

# Insurance Markets

## What Would Association Health Plans Mean for California?

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January 2004

### Introduction

Legislation passed by the U.S. House of Representatives<sup>1</sup> and advocated by the Bush administration would allow business associations to offer federally licensed health insurance plans that are exempt from state insurance regulation. Associations representing small business have been promoting such legislation for many years, arguing that it would result in lower premiums for health insurance, expand coverage to the uninsured, and give small business more bargaining leverage with insurers.

Small businesses face special challenges in providing health insurance to their employees. Compared to large employers, they are less likely to offer coverage, often face higher premium increases, and tend to provide more limited benefits. A large percentage of uninsured people work for small firms or are dependents of those who work for small businesses. Support for federal association health plan (AHP) legislation recently has taken on new urgency, in part because the double-digit annual premium hikes of the past few years have made it much more difficult for small businesses to afford health insurance.

On the other side of this debate are consumer groups, state government officials, and the insurance industry. They claim that the association

health plan legislation would cause considerable disruption to the market without reducing the number of uninsured. They raise concerns that AHPs would be able to attract healthier groups, thereby increasing prices for people in the state-regulated part of the health insurance market. They also argue that the legislation would allow AHPs to operate in a largely deregulated environment, resulting in inadequate health benefits for many consumers, managed care plans with fewer protections for patients, greater consumer exposure to the risk of plan insolvency, and, in some cases, fraud.

This brief provides a short summary of the AHP legislation and highlights the key findings of a study prepared for the California HealthCare Foundation that examines the likely consequences of the bill for California consumers and the state's health insurance market. (The complete study, "What Would Association Health Plans Mean for California?: Full Report" is available at [www.chcf.org](http://www.chcf.org).) In preparing the larger report, the authors analyzed the federal legislation, reviewed other studies of the legislation's impact, and interviewed experts and industry representatives familiar with the California market, as well as opponents and proponents of the legislation.

## Background

The AHP legislation (HR 660 and S 545) would directly affect people receiving coverage from private-sector employers as well as consumers who purchase individual policies. It would not apply to those enrolled in government-sponsored employee health plans and government insurance programs such as MediCal.

About 77 percent of covered workers in California are in fully insured plans that are licensed and regulated by state agencies. The rest are in self-insured plans. Self-insured, private-sector plans operate under federal employee benefit law and are not regulated by the state.<sup>2</sup> The prevalence of self-insurance is relatively low in California, due in part to the popularity of state-regulated managed care products. Therefore, California currently regulates a much larger percentage of its health insurance market than most states. The small-group health insurance market (serving employers with 2–50 employees) is the most heavily regulated. Under existing state and federal laws, insurers who sell small-group policies must offer coverage to small businesses upon demand—even when a group is expected to have high future medical claims. They must also renew such policies and stay within regulatory limits when pricing policies based on the medical conditions of group members.

In addition, California regulates five licensed multiple-employer welfare arrangements (MEWAs) that cover approximately 250,000 people. These provide a way for employee health plans to band together to try to increase their purchasing power, and in some cases they have improved access to health coverage for certain types of businesses and people with seasonal jobs, such as agricultural workers. However licensed MEWAs

now comprise a very small part of the market. What's more, California law does not permit any new MEWAs to be licensed, in part because these types of arrangements have a long history of financial instability. Under the proposed federal law, AHPs, which are a type of multiple-employer arrangement, would be licensed by the federal government and operate under federal supervision. AHPs would draw employer groups and individuals from existing market segments, leaving less of the market under state supervision.

### Highlights of Federal Association Health Plan Legislation (HR 660 and S 545)

- Creates federal licensure of health plans sponsored by professional and trade associations.
- Sets up criteria for association health plans (AHPs) to qualify for licensure.
- Allows AHPs to offer coverage to employers of any size or individuals.
- Establishes federal standards for fully insured and self-insured AHP coverage.
- Exempts AHPs from state insurance laws, including rating rules and benefit mandates.
- Requires self-insured AHPs to meet federal solvency standards. (Allows state solvency standards to continue to apply to fully insured policies offered by AHPs.)
- Authorizes AHPs to operate nationwide.
- Gives U.S. Department of Labor authority to license and regulate AHPs.

