# INCREASING SMALL-FIRM HEALTH INSURANCE COVERAGE THROUGH ASSOCIATION HEALTH PLANS AND HEALTHMARTS

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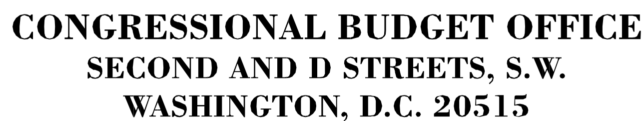

NOTES

Numbers in the text and tables of this paper may not add up to totals because of rounding.

All dollar values are expressed as 1999 dollars.

## PREFACE

The large and growing number of uninsured people in the United States, particularly uninsured workers in small firms, continues to be a concern to policymakers. In the 105th Congress and again in the 106th, the House passed legislation that would create two new vehicles, association health plans (AHPs) and HealthMarts, to facilitate the sale of health insurance coverage to employees of small firms. The effects of AHPs and HealthMarts on premiums and coverage in the small-group health insurance market are the subject of this Congressional Budget Office (CBO) paper.

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## SUMMARY AND INTRODUCTION

The rising number of people who lack health insurance continues to be a major concern to policymakers. According to the Census Bureau's Current Population Survey, about 43 million people under age 65 were uninsured in 1997. That estimate represents about 18 percent of the nonelderly population, compared with less than 15 percent who were uninsured a decade earlier.[1]

Given that the primary source of private health insurance coverage in the United States is employment, one might reasonably assume that people who lack insurance also lack jobs. Yet most uninsured people are members of families with at least one full-time worker. Uninsured workers are usually employees of small firms (those with fewer than 50 employees), and small firms typically face higher costs for health insurance than do larger firms, which may make small firms less likely to offer it. In 1996, 42 percent of small-firm establishments offered health insurance to their employees (see Table 1). (An establishment is a single geographic location of a firm.)[2] By contrast, more than 95 percent of establishments in firms with 100 or more employees offered insurance. Another reason for lower rates of health insurance coverage for workers in small firms is lower take-up rates when insurance is offered. In 1996, about 81 percent of employees in small firms accepted insurance coverage when it was offered by their employers, compared with 87 percent of employees in firms with at least 100 employees.[3]

Concerns about low rates of coverage for employees of small firms have led to a number of initiatives at both the state and federal levels as well as in the private sector. One example is the formation of group purchasing cooperatives, some private and some sponsored by state or local governments, in which firms join together to purchase insurance in larger volumes at more affordable prices. By one estimate, almost a third of small firms purchase their health insurance through some form of cooperative purchasing arrangement.[4] Even so, concerns persist about the affordability of insurance coverage and the lack of sufficient alternatives for reducing its cost. Recently, the House passed H.R. 2990, the Quality Care for the Uninsured Act of 1999, which among other things calls for establishing association health plans (AHPs) and HealthMarts, two new vehicles for offering health insurance coverage

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1. Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1998 Current Population Survey*, Issue Brief 204 (Washington, D.C.: Employee Benefits Research Institute, 1998), pp. 1 and 4.

2. A firm may have many establishments; however, most small firms have only one.

3. This paper considers only private-sector for-profit and not-for-profit firms.

4. Stephen H. Long and M. Susan Marquis, "Pooled Purchasing: Who Are the Players?" *Health Affairs*, vol. 18, no. 4 (July/August 1999), pp. 105-111.

TABLE 1. HEALTH INSURANCE COVERAGE BY SIZE OF FIRM

| | All Firms[a] | Firm Size (Number of Employees) 1 to 49 | 50 to 99 | 100 or More |
|---|---|---|---|---|
| Number of Private Establishments (Thousands) | 5,999 | 4,708 | 213 | 1,078 |
| Percentage Offering Health Insurance | 53 | 42 | 85 | 95 |
| Percentage Offering a Self-Insured Plan[b] | 28 | 11 | 20 | 63 |
| Number of Employees (Millions) | 104 | 31 | 8 | 65 |
| Percentage Offered Health Insurance | 70 | 50 | 73 | 80 |
| Percentage Who Take Up Health Insurance When Offered | 85 | 81 | 83 | 87 |

SOURCE: Congressional Budget Office calculations using data from the insurance component of the 1996 Medical Expenditure Panel Survey, Agency for Health Care Policy and Research (available at http://www.meps.ahcpr.gov/data.htm).

NOTE: An establishment is a single geographic location of a firm. Most small firms (less than 50 employees) have only one establishment.

a. Specifically, private-sector for-profit and not-for-profit firms.

b. As a share of establishments offering health insurance. Under self-insured plans, firms bear the financial risks of their employees' health care costs themselves rather than purchase coverage from a health insurer or health plan.

to small employers. (The House passed similar legislation—H.R. 4250—in the 105th Congress, but the bill was never considered by the Senate.) Several other proposals for AHPs and HealthMarts have also been introduced in the House.[5]

This paper considers how the introduction of AHPs and HealthMarts would affect premiums and coverage in the small-group health insurance market.[6] (Although entities known as association health plans already exist, all of the legislative proposals would create federally certified AHPs operating under a different set of rules.) The

5. See H.R. 448, H.R. 1136, H.R. 1496, H.R. 1687, and H.R. 2926.

6. At least one of the bills would create individual membership associations, or IMAs, that would face some regulatory rules similar to those for AHPs and HealthMarts. Unlike those proposed insurance arrangements, however, IMAs would not be sold as part of an employee benefit plan. This paper focuses on the market for employer-sponsored health insurance available through small firms and does not consider IMAs.

new entities would be exempt from some state insurance regulations that apply to insurance plans offered in the small-group market. Such regulations tend to increase premiums for those traditional plans.

Currently, about 48 million people either work for a small firm or are a dependent of someone who does. Under the most likely scenario for AHPs and HealthMarts, the Congressional Budget Office (CBO) estimates that approximately 4.6 million of those people might obtain their coverage through the proposed new insurance arrangements. But overall enrollment in employer-sponsored health insurance would increase by only about 330,000 people, because most firms purchasing coverage through an AHP or HealthMart would be switching from traditional insurance coverage—that is, insurance plans subject to the full array of state insurance regulations.[7] On average, premiums paid by small firms that purchased health insurance through an AHP or HealthMart would be about 13 percent lower than the premiums they would otherwise pay under current law. With AHPs and HealthMarts in place, the firms that continued to purchase traditional coverage would face an average increase in premiums of about 2 percent.

## THE HEALTH INSURANCE MARKET FOR SMALL GROUPS

As noted earlier, small firms are less likely than large employers to offer health insurance coverage to their employees, and small-firm employees are less likely to take up coverage when it is offered. Factors contributing to those lower rates of coverage include the characteristics of workers in small firms, firms' costs for providing insurance benefits, and state insurance regulations.

The earnings of employees in small firms are one of the chief reasons for lower rates of health insurance coverage among small employers. Compared with employees in large firms, those in small firms tend to be paid lower wages and have lower family income, although some employees are members of households with higher-paid workers. Given their lower income, employees of small firms may be unwilling to accept the even lower wages that would result if their employer sponsored a health benefits plan. Furthermore, because lower-income workers probably have fewer assets to protect in the event of a large medical expense, they may place less value on having insurance. Their lower wages also mean that small-firm employees have less of a tax incentive to purchase insurance than do higher-paid workers. (Because employees are not taxed on their employer's contribution for

7. Of nonelderly people in families headed by someone working for a small firm, CBO estimates that almost 26 million are currently insured through a small employer, a further 13 million are uninsured, about 3.5 million purchase coverage in the individual market, and the remainder obtain coverage from other sources.

health insurance, workers in higher tax brackets gain a larger subsidy for health insurance than do workers in lower tax brackets.)[8]

The cost of health insurance for small firms may be another factor in their lower rates of coverage. Health insurance premiums for equivalent benefit packages are higher for small firms than for large ones. The premiums themselves do not differ consistently on the basis of firm size, but the benefit packages that large firms offer their employees are more generous than those offered by small firms.[9] In addition, the administrative costs included in the premium are higher for small firms because they have fewer employees among whom to spread the fixed costs of a health benefits plan, including costs for marketing and enrollment. Premiums are also likely to be higher for small firms because they do not have as much purchasing power as large firms, which limits their ability to bargain for lower rates from providers and insurers.

