REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (I-05)
Association Health Plans
(November 2005)

EXECUTIVE SUMMARY

For several years, legislation has been introduced in Congress that would authorize the creation of federally regulated Association Health Plans (AHPs). Council on Medical Service Report 5, which is presented for the information of the House of Delegates, describes elements common to most AHP proposals; discusses the gaps in employer-based coverage, particularly as they relate to small businesses; presents arguments in support of and in opposition to AHPs; and discusses AMA policy as it relates to AHPs.

In general, AHPs would allow small businesses to pool together through professional or business associations to obtain health insurance coverage for their employees. Under proposed legislation, AHPs would be distinct entities subject to federal oversight, similar to the way most employer-sponsored plans are currently regulated under Employee Retirement Income Security Act of 1974 (ERISA). The Department of Labor would be primarily responsible for AHP oversight, rather than individual state departments of insurance.

Although more than 63% of Americans under the age of 65 receive health insurance coverage through their employers, employees of small businesses are disproportionately represented among workers without employer-based health insurance coverage. Smaller firms are less likely to offer health insurance, and compared to employees in large firms, covered employees in smaller firms pay a higher percentage of premiums, and face higher patient cost-sharing in the form of deductibles, co-payments, and co-insurance. As a result, employees in small firms have become less likely to accept coverage when offered.

Small businesses have several disadvantages relative to larger firms when seeking affordable health insurance for their employees, including limited negotiating ability; absence of administrative economies of scale; and smaller, less stable risk pools. These factors often lead to higher prices and fewer choices of coverage packages for their employees. Supporters of AHPs argue that they would offer small businesses a number of "tools" to help make health care coverage more affordable, including creating larger, more stable risk pools, and giving them increased bargaining power when dealing with third-party insurers, thus increasing the affordability, flexibility and range of coverage options that they would be able to offer their employees.

Opponents of AHPs argue that they would destabilize and exacerbate problems in the small group market by permitting "cherry picking" of healthier people; providing insufficient safeguards against insolvencies and fraud; eliminating important consumer protection safeguards; and cutting funds to state high-risk pools. Although sponsors of AHP legislation have attempted to include various provisions that would address many of these concerns, strong concerns still remain, especially in the area of patient and physician protections and the ability of the Department of Labor to adequately oversee AHP operations.

The report concludes that, in the context of existing AMA policy, AHPs have the potential to be an effective alternative to traditional employer-based group coverage, but that several issues need to be addressed to ensure that AHPs reliably meet the needs of patients and participating physicians.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5 - I-05
(November 2005)

Subject: Association Health Plans

Presented by: Joseph P. Annis, MD, Chair

Despite the dominance of employer-based coverage in the health insurance market, employment does not guarantee access to affordable health care coverage. Nearly 83% of uninsured Americans are from households headed by at least one worker. For several years, legislation has been introduced in Congress that would authorize the creation of federally regulated Association Health Plans (AHPs), which supporters argue would expand health insurance options and affordability for the large number of working Americans who currently are without health care coverage.

The details of AHP implementation vary from bill to bill, but, in general, AHPs would allow small businesses to pool together through professional or business associations to obtain health insurance coverage for their employees. Although such pooling arrangements already exist under current law, they remain subject to individual state regulations that govern insurance practices. Under proposed legislation, AHPs would be distinct entities subject to federal oversight, similar to the way most employer-sponsored plans are currently regulated under Employee Retirement Income Security Act of 1974 (ERISA). The Department of Labor would be primarily responsible for AHP oversight, rather than individual state departments of insurance.

In addition to AHPs sponsored by small businesses, the Bush Administration supports allowing other groups to form expanded AHPs based on individual membership, rather than on employment status. Under this framework, affinity groups such as charitable, religious or civic organizations would be able to offer federally regulated health insurance to their members, regardless of the member's employment status.

This report, which is presented for the information of the House of Delegates, discusses the gaps in employer-based coverage, particularly as they relate to small businesses; provides a brief overview of an early form of group purchasing for small businesses, multiple employer welfare arrangements; presents arguments in support of and in opposition to AHPs; and discusses American Medical Association (AMA) policy as it relates to AHPs.

GAPS IN EMPLOYER BASED COVERAGE

Previous reports of the Council on Medical Service (Report 6, A-05, and Report 4, I-04) have discussed the limitations of the nation's current reliance on employer-based health insurance, including lack of choice, flexibility, and stability for consumers; the regressive nature of tax subsidies awarded for policies obtained as part of an employee benefits package; and the skewing of the health insurance market away from meaningful alternatives to workplace coverage. However, for better or worse, employment-based health insurance is still the dominant source of health insurance coverage in the United States. More than 63% of Americans under the age of 65 receive health insurance coverage through their employer. (Employee Benefit Research Institute, December 2004) The workplace is currently the most convenient mechanism through which

individuals become part of the "group market," which can yield lower administrative costs and facilitate greater risk pooling, thus often enabling individuals to access richer benefit packages at lower rates than those found on the individual market for comparable coverage.

