Georgetown University Health Policy Institute
CENTER ON HEALTH INSURANCE REFORMS

DECEMBER 2017

State Options to Protect Consumers and Stabilize the Market: Responding to President Trump's Executive Order on Association Health Plans

Supported by the Robert Wood Johnson Foundation

In Brief:

- States have a critical role regulating association health plans (AHPs).
- This brief highlights two key areas for state action:
  - » Require insurance sold through AHPs to comply with key insurance market standards and practices;
  - » Require AHPs to meet the same financial solvency standards as commercial insurers.

Contact Sabrina Corlette at sabrina.corlette@georgetown.edu or (202) 687-3003 for additional information.

OVERVIEW

On October 12, 2017, President Trump issued an Executive Order calling for administrative action to expand access to certain health insurance products – short-term limited-duration plans, association health plans, and health reimbursement arrangements. While there is uncertainty about how it will be implemented, the Executive Order has raised concerns about its impact on the Affordable Care Act's (ACA) consumer protections and on insurance markets.

As the primary regulators of private insurance, states play a key role. This brief identifies a range of policy options that state policymakers can consider regarding the regulation of association health plans (AHPs).[1] These policy options include 1) requiring coverage purchased through associations to comply with the rules and standards of the market in which the coverage is offered and 2) ensuring that AHPs meet the same financial solvency standards as commercial insurers.

WHAT ARE ASSOCIATION HEALTH PLANS?

Prior to the ACA, millions of individuals and small employers bought health insurance through associations.[2] Some business and trade associations offer coverage as part of their broader mission to serve the economic or professional needs of their members; others existed exclusively to sell health insurance. Associations that provide health benefits to two or more employers or self-employed individuals are referred to as multiple employer welfare arrangements (MEWAs) under federal and many state laws. Because they are referred to as association health plans (AHPs) in the President's Executive Order, that is how we refer to them here.

1. We address state policy options regarding regulation of short-term limited duration plans here: https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf441920.
2. *See e.g.* 29 U.S.C. § 1002(40(A).

MEWAs/AHPs may be "self-funded", meaning that the member-employers bear the risk of paying employees' medical claims. In other cases, the AHP is "fully insured," meaning that it purchases insurance from an insurance company. In either case, states have broad authority to regulate financial solvency, marketing and rating practices, and insurance contracts.[3]

However, prior to the ACA, many states exempted AHPs from some of the rules and standards that applied to commercial insurers, such as underwriting restrictions, benefit mandates and solvency standards. In some cases, states defined AHPs as large-group coverage, even though they were marketed to small businesses. Additionally, AHPs would often set up headquarters in one state with limited regulatory oversight and market policies to businesses and consumers in other states with more robust regulation, thereby bypassing those states' more protective rating and benefit standards.

The ACA created a suite of new consumer protections. In its implementation of those protections, the Obama administration required that health insurance policies sold through an association to individuals and small employers must be regulated under the same standards that apply to the individual market or the small-group market, respectively. In other words, the coverage must comply with the ACA's protections for people with preexisting conditions and other benefit standards.

One important but thus far rare exception to this applies when an association is considered a large employer health plan under the Employee Retirement Income Security Act (ERISA). As a result, most of the federal ACA reforms that apply to the small-group market, such as rating rules and benefit standards, would not apply. (Exhibit 1). Associations with individual members cannot meet the definition of a large employer plan because individual members are not considered employers under federal law.[4]

Exhibit 1. Application of ACA Insurance Protections by Market Segment (Fully Insured)

ACA Market Reform	Description	Individual Market	Small-group Market*	Large-group Market*
Guaranteed issue	Insurers must accept every individual or employer that applies for coverage, regardless of their health status or claims experience	Yes	Yes	Yes**
Essential health benefits	Insurers must provide coverage that includes 10 categories of defined benefits***	Yes	Yes	No
Rating rules	Insurers cannot vary rates based on health status or gender	Yes	Yes	No

**Applies to fully insured products. The small-group market is defined in all states to be groups of up to 50 employees; the large-group market is composed of groups with 51 or more employees.*

***The ACA requires insurers that market in the large-group market to accept all employers that apply for coverage. However, this protection would not necessarily extend to individuals or small employers applying coverage through an AHP, nor does it protect employers from increased rates due to health status or other risk factors.*

****The 10 categories of benefits outlined in the ACA are: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive services and chronic disease management, and pediatric services, including vision and oral care.*

3. While state laws that relate to employee benefit plans are generally preempted under the federal Employee Retirement Income Security Act (ERISA), MEWAs are explicitly exempted from that preemption. This means that states may apply and enforce state insurance laws with respect to these arrangements. 29 U.S.C. §1144(b)(6)(A).

