► Myths Vs. Facts Regarding AHPs

A number of national business associations, like the U.S. Chamber of Commerce, are pressing for the creation of Association Health Plans by Congress. Below are arguments in favor of the legislation, presented by the U.S. Chamber, with our response.

U.S. Chamber:

Myth: Association Health Plans (AHPs) will allow organizations to "cherry pick" only the healthiest individuals, leaving the states' small group markets to care for the sickest individuals.

Fact: AHPs are prohibited from being able to "cherry pick." Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), an individual or employer cannot deny coverage based on health status or claims experience. AHPs would be subject to all the preexisting condition, portability, nondiscrimination, special enrollment and renewability provisions under HIPAA. The language clearly prohibits discrimination based on health status by requiring any member of an association who is eligible
for membership benefits must be furnished with information regarding all coverage options available under the plan.

Reality, Coalition:

The above regulations do not address pricing, which is the ultimate weapon for selecting risk and avoiding adverse selection (risky groups). While no group may be *denied* coverage, AHPs will be allowed to structure themselves in ways to charge older, sicker groups much higher *premiums*, by avoiding state laws. Moreover, AHPs are required to offer coverage only to the extent coverage is "geographically available." The legislation does not require that coverage be made "geographically available" in all neighborhoods or areas.

U.S. Chamber:

Myth: Association Health Plans are just another name for Multiple Employer Welfare Arrangements (MEWAs).

Fact: Association Health Plans are fundamentally different from MEWAs.

MEWAs are often "front" organizations for insurance companies or insurance agencies to sell insurance. Unscrupulous individuals or corporate entities can start them for the sole purpose of providing health insurance -- leading to adverse selection and fraud. Often there is no certification process before MEWAs can begin providing health benefits to workers. There are no federal solvency standards for MEWAs, which has often led to fraud and abuse. In contrast, the sponsor of an AHP must be a bona fide professional or trade association organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing annual meetings, and must be in existence for a minimum of 3 years for purposes other than that of obtaining or providing health coverage. Also, the association must collect dues from its members without conditioning them on the basis of the health status or the claims experience of the enrollees in the

plan or on the basis of the member's participation in a group health plan. Associations must set up a separate trust with Trustees who become fiduciaries under the plan and are subject to the same fiduciary responsibilities as fiduciaries of corporate and union health plans. The Trust must file for certification with the Department of Labor.

Reality, Coalition:

It's not so hard to create an association for other purposes, then after three years, use it primarily for insurance. This has occured. Moreover, there are thousands of associations across the country that could immediately qualify to sponsor AHPs. Nor is non-discriminatory dues the issue. The discrimination loophole lies in *premiums and contributions*, absent state standards or consistent federal standards.

A number of the largest MEWA failures over the past couple of years involved plans that could have met the sponsorship standards under the AHP legislation. These plans, which included the New Jersey Coalition of Automotive Retailers, the Indiana Construction Industry Trust and the Sunkist Growers Plan in California, left thousands of small businesses and their workers with millions in unpaid claims.

The federal government did not do a good job of regulating MEWAs after the passage of ERISA. Congress acknowledged the limited capacity for the federal government to regulate these plans when, after a string of MEWA failures, it gave regulatory responsibility back to the states in 1983. How will it be any different with AHPs and a federal government that is reeling under massive deficits? Where will the regulatory resources come from?

Simply requiring a "bona fide" association to sponsor the AHP will not prevent abuses. Earlier in 2003, The Wall Street Journal profiled existing association plans, including one group that is part of the coalition pushing this legislation, that have used aggressive rating and deceptive marketing practices (e.g., re-underwriting several times per year when an individual falls sick). One of the association groups profiled in the WSJ series (which was identified as front group for an insurance company) is part of the coalition pushing this legislation.

U.S. Chamber:

Myth: AHPs will lack adequate solvency protections.

Fact: The legislation contains extensive requirements for solvency. DOL will only certify AHPs if the sponsoring association has been in operation for more than 3 years for a reason other than selling insurance, and if it meets certain solvency and membership requirements.

Claims Reserves: Must establish and maintain reserves in amounts recommended by a qualified actuary.

Stop loss. The AHP must secure specific excess stop loss coverage and aggregate excess stop loss coverage to protect against unexpectedly large claims.

Indemnification. The AHP must secure indemnification insurance to cover any claims left outstanding as the result of a plan termination.

Surplus Requirements. In addition to claims reserves, plans must establish and maintain a surplus in an amount at least equal to $500,000 but not greater than $2,000,000 as may be set forth in regulations. None of the above-listed solvency provisions are required by ERISA plans operated today.

Additional Requirements. The legislation authorizes additional reserve and excess/stop loss insurance as may be deemed appropriate by the Secretary, taking into account the recommendations of the Solvency Standards Working Group established by regulation and/or negotiated rule making.