However, not all workers have equal access to health insurance benefits. The likelihood of accessing employer-based health insurance is strongly correlated with firm size. In 2004, the share of firms offering coverage varied from 52% for firms with three to nine workers up to 99% for firms with 200 or more workers (Employer Health Benefits Annual Survey, Kaiser Family Foundation and Health Research and Educational Trust, 2004 [KFF/HRET]). In large firms, offer rates have been both higher and more stable over time, with 98-100% of large firms offering coverage. In contrast, smaller firms have exhibited greater volatility in health insurance offer rates from year to year (KFF/HRET, 2004).

Firm size affects not only the likelihood of health care coverage being offered, but also the share of the costs borne by the employees. Compared to employees in large firms, covered employees in smaller firms pay a higher percentage of premiums directly out of their paychecks, and face higher patient cost-sharing in the form of deductibles, co-payments, and co-insurance. As a result, employees in small firms have become less likely to accept coverage when offered (down from 84% in 2001 to 80% in 2004) (KFF/HRET, 2004).

CHALLENGES FOR SMALL BUSINESSES IN THE HEALTH INSURANCE MARKETPLACE

Employees of small businesses are disproportionately represented among workers without employer-based health insurance coverage. According to 2002 data from the Kaiser Family Foundation, approximately 40% of all workers are employed in small firms or are self-employed, but more than 60% of uninsured workers are employed in these settings (Health Insurance Coverage in America: 2002 Data Update, KFF, 2003). Small businesses have several disadvantages relative to larger firms when seeking affordable health insurance for their employees, including limited negotiating ability; absence of administrative economies of scale; and smaller, less stable risk pools. These factors often lead to higher prices and fewer choices of coverage packages for their employees.

The size and stability of the risk pool are critical factors in determining the level and consistency of insurance premiums. The more employees a company has, the larger the population across which to spread risk, and the easier it will be for the population overall to absorb costly incidents or less healthy individuals. This usually results in lower premiums, and enables insurance companies to more accurately predict average risk levels. In addition, a large risk pool mitigates the effect of factors such as employee turnover or a single employee suffering from a chronic condition, leading to more consistent premium rates from year to year.

Naturally, smaller businesses are at significant disadvantage relative to risk pooling. The fewer employees a business has, the more difficult it becomes for insurance companies to predict risk, and the more susceptible premium rates are to the health conditions of individual employees or variations in the risk pool. For example, a single employee with heart disease could drive up insurance rates for the whole company, since there are fewer individuals across which to allocate the expenses associated with treatment. Similarly, a one-time catastrophic event experienced in a small risk pool can alter the risk rating for the entire population, possibly resulting in dramatic premium increases in subsequent years. Thus, small businesses are often faced with high base

premiums for health insurance, and may find it difficult to predict and budget for premium increases from year to year.

MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

The Council has previously examined the variety of existing employer health insurance purchasing alliances, including multiple employer welfare arrangements (MEWAs) (Council on Medical Service Report 5, A-99). MEWAs are risk-bearing entities created to offer one or more insurance plans to a group of small employers, and generally have their own set of regulations that are distinct from those of traditional insurers. Similar to AHPs, MEWAs were intended to address the risk pooling and economies of scale issues faced by small businesses, and also to provide some level of relief from state insurance regulations.

Past experience with MEWAs provides some concrete evidence of problems that could arise from AHPs, absent sufficient regulation and oversight. When first authorized, it was unclear whether MEWAs were subject to state or federal oversight, and, in the confusion, neither the Department of Labor nor state departments of insurance provide sufficient guidance. Some MEWAs successfully claimed to be exempt from state requirements by way of falling under ERISA, while at the same time the Department of Labor failed to exert authority over the plans because most were not ERISA-qualified. In the late 1990s, a proliferation of fraudulent MEWAs gained media attention by closing down in the wake of mounting unpaid health claims. Some MEWAs were operated by sham unions that attracted small businesses with underpriced premiums that could not cover claims costs. Although not all MEWAs are operated unscrupulously, the lack of clear oversight opened the door to a host of problems, which AHP opponents argue could be replicated under an AHP structure.

