. Robinson, A.F. Monroe, *Health Insurance Purchasing Alliances for Small Firms: Lessons from the California Experience*, May 1998; S.H. Long, and M.S. Marquis, *Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?*, Health Affairs, vol. 20, no. 1, Jan./Feb. 2001.

case of state laws that prohibit the exclusion of a specific disease from coverage, or relate to newborn and maternal minimum hospital stays and mental health parity.<sup>13</sup>

The bill would establish non-discrimination provisions that would prohibit AHPs from rejecting less healthy applicants from coverage or targeting those individuals for higher premiums. Reserve and solvency requirements would replace those states' laws that would no longer apply. Those provisions and the other requirements of the bill would be enforced by the "applicable authority" — sometimes the Secretary of the Labor and at other times, the states' agencies responsible for the regulation of insurance.

Certified plans would also include the following features:

- AHPs must offer at least one insured health coverage option unless: (1) the self-insured plan existed before the date of enactment of the bill; (2) membership is not restricted to one or more trades; instead, employers representing a broad cross section of trades and businesses or industries are eligible; or (3) the plan covers eligible participating employees in one or more high risk trades (as listed in the bill).
- The association sponsoring the plan must have been in existence for at least 3 years and be operated by a board of trustees with complete fiscal control and responsibility for all operations.
- AHPs must have at least 1,000 participants and beneficiaries, and have offered coverage on the date of enactment or represent a broad cross-section of trades, or represent one or more trades with average or above average health insurance risk.
- All employers who are members must be eligible to enroll, all geographically available coverage options must be made available upon request to eligible employers, and eligible individuals cannot be excluded because of health status.
- Premiums for any particular small employer are prohibited from being based on the health status or claims experience of its plan participants or on the type of business or industry in which the employer is engaged.

The bill would establish requirements regarding who may participate on the board of trustees for qualified AHPs. The board may include owners, officers, directors, or employees of the participating employers or partners with the participating employer who actively participate in the business. Service providers to the plan may also be members of the board if they constitute not more than 25% of the membership of the board and do not provide services to the plan other than those on behalf of the sponsor.

The bill would establish an "Association Health Plan Fund" from which the Secretary of Labor (or applicable authority) would make payments to ensure

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<sup>13</sup> And are not pre-empted by federal laws regarding minimum hospitals stays for newborn delivery and mental health parity (Sections 711 and 712 of ERISA Title I, Part 7).

continued benefits on behalf of AHPs in distress. The fund's activities would be financed by annual payments made by AHPs.

**Health Marts (HMs).** Health Marts were included in a number of bills considered by previous Congresses. While HMs have not been deliberated on recently, the concept continues to generate interest. HMs,<sup>14</sup> would be cooperatives like the existing HIPCs. Health Marts were generally defined in previous bills to be private, nonprofit entities that make health benefits coverage available and provide related administrative services to all small employers and eligible employees in a specified geographic area no smaller than a county. Health Marts would have been exempted from state laws related to benefits (except for laws requiring coverage of specific diseases, maternal and newborn hospitalization, and mental health) and from states' grouping requirements (which bar employers from joining together for the sole purpose of purchasing health insurance), and any other requirement that directly or indirectly impedes offering coverage through an HM. Other characteristics of HMs were to include the following:

- Health Marts would have operated under the direction of a board that includes representatives from small employers, employees, health care providers, and entities that underwrite or administer health benefits coverage.
- They would have been required to offer at least two coverage options and have had at least 10 purchasers and 100 members by the end of the first year of operation.
- They would not have been allowed to self-insure.
- Premiums for benefits offered through HMs would have been allowed to vary only as permissible under state law and would not have been allowed to vary among similarly situated individuals on the basis of health status.
- Health Marts would be prohibited from denying enrollment or renewal of coverage on the basis of health status-related factors.

The following table compares some of the features of proposed AHPs, and HMs with the most common features of existing purchasing cooperatives.

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<sup>14</sup> In this document HMs are described based on the provisions of H.R. 2990, the Quality Care for the Uninsured Act of 1999 as passed by the House of Representatives in October of 1999.

