

POLICY NOTE

Association Health Plans and Small Business Health Insurance Exchanges in the Affordable Care Act

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Key Findings

1. For years, groups of employers have joined together to form association health plans (AHPs) to provide employee benefits and thereby receive cheaper costs with less administrative overhead. The Washington state legislature legalized AHPs in 1995.
2. AHPs offer an excellent way for willing smaller employers to provide employee health benefits on an equal footing with larger employers.
3. The Washington State Insurance Commissioner has twice tried to limit the use of AHPs in the state. Both times the Court has ruled against the Commissioner and in favor of the plans.
4. AHPs provide better health insurance coverage with a smaller regulatory burden for employers than the Small Business Health Options Program (SHOP) which is part of the Affordable Care Act (ACA).
5. Congress should amend the ACA, therefore, to allow small employers and their workers to make greater use of the benefits of AHPs.

Introduction

The Affordable Care Act (ACA), or Obamacare, passed Congress along strict party lines and was signed into law by President Obama on March 23, 2010. Although the law is very complex and contains 2,700 pages, it fundamentally deals with health insurance reform for employers and individuals.

Employers with a small number of employees have provided health benefits using association health plans (AHPs) for decades. AHPs allow small employers to join together to buy health insurance, so their workers can gain access to the same pricing and coverage benefits enjoyed by large employers. This paper examines the impact of the ACA on existing AHPs and recommends reforms to the ACA so that small employers can still use AHPs to buy health coverage for their workers and remain in compliance with federal law. This paper also looks at the impact of the state health insurance exchanges that began under the ACA.

Background of Association Health Plans

For years, employers have joined together to provide employee benefits. The reason is that multiple employers can form one large group and thereby receive cheaper costs for employee health benefits with less administrative overhead.

The government broadly defines these groups as multiple employer welfare arrangements (MEWAs) and AHPs fall under this heading. Congress set rules for the conduct of MEWAs, and specifically for AHPs, under the Employee Retirement Income Security Act (ERISA) of 1974.

Some of the initial AHPs were undercapitalized and were forced to close. This left employees without benefits. Because of fraud and abuse, Congress amended ERISA in 1982 and gave states some ability to regulate MEWAs. ERISA was again amended in 1996 and gave the Department of Labor oversight authority of essentially all MEWAs.¹

AHPs can be organized in two ways. A consolidated AHP is underwritten at the group level, where all employees from all employers

1 "History of EBISA and ERISA," United States Department of Labor, at <http://www.dol.gov/ebsa/aboutebsa/history.html>.

are placed in one plan. An affinity AHP is underwritten at the individual employee level. This can save money if the AHP has a much higher percentage of young and healthy workers. Both consolidated and affinity plans can either self-insure or can purchase health insurance from a commercial insurance company.²

The Washington state legislature legalized AHPs in 1995. Although AHPs have been very popular in Washington state and have provided reasonably-priced health insurance to hundreds of thousands of people, the current state Insurance Commissioner has never been a fan. Commissioner Kreidler believes AHPs “cherry pick” only healthy people and exclude sicker individuals. In 2007, he imposed stricter rating requirements which eliminated health underwriting for AHPs. In effect, Commissioner Kreidler’s regulatory action repealed the state’s 1995 AHP law, since the regulation made the majority of such plans unavailable in the state. Employers using AHP plans sued that same year and the court ruled in favor of allowing AHPs to continue.

A few years later, the federal ACA imposed a new rating requirement called “community rating” for all health insurance plans sold in the United States. Except in very specific cases, this requirement means insurance companies cannot price insurance policies based on true risk, by charging more for sick individuals than for healthy people and they cannot account for higher health cost based on age by charging a significant difference for older people.

Republicans in Congress proposed an amendment to the ACA to make it clear that existing AHP plans in the states were allowed under federal law. However, the amendment was defeated in the Democratically-controlled House of Representatives and was not included in the final bill.