ERISA

Both supporters and critics of AHPs look to ERISA as a model for how AHPs could affect the delivery of health insurance coverage to employees of small businesses. ERISA established a set of uniform federal regulations related to the delivery of employer-sponsored benefit plans, including health insurance coverage. These regulations provide very basic requirements relative to patient information access, fiduciary responsibility, due process and appeals, and accessibility of coverage. The Department of Labor has jurisdiction over ERISA plans, and is responsible for ensuring adherence to the federal regulations.

Virtually all employer-sponsored benefit plans are subject to ERISA regulations. However, whether such plans are also subject to additional state regulations has traditionally depended on how the company provides the insurance coverage. Under ERISA, companies that self-insure (i.e., the company itself assumes the financial risk associated with health insurance) appear to have fewer regulatory restrictions than companies that contract with a third party for the coverage (i.e., fully-insuring). Fully insured plans are subject to both federal ERISA regulations and applicable state insurance regulations, because they are being serviced by an insurance company, which must be licensed and operate according to state rules. Companies that self-insure often successfully claim exemption from state regulations, since the company is not technically operating as an insurance company.

Many see this ERISA "pre-emption" for self-insured plans as a way to increase flexibility and keep health plan costs low. Absent individual state regulations and benefit mandates, employers and insurers often can design a variety of benefit packages to better serve the needs of those selecting the insurance. Conversely, companies that cannot afford to self-insure-- generally small businesses-- may find themselves at a disadvantage because they often must pay more to comply with myriad state regulations and mandates, and do not have the option of designing unique benefit packages based on employee needs. AHP legislation would essentially extend the ERISA pre-emption to AHPs, thus giving small businesses a vehicle through which to operate like a large, self-insured company.

However, many argue that ERISA regulations alone are insufficient to ensure adequate patient and physician protections, and look to individual state insurance regulations to supplement these areas. ERISA rules are, in fact, ambiguous relative to the jurisdiction of some state insurance laws over self-insured plans, and some courts have denied pre-emption claims. The AMA has filed several amicus curiae briefs in support of court challenges to ERISA pre-emption claims against state laws related to issues such as the liability of health plans that interfere in medical treatment, any willing provider contracting provisions, and prompt payment. Critics of AHPs fear a further erosion of state regulatory oversight, which could jeopardize important protections and safeguards.

ARGUMENTS IN SUPPORT OF AHPs

Supporters of AHPs argue that they would offer small businesses a number of "tools" to help make health care coverage more affordable. The Congressional Budget Office (CBO) estimated that health insurance benefits obtained through AHPs would result in premium reductions of an average of 13% for small businesses, derived primarily from economies of scale and administrative efficiencies that could be achieved by allowing companies to combine their workforces to create a single group for which to design and purchase group health insurance coverage (CBO, January 2000). In addition to creating larger, more stable risk pools, allowing businesses to centralize their insurance purchasing decisions would give them increased bargaining power when dealing with third-party insurers, thus increasing the affordability, flexibility, and range of coverage options that they would be able to offer their employees.

The proposed federal oversight of AHPs also would result in significant cost savings to small businesses by allowing them to bypass many state requirements and enjoy the same advantages that large, self-insured employers have as a result of ERISA preemptions. An analysis by the Council for Affordable Health Insurance (CAHI) found that benefit mandates can increase the costs of basic health insurance coverage from between 20% and 50%, depending on the state (CAHI, January 2005). Some argue that the burden of meeting all of these requirements, combined with the costs of coordinating benefits across states if necessary is a key barrier to securing affordable health insurance options. By allowing AHPs to operate under a uniform set of regulations, small businesses will gain access to more affordable coverage options and increased benefit design flexibility. In addition, by providing an alternative to traditional insurance options, AHPs would help lower costs by facilitating increased competition and choice in health insurance markets.

Recently proposed AHP legislation generally has contained a number of safeguards to ensure the integrity and fiscal solvency of AHPs. Supporters argue that these are sufficient to prevent the fraud and insolvency problems that plagued MEWAs. Current proposals require that an AHP be sponsored by only bona fide professional and trade organizations that have been in business for

several years, and exist for reasons other than providing health insurance. Supporters argue this helps ensure the integrity of the AHP, and also reduces the likelihood of "cherry-picking" of healthier plan enrollees, since the insured population will be defined by the members of the existing organization. Other safeguards include specific requirements for claims reserves, stop-loss and indemnification insurance, minimum surplus requirements, explicit registration, disclosure and actuarial reporting requirements, and criminal and civil penalties to combat fraud.