**Table 1. Comparison of HIPCs and Association-Sponsored Plans under Current Law with Proposed AHPs and HMs**

Feature or condition	Current Law/Current Practice		Proposals	
	HIPCs	Association-Sponsored	AHPs	HMs
Type of entity, governance	Governmental or nonprofit, subject to federal and state law	Private, subject to federal and state law	Private, subject to federal law only	Private, nonprofit, subject to federal and some state law
Interests represented on governing board	Employers, community	Sponsoring institution and members	Sponsoring institution and members. May include vendors, subject to restrictions	Employers, employees, providers, and insurers
Must accept all willing insurers	Generally not	No	No	No
Able to negotiate with plans over premiums, etc.	Typically only over administrative component	Yes	Yes	Yes, but seems unlikely given board structure
Who selects plan?	Employee	Employers (Not required to allow employee choice)	Employers (Not required to allow employee choice)	Employers (Not required to allow employee choice)
Standardized benefits	Normally	Not required	Not required	Not required
Subject to state-mandated benefits laws	Generally yes	No	No, except for coverage of specific diseases, maternal and newborn hospitalization and mental health.	Same as AHPs.
Group size limits	Usually 2-50 employees	None	None	2-50 employees

Feature or condition	Current Law/Current Practice		Proposals	
	HIPCs	Association-Sponsored	AHPs	HMs
Must take all small groups that apply, regardless of health status	Yes	Within association membership only; non-members excluded	Within association membership only; non-members excluded	Yes
Subject to state rating requirements	Yes, but can sometimes offer discounts	Yes	No, but establishes some federal limits on rating factors to apply within association	Ambiguous
Subject to other small-group insurance reforms	Yes	Yes	Only HIPAA, not state laws (with some exceptions)	Yes
Geographic service area	Usually whole state	Same as association membership, often multistate	Presumably the same as association membership, often multistate	County-specific, and counties need not be contiguous
Allowed to assume insurance risk (self-insure)	No	Yes	Yes, subject to reserve and solvency requirements	No

**Source:** Adapted from Hall, Wicks, and Lawlor, *Health Affairs*; Jan./Feb. 2001, p. 144.

**Note:** HIPAA is Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191).

## The Impact of AHPs and HMs

Opinions about the potential impact of AHPs and HMs on the small group market for insurance span the continuum of possibilities. Advocates of AHPs and HMs view removing the state regulatory barriers and creating federal standards as ways to encourage the growth of pooling options. By releasing multi-state pools from the regulatory burdens of each state in which enrollees reside, these provisions would increase the options available to small employers who want to offer insurance as a benefit but cannot. In addition, some argue that the increased risk of small firm coverage could become spread across larger groups of employers (through the pools) making health insurance as accessible to workers in small firms as to those in large firms. Most importantly, their supporters say that releasing AHPs and HMs from

most state benefit mandates will allow those groups to offer more affordable, slimmed down benefit packages that may be desirable to workers who are now uninsured.

Opponents raise concerns about the impact the legislation would have on adverse risk selection in the small group markets and the solvency of plans, and about the DOL's ability to ensure that enrollees are protected from enrolling in fraudulent or inept plans. These issues are examined in more detail below.

**Risk Segmentation.** Insurers naturally have incentives to select the most favorable risks among the individuals or groups that are seeking coverage, while rejecting others. While the goal of insurance is to spread risk, policies or practices that allow beneficial risk selection have the opposite effect. This risk selection concern is raised regarding AHPs and HMs because of provisions exempting AHPs and HMs from state laws mandating that certain benefits be covered in plans, limiting and defining how policies are to be priced, and defining fair marketing and business practices. All 50 states have such laws, many of which are intended to maintain well-spread risk in the small employer markets for insurance. Opponents fear that AHPs and HMs would attract healthier firms since firms with sicker employees would not want plans that exclude the state-mandated benefits and protections. If AHPs and HMs attract predominantly healthy small firms out of the traditional small group market, firms with less healthy employees could face even higher premiums. A risk selection spiral could become activated, to the detriment of those left outside of the AHPs or HMs, and firms with sick employees (or employees with sick family members) would be especially at risk.

Current AHP legislation takes concerns about adverse risk selection into consideration. H.R. 660 includes the following provisions intended to reduce these incentives.

