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Association Sponsored Health Plans: Legislation in the 109th Congress

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Summary

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 uninsured people work for — or are family members of — employees who work for small employers.

Legislation considered by the 109th and earlier Congresses is intended to assist small employers in offering health insurance as a benefit to their workers. Two bills, H.R. 525/S. 406 and S. 1955 offer alternative approaches to encouraging trade and professional associations to offer coverage to small employers who are members of those groups. The Small Business Health Fairness Act of 2005, introduced in the House as H.R. 525 and in the Senate as S. 406, would create new groups called Association Health Plans (AHPs) for small firms to join into to offer coverage to their employees. H.R. 525 was passed by the House of Representatives on July 26, 2005. S. 1955, the Health Insurance Marketplace Modernization and Affordability Act of 2005, as approved by the Senate Committee on Health, Education, Labor, and Pensions on March 15, 2006, offers an alternative approach. S. 1955 would create association-based health coverage groups called Small Business Health Plans (SBHPs) and would "harmonize" states' insurance laws to achieve a more universal regulatory environment for SBHPs and traditional insurers.

The association-based coverage approaches described by H.R. 525/S. 406 and S. 1955 would build on existing groups already available to some small employers and individual professionals — many trade and professional associations offer health insurance to their members. The bills would create incentives for association-based coverage and establish rules for the coverage offered through the associations. The goal of AHP and SBHP legislation is to reduce the administrative challenges for small employers in seeking out, contracting with, and administering health benefits. AHPs and SBHPs are hoped to provide small employers with the bargaining power that larger employers have in negotiating contracts with insurers. In addition, AHPs and SBHPs 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.

Opponents of the AHP and SBHPs approach raise concerns that unintended negative consequences would arise, negating the benefits that the new groups would create. This concern largely relates to fears that AHPs and SBHPs would increase risk segmentation in the small group market for insurance by covering mostly healthy groups, leading to increased instability and higher premiums for the remaining small employers who offer coverage outside of the associations. This report will be updated periodically.

Contents

List of Tables

Association Sponsored Health Plans: Legislation in the 109th Congress

Introduction

An estimated 45.8 million people were without health insurance in 2004.[1] The number of uninsured has risen in almost every year since 1989 and is expected to continue its rise in the near term. 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.[2]

Legislation under consideration by the 109th Congress is intended to assist small employers in offering health insurance as a benefit to their workers. The 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 Small Business Health Plans (SBHPs) would build on existing groups that are already available to some small employers today. Many trade and professional associations offer health insurance to their membership. Based on the most recent data available, about one-third of small firms

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[1] CRS Report 96-891 EPW, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2004*, by Chris L. Peterson.

[2] *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.

are believed to purchase health insurance through some type of pooled arrangement.[3] This report examines the track record of the existing pooled purchasing arrangements; evaluates the potential impact of AHPs, and SBHPs as defined in bills considered during the 109th Congress, on small employers' access to health insurance; identifies the stakeholders in the small group market for insurance that could have been impacted by such legislation; and discusses alternative approaches that could improve the potential impact of pooled purchasing arrangements in reducing the number of uninsured.

The reader may find the following definitions helpful.

Association-sponsored or association-based plans — This phrase is used to describe the universe of plans sponsored by trade and professional associations, and business coalitions under existing law. Bills considered by the 109th Congress (H.R. 525/S. 406, the Small Business Health Fairness Act of 2005 and S. 1955, the Health Insurance Marketplace Modernization and Affordability Act of 2005) and earlier Congresses would establish incentives for new association-based health coverage and create some market advantages for new and existing association-based plans that become certified under a process described in the bill. Such plans would be called *Association Health Plans* (AHPs — in H.R. 525/S. 406) or *Small Business Health Plans* (SBHBs — in S. 1955). Not all association-based plans that exist today would qualify as AHPs or SBHPs as defined in the bills under consideration. A more detailed description of the plans described by those bills and the differences between proposed AHPs, SBHPs, and existing association-based plans is below.

Under current law, association-based plans are regulated by states, even when those associations self-fund (see definition below) the health coverage. This authority for states 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.)