State insurance regulations may also contribute to higher premiums for small firms. For example, premium compression regulations, although reducing premiums for some firms, have raised premiums for others. Because of their size, small firms may experience much greater variation than large firms in their expenses for health benefits. One employee's serious illness can dramatically boost a small firm's health expenses, and in the absence of regulatory intervention, the firm's health insurance premiums could also rise substantially (since, in general, premiums are set to reflect those expenses).[10] Such significant rate variation, and even cancellation of policies, characterized the small-group market during the late 1980s.[11] In response, many states imposed new regulations that guaranteed availability and renewability of insurance and limited the degree to which premiums could vary among small firms.[12] In California, for example, the highest premium that an insurer may charge for a particular policy can be no more than 20 percent above its lowest premium for that policy. To comply with that kind of regulation, known as premium (or rate)

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8. For an extended discussion of this issue, see Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance* (March 1994). The average employee in a small firm has a relatively low income and therefore receives little benefit from the tax subsidy. However, the tax advantage is significant for employees in those small firms, such as law firms or other professional groups, that usually pay higher salaries.

9. See Len Nichols and others, *Small Employers: Their Diversity and Health Insurance* (Washington, D.C.: Urban Institute, June 1997).

10. That issue is discussed in Rick Curtis and others, "Health Insurance Reform in the Small-Group Market," *Health Affairs*, vol. 18, no. 3 (May/June 1999), p. 1.

11. Elliot K. Wicks and Jack A. Meyer, "Small Employer Health Insurance Purchasing Arrangements: Can They Expand Coverage?" *New Directions for Policy*, National Coalition on Health Care (May 1999) (available at http://www.americashealth.org/releases/stevesedit.html).

12. Federal law—specifically, the Health Insurance Portability and Accountability Act of 1996—also incorporates guaranteed availability and renewability of health insurance.

compression, the insurer must increase the premiums it charges its lowest-cost, or healthiest, firms and reduce the premiums it charges its highest-cost firms. The result is cross-subsidization—the increased premiums paid by the healthiest firms are used to help pay for the expenses of less healthy firms, whose premiums are no longer high enough to cover their expected costs.

Another way in which state regulations may have boosted premiums for small firms is by mandating the inclusion of certain benefits in all health insurance plans. (In a number of states, those mandates cover treatment for alcoholism, drug abuse, and mental illness as well as chiropractic care and bone marrow transplants.) If such regulations force insurers in the small-group market to provide benefits that firms would not otherwise purchase, the mandates will, in effect, push up premiums by more than the additional coverage's value to employees. Mandates may also discourage some small employers from offering coverage, particularly firms with employees who are relatively healthy and who—given the choice—would probably forgo at least some of the mandated benefits to obtain lower premiums. Another way in which state regulations may increase premiums is through premium taxes, which are paid by insurers. In 1996, such taxes ranged from less than 1 percent to as much as 4 percent of premiums.[13]

Although, in principle, mandates and premium taxes affect the premiums of any firm (regardless of size) that purchases insurance from a licensed insurer, they frequently have a greater impact on small firms. The reason is that larger firms can avoid such regulations by self-insuring—that is, by bearing the financial risks of their employees' health care costs themselves rather than purchasing coverage from a health insurer or health plan. The federal Employee Retirement Income Security Act (ERISA) exempts firms' self-insured health plans from most state insurance regulations. However, small firms are less likely than large firms to self-insure because they have fewer potential enrollees (employees and their dependents) among whom to spread expenditures and as a result are vulnerable to greater financial risk (see Table 1 on page 2). Small firms that offer coverage are much more likely to purchase it from a health insurer and must therefore bear the full cost of state insurance regulation.[14]

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13. General Accounting Office, *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance*, GAO/HEHS-96-161 (August 1996), pp. 26-27.

14. Some small firms have chosen to partially self-insure by combining a self-insured plan with stop-loss insurance (an insurance policy that covers catastrophic health care expenditures). Partially self-insuring limits a firm's exposure to the risk of excessive health care expenditures—a critical consideration for a small firm—yet allows the firm to benefit from the advantages of self-insuring. Depending on the regulations of their state, firms that partially self-insure may avoid providing mandated benefits and paying premium taxes. However, states may limit the attractiveness of this option by effectively restricting the amount of stop-loss coverage that firms may purchase.

## ASSOCIATION HEALTH PLANS AND HEALTHMARTS

AHPs and HealthMarts are intended to reduce the cost of health insurance for small employers. Like group purchasing cooperatives, they could enhance the purchasing power of their members, and they might reduce some administrative costs. But AHPs and HealthMarts would have two additional advantages compared with cooperatives: they would be exempt from most state benefit mandates, and they could avoid the full effect of state regulation of insurance premiums.

### Association Health Plans

AHPs would operate subject to several important requirements. Trade, industry, or professional associations that had been in existence for at least three years could sponsor an AHP, which would have to offer its insurance products to all member firms. Those products could constitute a full range of health plans, including a self-insured plan, under certain conditions: generally, the AHP would have to offer at least one fully insured plan (purchased from a licensed health insurer), and the sponsoring association would have to meet other qualifying criteria designed to limit favorable selection (attracting enrollees that are healthier than average) and the risk of financial insolvency. Both the AHP's self-insured and fully insured plans would be exempt from state benefit mandates, but they would not be exempt from state premium taxes.[15]

Because of their structure, AHPs would be subject in only a limited way to state laws that regulate premiums in the small-group health insurance market. In general, AHPs would have to abide by the premium-setting regulations of each state for their enrollees who resided in that state. Some states require insurers that offer small-group policies to community-rate their premiums (a practice in which the price for a given health policy must be the same for all purchasers despite variations in those purchasers' expected costs per enrollee). Other states limit the degree to which premiums for a particular policy can vary among firms. AHPs would have to follow the state's rating rules, but the premiums they offered would be based on the average expected costs per enrollee of only the association's member firms—not on the costs of the broader (and potentially more expensive) groups that insurers offering traditional coverage serve. As a result, AHP premiums are likely to be lower than they would be if they reflected the availability rules applying to traditional (fully regulated) plans.

15. Under some proposals, including H.R. 2990, states could charge premium taxes on self-insured AHP plans commencing operations after enactment of the legislation.

HealthMarts

In many respects, HealthMarts would be similar to AHPs, but certain features—in particular, eligibility based on geographic location rather than association membership—would set them apart. HealthMarts would be nonprofit organizations that offered health insurance products to all small firms within their geographic service area, which would have to cover at least one county or an area of equivalent size. All of the health benefits plans that a HealthMart offered would be available to any small employer within its service area. Employers who chose to participate would have to agree to purchase health insurance only from the HealthMart. (That is, participating employers could not offer their employees plans from the traditional market in addition to HealthMart plans.)

Like AHPs, health plans offered through HealthMarts would be exempt from most state benefit mandates but would have to pay state premium taxes. HealthMarts would also be subject to state premium regulations that applied within their service area.[16] Unlike AHPs, however, HealthMarts could offer only fully insured plans from insurance issuers licensed in the state; self-insurance would not be an option.