- To discourage AHPs from actively pursuing healthier employee groups and rejecting or discouraging higher risk groups from joining, the bill would prohibit discriminatory membership policies and plan pricing based on health status of employees or their dependents. It also would prohibit AHPs from requiring that member employers purchase health coverage through the AHP.
- It would restrict the ability of self-insured health plans to become qualified as AHPs. If an association establishes a new self-funded health coverage plan after enactment of the bill, then it would be required to either offer membership to a broad cross-section of trades and businesses or to employers representing one or more of a listed set of higher risk occupations. (Self-insured plans that exist on the date of enactment would be grandfathered in and therefore would not have to meet these rules.)
- It would prohibit a participating employer from providing health insurance coverage in the individual market for any employee excluded from the AHP which is similar to the coverage provided under the AHP, if such exclusion is based on a health status-related factor and such employee would otherwise be eligible for coverage under the AHP.

- It would require AHPs to offer their plans to all employers who are eligible to participate and also require upon request, that any employer who is eligible to participate be furnished information regarding all available coverage options.
- Finally, it would require AHPs to abide by any state laws mandating coverage of specific diseases, maternal and newborn hospitalization and mental health services.

Some consumer advocates and state regulators fear that those provisions may not be enough. The provisions, they say do not provide for the fair marketing rules and patient protections as established by the states. Moreover, their concerns relate not only to the ability of AHPs to reject higher risks, but also to the incentives that encourage certain small firms to sort themselves into AHPs versus insured plans, such as the ability of AHPs to offer trimmed-down benefits.

**Ensuring Financially Secure Plans.** Consumer advocates raise alarm bells about the risk of plan failures that could leave plan beneficiaries uncovered when they seek health benefits — precisely the situation Congress addressed in 1984 when the MEWA provisions were added to ERISA. They fear more insolvencies would arise if these plans are not subject to states' laws regarding plan funding and solvency. Current AHP legislation takes these concerns into consideration. H.R. 660 includes the following provisions related to plan funding:

- requires self-insured AHPs to establish and maintain reserves in amounts recommended by a qualified actuary;
- requires AHPs to establish and maintain aggregate and specific excess/stop loss insurance and solvency indemnification;
- requires AHPs to establish and maintain a minimum surplus in addition to claims reserves;
- authorizes the applicable authority (the DOL or the state) to provide such additional requirements related to reserves and excess/stop loss insurance as considered appropriate;
- establishes an Association Health Plan Fund for making payments to continue excess/stop loss insurance coverage and requires AHPs to make annual payments of \$5,000 to this account; and
- establishes a Solvency Standards Working Group to make recommendations in this area.

Detractors, however, do not feel these provisions go far enough. They say that the bills should explicitly provide for surplus/reserves, and indemnification/stop loss insurance that grows as the size of the plan grows even though the bill provides fairly broad authority for the applicable authority to establish additional requirements.

**Regulatory Authority.** H.R. 660 would establish federal laws regarding the practices, structures, quality and solvency of AHPs that would be enforced, for many plans, by DOL. There are pros and cons for removing states' regulatory authority over qualified AHPs and establishing a federal body of law that would be enforced by DOL. The pros include:

- Creating a single set of federal standards to apply to these health plans would reduce the cost of the benefits offered because multi-state plans would not have to comply with multiple states' insurance laws, and they would not have to include the mandated benefits as required by each of the states in which they operate.
- Very large employers that self-insure are exempt from state insurance regulation. Instead they are regulated only under ERISA as enforced by the DOL. Therefore, to treat self-insuring AHPs equitably, advocates say they should also be exempt from state insurance laws.
- Since 1996, DOL has added capacity for regulating and dealing with extensive new health plan requirements, especially following the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The agency has testified that it will be able to act in the role of regulating and enforcing AHP law if a bill should pass.<sup>15</sup>

Concerns with this regulatory approach include:

