# What Would Association Health Plans Mean for California?: Full Report

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*Prepared for the California HealthCare Foundation by*

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# I. Introduction

For many years, small business associations have been advocating the passage of federal legislation that would allow them to market nationwide health plans that would be exempt from state health insurance regulation. They believe that such legislation would help them lower premiums, expand coverage, and give them more bargaining leverage with insurers. But they face sharp opposition. The health insurance industry, consumer groups, and state insurance regulators oppose such legislation, expressing concerns that it would create an uneven playing field, cause higher prices for much of the health insurance market (especially for groups with people in poor health) and expose consumers to new risks, including plan insolvency and, potentially, fraud.

In recent years, support for federal association health plan legislation has taken on new urgency, in part because it has become more difficult for many small businesses to afford health insurance coverage. Small businesses face many challenges in providing health coverage for their employees. Compared to the large employers, they are less likely to offer health insurance, often face higher premium increases, and tend to provide more limited benefits. A large percentage of uninsured people work for small businesses or are dependents of those who work for small businesses.[1]

As health care costs continue to escalate and the number of uninsured people continues to grow, policymakers are increasingly interested in private-market reforms to help improve access to and lower the cost of health insurance. Federal and state policymakers across the nation have been considering various options, including promoting multiple-employer purchasing arrangements—of which association health plans (AHPs) are one variety—as a way to increase access to health insurance for small businesses, their workers, and self-employed people.[2]

In June 2003, the U.S. House of Representatives passed the Small Business Health Fairness Act of 2003 (H.R. 660).[3] The bill would promote multiple-employer purchasing arrangements by encouraging professional and trade associations, such as the U.S. Chamber of Commerce, as well as associations targeted to specific industries, to offer health insurance. The bill would replace state-based regulatory standards with far less stringent federal standards in California and other states. This is based on the premise that fewer regulatory requirements make it less costly for

associations to provide benefits. The U.S. Senate may consider similar legislation (S. 545) introduced in 2003. President Bush has promoted association health plans as a way to help address the problem of nearly 44 million Americans lacking health insurance.

**Highlights of Federal Association Health Plan Legislation (H.R. 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 full bill summary, see Appendix.]*

The purpose of this paper is to take a close look at H.R. 660 and S. 545 and to identify the potential impact in California on consumers, employer purchasers, the insurance industry, and the market. Before describing the legislation in more detail, the paper provides background information about past policy interventions to help small businesses gain access to coverage and regulation of multiple-employer organizations such as AHPs, which is one way small businesses and their workers access health coverage. It analyzes the federal AHP proposals and compares the regulatory standards in the legislation to the consumer protections Californians now have under federal and state law. It reviews a range of sometimes-conflicting existing evaluations of how the legislation might impact the small-group market and affect the total number of uninsured. Considering claims made by both supporters and opponents of the federal legislation, it discusses the potential impact on California's consumers in light of its current market and regulatory environment.

The report concludes that the legislation is likely to have a significant impact on private-sector health coverage in California, particularly in the small-group market. Although the legislation would likely result in little or no change in the total number of uninsured Californians, the small-group market would likely be subject to considerable change. While some employers and their workers would likely be able to purchase cheaper coverage through AHPs, others left in the state-regulated market would probably experience premium increases because AHPs would be able to attract relatively healthier, less expensive groups, while relatively sicker, costlier groups would tend to remain in state-regulated plans. While freeing AHPs from state regulations would allow them to offer less expensive products, people covered by AHPs would not enjoy many of the same consumer protections.

In preparing this report, the authors analyzed the legislation, conducted a literature review, and interviewed representatives of industry groups and people involved in and knowledgeable about the California health insurance market, representing a broad range of perspectives. Interviewees included representatives of business associations (both those who support and those who oppose the proposed legislation), large and small insurance and managed care companies, health underwriters, small-employer health insurance purchasing organizations, and state policymakers.

# II. Background

In order to ascertain how the legislation would impact the marketplace and consumers, it is important to understand the historical context in which newly licensed AHPS would operate. The following section summarizes federal and state efforts to regulate employment-based health insurance, previous policy interventions designed to help small businesses gain access to coverage, and a pattern of market instability associated with multiple-employer purchasing arrangements, including AHPs.

Over the years, small businesses have experienced many obstacles in gaining access to health insurance. Policy interventions such as small-group insurance market reforms have helped some small businesses gain access to health insurance but have not addressed many problems small businesses continue to face in the marketplace.[4]

In addition to small-group reforms, over the years policymakers have sought ways to put small business buyers on par with large employers by establishing and encouraging the growth of multiple-employer purchasing groups, which, in theory, would have the bargaining power to negotiate better rates on behalf of small business members or, through economies of scale, reduce operational costs.[5] In some states, such efforts predated small-group reforms; in others, such interventions followed. In addition to creating a purchasing organization for small employers called the Health Insurance Plan of California (HIPC),[6] the California legislature enacted a law under which existing self-insured, multiple-employer purchasing groups could be licensed by the state. These multiple-employer arrangements—called multiple-employer welfare arrangements, or MEWAs,[7]—were exempted from premium taxes and were subject to solvency rules less stringent than those for insurers. However, to help preserve small-group market reforms, the legislature did not exempt MEWAs from those reforms. California law also does not allow any new MEWAs to be licensed.

Multiple-employer purchasing arrangements have emerged in the marketplace both in California and around the nation. As described below, a significant number of these arrangements, however, experienced problems with financial instability and fraud, particularly those that were self-insured. These problems have led to policy interventions at both the federal and state levels.

The AHP bills under consideration would amend the federal law that established standards for private-sector employee health benefits. This law, the Employee Retirement Income Security Act of 1974 (ERISA), has played an important role in reshaping the marketplace and has limited states' authority to regulate and reform the health insurance market. Below is a brief discussion of ERISA, the framework it established for employment-based coverage, and its amendments aimed at helping states deal with financial instability among multiple-employer organizations. Also discussed is how the market responded to ERISA, problems experienced by multiple-employer purchasing groups, the evolution of insurers' practices, and problems faced by small businesses.

## ERISA

In 1974, Congress passed ERISA, primarily to protect private-sector pension plans from well-documented problems of fraud and mismanagement. ERISA broadly preempted state authority to regulate employee benefit plans, including health plans, but allowed states to continue regulating health insurance. At that time, the vast majority of employee health plans were fully insured. In the years after ERISA's passage, the health insurance market began splintering as most large employers withdrew some or all of their health plans from the state-regulated market, becoming self-insured.[8] Though presenting more risk for employee benefit plans, self-insuring can reduce costs associated with:

- having an insurance company assume risk for paying claims,
- benefit mandates,[9]
- premium taxes,
- assessments for high-risk pools covering uninsurable people and guaranty associations protecting consumers against insolvency of their insurance company,
- rating requirements,
- solvency standards, and
- other state regulatory requirements applicable to insurance companies.

Self-insuring employers also avoid having their employees' claims experience pooled with other employers; if an employer happens to have relatively young and healthy employees, avoiding being pooled with other groups can lower costs. Self-insured plans covering employees in many states can also realize administrative savings by not having to comply with insurance standards that vary across states.

## Multiple-Employer Groups

Multiple-employer purchasing is based on a premise that larger groups can negotiate better rates through their purchasing power and, through economies of scale, save on administrative costs.[10] However, over several decades, many multiple-employer health insurance purchasing

organizations—and particularly those that self-insured—have become insolvent (see Table 1), leading many to believe that self-insured multiple-employer organizations (called MEWAs under ERISA) pose higher risk to subscribers than plans in the state-regulated market.[11] Some analysts have concluded that aggregations of employer groups formed to buy health coverage are inherently unstable (if employers are free to enter and leave at will) because of incentives for healthier groups to opt out, leaving sicker, costlier groups in the pool. Multiple-employer purchasing arrangements tend to proliferate during periods of rapidly rising health care costs and general economic distress, when employers are under the greatest pressure to control premium costs.

A significant number of multiple-employer purchasing groups have become insolvent, leaving thousands of Americans with millions of dollars in unpaid medical bills. In recent years, due in part to double-digit increases in premiums, the number of insolvencies increased nationwide.

**Table 1. Examples of Recent Multiple-Employer Group Insolvencies[12]**

| State | Year | Name | No. of Covered People | Outstanding Medical Claims |
|---|---|---|---|---|
| CA | 2001 | Sunkist Growers Inc. | 23,000 | $11 million |
| IN | 2002 | Indiana Construction Industry Trust | 22,000 | $20 million |
| NJ | 2002 | Coalition of Automotive Retailers | 20,000 | $15 million |
| NJ | 2003 | Licensed Beverage Association | 1,000 | $2 million |

Twenty states have specific solvency standards for self-insured multiple-employer groups.[13] The rest require such self-insured multiple-employer groups to comply with solvency standards applicable to insurers, and the ones that fail to do so are considered unlicensed insurers and shut down when found.[14] States' authority to oversee multiple-employer purchasing groups was not expressly clarified under ERISA until 1982, however.

The passage of ERISA—along with its preemption of state law—left a gray area with regard to states' ability to regulate multiple-employer purchasing arrangements that was partly responsible for a rash of insolvencies in the late 1970s and early 1980s. Multiple-employer arrangements that were not ERISA plans—most were not—claimed that states could not regulate them. While the worst of these insolvencies were frauds or Ponzi schemes, many of the multiple-employer plans that had financial problems were undercapitalized, had well-intentioned leadership that simply mismanaged them, or encountered problems with adverse selection—attracting disproportionate numbers of people with existing medical conditions.

In response to the insolvencies and to widespread fraud, in 1982 Congress amended ERISA to clarify that states can regulate "multiple-employer welfare arrangements" (MEWAs), arrangements that provide medical benefits to employees of two or more employers or self-employed people. Currently, with few constraints, states can regulate any arrangement that qualifies as a MEWA.[15] However, as discussed below, the proposed federal legislation would restrict (once again) states' ability to regulate multiple-employer purchasing groups when such arrangements obtained federal licenses to operate as AHPs.

## Problems in the Insurance Market and Small-Group Reforms

In the 1980s, the health insurance market became more fragmented with respect to risk**.** Most significantly, community rating—establishing health insurance rates based on the cost of benefits and claims experience of everyone who buys the policy—all but disappeared as insurance companies faced strong incentives to compete on the basis of risk, seeking to attract healthy consumers and avoid sicker ones. To accomplish this, insurers used strict medical underwriting to avoid bad risk, charged people with past or present medical conditions significantly higher rates, and, in some cases, did not renew coverage once a person became sick. Small businesses with even one employee with health problems often were denied access to coverage altogether or could not get coverage for the employee with the health problems.

In the early and mid 1990s, in response, states passed new laws to reform the small-group health insurance market. These reforms were designed to improve access to coverage for small businesses by prohibiting or minimizing "cherry picking" (only selling coverage to healthy people) by insurers and to make coverage more secure. Key consumer protections included specific rules on how small-group premiums are established (e.g., rate bands or community rates), prohibitions on excluding a person with health conditions from the group's coverage, requirements to renew policies (thereby protecting people who become sick), and portability rules to help avoid job lock.[16] In 1996, the U.S. Congress passed the Health Insurance Portability and Accountability Act (HIPAA)—largely based on state small-group reforms. The law established national standards prohibiting insurers from denying coverage to small businesses, limiting use of preexisting condition exclusions from coverage, prohibiting discrimination based on one's health, and requiring guaranteed renewability. HIPAA, however, left it up to the states to decide whether, and to what degree, to constrain what insurers might charge groups with relatively higher health risks.

Most states, including California, established rate restrictions in the small-group market. Rate restrictions limit insurers' ability to surcharge groups with high claims.[17] This means that premiums from healthy groups are higher in order to subsidize groups with higher claims. This cross-subsidization makes insurance more affordable for businesses with employees who have medical conditions. It also means that healthy groups pay more for their coverage.

In summary, while some policy interventions have helped small businesses with higher risk employees gain access to health insurance, such interventions have not been able to address many problems small businesses continue to face in the marketplace.[18] The following section discusses some reasons why proponents of the AHP legislation believe that the AHP proposal will help small businesses. It also discusses reasons why opponents believe the legislation will not help most small businesses and their workers.

# III. Association Health Plan Legislation

## Arguments for and against AHP Legislation

Although most observers agree that small businesses face significant challenges in affording and keeping health coverage, views differ about the potential for AHP legislation to address these issues. Proponents and opponents of AHP legislation present starkly differing pictures of the legislation's potential impact.

Proponents of AHP legislation, primarily associations representing small employers, argue that it will help lower prices in the small-group market, give employers more bargaining power with insurers, help lower the number of uninsured, and result in more plan options. They argue that allowing AHPs to offer benefits exempt from state mandates and rating rules will force insurers in the traditional market to offer less expensive coverage. Insurers, for example, could respond by offering more affordable, less comprehensive coverage—either through AHPs or in the state-regulated segment of the market. (In the state-regulated segment, insurers would be barred by state law from stripping plans of mandated benefits but could offer an increased assortment of plans with higher consumer cost sharing in order to compete with AHP products.) Proponents also argue that providing the option of avoiding major elements of state regulatory regimes would give small employers a form of parity with large employers, who can avoid state regulation by self-insuring under ERISA. Additionally, in many states, one or two insurers control a large part of the health insurance market, thereby stifling competition; according to proponents, AHPs would introduce a greater range of competitive options.