Reality, Coalition:

The American Academy of Actuaries (AAA) found that the solvency standards in the bill are inadequate for associations with only 5,000 to 10,000 members. Why should we listen to the AAA? Under the legislation, actuaries would monitor and certify the solvency of AHPs to the Labor Department (effectively substituting for hands-on regulation by state insurance departments).

The solvency standards for AHPs are much weaker than the standards required by state insurance commissioners. The legislation would limit capital to $2 million, regardless of the size of the plan. While this may sound like a lot of money, just keep in mind that the AAA says it is only adequate for a plan with 5,000 to 10,000 members. No state limits the capital requirements for insurers – in all states the capital requirement increases as the plan grows.

Instead of maintaining adequate capital, the bill allows substitution of stop-loss and other types of insurance that do not provide as much protection. For example, under the stop-loss provisions, the sponsoring association could be responsible for millions of dollars in claims before the stop-loss insurance kicks-in. This is a risk that may surprise many associations that attempt to self-fund an AHP.

Let's assume these protections are adequate. In reality, will they be enforced? Can they be enforced? And if they are, given the "Additional Requirements," how many AHPs could survive the formation process? Yet their rationale is built on "competition" and "more choice."

Under the Clinton Administration, the Department of Labor testified that it had enough resources to review each AHP once every 300 years. Moreover, the GAO 2002 report concluded that DOL's staff is inadequate to regulate even its current pension responsibilities, saying it would take 90 years to do a baseline assessment of pension plan noncompliance.

Also bear in mind that the insurance industry is universally opposed to the legislation. They must know something about their business. If there really was an opportunity with AHPs, wouldn't some insurance groups be in favor of them?

U.S. Chamber:

Myth: AHPs will destroy consumer protections by pre-empting state benefit mandates.

Fact: Labor unions and large corporations operate across state boundaries, but their plans' consumer protections are not considered weak. To the contrary, these organizations offer some of the best health coverage in America—AHPs would do the same!

Reality, Coalition:

Don't compare apples and oranges. Voluntary small business markets are far different than large, captive, corporate markets. And union health benefit packages generally are richer than small business packages. If the goal is to reduce costs, and thereby increase access, small business plans will never approach union plans. You can be confident that AHPs will not "do the same."

U.S. Chamber:

The solvency standards, plan requirements and patient protections included in the AHP legislation are more stringent than those now required by some states.

Reality, Coalition:

This is simply not true. All states require the capital insurers maintain to assure payment of future claims to grow with the number of people the insurer covers. This legislation specifically limits the amount of capital that a "self-insured" AHP must maintain to a level that the American Academy of Actuaries has said is inadequate for even a small AHP (5,000+ members).

The capital requirements in the legislation are closer to the minimum level states require to apply for an insurance license, not the amount actually required once insurers have commenced operations.

The National Association of Insurance Commissioners has warned that the minimal solvency standards for AHPs in the bill would subject small employers and their workers to increased risk on insolvency and unpaid claims.

U.S. Chamber:

In order to be successful and retain membership, associations that offer AHPs will have to offer benefits equal to or superior to traditionally regulated insurance companies or products to attract employers and their employees.

Reality, Coalition:

Not so. All they'll have to do is register a subsidiary or work with an insurer in the most-friendly state for insurers, and then circumvent regulations of the other states. That's where AHPs get their compelling advantage.

U.S. Chamber:

AHPs would be subject to federal health insurance requirements that provide consumer protections, such as COBRA continuation coverage; ERISA's claims procedures for benefit denials and appeals; HIPAA's guaranteed portability and renewability of health coverage for those with preexisting conditions; the Mental Health Parity Act; the Women's Health and Cancer Rights Act; and the Newborns' and Mothers' Health Protection Act.

Reality, Coalition:

So what? These regulations do not govern initial pricing, underwriting, or marketing practices. AHPs will still be able to select risk and divide the market between the "haves" and the "have nots," as we have noted elsewhere. Federal ERISA standards were intended to regulate employers who provide coverage directly to their workers, not insurance plans that will collect millions of dollars in premium from thousands of independent small employers. Therefore, ERISA does not include many of the protections for small employers and their workers that exist today under state law. The AHP legislation would open the door to the aggressive insurer practices that caused states to enact small employer health insurance reforms in the first place.

U.S. Chamber:

Myth: The Department of Labor (DOL) is not capable of regulating AHPs effectively.

Fact: The U.S. Department of Labor has effectively regulated tens of thousands of self-funded employers for almost 30 years.

The Department of Labor currently administers ERISA protections covering approximately 2.5 million private, job-based health plans and 131 million workers, retirees and their families. Of these, 275,000 plans covering 67 million individuals are self-insured, and therefore subject exclusively to DOL oversight. In addition, self-insured multi-employer plans (established and operated jointly by a union and two or more employers) are overseen exclusively by DOL under the Taft-Hartley Act. These self-insured and union plans cover more than 72 million participants. The Department has testified that it stands prepared to allocate the necessary resources to ensure proper AHP certification and stringent oversight.