## HOW AHPs AND HEALTHMARTS WOULD AFFECT PREMIUMS AND COVERAGE

The effects of AHPs and HealthMarts on the premiums of and number of people enrolled in traditional plans would depend on the response of small firms to health insurance policies comprising fewer benefits coupled with lower premiums. Coverage might increase if AHPs and HealthMarts could offer plans with premiums that were lower than those for traditional coverage. Firms that do not currently offer insurance to their employees might choose to do so if the price was lower, even if the benefits were not as comprehensive as in some plans. Yet that response is only part of the coverage picture. Firms that already purchase traditional coverage might instead seek lower-cost coverage through an AHP or HealthMart. If the firms that dropped traditional coverage had healthier-than-average employees, and thus lower costs for insurance, fewer of those so-called low-cost firms would remain to subsidize the premiums of higher-cost firms. As a result, premiums for at least some firms purchasing traditional plans would have to rise, which could lead those firms to drop coverage.

16. Depending on the specific proposal, a HealthMart might be required to charge the same premium to every participating employer.

Premiums in the AHP/HealthMart Market

AHPs and HealthMarts could offer premiums that were lower than those for traditional coverage to the extent that they were exempt from state benefit mandates and could avoid some of the effects of state premium-setting regulations. Group purchasing of health insurance through AHPs and HealthMarts could also lower the cost of health insurance for small firms if it reduced administrative costs or increased firms' purchasing power. AHP premiums might undergo further paring depending on whether a particular AHP could achieve savings through self-insurance.

Avoiding State Regulation. According to their advocates, reducing the cost of state regulation is one of the principal attractions of AHPs and HealthMarts. Unlike the purchasing cooperatives that can now be found in many states, AHPs and HealthMarts would not be subject to state benefit mandates and might also avoid some restrictions on premiums. (Box 1 briefly discusses several kinds of purchasing cooperatives.) For example, small firms could obtain lower premiums if AHPs and HealthMarts dropped some of the benefits that states required insurers to cover and offered less generous benefit packages than were available in traditional plans. The extent of such savings and their effect on premiums would depend on whether employees of small firms still desired some of those mandated benefits. Firms take into account the preferences of their employees in designing their benefit packages and will not necessarily sponsor policies that omit all mandated benefits. (One study of self-insured employers found that many of those firms offered mandated benefits despite their exemption from state regulations under ERISA.)[17]

Exempting AHPs and HealthMarts from offering mandated benefits might substantially affect selection. With the exemption, AHPs and HealthMarts could design benefit packages that had fewer benefits and were relatively unattractive to firms whose employees had costly health care needs. Those firms would want more extensive benefit packages and would probably maintain their enrollment in traditional (fully regulated) plans. As a result, their high health care costs would not affect the premiums offered by AHPs and HealthMarts, which might allow those plans to lower their costs by more than the savings from the mandates exemption alone. Lower-priced plans with leaner benefit packages would appeal more to healthy firms (with lower-than-average expected health care costs)—both those that offered no coverage at all to their employees and those that already offered insurance. Some firms with higher-than-average expected health costs might also be attracted by the lower premiums, but they would be less likely to participate because of the leaner benefits.

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17. Jonathan Gruber, "State-Mandated Benefits and Employer-Provided Health Insurance," *Journal of Public Economics,* vol. 55 (1994), pp. 433-464.

BOX 1.
HEALTH INSURANCE PURCHASING COOPERATIVES

Health insurance purchasing cooperatives are relatively popular among small firms. A recent study estimated that 33 percent of establishments in firms with fewer than 10 employees and 28 percent of establishments in firms with 10 to 49 employees purchase health insurance through some type of group purchasing cooperative.[1] Such group purchasing arrangements can be divided into three broad categories: state-sponsored health insurance purchasing alliances, multiple-employer welfare arrangements (MEWAs), and multiemployer union-sponsored plans (also known as Taft-Hartley plans).

To encourage small firms to purchase health insurance, a handful of states sponsored health insurance purchasing alliances beginning in the early 1990s.[2] (An example is California's Health Insurance Purchasing Cooperative.) Typically, state alliances offer a variety of plans, including one or more managed care options, to any qualifying employer who wishes to purchase insurance through the alliance, and employees then enroll in the plan of their choice. The health plans that alliances offer are subject to normal state insurance regulations, including premium-setting rules and benefit mandates, although a few states exempt alliance plans from some of those requirements.

MEWAs can take many different forms including privately sponsored alliances, which function like the state-sponsored type, and association health plans, which can offer coverage only to members of their sponsoring association. (Those existing association health plans should not be confused with the proposed association health plans that are the focus of this paper.) The association-sponsored plans are employee benefit plans as defined by the Employee Retirement Income Security Act, or ERISA. They are more likely than purchasing alliances to offer a limited selection of health insurance options, and they can self-insure if they choose. In general, both fully insured and self-insured MEWAs are subject to state insurance regulations, including benefit mandates and premium-setting rules.

Union-sponsored plans are the only type of purchasing cooperative that does not have to adhere to state insurance regulations. Even though Taft-Hartley plans may involve many employers, ERISA classifies them separately from MEWAs and exempts them from state regulations such as benefit mandates and premium-setting rules.

There is little direct evidence about the effect of cooperatives on premiums. According to a study of a major purchasing alliance in California, the premiums that participating insurers offered to qualifying small employers were not as low as those offered to large firms.[3] Long and Marquis's analysis of a national survey of small firms found that premiums for cooperatives were roughly the same as those offered by traditional plans. The advantages of alliances appear to be primarily choice and information. For about the same premium, firms purchasing their coverage through a cooperative are more likely than other small firms to offer a choice of health plans to their employees. They also have better access to information about those plans, such as the benefits offered and the quality of care provided.

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1. Stephen H. Long and M. Susan Marquis, "Pooled Purchasing: Who Are The Players?" *Health Affairs*, vol. 18, no. 4 (July/August 1999), pp. 105-111.

2. Susan S. Landicina and others, *State Legislative Health Care and Insurance Issues: 1996 Survey of Plans* (Chicago, Ill.: Blue Cross/Blue Shield Association, 1996).

3. Jill Yegian and others, *Health Insurance Purchasing Alliances for Small Firms: Lessons from the California Experience* (Oakland, Calif.: California HealthCare Foundation, May 1998).

In the long run, one would expect the most successful AHPs to be sponsored by associations whose members had lower-than-average health care costs. Similarly, the most successful HealthMarts would probably be located in lower-cost areas of the country or areas where the costs of regulation and mandates were high.

Group Purchasing. To a limited extent, the advantages offered by group purchasing might enable AHPs and HealthMarts to offer premiums that were lower than those for traditional coverage. Like other group purchasing arrangements, AHPs and HealthMarts would probably have more negotiating power with health insurers than would small employers negotiating on their own. The larger the number of potential enrollees, the more willing health insurers and provider networks would be to discount their rates to attract business. Another advantage of group purchasing that might be reflected in lower premiums would be lower administrative costs—with group purchasing, some fixed costs would be shared among a larger number of enrollees.

Savings from group purchasing, however, are unlikely to induce many small firms to add coverage, because the group purchasing option, with its associated advantages, is already available to them through purchasing cooperatives. One exception may be AHPs and HealthMarts in states that have not been particularly supportive of cooperative purchasing arrangements.

Self-Insuring Through AHPs. Although AHPs would be able to offer self-insured plans, several factors would limit the attractiveness of that option. For example, all plans offered by AHPs, whether self-insured or fully insured, would be exempt from benefit mandates and would have to pay premium taxes. As a result, self-insured AHP plans would offer no advantage in those areas over fully insured AHP plans.[18] Other advantages of self-insuring might also go unrealized. For example, firms that self-insure can retain and earn interest on the money that they would ordinarily pay in premiums to a health insurer until the money is needed to pay medical claims.[19] But small firms enrolling in an AHP's self-insured plan would still have to pay premiums to a third party—the AHP. Moreover, to curb favorable-selection practices, some of the proposals being considered would restrict the self-insurance option to AHPs sponsored by associations whose member firms had higher-than-average health expenditures or represented a broad cross-section of industries (such as a chamber of commerce).