Opponents, primarily consumer groups, state officials, and insurers, argue that allowing AHPs to compete with state-regulated insurers will further splinter the market and allow AHPs to attract healthier groups, leaving sicker, more expensive groups in the state-regulated market. They argue that, although prices would end up being lower for the relatively healthier groups attracted to the AHPs' products (not subject to state benefit mandates), health insurance would be costlier and less accessible for relatively sicker groups more likely to need and want mandated benefits. In the AHP market, they add, there would be less stringent consumer protections and solvency standards. Furthermore, the risk segmentation resulting from the AHP legislation might

compromise small-group reforms, which have been effective in prohibiting industry practices that left many small businesses priced out or completely excluded from the market.[19] Opponents also argue that the limited solvency requirements for self-insured AHPs as well as the federal government's limited regulatory authority under the legislation and its lack of experience in regulating health insurers would prevent effective oversight of AHPs and might expose consumers to increased risk of plan insolvencies.

While some policymakers support AHPs as a way to cut insurance costs and broaden coverage options for small businesses, a health policy advisor to former Governor Gray Davis said the Davis administration was concerned that a large-scale migration of healthier lives into the AHP market would leave a smaller, sicker population in the state-regulated small-group market, thereby jeopardizing the combination of reforms, including guaranteed issue, guaranteed renewability, and rating standards, that helped ensure access to health insurance for small businesses in California. (Research for this report was done before the October 2003 recall vote. As of this writing, newly elected Governor Schwarzenegger had not made his position on AHPs known.) Proponents of AHPs counter that small-group reforms and other state mandates add costs that currently price many small firms out of coverage.

## Key Elements of Federal AHP Legislation (H.R. 660 and S. 545)

Legislation now before Congress could dramatically expand the purchase of health insurance through federally licensed multiple-employer organizations and thereby reduce the part of the market that falls under state control. The legislation would create federal licensure for association health plans. Below is a discussion of some key provisions. For a complete summary of proposed federal standards and a discussion of the differences between the House and the Senate bills, see Appendix.

H.R. 660 and S. 545 would create new federal standards for health coverage offered by qualified trade, industry, and professional associations, exempting such health plans from state insurance standards and oversight. To qualify, an association would have to be in existence for three years, be organized and maintained for purposes other than obtaining health coverage, have periodic meetings, and be supported by member dues. A qualifying association also could not condition membership in the association or AHP coverage that is offered on health factors. The legislation would allow associations to offer AHP coverage to individuals or employers of all sizes that are members.

Under the legislation, AHPs would be exempt from most state laws setting standards for health insurance policies. Both AHPs and insurers offering coverage through AHPs would have discretion, with few exceptions, to design coverage options and select covered benefits, care and services, and providers.

On the key issue of whether an association's small-business members would have to be offered access to an AHP on a guaranteed-issue basis (or, for example, whether some small businesses could be excluded on the basis of risk characteristics, including age of employees and employer size), the legislation could be interpreted in different ways (see Table 2). For example, one interpretation is that the legislation would not require associations sponsoring AHPs to accept every small business (regardless of the size of the business or other proxies for risk) as a member

**Table 2. Federal AHP Legislation**

| Standards | HR 660, passed by U.S. House of Representatives in June 2003 |
|---|---|
| **Guaranteed issue** | No clear requirement. One interpretation is that there is no requirement that an AHP accept every eligible small employer who applies (e.g., guaranteed issue requirements in HIPAA section 2711(a)(1)(A) of PHSA: "each health insurance issuer…must accept every small employer in the State that applies for such coverage"). There is no such requirement in the bill. Furthermore, the Board of Trustees of the AHP has sole authority to approve applications for participation in the plan (section 803(b)). Therefore, there is no clear guaranteed issue requirement. Another interpretation is that because the sponsoring association cannot condition coverage under the plan on health factors, then it must accept every eligible employer who applies for coverage. |
| **Rate restrictions** | The general rule is that "contribution rates" cannot vary based on health factors of employees/dependents and business/industry of employer. It is unclear if "contribution rates" means actual premiums or merely what the employer is required to contribute to the premium. For example, this might prohibit the AHP from requiring a 100% employer contribution from businesses with employees with medical conditions and only 50% contribution to the premium for businesses with healthy employees. Or, alternatively, this language might prohibit the AHP from charging premiums based on health or claims experience of the participating employer. Furthermore, it is not clear if "contribution rate" rules apply to both fully insured and self-insured coverage. |
| **Benefit design** | Generally, both fully and self-insured AHPs or insurers selling an AHP policy would have sole discretion to select covered benefits. Federal Newborns' and Mothers' Health Protection Act (requiring minimum hospital stays), Mental Health Parity Act, and Women's Health and Cancer Rights Act (requiring coverage for reconstructive breast surgery for mastectomy patients) and state laws implementing these requirements continue to apply.<br><br>Fully insured policies approved for sale by any state would still have to comply with state prohibitions on excluding specific diseases from coverage. This means that a fully insured AHP and its issuer would have to comply with specific disease laws of the state in which its coverage is approved for sale. If the insurer did business in other states, the benefit requirement laws of such other states would not apply. |

and would not have to offer its health plan to the small business member on a guaranteed-issue basis. The legislation states that the board of trustees of the AHP would have sole authority to approve applications for participation in the health plan. This may be interpreted as not requiring guaranteed-issue coverage. Another interpretation is that an AHP would be required to accept small businesses as members and to make health benefits available on a guaranteed-issue basis. One provision in the legislation would prohibit the sponsoring association from conditioning coverage under the plan on factors related to health status (although employer size and age are not specifically in the definition of such factors). Another provision of the legislation would require the AHP to allow employers who are members to qualify for geographically available coverage options. It could be argued that these provisions, read together, point to an intent by the legislation's drafters to require an association to accept every eligible employer who applies for

membership and for its health plan to accept every eligible association member regardless of size or other risk (or proxy for risk) factors.

The legislation is also open to interpretation about how premiums would be set. Its general rule is that "contribution rates" could not vary based on health factors of employees/dependents and business/industry of employer. The term "contribution," however, is not defined and may be interpreted to mean different things. For example, under one interpretation, an AHP might be prohibited from requiring a 100 percent employer contribution from businesses with employees with medical conditions and only 50 percent contribution to the premium for businesses with healthy employees. Alternatively, this language might prohibit an AHP from varying premiums based on health or claims experience of participating employers. It is also not clear if these standards would apply to both fully insured and self-insured AHP coverage.

In developing a regulatory structure for AHPs, the bills would establish a new standard on how ERISA preempts state laws. Because this new preemption language would have to be interpreted by the courts, there is increased uncertainty concerning the degree to which states might continue to apply consumer protections and other laws to insured products offered by AHPs.

The federal legislation would authorize AHPs to offer both fully insured and self-insured health plans. (Fully insured arrangements purchase insurance from an insurance company or an HMO, paying premiums in exchange for transferring the risk of paying claims to the insurer. Self-insured plans are directly responsible for paying claims themselves.)

**Qualifications for Self-Insured AHPs**

To qualify for self-insuring, an AHP would have to cover at least 1,000 people and meet one of the following requirements:

1. It was self-insuring when the legislation was enacted;

2. Employers eligible for its coverage represent a broad cross-section of trades/businesses/industry (e.g., local chamber of commerce); or

3. If membership were restricted to one or more trades, those trades must present average or above-average health risk or be one of approximately 30 identified industries (e.g., financial services, professional consulting services, theatrical and orchestra productions, etc.) [20]

Under this standard, many, if not most, associations could self-insure as long as the association covered 1,000 people (not all of whom would be required to participate in the self-insured plan; some could be covered by a fully insured plan if one were offered).

**Federal Solvency Standards for Self-Insured AHPs**

To qualify for licensing, the self-insured AHP must also:

- have adequate reserves;

- maintain a surplus between $500,000 and $2 million;

- purchase stop-loss insurance with an aggregate attachment point of 125% of expected gross annual claims and a specific attachment determined by its actuary;[21] and

- purchase "indemnification insurance" (that would pay claims if the U.S. Department of Labor (DOL) required the plan to terminate after a determination that the plan had become insolvent).

The legislation gives flexibility to the DOL to waive reserve, surplus, and stop-loss requirements when an AHP can demonstrate that its obligations would be met through other means, including assessments against participating employers.

**Issues Relating to Proposed Solvency Standards in H.R. 660/S. 545**

Many observers, including the American Academy of Actuaries and the National Association of Insurance Commissioners, have criticized the proposed AHP solvency standards as inadequate.[22] For example, they point out that there is no adjustment for inflation in the surplus standard and argue that the legislation's maximum required surplus of $2 million may not be sufficient for large self-insured plans.[23] For example, the National Federation of Independent Businesses (NFIB), a principal proponent of the legislation, has 600,000 members and if it chose to offer a self-insured plan to members, their members' employees and families, the plan might cover over a million people. A surplus of $2 million arguably might not be adequate for a plan of that size because a few high-cost hospitalizations (for example, for premature babies) could wipe out the entire surplus. In order to pay claims in the event of insolvency, the legislation relies heavily on stop-loss and indemnification insurance that self-insured plans would be required to purchase. The availability and cost of such insurance, especially for plans in financial distress, remain open questions.

According to AHP proponents, the bill's solvency standards would provide for greater protection against insolvency than what is currently required of MEWAs by most states. As discussed earlier, approximately 30 states require self-insured MEWAs to be licensed as insurers. These states' solvency standards for insurers are more stringent than those proposed in H.R. 660/S. 545.[24] Approximately 20 states have special licensing requirements—with less stringent solvency standards than those applicable to insurers—for self-insured MEWAs. A state-by-state analysis would have to be completed in order to determine whether the proposed federal AHP standards would be more or less stringent than what those 20 states currently apply to MEWAs.

If the final legislation were to include enhanced solvency requirements that resembled solvency standards that most states apply to insurers, the cost of AHP coverage would likely increase. In designing solvency requirements for AHPs, policymakers face a trade-off between AHP coverage with a relatively higher risk of insolvency and AHP coverage that would be less prone to insolvency but subject to more regulatory requirements and possibly higher costs.

Questions have also arisen about whether the legislation would provide an adequate safety net to help consumers in case of an AHP insolvency. Financial protections that consumers currently have under state-regulated health insurance policies are more stringent than federal solvency standards for AHPs. When an insurance company becomes insolvent, for example, a state guaranty fund pays outstanding medical bills and the consumer is not responsible for those.[25] There is no similar financial safety-net mechanism in the federal legislation. The bill relies on a

product it calls "indemnification insurance"—which, according to insurance regulators, is not readily available in the marketplace—and on stop-loss insurance to cover the cost of unpaid medical bills in case of insolvency. Indemnification insurance is supposed to pay claims in case of an AHP insolvency. Stop-loss insurance would pay claims once the triggers in the policy were reached. So, in the case of an AHP insolvency, indemnification insurance would pay until stop-loss is triggered. Under the legislation, a new AHP fund (established by the federal government and funded with annual assessments of $5,000 from each licensed self-insured AHP) would pay both the indemnification insurer and the stop-loss insurer to maintain the policies in force in cases when the AHP can no longer pay premiums. Insurance regulators and consumers have characterized these standards as inadequate when compared to existing state guaranty funds.

Additionally, questions have been raised pertaining to effective regulatory oversight. Some state regulators with experience in regulating MEWAs believe that extensive pre-licensing investigations and periodic financial monitoring are important tools to help ensure that only qualified arrangements receive a license and to identify financial problems early.[26] The legislation would not require such regulatory functions and it is not clear that the DOL would have the capacity to perform the type of extensive pre-licensing investigations state regulators can do, including site visits by investigators. With the exception of its oversight of federal notice requirements under COBRA and portability requirements under HIPAA, DOL has little experience regulating health insurance, and it has no experience in regulating the solvency of health plans.[27] Some proponents point out that, as with other new legislation, federal regulators would develop the necessary expertise to effectively regulate.

Because all health plan insolvencies cannot be prevented, it is important to have effective regulatory strategies to attempt to mitigate the adverse impact on covered individuals when an AHP becomes insolvent.[28] The legislation, however, is limited (compared to states) in the authority it would give to DOL—both in taking over an insolvent plan and in requiring plan termination. DOL would have to seek permission from a federal court to take over an insolvent plan. Because the assets of a failing health plan may disappear quickly, timely intervention is often important. Under the proposed legislation, even when DOL had determined that an AHP was having financial problems that might cause the plan to fail, the department would be allowed to require AHP termination only if an association's board of trustees did not notify the department that corrective action had been taken by the board. This means that if DOL were notified *falsely* that corrective action had been taken, but in fact such action had not been taken, the department might not be allowed to require the AHP to terminate without first seeking such authority from a federal court. Going to federal court would delay termination and might increase the risk that assets may be depleted, which would result in potentially more unpaid claims**.** The legislation's limitation on current state regulatory authority to oversee self-insured AHPs, coupled with solvency standards that are not as strong as what states typically require and the lack of a guaranty fund, are concerns being raised by consumer advocates and state regulators alike.

