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ISSUE BRIEF
AMERICAN ACADEMY of ACTUARIES

FAQs on AHPs

Frequently Asked Questions on Association Health Plans

Congress and the administration are considering various proposals to increase the availability, affordability, and accessibility of health insurance. One solution currently being proposed by President Bush and others would allow small businesses to band together to offer health insurance through an association health plan (AHP).

Legislation governing the creation of AHPs has been introduced in both the House and Senate in 2005.[1] The bills aim to expand access to affordable health insurance by promoting the use of AHPs. While the goals of the legislation are commendable, the bills do not directly address the core problem of America's health care system: the high cost of health care. Additionally, if AHP legislation is not crafted carefully, unintended negative consequences could result.

Policy-makers have come down on both sides of the debate over these plans. Questions that should be considered in this debate include: Can AHPs result in lower administrative costs? Can they improve access to coverage for those currently uninsured? Could AHPs work in the current marketplace without adversely disturbing the existing market?

This issue brief examines some common questions about AHPs. It also addresses some possible unintended consequences and related concerns that could arise if the creation of AHPs is not approached carefully.[2]

FREQUENTLY ASKED QUESTIONS

Will AHPs be regulated by the Department of Labor or will there be state-level oversight?

Governmental authority for regulating AHPs should 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. As demonstrated with the history of multiple employer welfare arrangements (MEWAs), when regulatory authority is unclear, consumers have limited avenues for redress. Self-funded MEWAs asserted that the Employer Retirement Income Security Act (ERISA) negated any state-level regulatory oversight authority over their operations. After many years and multiple bankruptcies, the federal government issued a written clarification of earlier amendments to ERISA that made it clear that states do have regulatory authority. If regulatory authority is not clearly specified, AHPs could suffer the same history as MEWAs, leaving millions without health coverage.

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The various state departments of insurance employ thousands of individuals whose primary purpose is to ensure compliance with state and, when applicable, federal laws. The U.S. Department of Labor will either have to retain similar staffing or delegate the oversight responsibilities to the states to maintain the same level of consumer protections. The other alternative, which would provide less consumer protection, is a formula for failure.

Often ignored in discussions of AHPs are the state-level consumer protection laws. These laws vary from requiring all willing providers to participate in networks to appeal processes for denied services. Some AHP proposals would waive AHPs from compliance with these state requirements. While AHPs will save money by not having to bear the costs of these consumer protections, the AHP members may not realize they do not have these protections until at the time of claim, when it is often too late for financial recourse.

Are surplus requirements sufficient for self-funded AHPs to remain solvent?

The minimum surplus requirements for self-funded AHPs should take into account both the size and the rate of growth of the AHP. Historically, there have been many examples of AHP-like organizations becoming insolvent because of inadequate surplus. Following such events, most states enacted solvency standards. To maintain the benefit of these standards to consumers, the surplus standards for (self-funded) AHPs should be similar to the minimum requirements for health risk-based capital (RBC) developed by the National Association of Insurance Commissioners (NAIC). Also, some AHP proposals rely on affordable reinsurance vehicles that do not currently exist in today's marketplace as a means to reduce surplus needs.

Will AHPs be on equal footing with other health plans in the states where the AHPs operate?

Any legislation that allows an AHP to choose a single state as its "applicable authority" and enables the AHP to follow the rating rules of that state nationwide creates an unlevel playing field that results in market segmentation. For instance, if an AHP chooses a state that has no restrictions on small-group rates, the AHP will be allowed to use this rating practice in all states, even those that require community rating for small groups. Non-AHP insurance plans, however, must adhere to each state's requirements. The consequence of different rules for AHPs versus state-regulated insured plans is a fragmentation of the market. AHPs will engage in cherry-picking, thus increasing the costs for sicker individuals and everyone else who remains in the traditional insured plans. In addition to differences in rating rules for new issues, an unlevel playing field would result between AHPs and other health insurers in a state due to different renewal rating requirements, different benefit requirements, and different underwriting requirements at both the group and member level.

The extent of the impact of an unlevel playing field will be directly related to the level of regulation currently in place in a particular state. For instance, states that require community rating will experience the greatest amount of selection from AHPs, who will be able to vary rates based upon age, gender, morbidity, etc. Healthier risks will realize lower rates from the AHPs while sicker groups will gravitate toward the state-regulated, community-rated pool. It is unclear whether AHPs will have a positive long-term impact on the number of uninsured under these circumstances. Individual states have adopted rating rules that their representatives believe best serve the needs of its citizens.