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18. Some association-sponsored plans in existence on the date of enactment of an AHP/HealthMart proposal might be able to claim an exemption from premium taxes.

19. See Martha Patterson and Derek Liston, *Analysis of the Number of Workers Covered by Self-Insured Health Plans Under the Employee Retirement Income Security Act of 1974: 1993 and 1995* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, August 1996).

The option to self-insure jointly with other firms is not new. ERISA already allows small firms to self-insure by joining together with other firms in so-called multiple-employer welfare arrangements (MEWAs). However, MEWAs might not be as attractive a vehicle for self-insuring as AHPs would be. Unlike AHPs, MEWAs must comply with some state regulations, including benefit mandates. In addition, some small firms may consider participation in a MEWA to be too risky. Overlapping state and federal laws have made regulating MEWAs a complicated and difficult task. According to the General Accounting Office, "MEWAs have proven to be a source of regulatory confusion, enforcement problems, and, in some instances, fraud."[20] As of December 1998, the Department of Labor had initiated 358 civil and 70 criminal investigations of MEWAs that affected over 1.2 million enrollees and involved monetary violations of more than $83.6 million.[21]

To bypass such problems, all of the AHP proposals include requirements to facilitate effective regulation of small firms that self-insure collectively. AHPs that offered self-insured plans would be subject to federal solvency standards, including requirements to set aside adequate reserves and to purchase stop-loss and indemnification insurance. Stop-loss insurance, which insures against the risk of unusually high claims, would apply to claims for a specific enrollee as well as aggregate claims for the plan as a whole. Indemnification insurance would pay outstanding claims if the plan was unable to meet its obligations. Thus, although self-insured AHP plans might not offer many advantages over their fully insured counterparts, they might still be more attractive to small firms than self-insuring through a MEWA.

Premiums for Traditional Insurance Plans

If firms with healthier-than-average employees switched from traditional insurance to AHPs and HealthMarts, premiums for some firms' traditional policies would rise. Moreover, that selection effect could be exacerbated by recently enacted federal requirements regarding the portability of insurance coverage. The Health Insurance Portability and Accountability Act of 1996 limits exclusions for preexisting conditions when purchasers of insurance switch from one policy to another. That provision could lead to the sorting of "healthy" and "sick" firms into AHP/HealthMart and traditional plans, respectively. For example, a firm with healthy employees (and thus relatively low expected health costs) might purchase a relatively inexpensive policy (covering few mandated benefits) in the AHP/HealthMart market. If one or

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20. General Accounting Office, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*, GAO/HRD-92-40 (March 1992), p. 2.

21. Department of Labor, Pension and Welfare Benefits Administration, Office of Public Affairs, "Fact Sheet on MEWA Enforcement" (December 1998).

more of its employees subsequently developed a serious illness, the firm could switch back to a traditional plan to obtain a more comprehensive policy, and its employees would face no exclusion (or only a limited exclusion) for preexisting conditions.[22]

To discourage favorable-selection practices, the proposals covering AHPs and HealthMarts generally include requirements that would limit their ability to attract healthier-than-average groups. For example, AHPs would have to offer their plans to any small firm that qualified for membership in the sponsoring association. Similarly, HealthMarts would have to make their plans available to any small firm located in their designated geographic area. A further factor tempering favorable-selection efforts may be that increasingly aggressive attempts by AHPs and HealthMarts to attract low-cost firms would add to administrative costs. Moreover, premium-setting regulations would still apply.

Even if AHPs and HealthMarts were successful in attracting primarily low-cost firms, the resulting premium increases for traditional plans would be relatively small. High-cost firms would be a small minority of those firms retaining traditional coverage, even though some lower-cost firms would switch to less costly AHP or HealthMart options. The low-cost firms that continued to purchase traditional health insurance would cross-subsidize the higher-cost firms, just as they do now.

Coverage

How AHPs and HealthMarts affected coverage would depend on how small firms responded to changes in premiums and benefits and, more specifically, on the differential responses by low-cost and high-cost firms. The effect on coverage of reforms in the small-group market that were enacted by many states in the early 1990s—reforms that AHPs and HealthMarts would weaken—may provide some insight into the potential impact of the proposed new insurance vehicles. Although the reforms may have stabilized premiums and made health insurance more available in the small-group market, they may also have led to reduced coverage: between 1987 and 1996, enrollment of small-firm employees in employer-sponsored health insurance declined by about 3 to 4 percentage points.[23]

22. For a limited set of categories, federal portability regulations allow plans to impose limitations on coverage of preexisting conditions if a person's previous plan did not cover those conditions. The coverage categories are mental health, substance abuse treatment, prescription drugs, dental care, and vision care.

23. See Philip Cooper and Barbara Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, vol. 16, no. 6 (November/December 1997), p. 14.

New insurance laws—including benefit mandates and premium compression requirements—that raised premiums for low-cost firms in the small-group market probably contributed to that loss of coverage. Benefit mandates may have caused firms to pay for benefits that their employees did not value highly. When those mandates resulted in higher-priced insurance policies, some losses in coverage probably occurred. Premium compression requirements, which lead to low-cost firms cross-subsidizing the coverage of higher-cost firms, raise the cost of insurance for firms with healthier employees and lower it for firms with less healthy employees.[24] Some empirical studies suggest that because low-cost firms and their employees have less immediate need for health insurance, they may be more sensitive to price changes than high-cost firms and their employees (see the appendix). Consequently, the studies show that the number of employees in low-cost firms who dropped coverage when their premiums rose was greater than the number of employees in high-cost firms who gained coverage when their premiums fell.

The differential responses to changes in premiums by firms with different expected health care costs is key to understanding the net effect of AHPs and HealthMarts on coverage. AHPs and HealthMarts would weaken some of the effects of state premium reforms; as a result, some low-cost firms would gain access to lower premiums, but some high-cost firms would see their premiums rise.[25] If, indeed, high-cost firms respond less to price changes than do low-cost firms, the resulting net coverage loss among high-cost firms would probably be less than the net coverage gain among low-cost firms, so overall coverage levels would probably increase. In addition, the mandates exemption of the AHPs and HealthMarts would allow them to offer plans with fewer benefits and at a lower price than the traditional plans can offer. The new plans are likely to be particularly attractive to low-cost firms, which would encourage some firms and workers to add coverage.

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24. Because premium compression requirements also effectively impose an upper limit on the price of policies sold to higher-cost groups, insurers may have responded by not aggressively marketing their plans to as many firms with relatively less healthy employees as they would have if they had been allowed to charge higher rates.

25. That statement would be true only in general. A number of low-cost firms might remain enrolled in traditional plans, even though some of them would face increased premiums as other low-cost firms switched to AHPs and HealthMarts. In addition, some high-cost firms might obtain access to an AHP or HealthMart with predominantly healthy firms, enabling the high-cost firms to pay lower premiums than they would have paid if they had purchased traditional coverage.

## ESTIMATING THE EFFECTS OF AHPs AND HEALTHMARTS ON PREMIUMS AND COVERAGE

CBO constructed an analytical model to project how small firms and their employees would respond to the introduction of AHPs and HealthMarts. Two measures of the potential impact of those proposed new insurance arrangements are the net increase in the number of people covered by insurance and the increase in total premiums paid to insurers. The latter measure reflects both the additional people covered by insurance and the net overall changes in the value of benefits offered to people with coverage. Changes in coverage might accompany either an increase or decrease in the total premiums paid. The estimates reported here indicate the long-term changes in premiums and coverage that would occur after the market had fully adjusted to the introduction of AHPs and HealthMarts.