## Impact of AHP Legislation

What might happen if AHP legislation were enacted would depend on how key players in the marketplace reacted in response to it. Most policy analysts who have studied the legislation and

most experts familiar with California's small-group market and interviewed for this report agree that if such legislation were passed, several events would be likely to occur. These include:

- Federally licensed AHPs, both self-insured and fully insured, would enter the market offering products that would tend to attract low-risk groups, in part by excluding some mandated benefits.
- Most AHPs would be new players. (Due to strong incentives for associations and insurers to offer federally licensed health plans, the few associations now permitted to offer self-insured health benefits under California law also would likely seek federal licensing.)
- Insurers would likely enter the AHP market, in part as a defensive strategy to avoid adverse selection.
- Prices would tend to go up for groups left in the state-regulated market and down for those covered by AHPs.
- AHPs' greatest impact would occur in the small-group segment (2–50 employees) of the market, in which insurers must guarantee issue products and observe rating rules.

**Studies of Potential AHP Market Impact**

Most studies of the legislation's impact assume that AHPs would be able to offer products at lower prices than are available in the state-regulated small-group market. But there is wide variation among these studies about key assumptions, including the amount of AHP cost advantage and the extent of AHP market penetration (see Table 3). Some studies conclude that AHPs would increase the number of total insured and some conclude the opposite. In most studies, the impact on the overall level of insurance is not significant or is relatively small, one way or the other. As might be expected, projected impacts are the most extreme in studies commissioned by AHP proponents or opponents.

*CONSAD Research Corporation Study*

In 1998, a study by CONSAD Research Corporation, an economic and public policy analysis consulting firm, concluded that a previous version of the AHP legislation would most likely increase the total number of insured workers and dependents by 4.5 million nationwide and by 772,000 in California.[29] Commissioned by proponents of AHP legislation, the study assumed that AHPs could offer lower prices due to three advantages:

- reduced administrative costs due to economies of scale,
- more market "clout" in negotiating with health care service providers, and
- reduced regulatory costs such as those imposed by mandated benefits.

The CONSAD study based its estimate, in part, on assumptions that AHP administrative costs would be greatly lowered. However, whether administrative savings would occur is disputed. The study cited previous studies that had shown administrative costs for larger employers can be 30 percent lower than for small employers and factored part of that difference into price savings

**Table 3: Estimates of AHPs' Potential Impact on Small-Group Market[*]**

| | Geographical Scope of Study | % of Small-Group Market Moving to AHPs | Average Price Change for Firms in AHPs | Average Price Change for State-Regulated Market | Change in Population with Health Insurance |
|---|---|---|---|---|---|
| CBO (2000) | U.S. | 19% | -13% | 2% | 1.3%[†] |
| CBO (2003) | U.S. | 24%[‡] | not available | not available | 1.8%[§] |
| Mercer (2003) | U.S. | 52% | -10% | 23% | -4% |
| Urban (2003) | California | 36%[#] | -14% | 5% | 0% |

The CONSAD study is not included in this table because it did not contain comparable data to the other studies mentioned. For example, it does not present data showing the impact on the small-group market (defined as firms with 2-50 employees). Readers should refer to the summary of the CONSAD study in the text or to the study itself to make general comparisons.

[†] This figure was derived by dividing CBO's estimated number of newly insured in the small-group market (330,000) by the estimated number of people covered in the small-group health insurance market (24.6 million).

[‡] 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).

[§] This figure was derived by dividing CBO's estimated number of newly insured in the small-group market under AHP legislation (550,000) by its estimate of the total number of people covered in the small-group market in 2008 should current law continue (30.1 million).

[#] This figure describes the percentage of small-group business establishments that would offer AHP coverage, not the percentage of people covered by AHPs in that market segment.

that AHPs might enjoy. A more recent study done for the U.S. Small Business Administration (SBA) found that administrative expenses for small-group insurers in West Virginia and Colorado averaged 25 percent and 27 percent respectively among insurers studied.[30] The SBA study found that these 25 percent to 27 percent administrative expenses as a percentage of premiums were equivalent to 33 percent to 37 percent of expenses as a percentage of claims. Larger health plans are able to self-insure with administrative expenses of 5 percent to 11 percent of claims, according to the study. Although small employers face much higher administrative costs than large ones, whether AHP legislation would reduce administrative costs for small employers is a matter of much dispute. Many analysts believe that AHPs would face similar administrative costs in signing up and serving small employer groups as insurers now face. The Congressional Budget Office estimates, for example, assume no additional savings for AHPs as a result of increased administrative efficiency or increased market clout (see discussion below).

The CONSAD study considered scenarios in which AHPs would be able to lower coverage prices by 5–20 percent. Unlike many other studies, this study assumed that every small firm would see beneficial changes in the small-group market as a result of the introduction of AHPs; the study does not appear to factor in potential price increases in the state-regulated segment of the market resulting from adverse selection (that is, that sicker and costlier groups would tend to remain in the state-regulated market).

*CBO Estimates*

In 2000 the Congressional Budget Office (CBO), the non-partisan agency that provides cost estimates of federal legislation, estimated that earlier versions of the legislation would lower

premiums by about 13 percent for firms purchasing in the AHP market segment as a result of both lower costs resulting from state mandate exemptions and the ability to attract firms with relatively lower expected medical costs.[31] This would increase premiums about 2 percent for firms left in the traditional state-regulated market. CBO estimated that about 48 million Americans either worked for a small firm (with fewer than 50 employees) or were a dependent of someone who did. Of these, almost 26 million were covered through a small employer, about 13 million were uninsured, about 3.5 million bought individual policies, and the rest obtained coverage from a variety of sources. CBO estimated that the number of people covered by fully insured plans in the state-regulated small-group market would drop by 4.3 million, while 4.6 million would take up coverage in new AHP plans. This would increase overall coverage in the small-group market by 330,000, or 1.3 percent, according to CBO.

In July 2003, CBO released a cost estimate of H.R. 660 (less detailed than its estimates of earlier versions of the legislation), stating that by 2008, when the effects of the legislation are assumed to have their full impact, about 550,000 more people (including employees and their dependents) would be insured through small employers than would have been insured under current law.[32] The number of newly insured is somewhat larger than in CBO's earlier estimate but still represents a tiny fraction of the small-group market as a whole; both estimates put the number of newly insured at between 1 percent and 2 percent of total small-group enrollment (see Table 3).

Using a similar analytic model to the one used for its previous estimate, CBO estimated that by 2008 about 7.5 million people would obtain health insurance through AHPs and 23.2 million would receive coverage through the state-regulated market. However, CBO noted that should current law remain unchanged, most of those AHP enrollees would have been insured in the state-regulated market rather than being uninsured. (CBO also estimated that about 10,000 people would lose coverage in response to rising premiums in the small-group market as a result of the legislation.)

*Mercer Study*

A recent study funded by National Small Business United, an opponent of AHP legislation, predicted that AHP legislation would have a more dramatic impact on the small-group market. According to the actuarial model that Mercer Risk, Finance & Insurance Consulting used in this study, health insurance premiums would increase by 23 percent for small employers continuing to buy state-regulated products after a four-year period, due primarily to AHPs' ability to tailor products to healthier-than-average populations.[33] According to this study, the total number of insured in the small-group market would decrease by 1 million, or by about 4 percent. Average small-group premiums would increase by 6 percent. This would occur because the size of the average premium increase for those left in the state-regulated market would be much larger than the estimated 10 percent price decrease for those enrolling in AHPs. According to the study, enrollment in state-regulated plans would drop from 24.8 million to 11 million, while AHP enrollment would total 12.8 million after four years.

*Urban Institute Study*

Unlike the analyses described above, the Urban Institute study, which was commissioned by the California HealthCare Foundation, uses many assumptions based on conditions in the California market. Urban researchers used an existing national simulation model and adapted it to reflect market conditions in California, adjusting for the state's socio-demographic characteristics, types

of employers, and state insurance regulations.[34] The main simulations done for this analysis also allow individuals (the self-employed and workers without employer offers) to purchase coverage within AHPs, consistent with the most recent legislation.

The Urban Institute researchers estimate that there would be no net change in health insurance coverage as a result of the introduction of AHPs. The analysis found that, although 27 percent of establishments that would offer AHPs had not been offering health insurance pre-reform, a roughly equal number of establishments would stop offering coverage altogether. In addition, some previously non-offering establishments would begin to offer other types of coverage post-reform, and some workers from those establishments who lost an offer would be able to purchase coverage through the AHPs on an individual basis.

Premiums in the remaining state-regulated market would increase by approximately 5 percent post-reform. However, the vast majority (93 percent) of those who had coverage in both the pre- and post-reform periods would experience only modest (within 5 percent) changes in their premium costs. Prior to introduction of AHPs, traditional, fully insured, state-regulated plans accounted for 83 percent of small establishments offering coverage to their workers. Post reform, the state-regulated share of the small-group market would fall to 50 percent, with 36 percent of offering establishments providing coverage through AHPs**.**

## Potential Impact in California

As in other states, there would be many advantages and, therefore, an incentive for associations in California to offer federally licensed policies. The legislation also provides incentives for insurers to offer AHP policies; such incentives include few standards compared to many regulatory standards applicable to state-regulated policies. To stay competitive and prevent adverse selection, insurers would be under pressure to either sell AHP policies or to slim down their products to compete against AHPs.

Assuming that associations would offer federally licensed health plans, it is likely that federal AHP legislation would lead to increased segmentation of California's health insurance market (see Table 4). Many of the roughly 22 million Californians whose health coverage is now regulated by state agencies would find themselves in plans licensed and regulated by the federal government and other states. AHPs would be able to avoid the state's many health care mandates and rating restrictions in the small-group market and offer products that attracted relatively healthier firms. These employers and their employees would likely experience premium reductions. However, employer plans with older and sicker workers would likely experience increased premiums.

As discussed below, some effects of the AHP legislation might be different in California than many other states because of the somewhat unique nature of the state's market, which is characterized by high penetration of managed care and relatively low concentration of self-insured plans. Additionally, due to an already highly complex regulatory environment, with two different state agencies regulating health coverage, the bill adds one more layer of complexity, which may make it more difficult for consumers looking for help from regulators. Finally, in California, as in other states, there may be a decline in revenue due to a limitation on taxing AHP premiums.

**Table 4. Regulation of Private-Sector Group Health Insurance Market Segments in California**

| | Current Law (Population Covered) | Post-AHP Legislation (Population Covered) |
|---|---|---|
| ***Entities in Current Market*** | | |
| Employment-based, single-employer and multi-employer (collectively bargained) plans under ERISA | Roughly 2/3 of state population has employment-based coverage (includes people in non-ERISA plans such as government plans)* | Unknown |
| Self-insured, single-employer plans (no state regulation, limited federal standards with no solvency standards) | c. 23% of covered workers in California are in self-insured plans† | Unknown |
| Fully insured single-employer plans | c. 77% of covered workers in California are in fully insured plans† | Unknown |
| Regulated by Department of Managed Health Care | c. 22 million (figure includes non-ERISA populations) ‡ | Unknown |
| Regulated by Department of Insurance (DOI) | c. 1.5–2million (figure includes non-ERISA populations)‡ | Unknown |
| DOI-licensed self-insured MEWAs | 250,000§ | Unknown |
| Unlicensed self-insured MEWAs reporting California operations | > 100,000§ | Unknown |
| ***Entities Added by AHP Legislation*** | | |
| Federally licensed AHP plans | Don't exist | Unknown |
| "Self-insured" AHPs | Don't exist | Unknown |
| Insured AHP, carrier licensed in California | Don't exist | Unknown |
| Insured AHP, carrier licensed out of state | Don't exist | Unknown |

*Paul Fronstin, *Health Insurance Coverage and the Job Market in California*, EBRI Special Report SR 36, Employee Benefit Research Institute (Sept. 2000).

†California Employer Health Benefits Survey, 2002, Kaiser Family Foundation and Health Research and Educational Trust (Feb. 2003).

‡Patricia Butler and Karl Polzer, *Regulation of ERISA Plans: The Interplay of ERISA and California Law*, California HealthCare Foundation (June 2002).

§Mila Kofman, Eliza Bangit, and Kevin Lucia, *Insurance Markets: Group Purchasing Arrangements: Implications of MEWAs,* California HealthCare Foundation (July 2003).

## Competitive Advantages for Federally Licensed AHPs

Once licensed, AHPs could reduce costs because they would be exempt from state rate standards, benefit mandates,[35] state solvency requirements, and other state-based consumer protections (see Table 5). For example, California's small-group reforms—including a limitation on how much extra insurers can charge small groups with medical conditions—would not apply to federally

licensed AHPs. State requirements to provide maternity coverage (now required for managed care plans), to allow adult disabled dependents to continue on their parents' policy, and to continue coverage under Cal-COBRA[36] would not apply to consumers enrolled in AHPs. In addition, state managed care requirements might not apply to AHPs.