- States have traditionally been in the role of regulating insurance. For this job, each state has a department of insurance with enforcement staff and procedures already in place. The DOL has not, until recently, had experience in this capacity. While DOL has always been responsible for enforcing ERISA's health plan requirements for self-insured plans, before 1996 there were few requirements to enforce.
- The body of law that states have established has been developed over the years to address market failures and to protect the consumers who purchase health plans. For example, the patient protection bills that were considered at the federal level over the last few years were mostly modeled after the best of the states' actions in this area. By removing AHPs from the regulatory authority of states and regulating those plans at the federal level, many of those existing state protections would be lost. There are federal protections H.R. 660 and in earlier proposals, but they are very few compared to the typical set of state laws.
- There is an equity argument here, as well. At least one of the groups of opponents of AHP legislation — those insured plans in the small group market that would remain subject to state insurance laws — say that they would be put at a market disadvantage by being left as the only group subject to state laws and patient protections. They fear that patients in need of such protections (those with histories of illness or sick family members) will flock to their plans and healthier groups that view themselves as not needing such protection will move to the AHPs, destabilizing an already unstable small group market, and will cause loss of coverage as insured plans increase

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<sup>15</sup> See February 5, 2003 testimony of Elaine L. Chao, Secretary of Labor before the Senate Committee on Small Business and Entrepreneurship.



their premiums to account for the increasingly less healthy groups covered.

## The Stakeholders

Who are the major stakeholders with interest in the debate over how to increase access to health insurance through small employers and what are their views on AHPs and HMs? Uninsured and insured workers and their families, small business owners, insurance carriers, and state and federal insurance regulators could all be impacted by the provisions considered during the 108<sup>th</sup> and earlier Congresses. The considerations important to each of those stakeholders and how they could be impacted by the AHP and HM proposals are examined below.

**Workers in Small Firms.** For workers whose employers do not offer health insurance as a workplace benefit, there are often few other options available for purchasing such coverage. Some workers could purchase insurance independently in the “individual market for insurance.” Access to comprehensive and affordable insurance similar to the policies available in the group market for insurance, however, is limited unless the workers and their families are young and healthy. If the workers (and their family members) become sick *and* impoverished, Medicaid *may* become an option for some. Children in families with income that falls below twice the poverty level (\$34,000 in 2002) may be eligible for Medicaid or SCHIP, but most adults in those families will not be able to meet the categorical requirements of those programs — meaning they do not fall into the “categories” of eligibility such as blind, aged, disabled, children or recipients of welfare program assistance.

AHPs and HMs would provide an insurance option for some workers where no option may exist today. The Congressional Budget Office’s (CBO) analysis of H.R. 660,<sup>16</sup> concluded that about 600,000 formerly uninsured workers and dependents would obtain coverage by 2008 under the proposed AHPs. They determined that a total of about 7.5 million people would become covered through the AHPs, but all but the 600,000 would already have had employer-based coverage.

Some individuals may lose their coverage, as well. The CBO estimated that about 10,000 workers and their dependents who are currently covered through small employer-provided plans would lose that coverage if the AHP provisions were to become law.<sup>17</sup> This would happen because of the relative appeal of the AHPs and HM to the better risk in the market. The effect on workers left in the traditional market in which the healthier groups have exited is rising premiums, resulting in individuals and/or their employers dropping the health coverage.

If there is a requirement that AHPs or HMs offer more than one plan, and if workers, instead of employers, are able to choose among those plans, then the

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<sup>16</sup> *Congressional Budget Office Cost Estimate of H.R. 660: Small Business Health Fairness Act of 2003 as passed by the House on June 19, 2003*, Congressional Budget Office, July 11, 2003.

<sup>17</sup> *Ibid.*, p. 5.

proposed groups will be providing something that very few workers in the small group market for insurance have today — the choice of plans.

**Small Employers.** Many small employers do not offer health insurance as a benefit to their employees. This is due to a number of factors. The strongest factor in the small business owner's decision not to offer coverage is generally understood to be the cost of health insurance.<sup>18</sup> But there are other important factors, as well.