For complete bill summary see Appendix on p. 30 of full report.  
[www.chcf.org/topics/view.cfm?itemID=21661](http://www.chcf.org/topics/view.cfm?itemID=21661)

## Key Elements of the AHP Legislation

The House and Senate legislation would create federal licensure for association health plans (AHPs) offered by qualified business associations, exempting such plans from state insurance standards and oversight. The U.S. Department of Labor would license and regulate AHPs.

The legislation would authorize qualified associations to offer both fully insured and self-insured coverage to member employers and individuals. Fully insured AHPs would pay a premium to an insurance company or a health maintenance organization (HMO), which would assume the risk for paying claims. Self-insured AHPs would retain the risk for paying claims. In either case, the AHP or a sponsoring organization would collect contributions from member employers or individuals.

Both the AHP and its insurer would have discretion, with few exceptions, to design coverage options offered through an AHP, and select covered benefits, care and services, and providers. AHPs would not be subject to most state laws setting standards for health insurance policies, such as those requiring inclusion of certain benefits and services and protecting vulnerable populations.

Although the legislation does require AHPs to renew coverage, the coverage may be different from the original policy bought by an employer. Therefore, an AHP would be able to switch an employer to another type of coverage if plan members developed expensive medical conditions. Current law requires insurers to renew policies regardless of the claims experience of the group and, if the insurer changes an employer's benefits upon renewal, such changes must apply to all employers with that policy.

The bills would allow insurers and managed care firms to sell AHP policies in the state without complying with California's standards as long as such policies were approved for sale by another state. Additionally, the bills would allow insurers selling AHP coverage to market these products not only to members of the association, but also to employers that are eligible for membership but not enrolled.

The bills would allow AHPs to target marketing to healthier risks in a number of ways. For example, depending on factors such as its membership base, an AHP could offer or restrict coverage to certain types of employers and individuals. The bills' language appears to allow an AHP to establish eligibility criteria based on the size of the firm. (In California, insurers interviewed said they already charge firms with fewer than 10 employees the highest allowable rates because utilization of health care is highest on average among the smallest employer groups.) AHPs also could attract healthier risks because these plans would not be subject to state benefit mandates and rating laws. Less comprehensive, lower-cost benefits offered by AHPs would tend to be more attractive to healthier groups and individuals than those with medical conditions.

Language in the legislation is ambiguous on many key consumer protection issues. These include:

*Guaranteed access to AHP coverage.* It is not clear if some small businesses could be excluded from AHPs on the basis of an employer's risk characteristics (e.g., by using a proxy for risk such as size of employer).

*Premiums.* The legislation does not require an AHP to comply with state premium rules, which limit insurers' ability to charge small groups with people in poor health a higher rate than groups with healthy people.

However, due to ambiguous provisions, it is unclear how premiums would be set for small businesses enrolled in AHPs and whether small businesses with relatively high medical costs could be surcharged without limitations.

*Managed care standards.* The federal legislation would establish new standards on how state law would be preempted with regard to AHP coverage. Because courts may interpret these standards differently than current preemption standards applying to private-sector health plans, it is not clear which, if any, state consumer protections would continue to apply to insurance and managed care products offered by AHPs. (See Table 1.)

## Findings

Despite claims made by some partisans on both sides of the AHP debate, studies of the legislation’s impact by impartial analysts estimate that the legislation would have a minimal effect, if any, on the number of uninsured. For example, in examining two versions of the AHP legislation, the non-partisan Congressional

Budget Office (CBO) determined that small-group enrollment would increase by less than 2 percent were they to become law. An Urban Institute study (commissioned by the California HealthCare Foundation in conjunction with this report) came to a similar conclusion with regard to California, finding that the legislation would do little to change the level of overall coverage in the state.<sup>4</sup> (The study, “The Effects of Introducing Federally Licensed Association Health Plans in California: A Quantitative Analysis,” is available at [www.chcf.org](http://www.chcf.org).)

Passage of federal AHP legislation could, however, significantly alter California’s private-sector health insurance market, with some small businesses and insurers benefiting and others being adversely affected. Many of the roughly 22 million Californians whose health insurance is now regulated by state agencies would find themselves in AHP plans licensed and regulated by the federal government and other states. The most significant impact would likely occur in California’s small-group market, which covers about