**Table 5. California's Authority to Apply State Consumer Protections under Federal Law, Currently and under Proposed AHP Legislation**

| Standards | California's Small Group Reforms[37] | California's Managed Care Standard | California's Benefits Requirements | California's Protection for Special Populations | California's Solvency Requirements† |
|---|---|---|---|---|---|
| ***Under current law:*** | | | | | |
| California regulated health insurance policies | Currently apply | Currently apply | Currently apply | Currently apply | Currently apply |
| Self-insured AHPs | Currently apply | Currently apply | Currently apply | Currently apply | Currently apply |
| Fully insured AHPs | Currently apply | Currently apply | Currently apply | Currently apply | N/A (solvency rules apply to insurer under contract with AHP) |
| ***Under H.R. 660 / S. 545:*** | | | | | |
| Self-insured AHPs | Would not apply | Would not apply | Would not apply | Would not apply | Would not apply (Federal solvency reqs. Apply, but are less stringent than California's reqs.) |
| Fully insured AHPs | Would not apply | Unclear (probably preempted) ‡ | Would not apply* | Would not apply | N/A |

* State laws implementing federal Newborns and Mothers Health Protection Act, Mental Health Parity Act, and Women's Health and Cancer Rights Act are not preempted. The state where policy form is approved may apply benefit requirements that prohibit exclusion of a specific disease. In California, a requirement that HMOs offer comprehensive benefits generally would not apply to fully insured AHPs even when such benefits are offered by California licensed HMOs. The exception would be in a case when the HMO's policy is approved by California and the state's benefit requirement merely prohibits exclusion of a specific disease. The legislation creates an incentive for HMOs and other insurers to seek policy approvals in states with fewest benefit mandates—California is not one of those states.

† Note that California has different solvency requirements for HMOs, insurance companies, and self-insured MEWAs. In case of insolvency, a guaranty fund pays outstanding medical claims of insurance companies licensed by the California Department of Insurance. Providers who participate in HMOs and other plans licensed by the state's Department of Managed Health Care are subject to "hold harmless" contract provisions and may not collect unpaid claims from consumers in case of HMO insolvency. Currently, there is no safety net for MEWA insolvency. However, the solvency standards for MEWAs are stronger than the solvency standards in HR 660.

‡ "Unclear" means that state law may be preempted by federal legislation. Additionally, if not preempted, then state law may not apply if 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

- For self-insured AHPs, the bill clearly preempts California's standards that under current law are applicable to self-insured AHPs—including standards concerning solvency, licensing, and small-group reforms. If either self-insured association health plans currently licensed by the state as MEWAs or new association plans became federally licensed, then California's consumer protections would no longer apply to them.

- With respect to fully insured AHPs, with few exceptions, most of California's state consumer protection standards would be preempted, including state benefit mandates and small-group rate reforms.[38] Few state standards would continue to apply. The legislation explicitly allows state prompt pay laws to apply to AHPs.[39] The bill is not clear, however, on the applicability of other managed care rules, such as a requirement to have a network of providers that is both adequate, given the number of enrollees, and includes specialists to deliver the type of care and services promised in the policy. The bills' preemption standard is vague: state laws that preclude or have the effect of precluding insurers from offering coverage to an AHP are preempted. Judges may interpret this standard to preempt state laws regulating managed care.

- The bills would allow an insurer to sell a policy approved in another state through an AHP in California. This means that some fully insured policies sold in California would not be subject to California's managed care standards even if a federal court determined that such standards were not preempted. For example, the state's Department of Managed Health Care (DMHC) would not have any authority over fully insured AHPs when a policy was approved for sale by a state other than California. As a result, California's external review procedures or other standards typically required of policies sold in California would not apply even to fully insured AHPs. This also means that when a consumer had a problem with a fully insured policy, he or she would have to call the state where the policy was approved. Neither the California Department of Insurance nor the DMHC would be able to help.

**Advantages for Insurers Selling AHP coverage**

Insurers selling coverage to a federally licensed association health plan could avoid state requirements pertaining to benefit mandates, small group rate restrictions, and small group market reforms designed to prevent "cherry picking" or soften its impact on consumers. As described in detail below, this would give insurers selling in the AHP market segment a competitive advantage over those selling in market segments under state regulation.

Additionally, the bill would allow insurers selling AHP coverage to market these products not only to members of the association, but also to employers eligible for membership but not enrolled in the association.[40] Such products sold outside the AHP also would be exempt from state regulations. Still an open question is whether such products must be available on a guaranteed issue basis in the small-group market. The legislation does not specifically require guaranteed access. If the courts or DOL interpret the bill to allow insurance companies to sell such policies only to employers with healthy employees (that is, not requiring guaranteed issue), then this could mark a reversal in national public policy. As discussed above, in 1996 Congress recognized the need to guarantee small businesses access to health insurance policies and to ensure access to coverage for small businesses with employees who have or had medical conditions.

The legislation also would allow insurers to market AHP products approved in one state across the country without other states' approval or compliance with other states' standards. This would mean that an insurance company could sell a product that did not meet the minimum standards

for policies in California. Due to broad preemption language in the bill, it is unlikely that the California legislature could prevent the sale of such products to California consumers.

## Impact on Consumers

*Total Number of Uninsured Unlikely to Change*

Despite claims made by some partisans on both sides of the AHP debate, it is not likely that AHP legislation would change the total number of uninsured in a significant way. Studies by impartial analysts estimate that the legislation would have a minimal effect, if any, on the number of uninsured. In estimates of two versions of the AHP legislation, the nonpartisan Congressional Budget Office determined that small-group enrollment would increase between 1 percent and 2 percent as a result of the new law. The Urban Institute study done in conjunction with this report estimates that the legislation would not significantly change the number of uninsured in California.

*Winners and Losers—Healthier Groups Better Off; Sicker Worse Off*

AHP legislation would likely create some winners and some losers among employer groups seeking coverage. Many small firms with relatively healthy employees might be able to buy less expensive coverage through AHPs than they can now buy in the state-regulated market. Employer groups with relatively sicker employees, however, would be more likely to remain in the state-regulated market, which would have more stringent (and costly) consumer protections. Premiums in the state-regulated portion of the market might rise as a result, with some groups being priced out of the market. (It is very difficult to predict the degree to which prices and the size of different market segments would change as a result of AHP legislation. It is generally easier for policy analysts to identify with confidence the likely direction of market responses to a new law than the actual magnitude of the responses. There are simply too many uncertain variables for predictions of market behavior to be precise.)

*Many of California's Workers and Their Families Likely to Lose Protections*

Workers and their families covered by state-regulated plans currently enjoy comprehensive protections pertaining to disputes over covered benefits. For example, individuals can appeal decisions of their health plans to an independent review body. Additionally, people covered by individual policies and, in some circumstances, by job-based coverage have redress in court in cases of negligence or gross misconduct by the health plan. Once individuals and employers became covered by AHPs, it is questionable what, if any, state-based dispute resolution options would be available. People in self-insured AHPs would lose all the state-based dispute resolution options they now have, including the opportunity for an independent review of a denial of a medical benefit claim.

*An Already Complex Regulatory Environment Would Become More Complex*

California's regulatory regime is more complex than in most states. Therefore, the increased layers of regulatory complexity added by AHP legislation might cause more confusion for consumers—and the potential for abuse by industry—than in other states.

Health insurance regulation in California is divided between two agencies. The DMHC regulates HMOs and managed care products, which make up most of the health insurance market, and some PPO products. The California Department of Insurance (CDI) regulates more traditional

insurers and most PPO products. Already there are reports of a limited amount of "forum shopping" among insurers seeking to operate under the generally less stringent regulations of the CDI,[41] a development that adds credence to the assumption that AHPs and insurers contracting with them would enter the market seeking competitive advantages of a less stringent regulatory environment. And, as noted above, many employers, especially the largest, "self-insure" some or all plans, thereby exempting them from state health insurance rules, though this practice is less prevalent in California than in most other states, and uncommon in the small-group market because of the risk posed.

For consumers, the number of regulatory agencies, coupled with federal preemption of state regulation for self-insured plans, already creates confusion because consumer protections differ, depending on which regulator or combination of regulators has jurisdiction over their coverage. AHP legislation would add additional confusion for consumers concerning which of many sets of regulations might apply to their health plan as well as where to go for help when there is a problem.

*Increased Risk of Insolvency*

While creating cheaper 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 an AHP insolvency because these AHPs would be subject to new federal solvency rules that are much weaker than state standards.

As discussed earlier in greater detail, self-insured, multiple-employer purchasing organizations, including 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. As noted above, 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 establishes 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. Additionally, 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 might 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.

*Potentially Inadequate Protection against Insurance Fraud*

During the last 25 years, hundreds of thousands of American workers and their families have been left without health insurance and with millions of dollars in unpaid medical bills by unscrupulous individuals who sold phony health insurance through multiple-employer group purchasing arrangements. These promoters collected premiums but did not pay claims. There is currently concern that the jurisdictional ambiguity that would be created by the AHP legislation

(i.e., confusion over which of many state and federal agencies might be responsible for regulating various types of plans) could fuel an ongoing resurgence of insurance scams.

Recently, the number and magnitude of such scams have grown to levels not seen since the last economic recession. In 2001 and 2002, for example, four nationwide arrangements left approximately 100,000 workers and their families without health insurance and facing an estimated $85 million in unpaid medical bills.[42] Between 1988 and 1991, also a period of high medical inflation and increased scams, nearly 400,000 patients were left with medical bills exceeding $123 million.[43]

To avoid state insurance regulators, promoters of illegal operations often disguise themselves by selling coverage through arrangements that raise questions about their legal status, claiming ERISA exemption from state law.[44] One major concern raised about the federal bill is that it creates new ambiguity in ERISA, which some argue may open the door to new scams. For example, exempting federally licensed AHPs from state regulation may result in promoters of phony health plans claiming to be federally licensed. This occurred during the period before 1983, when unscrupulous operators of MEWAs claimed exemption from state regulation. The legislation tries to address this problem by adding a new penalty for falsely claiming federal licensing. It remains to be seen whether this would be an effective deterrent or penalty for criminal behavior.

Another concern is that the preemption provisions in the bill are vague. The legislation preempts state laws that have the "effect of precluding" insurers from selling coverage to a federally licensed AHP. Promoters of phony health plans selling to a licensed AHP could exploit this preemption language and argue ERISA preemption when a state attempted to investigate (and ultimately shut down) the phony health plan. They might argue, for example, that the state's actions had the "effect of precluding" the company from selling to an AHP.

Given the differences in regulatory oversight between states and the federal government—including differences in legal tools, practices, and resources—both the new exemption and a vague preemption standard could lead to unintended, and potentially adverse, consequences for consumers, not only in California but nationwide. Under current law, California regulators, like those in other states, can quickly force a phony health plan to cease operating through administrative action and without going to court. Under the AHP bills, the DOL would have to go to federal court. Shutting down a plan could take a couple of years, whereas states could shut down plans in a couple of months. In dealing with fraudulent operations, time is of the essence to prevent depletion of assets to pay existing medical claims and to prevent more people from enrolling. Assets can disappear quickly through outright theft, embezzlement, or self-dealing with excessive salaries or other services.

### Impact on Insurers and Their Responses

*New Opportunities for "Cherry Picking"*

Insurers argue that although the AHP legislation includes some standards to prevent cherry picking, AHPs would still be able to design products to attract lower-utilizing groups by marketing to lower risk industries, and by segmenting the market in other ways, such as by group

size. The legislation appears to allow using employer size as a criterion for health plan eligibility. AHPs could restrict the health plan to groups of ten employees or more, for example.

Insurance experts interviewed said that most, if not all, carriers in the state already charge the smallest employer groups the highest rates allowable under state rating laws because health services utilization is highest for these groups. For example, one California managed care firm's data (drawn from its membership) shows that very small business groups (with one or two enrolled employees and excluding dependents) utilized more health care services than larger small business groups (with 25 or more enrolled employees and excluding dependents). Using a utilization index of 1.00, the firm found that the smallest groups had a relative utilization of 1.14 compared to 0.94 for the groups with 25 or more enrolled employees, constituting a difference of more than 20 percent. It is already common practice in the California health insurance market for insurers to charge the smallest groups (those with fewer than 8–10 employees, often called "micro groups") at the top end of the allowable rating band, regardless of members' health status or experience, according to several industry and policy experts interviewed. (For example, in order to increase its competitiveness, PacAdvantage, a purchasing cooperative serving small groups and their employees, recently changed its rating policy to conform with market practice and began rating micro groups higher than others.)

Restricting coverage to an AHP based on employer size might be difficult for the NFIB, a broad-based national business group representing 600,000 employers, half with five or fewer employees. However, broad-based AHPs such as the NFIB would face competition from associations whose members employ more than 10 employees, particularly specific industry AHPs with relatively lower expected health care costs. Such AHPs might restrict access to the health plan based on employer size. Such tactics might leave broad-based AHPs with a disproportionate share of smaller, sicker groups (compared to specific industry AHPs with lower predicted health costs); this, in turn, could cause broad-based AHPs' premiums to rise and lead them to consider ways to control inflows of high-risk, high-cost groups.