ARGUMENTS IN OPPOSITION TO AHPs

Opponents of AHPs argue that they would destabilize and exacerbate problems in the small group market by permitting "cherry picking" of healthier people; providing insufficient safeguards against insolvencies and fraud; eliminating important consumer protection safeguards; and cutting funds to state high-risk pools. Although AHP legislation sponsors have attempted to include various provisions that would address many of these concerns, strong concerns still remain, especially in the area of patient protections and the ability of the Department of Labor to adequately oversee AHP operations.

Some fear that allowing AHPs to operate under special federal rules could result in a stratification of the small business market by facilitating "cherry picking." For example, under some proposed legislation, there would be no limitations on premium variations among employers participating in the plan. Opponents of the legislation fear that businesses with significant health care costs would be squeezed out of plans by being subjected to high premiums, thus negating the value of being part of a larger, more stable risk pool. In addition, absent state benefit mandates, some analysts predict that plans may try to save costs by offering only bare bones coverage, which may be inadequate for many consumers, and could leave plan participants without access to necessary, but often expensive, treatments. The end result could be a crowding out of more comprehensive health plans in favor of minimalist plans that offer few protections for patients.

As noted above, many feel that state mandates and regulations provide an important layer of protection for patients, and for physicians who may contract with health plans. Similar to concerns currently associated with claims of ERISA pre-emption, some believe that AHPs will allow plans to avoid meaningful regulatory oversight in favor of weak or ambiguous standards that could ultimately jeopardize patient access to care. According to a recent analysis by the Blue Cross Blue Shield Association, AHPs could undermine state oversight in:

- 49 states that limit how much and how often employer's premiums can increase when an employee gets sick;
- 44 states that provide access to an independent, external review when an insurer denies a medical claim;
- 50 states and the District of Columbia that ensure health care providers are paid promptly and dependably; and,
- 50 states and the District of Columbia that prevent fraud and abuse and ensure that consumers are not left with unpaid medical bills (Association Health Plans: No State Regulation Means Loss of Protections for Consumers, Small Businesses and Providers, BCBSA, 2005).

There also has been some concern that the Department of Labor has insufficient resources to effectively monitor AHPs. A Congressional Budget Office analysis of one AHP bill (H.R. 525)

estimated that the Department of Labor would need to hire an additional 150 workers over the next three years, at a cost of $55 million between 2006 and 2010, to oversee the AHP market (CBO, April 2005). In addition, many argue that the Department of Labor would not have the expertise necessary to effectively regulate the insurance products offered by AHPs. According to the National Association of Insurance Commissioners, the exemption of AHPs from state oversight could lead to increased problems with fraud and loss of insurance, partly because of weak regulations, as well as because the Department of Labor would not be able to provide sufficient oversight to monitor the health plans. Many believe that, because individual state insurance departments exist solely to ensure compliance with insurance related laws, they are the most appropriate entities to monitor the health plans to ensure sufficient consumer protections.
In addition to concerns about the potential of AHPs to undermine patient protections and destabilize the health insurance market, the ability of AHPs to make a significant impact on the number of uninsured Americans has been questioned. The Congressional Budget Office projected that by 2010, if H.R. 525 were passed, about 620,000 more people would be insured through small employers than would be under current law, and about 8.5 million people total would obtain insurance through AHPs (CBO, 2005). CBO notes, however, that most of those AHP enrollees would have been previously insured in the state-regulated market, rather than being uninsured, so the net gain may not be significant. Some predict that AHPs could even result in premium rate increases, especially among employers with less healthy employees.

AMA POLICY

The AMA supports the concept of promoting new opportunities for pooling risks and facilitating alternative markets. Policy H-165.856[9], AMA Policy Database, emphasizes that the regulatory environment should enable rather than impede private market innovation in health insurance product development and purchasing arrangements. Specifically, the policy states that legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed, and benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options. Similarly, Policy H-185.964 opposes new health benefit mandates that are unrelated to patient protections.

Policy H-165.882[14] supports federal legislation to encourage the formation of small employer and other voluntary choice cooperatives by exempting insurance plans offered by such cooperatives from selected state regulations regarding mandated benefits, premium taxes, and small group rating laws. Policy H-165.882[15] supports the creation of voluntary choice cooperatives by a variety of organizations, such as religious groups, ethnic coalitions and fraternal organizations.

In acknowledgement of the problems generated by some MEWAs, Policy H-180.970 supports appropriate federal and state initiatives to regulate and oversee health care plans provided through MEWAs.

Policy H-165.882[14] advocates for the need to safeguard state and federal patient protection laws in any small employer or voluntary choice cooperatives. Similarly, Policy D-165.971 directs the AMA to work to ensure that any AHP program safeguard state and federal patient protection laws, including but not limited to those state regulations regarding fiscal soundness and prompt payment.

