

Small Business Pooling Arrangements and Association Health Plans

**American College of Physicians
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A Policy Monograph of the
American College of Physicians

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Introduction

Lack of health insurance in America is due, in large part, to an inadequate health insurance market for small employers. Of the now roughly 44 million Americans without health insurance, over 80 percent come from working families, 50 percent of which are either self-employed or work for businesses with fewer than 25 employees.¹ As employers continue to scale back coverage in response to increasing premiums and inflating health care costs, Congress has turned its attention to small businesses, which are particularly vulnerable to the rising cost of health care. One proposal that has gained support is federal encouragement of association health plans (AHPs). Under this proposal, bona fide trade, industry, and professional associations that have been in existence for at least three years for purposes other than providing health insurance would be permitted to offer federally licensed health insurance plans to the small businesses they represent. The plans would be exempt from the state insurance regulations under which they now operate. The intent is to allow small businesses to pool their resources in order to purchase affordable coverage. However, placing these arrangements under federal regulation would exempt them from critical consumer protections and other standards enacted by states to stabilize the health insurance market and address the issue of the uninsured.

The American College of Physicians, representing 116,000 physicians who specialize in internal medicine and medical students, has a longstanding history of advocating for reforms to provide all Americans with access to health insurance coverage. ACP urges all elected leaders and policymakers to focus their attention on the documented problems of uninsured Americans to ensure that all Americans benefit from the provision of health insurance.

With the publication of a series of white papers on the effects of a lack of health insurance,² ACP advances to the next step: searching for a solution. Various proposals exist on how to increase the number of insured Americans. ACP's core principles on access (see end of paper for an abridged version),³ approved by the Board of Regents in October 2000, can serve as a guideline to evaluate these proposals.⁴

In earlier monographs, ACP examined the effectiveness of a variety of strategies to reduce the number of uninsured Americans. These included an expansion of Medicaid and the State Children's Health Insurance Program (SCHIP);⁵ a move toward a system of individually purchased and owned health insurance as an alternative to employer-sponsored insurance;⁶ and the use of health insurance tax credits.⁷ These analyses helped ACP formulate a comprehensive plan that would enable all Americans to have access to affordable health insurance coverage within seven years.⁸ The proposal calls for a combination of measures that build on the nation's public and private health care systems, including expanding Medicaid and SCHIP, providing government-sponsored premium subsidies, and establishing new state programs.

In this monograph, ACP examines association health plans and other pooling arrangements that make health insurance more affordable for small businesses. In 1996, ACP published a similar position paper entitled, "Voluntary Purchasing Pools: A Market Model for Improving Access, Quality, and Cost in Health Care."⁹ Although the paper does not focus specifically on small businesses, and recommendations are made in the context of managed care, it describes how a system of voluntary purchasing pools should be designed. ACP's proposed framework, "Achieving Affordable Health Insurance Coverage for All within Seven Years,"¹⁰ also describes ACP's vision of the role of purchasing pools, including conditions of participation for qualified health plans and beneficiaries. The recommendations outlined in these two earlier papers continue to represent

current College policy and should be referenced as a supplemental information source when reading this paper.

The design and implementation of any pooling arrangement for small businesses determines how effective it is at reducing the number of uninsured Americans. This monograph weighs the structural components of small business pooling arrangements against ACP's core principles on access to determine how effective such policies are at reducing the number of uninsured Americans

Background

Although most employees in the U.S. receive health coverage through their employers, the rising cost of health insurance is making it more difficult for businesses to offer their employees health benefits. The Bureau of Labor Statistics reports that the sharpest decline in health care coverage was for full-time workers in the private sector for which the percentage covered by employer-sponsored plans dropped from 80 percent in 1989-1990 to 56 percent in 2003.¹¹

Small businesses are especially sensitive to rising health care costs, primarily due to their size. Small businesses do not have a considerable pool of employees through which to spread risk and thus find it very difficult to afford to cover employees. With a smaller pool of employees, total expected claims are less predictable and less stable than large businesses. If an employee unexpectedly incurs a high medical expense, such as diagnosis of a chronic disease, the rise in insurance costs would weigh much more heavily upon a small business relative to a larger firm and would most likely result in premium increases for experience-rated employees. Experience rating, a projection of future losses using the employer's past claims history, is common among small business owners to protect against such events. Employee turnover rates in small businesses are also relatively high, which reduces the stability of the risk pool and makes an employer providing health benefits more vulnerable to the effects of adverse risk selection.¹²

Administrative costs are also higher for small businesses, since they lack the economies of scale present in larger businesses. According to the Congressional Budget Office (CBO), overhead costs for providing insurance can be over 30 percent of the premium costs for businesses with fewer than 10 employees, compared with about 12 percent for businesses with more than 500 employees.¹³ Size also limits the ability of small businesses to negotiate with insurers and to offer a choice of plans to employees. The large number of individuals employed by a large employer gives the employer substantial bargaining power with insurers and providers, allows for custom-tailored coverage, and keeps administrative costs per worker relatively low.¹⁴