### Main Findings

The model's main findings rely on assumptions that were developed from the results of empirical studies about how firms and employees respond to changes in premiums and insurance regulations (see the appendix for details). Under those assumptions, the introduction of AHPs and HealthMarts would increase net coverage through small firms by about 1.3 percent, or 330,000 people, including employees and their dependents (see Table 2). The increase in the overall number of people with insurance, however, would be slightly lower, because some of those who gained employer-sponsored coverage through AHPs and HealthMarts would have otherwise obtained coverage through the individual market. The 330,000 figure represents a net increase of about 340,000 enrollees among low-cost firms that would be slightly offset by a net drop of 10,000 people among higher-cost firms. (For these estimates, low-cost firms are those with expected claims costs per enrollee in the lower 90 percent of the distribution for all small firms.) Altogether, CBO estimates that about 4.6 million people would be insured through AHPs and HealthMarts, with most of those people switching from the fully regulated market to the new plans.

Once AHPs and HealthMarts were in full operation, total premiums paid annually by small firms and their employees would be approximately $150 million more than they otherwise would be, which represents about a 0.3 percent increase in total spending for health insurance in the small-group market (see Table 3). Firms that continued to purchase traditional health insurance plans would pay an additional $800 million in premiums. That increase would be more than offset by the $1.2 billion in net premium savings that would result because firms faced lower premiums in AHP and HealthMart plans. In addition, the net increase in coverage among low-cost firms would add $600 million in premiums; among higher-cost

TABLE 2. ESTIMATED EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON COVERAGE IN THE SMALL-GROUP HEALTH INSURANCE MARKET

| | Number of Enrollees[a] |
|---|---|
| Coverage Under Current Law (Millions) | 24.6 |
| Changes When AHPs and HealthMarts Are in Full Operation | |
| Low-cost firms[b] | 340,000 |
| High-cost firms[c] | - 10,000 |
| Total | 330,000 |
| Coverage When AHPs and HealthMarts Are in Full Operation (Millions) | |
| AHP or HealthMart plans | 4.6 |
| Traditional plans[d] | 20.3 |
| Total | 24.9 |

SOURCE: Congressional Budget Office.

NOTE: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

a. Workers and their insured dependents. However, these figures exclude an estimated 1.3 million people who participate in self-insured employer-sponsored plans under current law.

b. Firms with expected health costs in the lower 90 percent of the cost distribution.

c. Firms with expected health costs in the upper 10 percent of the cost distribution.

d. Subject to full state regulation.

TABLE 3. ESTIMATED ANNUAL EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON TOTAL PREMIUMS IN THE SMALL-GROUP HEALTH INSURANCE MARKET

| | Millions of Dollars |
|---|---|
| Total Premiums Under Current Law | 50,400 |
| Changes When AHPs and HealthMarts Are in Full Operation | |
| Premium savings from net enrollee movement to AHPs and HealthMarts | -1,200 |
| Increased premiums for firms covered under traditional plans[a] | 800 |
| Net increase in coverage among low-cost firms[b] | 600 |
| Net decrease in coverage among high-cost firms[c] | -50 |
| Total | 150 |
| Total Premiums When AHPs and HealthMarts Are in Full Operation | 50,550 |

SOURCE: Congressional Budget Office.

NOTES: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

The term "enrollee" includes insured workers and their insured dependents but excludes an estimated 1.3 million people who participate in self-insured employer-sponsored plans under current law.

a. Traditional plans are subject to full state regulation.

b. Firms with expected health costs in the lower 90 percent of the distribution.

c. Firms with expected health costs in the upper 10 percent of the distribution.

firms, the increase in the price of traditional plans would lead to a cut of about $50 million worth of coverage.

The price of a policy would be lower for some firms as a result of introducing AHPs and HealthMarts. On average, premiums paid by firms that participated in AHPs and HealthMarts would be about 13 percent lower than the premiums they would pay in the small-group market under current law (see Table 4). Five percentage points of that reduction come from the benefit mandate exemption and savings from group purchasing (see the appendix). The other 8 percentage points stem from the expected health costs of firms in the AHP and

TABLE 4. ESTIMATED EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON AVERAGE PREMIUMS IN THE SMALL-GROUP HEALTH INSURANCE MARKET

| | Percentage |
|---|---|
| Change in the Average Premium Paid by Firms That Participate in AHPs or HealthMarts | -13 |
| Change in the Average Premium Paid by Firms That Retain Traditional Coverage[a] | 2 |

SOURCE: Congressional Budget Office.

NOTES: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

Changes are calculated relative to premiums under current law.

a. Traditional coverage is subject to full state regulation.

HealthMart market that are generally lower than average and that allow participating firms to avoid some of the premium-boosting effects of rate compression laws.

Once AHPs and HealthMarts became available, firms that continued to purchase traditional plans would, on average, see some increases in their premiums arising from the shift of some low-cost firms to the new insurance vehicles. CBO's projections indicate a net transfer of approximately 4.3 million enrollees in low-cost firms from fully regulated plans to an AHP or HealthMart plan. Those transfers would cause premiums offered to firms with traditional coverage to rise, on average, by 2 percent. The increase is relatively small because low-cost firms would continue to be a substantial part of the market for traditional plans.

## Findings Under Alternative Assumptions

To determine a plausible range of possible outcomes once AHPs and HealthMarts were introduced, CBO varied its assumptions about the behavioral responses of firms and employees (see the appendix). At one extreme, the model estimated that coverage through small firms would increase by only 10,000 enrollees. That figure is associated with a negligible increase in premiums for small firms purchasing traditional insurance and a 9 percent reduction in premiums for participants in AHPs and HealthMarts. At the upper end of the range, the model estimated that coverage could increase by as many as 2 million people. The accompanying changes in

premiums would be an increase of 2 percent for firms retaining traditional coverage and a reduction of 25 percent for firms participating in AHPs and HealthMarts. Under those alternative scenarios, the total number of enrollees in AHPs and HealthMarts ranges from less than 1 million to 5.7 million.

## CONCLUSIONS

CBO projects that the introduction of AHPs and HealthMarts would have only slight effects on insurance coverage nationwide, increasing the number of people insured through small firms by about 330,000. Although about 4.6 million people would enroll in the new plans, the net boost in the number of people insured through small firms would be far smaller because many enrollees in the new plans would otherwise have been insured through traditional plans and because the increase in enrollees from some firms (those that gained coverage through AHPs and HealthMarts) would be offset by the decrease in enrollees from others (those that dropped their traditional coverage). Although coverage among small firms would grow by about 1.3 percent, total spending for health insurance would actually rise by only 0.3 percent, for two reasons: some coverage would be less comprehensive—because AHPs and HealthMarts are exempt from most state-mandated benefit requirements—and the mix of low-cost and high-cost firms with coverage would change.

If low-cost firms moved to AHPs and HealthMarts, some firms with traditional coverage would see their premiums rise because fewer low-cost firms would remain to cross-subsidize the high-cost firms. In response, some firms and workers covered under traditional plans would drop coverage, but most would continue to be covered and pay slightly higher premiums. After summing the changes in enrollment in both AHP/HealthMart and traditional plans, CBO estimates that, on balance, high-cost firms would drop coverage and low-cost firms would add coverage. Consequently, among firms that have coverage, the proportion of low-cost firms would increase, and the share of high-cost firms would decrease.

Among the states, the impact of AHPs and HealthMarts would probably be uneven because states differ in the extent and intensity of their regulations. States that have imposed relatively strict premium compression rules would be likely to attract more of the new plans than states that allow insurers to charge a wider range of premiums. The reason is that in states with more tightly compressed premiums—where the most cross-subsidization occurs—low-cost firms would face the greatest potential difference in price between traditional and AHP/HealthMart plans. Similarly, states with benefit mandates that are more costly or that cover benefits perceived as having little value to the average employee would be riper markets for AHPs and HealthMarts, as would areas with greater concentrations of small firms.

