CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

April 8, 2005

H.R. 525
Small Business Health Fairness Act of 2005

As ordered reported by the House Committee on Education and the Workforce on March 16, 2005

SUMMARY

H.R. 525 would establish a regulatory framework and certification process for association health plans (AHPs). AHPs could be established by trade, industry, and professional associations as a vehicle for providing health care benefits to employees of businesses that are association members. AHPs would not, in general, have to offer coverage of state-mandated benefits and would be subject in a limited way to state rules that compress health insurance premiums across a state's small group market. Many firms would be able to pay lower health insurance premiums by purchasing such coverage through AHPs rather than through the traditional small employer health insurance market, where premiums would reflect the full extent of state insurance regulations. (Self-employed individuals also would be able to purchase coverage through AHPs; this analysis of H.R. 525 includes the impact of AHPs on the health insurance market for the self-employed.)

Because AHPs would be a vehicle for providing health care benefits to workers and such benefits are excluded from taxable income, enacting H.R. 525 could affect federal tax revenues by changing the share of employee compensation furnished as tax-excluded health benefits as opposed to taxable wages and salaries. CBO estimates that H.R. 525 would increase total spending on employer-sponsored health insurance, and, as a result, reduce federal tax revenues. As a result, CBO estimates that enacting H.R. 525 would decrease federal revenues by $3 million in 2006, by $71 million over the 2006-2010 period, and by $261 million over the 2006-2015 period. About $76 million of the 10-year revenue loss would be in off-budget Social Security payroll taxes.

By expanding private health insurance coverage to small business employees and their dependents, H.R. 525 would decrease enrollment in the Medicaid program. The bill also would cause some individuals to lose employer coverage and to enroll in Medicaid. CBO

estimates that the bill would reduce net federal spending for Medicaid by $1 million in 2006, by $24 million over the 2006-2010 period, and by $80 million over the 2006-2015 period.

H.R. 525 also would require additional spending for administration and regulatory activities by the Department of Labor (DoL). CBO estimates that DoL would hire 150 workers over the next three years to regulate the AHP market and certify AHPs, beginning in 2006. We estimate that implementing this provision would cost $4 million in 2006, $55 million over the 2006-2010 period, and $136 million over the 2006-2015 period, assuming the appropriation of the necessary amounts.

H.R. 525 would preempt a number of state laws that regulate health coverage, including the ability of states to tax existing entities that become certified as association health plans; those preemptions would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). The preemptions of state regulatory laws would limit the exercise of state authority and preclude the application of state laws, but would not result in additional costs to state, local, or tribal governments. Limitations on state taxing authority, however, would result in a net decrease in state revenues of over $25 million in 2006. As a greater number of the uninsured became insured through association plans, states would, over time, realize a net increase in revenues due to the new taxing authority. By 2010, that increase would total about $10 million. The losses that states would face in the early years would not exceed the statutory threshold established in UMRA ($62 million in 2005, adjusted annually for inflation). The effects of the bill on Medicaid would result in savings to states of $18 million over the 2006-2010 period and $60 million over the 2006-2015 period.

H.R. 525 contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 525 is shown in the following table. The effects of this legislation fall within budget functions 550 (health) and 600 (income security). This estimate assumes that H.R. 525 would be enacted by October 1, 2005.

	By Fiscal Year, in Millions of Dollars									
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
CHANGES IN REVENUES										
Income and HI Payroll Taxes (on-budget)	-2	-5	-9	-14	-19	-23	-25	-27	-29	-32
Social Security Payroll Taxes (off-budget)	-1	-2	-4	-6	-8	-9	-10	-11	-12	-13
Total Changes in Revenues	-3	-8	-13	-20	-27	-32	-35	-38	-41	-44
CHANGES IN DIRECT SPENDING										
Estimated Budget Authority	-1	-3	-5	-7	-9	-9	-10	-11	-12	-13
Estimated Outlays	-1	-3	-5	-7	-9	-9	-10	-11	-12	-13
CHANGES IN SPENDING SUBJECT TO APPROPRIATION										
Estimated Authorization Level	4	9	14	14	15	15	16	16	17	17
Estimated Outlays	4	9	14	14	15	15	16	16	17	17

Note: HI = Hospital Insurance (Part A of Medicare).

BASIS OF ESTIMATE

H.R. 525 would allow organizations such as trade, industry, and professional associations and chambers of commerce to sponsor association health plans for their members and affiliated members. These entities, which would be certified and regulated by DoL, could provide a range of health insurance options to employers under different sets of rules than apply to insurers or other health plan arrangements that fall under state insurance regulation. In general, an AHP would not have to comply with state benefit requirements and would not be subject to statewide availability rules, although it would have to make its plans available to all members of its sponsoring association.