As a result of these impediments, small businesses pay the highest premiums for employee health care coverage and experience the largest annual premium increases. In 2004, health insurance premiums in general rose by double digits for the fourth year in a row. Small business health insurance premiums grew 11.5 percent, to \$3,732 for single coverage, while large businesses experienced an 11.1 percent increase in premiums, bringing the cost of single coverage to \$3,678.¹⁵ According to Kate Sullivan Hare, the Executive Director of Health Care Policy for the U.S. Chamber of Commerce, the same family coverage, which costs a small business almost \$10,000 today, cost about \$4,500 six years ago.¹⁶ Two-thirds of U.S. small businesses now believe that health insurance costs have become a "critical problem," up from 47 percent in 2001, according to the National Federation of Independent Business.¹⁷

But simple premium comparisons, alone, do not capture the full range of obstacles faced by small businesses. Small businesses also are less likely to offer

employee health coverage, unable to offer as wide a range of coverage, and unable to cover as great of a share of the premium as larger businesses. For example, premium data do not reflect differences in offer rates, cost-sharing, or covered benefits between small and large firms. In 2003, 95 percent of businesses with 50 to 199 employees offered health benefits compared to 55 percent of businesses with 3 to 9 workers.¹⁸ “High premiums” was the reason cited by 68 percent of all companies with fewer than 200 employees that did not offer coverage.¹⁹

Even when workers in small businesses are offered coverage, they typically must pay a greater share of their health care costs compared to public employees and workers in large national companies.²⁰ Among the small businesses that offered coverage in 2003, nearly one-third provided less than a 50 percent subsidy for the cost of family coverage,²¹ causing many employees to forgo coverage. Deductibles also tend to be higher and are growing at a faster rate for small firm versus large firm employees across all types of plans.²² From 2000 to 2003, deductibles among small businesses doubled in preferred provider organization plans (PPO) when employees used in-network providers and increased 131 percent when they used out-of-network providers. For large businesses, deductibles rose only 33 percent when employees stayed in-network and 44 percent when employees sought care outside of the network.²³ In 2004, small business employees enrolled in PPOs had an annual deductible of \$420 for a preferred provider, compared to a \$232 average deductible for large business employees. Small business employees who used non-preferred providers had an average deductible of \$676, while large business employees only had a \$510 deductible if they went out-of-network.²⁴

Premiums also tend to bring fewer benefits to the workers of small businesses. An analysis of different sized businesses with comparable premiums found that 87 percent of workers in large firms were offered dental coverage, while only 57 percent of workers in small firms were offered the same.²⁵ One hundred percent of employees in large firms had access to prenatal benefits, compared to only 93 percent of employees in small firms.²⁶

The end result is that small business employees are more likely than other workers to lack health insurance. About 26 percent of self-employed workers are uninsured and nearly one-third (31 percent) of all workers in businesses with fewer than 25 employees are uninsured. Meanwhile, only 12 percent of workers in firms with 1,000 or more employees lack insurance.²⁷

Consequently, even when small businesses offer coverage, the quality is often not as high as that of large employers. Small businesses also tend to employ lower-income workers who have low marginal tax rates and therefore do not benefit nearly as much as higher-income individuals from the tax breaks associated with employer-sponsored coverage.²⁸

Pooling Proposals for Small Businesses

Federal law does not require that any business offer health coverage or require coverage of specific benefits. Employers that choose to provide health coverage to their employees have the option of purchasing insurance policies or using their own funds to pay for employees' health care costs directly rather than passing them along to an insurance company, a practice known as self-funding. Most small businesses cannot afford the risk of self-insurance and can only purchase coverage from state-regulated insurance companies.²⁹ Larger businesses, however, often choose to self-fund employee health coverage. A major advantage of self-funding is that the health plan is then governed by a relatively simple set of federal regulations set forth in the Employee Retirement Income Security Act (ERISA), which overrides state laws and regulations.³⁰

ERISA was originally enacted to address irregularities in the administration of certain large pension plans and to set minimum standards to protect workers under these and other benefit plans. However, multiple court rulings made since the law's enactment have led critics to contend that ERISA has accomplished the very opposite by replacing critical state laws that once protected workers' rights to benefits. In 2000, for example, in the case *Pegram v. Herdrich*, the U.S. Supreme Court issued a decision which significantly limited the right of an employee to sue a health maintenance organization (HMO) under ERISA.³¹

To even the playing field for small businesses, policymakers and legislators have suggested the formation of group insurance, which would essentially mimic the large pools of employees available to the biggest employers.³² On May 13, 2004, the U.S. House of Representatives passed for the second time in the 108th Congress the *Small Business Health Fairness Act* (H.R.4281), which would allow small businesses to band together across state lines, in what are known as association health plans (AHPs), to purchase health insurance. By grouping together small trade and professional association members, the legislation aims to help small businesses negotiate lower rates for health insurance. Under existing law, small employers may come together to purchase health insurance in what is known as a Multiple Employer Welfare Arrangement (MEWA). MEWAs must comply with certain federal requirements, but are generally subject to state regulation. The AHP legislation differs from MEWAs in that it would federalize the regulation of AHPs by eliminating state authority to regulate these arrangements. Instead, AHPs would be subject to ERISA and regulated by the U.S. Department of Labor (DOL). The legislation would also give associations the option of self-insuring or buying fully insured coverage.

