Insuring the Uninsured through Association Health Plans

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Executive Summary

The American health care system consists largely of employer-based group health insurance. After World War II, employers offered health care plans in order to attract employees. As the numbers of employer-provided health plans grew, the federal government and the states regulated them heavily.

One of the unintended consequences of increasing government regulation was to increase the numbers of people without health insurance. The high cost of complying with different state regulations has raised the cost of employer-sponsored health plans, leading many small businesses to drop coverage altogether. By the end of 2001, the Census Bureau estimated more than 41 million Americans were uninsured — many of them young, healthy people with modest or low incomes.

Part of the solution to insuring the uninsured is the creation of Association Health Plans (AHPs). These are plans created for individuals and groups who belong to associations that are related to jobs, careers, or hobbies and interests. The potential for growth of this type of insurance is quite large — given a favorable regulatory climate.

Proponents of AHPs argue that they have great potential to insure the uninsured. By uniting many small groups with similar interests across the country, AHPs could take full advantage of economies of scale to lower health care costs for their memberships.

- There are about 15,000 associations throughout the country.
- Some six million Americans are insured through associations and the number is growing.

AHPs are applicable to a variety of group memberships. For example:

- The American Association of Retired People offers supplemental medical insurance to all of the Medicare enrollees among its 35 million dues-paying members.
- The National Association for the Self-Employed (NASE) makes AHP insurance available to its members throughout the country.
- The National Restaurant Association could offer AHP insurance to restaurant employees in all 50 states, and the National Rifle Association could offer insurance to its members.

Perhaps the most important argument for AHPs is that millions of people who are not covered because of high costs or lack of availability would be able to obtain affordable coverage.

- A Congressional Budget Office (CBO) analysis of legislation pending in Congress estimates that small businesses can expect to reap savings averaging between 9 percent and 25 percent of the cost of their health insurance premiums.
- As a result, the CBO estimates that 330,000 — and potentially as many as 2 million — of the currently uninsured would obtain health insurance.
- CONSAD Research Corporation estimates that expanding AHPs could result in an increase in employer-sponsored insurance coverage of approximately 2.3 million workers and 2.2 million dependents.

Most of the uninsured are connected to the workplace, and most uninsured workers are employees of small businesses that are especially burdened by the lack of competition and by unwise regulations. Among the unwise regulations are mandated benefits, which are estimated to be responsible for as many as one in every four uninsured persons.

Many of the uninsured are healthy and can afford to purchase health insurance. The principal reason they are uninsured is that the premiums charged are too high relative to the value they place on being insured. The most important key to inducing them to buy insurance is to lower its price.

A barrier to low-cost health insurance is the lack of uniform regulations in all states. If small firms could buy AHP insurance with guaranteed uniform regulation, they could enjoy the same lower administrative costs now available to large company health plans that are federally regulated. AHPs would also be able to avoid mandated benefits and other complex, cost-increasing regulations that are imposed in different states.

In most of the United States, a few large firms dominate the health insurance marketplace and offer limited products to employers, their employees, individuals and the self-employed. These products meet the needs of some customers but not of many others. Given the size and diversity of the market, it is surprising how little diversity there is among insurance products.

Critics of AHPs would like to curtail their growth rather than expand it — principally by subjecting AHP insurance to the state regulations that apply to all other commercial health insurance. However, the answer to insuring the uninsured is not to limit competition, but to increase it. By making AHPs more competitive, we can lower the cost of insurance to small employers, their employees and the self-employed.

Introduction

"More than 41 million Americans are uninsured."

Depending on the point of view, America is facing a health care apocalypse, a health care crisis, or just "frictional dislocations" of health resources (Chollet and Kirk, 1998; Boushey et al., 2001). For those who are fortunate enough to work in a large firm, who have high incomes, and who have generous health plans, there is no crisis at all. For those who work in moderate-size firms, who have average incomes and limited choices among health plans with lower lifetime benefits, longer waiting periods, higher monthly premiums, and other restrictions, there is a health care crisis (Acs, 2001). For those who are underinsured or who are not insured at all, there is a health care apocalypse (Taylor, 2002; Blendon, 1999; De Posada, 2002).

Politicians in a position to affect public policy are typically focused somewhat narrowly (Litow, 2002; Nelson, 2002). They are usually caught in the crosscurrents of pressures to do what is right and to do what existing resources allow. Their actions are heavily influenced by their environment — close friends or neighbors who are disabled or whom they perceive to have been wronged by the system, political and social groups with whom they have intimate ties, and other channels from which they regularly receive information. This study is written in part to add to their perspectives.

Employer-Based Health Insurance. The American health care system is largely an employer-based system. After World War II, employers found that offering a health care plan was a way to attract employees (Bean and McFadden, 2000). Medium- and large-size employers began offering very basic benefits, typically as indemnity plans.

Health benefits were a powerful recruiting tool, and employers offering them enjoyed a significant competitive edge in the labor market. Labor unions increasingly saw them as a non-taxed alternative to taxable wages. The result was that employer-provided health care plans flourished with little regulation at any level of government.

Government Regulation. As employer-provided health plans became widespread, government at various levels began to intrude. Politicians and special interests began to grasp the potential to shift health care responsibilities and costs from the government to employers (Wilson, 2000). Society began to view employer-provided health care plans as an employer *responsibility* rather than an employment *benefit* (Westerfield, 1991). In time, government regulation became an important factor in determining the type of health insurance to which Americans had access. As we shall see, the unintended consequence of increasing government regulations was the creation of forces that increased the numbers of people without health insurance.

Who Are the Uninsured? As Table I shows, the Census Bureau estimates that more than 41 million Americans are uninsured (Levitt et al.,

"The uninsured are predominantly healthy 18-to-34-year-olds with modest or low incomes."

TABLE I

Total Population, Number Uninsured, Percent Uninsured for the Entire Year of 2001

(In Millions)

People	Population Total	Uninsured Number	Uninsured Percent
Total	*282.1*	*41.2*	*14.6 %*
Sex			
Male	137.9	21.7	15.8 %
Female	144.2	19.5	13.5 %
Ethnicity			
White	230.1	31.2	13.6 %
Non-Hispanic	194.8	19.4	10.0 %
Black	36.0	6.8	19.0 %
Asian & Pacific Islanders	12.5	2.3	18.2 %
Hispanic (Any race)	37.4	12.4	33.2 %
Age			
Under 18 years	72.6	8.5	11.7 %
18 to 24 years	27.3	7.6	28.1 %
25 to 34 years	38.7	9.1	23.4 %
35 to 44 years	44.3	7.1	16.1 %
45 to 64 years	65.4	8.6	13.1 %
65 years and over	33.8	.3	0.8 %
Household Income			
Less than $25,000	62.2	14.5	23.3 %
$25,000 - $49,999	76.2	13.5	17.7 %
$50,000 - $74,999	58.1	6.6	11.3 %
$75,000 or more	85.5	6.6	7.7 %
(18-64 years old)			
Total	175.7	32.4	18.5 %
Employment			
Worked during year	142.5	24.2	17.0 %
Worked full-time	118.8	19.0	16.0 %
Worked part-time	23.7	5.2	22.0 %
Did not work	33.2	8.2	24.7 %

Source: U.S. Census Bureau. "Health Insurance Coverage: 2001," Table 1, P60-220. September 30, 2002, Washington, D.C.

2000; Levitt et al., 2002). Who are they? They are predominantly young, healthy people with modest or low income.

Table I shows that people between ages 18 and 34 account for slightly over 60 percent of the uninsured by age. The male portion of this group is typically healthy and optimistic and prefers cash compensation to other benefits. Although this is the prime age for females to start families, professional women tend to forgo childbearing until later in life when their careers are well established and their financial status has improved.

Roughly one-quarter of people with incomes of less than $25,000 per year do not have health insurance. By contrast, among those who earn $75,000 or above, the percentage without insurance is 7.7 percent. Further, 62 percent of the uninsured are under the age of 35. Only 20 percent are over the age of 44. Annual health expenditure is far lower in young populations than in those nearing or at retirement (Fronstin, 2001). Moreover, 74.1 percent of the uninsured rate their health status as "excellent," "very good" or "good" (Brown et al., 2002).

"About one-quarter of people with incomes less than $25,000 per year do not have health insurance."

One of the reasons why people in the lower-income categories are not covered is that they are healthy and do not believe they need insurance, or at least they do not believe it is worth what it costs. Young, healthy and low-income are precisely the characteristics of people who are highly sensitive to the price of insurance. As a consequence, people with these characteristics tend to be the ones most adversely affected by public policies that raise insurance premiums and most positively affected by policies that lower premiums.

Notice also from Table I that more than 90 percent of uninsured adults have some attachment to the workforce. This means that public policies that make it easier for employers to provide insurance to their employees have a potential to substantially reduce the number of uninsured.