In addition to coverage design and employer size, other ways to "cherry pick" include pricing practices. The legislation does not prohibit AHPs from establishing premiums for member employer groups based on age or gender, which can be correlated with health risk. And, as discussed earlier, the standards for setting rates charged to small groups are vague.

*Pressure to Enter AHP Market*

Because California's laws are more stringent than what is being proposed federally, these rules would put insurers operating in the state-regulated market at a disadvantage, with AHPs offering leaner benefit packages. As in other states, insurers would be under pressure to enter the AHP market in order to compete and, ultimately, to stay in business. Many insurance experts interviewed predict that insurers would sell AHP policies and provide administrative services to self-insured AHPs even though the insurers strongly oppose passage of the legislation. Insurers' opposition arises in part because AHPs would harm their bottom line. For example, actuaries for one carrier interviewed in the state estimated that after three years, the carrier could lose 23–66 percent[45] of its current small-group membership to AHPs, which could result in an 18–105 percent drop in net income for small-group business. Facing potential losses in the state-regulated market, carriers would have strong incentives to sell insured products through AHPs. Some would also act as third-party administrators for AHPs.

*Pressure to Offer Less Comprehensive Benefits*

Carriers entering the AHP market could stem lost business by offering "slimmer" insured products through an AHP and marketing to lower risk groups, but insurer profits still might drop because the carrier might have to "split" profits with an association sponsor to gain access to that market[46] and because the benefit packages upon which profits were based would be less comprehensive. The proliferation of less comprehensive benefits could benefit some employer groups through lower prices but could harm others if benefits needed by sick participants were dropped.

As discussed earlier, insurers offering an AHP product to an association's members also could offer the same product to any firm eligible for membership (but not enrolled) in the association offering the AHP. In practical terms, by teaming up with a broad-based AHP such as a local chamber of commerce, an insurer could sell products to virtually any employer, avoiding state benefit mandates and other state-based requirements. The legislation is unclear on whether such coverage would have to be sold on a guaranteed-issue basis. By teaming up with an AHP in a low-risk industry, insurers could offer reduced benefits at lower prices aimed to attract only the best health risks.

*Special Challenges for Organizations Specializing in Managed Care*

While insurers generally argue that they would be potential losers under AHP legislation, some types of carriers and products probably could adapt to an AHP environment more easily than others. It might be far more difficult for carriers offering only HMO policies to compete in the AHP market because HMO policies provide more comprehensive benefits and in California are generally more highly regulated than PPO policies. Growth of AHPs offering PPO and high-deductible products could make inroads into the state's HMO market, which in the past has helped keep premiums in California below the national average. (AHPs are likely to offer less comprehensive coverage that would rely on higher consumer cost sharing, rather than coordination of care, in order to contain costs.) HMOs, of course, could offer products through AHPs but might have a more difficult time paring down the benefit package to make them attractive to lower risk groups. However, if the legislation allowed AHPs to offer HMO policies without complying with state managed care standards (current bills are unclear), then HMOs might be able to cut their regulatory costs. But this, in turn, might leave consumers with far fewer legal protections to help them in gaining access to care. Additionally, even if HMOs are able to offer AHP products, there is potential for them to experience adverse selection—with healthier groups buying cheaper and less comprehensive coverage elsewhere.

**Some Market Impacts Could Be Different in California Than in Other States**

While California might experience many similar impacts of AHP legislation as other states, it has many distinctive features that might present special issues or mitigate some impacts (see Table 6).

For example, California has much higher HMO enrollment among covered workers (54 percent) than the national average (26 percent), which, in the past at least, has resulted in somewhat lower average premiums in the state. Because employers are much more likely to buy "off-the-shelf," state-regulated managed care products in California, the state has fewer self-insured plans than the United States as a whole (23 percent v. 49 percent) and regulates more of the health

insurance market than most states do. AHP legislation might spur a move away from HMO coverage, as noted above, and cause an increase in the number of people in self-insured plans. This would leave less of the market under the control of California policymakers and regulators.

**Table 6. Selected Health Insurance Market Differences between California and U.S.**

| 2002 Data | California | U.S. |
|---|---|---|
| Among covered workers, percent employed by firms with 3-49 employees* | 21% | 15% |
| Percentage of firms with 3-9 workers that offer coverage* | 59% | 55% |
| Percentage of firms with 10-49 workers that offer coverage* | 82% | 77% |
| Average monthly premiums (single coverage)* | $237 | $255 |
| Average monthly premiums for HMOs (single coverage)* | $197 | $230 |
| Average monthly premiums for PPOs (single coverage)* | $307 | $260 |
| HMO enrollment (among covered workers in firms of all sizes)* | 54% | 26% |
| PPO and POS enrollment (among covered workers in firms of all sizes)* | 45% | 70% |
| Percentage of firms offering only one plan (3-199 workers)* | 79% | 93% |
| Percentage of employees in a partly or completely self-insured plan* | 23% | 49% |
| Number of state agencies regulating health insurance | 2 | 1 (in most states) |
| Number of statewide health insurance cooperatives or exchanges offering multiple plan choice to employees of small employers | 2 | 0 (in most states) |

*Source: California Employer Health Benefits Survey, 2002, Kaiser Family Foundation and Health Research and Educational Trust, February 2003.

*No Single Insurer Dominates in California*

AHP proponents argue that the legislation would increase competition, particularly in states where one insurer dominates. In California's small-group market, which covers roughly 3 million lives, unlike in some other states, no one insurer dominates.[47] Blue Cross of California and Kaiser Permanente are the largest players in California's small-group market, and together they occupy more than half of it. Five insurers cover 100,000 or more people and eight plans cover 10,000 or more in the state's small-group market, according to the California Association of Health Plans.

*More Plan Choices Available to Small Groups and Their Employees in California Than Elsewhere*

Another argument made to support AHPs is that they would provide additional choice of insurance options for small employers and, consequently, for their employees. Small employers in California tend to have more choice of health plans than they would if located in many other states.[48] California also is unique in having two private-sector health purchasing organizations offering *employees* of small employers who join (not just employers, themselves) a multiple choice of health plans on a statewide basis. These are CaliforniaChoice, which is operated by a

group of brokers and covers about 140,000 people, and PacAdvantage (formerly a state-operated purchasing group), which is run by the Pacific Business Group on Health and covers about 120,000 people. Introduction of AHPs could make it more difficult for purchasing cooperatives (such as PacAdvantage) that offer state-regulated plans to operate, in part due to the potential for AHPs to attract relatively healthier groups, leaving the relatively sicker, costlier groups in the state-regulated segment of the market.

### Impact on Viability of State Laws Regulating Small-Group Market

If a major portion of California's small-group market moved to AHPs, the viability of California's small-group reform laws could be compromised. For example, current restrictions on how much extra insurers can charge small groups with relatively sicker employees, in effect, cause healthier small groups to subsidize sicker groups. If AHPs drew off many of the healthier groups, the risk pool left in the state-regulated small-group market would be relatively sicker, more costly, and would have a harder time internally cross-subsidizing the sickest groups—driving up the average rate in this market and possibly leaving policymakers to contemplate what to do next to help the smallest, sickest firms afford coverage.

The history of state experiments exempting associations from insurance laws provides precedent for such a scenario. For example, after associations were exempted from Kentucky's small-group reforms, the market rapidly became segmented, with healthy people exiting the more regulated market and prices increasing as a result. Also, many insurers left the market.

### Loss of State Revenue

Finally, it is possible that federal AHP legislation could cause California to lose revenue from health insurance premium taxes and corporate taxes on managed care firms as the part of the market under state supervision became smaller. The amount of possible lost state tax revenue would depend on the degree to which final AHP legislation might allow states to continue levying such taxes as well as upon how much of the market moved away from state-regulated products.

# IV. Conclusion

Passage of federal AHP legislation could significantly alter the California private-sector health insurance market, particularly for small groups. In part because of the competitive advantages AHPs would enjoy, many would enter the market. Insurers would be under tremendous pressure to offer products in the AHP market. AHPs would tend to have the greatest impact on the small-group market, which currently is the most heavily regulated. While insurers competing in the state-regulated market would have to sell to all small groups, AHPs would have more ways to be selective about whom they covered.

AHP legislation would likely create some winners and some losers. Many small firms with relatively healthy employees might be able to buy less expensive coverage through AHPs than they now can. Employer groups with lower-than-average health status, however, would be more likely to remain in the state-regulated market, which would have more stringent (and costly) consumer protections. Premiums in the state-regulated portion of the market might rise as a result, with some groups being priced out of the market. It is not likely that the legislation would affect the total number of uninsured in a significant way, according to studies by neutral researchers.

AHPs would provide revenues for some business associations and might cut into the profits of insurance companies. Some insurance companies might gain a competitive advantage from selling through an AHP, while others might be adversely impacted. It is questionable whether companies that have specialized in providing HMO coverage, which has dominated California's health insurance market, could compete as well as those that offer PPO coverage and high cost-sharing plans in the AHP market because it would be harder for HMO policies to be stripped down. But managed care companies could offer HMO products through AHPs, and depending on the details of the final legislation and its interpretation, they might be able to lower costs by avoiding many managed care consumer protections currently required of them by the state.

While lowering plan costs, the avoidance of state regulations could expose California consumers to more risk. For example, the solvency rules governing self-insured AHPs are weaker than those imposed by California's two regulatory agencies. Furthermore, the U.S. Department of Labor, which would administer these standards, has no experience in regulating health plan solvency.

Should self-insured AHPs become insolvent, the legislation provides no guaranty fund to cover unpaid claims. The federal regulatory system designed to maintain self-insured AHP solvency also may put federal taxpayers at financial risk, should Congress opt at a later date to have the government cover the cost of future plan insolvencies. Self-insured multiple-employer purchasing organizations, including association plans, have a long history of financial instability.

In addition to the risk consumers face from plan insolvency due to mismanagement or simply adverse business conditions, small businesses and individuals may be defrauded by criminals. Over the years, multiple-employer purchasing organizations, including association health plans, have been attractive vehicles for criminals to sell phony health plans. The legislation's broad preemption of state law may open the door for additional fraud. States would not be able to stop promoters from selling coverage to federally licensed AHPs. The lack of state oversight could put consumers at increased risk of being defrauded out of health insurance premiums and potentially being responsible for unpaid medical bills.

If a major portion of California's small-group market moved to AHPs, the viability of California's small-group reform laws could be compromised. For example, current restrictions on how much extra insurers can charge small groups with relatively sicker employees in effect cause healthier small groups to subsidize sicker groups. If AHPs drew off many of the healthier groups, the risk pool left in the state-regulated small-group market would be relatively sicker, more costly, and would have a harder time internally cross-subsidizing the sickest groups—driving up the average rate in this market and possibly leaving policymakers to contemplate what to do next to help the smallest, sickest firms afford coverage.

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). As in other states, private-sector employers also can self-insure their plans and avoid state regulation. Adding various types of AHPs to the regulatory mix could be very confusing for consumers, especially for people encountering problems with their coverage and needing to figure out which set of regulations might apply to their health plan as well as where to turn for help in navigating those rules.

While AHPs might present consumers with more plan choices initially, it is questionable whether they would create a more competitive (and stable) market in the long run because AHPs would be competing under a different set of rules than insurers in the state-regulated market. Over time, this might force certain types of insurers out of the market. Unlike the situation in some other states, California's small-group market now includes many carriers actively competing for market share.

Finally, neither the AHP legislation nor, for that matter, the laws currently governing insurers and employee benefit plans provide long-term solutions to escalating health care costs that make it increasingly difficult for small employers 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 increase coverage levels significantly, 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.[49] The AHP legislation provides neither.

