

ASSOCIATION HEALTH PLANS

STATUS

When Republicans controlled the House, they passed Association Health Plan (AHP) legislation in the 108th and 109th Congresses. In the 110th, the effort began to morph into other various initiatives, and eventually the Patient Protection and Affordable Care Act (PPACA) introduced the concept of the state health care exchanges which makes the AHPs a moot point. The exchanges are scheduled to go into effect in 2014.

The House majority, having voted to repeal PPACA, has indicated they intend to pass a revived AHP bill.

LEGISLATION

The version of the AHP bill in the 110th Congress, the Small Business Health Fairness Act, would have established a number of provisions that plans must include to become certified as Association Health Plans (AHPs), and would have exempted such plans from state insurance laws and regulatory oversight. The proposal would have removed states' authority to apply a large body of insurance laws and regulations including consumer protections, solvency and fair market practices, grievances and appeals procedures, premium taxation, and prohibitions on discrimination. Instead, the measure would have established the federal government as having the sole regulatory authority over these entities except in the case of state laws that prohibit the exclusion of a specific disease from coverage, or relate to newborn and maternal minimum hospital stays, and mental health parity.

This bill would establish non-discrimination provisions that would prohibit AHPs from rejecting less healthy applicants from coverage or targeting those individuals for higher premiums. Reserve and solvency requirements would replace states' laws that would no longer apply. [Those provisions and the other requirements of the bill would be enforced by the "applicable authority" sometimes the Secretary of Labor and at other times, the state agencies responsible for the regulation of insurance.]

Certified AHPs would also include the following features:

- AHPs must offer at least one insured health coverage option unless:
- the self-insured plan existed before the date of enactment of the bill;
- membership is not restricted to one or more trades; instead, employers representing a broad cross-section of trades and businesses or industries are eligible;
- the plan covers eligible participating employees in one or more of the high-risk trades (as listed in the bill).

The association sponsoring the plan must have been in existence for at least three years and be operated by a board of trustees with complete fiscal control and responsibility for all operations.

AHPs must have at least 1,000 participants and beneficiaries, and have offered coverage on the date of enactment or represent a broad cross-section of trades, or represent one or more trades with average or above average health insurance risk.

All employers who are members must be eligible to enroll, all geographically available coverage options must be made available upon request to eligible employers, and eligible individuals cannot be excluded because of health status.

Premiums for any particular small employer are prohibited from being based on the health status or claims experience of its plan participants or on the type of business or industry in which the employer is engaged.

The bill would establish requirements regarding who may participate on the board of trustees for qualified AHPs. The board may include owners, officers, directors, or employees of the participating employers or partners of the participating employer who actively participate in the business. Service providers to the plan may also be members of the board if they constitute not more than 25 percent of the membership of the board and do not provide services to the plan other than those on behalf of the sponsor.

The bill would establish an "Association Health Plan Fund" from which the Secretary of Labor (or applicable authority) would make payments to ensure continued benefits on behalf of AHPs in distress. The fund's activities would be financed by annual payments made by AHPs.

Senator Enzi (R-WY) laid out five principles in the 110th Congress for AHP legislation:

- Association-based plans should have the opportunity to harness the advantage of independent pooling and play a commercially meaningful role in the coverage marketplace, and if that puts market pressure on insurers, so much the better. At the same time, however, the coverage provided to association members should be subject to underlying regulatory and consumer protection requirements substantially comparable to those applicable to all entities offering similar coverage.
- The current hodgepodge of varying state health insurance regulations should be streamlined, thereby easing administrative and regulatory costs, and facilitating a larger number of plans in more states. Under such an approach, states would be encouraged or required to adopt common sets of rules in targeted areas of health insurance regulation, such as rating and underwriting, though state oversight and enforcement authority would remain.
- Individuals and businesses should have the opportunity to purchase lower-cost plans that are free or largely free of state benefit mandates. Though most purchasers will likely choose fuller coverage, it is important to assure that lower-cost alternatives exist as a safeguard for those who are struggling at the margin.

- Primary responsibility for most insurance oversight and consumer protection should remain with the state insurance commissions--including the right to assess health plans, including association health plans.
- The focus of immediate efforts should be on policies that do not require significant Federal outlays.