Are Association Health Plans the Answer? In general, health insurance sold in the marketplace is regulated by state governments. However, about half of the people with private health insurance obtain it from an employer that is self-insured and is exempt from state regulation (Kaiser, 2002). These exempt plans fall under regulations enforced by the Department of Labor.[1] As a result, a large company with employees in every state can rely on uniform, nationwide rules instead of confronting the disparate regulations of 50 separate states. Moreover, as a practical matter, only large companies can self-insure.

Association Health Plans (AHPs) are plans created for individuals and groups who belong to associations. For example, the National Association for the Self-Employed (NASE) makes AHP insurance available to its members throughout the country. NASE insurance is typically subject to some of the same state regulations as other insurers but is exempt from other regulations. AHP insurance may be thought of as a third kind of

insurance, and the potential for growth of this insurance is quite large — given a favorable regulatory climate. For example, the National Restaurant Association could potentially offer AHP insurance to restaurant employees in all 50 states, and the National Rifle Association could potentially offer insurance to its members.

"Association Health Plans have the potential to insure the uninsured."

There are about 15,000 associations in the United States. Many of these are job- or career-related. Many others are related to hobbies or interests. For example, among the largest associations is the American Association of Retired People (AARP), which collects dues from about 35 million members and provides services in return. One of those services is supplemental medical insurance for seniors enrolled in Medicare. Although most associations do not offer health insurance, the potential is there. Some 6 million Americans are insured through associations and the number is growing (Matthews, 2002).

Proponents of AHPs argue that they have great potential to insure the uninsured. If AHPs could operate under uniform, nationwide regulations, they would be able to offer individuals and small businesses some of the same cost-cutting advantages now available only to large businesses. Accordingly, some proposals in Congress would allow AHPs to be chartered under federal law and avoid many state regulations. Other proposals would allow an AHP chartered in any one state to sell insurance in the other 49 states, abiding only by the regulations in its home state.[2] Critics of AHPs would like to curtail their growth rather than expand it — principally by subjecting AHP insurance to the state regulations that apply to all other commercial health insurance (Terhune, 2002 a, b).

This study carefully considers these issues and concludes that AHPs have a significant potential to solve a major social problem: insuring the uninsured by providing lower-cost products more likely to meet the needs of those who have been priced out of the market for other health insurance.

The Need for Increased Competition

In most of the United States, a few large firms dominate the health insurance marketplace. Moreover, these insurers tend to offer a limited product range to employers and their employees, as well as to individuals and the self-employed. While the products may meet the needs of some customers, they do not meet the needs of many others. In fact, given the size and diversity of the market, it is surprising how little diversity there is among the insurance products offered.

Large employers can negotiate health care plans with insurers on a bilateral basis, where the bargaining strengths of the insurer and the employer are more even. Small firms and individuals are more likely to be "price takers," with little ability to affect the price or composition of a health care plan. Their options are either to accept the package at the

offered price or have no package at all (Koehler, 2002; Wilson, 2002). The only way individuals and small firms can increase their bargaining power, and hence their range of choices, is to join with others as members of a group or an association that can bargain with an insurer on the basis of more comparable strength.

The inequality of bargaining positions makes it difficult for individuals and small employers to obtain an attractive health plan at a favorable rate (Milam, 2002). Small employers report that insurers offer plans that have high rates, high deductibles, long waiting periods, and inflexible provisions (Manzullo, 2002). Lacking a range of insurance alternatives, the small employer must choose an unattractive plan, offer employees some other (less desirable) employee benefit, or pay higher (taxable) wages instead.

"It is difficult for individuals and small employers to obtain attractive health plans at favorable rates."

Measuring the Degree of Competition: Herfindahl-Hirshman Index. We introduce the concept of the Herfindahl-Hirshman Index (HHI) with a short anecdote about the Microsoft merger plans with Intuit, given as a student question in Baye's *Managerial Economics & Business Strategy* (Baye, 2000):

> In April 1995 the nightly news and newspapers across the world reported that the U.S. Justice Department filed suit to block software giant Microsoft's planned acquisition of financial software maker Intuit. Estimated reports placed Microsoft's share of the personal finance software market at about 20 percent, compared with Intuit's 70 percent share.
>
> After spending over $4 million on merger plans, Microsoft announced in May 1995 that it had decided to call off the merger. In light of the dynamic nature of the software industry, Microsoft did not want to be tied up in a lengthy legal battle. In addition to the lost $4 million, Microsoft paid Intuit over $40 million for calling off the deal.
>
> … the Justice Department generally challenges mergers when the relevant Herfindahl-Hirshman index is greater than 1,800 and the resulting increase in the index as a result of the merger is more than 100. Based on the reported market shares of Microsoft and Intuit, the Herfindahl-Hirshman index for the personal finance software market was at least 5,300 before the proposed merger, and would have increased to at least 8,100 after the merger. Thus, it seems that Microsoft should have realized that the Justice Department would attempt to block the merger. Spending $4 million attempting to justify the merger on technological or efficiency grounds was a gamble that did not pay off for Microsoft.

"A few large firms dominate the health insurance marketplace."

EXHIBIT I

Market Concentration Criteria

HHI Index*	Market Concentration
HHI < 1000	Low Concentration
1000 < HHI < 1800	Moderately Concentrated
HHI > 1800	Highly Concentrated

* The Herfindahl-Hirshman Index (HHI) is a function of the number of firms in a market and their respective market shares.

Source: Author derived from U.S. Department of Justice documents.

The Herfindahl-Hirshman index is simple to calculate and is often used as a yardstick to indicate the competitiveness of a market (O'Sullivan and Sheffrin, 2001; Boyes and Melvin, 2002; Baye, 2000). For example, it is used as a measure of industry/market concentration before and after a proposed merger (Coate and Langenfield, 1993), as in the Microsoft case above. The contrast of the market positions of the insurers versus individuals and small employers is stark. The insurer market is highly concentrated, with only a few small firms serving niche markets. The U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC) have jointly issued guidelines for horizontal mergers (Coate and Langenfield, 1993) that are used as regulatory measures of industry concentration. The guidelines state in part:[3]

> … in some circumstances, where only a few firms account for most of the sales of a product, those firms can exercise market power, perhaps even approximating the performance of a monopolist, by either explicitly or implicitly coordinating their actions. Circumstances also may permit a single firm, not a monopolist, to exercise market power through unilateral or non-coordinated conduct — conduct the success of which does not rely on the concurrence of other firms in the market or on coordinated responses by those firms. In any case, the result of the exercise of market power is a transfer of wealth from buyers to sellers or a misallocation of resources.

Note that the existence of only a few firms in a market does not always mean resources are being misallocated, especially if potential entrants into the market stand ready to meet unmet consumer needs. However, such *competition for the market* is unlikely to produce the desired outcome if there are artificial barriers to entry. Put another way, the most

important antidote for monopoly or near monopoly is ease of entry into the market by outside potential competitors.

As a tool for assessing the degree of market concentration, the Herfindahl-Hirshman Index (HHI) is a function of the number of firms in a market and their respective market shares (Gilligan, 2002; Hirschey and Pappas, 2000; Katz and Rosen, 1991). It is calculated by the following formula:

$$\mathbf{HHI = 10{,}000\ [\Sigma(Si)2\ ] = 10{,}000\ [(S1)2 + (S2)\ 2 + (S3)2 + \ldots + (Sn)2\ ],}$$

where the S_i represent market share of each of the firms. For example, a market consisting of four firms with market shares of 30 percent, 30 percent, 20 percent and 20 percent has an HHI of 10,000 x $(.3)^2 + (.3)^2 + (.2)^2 + (.2)^2 = 2600$. In general, the HHI ranges from 10,000 (in the case of pure monopoly) to a number approaching zero (in the case of an atomistic market). Exhibit I shows how the index is used to judge whether the firms are highly concentrated in a given industry. Current market share data for specific insurers is not easily obtainable because it is not in the public domain. However, the formula is a useful measure of market concentration where the data are available.

Measuring the Degree of Competition: The Four-Firm Concentration Ratio and Other Ratios. Another measure of market concentration is the Four-Firm Concentration Ratio. It is simply the sum of the respective market shares of the top four firms in a given industry for the area of interest. The formula is:

$$\mathbf{CR_4 = S\ (S_i) = S_1 + S_2 + S_3 + S_4,}$$

"The antidote for monopoly is free entry into the market by competitors."

EXHIBIT II

Concentration Ratios and Their Market Structures

Concentration Ratio[1]	Associated Market Structure
$CR_4 < 20$	Effective Competition
$20 < CR_4 < 60$	Positive Oligopoly Tendencies
$60 < CR_4 < 80$	Strong Oligopoly Approaching Monopoly
$CR_4 > 80$	Tendency Toward Monopoly
$CR_1 > 90$	Virtual Monopoly

[1] CR_4 = Four-Firm Concentration Ratio. CR_1 = One-Firm Concentration Ratio.

Source: Author derived from U.S. Department of Justice documents.

TABLE II

Concentration in the Market for HMOs[1]

Largest Firms	Percentage
4 Largest Firms	65.0%
8 Largest Firms	93.7%
20 Largest Firms	99.7%
50 Largest Firms	100.0%

[1] Concentration by Largest HMO Medical Centers Subject to Federal Income Tax: 1997; NAICS #621491 HMO Medical Centers.