4. Federal law prevents associations that market coverage to self-employed individuals from being considered an ERISA-covered plan. ERISA requires that such plans be maintained by an employer or employee organization. Self-employed individuals without common law employees are not "employers" under federal law. 29 U.S.C. § 1002(1), (5). *See also* U.S. Department of Labor, *Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation (2013).* Available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf.

HOW PRESIDENT TRUMP'S EXECUTIVE ORDER MIGHT BE IMPLEMENTED

President Trump's Executive Order suggests that the federal government will allow more AHPs to be regulated as large employer health plans, even if they market coverage to small businesses and, potentially, to self-employed individuals. Specifically, the Executive Order gives the Secretary of Labor 60 days to develop rules that expand the ability of AHPs to demonstrate a "commonality of interest" among member-employers so that the AHP can be considered a large employer group plan. Once given large-group designation, AHPs become exempt under federal law from the ACA protections and standards that apply to small-group and individual market insurance. (Exhibit 1).

Although states have broad authority to regulate both fully insured and self-funded AHPs (MEWAs), President Trump has signaled that his administration may attempt to preempt most state laws as they apply to certain self-funded AHPs.[5] (Exhibit 2). If so, the federal government would be the primary regulator of insurance marketed through AHPs. States would not be permitted to require AHPs to meet state rating, insurance contract, or marketing standards, and consumers who run into problems with their AHP would need to appeal to a federal agency, not their state department of insurance, for help. However, the Department of Labor has to date interpreted ERISA to say that federal preemption would not extend to states' ability to set certain financial solvency requirements.

Exhibit 2. What is State Authority to Regulate Insurance Offered through AHPs (MEWAs) Under Federal Law?

Type of AHP (MEWA)	Rating Rules	Insurance Contract (including benefit standards)	Marketing Standards	Solvency
Fully insured	Yes	Yes	Yes	Yes
Self-funded	Yes	Yes	Yes	Yes
Self-funded, federally exempted	No	No	No	Yes

Proponents of AHPs argue that exempting them from federal and state rules that apply to individual and small-group market health insurance will allow employers to find more affordable coverage options. This could be especially true for small employers with young and relatively healthy workforces as well as for self-employed, healthy individuals who do not qualify for marketplace subsidies in the face of rising premiums for ACA-compliant plans.

Critics, however, note that AHPs will be able to charge higher premiums to employers with less-than-perfect claims experience.

> AHPs could "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."
>
> – *American Academy of Actuaries (Feb. 2017)*

5. *See* 29 U.S.C. § 1144(b)(6)(B).

Because they would not fall under the ACA's small-group or individual market rules, they may also exclude important benefits, such as prescription drugs or mental health and substance use treatment. AHPs are also likely to siphon healthy risk away from ACA-compliant plans, leaving a smaller and sicker risk pool for the traditional insurance market and fewer plan options and higher prices for the small businesses and individuals that remain.

In addition, AHPs have a long history of insolvencies and even fraud, leaving policyholders and providers with millions of dollars in unpaid claims. Federal preemption of state regulation of AHPs could exacerbate this problem.

STATE POLICY OPTIONS TO ADDRESS CONCERNS ABOUT ASSOCIATION HEALTH PLANS

In the absence of federal preemption, states have broad authority to regulate fully insured and self-funded AHPs. (Exhibit 2). Given the changes anticipated under President Trump's Executive Order, we have identified a number of state policy options regarding the regulation of AHPs. While we cannot predict how federal AHP regulations will be changed, we consider state options under two possible scenarios: (1) federal rules do not exempt self-funded AHPs from state regulation and (2) federal rules do preempt states' authority over self-funded AHPs, but not their ability to set minimum financial solvency requirements.

