# CRITIQUE OF CONGRESSIONAL BUDGET OFFICE COST ESTIMATE FOR THE "SMALL BUSINESS HEALTH FAIRNESS ACT OF 2005" (H.R. 525)

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The purpose of this brief paper is to critique the Congressional Budget Offices (CBOs) estimate of H.R. 525 with particular emphasis on the number of persons who would benefit from the Act. 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.)

## SUMMARY OF FINDINGS

In developing its cost estimate for H.R. 525, a bill to encourage coverage of Association Health Plans (AHPs), CBO has estimated that, by 2010, when the legislation is expected to have its full impact, only about 620,000 people, both employees and dependents, will gain health insurance coverage as a result of the legislation. This estimate is approximately double the number of people CBO estimated would become newly insured when estimates were provided for similar legislation in 2000. However, we believe that CBO has substantially underestimated the number of currently uninsured people who would gain coverage if H.R. 525 were enacted. Other research, which we discuss below, has estimated that AHP legislation would result in insurance for an additional 4.5 million uninsured.

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We believe that CBO has substantially underestimated the number of people who would become insured as a result of AHP legislation. This underestimate arises from four factors. Two of the factors are the failure of CBO's model to fully account for 1) the number of uninsured who could be potentially affected by the legislation, and 2) the economic and demographic characteristics of the uninsured that might be affected. Most importantly, we believe that CBO's model is flawed because 3) it focuses on the price sensitivity of the uninsured to the cost of health insurance in the market. We believe that any analysis of the response of the uninsured to AHPs needs to focus on the value of the benefits in comparison to the premiums paid, not just the price. The uninsured are uninsured because the health insurance available to them provides them a poor value for the money they pay in premiums, not just because the price of health insurance is high. In this regard, we believe that 4) CBO has underestimated the potential for AHPs to provide value for the premiums paid and to reduce the cost of health insurance for the uninsured population. We discuss each of these factors below:

## UNINSURED POTENTIALLY AFFECTED BY THE LEGISLATION

There were 44.7 million uninsured in 2003 (EBRI Issue Brief No. 276, December 2004). All but 7.7 million of these uninsured had some connection to the workforce, and fully 27.0 million were in a family where the head was a full time full year worker. There is no data to indicate how many of these people either are, or could be, members of associations, and could thus potentially gain insurance through AHPs. However, the fact that a number as large as 27 million are in families with full time full year workers indicates that a significant portion could gain insurance through work based associations such as the National Association of Restaurant Workers, or National Association of Realtors. There are over 15,000 associations in the United States (NCPA Policy Report No. 259, April 2003). Many of these are employment related. Many of the uninsured who could not obtain insurance through an employment related AHP could gain it through a non-employment related AHP such as AARP. It is hard to imagine an uninsured person who could not gain health insurance through membership in some association if affordable health insurance were made available.

## ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF UNINSURED POTENTIALLY AFFECTED BY THE LEGISLATION

The uninsured population is composed substantially of healthy young workers in service, sales, or blue-collar jobs. These uninsured workers have low to moderate income and work for smaller firms (EBRI Issue Brief No. 276, December 2004). In most cases, if these workers chose to purchase health insurance, or if their employers chose to offer health insurance, their premiums would exceed the value of the health insurance product available to them. State regulations requiring community rating and mandated benefits would force these young, healthy, low income workers to pay higher premiums to pay for benefits they don't use and to subsidize older workers in larger firms with higher incomes.

## SENSITIVITY OF UNINSURED TO PERCEIVED VALUE OF INSURANCE

Being primarily young and healthy, and having low to moderate income, it is not surprising that the uninsured would be sensitive to the perceived value of health insurance to them. If the only health insurance available to the uninsured in the market place is loaded up with extra benefits that they don't feel they need or would use (such as benefits required by state of federal mandates), then they are wise not to purchase that product. Likewise, if the only health insurance available to them in the market place is insurance that forces them to subsidize older, higher income workers (because of state laws regarding community rating), then they are wise not to purchase that product. In fact, the only health insurance available to young, low income workers who work for small employers has both of these disadvantages.