# Appendix

| Type of Standards | Summary of Requirements – H.R. 660 | Summary of Requirements – S. 545 |
|---|---|---|
| ***Qualifications*** | | |
| Who can sponsor a federal AHP? | Any entity (trade association, industry association, professional association, chamber of commerce or similar business associations, and associations of these) that meets the following requirements for 3 years (ending on date of certification):<br>• organized & maintained in good faith, for substantial purpose other than obtaining or providing medical care;<br>• its bylaws provide for periodic meetings of the association;<br>• supported by members with periodic dues;<br>• does not condition membership or coverage under the plan on health status-related factors* (health factors); and<br>• does not condition membership fees on basis of participating in the health plan. [section 801, 803(a)].<br>** Health status-related factors include: health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. These factors do not include age and gender of employees/ dependents and industry and size of employer.* | Same |
| Trust Agreement (for AHP Board of Trustees) | AHP Board of Trustees' authority (must be operated pursuant to a trust agreement):<br>• Board must have complete fiscal control and be responsible for all operations;<br>• Rules of operation must be based on 3-year plan to carry out terms and meet requirements of certification and ERISA Title I; and<br>• Board has sole authority to approve applications for participation in the plan [section 803(b)]. | Same |
| AHP Board of Trustees | An association health plan in existence on the date of enactment: no specified standards for the board of trustees in the bill [section 803(b)(3)(A)(iii)]<br>An association health plan not in existence on the date of enactment must have a Board of Trustees subject to the following criteria [section 803(b)(3)(A)]:<br>• Board members must be owners, officers, directors, partners, or employees of participating employers who are active in the business; | Same |

| Type of Standards | Summary of Requirements – H.R. 660 | Summary of Requirements – S. 545 |
|---|---|---|
| | • Conflict of interest requirements: contract administrator or other service provider to the AHP may not serve on its Board of Trustees except:<br>  • a sponsoring association's officers/employees may serve on the AHP's Board of Trustees even when the association provides services to the AHP; they cannot constitute more than 25% of the board's membership; or<br>  • if AHP's membership is primarily of providers of medical care, then conflict of interest requirements does not apply. | |
| Qualifications for offering self-insured options | Additional qualifications an association must meet to offer a self-insured health plan:<br>• Size: there must be a minimum of 1000 people in the plan (although not all are required to participate in the self-insured option; some may participate in fully insured option under the plan) [section 805(a)(3)], **and**<br>• It meets one of the following criteria:<br>  • it offered such coverage when legislation was enacted;<br>  • eligible employers represent a broad cross-section of trades/businesses/industry; OR<br>  • if membership is restricted to one or more trades/businesses/industries:<br>  ▪ it is any trade/business/ industry which has average or above-average risk or health claims; OR<br>  ▪ is one of the following specifically listed trade/business/industry: agriculture, equipment and automobile dealerships, barbering and cosmetology, CPAs, child care, construction, dance, theatrical and orchestra productions, disinfecting and pest control, financial services, fishing, foodservice establishments, hospitals, labor organizations, logging, manufacturing (metals), mining, medical and dental practices, medical laboratories, professional consulting services, sanitary services, transportation (local and freight), warehousing, and wholesaling/distributing [section 802(f)] | Same |
| Other qualifications | Grandfathered arrangements:<br>• if in existence for at least 10 years, with 200 employers, and is licensed in a state, arrangement is deemed to have met certain requirements [section 6 of bill subsection (b)]; and<br>• Franchise plans [section 803(c)] are deemed to have met certain requirements. | Additional standards:<br>• Collectively bargained arrangements are deemed to have met certain requirements if they choose to seek certification as an AHP [section 803(d)] |

| Type of Standards | Summary of Requirements – H.R. 660 | Summary of Requirements – S. 545 |
|---|---|---|
| ***Eligibility for Association Health Plan*** | | |
| Large and small business members<br><br>Employees of members and others eligible to enroll | Large and small businesses are eligible for health plan if they are members or affiliate members of the association. [§ 804]<br><br>Affiliate member is:<br>• a "person" (can mean company, partnership, etc.) who is eligible for membership but elects an affiliate status;<br>• if a sponsor's members are associations, then a person who is a member of any such association who elects affiliate status with the sponsoring association; or<br>• if plan existed on date of enactment, a person eligible to be a member or one of its member associations [section 812(a)(11)]<br><br>Affiliate members are eligible for the health plan if the health plan existed when legislation was enacted and:<br>• the member was an affiliate on the date of certification, or<br>• during 12-month period preceding offer did not maintain/contribute to a health plan.<br><br>*(Note: rule not clear on affiliate members qualifying for a health plan established after the enactment of the bill)*<br><br>Additional criteria for employers:<br>• employers may not provide individual health insurance similar to AHP's coverage to employees if such employees are excluded from employer's plan due to health factors; (Authors' note: the Health Insurance Portability and Accountability Act of 1996 (HIPAA) already prohibits exclusion of employees and dependents from a health plan based on health factors, ERISA section 702)<br>• AHP's eligibility requirements may include minimum contribution/participation requirements (e.g., employer may have to contribute toward the premium and/or a certain percent of eligible employees may be required to enroll; if minimum requirements are not met, the AHP may refuse to enroll the employer group)<br><br>Health plan prior to certification: no standards<br><br>Health plan after certification is open to: active and retired employees, officers, directors, partners, and their dependents [section 804(a)(2)] | Same |
| Individual (non-employer) members | In case of a professional or other individual-based association, individuals may be eligible for health plan if an officer, director, partner, or employee of a business is a member/affiliate member of the association even if the employer is not a member (such employers are also eligible) [section 804] | |
| ***Guaranteed Issue*** | | |
| Employer's access to | The bill's language is unclear. | Same |

| Type of Standards | Summary of Requirements – H.R. 660 | Summary of Requirements – S. 545 |
|---|---|---|
| health plan–guaranteed access? | • One interpretation is that although there are qualification standards (discussed below), there is no requirement that the AHP accept every eligible small employer who applies (e.g., guarantee issue requirements in HIPAA section 2711(a)(1)(A) of the Public Health Service Act: "each health insurance issuer…must accept every small employer in the State that applies for such coverage"). Furthermore, as noted above, the Board of Trustees has sole authority to approve applications for participation in the plan [section 803(b)]. Therefore, read one way, there is no clear guarantee issue requirement.<br>• Another interpretation is that because the sponsoring association cannot condition coverage under the plan on health factors, then it must accept every eligible employer who applies for coverage. | |
| Geographic-ally available options | Participating employers qualify for all geographically available coverage options. Employers must be given information about options upon request. [section 804(d)] | Same |
| Member employers' employees/ their dependents | Existing HIPAA requirements that apply:<br>• portability (rules on use of preexisting conditions, special enrollment periods, etc.); and<br>• nondiscrimination based on health factors (in premiums and eligibility) (ERISA section 701-702) [section 804(d)(3)]. | Same |
| Individual (non-employer) member's access to health plan | No standards (requirements applicable to employer members—discussed above – do not apply to individual members). | Same |
| ***Guaranteed Renewability*** | | |
| Renewability | AHP must renew same or different coverage in accordance with ERISA section 703 [section 804(d)(3)]. | Same |
| ***Rates*** | | |
| Large employer premiums | No requirement. However, bill allows AHP or insurer to use claims experience of "the plan." State laws prohibiting the use of claims experience of the plan are preempted. [805(a)(2)(B)(i)]<br>*(Notes/Issues: It is not clear if "the plan" refers to the association's experience as a whole or, if the association had established a number of plans, whether each one could be rated separately. An additional layer of confusion is that under ERISA each employer that is part of an AHP would be establishing an individual "plan.")* | Same |
| Individual members | No requirement. However, bill allows AHP or insurer to use claims experience of "the plan." Laws prohibiting the use of claims experience of the plan are preempted. [805(a)(2)(B)(i)] | Same |

| Type of Standards | Summary of Requirements – H.R. 660 | Summary of Requirements – S. 545 |
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| | *(Notes/Issues: It is not clear if "the plan" refers to the association's experience as a whole or, if the association had established a number of plans, whether each one could be rated separately.)* | |
| Small employers (2 to 50 employees) | General rule: "contribution rates"* cannot vary based on health factors of employees/dependents and business/industry of employer.<br>Exception to general rule:<br>• Although **not required** to do so, AHP or insurer may use claims experience of "the plan." Laws prohibiting the use of claims experience of the plan are preempted. [805(a)(2)(B)(i)]<br>• AHP or insurer is **allowed but not required** to use rules applicable in the state small group market for varying premiums for bona fide associations (bona fide associations are defined as: actively in existence for 5 years, formed and maintained in good faith for purposes other than obtaining insurance, does not condition membership on health factors, makes health insurance available to all members, coverage not available to nonmembers, and meets state law requirements. PHSA 2791(d)(3)) [section 805(a)(2)]<br>*(Notes:*<br>*1. it is not clear if contribution rate restrictions in the bill would apply both initially and at renewal of the policy;*<br>**2. "contribution rates" potentially means two different things – 1.) a percent of the premium an employer is required to pay, e.g., 50%, or 2.), the entire cost of coverage, e.g., premium; also it is not clear if contribution rates include premium rates (if not, then the rule might not apply to insurers);*<br>*3. not clear if "the plan" refers to the association's experience as a whole or, if the association had established a number of plans, whether each one could be rated separately.)* | Same |
| ***Benefits Covered*** | | |
| AHP or insurer designs benefits options | Sole discretion of AHP or insurer to select covered benefits (items and services) regardless of state law except must cover benefits required by:<br>• state laws implementing/not preempted by federal Newborns' and Mothers Health Protection Act (requiring minimum hospital stays) (ERISA section 711), Mental Health Parity Act (ERISA section 712), and Women's Health and Cancer Rights Act (requiring coverage for reconstructive breast surgery for mastectomy patients) (ERISA section 713); and<br>• if a policy was approved for sale in a state and the state prohibits exclusion from coverage of a specific disease.<br>[section 805(b)]<br>*(Notes: AHP and its issuer must comply with specific disease* | Sole discretion of AHP or insurer to select covered benefits (items and services) except:<br>• state laws implementing/not preempted by federal Newborns' and Mothers Health Protection Act (requiring minimum hospital stays) (711) and Mental Health Parity Act (712) *(note: Women's Health and Cancer Rights*<br>*Act is not specifically mentioned and therefore state laws implementing it* |

| Type of Standards | Summary of Requirements – H.R. 660 | Summary of Requirements – S. 545 |
|---|---|---|
| | *laws of the state in which it's coverage is approved for sale. If it does business in other states, the benefit requirement laws of such other states would not apply)* | *would not apply to AHP coverage);* **and**<br>• state laws prohibiting exclusion from coverage of a specific disease *(note: presuming the state law where AHP is operating applies to insured AHPs if it prohibits exclusion of a specific disease from coverage. This is different than the House bill which references the state where the policy is approved)*[section 805(b)] |
| ***Federal Solvency Rules for "Self-Insured" Coverage*** *(Requirements do not apply to fully insured plans. Insurers selling coverage to an AHP would be subject to state solvency requirements)* | | |
| Reserves | Establish and maintain reserves for each of the following:<br>• sufficient for unearned contributions;<br>• benefit liabilities incurred but not satisfied, for which risk of loss has not yet been transferred (and administrative costs);<br>• any other obligations of the plan; and<br>• margin of error and other fluctuations. | Same |
| Surplus | $500,000 to $2 million (Department of Labor sets amount considering plan's stop-loss coverage, factors related to solvency risk, and assets) | $500,000 to $2 million (Department of Labor sets amount based only on the amount of stop-loss.) *(Note: House bill allows consideration of other factors related to solvency risk, including liabilities and assets.)* |
| Stop-loss insurance | Stop-loss insurance required (payout made to the plan even if the plan became insolvent due to mismanagement or fraud):<br>• aggregate attachment point: not greater than 125% of expected gross annual claims (may be higher if AHP has higher than required reserve amounts);<br>• individual attachment point: to be determined by an actuary (no dollar value specified; prior proposals had specific requirements, e.g., $175,000); and<br>• Dept. of Labor is allowed to set aggregate attachment points higher if plan maintains reserves for claims in excess of the recommended amount.<br>*(Notes: It is not clear whether federal regulators would have authority to perform an on-site financial examination.)* | Same |

| Type of Standards | Summary of Requirements – H.R. 660 | Summary of Requirements – S. 545 |
|---|---|---|
| Waiver of solvency requirements | Alternative to reserves, stop-loss insurance, and surplus minimums:<br>• Dept. of Labor may waive when AHP can demonstrate that its obligations would be met through security, guarantee, hold-harmless arrangements, or plan sponsor's assumption of risk (bonding, letter of credit, recourse and assessments against participating employers, security, or other financial arrangement).<br>• standard for waiver: To waive these solvency standards, DOL may ascertain that alternative standards are "no less protective" [section 806(e)] | Same |
| Indemnification Insurance | Indemnification insurance required (purpose: to cover unpaid claims in the event a plan is required by the Dept. of Labor to terminate.) | Same |
| Indemnification and stop-loss insurance standards | For insurers providing stop-loss or indemnification insurance:<br>• contracts are guaranteed renewable for AHPs;<br>• prior to cancellation must notify Dept. of Labor if plan fails to pay premiums for such insurance;<br>• Dept. of Labor may establish standards for insurers selling such coverage (e.g., requiring that the insurer be licensed and authorized to sell such coverage in the United States) | Same except no requirement to notify Dept. of Labor prior to cancellation of stop-loss or indemnification insurance.<br>Dept. of Labor may establish standards for insurers selling stop-loss coverage but not indemnification coverage. *(Note: House bill allows additional standards to be set for both.) [section 806(c)]* |
| Other solvency standards | Standards:<br>• Reserve levels for claims to be determined by a qualified actuary;<br>• Dept. of Labor may establish additional requirements relating to reserves and stop-loss insurance;<br>• Solvency standards working group: must be established within 90 days of enactment of bill and the recommendations of such group must be considered by Dept. of Labor. [section 806(j)] | Same |
| ***Dept. of Labor Solvency Protections for Consumers in AHPs*** | | |
| New Federal Association Health Plan Fund | New Fund:<br>• funded by self-insured AHP's annual payment of $5,000 (plus supplemental payments as determined by Dept. of Labor);<br>• used to pay premium to continue stop-loss and/or indemnification insurance if there is reason to believe that an AHP would not satisfy its financial obligations; and<br>• fund only available for use to the extent appropriated by Congress. [section 806(f)(1)] | Same |