- Some small employers are not able to undertake the many complex tasks required to offer health insurance as a benefit, such as reviewing plans, negotiating the terms of the contract with health insurers or HMOs, administering the benefit, and collecting and paying premiums — especially on behalf of a workforce with high turnover.
- The condition of the labor market may make health insurance unnecessary for attracting a sufficient workforce for certain employers. In a tight labor market where workers are scarce, the desire to offer insurance tends to increase. On the other hand, when labor is plentiful certain firms may have no incentive to offer insurance because even without such a benefit, workers are available.
- Demand for insurance among small-firm workers may be low relative to workers in larger firms. Workers at small firms, on average, earn less and have lower wages than workers in larger firms. Having less income with which to purchase insurance may suppress their demand for insurance.
- Some small employers cannot meet the minimum enrollment requirements imposed by insurers. In the small group market many insurers require small employers to enroll all or almost all workers in the health plan. Without a significant employer contribution, these minimum enrollment figures are often difficult to meet.
- Finally, the costs of the same benefits are likely to be higher for a small firm than for a large firm. This is because small firms lack a large group to spread risks among and because the administrative costs of dealing with many small firms is high relative to the cost of fewer larger firms.

AHPs and HMs could offer small employers inclined to provide health insurance to their workers with a significant advantage. The small employer would not have to independently seek coverage, to compare plans and prices, nor administer the benefit. This is likely to make offering insurance as a benefit significantly easier for those employers.

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<sup>18</sup> P. Fronstin, and R. Helman, *Small Employers and Health Benefits: Findings from the 2000 Small Employer Health Benefits Survey*, Employee Benefits Research Institute, Oct. 2000; M.S. Marquis, and S.H. Long, *To Offer or Not to Offer: The Role of Price in Employers' Health Insurance Decisions*, Health Services Research, vol. 36, no. 5, Oct. 2001.

Exempting AHPs from state insurance laws would impact small employers' ability to offer health insurance. But not all employers who are able to purchase insurance through the AHPs would find that their cost of insurance is reduced. Some of those left in the traditional market for insurance may find prices rising too high to continue purchasing health insurance for their employees.

**Insurance Carriers, Agents and Brokers.** Traditional insurance carriers are important stakeholders in this debate although their role and positions are different for AHPs versus HMs. Insurance carriers have generally rejected AHP proposals because they fear that providing AHPs with increased risk segmenting opportunities will leave the insurer with a relatively more disadvantaged population. They oppose legislation that creates competitive advantages for AHPs and are concerned that sicker workers will be left to the traditional insurance market increasing market instability.

State small group market reforms have successfully achieved some stability in the small group market by establishing rating restrictions intended to spread the cost of high risk groups more broadly across small employers, and by requiring insurers that drop plans to offer other alternatives. Those laws would not apply to AHPs (although they would apply to HMs), in effect turning back time to the days before small group market reforms were passed to reduce competition based on risk selection as a method for reducing costs.

While insurers do not object to HMs, traditional insurance carriers have been largely disinterested in the existing HPCs. This disinterest has contributed to the instability and low enrollment of most of the existing HPCs. Without participation by major insurance carriers, HPCs do not have an attractive product to offer. Even those carriers that have participated have resisted offering lower prices through pools than they offer to small employers outside of the pool and have little incentive to join such groups where they will be forced to negotiate with one larger, more powerful group instead of many small employers that they now serve through direct exclusive contracts.

The good will of agents is critical to the success of purchasing groups, as well, because they are small employers' primary source of information on insurance matters. But when pools are advanced as part of a mechanism to reduce costs by eliminating administrative fees such as agents' commission, brokers and agents have seen them as a threat to their business and have refused to promote them.

**Regulators.** Regulating the business of insurance has largely been left to states.<sup>19</sup> The federal government, until 1996, had very few laws or regulations that directly addressed the requirements of health insurance. In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA) which significantly expanded the federal role in the regulation of insurance.

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<sup>19</sup> See the following CRS products for further discussion of the regulation of the business of insurance: CRS Report RL31631, *Patient Protection and Managed Care*, Oct. 25, 2002, by Jean Hearne and Hinda Chaikind, and CRS Fact Sheet RS20315, *ERISA Regulation of Health Plans: Fact Sheet*, updated June 18, 2001, by Hinda Chaikind.

All states, on the other hand, have an extensive body of law establishing the rules for those who sell insurance products. Those rules include benefit mandates, or rules about what insurance carriers must include in their coverage, patient protections, financial solvency standards, fair marketing practices, non-discrimination requirements, and rating (or pricing) rules.