Despite the attention paid to AHPs, the proposal faces an uphill battle in the 108th Congress. Amendments offered during floor consideration of the *Small Business Health Fairness Act* reflected many of the concerns raised by opponents. The bulk of these amendments recommended targeted federal preemption of state insurance requirements—such as requiring AHPs to comply with state coverage mandates for various health conditions and preventive screenings and to adhere to state laws concerning prompt payment of claims and external review of coverage decisions—as an alternative to AHPs.³³

Still others suggested either expanding the Federal Employees Health Benefits Program (FEHBP) to include non-federal, small-business employees or creating a small business health insurance pool run by the federal government and mirroring the FEHBP that would enable small businesses to buy into pooled health insurance coverage with the aid of federal subsidies.³⁴ All of these alternative proposals were defeated.

ACP has supported the concept of voluntary, federally supported state purchasing pools, paired with tax relief, as part of its seven-year plan to extend

health care coverage to all Americans. The plan, as reflected in the *Health Coverage, Affordability, Responsibility and Equity Act of 2003* (HealthCARE Act) (S.1030/H.R. 2402), combines tax credits with state purchasing pools to provide a means for small businesses to band together to purchase coverage comparable to that available under the FEHBP. ACP views this idea as an incremental mechanism for expanding access to small groups and individual persons, reducing administrative costs, and maintaining quality in the marketplace.³⁵

Some state governments have begun to experiment with FEHBP-style purchasing groups. In July 2004, Indiana Gov. Joe Kernan (D) announced plans to create a statewide health care insurance pool by the end of 2005 for employees of small businesses, people who are self-employed and other uninsured residents. Under the plan, state officials would organize the pool, find a vendor and negotiate rates. Premiums would be paid by the small businesses and individuals who receive coverage. Although officials have not decided how much businesses and individuals would have to pay for coverage or what services would be covered, the Governor stated that he would consider a plan that does not cover all the services currently mandated by state law.³⁶

Other proposals call for allowing small businesses to join existing state employee pools. In many states, the single largest employer is the state itself. Therefore, states are often able to offer their employees a choice of plans and competitive rates that are rarely available to small firms. While it would be fairly easy to allow small businesses to bring their employees into the state pool, state employees fear that the pool would attract the sicker employees of small businesses, thereby posing a risk to the pool. Supporters of the proposal claim that the likelihood of that happening is low, since state employees often tend to be older and sicker than workers in general.³⁷

Any group purchasing arrangement, whether it be allowing small businesses to buy into state or federal employee plans or even into the Medicaid program, could in theory lower the administrative costs per worker that now drive small business premiums so high.³⁸ Intermediaries, such as groups of churches, trade unions, farm bureaus, and credit unions also can serve as negotiators with insurance companies on behalf of members.

The Argument for AHPs

According to proponents, AHPs would extend to small businesses the economies of scale that currently exist for larger businesses and unions, resulting in marketing efficiencies and reduced administrative costs. In the small group and individual insurance market, one-fourth to one-third of every premium dollar is currently spent on administrative costs, including premium taxes, commissions, and compliance costs. Large, self-funded employers are exempt from many of these costs and can spend as little as five percent of every premium dollar on such costs.³⁹ As part of an association, small businesses would also benefit from increased bargaining power with health care providers, while employees would experience an expanded choice of benefit plans.

The Congressional Budget Office (CBO) has estimated that small businesses that obtain insurance through AHPs could experience premium reductions of up to 25 percent (13 percent on average).⁴⁰ The CBO also concluded that AHPs could cover as many as 4.6 million Americans with no extra cost to the government, but that only about 330,000 of them would be people who did not already have health insurance.⁴¹

Proponents also tout the ease with which AHPs would be able to operate. Rather than having to comply with the disparate regulations of 50 states,

including a plethora of varying mandated benefit laws, associations would be subject to uniform federal insurance regulations that would be identical for each member company. The more than 1,500 separate mandated health benefit laws passed by states often confuse employers, who currently must comply with state mandates if they provide employee health insurance. Even the number of mandated benefit laws varies substantially from state to state. A 2002 Blue Cross and Blue Shield Association study pointed to five states that mandated fewer than 10 benefits and seven states with more than 30 mandated benefits.⁴²⁻⁴³

Finally, advocates point to specific provisions in the current AHP proposal that would safeguard consumers. These include requirements regarding AHP certification, participation and coverage, nondiscrimination, and contribution rates. For example, AHPs would be subject to rules regarding preexisting conditions, portability, and enrollment under the federal Health Insurance Portability and Accountability Act (HIPAA).⁴⁴ The legislation would also require that self-insured AHPs maintain certain reserves and comply with other solvency provisions, and have at least 1,000 participants, representing one or more trades with average or above-average health insurance risk.

Groups Supporting AHPs

During his State of the Union address on January 20, 2004, President Bush urged Congress to approve federal legislation allowing associations to offer health insurance without state regulation. A coalition of more than 130 groups has also endorsed the pending AHP legislation, including the U.S. Chamber of Commerce, the National Federation of Independent Business, the American Farm Bureau Federation, the Associated Builders and Contractors, the Latino Coalition, the National Black Chamber of Commerce, the National Association of Women Business Owners, and the National Restaurant Association.