**Table 1: Impact of Proposed AHP Legislation on California Consumer Protections**

CALIFORNIA STANDARDS	CA-regulated Insurance (non-AHP)		Self-insured AHPs		Fully insured AHPs	
	Current Law	Proposed Legislation	Current Law	Proposed Legislation	Current Law	Proposed Legislation
<b>Small Group Reforms<sup>3</sup></b>	Apply	Still Apply	Apply	Would Not Apply	Apply	Would Not Apply
<b>Managed Care Standards</b>	Apply	Still Apply	Apply	Would Not Apply	Apply	Unclear* (probably preempted)
<b>Benefits Requirements</b>	Apply	Still Apply	Apply	Would Not Apply	Apply	Would Not Apply**
<b>Protection for Special Populations (e.g., Cal-COBRA)</b>	Apply	Still Apply	Apply	Would Not Apply	Apply	Would Not Apply
<b>Solvency Requirements</b>	Apply	Still Apply	Apply	Less Stringent Federal Solvency Requirements	Solvency rules apply to insurer under contract with AHP.	

\*State law may be preempted by federal legislation. Additionally, if not preempted, then state law may not apply if the insurance company or HMO files the policy form for approval in another state. Only that state’s standards would apply. “Prompt pay” law explicitly not preempted.

\*\*State laws implementing the federal Newborns and Mother’s Health Protection Act, Mental Health Parity Act, and the Women’s Health and Cancer Rights Act would still apply. For a detailed discussion of benefits requirements, see full report.

three million people, because this is the most highly regulated part of the market. The following section describes some of the key ways federal AHP legislation would affect consumers and the California market.

### **Impact on Consumers**

*Winners and losers.* The AHP legislation would create winners and losers among consumers, particularly those covered by the small-group market. Many small firms with relatively healthy employees might be able to buy less-expensive, less-regulated coverage through AHPs than they now can in the state-regulated market. Employer groups with higher-than-average health costs, however, would be more likely to remain in the state-regulated market. As premiums in the state-regulated portion rose, some groups might be priced out of the market.

If AHPs drew off many of the healthier groups, the risk pool in the state-regulated small-group market would become comparatively sicker — driving up their premium rates. Over time, this could make it difficult or impossible for some small businesses and workers to obtain and afford coverage.

*Loss of consumer protections.* Consumers enrolled in AHPs would lose state-based consumer protections. Federally licensed AHPs would be exempt from many state insurance laws, including most benefit mandates, coverage continuation requirements, solvency standards (for self-insured AHPs), and small-group market reforms, which include requirements for insurers to sell products to small groups regardless of their health status and limitations on surcharging groups with sicker employees. (See Table 1.) Due to ambiguous language in the legislation, it is unclear whether California standards for managed care plans, which currently

apply to health plans covering most state residents and include independent external review of coverage denials, would be nullified for workers whose employers bought AHP coverage. People in self-insured AHPs would lose state-based dispute resolution options they now have. Broadly preempting state laws while not replacing them with comprehensive federal standards would result in fewer protections for consumers covered by AHPs than consumers would have in state-regulated health plans. On the other hand, fewer regulatory standards would make AHP coverage less expensive.

*Increased market complexity.* The introduction of self-insured AHPs regulated from Washington, D.C., and of fully insured AHPs regulated both by the federal government and by out-of-state insurance departments would greatly complicate California's health insurance market.

California's health insurance market is already more complex than most because two state agencies split jurisdiction for managed care and more traditional health insurance products (with some overlap).<sup>5</sup> As in other states, federal law also currently allows private-sector employers to self-insure their plans and avoid state regulation.<sup>6</sup> Adding various types of federally licensed AHPs to the regulatory mix, as would occur under the proposed legislation, could be very confusing for consumers; people encountering problems with their coverage often need to figure out which set of regulations apply to their health plan as well as where to turn for help in navigating those rules. To settle disputes with the health insurers, consumers might have to negotiate with insurers and seek help from regulators in other states. And if disputes were not resolved, individuals might have to take insurers to court in other states.

## Impact on Health Insurers and the Market

*A shift to AHPs.* A significant portion of the existing state-regulated small-group market could shift to federally licensed AHPs. Due to the complexity both of the market and the legislation, it is difficult to predict the degree to which AHPs would draw employer groups away from the state-regulated small-group market and the degree to which premiums in various market segments would change.