Commissioner Kreidler, using the community rating requirement in the ACA, renewed his effort to restrict or eliminate AHPs in Washington state. There were over 60 AHPs serving 500,000 members in our state when the ACA passed in 2010. The Commissioner has established a two part test. First, he says associations must have been formed for purposes other than buying health insurance and second, he says associations must abide by the community rating in the federal ACA.

In defense against the new regulations, multiple AHP plans filed lawsuits against the Insurance Commissioner. The basis of these lawsuits was that the ACA does not supersede the 1974 federal ERISA law which outlines rating methodology. In 2015, the Court agreed and ruled in favor of the plans. For the second time, Commissioner Kreidler’s efforts to restrict or end AHPs in Washington state had failed.

The ACA and AHPs

The ACA requires all adults age 18 and older to purchase health insurance and all employers with 50 or more employees to provide health benefits or pay a penalty to the IRS. To facilitate this requirement, the law expanded the Medicaid

2 “Association health plans: What’s all the fuss about?,” by M.Kofman, K.Lucia, E.Bangit and K.Pollitz, *Health Affairs*, vol.25, no.6, pages 1591-1602, November, 2006 at <https://www.venable.com/association-health-plans-and-health-care-reform-a-trap-for-the-unwary-04-22-2013/>.

entitlement program and established insurance exchanges where people could purchase health insurance with taxpayer subsidies and meet the federal mandate.

In addition, the ACA mandates certain insurance requirements in the individual and small group markets. Starting in 2016, a small group is defined as any organization with 100 or fewer employees. The mandates include community rating, no denial for pre-existing conditions, benefits set by the government and minimum actuarial value. An AHP with multiple employers and covering more than 100 employees total therefore qualifies as a large group and is not subject to these federal mandates.³

SHOP in the ACA

The ACA attempts to establish an exchange marketplace for employers with fewer than 50 full-time-equivalent (FTE) employees. The Small Business Health Options Program (SHOP) was designed by Congress to help “businesses provide health coverage to their employees.”⁴

Under the ACA, small businesses with fewer than 25 FTEs may qualify for tax credits if they pay at least 50 percent of the total health insurance premium cost for employees and the average wage of their employees is below \$50,000. The tax credit is determined by the number of employees and by average wages. Basically, the smaller a business is, the larger the tax credit it could receive.

Phase I of the employer tax credit began in 2010. Eligible employers may qualify for a tax credit of up to 35 percent of their contribution toward employees’ insurance premiums. The employer must pay at least 50 percent of the employee-premium.

Phase II of the employer tax credit began in 2014. Eligible employers may receive a credit of up to 50 percent of their portion of premium costs. However, these employers must purchase coverage through a SHOP Marketplace, or qualify for an exception to this requirement, to be eligible for the credit. The credit is only good for two consecutive tax years.⁵

At least 70 percent of employees must be enrolled in the SHOP Marketplace for the employer to qualify for tax credits. Employees who purchase their own health insurance count toward the 70 percent. Employees who have insurance through their spouse or who have government insurance, such as Medicare or Medicaid, do not count toward the 70 percent total.⁶

3 “Association health plans and health care reform: A trap for the unwary,” by Harry Atlas and Thora Johnson, *News and Insight*, April 2013 at <https://www.venable.com/association-health-plans-and-health-care-reform-a-trap-for-the-unwary-04-22-2013/>.

4 “What is the SHOP Marketplace,” Federal Health Care Exchange, at <https://www.healthcare.gov/what-is-the-shop-marketplace>.

5 “What You Need to Know About the Small Business Health Care Tax Credit,” Internal Revenue Service at <http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers>.

6 “It’s Still Hard for Small Businesses to Shop Around for Health Coverage,” by Meir Rinde, *National Journal* at <http://www.njspotlight.com/stories/14/04/29/it-s-still-hard-for-small-businesses-to-shop-around-for-health-coverage/>.

Some state exchanges started accepting enrollees through a SHOP Marketplace in 2014. The federal exchange started accepting online applications in 2015.