The Argument against AHPs

The most common argument against federally regulated AHPs is that through ERISA preemption, AHPs would be exempt from critical state regulations currently governing the health insurance market. These include consumer protections, such as external appeals and prompt-payment laws, tougher solvency requirements, benefit mandates, community-rating requirements, premium taxes, and restrictions on the look and language of insurance contracts. The Blue Cross Blue Shield Association recently highlighted the states' longstanding role in regulating health insurance when it released a state-by-state analysis showing which consumer protections and benefit mandates would be lost as a result of AHP legislation. Forty-nine states have prompt-payment rules, 47 states have laws preventing "gag rules" against physicians, 42 require plans to cover emergency services that a "prudent layperson" would consider necessary, 41 mandate direct access to obstetricians-gynecologists, and 37 require plans to cover transitional care from a practitioner who leaves a network. Most states also require coverage for mammography, alcoholism treatment, and well-child care.⁴⁵ The prompt payment laws are of particular concern to state medical societies, who, after fighting hard for their passage, would not like to see them overridden. Passage of federal patients' rights legislation, which has been unsuccessful so far, could address many of these concerns.

Critics also are concerned that AHPs will likely lead to market segmentation and eventual cost increases for those most in need of care. With fewer mandates to follow, AHPs are likely to offer pared-down coverage. While healthier people

can afford this type of coverage, a greater proportion of those remaining in state-regulated plans that offer more comprehensive benefits would be higher-risk patients. This market segmentation and adverse risk problem could eventually raise group health premiums for most small businesses. According to a study released in June 2003 by Mercer Risk, Finance & Insurance Consulting and commissioned by National Small Business United, over a short period of time:

- Those not participating in AHPs would experience premium increases of 23 percent.
- The entire small-business market would experience a 6 percent average premium increase.
- Premium increases would create more than 1 million newly uninsured individuals.⁴⁶

Referencing the same CBO report that proponents cite to bolster their position, opponents note that federal AHPs only would expand coverage to 330,000 previously uninsured people. While premiums would decrease by an average of 13 percent for those moving into AHPs, the bulk of savings would be a result of limiting benefits. Furthermore, those remaining in plans subject to state insurance regulation—more than 20 million people—would see their premiums rise by an average of two percent, according to the CBO.⁴⁷

A similar pair of reports prepared for the California HealthCare Foundation and released in January 2004 concluded that the proposed AHP legislation could disrupt California's small group health insurance market without significantly reducing the number of uninsured in the state. According to the reports, AHPs would result in an increase in overall health insurance enrollment of only one to two percent. Although groups entering AHPs would save up to 14 percent on premiums, those remaining in traditional small group insurance plans would see increases of 5 percent.⁴⁸

Also at issue is the legislation's solvency requirements, which critics argue are much weaker than the standards required by state insurance commissioners. According to the American Academy of Actuaries (AAA), the proposed solvency standards would be inadequate for associations, particularly those with only 5,000 to 10,000 members⁴⁹ and those who self-insure.⁵⁰

Stripped of state protections, opponents also fear AHPs would be more susceptible to fraud. When MEWAs first emerged in the 1970s, they were initially allowed to operate outside state law under ERISA preemption. However, these arrangements became so rife with fraud and bankruptcies that Congress quickly responded by bringing them back under state purview.⁵¹ More recently, there has been a surge in the number of phony discount health plans which, over the past two years, has left nearly 100,000 individuals without insurance and \$85 million in unpaid medical bills.⁵² Despite reforms, operators of these unauthorized plans continue to inappropriately use ERISA preemption as a shield to avoid state enforcement actions, selling coverage through professional and trade associations, phony unions, and professional employee organizations.⁵³

Finally, critics have questioned the federal government's ability to take on additional oversight that may best be left to existing state regulatory authorities. Under the Clinton Administration, the Department of Labor (DOL), which would regulate AHPs under this newest proposal, testified that it had only enough resources to review each AHP once every 300 years. In 2002, a Government Accountability Office (GAO) report concluded that DOL's staff was inadequate to regulate even its current pension responsibilities, saying it

would take 90 years to do a baseline assessment of pension plan noncompliance.⁵⁴ The chairman of the Senate Finance Committee recently called on the GAO to assess the effectiveness of the federal government's oversight of employer sponsored health benefits. The chairman also called on his staff "to work with DOL and other relevant committee staff to see if we can tighten up [ERISA] and to examine the civil, criminal, and administrative remedies available to the DOL to see if some improvements can be made to address [health plan fraud] once and for all."⁵⁵

Groups Opposing AHPs

Consumer groups, the National Governors Association, the National Association of Insurance Commissioners, many state insurance regulators, and a variety of insurance groups led by the Blue Cross Blue Shield Association, oppose the AHP proposal. The American Nurses Association, American Academy of Pediatrics, and the American Diabetes Association also are opposed. Thirty-eight members of the National Association of Attorneys General signed an April 24, 2003 letter to congressional leaders contending that the elimination of the state role in regulating insurance would open the door to fraud, worsen the problem of the uninsured, and place small businesses under weak, under-resourced federal authorities.⁵⁶ Although the American Medical Association has not weighed in on the issue, it passed a resolution on June 17, 2003 stating that it will "work with federal legislators to ensure that any AHP program safeguard state and federal patient protection laws, including, but not limited to state regulations regarding fiscal soundness and prompt payment."⁵⁷ This language was appended to previous AMA policy on AHPs, which encourages legislation allowing AHPs to be exempt from state laws on mandated benefits and premium rating.⁵⁸