Several AMA policies support eliminating ERISA preemptions of state laws that relate to prompt payment (D-385.984) and the liability of managed care organizations (H-165.875, H-165.883,

H-165.898, H-285.945). In addition, Policy H-165.883 advocates that ERISA be modified to ensure that self-insured health plans are required to adhere to a series of principles related to patient and physician interactions, including ensuring that plan enrollees have access to all needed health care services; clearly disclosing any provisions restricting patient access to or choice of physicians, or imposing financial incentives concerning the provision of services on such physicians; and being subject to breach of contract actions by providers against their administrators.

DISCUSSION

Several iterations of AHP legislation have been proposed in Congress, and modifications continue to be introduced. In preparing this report, the Council on Medical Service has attempted to address some of the more common elements of recent AHP proposals; specifically, the ability of small businesses to band together to provide health coverage to their employees under a uniform set of standards which would likely be overseen by the federal government.

AMA policy generally supports mechanisms that facilitate alternative risk pooling and minimize regulatory barriers to the development of insurance products. However, specific AHP legislation would need to be evaluated against several standards relative to the safeguarding of existing patient and physician protections. Assuming that ERISA pre-emptions serve as a model for AHP regulation, the AMA has several concerns that should be addressed by AHP legislation to ensure its implementation as a fair and viable alternative in the health insurance market.

Although the AMA is generally opposed to excessive benefit mandates (Policy H-165.856) because of their potential to increase insurance costs and interfere with health insurance market innovations, there are some state-level insurance regulations that provide important protections for patients and physicians (e.g. mental health parity, prompt pay standards). The AMA already has serious concerns about attempts by employers and insurers to avoid these protections via the ERISA pre-emption, and has several policies that advocate for modifications to ERISA regulations to address these issues (D-385.984, H-165.875, H-165.883, H-165.898, H-285.945).

In particular, patients have limited remedies under ERISA alone if they suffer as a result of a coverage determination imposed by a health plan. State liability laws allow for patients to attempt to recover losses related to coverage denials, but ERISA limits damage awards to the value of the denied service. Other compensatory factors such as lost wages or additional medical costs are excluded from consideration under ERISA. Under ERISA patients also have no right to external review of benefit denials, or expedited review for urgent care decisions. A number of physician protections are also absent from current ERISA regulations, but available at least to some degree through state laws. Specifically, many benefit providers claim exemption from state regulations related to prompt payment, and fair contracting because of their pre-emption by ERISA.

The AMA and state medical associations have been working together for several years to secure patient and physician protections at the state level, and to ensure that ERISA pre-emption claims against these state laws are denied. Several AMA units, including the Advocacy Resource Center and Private Sector Advocacy, continue to pursue opportunities to advocate for changes in ERISA regulations, and to educate the US Department of Labor and large employers about the value of these important protections. In addition, the AMA Litigation Center has worked aggressively with state medical associations to defend against ERISA pre-emption claims that undermine state oversight of critical consumer and provider protections.

Current AHP legislation appears to extend ERISA pre-emptions to AHPs, and does not include any provisions to tighten the loopholes that compromise patient access to care and fair contracting for physicians. Rather than replicating the weaknesses of ERISA legislation, the Council believes that it is critical that AHP legislation include standards related to patient and physician protections such as those highlighted previously. Alternatively, the legislation must ensure that states retain authority over these specific areas, and that any pre-emptions are not applicable.

The Council also notes that the majority of AHP legislation operates within the employer-sponsored health insurance framework. The AMA's plan for expanding health insurance coverage and choice emphasizes moving away from a reliance on employment-based insurance to a system of individually selected and owned insurance. To that end, AHPs could be combined with other reforms to further promote the expansion of health care coverage, specifically a shift from employer-based coverage to individual based coverage, and a revision in the tax treatment of health insurance. As previously noted, the Administration also supports allowing non-employer groups to sponsor AHPs. Enabling individuals to participate in AHPs sponsored by their church or favorite membership organization would create another alternative to the employer-based group market.

In the context of existing AMA policy, the Council believes that AHPs have the potential to be an effective alternative to traditional employer-based group coverage. However, the Council believes that several issues need to be addressed to ensure that AHPs reliably meet the needs of patients and participating physicians. The Council remains confident that the Council on Legislation will continue to carefully review pending and new AHP legislation and make recommendations for working with Congressional sponsors to ensure that the AHPs are designed in the best interest of our physicians and patients.

References for this report are available from the AMA Division of Socioeconomic Policy Development.