State regulators, as represented by the National Association of Insurance Commissioners, object to provisions in AHP and HM proposals that would exempt those entities from some (HIPC) or most (AHP) state regulatory requirements. They raise concerns that the states' patient protections, developed in response to consumer complaints about insurance practices and unstable plans, will be undermined without federal protections to replace them.

## Other Proposals

Several new ideas have been advanced that build on the purchasing pool concept as well as the experience of purchasing coalitions in California and other locations. These ideas largely focus on creating incentives for employers to take advantage of the pooling options without exempting a portion of the small group market from states' laws. Some of those ideas include:

- Establish a tax credit or premium subsidy that can be redeemed only for health insurance coverage offered through purchasing cooperatives.

The 107th and 108th Congresses have considered a number of new or expanded tax benefits for health insurance. A proposal presented at a seminar exploring ways to reduced the number of people who are uninsured, called for combining tax credits with purchasing pools. Under this approach, individual recipients of the tax credits would be required to use them toward insurance purchased through a purchasing cooperative.<sup>20</sup>

The Progressive Policy Institute, a think tank affiliated with the Democratic Leadership Council, devised a similar approach. Under the plan, tax credit recipients would be able to purchase their health insurance through purchasing groups. The plan would provide for federal grants to help states set up purchasing groups that would let workers pool their buying power and choose among competing health plans. As a condition for receiving the federal grants, states would make sure all employers and individuals could choose among competing group insurance plans through at least one, but preferably several private purchasing groups.<sup>21</sup>

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<sup>20</sup> Rick Curtis of the Institute for Health Policy Solutions, presented this proposal on December 11, 2000 at "Strategies to Expand Health Insurance for Working Americans", a seminar sponsored by The Commonwealth Fund's Task Force on the Future of Health Insurance.

<sup>21</sup> Jeff Lemieux, David Kendall, and S. Robert Levine, M.D., *A Progressive Path Toward Universal Health Coverage*, PPI Policy Report, Dec. 20, 2000.

Purchasing groups are included as a key element in the tax credit proposal developed by the Heritage Foundation, a think tank representing conservative views. The plan's details are not yet available, so it is not clear if funding would be made available only for establishing purchasing groups or would include continued operations, if they would be made available throughout the country, or if the credits could be redeemed *only* through the purchasing groups.<sup>22</sup>

Each of these approaches recognizes that combining tax credits with expanded purchasing groups would address two of the problems faced by uninsured workers in small firms and their employers. The credits could reduce the cost of the plans for workers while the purchasing groups would make attaining plans easier for employers. Proposals *requiring* that credits be used *only* for coverage purchased through purchasing groups, are aimed at providing those groups with an enrollment boost, increasing their ability to become a significant market presence, allowing them to negotiate more aggressively with insurers, and appearing to be more appealing to insurers who are asked to offer plans through the HIPC.

- Provide start-up and ongoing administrative funding to establish nationwide access to purchasing groups.

The AHP and HM approaches, as proposed by the 108<sup>th</sup> and earlier Congresses would define the entities, establish board membership and other structural requirements, and provide access to lower cost plans by allowing them to forego certain state regulation. None of the proposals, however, would have provided funding for the new groups. Without set-up or administration funds, observers say it is unlikely that purchasing groups will expand much beyond current law. While providing subsidies or credits through purchasing groups would have a larger potential to boost their impact in the small group market, the costliness of such an approach may make it considerably more challenging to pass, especially considering the recent tightening of federal, state and local government budgets. Some suggest a more modest approach may be to provide start-up funds, feasibility studies, ongoing administrative support or demonstration projects. Wicks and Meyer, in a report analyzing the potential impact of AHPs and HMs, recommended such activities — similar to those used by earlier Congresses to encourage the growth of HMOs, to encourage the growth of purchasing cooperatives.<sup>23</sup>

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<sup>22</sup> Stuart M. Butler, Ph.D. *Health Care: Time for Bipartisan Action to Help Families Without Health Insurance*, no. 1528, Mar. 20, 2002.  
[<http://www.heritage.org/Research/HealthCare/BG1528.cfm>]

<sup>23</sup> E.K. Wicks, and J.A. Meyer, *Small Employer Health Insurance Purchasing Arrangements: Can They Expand Coverage?* New Directions for Policy, National Coalition on Health Care, May 1999.