AHPs Compared to ACP's Core Principles on Access

There is no doubt that the small business health insurance market is in need of reform. Innovative strategies must be constructed so that small businesses can enjoy the same advantages that larger businesses experience when purchasing and providing health care benefits. In its 1996 paper, "Voluntary Purchasing Pools: A Market Model for Improving Access, Quality, and Cost in Health Care,"⁵⁹ ACP stated that pools make health care more affordable and more accessible through administrative savings, group leverage, and reduced risk-selection opportunities. Pools encourage plans to compete to deliver high-quality, cost-effective care, since consumers have more control over their health plan selections. ACP also stated that pools break the employment-insurance link and increase the likelihood that patients who change jobs can keep their personal physicians. ACP continues to support the principles inherent to pools: expanded access to care, market-induced quality improvement, and cost-containment.⁶⁰ However, current proposals to create AHPs include very specific requirements, many of which were not discussed when the College first took a position on voluntary purchasing pools. In this section, we evaluate AHPs against the College's core principles on access as a first step to formulating College policy on the issue.

Core Principles on Coverage, Enrollment, and Eligibility

Core Principle #1 recommends expanding access to coverage with an explicit goal of covering all Americans by a specified date. The principle also recommends a uniform benefits package for all Americans. It recommends that coverage and benefits be continuous and independent of residence or employment status.

Core Principle #2 states that sequential reforms that expand coverage to targeted groups should be considered but such proposals should 1) identify the subsequent steps, targeted populations, and financing mechanisms that will result in all Americans having access to affordable coverage; 2) include a defined target date for achieving affordable coverage for all Americans; and 3) include an ongoing plan of evaluation.

Core Principle #3 advocates mechanisms to encourage individuals who otherwise might voluntarily choose not to obtain coverage to participate in the insurance pool, using incentives to participate or disincentives to discourage non-participation.

Core Principle #4 calls for providing flexibility to the states to investigate different approaches that contribute to the overall goal of providing all Americans with access to affordable coverage, subject to national standards to ensure portability and access to a basic benefits package.

Core Principle # 7 states that the College should address sources of patient and physician dissatisfaction with the system, including lack of care continuity.

Core Principle # 8 advocates for reduced administrative and medical liability costs that do not improve access and quality of care.

Core Principle # 9 calls for providing a choice of physicians to patients.

Recommendation #1: ACP supports federal legislation that provides small businesses with the group purchasing advantages enjoyed by larger companies, provided that such “pooling” arrangements:

- 1) Do not weaken existing federal and state consumer protection safeguards including, but not limited to, state regulations regarding fiscal soundness, prompt payment, and consumer grievance and appeals rights.**
- 2) Protect enrollees against under-insurance by requiring or creating incentives for health plans offered under the pooling arrangement to provide a package of essential benefits, including coverage for preventive and primary care services.**

Recognizing the extreme financial pressure under which small businesses continue to operate, ACP supports efforts to increase the availability, affordability, and accessibility of health insurance to this vulnerable group. ACP also realizes the value of alternative means of pooling risk for small businesses. Nevertheless, the AHP proposal before Congress, as currently written, risks too many unintended negative consequences. The dangers of market segmentation, AHP insolvencies, and the removal of state market protections— including prompt payment laws and mandated benefit laws that cover preventive and other critical services— are inconsistent with ACP policy and of major concern to the College.

In past statements on improving our health care system, the College has supported reforms in the small group insurance market, such as legislation that would require insurance companies to establish rating and renewal standards, prohibit medical underwriting, limit pre-existing condition exclusions, and require states to develop a reinsurance mechanism.⁶¹ ACP has also supported amendments to ERISA that preserve and enhance the states' regulatory role and protect the interests of consumers. These include requirements that self-insured plans meet state standards that restrict capricious and unfair changes in benefit packages and are subject to state oversight, including penalties, for improper claims processing.⁶²

The College is also not convinced that the federal government is currently prepared to take on the enormous task of regulating and enforcing AHPs. As mentioned earlier, in 2002, the GAO reported that the Department of Labor was facing an "overabundance of work," and admitted that its enforcement program was already affected by "limited investigative resources" and "staff shortages."⁶³ The AHP provisions would simply add to the breadth and complexity of the Department of Labor's work without correcting the lack of regulatory resources that currently exists.⁶⁴

Furthermore, the College is concerned that AHP legislation, as currently proposed, carries too great a risk that patients enrolled in association health plans will be denied access to essential medical benefits, including cost-effective primary care and preventive services, leading to an increase in the number of Americans who are "under-insured." State laws requiring health plans to offer such benefits would be invalidated, without any uniform federal requirements regarding essential benefits that would have to be offered by AHPs but would no longer be subjected to state benefit mandates. ACP policy, as articulated in core principle # 1, clearly supports the view that all Americans should have access to a uniform package of essential health benefits.

