American Academy of Actuaries

Issue Brief

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Association Health Plans

Some proposals put forward to modify or repeal the Affordable Care Act (ACA) would expand the ability of small employer groups and individuals to band together to obtain health insurance through association health plans (AHPs). Proponents of such an approach point out that one of the biggest obstacles to employers offering coverage and individuals obtaining coverage is cost, and argue that AHPs would expand access and drive down costs. The success and practicality of such an approach for increasing coverage options and reducing premiums would depend on how the rules governing AHPs were written.

KEY POINTS

- Expanding the use of association health plans (AHPs) could result in market segmentation that could threaten non-AHP viability and make it more difficult for high-cost individuals and groups to obtain coverage.
- To avoid increased solvency risk, AHPs would need clearly defined regulatory authority and solvency requirements.
- AHPs would need to be subject to state-level consumer protection laws.

AHPs could create adverse selection concerns if they operate under different rules.

A key to sustainability of health insurance markets is that health plans competing to enroll the same participants must operate under the same rules. Although AHPs would be offered in competition with other small group and individual market plans, they could operate under different rules. In particular, if an AHP is allowed to follow the issue, rating, and benefit rules of a single state nationwide, or be pre-empted from state regulation by being self-insured, it would impose different rules on insurance providers offering coverage in the same market. The viability of many state-based markets would be challenged as a result. For example, if an AHP establishes itself in a state with fewer coverage requirements and less restrictive issue and rating rules relative to other states, the AHP would be allowed to use that state's requirements in all states, even those with greater regulatory requirements. Non-AHP insurance plans, however, would continue to be subject to each state's requirements. Such a development would fragment the market as lower-cost groups and individuals would move to establish an AHP, and higher-cost groups and individuals would remain in traditional insurance plans. Such adverse selection would result in higher premiums in the non-AHP plans. Ultimately, higher-cost individuals and small groups would find it more difficult to obtain coverage.

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If the rules governing AHPs were consistent with those governing non-AHPs, there would be fewer concerns about market fragmentation. The ACA made many of the rules applying to the individual and small-group markets uniform with each other and nationwide, decreasing the threat of adverse selection and also reducing any cost advantages of AHPs. If the encouragement of AHPs were coupled with an increased flexibility for states to change their issue, rating, and benefit requirements as some have proposed, however, AHPs would raise adverse selection concerns and threaten the viability of the individual market in states with more restrictive rules. Similarly, allowing AHPs to avoid state regulation by self-insuring would result in market fragmentation and threaten the viability of the insured market.

AHPs face increased insolvency risk without clearly defined regulatory authority.
Governmental authority for regulating AHPs would need to be clearly defined. Absent this clarification, it is likely that no entity will bear the sole responsibility for regulating AHPs, or that there will be conflicting regulation. The history of multiple employer welfare arrangements (MEWAs) is instructive. Self-funded MEWAs had no clear regulatory authority, as initially it appeared that ERISA exempted them from state-level regulatory oversight. Multiple MEWA bankruptcies resulted, and consumers had limited avenue for redress. Eventually, the federal government issued a written clarification of earlier amendments to ERISA that made it clear that states do have regulatory authority over MEWAs. If regulatory authority for AHPs is not clearly specified, they could suffer the same fate as MEWAs, leaving millions without health coverage due to insolvencies. Surplus requirements for self-funded AHPs should be similar to the minimum requirements for health risk-based capital developed by the National Association of Insurance Commissioners.

AHPs would need to be subject to state-level consumer protection laws.
It is important to recognize the need for AHPs to abide by state-level consumer protection laws, which vary from requiring network adequacy to appeal processes for denied services. While AHPs may save money if they do not have to bear the costs of these consumer protections, AHP enrollees may not realize they lack these protections until the time of claim, when it is often too late for recourse.

AHPs would be unlikely to obtain lower provider payment rates than larger insurance companies.
It is unlikely that any AHP would be able to achieve the critical mass of enrollees needed to negotiate the deep provider discounts that large health maintenance organizations (HMOs) and insurance companies currently obtain. A more realistic scenario is one in which AHPs "rent" provider networks and pay access fees that depend in part on market leverage and savings. Some of these networks are owned by HMOs and insurance companies that rent out their networks to smaller competitors.

As high health care costs persist, insurance affordability remains a challenge for many employers and individuals. However, AHPs could result in unintended consequences such as market segmentation that could threaten non-AHP viability and make it more difficult for high-cost individuals and groups to obtain coverage, AHP insolvencies if they are not subject to clear regulatory authority and solvency requirements, and lack of consumer protections if AHPs are not subject to state-level protections.

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