If the U. S. Congress decides to regulate some small-group insurance at the federal level, then a level playing field for all participants is attainable only if all insurers/HMOs are allowed to follow the same rules, whether they are licensed in multiple states or single states and whether they insure AHPs or other small groups. This will foster equal competition.

Will AHPs provide similar benefits to those provided by other health plans in the states where AHPs operate?

AHP groups will be exempt from state-mandated benefits. Healthier groups are less likely to utilize mandates and, therefore are more likely to choose AHP coverage. Groups with higher health risks and higher utilization of these mandated services are more likely to remain in the traditional state-regulated insured market, thus widening the gap between the two markets. Currently, both high and low utilizers are in the same insured pool and the cost for mandates is spread across a larger pool for a smaller incremental cost. Applying a different set of required mandates to different markets would lower the cost for some, but raise the incremental cost for others.

Will allowing AHPs to have different rating rules benefit the market?

Market destabilization could result from disparities between AHPs and insured plans with respect to allowable rating practices, mandated benefit requirements, and consumer protections. The only way to maintain a level playing field is to have a common set of rating rules and consumer protection laws for every entity, whether it is an insurance company, health maintenance organization (HMO), or a self-funded AHP.

Will AHPs allow small employers to have more buying power and thus reduce costs?

Many small employers already benefit from the same provider discounts that HMOs and health insurers obtain for their large-employer groups.

However, it is difficult to create a scenario that would result in any AHP being able to realize the critical mass of members that would allow them the leverage to negotiate the deeper discounts that large HMOs and insurance companies currently enjoy with providers. A more realistic scenario is one in which AHPs "rent" provider networks and also pay access fees (or a percentage of savings) that depend in part on market leverage. Some of these "for rent" networks may be owned by HMOs and/or insurance companies who rent out their networks to smaller competitors generally in return for performing all the policy administration and for substantial access fees (or percent of savings) as well. It is reasonable to expect that while the AHPs may be able to rent networks, the provider discounts (net of access fees) they realize will not exceed and probably be less than the provider discounts the large HMOs and/or insurance companies currently enjoy.

The other functions performed by HMOs and/or insurance companies for small employers, e.g. underwriting, enrollment, policy issue, billing, claim adjudication, customer service, marketing, sales, etc. will not disappear. These functions will need to be performed either by the AHP, its administrator (if it is self-funded), or its insurance company (if it's fully insured). Once again, it is difficult to construct a scenario where these administrative services can be provided at lower costs for AHPs, which will have fewer members, than by large HMOs and/or insurance companies, which already enjoy economies of scale. Health Insurance Purchasing Cooperatives (HIPCs) have not realized any material administrative savings. It is highly unlikely that AHPs will result in higher provider discounts and lower administrative costs for small groups.

CONCLUSION

As high health care costs persist, many employers in the small-group health insurance market remain unable to provide health coverage for their employees. Any proposal to expand access to affordable coverage, particularly in the small-group market, is commendable. However, AHPs could result in unintended consequences that could adversely affect consumers and providers in the health insurance market place.

First, sound regulation of AHPs, including consumer protections and adequate solvency, may require a more stringent regulatory environment and stricter solvency standards than have been seen in AHP proposals to date.

Second, AHPs may be able to temporarily offer insurance at lower rates than currently available for small groups through the elimination of certain mandated benefits and/or the use of rate structures and practices not permitted in many states. However, the benefit limitations and rate structures in those AHPs could well be in conflict with the public policy goals as set out in the states' legislative and regulatory promulgations, and may also lead to long-term increases in the uninsured population.

Finally, AHPs are not expected to generate the higher provider discounts and lower administrative costs necessary to produce lower premium rates on a sustainable basis than premium rates currently available to small groups.

1. AHP legislation passed the House in 2003 during the 108th Congress, and similar legislation was considered, but did not pass, in the Senate.
2. The Academy's Association Health Plan Work Group addresses these unintended negative consequences and related concerns in more detail in their April 28, 2003 comment letter, which is available on the Academy website (http://www.actuary.org/pdf/health/ahp_042803.pdf).

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