In addition to considering who would gain and who would lose under these proposed new insurance arrangements, policymakers must address issues of regulatory authority and solvency standards. Much uncertainty attends the overlapping of federal and state jurisdiction over AHPs and HealthMarts. States, for example, would exercise considerable regulatory authority over HealthMart plans—which could only be fully insured products offered by state-licensed insurers. But the Department of Health and Human Services would also be given regulatory authority over HealthMarts. States would have some authority over AHPs but might rely on the Department of Labor to oversee those plans—especially since self-insured AHPs would have to comply with federal solvency standards. How great a role the federal government or the states played in regulating the new entities would depend, in part, on the resources that the two designated federal oversight agencies devoted to that function.

## APPENDIX: MODELING THE EFFECTS OF AHPs AND HEALTHMARTS

In modeling the effects on the small-group market of introducing association health plans and HealthMarts, the Congressional Budget Office based its analysis on legislation recently introduced in the Congress, although the analysis may not reflect the specific provisions of any particular bill. CBO's model took into account how benefit mandates affect insurance costs and how firms respond to changes in premiums. Its estimates of premiums are based on the expected insurance costs of participants in the small-group market after factoring in state regulatory rules that restrict the range of premiums an insurer can charge.

The analysis considered two regulatory environments. In the first, which follows current law, small firms purchase traditional, or fully state regulated, insurance plans. In the second, firms may either purchase an AHP or HealthMart plan or obtain traditional coverage. By comparing the outcomes under the two sets of circumstances, the model estimated how AHPs and HealthMarts would affect coverage and premiums among small firms.

### Assumptions

To choose assumptions to feed into the model, CBO reviewed studies of the health insurance market and tabulations from available data files. The major assumptions used in modeling the effects of AHPs and HealthMarts covered the following areas:

- Savings achieved through exemption from state benefit mandates;
- Savings from group purchasing arrangements;
- Coverage changes in response to a change in the price of insurance;
- Insured firms' willingness to switch to less expensive, less comprehensive plans;
- Differences in insurance costs between firms with healthy employees and those with sicker employees; and
- Premium reductions in the AHP/HealthMart market from avoiding rate compression.

Savings Achieved Through Exemption from State Benefit Mandates. The main findings reported earlier were based on the assumption that AHPs and HealthMarts

would save 5 percent of insurance costs because of their exemption from state benefit mandates. CBO developed that assumption after analyzing empirical studies whose results imply a wide range of costs imposed by such requirements.

Some firms and employees will drop coverage when the price of an insurance policy rises. Therefore, studies of how mandates affect coverage will also yield some insight into how they affect costs. Gruber studied how state mandates influenced insurance coverage in firms of less than 100 employees and found that they had a negative but not statistically significant effect.[1] He estimated that states passing all five of the mandates he designated as expensive (which included mental health services and drug abuse treatment) would see coverage drop by 1.2 percentage points, measured from a base of 46.5 percent of workers with employer-sponsored insurance in firms with less than 100 workers. He also found that a 1 percent increase in the actuarial costs of mandated benefits reduced coverage by 0.17 percentage points. (Actuarial costs are the costs of the claims paid for those benefits.) As Gruber recognized, a reason for the small effects he found was that his measure of costs overstated the actual additional costs that a mandate law imposes on insurance plans because many plans would have covered some benefits even in the absence of a legal mandate.

Summarizing studies that examined several states, the General Accounting Office found that the actuarial costs of mandated benefits ranged from 5.4 percent to 22.0 percent of total claims costs.[2] But the potential savings from the mandates exemption are smaller than the actuarial costs of the required benefits to the extent that health plans would have covered those benefits anyway. To adjust the results of studies that looked at actuarial costs, CBO used data on the frequency with which a health plan covered certain benefits (those that fell under the mandates Gruber designated as expensive) even though the state in which the plan operated did not require such coverage. Those calculations suggest a range of 0.28 percent to 1.15 percent as the effective marginal cost of state mandates.

Compared with the evidence noted above, the work of other researchers indicates that mandates impose greater costs and exert much larger and statistically significant effects on coverage. Such studies suggest that firms' and workers' decisions about coverage are more sensitive to premiums than is typically assumed. For example, Marsteller and others found that a mandate to cover alcoholism or drug abuse treatments significantly reduced private insurance coverage by about 2.5

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1. Jonathan Gruber, "State-Mandated Benefits and Employer-Provided Health Insurance," *Journal of Public Economics,* vol. 55 (1994), pp. 433-464.

2. General Accounting Office, *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance*, GAO/HEHS-96-161 (August 1996).

percentage points.[3] And Jensen and Gabel's study of small firms indicated that about one-fifth to two-fifths of firms not offering coverage would do so if state mandates were eliminated.[4] Sloan and Conover analyzed individual-level data gathered from multiple states over time and concluded that removing the average number of benefit mandates would increase coverage by 4 percentage points—a figure suggesting that the lack of coverage for between one-fifth and one-fourth of the uninsured is attributable to benefit mandates.[5] The findings from Jensen and Gabel and Sloan and Conover are consistent with either or both of the following statements: firms' and workers' decisions about coverage are more sensitive to premiums than is generally assumed, and the marginal cost of mandates could be 10 percent or more.[6]

Savings from Group Purchasing Arrangements. As discussed earlier, CBO assumed that cost savings arising from the group purchasing feature of AHPs and HealthMarts would be negligible. The work of Long and Marquis supports that assumption; they found no substantial evidence that joining a purchasing cooperative produced lower insurance costs for firms.[7]

Coverage Changes in Response to a Change in the Price of Insurance. Elasticity of demand is a way of gauging responsiveness to price changes. For the estimates presented in the text, CBO assumed that the overall elasticity of demand for insurance through small firms is -1.1, meaning that an increase of 1 percent in the price of insurance will reduce coverage by 1.1 percent. That elasticity is larger than many researchers would typically use in evaluating the health insurance market in general. Nevertheless, studies focusing on the insurance-purchasing behavior of small firms suggest that an elasticity of that size is reasonable and that compared

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3. Jill A. Marsteller and others, *Variations in the Uninsured: State and County Level Analyses* (Washington, D.C.: Urban Institute, June 1998).

4. Gail A. Jensen and Jon R. Gabel, "State Mandated Benefits and the Small Firm's Decision to Offer Insurance," *Journal of Regulatory Economics*, vol. 4 (1992), pp. 379-404.

5. Frank A. Sloan and Christopher J. Conover, "Effects of State Reforms on Health Insurance Coverage of Adults," *Inquiry,* vol. 35 (Fall 1998), pp. 280-293.

6. Selecting the most "reasonable" assumption from among a wide range of empirical findings is not always an easy task. Yet models require such choices to produce estimates of effects. Other researchers besides CBO analysts have also had to make assumptions about the savings achieved through the exemption from state benefit mandates. In a recent study, for example, Blumberg, Nichols, and Liska developed a microsimulation model that required such an assumption. Like CBO, they reviewed the literature and chose to assume that AHPs and HealthMarts would save 5 percent as a result of the exemption. See Linda J. Blumberg, Len M. Nichols, and David Liska, *Choosing Employment-Based Health Insurance Arrangements: An Application of the Health Insurance Reform Simulation Model* (Washington, D.C.: Urban Institute, March 1999).

7. Stephen H. Long and M. Susan Marquis, "Pooled Purchasing: Who Are the Players?" *Health Affairs*, vol. 18, no. 4 (July/August 1999), pp. 105-111.

with large firms, small firms are significantly more responsive to changes in the price of insurance.