Source: Table 6a, "Concentration of Firms," Health Care & Social Assistance — Subject Series, 1997 Economic Census, Oct. 25, 2000, U.S. Census Bureau, Washington, D.C.

"The largest four firms in the small group insurance market account for 65 percent of HMO business."

where S_i is the market share of the i^{th} firm. Thus, in the example given above, the Four-Firm Concentration Ratio would be 100 percent.

Table II presents similar measures for four firms, eight firms, 20 firms and 50 firms. The four-firm ratio is most widely used, since it indicates a greater degree of clustering of firms. As an aid to interpreting the results, Exhibit II presents concentration ratios and their relationship to market structure.

Concentration in the Health Insurance Marketplace. A number of reliable sources of market share data are available from governmental agencies and research institutes.[4] Table II shows the Census Bureau calculation of the share of the largest firms in the market for small group insurance. As the table shows, the largest four firms account for 65 percent of HMO business or a 65 percent market share that, according to most analysts, would be a strong oligopoly market structure. The table also shows that the eight largest firms account for almost all of the remaining market share.

Table III shows a state-by-state assessment of the small group market as of December 2002, by the General Accounting Office (GAO), based on reports from state insurance regulators. The GAO provided the following summary:

- The median number of insurers in the small group market per state was 28, with a range from 4 in Hawaii to 77 in Indiana.
- The median market share of the largest insurer was about 33 percent, with a range from about 14 percent in Texas to about 89 percent in North Dakota.

TABLE III

Number of Carriers, Largest Carrier and Market Share Data for Small Group Health Insurance Carriers, by State

State	Number of Licensed Carriers	Largest Carrier	Market Share of Largest Carrier (percent)	Market Share of Five Largest Carriers (percent)	Rank of Largest BCBS Carrier	Market Share of All BCBS Carrier(s) (percent)
Alabama	10	BCBS of Ala.	87.4	93.8	1	87.4
Alaska	9	Premera Blue Cross	51.9	81.5	1	51.9
Arizona	53	United Health Care of Ariz.	24.5	66.9	2	20.8
California[a]	14[b]	Blue Cross of Calif.[b]	NA	NA	1[b]	NA
Colorado	44	Employers Health	15.6	57.9	9	5.3
Connecticut[c]	47	Anthem BCBS of Conn.	33.1	97.9	1	33.1
Delaware[a]	17	NA	NA	NA	NA	NA
District of Columbia[a]	9	NA	NA	NA	NA	NA
Florida	26	United Healthcare of Fla.	21.6	64.6	2	26.9
Georgia	[d]	BCBS Health Care of Ga.[d]	19.7[d]	47.3[d]	1[d]	28.3[d]
Hawaii[a]	4	NA	NA	NA	NA	NA
Idaho[a]	15	Regence Blue Shield	44.4	92.7	1	81.9
Illinois	36	NA	NA	NA	NA	NA
Indiana	77	Anthem Ins. Co.	18.5	51.1	1	18.5
Iowa	54	Wellmark[o]	46.5[e]	76.7[e]	1[e]	52.8[e]
Kansas[a]	35	BCBS of Kan.[l]	NA	NA	1[f]	NA
Kentucky	10	Anthem BCBS	43.7	89.2	1	43.7
Maine	13	Aetna US Healthcare	45.6	90.9	2	39.1
Maryland	18	CareFirst	48.2	95.3	1	48.2
Massachusetts	24	HMO Blue	30.6	79.0	1	37.1
Michigan[g]	64	BCBS of Mich.	63.2	84.8	1	79.1
Minnesota	20	BCBS of Minn.[h]	42.0[h]	87.7[h]	1[h]	49.6[h]
Missouri[a]	47	Healthy Alliance Life Ins.	18.9	51.8	1	32.2
Montana	[i]	BCBS of Mont.	40.8	78.0	1	40.8
Nebraska[a]	30	NA	NA	NA	NA	NA
New Hampshire[j]	9	Healthsource N.H.	40.0	75.2[l]	2	35.2
New Jersey[k]	22	Horizon BCBS of N.J.	30.1	84.4	1	46.0
New York	34[l]	Oxford[m]	18.5[m]	57.2[m]	2[m]	26.5[m]
North Carolina	37	BCBS of N.C.	26.6	67.5	1	26.6
North Dakota	12	Noridian/BCBS	88.8	95.7	1	88.8
Ohio[c]	70	Anthem BCBS	32.6	66.4	1	32.6
Oklahoma[a]	64	Group Health Services of Okla.[1]	NA	NA	1[l]	NA
Oregon[a]	13	Lifewise, A Premera Health Plan	22.7	73.7	3	23.1
South Carolina	54	PHP	31.4	72.8	2	25.4
South Dakota[a]	15	Wellmark BCBS of S.D.	28.6	60.3	1	28.6

TABLE III continued

State	Number of Licensed Carriers	Largest Carrier	Market Share of Largest Carrier (percent)	Market Share of Five Largest Carriers (percent)	Rank of Largest BCBS Carrier	Market Share of All BCBS Carrier(s) (percent)
Tennessee	59	BCBS of Tenn.[n]	54.7[n]	81.1[n]	1[n]	61.4[n]
Texas	59[a]	Employers Health Ins.	13.9	36.1	2	6.9
Utah	44	IHC Health Plans, Inc.	29.1	83.5	2	22.7
Vermont	6	MVP Health Plan	45.8	98.6	5	2.6
Virginia[o]	56	NA	NA	NA	NA	NA
Washington[p]	[q]	Premera Blue Cross	40.5	86.5	1	78.8
Wisconsin	64	United Healthcare of Wis.[h]	16.1[h]	45.4[h]	2[h]	9.1[h]
Wyoming	14	BCBS of Wyo.[n]	38.5[n]	55.1[n]	1[n]	38.5[n]

NA = not available.

Notes: Reported data are for December 2000 unless otherwise noted.

Ranking and market share data are based on the number of covered lives unless otherwise noted.

Three states did not respond to the survey: Nevada, New Mexico and Rhode Island. In addition, five states responded but did not provide data on small group carriers or on market share: Arkansas, Louisiana, Mississippi, Pennsylvania and West Virginia.

[a] Data are for December 2001.

[b] Data only include carriers regulated by the California Department of Managed Health Care.

[c] Data are for December 1999.

[d] Georgia reported that there are no standard reporting sources on the number of carriers and the total number of covered lives in the small group market, but estimated the number of carriers at about 100 and estimated the total number of covered lives to be 500,000. We used the estimated number of covered lives to calculate rankings and market share.

[e] Ranking and market share calculation are based on the number of covered small employer groups.

[f] Ranking is based on gross premiums.

[g] Data are for March 2001.

[h] Ranking and market share calculation are based on gross premiums.

[i] A Montana official estimated 10 or fewer carriers had plans that were approved for the small group market.

[j] New Hampshire did not report data for the five largest carriers. Market share calculation is based on the data reported for the two largest carriers.

[k] Data are for September 2001.

[l] Data are for January 2002.

[m] Data are for January 2001.

[n] Ranking and market share calculation are based on the number of covered employees.

[o] Data are for November 2001.

[p] Data are for various time periods in 2000 and 2001.

[q] Washington reported that 16 state-based carriers and an unknown number of out-of-state carriers offer health insurance in the small group market.

Source: This table was adapted from "Small Group Health Insurance Markets," GAO-02-536-R, U.S. General Accounting Office, March 25, 2002.

- The five largest insurers, when combined, represented three-quarters or more of the market in 19 of 34 states supplying information, and they represented more than 90 percent in 7 of these states.
- Twenty-five of 37 states supplying information identified a Blue Cross Blue Shield (BCBS) insurer as the largest organization offering health insurance in the small group market, and in all but one of the remaining 12 states a BCBS insurer was among the five largest.
- The median market share of all the BCBS insurers in the 34 states supplying information was about 34 percent, with a range from about 3 percent in Vermont to about 89 percent in North Dakota; in 9 of these states BCBS carriers combined for half or more of the market.

Table III is instructive in many ways. Simply put, there is a very high degree of market concentration in most states. In Oklahoma, Connecticut, Idaho, Maine, Maryland, North Dakota and Vermont, the largest five carriers have more than 90 percent of the total market share. The numbers also imply that the markets are concentrated, no matter how concentration is measured.[5]

"The largest insurer is often the only insurer, and its products are often offered on a 'take it or leave it' basis."

What the numbers do not show is perhaps the most important feature of health insurance markets: the impact of the largest carriers in geographic regions within states. Indeed, in many cities and towns the largest insurer is the only insurer (De Posada, 2002; Turner, 2002; Dressler, 1999). In these markets products are often offered on a "take it or leave it" basis. They may be overpriced, with benefits that do not fit the needs of many firms and many employees. With few or no alternatives, buyers must purchase an imperfect substitute for the type of insurance they prefer or forgo insurance altogether. For individuals and very small firms, the latter alternative is increasingly the alternative of choice (Tucker, 2003).