ANALYSIS

Opinions about the potential impact of AHPs on the small group insurance market span the continuum of possibilities. Advocates for AHPs view removing the state regulatory barriers and creating federal standards as ways to encourage the growth of pooling options. By releasing multi-state pools from the regulatory burdens of each state in which enrollees reside, these provisions would increase the options available to small employers who want to offer health insurance as a benefit but cannot. In addition, some argue that the increased risk to small firm coverage could become spread across larger groups of employers making health insurance as accessible to workers in small firms as to those in large firms. Most importantly, their supporters say that releasing AHPs from most state benefit mandates will allow those groups to offer more affordable, slimmed down benefit packages that may be desirable to workers who are now uninsured.

Opponents raise concerns about the impact the legislation would have on adverse risk selection in the small group markets and the solvency of plans, and about the Department of Labor's (DOL) ability to ensure that enrollees are protected from enrolling in fraudulent or inept plans.

Insurers naturally have incentives to select the most favorable risks among the individuals or groups that are seeking coverage, while rejecting others. While the goal of insurance is to spread risk, policies or practices that allow beneficial risk selection have the opposite effect. This risk selection concern is raised regarding AHPs because of the provisions exempting AHPs from state laws mandating that certain benefits be provided by plans, limiting and defining how policies are to be priced, and defining fair marketing and business practices. All 50 states have such laws, many of which are intended to maintain well-spread risk in the small employer insurance markets. Opponents fear that AHPs would attract healthier firms since firms with sicker employees would not want plans that exclude the state mandated benefits and protections. If AHPs attract predominantly healthy small firms out of the traditional small group market, firms with less healthy employees could face even higher premiums. A risk selection spiral could become activated, to the detriment of those left outside of the AHPs and firms with sick employees would be especially at risk.

The bill tries to address the concerns about risk selection by including provisions that discourage AHPs from actively pursuing healthier employee groups and rejecting or discouraging higher risk groups from joining. The bill would prohibit discriminatory membership policies and plan pricing based on health status of employees or their dependents. It would also prohibit AHPs from requiring that member employers purchase health coverage through the AHP. The bill restricts self-insured health plans from becoming qualified AHPs. However, self-insured plans that existed prior to enactment would be grandfathered in. The bill would also prohibit a

participating employer from providing health insurance coverage in the individual market for any employee excluded from the AHP which is similar to the coverage provided under the AHP; if such exclusion is based on a health status related factor and such employee would otherwise be eligible for coverage under the AHP. Finally, it would require AHPs to offer their plans to all employers who are eligible to participate and also require, upon request, that any employer who is eligible to participate be furnished information regarding all available coverage options.

Some consumer advocates and state regulators fear that those provisions may not be enough. The provisions, they say, do not provide for the fair marketing rules and patient protections as established by the states. Moreover, their concerns relate not only to the ability of AHPs to reject higher risks, but also to the incentives that encourage certain small firms to sort themselves into AHPs versus insured plans, such as the ability of AHPs to offer trimmed down benefits.

Opponents cite Congressional Budget Office (CBO) estimates that 20 million employees and dependents, 80 percent of workers in small firms, would face rate increases and 10,000 of the sickest people would lose coverage while overall enrollment in employer-sponsored health care would increase by only about 330,000.

Opponents believe the AHP legislation would preempt traditionally state-regulated areas such as solvency requirements, consumer protection rules, benefit mandates, and certain ratings laws. The proposal would place self-funded AHPs under the jurisdiction of the DOL. Opponents claim the DOL lacks the funding and manpower needed to regulate AHPs.

STATE EXCHANGES UNDER PPACA

States are required to establish American Health Benefit Exchanges by 2014. Individuals may obtain their coverage through these Exchanges. Most subsidies under PPACA for individuals are tied to coverage through the Exchanges.

These Exchanges will include Small Health Option Programs (SHOPs) through which small businesses may obtain coverage. Generally, small businesses with up to 100 employees will be able to acquire coverage through the Exchanges. After 2016, States may expand the pools to include larger employers.

OUTLOOK

On a theoretical level, it does not appear possible state health Exchanges and AHPs could co-exist. AHPs would draw all the low risk insured out of the state pool.

As a practical matter, the Senate majority will not allow any health care “reform” legislation come to the floor if they view as incompatible with last year’s reform law.