For example, Feldman and others analyzed decisions about coverage made by small firms in Minnesota and found elasticities that ranged from -3.9 to -5.8.[8] Blumberg, Nichols, and Liska used a more representative data set covering firms in 10 states and found that the smaller the firm, the greater its sensitivity to price.[9] They calculated elasticities of about -1.5 for firms with fewer than 10 workers. Jensen and Gabel studied losses in coverage as a result of mandates. On the basis of their findings, CBO estimated that if the costs to a firm for mandated benefits are 15 percent of premiums, then the elasticity of demand for coverage by small firms is about -1.8.[10] If mandates cost a firm less than 15 percent, the implication is that small firms are even more responsive to price changes than a -1.8 elasticity would indicate.

Studies that have examined the demand for health insurance more generally—that is, not restricting the analysis to small firms—have for the most part found less responsiveness. That viewpoint is illustrated by CBO's 1993 survey, which adopted an elasticity of -0.6.[11]

Insured Firms' Willingness to Switch to Less Expensive, Less Comprehensive Plans. CBO's model also required assumptions about the willingness of otherwise insured employees and employers to switch to less expensive, less comprehensive health benefits plans. For its main findings, CBO thus assumed that more than 20 percent of otherwise insured people would switch to an AHP or HealthMart plan in exchange for a premium reduction of 13 percent. High-cost firms and their employees were assumed to be only one-fourth as willing as low-cost firms to switch to a lower-priced but less comprehensive plan.

CBO considered the results of several empirical studies in developing its assumptions about this factor. For example, Buchmueller and Feldstein, who examined the willingness of employees to switch health plans in response to changes in premiums, found that a $10 increase in the monthly premium would cause about 26 percent of enrollees to switch to a less expensive plan, whereas an increase of

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8. Roger Feldman and others, "The Effect of Premiums on the Small Firm's Decision to Offer Health Insurance," *Journal of Human Resources,* vol. 32, no. 4 (Fall 1997), pp. 637-658.

9. Blumberg, Nichols, and Liska, *Choosing Employment-Based Health Insurance Arrangements*.

10. Jensen and Gabel, "State Mandated Benefits."

11. Congressional Budget Office, *Behavioral Assumptions for Estimating the Effects of Health Care Proposals*, CBO Memorandum (November 1993).

$20 per month would cause about 30 percent to switch.[12] Those findings are consistent with an assumption that a price discount of 15 percent relative to the price of a more comprehensive plan would cause about 26 percent of policyholders to switch, whereas a 30 percent discount would cause about 30 percent to switch. Morrisey and Jensen focused on small firms switching from fee-for-service plans to managed care plans in response to premium changes.[13] They found that a change of 10 percent in premiums would cause an increase of only about 3 percentage points in the fraction of firms switching plans. In its model, CBO used Buchmueller and Feldstein's results for its central assumption, but analysts reduced those results by their statistical margin of error to reflect the overall range of findings in the literature.

Differences in Costs for Low- and High-Cost Firms. CBO designated firms as either low or high cost depending on their average expected health expenses. For the main findings reported in the text, CBO defined low-cost firms as those with expected costs per enrollee in the lower 90 percent of the distribution of expected health costs among small firms; high-cost firms were those with costs in the highest 10 percent. CBO further assumed that low-cost and high-cost firms would be segregated in the AHP/HealthMart market because AHPs and HealthMarts face less sweeping availability requirements than those confronting insurers offering traditional plans. CBO chose to divide firms at the 90th percentile because of the skewed nature of expected health costs—relatively few firms have unusually high expected costs. Since small firms with high expected costs stand out in the distribution much more than do firms with low expected costs (which tend to cluster together toward the bottom), AHPs and HealthMarts could probably avoid enrolling those few least-healthy (high-cost) groups, but they would have difficulty limiting their enrollment only to the healthiest groups. Moreover, AHPs and HealthMarts would face association-wide or geographic availability requirements that would limit the degree of favorable selection they could achieve.

Direct data on the distribution of expected costs among small firms were not available, but since premiums reflect expected costs, CBO used data on premiums to estimate the distribution. CBO drew premium data for small firms from the late 1980s; its estimates are consistent with the results from Cutler's 1994 study of the small-group market, which was based on data from the early 1990s.[14] The advantage of using data from the late 1980s or early 1990s is that they predate the

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12. Thomas C. Buchmueller and Paul J. Feldstein, "The Effect of Price on Switching Among Health Plans," *Journal of Health Economics,* vol. 16 (1997), pp. 231-247.

13. Michael A. Morrisey and Gail A. Jensen, "Switching to Managed Care in the Small Employer Market," *Inquiry,* vol. 34 (Fall 1997), pp. 237-248.

14. David M. Cutler, *Market Failure in Small Group Health Insurance*, Working Paper 4879 (Cambridge, Mass.: National Bureau of Economic Research, October 1994).

widespread introduction of premium compression laws by the states (which reduce the variation in premiums relative to the variation in expected costs). More recent data on premiums would have reflected the laws' effects and would therefore be less accurate in indicating how expected costs were dispersed among firms. Under CBO's definitions of low- and high-cost firms, the data indicate that average annual expected health costs per enrollee would be $1,810 for low-cost firms and $4,200 for high-cost firms.

Premium Reductions in the AHP/HealthMart Market from Avoiding Rate Compres-sion. Under the proposed legislation, AHPs and HealthMarts would face different availability rules than those applying to insurers offering traditional plans. As a result, low-cost firms purchasing coverage through AHPs and HealthMarts could obtain lower premiums (in addition to the reduction stemming from the benefit mandates exemption) because state premium compression rules would exert less of an upward effect. Premium compression laws differ among the states. To simplify the analysis, CBO assumed that on average, the state rules allowed premiums to vary around a 20 percent band. It also assumed that low-cost firms switching to AHPs or HealthMarts would pay premiums that reflected only the expected costs of low-cost firms.

Several studies have found that overall, premium compression rules decrease coverage. Marsteller and others found a decrease in private coverage of 1 percentage point when premium compression laws were imposed on the small-group market.[15] CBO estimated that the drop in coverage reported in the Marsteller study would translate into a loss of approximately 2.3 million enrollees (in 1999 population figures). Simon's study of insurance coverage using a nationally representative sample and the microsimulation study by Buchanan and Marquis also support the finding of a significant loss in coverage as a result of premium compression laws.[16] In contrast, Sloan and Conover found no significant effect on coverage in the small-group market.[17] Buchmueller and DiNardo found no effect on coverage but noted a switch from fee-for-service plans to managed care plans in response to premium compression rules.[18]

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15. Marsteller and others, *Variations in the Uninsured*.

16. Kosali I. Simon, "Did Small-Group Health Insurance Reforms Work? Evidence from the March Current Population Survey, 1992-1997" (draft, Department of Economics, University of Maryland, March 1999); and Joan L. Buchanan and M. Susan Marquis, "Who Gains and Who Loses with Community Rating for Small Business?" *Inquiry*, vol. 36 (Spring 1999), pp. 30-43.

17. Sloan and Conover, "Effects of State Reforms on Health Insurance Coverage of Adults."

18. Thomas Buchmueller and John DiNardo, *Did Community Rating Induce an Adverse Selection Death Spiral? Evidence from New York, Pennsylvania, and Connecticut*, Working Paper 6872 (Cambridge, Mass.: National Bureau of Economic Research, January 1999).

A decrease in coverage stemming from premium compression laws can occur if low-cost firms and their employees, in deciding to buy coverage, are more sensitive to changes in premiums than are high-cost firms. On the basis of the above studies, CBO assumed for its main estimates that low-cost and high-cost firms have different elasticities of demand for coverage and, as a result, that prevailing rate compression laws are responsible for 1.7 million fewer people having health insurance.