Barriers to Entry. The small group market, like the individual market, is highly concentrated on the insurer side and atomistic on the purchaser side. The result is that many needs go unmet. So why don't other insurers enter the market to meet these needs? The reason is the existence of many barriers to entry. Gerard Conway, of the Medical Society of the State of New York (Conway, 2001), gives some concrete examples:

> For example, in order to be financially viable, health insurers need to develop sufficient business to permit the spreading of risk. In its challenge to the Aetna/Prudential merger, the Department of Justice noted that 'effective new entry for an

> HMO or HMO/POS plan in Houston or Dallas typically takes two to three years and costs approximately $50,000,000.'
>
> Many insurance companies spend millions of dollars a year in local television and print ads, typically during employer 'open enrollment' seasons. In markets where a limited number of insurers already cover a large percentage of a market's population, it could take several years for a new health insurer to develop name and product recognition with purchasers and convince them to disrupt their current relationships with existing health insurers.
>
> Health insurers also depend on a network of physicians, hospitals and health care providers. As the Department of Justice noted in the Aetna/Prudential merger, building a network can take years. In addition, exclusive contracts between existing insurers and providers can thwart or deter efforts by a new entrant to build a network.
>
> All of these factors can operate as formidable barriers to entry for a new health insurance company trying to establish a foothold in a concentrated market, and even more so in the highly concentrated markets identified in this study.

The insurance company and its product are only one part of the competitive picture. Multiple tie-ins are both formal and informal. The tie-in between the health care provider network and the insurer, for example, is a significant barrier to entry.

Every large managed care organization (MCO) has a development staff that negotiates with medical providers. Those that are included in the managed care network are listed in a directory as providers of choice for the MCO, and patients are referred to those providers. In a preferred provider organization (PPO), patients must pay more out of pocket for the service if their doctor is not listed as a recommended provider. In an exclusive provider organization (EPO), they must pay the entire amount out of pocket. The very existence of such networks of approved providers is a barrier to a new entrant, who has no established network.

"Large insurers use market power to negotiate lower rates with doctors and hospitals."

Large insurers also use their market power to negotiate lower rates with doctors and hospitals than a smaller insurer or a new entrant can negotiate. The extent of this power was revealed in an eye-opening study by the Division of Governmental Affairs of the Medical Society of the State of New York (Conway, 2001). The Executive Summary of that study concludes:

> With only one or a few HMOs in a region controlling all of the patient lives compared against thousands of individual

A Case Study

In *Blue Cross and Blue Shield of Montana v. Max D. Agather and Larry Managhan*, Montana 1st Dist. Ct., Lewis and Clark Co., Order, BDV 97-181, August 18, 1999, Agather, an insurance agent, alleges that Blue Cross and Blue Shield of Montana, Inc., engaged in, among other things, activities in restraint of trade, monopoly and unfair competition.

In January 1998, the Court issued its order that generally granted a motion for summary judgment filed by BCBS but left to Agather the claim that BCBS violated statutes relating to unlawful restraint of trade, monopoly and unfair competition. The court ruled in part:

> Discovery materials furnished by Agather to BCBS establish that he had a detailed conversation with Lee Shannon, a vice president of BCBS, approximately three weeks prior to the letter of termination. Mr. Agather was trying to obtain from BCBS bids for a large group of insureds that were being assembled, as well as in connection with a PPO which Mr. Agather was trying to establish. Shannon advised Agather that BCBS did not wish to participate because it was not consistent with the "strategic plan of BCBS." *BCBS wanted to control large group insurance in the state of Montana, and they effectively did this by subsidizing the premiums charged large groups by charging higher premiums to individuals and small groups.* Discovery materials furnished to BCBS by Agather establish this fact. BCBS wanted to control large groups because then they could control the discounts provided by doctors and hospitals. This also provided BCBS with control of doctor involvement throughout the state of Montana. BCBS did not wish to dilute the control which it exercised over large groups of insureds in Montana by allowing a local insurance producer to be involved in such activity.
>
> At the same time, BCBS, through the use of wholly owned subsidiary corporations, was aggressively purchasing insurance agencies throughout the state of Montana. It was actively becoming involved in the casualty and property insurance areas, as well as its past involvement in medical hospital insurance. It did not want competition and that is the reason Agather was told by the district representative of BCBS that he would have to move out of the property and casualty insurance office operated by Agather's brother in Kalispell, Montana. [Emphasis added.]

Many of the activities alleged in the court document just cited happen elsewhere as well. Networks, contracts, "invisible handshakes," tying agreements, differentiated products, market segmentation, and price discrimination are different manifestations of market power and market dominance (Katz and Rosen, 1991).

health care providers who are legally prohibited from coming together to negotiate contracts with these dominant regional entities, the tremendous imbalance in market power becomes obvious.

This imbalance of power relegates the contracts that physicians and other providers must sign with the HMOs to those of contracts of adhesion: "take-it-or–leave-it" contracts that do not afford physicians and others any realistic opportunity to negotiate the terms therein.

Another powerful (maybe the most powerful) barrier to entry concerns the role of information about claims loss events and histories. In the property and casualty market it is a common practice to have up-to-date information that is well documented and is freely dispersed throughout the industry (Shaker and Gembicki, 1999). By contrast, health insurers hold loss experience as *proprietary data* and generally refuse to share it with any entity except their large corporate clients. Small insurers must purchase the information a few fragments at a time.

"Large insurers with networks have information that small insurers and small AHPs do not."

In every business, *information is power.* In health insurance, large insurers with networks have information that small insurers and small AHPs do not (Shaker and Gembicki, 1999; Fialka, 1997). This constitutes an enormous barrier to entry. [See the Case Study sidebar.]

How Association Health Plans Can Help Reduce the Number of Uninsured in America

Association Health Plans have the potential to make the market for health insurance more competitive and to help reduce the number of uninsured Americans.

Insuring the Uninsured by Creating More Insurance Options. The needs of small employers vary to some degree with the size of the firm and definitely by the composition of the firm's workforce. The one-size-fits-all packages often offered to small employers do not allow the employer to access a health plan that fits the particular needs of the firm's employees. The same is true in the market for individual insurance.

To address this problem, members of Congress (Bilirakis, 2002; Whitfield, 2002) as well as representatives of industry (Wilson, 2002) have noted the need for a health insurance market that is more responsive to individual purchasers, small businesses, and their employees.

Migrant workers have different workplace needs than do accountants. Construction firms with all-male crews have different needs than do all-female service workers. Different employers have special needs that

require custom health plan options. Large insurers have typically not served these needs very well, nor have they been responsive to the changing circumstances of very small employers.

The potential to increase the number of healthy people who obtain insurance is indicated by the experience of Medical Savings Account (MSA) plans under the federal government's pilot program. These are high-deductible plans combined with a savings account (the MSA). Individuals who have such plans spend from their MSA and out of pocket until they reach the deductible, with the plan typically paying all costs above the deductible. Because people get to keep (in their MSA) all the funds they do not spend, they are rewarded for being prudent, careful buyers of health care. Evidence shows that MSA plans significantly increase the perceived value of health insurance for healthy, uninsured people. In fact, the Internal Revenue Service recently estimated that 73 percent of all the people who have obtained an MSA plan were previously uninsured. Currently only about 100,000 people are enrolled in tax-favored MSA plans (Internal Revenue Service, 2002). The spread of these plans has been delayed by cumbersome restrictions and regulations, but their success to date illustrates the tremendous untapped potential of allowing the market to meet consumer needs in innovative ways.

AHPs would also afford small firms the economies of scale and bargaining power that large companies now enjoy (Fletcher, 2002). This is important because the Department of Labor estimates that six of 10 Americans without health insurance are in families headed by someone working for a small business (Chao, 2002). As Rep. John Boehner, Chairman of the Subcommittee on Employer-Employee Relations of the U.S. House of Representatives (Boehner, 1999), points out:

"AHPs would give small firms the bargaining power of large companies."

> AHPs allow small employers and the self-employed to band together voluntarily in associations to form multiple employer groups. Under this concept, these large groups could self-insure or fully insure, gaining all of the advantages of pooling including greater economies of scale and lower costs. The result could be a 'rising tide that lifts all boats.' Small employers who now cannot afford coverage could offer it to their uninsured workers. States may benefit by having fewer people on Medicaid or dependent on state high-risk pools.

Insuring the Uninsured by Lowering the Cost of Basic Insurance. As noted above, many of the uninsured are healthy and can afford to purchase health insurance. The principal reason they are uninsured is that the premiums charged are too high relative to the value they place on being insured. The most important key to inducing them to become insured is to lower the price of insurance. There are three principal reasons why healthy people have been priced out of the market. As explained below, Association Health Plans offer a partial solution for all three.

First, in most health insurance markets the healthy are overcharged so that the sick can be undercharged. In some cases this occurs because it reflects the traditional pricing philosophy of such organizations as Blue Cross Blue Shield (Goodman, 1980). In other cases, state law effectively creates cross-subsidies and cost shifting.[6] In either case, there are two bad consequences: (1) the healthy who are overcharged respond by underinsuring or by not buying insurance at all, and (2) the sick who are undercharged overinsure — thus driving up the average cost of insurance even more.