The Department of Labor has firsthand experience dealing with group health plan regulation, as well as combating insurance fraud. In fact, DOL benefit advisors assisted 114,000 individual workers, retirees and their families with their inquiries about
their health benefits in FY 02.

DOL has a strong record of enforcement, protecting workers, retirees and their families in health plans. In FY2002, DOL recovered $140 million in assets restored to health and welfare plans.

Reality, Coalition:

The federal government was a miserable failure in regulating MEWAs. Other than "Yeah, we can do that," where is the regulatory plan, where are the resources, and where is the capability to take on an additional small-markets burden? In small markets, we're talking about enterprises as small as two employees, potentially millions more businesses. We're willing to bet that regulation will be "by exception,, or, "See a crime; call the police."

And what about the issue of the under-funded plans among many of America's largest employers we've been reading about recently? And solution under consideration by the federal government is to just wave it away by changing the assumptions?

The fact is that the DOL does not regulate multi-employer health insurance plans (only employers providing coverage to their own workers). DOL has very little local presence. DOL does not have any experience in reviewing premiums, assuring fair marketing standards, or guaranteeing the solvency of health plans for small employers. The GAO 2002 report concluded that it would take DOL 90 years to do a baseline assessment of noncompliance in current pension plans.

U.S. Chamber:

Myth: AHPs will only market association membership in areas of the state with lower health costs and a younger, healthier population.

Fact: All bona fide associations must be in existence for three years prior to offering health coverage and exist for purposes other than to provide health coverage to its members. Typically, associations represent a cross-section of the population.

The language clearly states that the bona fide association must provide all interested employers (regardless of age, health status, etc.) with information regarding all coverage options available under the plan.

The bill prohibits AHPs from varying contribution rates on the basis of health status or claims experience of a particular employer or particular individual, or on the type of business in which such employer is engaged, except to the extent already allowed by state law in which a given employer is located. Bona-fide associations exist solely for their members -- developing services to attract and retain members. Associations
will need to develop benefit packages that are comprehensive and attractive to their members, or they will face losing membership.

Reality, Coalition:

Note the phrase, "except to the extent already allowed by state law in which a given employer is located." We've covered this before, but AHPs will establish themselves in the state(s) least friendly for the insured (small business), and override the laws and requirements in the other states. There are no restrictions against this in the legislation. In fact, the House did not accept any amendments imposing rating, underwriting or marketing standards. Nor did it accept any amendments to coordinate regulatory activities of the states.

It won't make any difference where "a given employer is located." Keep in mind that AHPs get their advantages in small employer markets by overriding state requirements. While as a rule we don't like state requirements, many of them were enacted in the 1990s for good reasons, including protecting thousands of small businesses that have been burned in the past.

Also remember that AHPs are not required to offer product in all areas. They are also not required to actively market coverage to all members (i.e., they are only required to provide information on their health plan when an employer requests it). This would allow AHPs to selectively market to low risk firms and avoid high risk firms.

It is important to keep in mind that the Congressional Budget Office found that the vast majority of small employers would experience higher premiums under this legislation. Fragmenting the small employer market will help the healthy few at the expense of every other small employer.

U.S. Chamber:

Myth: Fully insured AHPS would only be subject to the rate bands in their state of domicile and would use those rules in all other states in which they operate.

Fact: AHPs will generate a set of rates for all insured groups within the plan based upon the overall claims experience of the entire AHP. AHPs would utilize the standard insurance factors currently used by the insurance industry to calculate rates for the plan. When varying rates for different employer groups within the AHP, the plan can only use the state rating bands for those employers located in a given state, to the same extent as currently used by insurance companies.

Reality, Coalition:

Regarding marketing, rating, and underwriting, nothing prevents AHPs from structuring themselves to accept only risks within certain parameters. Other than solvency requirements by state, the legislation clearly states that AHPs will be subject to the regulations of the state(s) where they domicile, not to the regulations of other states where they also operate. If that was not so, we would not be having this debate. Otherwise, AHPs would have no advantage and there would be no point to the proposal.

The bill contains very broad language that preempts "any and all state laws" that may preclude the offering of a policy type approved in one state in any other state. However, in order to clarify that insured AHPs comply with state prompt pay laws and solvency rules, proponents added language specifically stating that the bill's preemption language shall not "supercede or impair" such laws. Proponents chose not to do the same for rating laws.

During consideration of this legislation by the House Committee on Education and the Workforce, three amendments were considered to tighten the rating standards for AHPs. All three amendments were defeated. If proponents were truly interested in addressing this problem, they should make it absolutely clear that *no state rating laws* would be preempted for either self-funded or insured AHPs.