Sensitivity of the Estimates to Alternative Assumptions

As the preceding discussion suggests, the range of estimates in the economics literature for some of the key assumptions in CBO's model is quite large. The findings from the model that are reported in the text are based on assumptions that tend to fall near the middle of those ranges. To test the sensitivity of CBO's estimates to those assumptions, analysts reestimated the model using plausible upper and lower bounds. (The parameters used in the alternative assumptions fall short of the most extreme estimates in the literature when those extremes are clearly unreasonable.)

CBO used the following ranges of alternative assumptions in testing the model's sensitivity:

- Savings achieved through exemption from state benefit mandates—1 percent to 15 percent of premiums;

- Coverage changes in response to a change in the price of insurance —elasticities of -0.6 to -1.8;

- Insured firms' willingness to switch to less expensive, less comprehensive coverage:

  - For the lower bound, about 3 percent of otherwise insured employees would switch for a 10 percent reduction in price;

  - For the upper bound, about 28 percent would switch in response to a 25 percent savings in premiums; and

- Degree of favorable selection in the AHP/HealthMart market (which relates to cost differences between firms with healthy employees and sicker employees and to reductions in premiums from avoiding rate compression):

- For the lower bound, AHPs and HealthMarts would avoid enrolling firms with expected costs in the top 10 percent of the expected cost distribution of small firms (this is the assumption CBO used to generate the model's main findings, discussed earlier); and

- For the upper bound, AHPs and HealthMarts could avoid enrolling firms with expected costs in the top 20 percent of the cost distribution.

For all estimates, CBO maintained the assumption of no net savings arising from the economies of group purchasing.

Lower-Bound Estimates. Establishing AHPs and HealthMarts would have a minimal impact on coverage and premiums under the following conditions: the potential for mandate savings is small, AHPs and HealthMarts can achieve only modest favorable- selection effects, rate compression laws have no effect on coverage, and firms are minimally responsive to changes in premiums and unwilling for the most part to switch to less expensive, less comprehensive coverage. In those circumstances, the net increase in coverage among low-cost firms would be small (representing an increase of about 10,000 enrollees), and relatively few firms (representing 700,000 enrollees) would be covered through AHPs or HealthMarts, despite the somewhat lower premium costs (see Table A-1). Total premiums paid by small firms would decrease only slightly because the number of people covered by insurance would change very little (see Table A-2). For people who already had coverage, the net effect on total premiums would be only a slight drop because some people would switch to coverage that omitted some mandated benefits. Average premiums for firms that participated in the new AHP/HealthMart market would be only 9 percent lower than they would have been for traditional coverage in the absence of any regulatory changes (see Table A-3). Premiums for firms that retained traditional coverage would increase by less than 0.5 percent.

Upper-Bound Estimates. AHPs and HealthMarts would have the largest effects in the following circumstances: the potential for mandate savings is great, AHPs and HealthMarts are able to achieve a substantial degree of favorable selection, and firms respond strongly to changes in premiums and are more willing to switch to less expensive, less comprehensive coverage. Under those assumptions, coverage in the small-group market would increase by almost 8 percent (about 2 million people), with low-cost firms adding about 2.1 million people to coverage and high-cost firms reducing coverage by about 100,000. In that case, total premiums paid by small firms and their employees would increase by about $1.8 billion, or about 3.6 percent. That relatively large increase occurs because this scenario is based on assumptions that give an upper-bound increase in coverage. The almost $3.1 billion in total premiums paid for employees and their dependents who become covered by an

employer-sponsored plan exceeds the reductions that would occur as some high-cost groups dropped coverage and some firms and enrollees that were already covered switched to the new, lower-priced plans. The price of a policy for firms desiring traditional coverage would increase by 2 percent, and firms switching to the AHP/HealthMart market would pay premiums that were 25 percent lower than they would otherwise have been.

TABLE A-1. ESTIMATED LOWER AND UPPER BOUNDS OF EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON COVERAGE IN THE SMALL-GROUP HEALTH INSURANCE MARKET

| | Number of Enrollees[a] | |
|---|---|---|
| | Lower-Bound Effect | Upper-Bound Effect |
| Coverage Under Current Law (Millions) | 24.6 | 24.6 |
| Changes When AHPs and HealthMarts Are in Full Operation | | |
| Low-cost firms[b] | 10,000 | 2,130,000 |
| High-cost firms[c] | d | -100,000 |
| Total | 10,000 | 2,030,000 |
| Coverage When AHPs and HealthMarts Are in Full Operation (Millions) | | |
| AHP or HealthMart plans | 0.7 | 5.7 |
| Traditional plans[e] | 23.9 | 20.9 |
| Total | 24.6 | 26.6 |

SOURCE: Congressional Budget Office.

NOTE: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

a. Workers and their insured dependents. However, these figures exclude an estimated 1.3 million people who participate in self-insured employer-sponsored plans under current law.

b. For the lower-bound effect, low-cost firms are those with expected health costs in the lower 90 percent of the cost distribution. For the upper-bound effect, low-cost firms are those in the lower 80 percent.

c. For the lower-bound effect, high-cost firms are those with expected health costs in the upper 10 percent of the cost distribution. For the upper-bound effect, high-cost firms are those in the upper 20 percent.

d. Decrease of less than 5,000.

e. Subject to full state regulation.

TABLE A-2. ESTIMATED LOWER AND UPPER BOUNDS OF ANNUAL EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON TOTAL PREMIUMS IN THE SMALL-GROUP HEALTH INSURANCE MARKET

| | Millions of Dollars | |
|---|---|---|
| | Lower-Bound Effect | Upper-Bound Effect |
| Total Premiums Under Current Law | 50,400 | 50,400 |
| Changes When AHPs and HealthMarts Are in Full Operation | | |
| Premium savings from net enrollee movement to AHPs and HealthMarts | -100 | -1,900 |
| Increased premiums for firms covered under traditional plans[a] | 100 | 900 |
| Net increase in coverage among low-cost firms[b] | c | 3,050 |
| Net decrease in coverage among high-cost firms[d] | e | -250 |
| Total | e | 1,800 |
| Total Premiums When AHPs and HealthMarts Are in Full Operation | 50,400 | 52,200 |

SOURCE: Congressional Budget Office.

NOTES: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

The term “enrollee” includes workers and their insured dependents but excludes an estimated 1.3 million people who participate in self-insured employer-sponsored plans under current law.

a. Traditional plans are subject to full state regulation.

b. For the lower-bound effect, low-cost firms are those with expected health costs in the lower 90 percent of the cost distribution. For the upper-bound effect, low-cost firms are those in the lower 80 percent.

c. Increase of less than $25 million.

d. For the lower-bound effect, high-cost firms are those with expected health costs in the upper 10 percent of the cost distribution. For the upper-bound effect, high-cost firms are those in the upper 20 percent.

e. Decrease of less than $25 million.

TABLE A-3. ESTIMATED LOWER AND UPPER BOUNDS OF EFFECTS OF ASSOCIATION HEALTH PLANS AND HEALTHMARTS ON AVERAGE PREMIUMS IN THE SMALL-GROUP HEALTH INSURANCE MARKET

| | Percentage | |
|---|---|---|
| | Lower-Bound Effect | Upper-Bound Effect |
| Change in the Average Premium Paid by Firms That Participate in AHPs or HealthMarts | -9 | -25 |
| Change in the Average Premium Paid by Firms That Retain Traditional Coverage[a] | b | 2 |

SOURCE: Congressional Budget Office.

NOTES: All figures refer to health insurance coverage obtained through private-sector for-profit and not-for-profit firms with 50 or fewer employees.

Changes are calculated relative to premiums under current law.

a. Traditional coverage is subject to full state regulation.

b. Increase of less than 0.5 percent.