Second, guaranteed issue laws in the small group market (in every state) and in individual markets (in a few states) force insurers to take all comers, regardless of health status. This means that people can avoid costly premiums while they are healthy, secure in the knowledge that they can buy insurance for a reasonable price after they get sick. Of course, as more healthy people act on this incentive, the remaining pool of people who are insured at any point in time will become sicker and therefore more costly.

Third, regulatory burdens discussed below increase the cost of insurance, and these burdens have a larger impact on the individual market and on small firms than they have on large firms.

Association Health Plans cannot solve all these problems. They do have the potential to avoid some of the costs, however. They also have the potential to lower other costs. By one estimate, small employers pay 18 percent more for health insurance than large employers (Fletcher, 2002). By allowing small and large employers to purchase insurance in much the same way, AHPs can reduce that difference.

Overall, small employers (and their employees) are the first to be priced out of the market by cost increases, and they will be the first area of expansion if those costs can be lowered (Turner, 2002).

Insuring the Uninsured by Avoiding Costly Mandated Benefits. Mandated health insurance benefits are state regulations that require insurers to cover specific services and specific providers. Currently, there are more than 1,000 such mandates among the 50 states. Mandates cover services ranging from acupuncture to in vitro fertilization, from mental health care to cosmetic surgery. They cover providers ranging from chiropractors to naturopaths. They cover bone marrow transplants in New Jersey, clinical trials in Virginia, hairpieces in Minnesota, marriage counseling in Connecticut, and pastoral counseling in Maine (Laudicina, Losleben and, Walker, 2001).

"There are more than 1,000 health insurance mandates among the 50 states."

In many cases, benefits mandated by state governments are already included in the richer health plans of larger employers. These benefits often would not have been included in plans sold in the individual and small group markets, however, because buyers in the latter markets would typically

prefer lower premiums in order to acquire basic coverage (Mills, 2002; Baumgardner, 2000). Mandated benefits in these markets create additional costs that must be borne by those who have no market power or negotiating clout.

"Mandated benefits price healthy people out of the market."

Mandated benefits raise the cost of insurance and price otherwise healthy people out of the market. In fact, studies estimate that as many as one out of every four uninsured Americans has been priced out of the health insurance market because of mandates (Goodman and Musgrave, 1988; Jensen and Morrisey, 1999). The impact has been especially severe for small business (Keating, 2002; Close, 2002), for agricultural communities (Nelson, 2002), and for minority populations, including Hispanics (De Posada, 2002).

The author has reviewed scores of testimonies of employer groups, institutions, and specialists before both the U.S. House of Representatives and the U.S. Senate. The testimonies make compelling arguments regarding the heavy and unnecessary burden of state mandates. These are credible witnesses representing large sectors of our economy, especially small businesses. They are unanimous in their position that mandates cause great harm.

If mandates do so much harm, then why do they exist? Very few mandates have been enacted because of patient pressure. Almost all are the result of the lobbying power of special interest providers, including doctor groups. Nevertheless, in an unexpected but welcome move, an American Medical Association study (Carpenter, 2002) indicated support for AHPs and for exemption from state mandates, premium taxes, and small group rating laws. The report states, in part:

> Therefore, the AMA supports federal legislation enabling the formation of alternative means of pooling risk in order to increase individual choice of coverage and cost consciousness. Some alternative prototypes already exist in the form of association health plans (AHPs), consumer-directed health care arrangements, and some Internet-based health insurance companies. In addition, the AMA supports legislation allowing individuals to "buy in" to state employee purchasing pools … Businesses are increasingly interested in AHPs as a way to control costs and [in] consumer-directed health care options as a way to allow their employees to control their own health care decisions. In addition, creative alternative insurance pools would be encouraged by *exempting them from selected state regulations regarding mandated benefits, premium taxes and small group rating laws*, while safeguarding state and federal patient protection laws. [Emphasis added.]

U.S. Small Business Administration Assessment of AHP Advantages

The U.S. Small Business Administration, in its "Study of the Administrative Costs and Actuarial Values of Small Health Plans," listed a number of advantages small employers would gain from forming or joining Association Health Plans:

- AHPs would not have to offer state-mandated benefits.
- Regulation and enforcement would be through the Department of Labor (DOL).
- AHP coverage would not be subject to state premium taxes or other forms of state taxation, but would instead pay a lower assessment intended to cover the cost of DOL regulatory activities.

A House bill on association health plans not passed in the Senate would allow many associations to obtain health insurance for small employer members at significantly lower premium rates from AHPs. The legislation would free small employers who offer health insurance from a number of forms of direct and indirect taxation by the states. For example, although state premium taxes are nominally intended to cover the cost to the states to regulate insurance, in practice they are predominantly a way of raising revenue the states use for other purposes.

AHPs could also offer small employers health insurance that did not involve indirect subsidies to higher-cost small employers, especially the indirect subsidies involved in requiring guaranteed issue and the same premium rates for very small "baby" groups (e.g., those with 1-4 employees). Very small groups cost much more to insure due to the potential for anti-selection, fraud and abuse, and disproportionate administrative expenses.

Other advantages would accrue from avoiding certain state regulations. Although AHPs would have to follow the premium rating of the state of domicile, the pool could be limited to association members and would have to comply with only one state's rules. Thus AHPs located in states with less stringent state laws could offer insurance to the lower-cost groups that are now forced to subsidize higher-cost groups in those states that require community rating or narrow rate bands.

Source: U.S. Small Business Administration, Office of Advocacy, "Study of the Administrative Costs and Actuarial Values of Small Health Plans," January 2003, Washington, D.C.

There is no question that most state mandates are beneficial to specific persons for specific situations. The paramount question is whether they should be forced on others. Small employers could offer bare-bones packages or plans with minimal state mandates that satisfy the basic needs of employees and are affordable. Such benefits as drug rehabilitation, mental health care, and treatments for chronic ailments or long-term disabilities could be covered in a supplement to an employer-provided plan and paid for by the employees on an optional basis.

Small employers should be concentrating on making a quality product at a reasonable price. It is unrealistic to expect them to also function as a "mini insurance company" on site to serve the social welfare functions demanded by special interests and the government. The choice of benefits, however, should be the prerogative of the employer and the employees or of the employer acting as agent for the employees.

In order to serve the needs of purchasers of insurance, the Department of Labor should encourage AHPs to design plans with basic major medical benefits and few or none of the special benefits currently mandated by the states. AHPs could use a managed care network with limited access to specialists, reasonable and appropriate waiting periods for qualification, and affordable monthly premiums (lower than premiums for individual coverage outside the group). Alternatively, they could provide an indemnity plan with a fee schedule and lower the costs even further. They also could take a Medical Savings Account approach. Such plans could be designed to attract relatively healthy young workers. The AHPs' ability to avoid costly state mandates and sell lower-priced insurance to healthy uninsured people would help overcome much of the damage caused by unwise regulation.

"AHPs can sell lower-priced insurance to healthy uninsured people."

Insuring the Uninsured by Avoiding Other Regulatory Burdens. Unnecessary state regulations add costs to employer health plans, and they may add legal fees and administration costs. This is especially true for small employers (Langer, 2002), who often must hire consultants to ensure compliance with the sometimes conflicting state and federal regulations. AHPs would have state regulation preemption, thus resulting in savings significant enough to make the difference between affording and not affording a health plan. [See the sidebar on the Small Business Administration report.]

For example, state regulations that require prior rate approval are costly and time-consuming and are often administered unfairly and unwisely. Rate hearings may last six to nine months and require that the insurer be represented at least by an attorney and often by specialists in order to present an effective case before the administrative judge or regulatory agency. This often results in opportunities lost and restrictions on the management of resources. AHP preemption from this type of regulation would yield significant savings, which could be passed along to the

firm's employees. It would allow the insurer to respond quickly to changing circumstances, controlled by competition and market forces rather than by a political body.

"Regulation often gives larger companies a competitive advantage over smaller companies."

Regulations also burden such large insurers as Blue Cross Blue Shield. However, large insurers may oppose unwise regulation less vigorously and may even perceive it as a source of competitive advantage. John Graham, Administrator, Office of Information and Regulatory Affairs, Office of Management and Budget, explains it this way:

> Large corporations… oftentimes see regulation as an opportunity to raise capital costs for participants in an industry and to *create entry barriers for new companies* into those businesses.
>
> That leads to the key finding of the Crain/Hopkins Report commissioned by the Small Business Administration. Firms with less than 20 employees face 60 percent larger regulatory burdens per employee than firms with greater than 500 employees. So I think it is important to realize that… *larger companies, in certain circumstances… see [regulation] as a competitive advantage relative to small companies.* [Emphasis added.]