| Type of Standards | Summary of Requirements – H.R. 660 | Summary of Requirements – S. 545 |
|---|---|---|
| | *(*Notes*/Issues: Unlike a state guarantee fund, this fund would not pay claims directly. The AHP fund would pay premiums to maintain stop-loss and indemnification insurance of AHPs in financial distress. In theory, in case of an insolvency, outstanding claims would be paid for either by indemnification insurance policy and/or stop-loss policy.* | |
| Trusteeship of AHPs in financial distress | Dept. of Labor must go to federal court to be appointed Trustee. It can do so:<br>• if plan is unable to provide benefits when due or is in a financially hazardous condition;<br>• Department must give notice to plan; and<br>• apply to federal district court for appointment (not limited by other pending court proceeding, e.g., bankruptcy) [section 810(a) and (e)];<br>Federal courts:<br>• have exclusive jurisdiction over plan and property;<br>• may stay other actions against plan/sponsor;<br>• venue: where plan/sponsor resides or where assets are located [section 810(h)] | |
| ***Certification*** | | |
| Self-insured and fully insured AHP certification | Self-insured AHPs certified individually as meeting or that "will meet" requirements when begin operating.<br>Fully insured AHPs certified as a class as meeting or that "will meet" requirements when begin operating.<br>Dept. of Labor may require continued certification standards (on-going requirements); [section 802]<br>Fees for certification:<br>• AHP pays $5,000 for a certification (even if the AHP offers more than one coverage option, the filing fee is $5000). These fees are available to defray Dept. of Labor's administrative costs to the "extent provided in appropriations Acts" and may not be used for purposes other than the certification procedures (e.g. enforcement) [section 807(a)] | Same |
| Information to be included in the application | The application must include the following information:<br>• name and address of sponsor and of members of the Board of Trustees of the health plan;<br>• states in which AHP intends to do business including number of people expected to be covered in each state;<br>• bonding requirements (under ERISA section 412);<br>• plan documents including summary plan description, governing documents, and other material describing covered benefits; and | Same |

| Type of Standards | Summary of Requirements – H.R. 660 | Summary of Requirements – S. 545 |
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| | • agreements with service providers including contract administrators.<br>Self-insured arrangements must also provide a funding report that includes the following:<br>• statement certified by AHPs Board of Trustees and an actuarial opinion certifying that solvency requirements are/will be met;<br>• an actuarial opinion indicating that contribution rates are adequate to provide for payment of obligations and to maintain required reserves for a 12-month period (if rates are inadequate, then recommendations about changing rates to ensure adequacy);<br>• an actuarial opinion setting forth current and projected value of assets and liabilities for a 12-month period (income statement must identify separately administrative expenses and claims); and<br>• a statement of costs of coverage to be charged, itemized administrative costs, reserves, and other expenses.<br>Dept. of Labor may require additional information necessary to carry out the purposes of the legislation. [section 807(b)]<br>*(Notes: no requirement to provide information on benefit plan premiums and marketing materials)* | |
| Effective date of certification | Certification becomes effective upon notice to states in which 25% of covered people live or work. [section 807(c)]. | Same |
| Additional requirements for certified AHPs | Certified AHPs must:<br>• notify the Dept. of Labor of material changes [section 807(d)];<br>• self-insured AHPs must provide an annual report (Form 5500) within 90 days of the close of the plan year [section 807(e)];<br>• annual report must include an actuarial opinion whether contents reported are reasonably related to the experience of the plan and to reasonable expectations and represent actuary's best estimate of anticipated experience under the plan [section 807(f)] | Same |
| ***Termination of Association Health Plan*** | | |
| Voluntary | Board of Trustees can terminate health plan:<br>• after cessation of accruals in benefit liabilities;<br>• must give 60-day prior-to-termination written notice to covered individuals; | Same |

| Type of Standards | Summary of Requirements – H.R. 660 | Summary of Requirements – S. 545 |
|---|---|---|
| | • must develop a plan for winding up its affairs which will result in timely payment of all benefits for which the plan is obligated; and<br>• submit a plan in writing to Dept. of Labor. [section 808] | |
| Mandatory (applies to self-insured AHPs only) | Corrective actions:<br>• if found not to meet solvency requirements either through self-evaluation (must evaluate quarterly) or by Dept. of Labor, corrective actions must be taken to ensure compliance (even if AHP loses its certification) and must be reported to Dept. of Labor [section 809(a)]<br>Mandatory health plan termination by Board of Trustees at the direction of Dept. of Labor if:<br>1. Dept. of Labor has been notified by the board of trustees of failure to meet solvency requirements or by stop-loss/indemnification insurer (in case of failure to pay those premiums) and has not been notified by the board of trustees that corrective action has restored compliance with solvency requirements; **and**<br>2. Dept. of Labor determines that there is a reasonable expectation that the plan will continue to fail to meet solvency requirements. [section 809]<br>*(Notes/Issues: Dept. of Labor's authority appears limited. For example, it could not require termination in a case where an association's Board of Trustees notified the Department falsely that corrective action had been taken but in fact such action had not been taken. The Department could not terminate the plan through an administrative action and thus would have to go to federal court to seek appointment as Trustee to terminate the plan. Going to federal court would delay termination and might increase the risk that assets may be depleted, which would result in unpaid claims. )* | Same except does not have a provision for mandatory termination in case stop-loss/indemnification insurer notifies of a failure to pay premium (Note: the Senate bill does not require insurers to notify Dept. of Labor of failure to pay premiums and of insurance cancellation) [section 809(b)] |
| Trusteeship (by Dept. of Labor) | See discussion under "Dept. of Labor solvency protections for consumers in AHPs." | Same |
| ***Preemption of State Law*** | | |
| State laws preempted | State laws are preempted [section 2(b) of bill amending section 514 of ERISA]:<br>• if "preclude or have the effect of precluding" an insurer from offering coverage to a certified AHP [new section(d)(1) amendment to 514];<br>• if "preclude" an insurer from selling a policy that is the same as an AHP policy to any employer eligible for coverage under an AHP but not enrolled [new section (d)(2)(A) amendment to 514] (The language in the bill could be interpreted in the following two ways: 1.) insurers would be allowed to sell AHP policies to employers who are members of an association but who | Same |

| Type of Standards | Summary of Requirements – H.R. 660 | Summary of Requirements – S. 545 |
|---|---|---|
| | are not enrolled in the health plan offered by the association; or 2.) insurers would be allowed to sell AHP policies to employers who are not members of an association but who are eligible for membership in the association (and its health plan). The second interpretation seems more likely);<br>• if one state approves AHP policy for sale, then it can be sold in any other state; state laws precluding approval of such policy are preempted [section (d)(2)(B) amendment to 514];<br>• if "preclude" an AHP or its insurer from setting rates based on claims experience of AHP (or experience of its employers – bill is vague as discussed above) or varying rates for small employers based on state premium regulation applicable to small employers with coverage through a bona fide association; or<br>• if "preclude" an AHP or insurer from selecting specific items and services to cover, except state law would not be preempted [section (d)(4) amendment to 514]:<br>  • if it implements federal Newborns' and Mothers Health Protection Act (requiring minimum hospital stays) (711), Mental Health Parity Act (712), and Women's Health and Cancer Rights Act (requiring coverage for reconstructive breast surgery for mastectomy patients) (713);<br>  • if a policy was approved for sale in a State and the state prohibits exclusion from coverage of a specific disease.<br>*(Note: the new preemption standard of "preclude or have the effect of precluding" is a broad standard (different than the preemption standard ERISA applies to non-AHP employee health benefit plans). This new preemption standard may result in preemption of almost any state insurance law if it is construed to have the effect of precluding an insurer or AHP from engaging in specified activities. Furthermore, because there are specific state laws identified as not preempted (e.g., solvency laws applicable to insurers and prompt pay laws), it could be argued that almost all other state laws are in fact preempted. For example, one may argue that a state law requiring external independent review of benefit denials adds significantly to the cost of insured plans and therefore has the effect of precluding an insurer from offering coverage to a certified AHP. Such law is not explicitly saved from preemption and therefore might not apply to AHP health insurance policies, depending on how courts interpret the new standard. State rating laws are most likely preempted.)* | |
| Future federal laws | Future federal laws do not affect any employer plan, AHP, or other arrangement subject to ERISA Title I unless there is a specific cross-reference to specific section in ERISA [amendment to 514] | Same |

| Type of Standards | Summary of Requirements – H.R. 660 | Summary of Requirements – S. 545 |
|---|---|---|
| State laws not preempted | State solvency standards applicable to insurers and laws applicable to insurers relating to prompt payment of claims [section (d)(3)(A) and (B) amendment to 514]. | No comparable provisions |
| State regulation of MEWAs | Changes in what states are allowed to do in their regulation of multiple employer welfare arrangements (MEWAs):<br>• AHPs are not considered MEWAs under section 514(b)(6);<br>• if a MEWA provides medical coverage and is self-insured, any state law which regulates insurance may apply (this provision codifies current judicial interpretation of what ERISA allows states to do to regulate self-insured MEWAs) [section (b)(3) of bill amendment to 514(b)(6)(A)] | No comparable provision to clarify state regulation of self-insured MEWAs (Notes/Issues: House bill clarifies that if a MEWA provides medical coverage and is self-insured, any state law which regulates insurance may apply) |
| ***State Taxes*** | | |
| | May not tax existing self-insured AHPs.<br>States may levy a contribution tax on self-insured AHPs established after date of enactment of the bill if:<br>• contribution tax is computed by a rate to premiums/contributions;<br>• rate is not greater than states apply to insurers or HMOs;<br>• tax is nondiscriminatory; and<br>• tax is offset by taxes on insurers providing services to AHP. [section 811] | Same |
| ***Miscellaneous*** | | |
| Insurance Agents | State licensed insurance agents must be used if plan offers both fully and self-insured options. Agents must be used to sell both fully and self-insured options [section 805(a)(4)] (preempts state prohibition on insurance agents selling self-insured plans) | Same |
| Other standards | An AHP covering employer groups is considered an "employee welfare benefit plan" under ERISA after it is certified. [section 812(b)(2)] Note: It is not clear if an AHP covering only individual members is also considered an employee welfare benefit plan.<br>Board of Trustees serves as "named fiduciary" and plan administrator [section 805(a)(1)(A)] | Same |

| Type of Standards | Summary of Requirements – H.R. 660 | Summary of Requirements – S. 545 |
|---|---|---|
| ***Enforcement*** | | |
| | If willfully falsely claim that an arrangement is a federally certified AHP or is a collectively bargained union plan, can be imprisoned for up to 5 years, be fined, or both [amendment to section 501]<br>Federal district court may issue a cease and desist order against an arrangement that is not licensed by a state or federally certified. | Same |
| ***Effective Date*** | | |
| | One year after date of enactment. Dept. of Labor must issue regulations within one year of enactment date. | Same |
| ***Authority to issue guidance*** | | |
| | Authorized to issue regulations | Authorized to issue regulations only through negotiated rule making. |
| ***Other provisions*** | | |
| Clarification of treatment of collectively bargained arrangements | | Clarification of treatment of collectively bargained arrangements. *(Note: not in the House bill. This bill was introduced prior to the Dept. of Labor promulgating final regulations on collectively bargained arrangements. In light of the new regulations, such provisions may not be necessary.)* |

# Endnotes

1. In 2001, small firms (up to 99 employees) employed 13.6 million uninsured people. Out of the uninsured workers who worked for small firms, 84% worked for firms that did not offer health benefits; 7% were not eligible for benefits that were offered and 9% were eligible but not enrolled. Sherry Glied, Jeanne Lambrew, and Sarah Little, *The Growing Share of Uninsured Workers Employed by Large Firms*, p. 19, The Commonwealth Fund, Oct. 2003.

2. Policymakers have been considering how to aggregate groups of small employers for the purpose of buying health coverage for many years—and at some peril. The Clinton Administration's failed health reform initiative, for example, would have required most employers to buy coverage through "alliances." Threatened by the prospect of an employer mandate, small business groups were among the most active opponents of the legislation. While most employers would have been required to purchase through such alliances, under legislative proposals now being considered by the Congress, employers would be free to join AHPs, stay in the state-regulated market, or refrain from providing coverage.

3. In recent years, similar legislation has moved through the House of Representatives but languished in the Senate. With the Bush Administration voicing strong support for AHP legislation, the odds that the legislation might be enacted have increased, though it still faces formidable opposition.

4. Debra L. Roth, *Insurance Markets: Rules Governing California's Small Group Health Insurance Market*, California HealthCare Foundation, June.

5. Mila Kofman, Eliza Bangit, and Kevin Lucia, *Insurance Markets: Group Purchasing Arrangements: Implications of MEWAs*, California HealthCare Foundation, p. 2, July 2003.