Recommendation #2: ACP supports the creation of a federal regulatory structure to ensure that all health plans, including association health plans, meet essential consumer protection and benefit requirements. Specifically, legislation to exempt AHPs from state consumer protection and benefit requirements is not desirable until an alternative federal regulatory structure is created that includes:

- 1) Enactment of a comprehensive federal patient bill of rights law to be applicable to all health plans, including AHPs.**
- 2) Creation of a federal process to require or create strong market-based incentives for all health plans, including AHPs, to offer a package of essential health benefits to enrollees as approved by Congress.**

AHP legislation, as currently proposed, would further weaken existing patient rights by exempting AHPs from most state consumer protection laws. Until a strong federal regulatory structure is created that adequately protects the rights of patients, ACP cannot support legislation to exempt AHPs from state consumer protections. This is not to say that the College does not support the concept of pooling arrangements or even the replacement of state laws with a stronger, more uniform federal system that guarantees essential consumer rights. Many state-mandated benefits should be repealed, particularly those that are not evidence-based. Rather, ACP believes that adequate federal protections have not yet been created to allow for the dismantling of current state protections. Doing so prematurely would place patients in a vulnerable and dangerous position.

While state protections in many cases continue to protect the patient, they are quickly being eroded. In June 2004, the Supreme Court ruled unanimously that patients cannot sue managed care companies in state courts whose refusal to pay for treatment allegedly results in death or injury.⁶⁵ Instead, such lawsuits must be handled by more restrictive federal courts, where patients can only receive rewards for the value of the benefit denied and not for the harm caused by the denial of treatment. This ruling, which denies patients the right to hold managed care plans accountable in state court for negligent treatment decisions, was one of many over the past decade that has made it more difficult for patients to rely on state protections. It is more essential than ever that Congress quickly enact a comprehensive federal statute that provides all patients with a minimum set of protections, including but not limited to grievance and appeals rights. ACP policy strongly supports enactment of a comprehensive federal patient bill of rights law that builds on the weak protections currently afforded through ERISA.⁶⁶

The HealthCARE Act of 2003,⁶⁷ which is based on ACP's proposal to provide affordable health coverage to all Americans within seven years, includes an innovative mechanism to encourage all health plans to provide a package of essential health benefits. The legislation would establish a national commission to develop recommendations on essential benefits, which would be then presented to Congress for enactment using legislative procedures that minimize amendments to the package (up and down "base closing" procedures). The Commission would review and revise the essential benefits and report back to Congress with recommendations for change on a biennial basis. Health plans that participate in an FEHBP-based pooling arrangement would be required to inform consumers of how their benefits compare to the essential benefits as recommended by the Commission and enacted by Congress. Health plans that did not offer the essential benefits would be at a marked disadvantage in the marketplace, creating strong incentives for all health plans to provide the essential benefits.

ACP understands that excessive benefit mandates can sometimes lead to more harm than good. For instance, mandated benefits can increase premiums and may interfere with a physician's right to practice freely and make independent health care decisions. They may also cause concern when the system under which they are mandated does not provide for adequate reimbursement of the benefit. Conversely, if chosen prudently, mandated benefits can be cost-effective in the long run, as is the case when preventative medical procedures are mandated. ACP is confident that the mechanisms included in the HealthCARE Act to study and carefully assemble a package of the most essential evidence-based benefits will allay physician skepticism. The proposal would replace the current patchwork of mandated state benefits with a strong, uniform federal standard that would substantially reduce the risk of under-insurance and ensure patient access to the most essential services by creating strong incentives for all health plans to offer an approved package of benefits.

Recommendation #3: ACP believes that until an adequate infrastructure to regulate insurance is established at the federal level, these responsibilities are best left to the states, which traditionally hold the authority, expertise, and experience needed to regulate insurance.⁶⁸

A 2003 GAO report highlighted the states' longstanding role in providing consumer protections for health insurance, including small group market reforms for premium rates and eligibility practices, internal and external review requirements, marketing standards, fraud prevention, solvency requirements and other

financial protections. The report found that in most cases, state requirements exceed federal requirements.⁶⁹ Until a federal comprehensive federal patient bill of rights law is passed, consumer protections should be left up to the states.

Recommendation #4: Purchasing pool arrangements should be designed according to criteria likely to encourage broad membership that minimizes risk selection and maximizes choice.⁷⁰

In its 1996 position paper on voluntary purchasing pools, ACP warned that allowing small businesses to form self-insured pools that escape state requirements for open enrollment and ratings will further contribute to market fragmentation.

Pools that provide the broadest possible choice of health plans provide the greatest opportunity for individual persons to maintain the same plan despite changes in employment or payer status.⁷¹

Recommendation #5: In supporting proposals that promote voluntary hybrid state-employer programs, ACP supports proposals that would enable small businesses to buy into Medicaid or SCHIP for coverage of their employees.

As a supporter of voluntary, federally supported state purchasing pools, ensuring that our most vulnerable individuals are first to receive coverage, and expanding our nation's safety net, this policy option seems within the College's realm of support. The proposal would assist the lowest-income individuals who might actually already be eligible for public insurance. Since the benefit package for Medicaid tends to be more comprehensive than private employment-based plans, small employers should be provided subsidies to help them afford the more generous package.