Multiple Employer Welfare Arrangement (MEWA) — This is a legal term established in 1983 within the Employee Retirement and Income Security Act of 1974 (ERISA)[4] for all group purchasing arrangements through which two or more 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 based plans are considered MEWAs and thus, are 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 set aside funds to cover the cost of health benefits for their employees instead of purchasing an insurance plan from

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[3] 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?*)

[4] P.L. 93-406, Sec. 514(b)(6).

a traditional insurance company or a health maintenance organization (HMO). Sometimes the employer or employers directly establish contracts with providers and administer 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.[5]

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

Association-based plans have been the subject of a great deal of bipartisan interest in the 109th and past Congresses. Many hope that association-based coverage, with the right legislative encouragement, could reduce the administrative costs and burden for small employers 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, the latest year for which we have data, 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.[6] The distribution of firms and employees between association-based plans versus other types of pooled arrangements[7] is not available.

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[5] Derived, in part, from *Glossary of Terms Commonly Used in Health Care*, Alpha Center.

[6] Long and Marquis, *Pooled Purchasing: Who Are the Players?*, 1999.

[7] A small number of health insurance purchasing cooperatives (HIPCs) exist under current law. Like the proposed AHPs, they allow small employer groups to combine their risk and purchase coverage together. A few of the differences between HIPCs and proposed AHPs are that HIPCs usually offer a choice of insured plans and are not exempt from state laws.

Association-Based 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.[8] While the primary purpose of most association-based 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[9], 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 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 long history 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-based plan failures.[10] These plans seem to have fallen through the regulatory cracks — some states' laws do not apply to out-of-state associations. Other association-based plans suffer from fundamental instability, despite the states' regulations intended to strengthen those entities against such risk. 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

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[8] 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.

[9] 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.

[10] "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.

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.

Legislative Proposals

The group purchasing provisions considered by the 109th Congress 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; and to increase the number of workers in small firms who have health insurance.

AHPs. H.R. 525, introduced by Representative Sam Johnson, was passed by the House of Representatives on July 26, 2005.[11] Its companion bill, S. 406, was introduced in the Senate on April 21, 2005 by Senator Snowe. H.R. 525/S. 406 would establish Association Health Plans as generally defined above.

Associations offering health coverage that seek certification as AHPs under the authority established by H.R. 525/S. 406, would be required to undergo a certification process established by the Department of Labor (DOL). A class certification process, however, would apply to AHPs that offer only insured coverage options, while a separate process would apply to those offering one or more self-funded options.

The bill would establish a number of features that plans must have to become certified as AHPs. In addition, it would exempt many such plans from state insurance law and regulatory oversight and would remove certified AHPs from states' authority to apply a large body of insurance laws and regulations regarding benefits, consumer protections, grievance and appeals procedures, premium taxation, prohibitions on discrimination and fair marketing practices. It would exempt certified AHPs offering one or more self-funded coverage options from states' solvency and funding laws and would establish the federal government as having the sole regulatory authority over these entities except in the case of state laws that prohibit the exclusion of a specific disease from coverage, relate to newborn and maternal minimum hospital stays and mental health parity, or require prompt payment of claims.[12]

The bill would establish non-discrimination provisions prohibiting all certified AHPs from rejecting less healthy applicants from coverage or targeting those individuals for higher premiums. AHPs offering one or more self-funded options would be subject to federal reserve and solvency requirements that would replace those in state statutes. Those provisions and the other requirements of the bills 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.

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[11] There is a committee report available; H.Rept. 109-41.

[12] 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).

To be certified as AHPs, association-based coverage would be required to 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 three years and be operated by a board of trustees with complete fiscal control and responsibility for all operations.
- AHPs offering one or more self-funded coverage option 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 of the association 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 would be 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 was engaged.

The bill would establish requirements regarding who may participate on the board of trustees for qualified AHPs offering one or more self-funded options. The board would have to 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 could 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 continued benefits on behalf of AHPs in distress. The fund's activities would be financed by annual payments made by AHPs.

SBHPs. S. 1955, introduced in the Senate by Senators Enzi, Nelson, and Burns on November 2, 2005, and reported out of the Senate Health Education Labor and Pensions (SHELP) Committee on March 15, 2006, would establish health plans for small employers that are similar to AHPs, but with a number of important differences. Under S. 1955, only associations offering *insured* health benefits coverage could seek certification as SBHPs. As with AHPs, they would be required to undergo a certification process established by the Department of Labor (DOL), and a class certification process would be available to SBHPs so long as only insured coverage options are offered.

