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Association Health Plans – Part Two: Answering the Critics

by Greg Scandlen

A cornerstone of President Bush's approach to health care reform is the introduction of Association Health Plans (AHPs). These plans would enable business and professional associations to offer health benefits to their members. For example, the National Restaurant Association potentially could offer health insurance to mom-and-pop restaurants across the country.

An association could negotiate for coverage on behalf of thousands of members. Instead of individual members shopping for the best deal, it would and offer them the same marketing efficiencies a large employer now gets.

AHPs already exist, although different states impose different types of regulations on them. The Bush administration would allow AHPs to become certified under federal law, thus avoiding 50 sets of state regulations.

Not everyone agrees this is a good idea. State insurance commissioners and some state-based Blue Cross Blue Shield plans vehemently oppose it. Obviously, these two groups have self interests to protect. The insurance regulators would lose some authority; Blue Cross Blue Shield plans usually operate in a single state and so avoid multistate compliance issues. These and other critics have raised a number of questions.

Would AHPs have an unfair advantage? No: the Bush proposal would simply help to level the playing field. State laws governing the sale of insurance are ever more complicated and burdensome. Already, they include more than 1,500 separate mandated benefits requiring that insurers cover providers ranging from chiropractors to naturopaths and services ranging from acupuncture to in vitro fertilization. They also include premium taxes, controls on premiums, mandatory disclosure and appeals procedures, requirements to subsidize high-risk pools, community-rating requirements, limits on the use of provider networks, and restrictions on the look and language of insurance contracts.

It is difficult for a company to comply with these regulations in a single state. And when a company does business in several states, or across the nation, it finds compliance virtually impossible and extremely expensive. Each state has its own set of rules and regulations. Those of one state often contradict those of another.

That is why in 1974 Congress passed and the president signed a federal law exempting "self-funded" employers from state laws and substituting a relatively simple set of federal regulations. (Self-funded means that the employer bears its employees' health care costs directly rather than passing them along to an insurance company.) To the employee, the health plan looks like insurance, and often the employer hires an insurance company to process the claims and pay the bills. But it is the employer's money that is at stake.

Smaller employers cannot afford to take the risk of self funding their employees' benefits, however. Lacking the resources to cover sudden surges in claims expenditures, they must buy coverage from an insurance company. And that coverage must comply with all the complex and expensive regulations their state has enacted.

"An association could buy coverage for thousands of members."

President Bush's proposal would allow AHPs either to fund their own benefits or to buy fully insured coverage and be regulated by the U.S. Department of Labor, much as larger employers are today. Also like today's larger employers, a national or multistate association could provide consistent benefits to all its members across state lines.

Would AHPs undermine state efforts to reform the insurance market? Over the past 10 or 15 years, most states have enacted laws to "reform" or "stabilize" the small group insurance market. Unfortunately, these laws have for the most part been misguided and extremely negative in their effects. Small employers are facing 50 percent — even 70 percent! — premium hikes this year, and and insurers are leaving the small group market. So many insurers have left that the small group insurance market is a near monoply in most states. The General Accounting Office (GAO) looked at small group insurance in 19 states and concluded that a mere five insurance companies control 75 percent of the market. Small businesses are much less likely than larger employers to offer health insurance to their workers. The Census Bureau recently reported that the proportion of workers with health insurance at companies with fewer than 25 employees declined in 2001 to 31.3 percent. Far

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from undermining the market, AHPs would increase the number of competitors and make the market more robust.

Would AHPs reduce funding for high-risk pools? Most states have created risk pools to act as "insurers of last resort" for people who are not able to buy coverage in the private market. These pools charge substantial premiums but still must be subsidized because claims costs are so high.

Unfortunately, most states subsidize the pools through an assessment on individual and small group insurance companies, allowing self-funded employers and enrollees in public programs to escape these costs.

Self-funded AHPs also would escape these costs under the Bush plan. But this reduction in funding for risk pools is not a bad result. Asking small group and individual insurance buyers to pay the entire cost of the risk pool is neither fair nor wise. It raises costs on the segment of the market that is least able to bear them, and it results in lesser benefits for workers, greater numbers of uninsured, and heavier burdens on taxpayers — who ultimately fund the health care of these newly uninsured.

More enlightened states have chosen to subsidize their risk pools through fairer means, such as general revenues or tobacco settlement funds. AHPs likely would force more states to spread the cost of the risk pools to the broader population.

Will AHPs encourage risk selection and reduce risk pooling? Critics argue that AHPs will select only healthy groups for coverage, leaving the unhealthy behind in the regular insurance market. They also argue that AHPs will decrease the number of people in the insurance pool. These arguments are disingenuous. Federal law already requires "guaranteed issue" of health insurance for all employer groups and limits waiting periods for preexisting conditions. And AHPs would encourage more pooling of risk, as hundreds or thousands of small employers formed a single pool. Such associations represent a far better risk-pooling mechanism than the small group market has at present.

Will the Department of Labor be able to regulate AHPs effectively? Critics maintain that the U.S. Department of Labor is incapable of overseeing AHPs. Yet the department has effectively regulated tens of thousands of self-funded employers for almost 30 years. Even in the current atmosphere of massive bankruptcies and corporate corruption, the large employer market is experiencing very few problems. State regulators could learn a thing or two from this track record, including how to focus on plan solvency and fiduciary responsibilities rather than health plan micromanagement.

Will AHPs succeed in reducing administrative expenses? Critics believe that AHPs could actually increase administrative costs by inserting another layer between the employer and the health plan. It is hard to imagine how. Smaller employers today are saddled with administrative costs that are typically 25 percent to 40 percent of their premium. As little as 60 cents of every premium dollar the small employer pays goes for health care delivery. By contrast, self-funded large employers typically pay only 10 percent or even 5 percent in administrative costs.

"The Bush proposal would help to level the playing field."

Only practice, not theory, can answer questions about what levels of savings AHPs can deliver. The safeguard is that if AHPs cannot deliver significant savings, they will not gain traction in the market. After all, membership in an AHP would be voluntary.

Conclusion. AHPs would not solve all the problems in the small group and individual markets. Nor would they make health care suddenly cheap or abundant. Nor would they substantially reduce the numbers of uninsured. But they would introduce more competition into the market, reduce unnecessary regulation and administrative costs and make health coverage more affordable for many small employers and their employees. And they would do so without new federal subsidies or expenditures.

On that basis alone, they deserve the opportunity to succeed.

Also see Part One, which explains how AHPs can lower small group costs.

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