Insuring the Uninsured by Avoiding the Costs of Unfair Taxes. AHPs would be preempted from taxes on the premiums of their health plans. Taxes on the premiums of individually purchased insurance and employer health plans are a source of general revenue for the states. Large self-funded employers and their employees do not pay this tax, nor do enrollees in Medicare and Medicaid, nor do state employees. Virtually the entire burden of the tax on health plan premiums falls on the most defenseless part of the market — where people pay the tax through higher premiums. The revenues from these taxes often go into the general revenue funds of the states and are spent on projects that have nothing to do with the health of the citizens. In other cases, the revenues are used to fund the state's high-risk pool. Even though the goal of the risk pool is to insure more people, the burden of accomplishing this socially important task is not shared equitably. The taxes are clearly a form of regulatory discrimination against individuals, the self-employed, and employers of small business.

The small employer joining an AHP would not be subject to the premium tax and would therefore be able to use those resources to hire more people and/or increase benefits to existing employees. With more affordable rates, more people would either purchase their own insurance or enroll in their small employer's health plan.

Expected Results. The case for offering lower-cost health plans to individuals, the self-employed and small business is strong. Perhaps the

most important argument for AHPs is that millions of people who are not covered because of high costs or lack of availability would be able to obtain affordable coverage. The Congressional Budget Office (CBO) analysis of legislation pending in Congress estimates that small businesses can expect to reap savings averaging between 9 percent and 25 percent of the cost of their health insurance premiums. As a result, the CBO estimates that 330,000 — and potentially as many as two million — of the currently uninsured would obtain health insurance (Baumgardner and Hagen, 2000).

"AHPs could insure approximately 4.5 million workers and dependents who are currently uninsured."

Some experts believe that the CBO study underestimated the number of persons without health insurance that would be covered if the Association Health Plan legislation is enacted (Wilson, 2000; Talent, 2000; Joensen, 2000). Mark Joensen of CONSAD Research Corporation estimates that the creation of Association Health Plans would result in an increase in employer-sponsored insurance coverage of approximately 2.3 million workers and 2.2 million dependents (Joensen, 2000).

Answering Objections to Association Health Plans

With regard to Association Health Plans, the hundreds of pages of Capitol Hill testimony the author reviewed presented common messages and common arguments on each side. This section will examine some of the main arguments and seek to determine their relevance to reducing the uninsured in America.

Would AHPs Be Able to Unfairly Escape State-Mandated Benefits? Mandated benefit laws, as we have seen, force buyers of insurance to accept benefits they may not want and may not need. The laws increase the price of health insurance and make it more costly than it otherwise would be. As a result, many healthy people who are potential buyers of bare-bones insurance have been priced out of the market (Dressler, 1999; Wilson, 2000; Weil, 2000).

AHPs would avoid costly mandates and provide healthy people with affordable basic health insurance.

The answer to the question "Is it fair?" is "Fair to whom?" Certainly AHP insurance is fair to the uninsured who have been unfairly priced out the market. Is it fair to large insurers who currently dominate the markets and live under mandated benefit laws? Perhaps not, but two considerations are worth noting.

First, the primary social goal should be insuring the uninsured rather than making large insurers more comfortable. Forced to choose between the two, the needs of the uninsured should come first.

Second, between the two groups, large insurers are much better positioned to deal with the unfairness. For one thing, they already posses competitive advantages in the marketplace, as we have seen. For another, they are politically more powerful. Allowing AHPs to sell mandate-free insurance would undoubtedly put great pressure on state governments to extend this privilege to other insurers and the people who purchase their products. Large insurers would be welcome allies in this noble cause.

Would AHPs Be Able to Unfairly Escape Other Government Regulations? Private health insurance for most Americans is already exempted from regulation by state governments. However, those who buy state-regulated insurance face 50 separate regulatory regimes, with 50 different sets of laws, rules, processes, procedures, language requirements, and the like. In principle, a large company with employees in many states faces many sets of regulations. To free large employers from this potential regulatory nightmare was the goal of the Employee Retirement Income Security Act (ERISA), which exempts firms that self-insure from state regulations. The ERISA preemption allows large companies to conduct business under regulations devised by the U.S. Department of Labor. Since regulation by the Department of Labor is uniform across state jurisdictions, this reduces the firm's legal and administrative costs.

Unfortunately, as a practical matter the ERISA preemption is available only to large businesses. Firms with fewer than 50 employees are not in a position to self-insure. If small firms could buy AHP insurance sold under uniform regulations in all states, they could enjoy the same lower administrative costs now available to large companies. Lack of uniformity among the states with regard to laws and regulations is a problem for AHPs in the same way that it would be a problem for large firms, absent the ERISA preemption. Even if the laws on the books were the same, the 50 distinct insurance commissioners whose job is to interpret the laws each may interpret them in different ways.

"AHP insurance sold under uniform regulations would have lower administrative costs."

There are several estimates of the potential cost savings. Donald Dressler, testifying to the House Committee on Education and the Workforce about insurance services provided to the Western Growers Association, estimated that uniform regulations across state lines would reduce administrative costs by as much as 30 percent (Dressler, 1999). A CONSAD study yielded a range of 5.4 percent to 22 percent (CONSAD 1998). Not long ago, the Congressional Budget Office estimated that the AHP legislation before Congress would reduce premiums for small businesses between 9 percent and 25 percent (Baumgardner and Hagen, 2000).

Lower administrative costs, of course, mean lower premiums and more people insured. By one estimate, there would be a gain of 200,000 additional insured for each percentage decrease in health care costs (Congressional Budget Office, 2000). CONSAD estimates that figure to be

closer to 300,000 (CONSAD, 1998). The numbers vary, but the message is clear: lowering the costs of meeting regulatory burdens will lower the costs of health care plans, and that in turn will increase the number of insurers and the number of insured.

Is it fair to allow AHPs access to uniform federal regulation and not allow other insurers the same opportunity? Perhaps not, but large insurers have large legal departments and retain lawyers who specialize in state regulations. That infrastructure is already in place and has been for decades. To require AHPs to duplicate those resources in their infancy is irrational from an economic point of view, especially in light of the alternative of federal oversight by the Department of Labor.

"Uniform federal regulation would protect AHPs against hundreds of frivolous lawsuits."

Being under uniform federal regulation would protect AHPs against hundreds of frivolous potential lawsuits based on compliance with conflicting state regulations (Dressler, 1999; Turner, 2002; McIntosh, 2002). Having a uniform federal jurisdiction rather than 50 different jurisdictions drastically reduces the legal and organizational costs for small businesses, giving them the competitive advantage that large self-funded corporations have enjoyed for years.

Would AHPs Destabilize Insurance Markets? There are two issues here that are hard to separate. We will consider each in turn.

First, the existence of monopoly power is itself a market failure. Monopoly output is restricted compared to competitive output and monopoly prices are higher than competitive prices. The result is a social welfare loss (Amato, 1988; Bennefield, 1998; Canary, 2001; Gupta, 1994). Entry into the market is a way to correct that market failure — as competition lowers prices and expands output. What the dominant firm sees as destabilization, however, the new entrant and its customers see as competition. The status quo will, of course, be disturbed. The economic question is: Will people be better off?

Second, the small group market already suffers from instability, courtesy of unwise regulation. Because of state and federal laws, every state in the union has guaranteed-issue legislation requiring insurers to accept all comers, regardless of health status. Almost every state has some form of premium restriction as well (rate bands, community rating, etc.). These regulations keep the premiums artificially low for the sickest groups and artificially high for the healthiest.

As a consequence, small groups have an incentive to "game" the system. That is, they have an incentive to remain uninsured and avoid paying expensive premiums while everyone in the group is healthy, then immediately purchase insurance if a member of the group develops a serious illness. This activity causes the overall pool of people who are insured to be sicker than otherwise and contributes to the overall rise in the cost of insurance. Moreover, the more costly insurance becomes, the

greater the incentive to game the system. The more serious version of this spiral is called a "death spiral," because with each iteration conditions get worse.

Mark Litow, representing the Council for Affordable Health Insurance, opened his testimony before the U.S. House Committee on Small Business with this observation (Litow, 2002):

> The small group market is in very bad shape. That is so because of a continuing series of incentives… [that were] seriously exacerbated by the use of community rating or rating bands and guaranteed issue as implemented during the 1990s. These incentives have caused skyrocketing premiums in the market combined with a gradually decreasing proportion of eligible groups being insured.

Regulations are worse in some states than in others. Raymond Keating, Chief Economist, Small Business Survival Committee, testifying before the U.S. House Committee on Small Business, comments on the aftermath of community-rating and guaranteed-issue legislation by saying (Keating, 2002):

> The results are completely predictable — much higher insurance costs, and fewer insured individuals. And that has been the case in the states that have imposed guaranteed issue and community rating.
>
> For example, New Jersey imposed guaranteed issue in the individual market in legislation passed in 1994. From December 1994 to January 2002, among four insurers offering family coverage during this period, monthly premiums increased by 556 percent (Aetna), 344 percent (Blue Cross Blue Shield NJ), 612 percent (Metropolitan Life), and 471 percent (National Health Insurance).
>
> In Kentucky, after the state adopted guaranteed issue and community rating in 1994, 45 insurers fled the state and premiums skyrocketed. Also in 1994, a similar scenario played out in New Hampshire in response to passing guaranteed issue and community rating.