Employers with more than 50 FTEs will be able to use SHOP starting on November 1, 2015, and employers with more than 100 FTEs will be able to access the program starting in 2016.⁷

The demand and interest level of employers in an insurance exchange such as SHOP was never determined. There is speculation and anecdotal evidence that SHOP was placed in the ACA for political convenience, rather than at the insistence of the law's architects or for any real benefit it might bring to small employers.⁸

SHOP in Washington State

When the ACA became law in 2010, estimates showed that 1.4 million to four million employers nationally were eligible for tax credits. However, only 170,300, or four to 12 percent of employers, filed for tax credits that year.⁹

Officials in Washington state chose to establish a state-run health insurance exchange, including a SHOP. Coverage began in 2014, with SHOP having an open enrollment period. Only one insurance carrier, Kaiser Permanente, offered plans and only offered those five plans in two counties in Southwest Washington. Although 4,300 small businesses created online accounts, only 11 companies, with a total of 40 people, actually purchased insurance on the Washington state SHOP exchange in 2014.¹⁰

A second insurance company, Moda, began offering state-wide health coverage in 2015. The two carriers now cover 115 employers and 600 people. United Health Care has applied for regulatory approval to sell insurance through SHOP in 2016.

The Director of the Washington state SHOP Marketplace, Catherine Bailey, stated that “many of the carriers were not interested in expending additional resources to be in the small business exchange right away.”¹¹

The Government Accountability Office (GAO) has speculated that the use of tax credits and the SHOP enrollment are so low for several reasons. The first reason is the complexity in doing all the paperwork.¹² Tax preparers tell GAO investigators

7 “Obamacare Small Business Facts,” at <http://obamacarefacts.com/obamacare-smallbusiness.php>.

8 “SHOP Flop: Obamacare for Small Businesses,” by Brett Norman, *Politico*, at <http://www.politico.com/story/2014/06/shop-small-business-health-options-program-delay-107649.html>.

9 “Small Employer Health Tax Credit: Factors Contributing to Low Use and Complexity,” at <http://kstp.com/kstpImages/repository/cs/files/SMALL%20EMPLOYER%20HEALTH%20TAX%20CREDIT.pdf>.

10 “With Statewide Insurance Options, Washington’s Business Health Exchange Readies For Close-up,” by Gregg Lamm, *Puget Sound Business Journal* at <http://www.bizjournals.com/seattle/blog/health-care-inc/2014/09/with-statewide-insurance-options-washington-s.html>.

11 Ibid.

12 “How will Obamacare impact your small business?”, Obamacare Small Business Facts, at <http://obamacarefacts.com/obamacare-smallbusiness.php>.

that employers must spend from two to eight hours, or possibly longer, collecting employee data, and that tax preparers must spend an additional three to five hours calculating the credit.

Second, the GAO reports the tax credit is not large enough to be an incentive for many small employers; they find that any financial gain from SHOP is not worth the time and cost to apply for it.

Third, the majority of small businesses have never offered health benefits to employees. Only 33 percent of employers with less than ten employees offered health insurance in 2010 when the ACA became law.¹³

In addition, insurance companies are seeing a drop-off in employer-sponsored health insurance for small businesses. The CEO of Anthem, Joseph Swedish, stated that “small employers [are] shifting employees to the individual exchange or [are] dropping coverage completely.” He said small employers are making “a very radical, fast shift to walking away from the so-called moral imperative” of providing health insurance.¹⁴

Policy Analysis

Small businesses are typically start-up or low-margin companies where the added cost of employee health insurance can mean the difference between success and bankruptcy. The heavy paperwork and regulatory burden in the SHOP exchange are obstacles for a small business employer. The SHOP Marketplace duplicates the private insurance marketplace and, because of the tax credits, puts an added burden on taxpayers who don't receive the credits.

There are no real free-market choices in the individual exchanges or in SHOP. ACA proponents will claim that competition exists, yet all insurance plans offered in the exchanges must contain the ten federal government-mandated essential benefits. Insurance premium prices must be approved by the government. Consequently, individuals and employers only have government-approved plans and not meaningful choices or real competition.