6. The HIPC is now called PacAdvantage and is administered by the Pacific Business Group on Health. For more information about the HIPC and its role in the California marketplace, see Jill Yegian, Thomas Buchmueller, Mark Smith, and Ann Monroe, *The Health Insurance Plan of California: The First Five Years*, Health Affairs, Sep./Oct. 2000.

7. As noted later in this paper, in 1982 Congress amended ERISA to clarify that states can regulate "multiple-employer welfare arrangements" (or MEWAs), arrangements that provide medical benefits to employees of two or more employers or self-employed people.

8. Large employers buying fully insured products also were able to segregate their risk pools from small employers through the practice of experience rating (i.e., insurers taking a group's particular claims experience into account when determining its premium).

9. Several national studies have shown that benefits and cost-sharing features of insured and self-insured plans were very similar—that is, in some respects, insured plans were more

generous, while in other ways, self-insured plans were more generous. Results of these comparative studies are probably most relevant to analyzing large employer health coverage because many large employers self-insure their health plans while the practice is much less prevalent among small employers due to the risk that it poses. Small employers, on average, offer less generous benefits than large employers do. See Patricia Butler and Karl Polzer, *Regulation of ERISA Plans: The Interplay of ERISA and California Law*, California HealthCare Foundation, p. 32, June 2002 (hereinafter *Regulation of ERISA Plans*).

10. These claims have largely not been substantiated, however. For an in-depth discussion of multiple employer arrangements, see Stephen Long and Susan Marquis, *Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?*, Health Affairs, Jan./Feb. 2001, p. 154; Jill Yegian, Thomas Buchmueller, Mark Smith, and Ann Monroe, *The Health Insurance Plan of California: The First Five Years*, Health Affairs, Sep./Oct. 2000, p. 158; U.S. General Accounting Office, *Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices,* GAO/HEHS-00-49, Mar. 2000; Richard Curtis, Edward Neuschler, and Rafe Forland, *Consumer-Choice Purchasing Pools: Past Tense, Future Perfect?* Health Affairs, Jan./Feb. 2001, p. 164.

11. For more details see Arlene Leibowitz, Cheryl Damberg, and Kathleen Eyre, *Study 5: Multiple Employer Arrangements*, in Health Benefits and the Workforce (Washington DC: U.S. Department of Labor, Pension and Welfare Benefits Administration, 1992); Karl Polzer, *Preempting State Authority to Regulate Association Plans: Where Might It Take Us?*, Issue Brief No. 604, George Washington University, Oct. 1997; and Karl Polzer, *Multiple Employer Purchasing Groups (METs, MEWAs, HINs, HIPCs): The Challenge of Meshing ERISA Standards with Health Insurance Reform,* National Health Policy Forum, Issue Brief No. 604, George Washington University, Sept. 1992. If a multiple-employer group buys coverage from a state-licensed insurer, the state simply regulates the insurers.

12. Mila Kofman, *Issue Brief: Group Purchasing Arrangements: Issues for States*, State Coverage Initiatives, V. 4, No. 3, April 2003.

13. Based on preliminary research funded by a HCFO-RWJ grant. Health Policy Institute, Georgetown University, August 2003.

14. If a multiple-employer group buys coverage from a state-licensed insurer, the state simply regulates the insurer.

15. In 1982 Congress passed an amendment to ERISA sponsored by former Rep. John N. Erlenborn (R-Ill.), whose state had experienced a major multiple-employer plan bankruptcy. The amendment allows states to apply the full extent of state law to MEWAs that do not meet ERISA's definition of an employee benefit plan. (An ERISA plan has to be established or maintained by an employer or employee organization or both.) For fully insured MEWAs meeting ERISA's definition of employee benefit plan, states may apply insurance laws regulating reserve and contribution levels. For self-insured MEWAs that are ERISA plans, states may apply insurance laws that are not inconsistent with ERISA. Collectively

bargained arrangements and rural telephone and electric cooperatives are not considered MEWAs.

16. Job-lock means that consumers with health problems might choose to remain with their employer and forgo a better job opportunity due to potential barriers in obtaining health coverage. Switching employers may mean being excluded from the new health plan based on one's health or past medical history or facing exclusion for their medical conditions. HIPAA prohibits excluding one from a group health plan based on that person's health status.

17. In the small group market, 46 states have rate restrictions and of those, 11 require community or adjusted-community rating. Health Policy Institute, Georgetown University database, Fall 2002.

18. Debra L. Roth, *Insurance Markets: Rules Governing California's Small Group Health Insurance Market*, California HealthCare Foundation, June 2003.

19. Under such reforms in California and other states, insurers must "guarantee issue" products in the small group market and constrain differences in rates based on health risk factors. (Under California law, in the small-group market, insurers can only vary their rates by 10% above or below their standard rate based on the health status of a group.)

20. Indicators of average or above-average risk or health claims experience include state rate filings, denials of coverage, proposed premium rate levels, or other means demonstrated by an AHP pursuant to regulations issued by the U.S. Department of Labor. See § 802(f)(3) of H.R. 660 amending ERISA Title I.

21. An aggregate attachment point is triggered when total group health claims reach a certain amount, agreed to in the contract between the stop-loss insurer and the AHP. Once the threshold is reached, any additional claims are paid for by the stop-loss insurance company. For example, assuming 125% attachment (a maximum allowed by the bill) and expected claims of $5 million, the AHP would be responsible for $6.25 million, while the stop-loss insurer would cover claims exceeding that amount. Similar to an aggregate attachment point, a specific attachment point is triggered when a claim/claims for a covered individual (not the entire group) reaches a pre-specified amount agreed to in the stop-loss contract. The bill allows an actuary to determine this amount.

22. See Letter to Representative Boehner, Chairman of the House Committee on Education and the Workforce, from Karen Bender, Chairperson of the Association Health Plan Work Group, American Academy of Actuaries, April 29, 2003 (on file with authors); see also Testimony of the National Association of Insurance Commissioners before the Senate Small Business and Entrepreneurship Committee on Small Business and Health Care presented by Sandy Praeger, Commissioner of Insurance, State of Kansas, Feb. 5, 2003.

23. In California, a major insolvency of a licensed MEWA, Sunkist Growers, led to a reevaluation of a low surplus requirement. Although higher surplus requirements were

enacted ($7 million by 2004), existing licensed, self-insured MEWAs in California have criticized a bright-line statutory requirement for being inadequate. Staff from existing MEWAs interviewed for another paper believe that a bright-line surplus requirement is inadequate in ensuring solvency because it does not reflect the size and other financial risk factors of licensed arrangements. See Mila Kofman, Eliza Bangit, and Kevin Lucia, *Insurance Markets: Group Purchasing Arrangements: Implications of MEWAs,* California HealthCare Foundation, July 2003.

24. U.S. General Accounting Office, *Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses,* GAO-03-1133, Sep. 2003. (See Table 10, p. 55 for solvency standards applicable to insurers.)

25. Although a state guaranty fund pays outstanding claims in case of insurance company insolvency, HMOs and MEWAs are not generally covered by the guaranty fund. However, there are other protections for consumers with such policies. Providers who participate in HMOs not covered by a guaranty fund are subject to ”hold harmless” contract provisions and may not collect unpaid claims from consumers in case of HMO insolvency. Although there is no safety net for MEWA insolvency, the standards for California licensed MEWAs and regulatory tools available to California regulators are stronger than what is proposed in H.R. 660.

26. Mila Kofman, Kevin Lucia, and Eliza Bangit, *Self-Insured MEWAs: Insolvency and Other Challenges, Lessons from California, Michigan, and Oklahoma* (publication forthcoming, Spring 2004; draft on file with authors).

27. COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985, which amended ERISA to require continuation coverage to be offered by employee health plans. See Part 6, Title 1 of ERISA. HIPAA is the Health Insurance Portability and Accountability Act of 1996, which amended ERISA, establishing portability and nondiscrimination rules for group health plans. See Part 7, Title 1 of ERISA. Although DOL does not currently have expertise, over time this expertise should be developed, assuming enough resources are allocated to oversight and regulation of AHPs.

28. Ibid.

29. The Projected Impacts of “The Expanded Portability and Health Insurance Coverage Act” on Health Insurance Coverage, CONSAD Research Corporation, Pittsburgh, Pennsylvania, July 10, 1998.

30. See Study of the Administrative Costs and Actuarial Values of Small Health Plans, Actuarial Research Corporation, January 2003, downloaded from SBA’s web site Sept. 5, 2003. http://www.sba.gov/advo/research/rs224tot.pdf.

31. *Increasing Small-Firm Health Insurance Coverage through Association Health Plans and Healthmarts*, Congressional Budget Office (Jan. 2000). Downloaded from CBO website 04/03/2003. http://www.cbo.gov.

32. 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 Aug. 8, 2003: http://www.cbo.gov/showdoc.cfm?index=4352&sequence=0 , and Congressional Budget Office Cost Estimate: H.R. 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 Aug. 6, 2003: http://www.cbo.gov/showdoc.cfm?index=4413&sequence=0 .

33. Beth Fritchen and Karen Bender, *Impact of Association Health Plan Legislation on Premiums and Coverage for Small Employers*, Mercer Risk, Finance & Insurance Consulting. Prepared for National Small Business United, June 2003.

34. The Urban Institute's model is called the Health Insurance Reform Simulation Model (HIRSM). For a complete description of the national model, see Linda Blumberg, et al., *The Health Insurance Reform Simulation Model (HIRSM): Methodological Detail and Prototypical Simulation Results*, Final Report to the U.S. Department of Labor, Employee Benefits Security Administration, July 2003. http://www.urban.org. The California analysis is described in Linda Blumberg and Yu-Chu Shen's companion piece to this report, *The Effects of Introducing Federally Licensed Association Health Plans in California: A Quantitative Analysis*, California HealthCare Foundation, January 2004.

35. The AHP legislation does impose at least one new mandate on both self-insured and fully insured AHPs by requiring them to use insurance agents, which means premiums must include commissions for agents. ERISA currently does not require self-insured plans to use agents.

36. Under Cal-COBRA, insurers are required to offer continuation coverage to former employees of firms with 2 through 19 employees. The federal COBRA law applies only to firms employing 20 or more workers.

37. Debra L. Roth, *Rules Governing California's Small Group Health Insurance Market*, California HealthCare Foundation, June 2003.

38. The AHP could choose to comply with California's rate restrictions, but could not be compelled to comply by the state.

39. Such laws require insurers to pay providers for covered services within a specified time period.

40. The language in the bill could be interpreted in the following two ways:

    1. insurers would be allowed to sell AHP policies to employers who are members of an association but who are not enrolled in the health plan offered by the association; or
    2. insurers would be allowed to sell AHP policies to employers who are not members of an association but who are eligible for membership in the association (and its health plan).

It seems that the second interpretation is most likely.

41. Insurers generally consider regulation by the CDI to be less restrictive than under the DMHC, though CDI licensure is more costly and means having to comply with stricter solvency rules. See *Regulation of ERISA Plans* at 10.

42. Mila Kofman, Kevin Lucia, and Eliza Bangit, *Proliferation of Phony Health Insurance: States and the Federal Government Respond*, BNA Plus, August 2003.

43. U.S. General Accounting Office, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements,* GAO/HRD-92-40, at 2-3, Mar. 10, 1992.

44. Currently, the most prevalent way to sell unauthorized insurance is through associations (a type of MEWA) and through phony unions. Some sell through professional employee organizations (PEOs). Arguably, all of these arrangements can raise questions about state jurisdiction. For example, ERISA exempts collectively bargained union plans from its MEWA definition. This means that states cannot regulate such plans. Ambiguity over what is a collectively bargained plan has resulted in health insurance scams promoted through phony unions. When found by state investigators, operators of such plans often claim ERISA preemption.

45. The wide range of these estimates demonstrates the amount of uncertainty involved in projecting the impact of complex legislation.

46. Associations might be able to use their bargaining leverage to negotiate discounts from insurers wanting to sell policies to their members. Associations could share such discounts with their members or keep all or part of them through the mechanism of plan membership fees. From an association member's point of view, for an AHP to be attractive, the combination of any AHP membership fee and the AHP premium would have to be competitive with premiums for similar coverage options available in the market at large.

47. In 2002, the U.S. General Accounting Office (GAO) reported that 25 of 37 states it surveyed identified a Blue Cross Blue Shield (BC/BS) carrier as the largest offering health insurance in the small-group market. The median market share of all the BC/BS carriers in 34 states reporting was 34%, ranging from about 3% in Vermont to about 89% in North Dakota. BC/BS carriers combined for half the market or more in nine states surveyed. U.S. General Accounting Office, *Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market*, GAO-02-536R, letter to Hon. Christopher "Kit" Bond, Ranking Minority Member, Committee on Small Business and Entrepreneurship, U.S. Senate, March 25, 2002.

48. For example, 79% of California firms with 3–199 employees offered only one plan compared to 93% nationally. *California Employer Health Benefits Survey, 2002,* Kaiser Family Foundation and Health Research and Educational Trust, Feb. 2003.

49. See Karl Polzer and Jonathan Gruber, *Assessing the Impact of State Tax Credits for Health Insurance Coverage*, California HealthCare Foundation, June 2003.