Ironically, state reforms designed to make it easier for people to obtain health insurance more often than not have led to fewer people being insured. For example, a study by Schriver and Arnett (1998) concluded that the 16 states that had been most aggressive in regulating their health insurance markets through guaranteed issue, community rating, and other directives had uninsured rates that rose eight times faster than the 34 states that were less regulatory. Wayne Nelson of Communicating for Agriculture

"Ironically, state reforms have led to fewer people being insured."

and the Self-Employed explained the consequences in testimony before the House Committee on Small Business (Nelson, 2002):

> Many of the federal and state reforms that were enacted in the 1990s with the intent of helping the small group market have backfired and actually done harm. Also, several *states have tried reforms* in the individual market, tried to make them more like the employer market *with disastrous results*. Some state legislatures believe[d] that simply legislating that every insurance company had to offer insurance to anyone at any time, regardless of their medical conditions, could really solve the problem. And *this has led to sky-high premiums* and *no competition*, with *many companies leaving states* that have guaranteed issue in the individual market. [Emphasis added.]

"In the United States, we are making it easy for people to get insurance after they get sick."

In the United States, we are making it increasingly easy for people to get insurance after they get sick. As a consequence, they have no reason to buy insurance while they are healthy. Increasingly, there is no relationship between the premium charged and the risk transferred by those who pay that premium.

Such a market is inherently unstable. Moreover, virtually any self-interested act by any participant in the market is likely to add to that instability. The answer is not to limit competition. The answer is to change the regulations that cause the instability in the first place.

Do AHPs Unfairly Compete by Engaging in Risk Selection? Closely related to the issue of stability is the issue of risk selection. Critics maintain that AHPs will use unfair methods of risk selection. By this they usually mean that AHPs will "cherry pick" and seek good risks while avoiding bad risks. What critics rarely acknowledge is that there is no such thing as a good risk or a bad risk independent of price. What the term "good risk" means is someone who is paying a premium substantially greater than the expected costs of that person's health care. In other words, a good risk is someone who is profitable because he or she is being overcharged. Conversely, "bad risks" are people who are charged less than the cost of their care. Accordingly, these people are unprofitable.

The business of insurance is the business of pricing and managing risk. Competition in the insurance marketplace tends to ensure that risk is priced accurately. Thus in a competitive market, every new person in a plan will tend to be charged a premium that reflects the expected costs of that person's health care at the time of entry into the plan.

New entrants into almost any market seek to sell to the most profitable customers. The reason these customers are profitable is that they are being overcharged by the insurers already in the market. In seeking to better meet the needs of these customers and give them a better deal, new

entrants should be regarded as heroes and encouraged to provide the best, lowest-cost, richest product they can. In any normal market, that is exactly the way they would be viewed. However, in health insurance the tradition is to scorn new entrants for "cherry picking." Yet cherry picking is nothing more than trying to satisfy consumer needs better than a rival. Moreover, the dominant insurers routinely practice various forms of cherry picking. For example, segmenting the market by client demographics is cherry picking. Insuring certain market segments and not insuring others or refusing to write policies in a given market or state is cherry picking. In fact, many large insurers built their businesses in this way.

The foundation concepts of *underwriting* are risk measurement, risk assessment, risk selection, and risk classification. The largest underwriting departments are found in the largest insurance companies and for good reason. Underwriting and risk pricing is exactly what an insurance company is supposed to do. Rates charged for health benefit packages must be approved by the underwriting department, based on risk measurement, sophisticated actuarial models, and predictive risk assessment. When an insurer excludes certain individuals or firms from a plan, the decision is made based on risk selection, which enables the insurer to offer a more competitive product at a lower cost to the risk pool it chooses.

Many major health insurers have withdrawn from the small group market and from the individual market in various states. When an insurer quits writing business in a state, it exercises the ultimate risk selection technique — avoiding the market altogether. Short of leaving the market, large insurers select risks in other ways. Do they take any person or group irrespective of their state of health and without waiting periods? No. The prospective subscriber must meet certain underwriting requirements before being covered. For example, insurers usually refuse to insure a group unless at least 75 percent (the minimum "group participation ratio") of employees who are eligible enroll in the plan. As a result, a small group in which a significant number of employees choose not to participate will be refused insurance. Insurers will also refuse to insure a group if the employer does not pay a certain share of the premium (usually 50 percent or more). All of these practices involve risk selection. All are designed to attract healthier and avoid less-healthy groups.

"Many major health insurers have withdrawn from the small group market and from the individual market."

It is likely that AHPs will use the same underwriting techniques to fashion health care plans that suit the needs of their membership. They may even contract with a large insurance underwriter to assist in the design and delivery of benefit plans that fit their needs. There is no credible evidence that the AHPs will engage in more selection activities than do existing insurers.

Would AHPs Avoid Socially Desirable Cross-Subsidies? The view that the goal of insurance companies is to measure, assess, price and manage risk is not universally held. Some would like to use the private

health insurance system to achieve a sort of private sector socialism in which insurers take from those who are healthy in order to give to those who are sick. Mary Nell Lehnhard, representing Blue Cross Blue Shield (Lehnhard, 2002), expressed this view when she said:

> To address wide variations in premiums charged to particular groups based on health status, all states adopted risk-spreading requirements that assured cross-subsidization between low- and high-cost groups. These rules set limits on what an insurer could charge its sickest group compared to its healthiest group (both within a single product and across all products offered by the insurer). Insurers are now forced to pool all their business; this assures cross-subsidies and prevents insurers from pricing their products in a manner that avoids high-cost small employers.

"There must be imperfections in the market in order for cross-subsidies to exist."

In order for one group to serve as a source of cross-subsidy for another group, however, there must be imperfections in the marketplace. Competitive markets do not have cross-subsidies because competition insures that each buyer is charged a price that reflects the expected cost of services he or she consumes.

For one group to subsidize another for any reason means that one group is paying too much and the other is paying too little (Boyes and Melvin, 2002; O'Sullivan and Sheffrin, 2001). It is easy to understand how a large, dominant firm has the capacity to cross-subsidize among client bases, since economies of scale and scope afford the firm excess or redundant resources. It is not easy to understand why that philosophy should be imposed on everyone else.

Would AHPs Siphon Off the Healthiest Customers at the Expense of the Sick? This issue is closely related to the previous one. We list it separately in order to draw attention to some special problems in the small group market. Mary Nell Lehnhard explains the Blue Cross Blue Shield position this way (Lehnhard, 2002):

> … what we are concerned about is that AHPs will raise the cost for our small employer pools by making it very attractive for healthier groups to leave the pools, whether it is us or another insurance company, and join an AHP where there are no mandated benefits, and they do not need those benefits. The people who need the benefits would stay with the state-insured pools and make the costs go up for those sicker small groups.

Notice again the implicit assumption that healthy groups should subsidize the sicker groups. The tacit goal is to *overcharge* the group that has fewer claims so that the group that incurs the higher claims can be

undercharged. In other words, BCBS is arguing that healthy people should be forced to pay a higher premium for their health plans in order to support or subsidize the less-healthy people. This is another way of saying that healthy employees should be penalized for their good health and the unhealthy rewarded for their bad health.

In fact, there is a problem in the small group market. However, that problem is not caused by unfair competition, and it will not be solved by suppressing competition.

We noted above that the market for small group insurance today is in most respects dysfunctional. One sign of that dysfunction is that small firms cannot buy the kind of health insurance that is routinely sold in the individual market. For example, when an *individual* buys insurance he or she is guaranteed the right to remain in the insurance pool indefinitely. Each year, premiums are likely to increase, but they increase the same percent for everyone in the pool. Those whose health condition has worsened cannot be kicked out or singled out for special premium increases.

"The structure of the smaller group market is not the result of normal market forces."

Once insured, each person in the pool is treated the same and premium increases are the same for all, regardless of subsequent health history. This is the true meaning of the concept of insurance. Once in the pool, premiums for the ill and unhealthy increase no faster than for the healthy.

Things are very different in the market for small group insurance, where people generally cannot stay in an insurance pool for more than a year. At the end of the year, the small firm and its employees are kicked out of the pool, re-rated on the basis of changes in its employees' health status, and allowed to reenter the pool only if they pay the new rates. Firms with employees who develop costly illnesses are forced to pay higher premiums the following year precisely because some have become ill.

Another sign of dysfunction is asymmetry in the market contract. Basically, at the end of a one-year insurance period, the insureds can leave one insurer and give their patronage to another. The reverse is not true. Because of guaranteed issue, the insurer cannot leave the insured by refusing to renew the group. If both sides of the market were allowed to sign longer-term contracts, stability would be greatly enhanced.

The structure of the small group market is not the result of normal market forces. It is the result of unwise regulation. The solution to the problems in this market is to reform the unwise regulations, not to stifle competition.