Studies summarized in the full report provide a range of estimates. In July 2003, the CBO, the agency that provides cost estimates of federal legislation, released a cost estimate of HR 660 finding that by 2008, when the effects of the legislation are assumed to have their full impact, about 24 percent<sup>7</sup> of people covered in the small-group market nationwide would be enrolled in AHPs.<sup>8</sup> In 2000, the CBO estimated that an earlier version of the legislation would result in a somewhat smaller AHP market penetration (19 percent) and would lower premiums by about 13 percent for firms purchasing in the AHP market segment, due to lower costs resulting from both state mandate exemptions and the ability to attract firms with relatively lower expected medical costs.<sup>9</sup> This would increase premiums by about 2 percent for firms left in the traditional state-regulated market.

A model developed by the Urban Institute to estimate the impact of HR 660 on California found that 36 percent of covered business establishments in the small-group market would be covered by AHPs after the law took full effect. The Urban Institute study estimated that AHPs would experience an average price decrease of 14 percent, in part due to favorable risk selection, causing premiums to rise in the state-regulated portion of the small-group market by

5 percent. Studies commissioned by proponents and opponents of AHP legislation have estimated larger effects on the market.

One reason that AHP market penetration would be significant is that insurers would face strong financial incentives to enter and provide restricted benefits through the AHP market, in part as a strategy to defend against adverse selection. Insurers operating in the state-regulated portion of the market also might respond by offering policies similar to health benefits offered by AHPs to the extent allowable under state law.

*Erosion of managed care.* Some types of insurance companies might gain a competitive advantage from selling through an AHP, while others may not be able to adjust. It is questionable whether companies that have specialized in providing HMO coverage, which has dominated California's health insurance market and helped keep premiums below the national average (at least in the past), could compete as well as those that offer PPO coverage and high cost-sharing plans in the AHP market. It might be harder for HMOs that traditionally have offered comprehensive benefits and first-dollar coverage to increase cost-sharing (through deductibles) and more difficult to offer HMO coverage that is stripped down. Depending on the language in the final legislation, however, HMOs might be able to offer lower-cost policies through AHPs by avoiding managed care consumer protections (for example, laws requiring that HMOs have adequate provider networks, provide maternity coverage, and give consumers access to independent external review of coverage denial decisions).

## Increased Risk of Plan Insolvencies, Fraud

*Weaker financial standards.* Consumers receiving coverage from AHPs might be at increased financial risk due to federal solvency standards that are less stringent than state standards. While creating less-expensive coverage options that may be beneficial to some employer groups, self-insured AHPs could place many California consumers at risk of having to pay their own claims in case of a plan insolvency because these AHPs would be subject to new federal solvency rules that are much weaker than state standards.

Self-insured, multiple-employer purchasing organizations, including MEWAs and those sponsored by associations, have a long history of financial instability that ultimately prompted the U.S. Congress in 1983 to give states a great deal of latitude to regulate them. California is among the states that regulate self-insured MEWAs, including those sponsored by business associations, but the majority of states require such arrangements to be licensed as insurers and do not allow self-insured MEWAs to operate.

The legislation would establish new federal solvency standards governing self-insured AHPs. However, the proposed standards are much less stringent than those that California applies to insurance companies and HMOs. The U.S. Department of Labor, which would administer these standards, has no experience in regulating health plan solvency and would have to develop such expertise. Should self-insured AHPs become insolvent, the legislation provides no guaranty fund to cover unpaid claims. The lack of strong solvency standards—coupled with an inexperienced federal regulatory agency with limited administrative tools to prevent insolvency—may increase the risk of plan failures. Insolvent federally regulated AHPs may leave

California small businesses and their employees with unpaid medical bills and without health insurance. Ultimately, this could result in pressure on Congress to have the government cover the cost of future plan insolvencies, thereby putting federal taxpayers at financial risk.

*Exposure to fraud.* In addition to the financial risk health insurance consumers generally face due to potential plan insolvencies resulting from mismanagement or adverse business conditions, businesses and individuals may be at increased risk of fraud.<sup>10</sup> In the past, promoters have sold illegal health plans through associations they established or through existing legitimate trade and professional associations. States have an array of tools enabling state regulators to find and quickly shut down phony health plans to protect associations, small businesses, and their workers. Given past experience in addressing fraud, by not expanding administrative tools available to the federal regulators, the legislation may not give the U.S. Department of Labor the authority it needs to respond quickly and effectively. The bills' broad preemption of state law would severely limit states' ability to stop promoters from selling phony health plans to federally licensed AHPs. The combination of restricted state jurisdiction and limited federal authority may open the door to opportunities for additional fraud.