While no direct studies of the sensitivity of the uninsured to the perceived value of health insurance have been performed, anecdotal evidence suggests that the uninsured respond much more favorably to perceived value in health insurance then the population in general. Two health insurance vehicles that provide appropriate value for the money paid in premiums for virtually everyone are Medical Savings Accounts (MSAs) and Health Savings Accounts (HSAs). When MSAs were introduced as a temporary pilot program, the IRS estimated that 73 percent of the people who bought them were previously uninsured (NCPA Policy Report No. 259, April 2003). Likewise, when HSAs, which are much more widely available, were made available in 2004, nearly 40 percent of the purchasers were previously uninsured (AHIP web site, April 2005). We believe these results show that the uninsured are particularly sensitive to perceived value in the health insurance market. In other words, the uninsured would purchase insurance if they could purchase an insurance product that provided appropriate value for the premiums they pay.

## POTENTIAL FOR H.R. 525 TO PROVIDE APPROPRIATE VALUE AND REDUCE PREMIUMS FOR AHPS

Having established that the number of uninsured who might benefit from H.R. 525 is in the tens of millions, and that these people are sensitive to perceived value in health insurance premiums, the question remains whether H. R. 525 could result in AHP plans that provide appropriate value and lower AHP premiums by an amount sufficient to induce a substantial portion of the uninsured to purchase health insurance. H.R. 525 will result in appropriate value and reduce premiums for AHPs substantially in two ways: 1) eliminating state mandates from the cost of insurance, 2) reducing the impact of state regulations requiring community rating from their premiums. Community rating regulations force younger, lower paid workers in small firms to subsidize older, higher paid workers in larger firms.

CBO has estimated that changes similar to those in H. R. 525 could reduce premiums by between 9 percent and 25 percent (INCREASING SMALL-FIRM HEALTH INSURANCE COVERAGE THROUGH ASSOCIATION HEALTH PLANS AND HEALTHMARTS, CBO, January, 2000). These estimates are national average estimates. The reductions would be much greater in states with the highest benefit mandates and the most stringent community rating requirements. We believe that if CBO were to take into account the higher impact of the legislation in states with the highest benefit mandates and the most stringent community rating requirements, their estimates of the increase in the number of insured would increase significantly.

## COMPARISON WITH OTHER ESTIMATES

When similar legislation was introduced in 2000, Mark Joensen of CONSAD Research Corporation testified before the House Committee on Small Business on February 16, 2000 that his best estimate was would that AHP legislation would increase employer-sponsored health insurance coverage by 2.3 million workers and 2.2 million dependents, for a total increase in health insurance coverage of 4.5 million persons. He also presented a more optimistic estimate of 8.5 million persons newly covered as a result of the AHP legislation. In light of what we know about the number of uninsured, their income, their connection to the work force, and their sensitivity to value, we believe that the CONSAD estimate is much closer to the mark then the CBO estimate. Even the CONSAD estimate could be too low because of its use of price sensitivity rather than value for the premiums paid.

## CONCLUSION

There are over 44 million uninsured in the United States. More than 27 million of these uninsured are in families with at least one full time full year worker. The uninsured are primarily young workers with low to moderate income working for smaller firms. The evidence suggests that these workers choose not to buy health insurance, or their employers choose not to offer it, because state insurance regulations mandating benefits and requiring community rating make the insurance products currently on the market a poor value in comparison to the premiums that the uninsured would have to pay. H. R. 525 would allow AHPs to largely bypass these state regulations and offer health insurance that offers appropriate value for the premiums paid. The evidence further suggests that AHPs could become available to the vast majority of the uninsured and that the uninsured population would purchase health insurance that provided appropriate value for their premiums. CBO should consider revising its estimation methodology to take into account the value of health insurance in relation to the premiums paid, rather than the sensitivity to the cost of insurance.