This proposal is not without its faults, including the Medicaid stigma issue, the fact that Medicaid enrollees may be more expensive than small employers' workers, and the fact that low Medicaid payments may limit patient access to care. However, allowing small employers to opt-in to the Medicaid purchasing apparatus would clearly offer administrative savings and a stable risk pool compared to buying insurance alone in the small group market.⁷²

Another issue associated with an increased reliance on public programs is inadequate provider reimbursements, which, if not addressed, can seriously undermine access to care for our most vulnerable populations. Physicians must not be reluctant to take on publicly insured patients. Ensuring that Medicaid and SCHIP are properly funded and that providers are adequately reimbursed is a critical part of ACP's efforts to enhance the strength of the safety net. The issue of resolving payment and practice hassles for physicians is a top priority of ACP and is addressed extensively in a separate policy paper.⁷³

Recommendation #6: As an alternative to association health plans, ACP believes that Congress should enact legislation that includes the key "pooling" requirements in the HealthCARE Act of 2003, including:

- 1) Allowing employers with 100 or fewer employees to join together in state group purchasing arrangements to obtain coverage through a program modeled on the Federal Employee Health Benefit program.**

- 2) **Requiring that health plans offered under such pooling arrangements meet existing federal requirements governing plans offered under the FEHBP program.**
- 3) **Requiring that all participating health plans offer benefits equivalent to those provided under the FEHBP.**
- 4) **Establishing a process for congressional approval of an essential benefit package, with requirements that all health plans offered under the pooling arrangements disclose to consumers how their benefits compare with the essential benefits package.**

The College believes that the group purchasing arrangements proposed in the HealthCARE Act of 2003 would provide small businesses with many of the advantages envisioned by proponents of AHPs—group purchasing leverage, administrative savings, and access to health plans with modified community rating—without subjecting their employees to the risks of under-insurance and elimination of essential consumer protections.

Conclusion

High rates of uninsurance among working families in small businesses attest to the limitations of the employment-based health system in the small-business sector.⁷⁴ Voluntary purchasing pool arrangements have the ability to provide small businesses with some of the advantages now shared by large businesses, such as lower administrative costs through the realization of economies of scale, increased clout over insurers, and the ability to spread risk across a larger pool of people. However, a comparison of AHPs to the College's core principles on access reveals that their potential benefit—to lower the cost of coverage for a small number of healthy people—does not outweigh the possibility that this proposal could disrupt the small group health insurance market, increase premiums for those who remain in traditional policies, and ultimately increase the number of underinsured and uninsured.

Glossary

AHPs	Association Health Plans: plans that would permit small businesses to band together across state lines to purchase health insurance as a group.
AMA	American Medical Association
CBO	Congressional Budget Office: a supportive agency of Congress that provides nonpartisan analyses needed for economic and budget decisions, as well as information and estimates required for the Congressional budget process.
DOL	Department of Labor
ERISA	Employee Retirement Income Security Act of 1974: a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. ERISA requires plans to provide participants with plan information, including important information about plan features and funding; provides fiduciary responsibilities for those who manage and control plan assets; requires plans to establish a grievance and appeals process for participants to get benefits from their plans; and gives participants the right to sue for benefits and breaches of fiduciary duty. In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment, or disability laws.
FEHBP	Federal Employees Health Benefits Program: a system of competing private health plans in which the government contributes a relatively fixed amount toward the employee's coverage and employees pay a premium based on the cost of the individual plan they choose. Created in 1959, it currently provides health insurance benefits to more than eight million federal enrollees and dependents. It is often looked to as a model because of its ability to constrain cost growth reasonably well with limited government intervention.
GAO	Government Accountability Office (formerly the Government Accounting Office): an independent and nonpartisan agency that provides Congress and executive agencies with studies of programs and expenditures of the federal government. The GAO is commonly known as the investigative arm of Congress, since it evaluates federal programs, audits federal expenditures, and recommends ways to make government more effective.
HIPAA	Health Insurance Portability and Accountability Act of 1996: an amendment to ERISA that provides rights and protections for participants and beneficiaries in group health plans. HIPAA includes protections that limit exclusions for pre-existing conditions; prohibit discrimination against employees and dependents based on their health status; and allow a special opportunity to enroll in a new plan to individuals in certain circumstances.

- MEWA Multiple Employer Welfare Arrangement: arrangements that allow a group of employers collectively to offer health insurance coverage to their employees. Generally, MEWAs are created by small employers often belonging to a common trade, industry, or professional association. Promoters of MEWAs have traditionally persuaded employers and state regulators that the MEWA is an employee benefit plan covered by ERISA and, therefore, exempt from state insurance regulation under ERISA's broad preemption provisions. However, after a number of MEWAs were unable to pay claims because of excessive administrative fees or outright fraudulent activities, Congress amended ERISA in 1983 to provide an exception to ERISA's preemption provisions for the regulation of MEWAs under state insurance laws. While this reform was intended to remove federal preemption as an impediment to state regulation of MEWAs, many still claim ERISA coverage and protection from state regulation under ERISA's preemption provisions.⁷⁵
- SCHIP State Children's Health Insurance Program: created under the Balanced Budget Act of 1997, SCHIP allows each state to offer health insurance for children, up to age 19, who are not already insured. SCHIP is a state-administered program, and each state sets its own guidelines regarding eligibility and services.