## Conclusion

Although the total number of uninsured is not likely to change much under AHP legislation, small groups with healthier employees might enjoy lower premiums than they now have, but groups whose members have medical conditions might have increased difficulty in finding affordable coverage. Premiums for most people

covered by California's small-group market would likely rise somewhat. Additionally, the legislation may leave millions of Californians without many consumer protections available under state law while increasing the risk of insolvency and fraud.

The introduction of AHPs could provide small employers with more leverage to prompt insurers to experiment with new, less expensive benefit designs. However, AHPs also could cause an erosion of managed care in California, which ultimately could result in higher costs for employers and individuals.

Finally, neither the AHP legislation—nor, for that matter, the state and federal laws currently governing insurers and employee benefit plans—provide long-term solutions to escalating health care costs that make it increasingly difficult for small businesses to offer and pay for employee health benefits. Many small businesses, especially those with many low-wage workers, simply lack the financial resources to provide health benefits. To begin offering insurance, small businesses may need additional financial resources. They also need guaranteed access to affordable insurance, regardless of whether some group members happen to have medical conditions.<sup>11</sup> The AHP legislation provides neither.

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## ACKNOWLEDGMENTS

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## ENDNOTES

1. The U.S. House of Representatives passed the Small Business Health Fairness Act of 2003 (HR 660) in June 2003. The legislation faces an uncertain future in the U.S. Senate where opposition to it has been stronger than in the House over the years.
2. Employers offering fully insured health benefits must also comply with federal employee benefits law.
3. For more information see Debra L. Roth, *Insurance Markets: Rules Governing California's Small Group Health Insurance Market*, California HealthCare Foundation, June 2003 (hereinafter CHCF Small Group Market) (<http://www.chcf.org/topics/view.cfm?itemID=20740>).
4. Urban researchers modeled the impact of the AHP legislation using a range of assumptions, all of which resulted in a change in the number of uninsured of one percent or less.
5. The California Department of Managed Health Care regulates HMO coverage under the Knox Keene Act and the state Department of Insurance regulates more traditional health insurers. Insurers or managed care firms offering preferred provider organization (PPO) products can obtain licenses to sell such products from either agency.
6. The larger the employer, the more likely it will self-insure its health plan. Very few small employers (with 2–50 employees) self-insure their health plans because of the financial risk posed. See Patricia Butler and Karl Polzer, *Regulation of ERISA Plans: The Interplay of ERISA and California Law*, California HealthCare Foundation (June 2002) for further discussion.
7. This figure was derived by dividing CBO's estimated number of AHP enrollees in the small-group market (7.5 million) by its estimate of the size of the small group market in 2008 (30.7 million) (<http://www.chcf.org/topics/view.cfm?itemID=19795>).

8. See Congressional Budget Office, letter to the Honorable George Miller, Senior Democratic Member, Committee on Education and the Workforce, U.S. House of Representatives, June 18, 2003, downloaded from CBO's Web site August 8, 2003 (<http://www.cbo.gov/showdoc.cfm?index=4352&sequence=0>), and Congressional Budget Office Cost Estimate: HR 660: Small Business Health Fairness Act of 2003 (as passed by the House on June 19, 2003), July 11, 2003, downloaded from CBO's Web site August 6, 2003 (<http://www.cbo.gov/showdoc.cfm?index=4413&sequence=0>).
9. *Increasing Small-Firm Health Insurance Coverage through Association Health Plans and Healthmarts*, Congressional Budget Office, January 2000. Downloaded from CBO Web site April 3, 2003 (<http://www.cbo.gov>).
10. For more information see Mila Kofman, Kevin Lucia, and Eliza Bangit, *Proliferation of Phony Health Insurance: States and the Federal Government Respond*, BNA Plus, August 2003.
11. See Karl Polzer and Jonathan Gruber, *Assessing the Impact of State Tax Credits for Health Insurance Coverage*, California HealthCare Foundation, June 2003 (<http://www.chcf.org/topics/view.cfm?itemID=20727>).

Future editions will identify trends in California's insurance markets, analyze regulatory and policy issues, and provide industry updates. Analyses will be posted as they become available at the California HealthCare Foundation's Web site at [www.chcf.org](http://www.chcf.org).

The California HealthCare Foundation's program area on Health Insurance Markets and the Uninsured seeks to improve the functioning of California's health insurance markets, particularly the small group and individual markets, and to expand coverage to the uninsured. For information on the work of Health Insurance Markets and the Uninsured, contact us at [insurance@chcf.org](mailto:insurance@chcf.org).

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