State approaches will vary based on the state's legal authority and regulatory capacity; some states may need new legislation to fully regulate AHPs while others can leverage existing law to do so. The policy options below are not mutually exclusive and could be adopted as part of comprehensive market stabilization policy. Additionally, this brief does not discuss possible litigation options for states.

If state regulation is not preempted, state legislatures and insurance regulators could:

- Adopt rules that set a level playing field for AHPs and traditional insurers. Under the Obama administration, federal regulators required AHPs marketing to small businesses to comply with small-group market rules; those marketing to individuals were required to comply with individual market rules. This included ACA requirements as well as state mandates. Prior to the ACA, states like New Mexico prohibited AHPs from using health status to determine an individual's membership or premium; New Jersey subjected AHPs selling to individuals to the state's individual market rules. A state's adoption of similar rules would likely reduce the incentives for the formation of AHPs and reduce the risk of adverse selection against the ACA-compliant small-group and individual markets.
- Limit AHP membership to businesses with at least one employee. Under current federal rules, employers who want to purchase small-group coverage must have at least one employee who is not a spouse. It's possible, however, that proposed federal rules will encourage AHPs to market insurance to self-employed individuals. A state could counteract this change by limiting enrollment into AHPs to employers with at least one employee. Doing so would take away a new coverage option for healthy unsubsidized individuals facing high premiums in the ACA-compliant market. But it would also prevent AHPs from destabilizing the ACA-compliant individual market by siphoning away healthy individuals.
- Assess AHPs and reinvest funds in a reinsurance program for the ACA-compliant market. States could require AHPs to price plans in a way that more closely resembles their true costs through a "free rider" assessment. The assessment could apply to self-funded and fully insured AHPs and be calculated to reflect the benefit they gain from siphoning healthy employee groups and individuals away from the ACA-compliant market. This change would help limit free-riding and require AHPs to contribute towards the health of the traditional market.

- Require out-of-state AHPs to comply with relevant state insurance standards. If not already doing so, states could require out-of-state AHPs selling policies to their residents to be state licensed and comply with state insurance standards, including rate and plan review, benefit mandates, and rating rules. Doing so would help prevent "forum shopping," in which AHPs headquarter in states with less regulatory oversight to bypass consumer protections in other states.

If state regulation of AHPs is preempted, state legislatures and insurance regulators likely would have authority to:

- Require AHPs to meet the same solvency and governance standards as commercial carriers. States could require self-funded AHPs to have the same specified levels of reserves and submit to the same financial reporting and examination processes as commercial insurers. Although many states have solvency standards for self-funded AHPs, in many cases they are less stringent than for commercial carriers. Increasing those standards so that they are on par with commercial carriers would help protect employers, consumers, and health care providers from AHP insolvencies and help ensure that AHPs and traditional insurers operate on a more level playing field.
- Require AHPs to contribute to state guaranty funds. State guaranty funds exist to protect policyholders in the event an insurance company defaults on paying claims or goes insolvent. However, many states currently exempt AHPs from paying into these funds, in spite of a long history of AHP insolvencies. Requiring AHPs to contribute to a state guaranty fund would help protect employers, consumers, and providers from potentially significant financial losses.
- Clarify or enact state law allowing state insurance departments to place AHPs into receivership if needed. State receivership laws allow the state to take over financially failing insurance companies. But many states exclude AHPs from these laws or are vague about the state's authority to step in when an AHP goes insolvent. Clarifying or amending these state laws can protect policyholders and help ensure a more orderly resolution of a failed AHP's outstanding debts.

Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

About Georgetown University - Center on Health Insurance Reforms

The Center on Health Insurance Reforms at Georgetown University's Health Policy Institute is a nonpartisan, expert team of faculty and staff dedicated to conducting research on the complex and developing relationship between state and federal oversight of the health insurance marketplace. For more information, visit www.chir.georgetown.edu/.

About the Robert Wood Johnson Foundation

For more than 40 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working with others to build a national Culture of Health enabling everyone in America to live longer, healthier lives. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook. The views expressed here do not necessarily reflect the views of the Foundation.