The financial incentive of tax credits has not been significant enough to encourage employers to use SHOP. Obtaining the credit is so complicated that small businesses are unwilling or unable to spend the time and effort to complete the necessary forms. There is no point in employers trying to use the SHOP program if the effort ends up hurting their business. Since employer interest and utilization of the tax credit is so small, the benefits of the SHOP Marketplace are unclear.

Association health plans, on the other hand, offer a real solution for small business owners who want to provide employee health benefits without the massive regulatory burden associated with the government's SHOP Marketplace. AHPs are

13 “Health insurance in the small business market: Availability, coverage, and the effect of tax incentives,” by Quantria Strategies, LLC, September 2012. Pdf.

14 “But Small Employers are Walking Away From Coverage,” by Sarah Wheaton, *Politico*, at <http://www.politico.com/politicopulse/0914/politicopulse15173.html>.

based on voluntary associations, and they have a track record of offering quality health insurance at a reasonable price. If structured properly, the AHP market can be competitive and can allow small employers to access the same health insurance price and benefit advantages that large employers enjoy. The key is the voluntary choices made by small employers and their employees in seeking affordable health coverage, rather than attempting to navigate a narrow and complex state-run program as is the case with SHOP.

Policy recommendations

It is clear that voluntary AHPs are much more popular and effective than the state-run SHOP exchanges. Congress should amend the ACA, therefore, to allow small employers and their workers to make greater use of the benefits of AHPs. There are five changes that would improve federal policy and serve the public interest by making health coverage more available to people who work for small employers.

First, all AHPs should be treated as large groups (which they are) for regulatory purposes and they should not be subject to the ACA benefit mandates. At the same time, federal legislation should protect AHPs from onerous state-imposed benefit and provider mandates. This would protect people who receive affordable health coverage through AHPs from hostile efforts to shut them down, as was twice attempted in Washington state.

Second, competition in the employer health insurance market should be increased. Allowing people to buy health insurance across state lines, or enacting legislation to create a national market, would expand choices and lower prices as happens today with auto and home-owners insurance.

Third, strengthen oversight to eliminate fraud and abuse in AHPs. This would guarantee security and safety for employees enrolled in AHPs and would reduce one of the biggest criticisms of the plans.

Fourth, if SHOP exchanges continue, they should be transparent, information-based markets where individuals and small businesses could select the plan most appropriate to their needs. The exchange should be easy to use and should promote decreased health care costs, not add complexity and confusion. Insurance rates and benefit levels should be set by the insurance market, not by government regulators. The administration of the exchange should be managed by a non-political, independent board, not by a politicized state bureaucracy.

Fifth, Congress should repeal the employer mandate in the ACA. Employers do not provide the other necessities of life, such as food, shelter and clothing as part of national policy. There is no greater moral reason for employers to provide workers with health insurance than with other basics of life, like housing. In fact, these essentials of daily living are best provided by employees themselves, because they know the needs of themselves and their families best. Employers should not be forced by law to pay for employee health benefits – employees may prefer to receive the same value as cash instead. Of course, this does not preclude those employers who want to provide those benefits voluntarily from doing so.



Dr. Roger Stark is a health care policy analyst at WPC and a retired physician. He is the author of two books including *The Patient-Centered Solution: Our Health Care Crisis, How It Happened, and How We Can Fix It*. He has also authored numerous in-depth studies on health care policy for WPC, including *Health care reform: lowering costs by putting patients in charge*. Over a 12-month period in 2013 and 2014, Dr. Stark testified before three different Congressional committees in Washington DC regarding the Affordable Care Act. He completed his general surgery residency in Seattle and his cardiothoracic residency at the University of Utah. After practicing in Tacoma he moved to Bellevue and was one of the co-founders of the open heart surgery program at Overlake Hospital. He has served on the hospital's governing board.

Existing association health plans should be preserved so employees can keep their current insurance which was promised when the ACA became law. All employers, whether large or small should be legally treated the same. AHPs offer an excellent way for willing smaller employers to provide employee health benefits to their employees on an equal footing with larger employers.

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