Would AHPs Make Fraud, Insolvency and Abuse More Likely? Critics assert that the Department of Labor (DOL) has inadequate experience and resources to monitor AHPs and prevent fraud, insolvency

and abuse. What the critics overlook is that the DOL already oversees 2.5 million job-based health plans, covering 131 million workers, retirees and their families (Chao, 2003). Put another way, most of the people with private health insurance in the United States already rely on the DOL for oversight and appear to be no worse off for the experience.

"The Department of Labor oversees 2.5 million job-based health plans, covering 131 million workers, retirees and their families."

One source of concern regarding the formation of Association Health Plans has been the increasing number of allegations of fraud and abuse by the Multiple Employer Welfare Arrangements (MEWAs). The MEWA is an association-type arrangement similar to the Association Health Plan but distinct from it structurally and legally; it does not meet the ERISA definition of an employee benefit plan and is not certified by the U.S. Department of Labor. It may be regulated by states. MEWAs that are fully insured and certified must meet only broad state insurance laws regulating their reserves.

Conclusion

Based on a review of the technical literature and the testimony of scores of witnesses before the U.S. House of Representatives and the U.S. Senate, as well as first-hand experience in the field for about 20 years, this author draws a number of conclusions with regard to Association Health Plans and their position in the political arena and in the marketplace.

- The market for health insurance is dominated by a few large insurers in most states, and in some cities and towns there is only one insurer.
- While these large insurers may meet the needs of many customers, often they do not meet the needs of individuals and small businesses.
- It is difficult for rivals to enter the health insurance marketplace in most states because of national barriers to entry as well as artificial barriers created by unwise state regulations.
- Most of the uninsured tend to be young and healthy, have low to moderate incomes, and be especially sensitive to the price of insurance.
- Most of the uninsured are connected to the workplace, and most uninsured workers are employees of small businesses.
- Small businesses are especially burdened by the lack of competition and by unwise regulations.
- Among the unwise regulations, state-mandated health insurance benefits are estimated to cause as many as one in every four uninsured persons to be without health insurance.

- Guaranteed issue requirements, community rating, and other restrictions on underwriting also make things worse by causing the sick to overinsure and the healthy to underinsure and by destabilizing the small group market.
- By uniting many small firms with similar interests across the country, AHPs potentially could take full advantage of economies of scale and lower health care costs for their members.
- Costs would be further lowered because AHPs would be able to function under one uniform set of federal regulations rather than 50 sets of state regulations.
- AHPs would be able to avoid mandated benefits and the other complex, cost-increasing regulations imposed in different states.
- AHPs have the potential to insure millions of people who are currently uninsured.

No one can predict the exact effects of the expansion of AHPs into the health insurance marketplace. Estimates are that AHPs, operating under federal law, could lower small business insurance costs by as much as 25 percent. Estimates of the number of additional people who would obtain health insurance range as high as 4.5 million.

"AHPs could lower small business insurance costs by as much as 25 percent."

This is why AHP legislation is a high priority for the Bush administration. As Department of Labor Secretary Elaine Chao explained:

> The president has made affordable and accessible health insurance for small businesses a priority of this administration. By banding together to leverage their purchasing power, Association Health Plans will enable small companies to obtain health insurance on terms similar to those now enjoyed by large firms, establishing an important new way to lower costs and expand coverage.

NOTE: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any bill before Congress.

Notes

[1] The plans fall under the provisions of the Employee Retirement and Income Security Act (ERISA) of 1974.

[2] In all versions, AHPs would be subject to the provisions of the Health Insurance Portability and Accountability Act (HIPAA), which among other things makes health insurance "guaranteed issue" in the small group market.

[3] "Horizontal Merger Guidelines," U.S. Department of Justice and the Federal Trade Commission, Washington, D.C., April 2, 1992.

[4] They are usually derived by stating a firm's market share as a percentage of the total receipts for a given NAICS (North American Industry Classification System) code. One such source is the U.S. Census Bureau (USCB) Health Care & Social Assistance – Subject Series, Table 6a. "Concentration by Largest Firms Subject to Federal Income Tax: 1997" and Table 6b. For those firms that are not subject to federal income tax, it contains information regarding the number of establishments, receipts – amount and percent of total, annual payroll, first quarter payroll, and number of paid employees. This study uses the NAICS codes for industry number 62 and its respective subcategories. Table 3.1 in the text was adapted from USCB Table 6a.

[5] For example, when the top five firms represent 90 percent of the market, the Four-Firm Concentration Ratio is at least 72 percent and the Herfindahl-Hirshman Index is at least 1,296.

[6] Some states have passed laws mandating insurance rate bands, whereby insurers are limited in their ability to charge rates based on actuarial risk. For instance, such laws might mandate that the sickest individuals cannot be charged more than 50 percent more than the average rate and the healthiest cannot be charged less than 50 percent of the average rate. Grouping people with diverse actuarial risks in more closely banded pools results in a cross-subsidy, whereby the young and healthy are charged more than the expected cost of their care so that older or less-healthy individuals can pay less than the expected cost of their care.

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About the NCPA

The NCPA was established in 1983 as a nonprofit, nonpartisan public policy research institute. Its mission is to seek innovative private sector solutions to public policy problems.

The center is probably best known for developing the concept of Medical Savings Accounts (MSAs). The *Wall Street Journal* called NCPA President John C. Goodman "the father of Medical Savings Accounts." Sen. Phil Gramm said MSAs are "the only original idea in health policy in more than a decade." Congress approved a pilot MSA program for small businesses and the self-employed in 1996 and voted in 1997 to allow Medicare beneficiaries to have MSAs. And a June 2002 IRS ruling frees the private sector to have a flexible medical savings account and even personal and portable insurance. A series of NCPA publications and briefings for members of Congress and the White House staff helped lead to this important ruling.

The NCPA also outlined the concept of using tax credits to encourage private health insurance. The NCPA helped formulate a bipartisan proposal in both the Senate and the House, and Dr. Goodman testified before the House Ways and Means Committee on its benefits. Dr. Goodman also helped develop a similar plan for then presidential candidate George W. Bush.

The NCPA shaped the pro-growth approach to tax policy during the 1990s. A package of tax cuts, designed by the NCPA and the U.S. Chamber of Commerce in 1991, became the core of the Contract With America in 1994. Three of the five proposals (capital gains tax cut, Roth IRA and eliminating the Social Security earnings penalty) became law. A fourth proposal — rolling back the tax on Social Security benefits — passed the House of Representatives in the summer 2002.

The NCPA's proposal for an across-the-board tax cut became the focal point of the pro-growth approach to tax cuts and the centerpiece of President Bush's tax cut proposal. The repeal by Congress of the death tax and marriage penalty in the 2001 tax cut bill reflects the continued work of the NCPA.

Entitlement reform is another important area. With a grant from the NCPA, economists at Texas A&M University developed a model to evaluate the future of Social Security and Medicare. This work is under the direction of Texas A&M Professor Thomas R. Saving, who was appointed a Social Security and Medicare trustee. Our online Social Security calculator (www.mysocialsecurity.org) allows visitors to discover their expected taxes and benefits and how much they would have accumulated had their taxes been invested privately.

An innovative nationwide volunteer campaign called Team NCPA (www.teamncpa.org) is under way to raise awareness of the problems with the current Social Security system and the benefits of personal retirement accounts. The late Sen. Daniel Patrick Moynihan (D-N.Y.), speaking at an NCPA Sumners Lecture, said there is no serious proposal anywhere in the United States that would cut benefits for current retirees.

In the 1980s, the NCPA was the first public policy institute to publish a report card on public schools, based on results of student achievement exams. We also measured the efficiency of Texas school districts. Subsequently, the NCPA pioneered the concept of education tax credits to promote competition and choice through the tax system. To bring the best ideas on school choice to the forefront, the NCPA

and Children First America published an *Education Agenda* for the new Bush administration, policy makers, congressional staffs and the media. This book provides policy makers with a road map for comprehensive reform. And a June 2002 Supreme Court ruling upheld a school voucher program in Cleveland, an idea the NCPA has endorsed and promoted for years.

The NCPA's Environmental Center works closely with other think tanks to provide commonsense alternatives to extreme positions that frequently dominate environmental policy debates. A pathbreaking 2001 NCPA study showed that the costs of the Kyoto agreement to halt global warming would far exceed any benefits. The NCPA's work helped the administration realize that the treaty would be bad for America, and it has withdrawn from the treaty.

NCPA studies, ideas and experts are quoted frequently in news stories nationwide. Columns written by NCPA scholars appear regularly in national publications such as the *Wall Street Journal*, the *Washington Times*, *USA Today* and many other major-market daily newspapers, as well as on radio talk shows, television public affairs programs, and in public policy newsletters. According to media figures from Burelle's, nearly 3 million people daily read or hear about NCPA ideas and activities somewhere in the United States.

The NCPA home page (www.ncpa.org) links visitors to the best available information, including studies produced by think tanks all over the world. Britannica.com named the ncpa.org Web site one of the best on the Internet when reviewed for quality, accuracy of content, presentation and usability. NCPA Web sites average 4 million hits per month.

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