Like H.R. 525/S. 406, S. 1955 would exempt coverage offered through SBHPs from some state insurance laws, and would replace some of those laws with a new regulatory scheme intended to achieve consistent insurance rules across states. With respect to establishing premium rates, rates for SBHPs could not vary based on the health status of employees, nor the type of business or industry of employers. On the other hand, rates would be allowed to vary based on the claims experience of the plan, so long as the rates comply with a more liberalized version of the harmonized rating rules as established in Title II of the bill. The harmonized rating rules in Title II generally follow, after a transitional implementation period, the recommendations of the National Association of Insurance Commissioners (NAIC) as specified in the Small Employer Health Insurance Availability Model Act adopted in 1993. SBHPs would be subject to a more liberal version of those rules — the NAIC-recommended variation for index rates for different classes of business and the limitation on the number of classes of businesses for rating purposes would not apply to SBHPs.

With respect to benefits, SBHPs would be allowed to offer a basic benefit plan that would be exempt from all states' benefits requirements as long as the SBHP also offers an enhanced benefit option to participating employers. The enhanced benefit option must include at least those covered benefits, services, and categories of providers as are covered by a state employee health benefit plan in one of the five most populous states (California, Texas, New York, Florida, and Illinois). The bill provides the SBHPs with the "sole discretion" to determine the benefit plans, except that the plans must be consistent with the basic benefit and enhanced benefit rules.

States' laws in the other areas would be retained so long as they do not interfere with the plans' "sole discretion" to determine the benefits provided. Those retained states' laws could include consumer protections, grievance and appeals procedures, premium taxation, prohibitions on discrimination, fair marketing practices, and solvency and funding standards. Coverage offered through SBHPs would continue to be subject to the states' regulatory oversight related to such items.

To be certified as SBHPs, association-based coverage would be required to include the following features:

- The association sponsoring the plan must have been in existence for at least three years and be operated by a board of trustees with complete fiscal control and responsibility for all operations.
- All employers who are members of the association 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.

The bill would establish requirements regarding who may participate on the board of trustees for qualified SBHPs that are the same as those for AHPs. In addition, the bill includes provisions that would deem existing health benefits programs to be SBHPs so long as, as of the date of enactment, the arrangement provides health care benefits for at least 200 participating employers, has been in existence for at least 10 years, and is licensed under the laws of the state.

Finally, S. 1955 includes provisions that go beyond SBHPs and that are intended to simplify the regulatory environment for all health insurers, especially those that make their products available across state lines. S. 1955 includes a plan to create national standards regarding pricing of health plans, required benefits, rate form and filing, market conduct, prompt payment of claims, and internal review requirements. Under these provisions, states would choose to either adopt the national standards or retain their own laws. For insurers that choose to become certified under the provisions of the bill and that sell plans in states that do not adopt the national standards, the states' laws in those three areas would be pre-empted and the national standards would apply.

Table 1. Comparison and Association-Based Plans Under Current Law with Proposed AHPs

Feature or condition	Current law or current practice	Proposals	
	Association-based	AHPs	SBHPs
Type of entity, governance	Private — subject to federal and state law	Private — if self-insured, subject to federal law only	Private — cannot self-insure
Interests represented on governing board	Sponsoring institution and members	If new, sponsoring institution and members; may include vendors, subject to restrictions	Same as AHPs
Must accept all willing insurers	No	No	No
Able to negotiate with plans over premiums, etc.	Yes	Yes	Yes
Who selects plan?	Employers (Not required to allow employee choice)	Same	Same
Standardized benefits	Not required	Same	Same
Subject to state-mandated benefits laws	Yes	No, except for coverage of specific diseases, maternal and newborn hospitalization and mental health	Not in "basic" plan, but must also offer "enhanced option" plan.

Feature or condition	Current law or current practice	Proposals	
	Association-based	AHPs	SBHPs
Group size limits	None	No limits to size of participating employers. To offer self-insured AHP coverage, the plan must have at least 1,000 participants and beneficiaries at the beginning of the year	None
Must take all small groups that apply, regardless of health status	Within association membership only; non-members excluded	Within association membership only; non-members excluded	Similar to AHPs, but are not required to guarantee issue to self-employed if state otherwise does not require it.
Subject to state rating requirements	Yes	No, but proposals would establish some federal limits on rating factors to apply within association	No.
Subject to other small-group insurance reforms	Yes	Only HIPAA, not state laws (with some exceptions)	Yes, except those related to benefits (see above)
Geographic service area	Same as association membership, often multi-state	Presumably the same as association membership, often multi-state	Same as AHPs
Allowed to assume insurance risk (self-insure)	Yes, subject to state reserve and solvency requirements	Yes, but self-insered AHPs subject to federal 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 SHBPs

Opinions about the potential impact of AHPs and SBHPs on the small group market for insurance span the continuum of possibilities. Advocates of the association-based plans view removing some or all of the state regulatory control 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 SBHPs 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 SBHPs because of provisions exempting those entities from state laws mandating that certain benefits be covered. AHPs are further exempted from laws 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 to a lesser extent, SBHPs, would attract healthier firms since firms with sicker employees would not want plans that exclude the state-mandated benefits and protections. If AHPs/SBHPs 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/SBHPs, and firms with sick employees (or employees with sick family members) would be especially at risk.