AHPs could offer both fully-insured health insurance plans (products issued by a state-licensed insurance carrier) and, subject to certain limitations, self-insured plans. An AHP could offer the same fully-insured plans to member firms of its sponsoring association in any state; it would only have to obtain plan approval in the original state in which it filed. (It also would have to comply with the original state's laws mandating coverage of certain diseases.) All other states would be obligated to accept that approved plan. The bill would not exempt health insurance carriers offering AHP coverage from state licensing requirements and other state laws regulating health insurance except to the extent that the laws and regulations would effectively preclude the AHP from offering coverage in that state.

State laws regulating premiums would affect AHPs differently than they would carriers in the traditional small group health insurance market. In general, fully-insured AHP plans would have to abide by the premium-setting regulations of each state for their member firms that reside 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 firms despite variations in those firms' expected costs per enrollee). Other states limit the degree to which premiums for a particular policy can vary among firms. Fully-insured AHP plans 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 the association's member firms—not on the costs of the broader (and potentially more expensive) groups that insurers offering traditional coverage must serve under availability rules that apply to the traditional small group market.

Self-insured plans offered by AHPs would not be subject to state insurance regulations. To offer such coverage, AHPs would follow a certification process with the Department of Labor. The requirements for certification include meeting certain solvency standards and paying $5,000 annually into a fund, which would be used by the Secretary of Labor to maintain in force excess stop-loss insurance coverage or indemnification insurance coverage to ensure payment of the health care claims of self-insured AHPs that became insolvent. AHPs would be restricted from varying premiums on the basis of health status (or industry) except to the extent allowed by each state's premium-setting rules for coverage offered through associations. In any case, such AHPs could charge different premiums to different employers on the basis of factors other than health status and industry.

CBO's estimate of H.R. 525 used an analytical model designed to simulate how small firms and their employees would respond to the introduction of AHPs.[1] The model incorporates assumptions that characterize economic behavior in the small group health insurance market. Those assumptions include the responsiveness of firms and their employees to changes in the price and quality of health insurance, the variation of health insurance premiums likely to occur in the AHP market compared with premium variation as it exists today in the regulated market for small-group health insurance, savings arising from the exemption from state-mandated benefits, and administrative cost savings that could be achieved by spreading fixed costs over more enrollees.

CBO estimates that, by 2010, when the legislation is assumed to have its full impact, about 620,000 more people (including employees and their dependents) would be insured through small employers than would be insured under current law. In total, about 8.5 million people would obtain health insurance through association health plans. However, under current law,

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1. See Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts*, CBO Paper, January 2000.

most of those AHP enrollees would have been insured in the state-regulated market rather than being uninsured. CBO also estimates that about 10,000 people would lose coverage in response to rising premiums in the small-group market.

Effects on Federal Revenues

The bill would reduce federal tax revenues because the share of employee compensation paid in the form of taxable wages and salaries would decrease as employers and employees spent more on tax-excluded health benefits. That increase in net spending on health benefits is the result of several factors that move in different directions. In general, spending on health benefits would decline for firms that switched from coverage purchased in the traditional, state-regulated market to AHP coverage due to savings from the exemption from requiring certain benefits, and from administrative savings. Eligible firms could attain additional premium savings by joining an AHP whose members had lower average costs than those of the insurance pools existing in the state-regulated market.

As relatively low-cost firms are attracted to the new AHP market, the average costs and thus the premiums facing firms in the state-regulated market would increase. In general, firms that remained in the state-regulated market would spend more on health benefits under the proposal while firms that dropped coverage in response to those premium increases would spend less on health coverage. Since AHPs would offer lower premiums, on average, than did state-regulated insurers, some otherwise-uninsured firms would become covered through AHPs. For those firms, spending on tax-excluded health benefits would increase (since they would have spent nothing on health insurance in the absence of AHPs).

CBO estimates that the net effect of those various changes would be a small increase in total spending by employers on employer-sponsored health insurance. Since the composition of the total compensation packages of employees would shift toward nontaxable health benefits and away from taxable wages and salaries, CBO estimates that total federal revenues would decrease by $3 million in 2006, by $71 million over the 2006-2010 period, and by $261 million over the 2006-2015 period. Social Security receipts, which are off-budget, would account for about 30 percent of that total.