ACP CORE PRINCIPLES FOR EVALUATING PROPOSALS TO INCREASE ACCESS TO HEALTH INSURANCE COVERAGE

1. Include an explicit goal of covering all Americans by adequate health insurance by a specified date.
 - a. Includes a mechanism for determining scope of benefits.
 - b. Includes a uniform minimum package of benefits for all.
2. Consider sequential reforms to expand coverage.
 - a. A sequential plan identifies the subsequent steps, targeted populations, and financing mechanisms.
 - b. A sequential plan identifies a target date for achieving affordable coverage for all Americans.
 - c. A sequential plan identifies an ongoing plan of evaluation.
3. Include strong incentives for participation in the health insurance pool or strong disincentives to discourage non-participation.
4. State flexibility to investigate different approaches that contribute to the overall goal of providing all Americans with access to affordable coverage, subject to national standards to ensure portability and access to the basic benefits package.
5. Create mechanisms to make prescription drugs more affordable. Does not allow formularies that are determined solely or principally on the basis of cost.
6. Financing should be adequate to eliminate barriers to care:
 - a. Highest priority towards ensuring adequate financing for “critical access” institutions and providers with a higher burden of uncompensated care.
 - b. Reimbursement level for covered services must be fair and adequate to reduce barriers to care; mechanisms to improve ease of administration should be included to enhance physician participation.
 - c. Substantial portion of federal budget surpluses should provide funds to expand health insurance coverage.
 - d. Financing for public insurance programs should be progressive; explicit means testing should be discouraged.
7. Should address sources of patient and physician dissatisfaction with the system:
 - Micro-management of clinical decision-making
 - Diversion of health care dollars away from patient care to administrative inefficiencies
 - Excessive pressure on physicians to reduce time spent with patients
 - Duplicative and inconsistent coverage and payment policies by payers
 - Lack of continuity of care
 - Erosion of physician-patient relationship
 - Unnecessary or excessive administrative burdens
 - Excessive documentation requirements
 - Lack of choice of insurance plans and physicians
8. Should be designed to reduce administrative and medical liability costs that do not improve access and quality of care:
 - a. Public and private research bodies should support research on information systems to make administration and financing more efficient.
 - b. Reforms should be enacted to limit excessive medical liability costs.
 - c. Should include a description of mechanisms to ensure that health care dollars are directed principally for patient care, not administrative tasks.
9. Patients should have a choice of physicians:
 - a. Should be designed to respect the importance of patients being able to select a primary care and specialty care physician of their choice.
 - b. Patients should be able to stay with the physician of their choice from year to year.

- c. Patients should have sufficient and prompt access to specialty care with a real choice of specialist.
 - d. Use of hospitalists should not be mandated.
 - e. Requiring a reasonable but higher level of patient co-payments for open-ended access to a physician of their choice is an acceptable mechanism to control costs while providing patients with greater choice of physician than would be available through closed network or staff model health plans.
 - f. Research ways to provide patients with meaningful quality measurements that will factor into their choice of physician.
10. Decisions on expansion of the scope of practice of non-physician health care professionals should be based on evidence that they have the requisite skills and training:
 - a. Should establish a defined level of responsibility, based on skills and training, for each type of non-physician provider.
 - b. Physician-directed health care teams, with sufficient built-in controls.
 11. Provide incentives to encourage individuals to take responsibility for their own health, seek preventive care, and pursue health promotion activities.
 12. Should have as a goal elimination of disparities in the medical care of patients based on social, ethnic, racial, gender, sexual orientation, and demographic differences:
 - a. Should be designed to address barriers to care in inner city, rural, and other under-served communities.
 - b. Should recognize that lack of health insurance is in itself a cause of disparities in the quality of care received by patients.
 13. Should promote accountability at all levels of the system for quality, cost, access, and patient safety:
 - a. Should include incentives for physicians and other health care professionals to participate in the design systems of accountability (non-punitive and educational approaches should be favored).
 - b. Decisions on medical necessity, coverage, and appropriateness of care should be based on evidence of the clinical effectiveness of medical treatments as determined by physicians and other health care professionals based on review of relevant literature.
 - c. Should foster innovation and improvement, including innovation in use of Internet technologies with safeguards to protect the confidentiality of medical information that is transmitted electronically.
 - d. Patients should have certain basic consumer protection rights, including the right to appeal denials of coverage to an independent external review body, the right to hold a health plan accountable in a court of law, the right to be informed about how health plan policies will affect their ability to obtain necessary and appropriate care, and the right to have confidential health information protected from unauthorized disclosure. Denials of care by insurance companies for a particular problem or perceived problem should be based on evidence of clinical effectiveness and pre-determined benefits.
 14. Medical profession must embrace its responsibility to participate in the development of reforms to improve the US health care system:
 - a. The tenets of professionalism and the highest ethical standards, not self-interest, should at all times guide the medical profession's approach to reforms.
 - b. The medical profession should partner with government, business, and other stakeholders in designing reforms to reduce barriers to care, to improve accountability and quality, to reduce medical errors, to reduce fraud and abuse, and to overcome disparities in the care of patients based on social, ethnic, gender, sexual orientation, or demographic differences.

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