The AHP and SBHP bills under consideration have taken concerns about adverse risk selection into consideration. H.R. 525/S. 406 and S. 1955 include the following provisions intended to reduce these incentives.

- To discourage AHPs and SBHPs from actively pursuing healthier employee groups and rejecting or discouraging higher risk groups from joining, the bills would prohibit discriminatory membership policies and plan pricing based on health status of employees or their dependents. It also would prohibit AHPs and SBHPs from requiring that member employers purchase health coverage through the AHP.
- The bills would prohibit a participating employer from providing health insurance coverage in the individual market for any employee

excluded from the AHP or SBHP, which is similar to the coverage provided under the AHP or SBHP, if such exclusion is based on a health status-related factor and such employee would otherwise have been eligible for coverage under the AHP.
- AHPs would be required 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. SBHPs requirements are similar, except that they apply only to employers of more than one employee.

Further, H.R. 525/S. 406 would

- require AHPs to abide by any state laws mandating coverage of specific diseases, maternal and newborn hospitalization and mental health services; and
- 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.)

Some consumer advocates and state regulators have raised the concern that those provisions may not be enough to prevent risk segmentation problems over time, particularly under the provisions of H.R. 525/S. 406. That bill does not provide for the fair marketing rules and other patient protections as established by the states. (Those laws are retained by S. 1955.) Moreover, concerns about both bills relate to the incentives that they create for small firms with healthier or younger workforces to sort themselves into the AHPs/SBHP mandate-free plans, leaving employers with older or higher risk groups to purchase the plans that include mandated benefits. Without the benefit of a broad distribution of risk, those plans could quickly become unaffordable.

Ensuring Financially Secure Plans. The alternative solvency and funding rules established under H.R. 525/S. 406 for self-insured AHPs have raised alarms about the risk of plan failures that could leave plan beneficiaries uncovered when they seek health benefits — the situation Congress addressed in 1984 when the MEWA provisions were added to ERISA. They claim that more insolvencies would arise if these plans are not subject to states' laws regarding plan funding and solvency. The AHP legislation took these concerns into consideration. H.R. 525/S. 406 include the following provisions related to plan funding. The bill

- would require self-insured AHPs to establish and maintain reserves in amounts recommended by a qualified actuary;
- would require AHPs to establish and maintain aggregate and specific excess/stop loss insurance and solvency indemnification;

- would require AHPs to establish and maintain a minimum surplus in addition to claims reserves;
- would authorize the applicable authority (the DOL or the state) to provide such additional requirements related to reserves and excess/stop loss insurance as considered appropriate;
- would establish an Association Health Plan Fund for making payments to continue excess/stop loss insurance coverage and would require AHPs to make annual payments of $5,000 to this account; and
- would establish a Solvency Standards Working Group to make recommendations in this area.

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

Because S. 1955 retains states' solvency and funding standards, the same issues are not likely to be raised with respect to SBHPs.

Regulatory Authority. H.R. 525/S. 406 would establish federal laws regarding the practices, structure, 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 for these plans that would be enforced by DOL. The pros include:

- Creating a single set of federal standards to apply to AHPs 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,[13] although a recent report raises significant concerns. Researchers analyzing MEWA registration filings, requested by Congress in 1996 to understand the current market for pooled

[13] See February 5, 2003 testimony of Elaine L. Chao, Secretary of Labor before the Senate Committee on Small Business and Entrepreneurship.

employer purchasing arrangements, suggest that DOL's enforcement and oversight has been inadequate.[14]

Concerns with this regulatory approach:

- States as traditional regulator of insurance: 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.
- Extensive body of law: 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. 525/S. 406 and in earlier proposals, but they are very few compared to the typical set of state laws.
- Equity: 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 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 SBHPs? 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 109th and earlier Congresses. The considerations important to each of those stakeholders and how they could be impacted by the AHP 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

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[14] M. Kofman, E. Bangit, K. Lucia; *Multiple Employer Arrangements: Another Piece of a Puzzle, Analysis of M-1 Filings*; Journal of Insurance Regulation; V. 23, Issue No. 1; Fall 2004

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 ($33,200 for a family of three in 2006) 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.