The size and direction of the predicted change in employer spending on health insurance are sensitive to assumptions about the health insurance purchasing behavior of small firms. If fewer uninsured firms picked up coverage for their employees through the existence of AHPs than CBO has estimated, federal revenues could actually increase because aggregate spending by employers on health insurance could fall as otherwise-insured employees switched to lower-cost AHPs. Alternatively, if more otherwise-uninsured firms become covered by AHPs than CBO has estimated, the decline in federal revenues would be larger

than projected because even more employer compensation would take the form of tax-excluded health care benefits.

Effects on Medicaid Spending

Because H.R. 525 would increase (on net) the number of people with employer-sponsored insurance, it would affect the number of people who enroll in Medicaid. Some people who would lose employer-sponsored health insurance would enroll in Medicaid, whereas others who, under current law, would be covered by Medicaid would instead enroll in health insurance offered by AHPs. On net, CBO estimates that enacting H.R. 525 would reduce spending in the Medicaid program by $1 million in 2006, by $24 million over the 2006-2010 period, and by $80 million over the 2006-2015 period.

Medicaid spending for people who lose private coverage. About one-third of employees in small firms are in families with incomes under 200 percent of the Federal Poverty Line (FPL). Many children and some adults in families with incomes below 200 percent of the FPL are eligible for Medicaid. CBO estimates that about 40 percent of people losing employer-sponsored coverage would be under 200 percent of the FPL, and about one-eighth of them would enroll in Medicaid. CBO assumes that those people would be somewhat more costly than the average Medicaid-eligible individual, and that federal spending for Medicaid would increase by about $38 million over the 2006-2015 period.

Medicaid savings for people who gain private coverage. Of the people gaining employer-sponsored insurance via AHPs under H.R. 525, CBO estimates that approximately 10 percent would be under 200 percent of the FPL. Of these, about 40 percent are children and 60 percent are adults. About one-third of those children would otherwise be enrolled in Medicaid, and about 8 percent of adults would otherwise be enrolled in Medicaid, CBO estimates. Assuming that those children and adults would be less costly than average, implementing H.R. 525 would decrease federal Medicaid spending by $118 million over the 2006-2015 period as a result of this shift to private health insurance coverage.

Spending Subject to Appropriation

The bill also would require additional spending for administration and regulatory activities, subject to appropriation of the necessary amounts. CBO assumes that DoL would hire an additional 150 workers over the next three years to certify AHPs and to regulate the AHP market, beginning in 2006. CBO estimates that DoL would need about 125 employees at the GS-12 level (on average) to implement and regulate the program and about 25 support staff. We estimate that implementing this provision would cost $4 million in 2006, $55 million

over the 2006-2010 period, and $136 million over the 2006-2015 period, assuming the appropriation of the necessary amounts.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 525 would preempt state laws that would limit an AHP's ability to determine which services or items are part of their package of health benefits. (A law in the state in which an AHP initially filed its policy for approval that prohibits the exclusion of specific diseases would still apply, as would requirements in the Employee Retirement Income Security Act governing minimum maternity stays, mental health benefits, and reconstructive surgery following mastectomies). The bill also would preclude states from regulating reserve levels, contribution amounts, and trusts of AHPs. Those preemptions would not result in additional costs to state, local, or tribal governments, but because they would limit the exercise of state authority and preclude the application of state laws, they would be intergovernmental mandates as defined in UMRA.

H.R. 525 also would limit the ability of states to tax association health plans that operated before the enactment of the bill, while allowing states to levy a contribution tax, similar to a premium tax, on new AHPs. On the one hand, state contribution taxes on new AHPs that become certified under the bill would increase state tax collections to the extent that those AHPs provide coverage to individuals who were previously uninsured. On the other hand, some existing multiple employer welfare arrangements (MEWAs) could become certified to operate as AHPs, and it is not clear that states would be able to collect contribution taxes from them. Some states currently levy taxes on MEWAs, so if they were unable to collect the contribution tax from MEWAs that became certified AHPs, their tax revenues would decrease.

The combination of these changes would have mixed effects on state tax collections, and CBO estimates that the effect would be a net decrease in state revenues in the early years after enactment, and a net increase in state revenues in later years. CBO estimates that state revenues would decrease by over $25 million in 2006, but as a greater number of the uninsured became insured through association plans, states would realize a net increase in revenues due to the contribution tax totaling about $10 million in 2010. The losses that states would face in the early years would not exceed the statutory threshold established in UMRA ($62 million in 2005, adjusted annually for inflation).

The effects of the bill on Medicaid would result in estimated savings to states of $18 million over the 2006-2010 period and $60 million over the 2006-2015 period.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

This bill contains no private-sector mandates as defined in UMRA.

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