S. 1955: Cost Savings via Thinner Benefits

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The present administration and some members of Congress have for a number of years supported nationwide use of “association health plans.” Association health plans are insurance plans that allow groups of small employers to band together specifically to buy health insurance at cheaper rates due to economies of scale.\(^1\) Such plans can also be cheaper because they avoid state health insurance mandates – laws that require all plans sold by health insurers in a particular state to cover certain conditions, supplies or procedures.\(^2\) Supporters of association health plans tout them as a way to help solve the twin problems of dwindling employer-sponsored health coverage and rising health insurance costs.\(^3\)

Senate Bill 1955 (“S. 1955”), the “Health Insurance Marketplace Modernization and Affordability Act of 2006,” would create a federal structure for certifying association health plans, here termed “small business health plans.” The bill would allow small employers\(^4\) in one or more states to become members of a small business health plan sponsor, or to themselves form such a sponsorship, for the purpose of obtaining or providing medical care.\(^5\) The bill provides requirements that both sponsors and plans must meet to obtain certification as a small business health plan.\(^6\) Under the bill, the Department of Labor, not individual states, would have authority to ensure that sponsors and plans met the requirements of the statute.\(^7\)

According to a recent Congressional Budget Office (“CBO”) study, S. 1955 would both increase federal tax receipts and decrease federal spending on Medicaid.\(^8\) The presumption behind the increased tax revenues presupposes that employers would spend less for health insurance, on the value of which employees pay no federal income tax, and would allocate the savings to increased monetary compensation of employees, which is

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\(^4\) A small employer is one who had an average of at least two but no more than 50 employees during the preceding calendar year and who has at least two employees at the start of the plan year. See 42 U.S.C. § 300gg-91(e)(4) (West 2006).


\(^6\) See, e.g., id., §§ 802 – 805.

\(^7\) Id., § 808.

of course taxable. It would decrease federal spending on Medicaid because an estimated 135,000 people who are presently on Medicaid would obtain private health insurance benefits as a result of the bill, if Congress enacts it. It would also yield an estimated net increase of 600,000 in the number of people nationwide with employment-based coverage.

This bill furthermore appears to harmonize quite well with the recent section 1115 waiver granted to Florida, and with other waiver proposals contemplated or pending in other states. The Florida waiver, among its other provisions, permits Medicaid beneficiaries to “opt out” of Medicaid in favor of obtaining private health insurance coverage through their employers, if their employers offer any coverage, and having the state pay the employees’ share of the premium. Small employers who may offer only low wages to a majority of their employees and who presently offer no health benefits at all are one target of the sponsors of S. 1955. Such employers may have employees who are covered by Medicaid or whose dependents are covered by Medicaid. Association health plans under the bill offer the possibility of less expensive coverage with thinner benefits for those employers who will not or cannot provide more comprehensive coverage for their employees. By encouraging such employers to offer coverage where some, at least, may previously have offered none, the bill furthers the present administration’s stated goal of shifting individuals from public coverage to private coverage.

From the foregoing assessment, S. 1955 would appear beneficial to nearly everyone. This, however, is not necessarily the case. It may indeed be beneficial to the federal government, in yielding it an estimated $3.3 billion in additional tax revenues between 2007 and 2016 and in reducing federal spending on Medicaid by an estimated $790 million over the same period. State governments would also share in some savings, by reducing their Medicaid outlays by an estimated $600 million between 2007 and 2016. However, there is more at stake here than achieving cost savings. Here, cost savings would be achieved not only by achieving economies of scale, but also by providing coverage for fewer benefits. A small business health plan, under S. 1955, would be

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9 Id.
10 Id. at 5.
11 Id.
15 See, e.g., CONGRESSIONAL BUDGET OFFICE, supra note 8, at 4 (observing that, “under the bill, premiums in the small-group market are expected to average about 2 percent to 3 percent lower than otherwise”).
17 CONGRESSIONAL BUDGET OFFICE, supra note 8, at 6.
18 Id. at 9.
permitted to “exercise[e] its sole discretion in selecting the specific benefits and services consisting of medical care to be included as benefits under such plan or coverage,” apart from meeting certain minimal requirements under the bill.19 As such, it could forgo offering various benefits that many of us who enjoy relatively comprehensive health insurance presently take for granted. This result would leave employees who need such benefits paying for their care out-of-pocket or going without any care at all.20

If the purpose of health insurance is to provide coverage for unexpected health care needs and, more recently, to encourage us to use preventive care in the hope that we forestall more costly illnesses, then the baring of benefits is not a trend that we should encourage. It would be one thing, perhaps, if small business health plans under S. 1955 would cover only those who are presently uninsured. Arguably, thin coverage is better than no coverage at all. But this is not the case. Any small employer can potentially participate, whether or not it presently provides health coverage to its employees.21 Small employers who are struggling to keep up with premium cost increases that have outstripped the rate of inflation for nearly a decade now may find the cost relief potentially offered by association health plans too enticing to pass up.

Yet the cost relief such employers may experience will not somehow make their employees healthier or less liable to be injured. When illness and injury occur, someone will have to pay the price. Association health plans leave employees bearing more of the costs. We should consider carefully whether this is the sort of health insurance that we, as a country, want to foster.

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19 S. 1955, supra note 5, at § 805.
20 This is hardly the only complaint one can make about the bill. For example, S. 1955 would give oversight of such plans to the Department of Labor. Presently, health insurance is largely regulated by the states under the McCarran-Ferguson Act. See 15 U.S.C.A. §§ 1011, 1012 (West 2006). According to at least one observer who served as Deputy Secretary of Labor in the first Bush administration, the Department of Labor currently does not possess the staff, the budget, or the regulatory expertise to properly oversee a federal association health plan regime of this sort. Roderick A. DeArment, The Department of Labor Lacks the Staff, Experience, and Regulatory Authority to Regulate Association Health Plans, 1 BUS. L. BRIEF 5 (2004). A weak regulatory regime can lead to problems such as those experienced with Multiple Employee Welfare Arrangements in the late 1970s and 1980s. See, e.g., id. at 9.
21 See S. 1955, supra note 5, at §§ 801, 804.