Encouraging the growth of association based coverage through AHPs and SBHPs could provide an insurance option for some workers who do not purchase coverage today. The Congressional Budget Office's (CBO) analysis of H.R. 525,[15] concluded that about 620,000 formerly uninsured workers and dependents would obtain coverage by 2010 under the proposed AHPs. They determined that a total of about 8.5 million people would become covered through the AHPs, but all but the 620,000 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.[16] 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.

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.[17] 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

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[15] U.S. Congressional Budget Office, *Congressional Budget Office Cost Estimate of H.R. 525: Small Business Health Fairness Act of 2005 as ordered reported by the House Committee on Education and the Workforce on March 16, 2005*, Apr. 8, 2005. CBO has not issued a cost estimate for S. 1955 yet.

[16] Ibid., p. 5.

[17] 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.

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 SBHPs could offer a significant advantage to small employers who are inclined to provide health insurance to their workers. 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.

Insurance Carriers, Agents and Brokers. Traditional insurance carriers are important stakeholders in the debate over the impact of encouraging association based health coverage. Insurance carriers have generally rejected association-based proposals because they fear that providing associations that offer health plans with increased risk segmenting opportunities will leave the insurers 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 offering self-funded plans, 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.

The issue of creating an uneven playing field between association-sponsored insurance and traditional health care carriers is very different under the provisions of

S. 1955. The bill includes "harmonization" provisions, provisions that would, once implemented, subject all SBHPs as well as other qualified insurers to a somewhat standardized set of laws related to rating and benefits rules. In addition, the bill would authorize a commission tasked with making recommendations on standardizing other areas of insurance law as well. Once implemented, all SBHPs and insurers seeking qualification could be regulated under this standardized set of provisions that would apply across all states.

The good will of agents is critical to the success of any purchasing group 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.[18] 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.

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 proposals that would exempt those entities from some or most 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. At this time, the Commissioners' position on the harmonization plan under S. 1955 is not clear.

Other Proposals

Other bills have been advanced that build on the idea of creating larger purchasing pools for small employers. The following approaches differ from the AHP legislation in that they create incentives for employers to take advantage of pooling options but rely largely on insured plans subject to state law. Both bills summarized below are based on the Federal Health Employees Benefit Program (FEHBP) model for providing health insurance. Both proposals combine tax credits with pooling incentives to address the high cost of insurance as a factor in the low

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[18] See the following CRS products for further discussion of the regulation of the business of insurance: CRS Report RL31631, *Patient Protection and Managed Care*, by Jean Hearne and Hinda Chaikind, and CRS Report RS20315, *ERISA Regulation of Health Plans: Fact Sheet*, by Hinda Chaikind.

coverage rates among small employers. Finally, both proposals make available federal funds to assist with start-up costs of the pooling arrangements.

The Small Employees Health Benefits Program Act of 2005, introduced in the Senate by Senator Durbin as S. 874 and in the House of Representatives by Representative Kind as H.R. 1955, would establish a set of plans, modeled after the Federal Employees Health Benefits Program (FEHBP) to be offered nationwide. Employers with 100 or fewer employees could buy insurance through these federally-sponsored offerings. The plans would be preempted from some state regulation, although how extensive the preemption is intended to be is unclear. Specifically, states laws regarding the "nature, provision, or extent of coverage or benefits" would not apply.[19] In addition, the bill would establish a refundable tax credit for participating employers who did not previously offer health insurance and who pay at least 60% of the health insurance premium for employees.

H.R. 2073, The Small Business Health Insurance Promotion Act of 2005, was introduced in the House of Representatives by Representative Barrow. It would provide for temporary tax credits for employers of 50 or fewer employees offering health coverage through qualified health pooling arrangements. Half of the amount paid for health insurance premiums through the purchasing pools would be eligible for the credit as long as those employers pay half of the premiums for employees. The credit would only be available for four years after the employer begins to participate in the pooling arrangement. Qualified pooling arrangements could be of two types; state or federal. Qualified state health pooling arrangements would be comprised of at least two plans offered via states that are substantially similar to health benefits coverage in any of the four largest health benefits plans offered under the FEHBP program. Plans offered under these arrangements would not be pre-empted from the application of states' insurance laws. In addition, a national health pooling arrangement, modeled after the FEHBP program, would be established jointly by the Secretaries of HHS, and Labor, in consultation with the Director of the Office of Personnel Management.

These approaches recognize 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.

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[19] S. 874, p. 13.