A REPORT OF THE VIRGINIA LIAISON OFFFICE

2010 Annual Report

Federal Legislation Pertaining to Association Health Plans

To the Governor and General Assembly of Virginia

9/30/2010

COMMONWEALTH OF VIRGINIA
Virginia Liaison Office

Jeannemarie Davis
Director

MEMORANDUM

TO: The Honorable Robert McDonnell
Governor of Virginia

The Honorable Lacey Putney, Chairman
House Appropriations Committee

The Honorable Charles Colgan, Chairman
Senate Finance Committee

FROM: Jeannemarie Davis

SUBJECT: Virginia Liaison Office's Annual Report on Federal Legislation Pertaining to Association Health Plans

I am pleased to submit the Virginia Liaison Office's Annual Report on Federal Legislation Pertaining to Association Health Plans as mandated by section § 2.2-302.1 of the Virginia Code.

If you have questions or need additional information concerning this report, please contact me.

Jeannemarie Davis

JD/kzc

Preface

The Virginia Liaison Office has been tasked with writing the following report:

"[An] annual report that summarizes the status of the development, support, and federal legislation that provides for the establishment and governance of group health plans sponsored by trade, industry, professional, chamber of commerce, or similar business associations, which are referred to as association health plans [AHP], provided that such plans remain subject to the laws of the Commonwealth and activities by the Office."[1]

[1] VA S.B. 487.

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Executive Summary

Under Virginia Code § 2.2-302.1 it is the Commonwealth of Virginia's official public policy to encourage pooling of health insurance efforts by small businesses, and to support federal legislative efforts that facilitate this pooling, provided that these Association Health Plans (AHPs) remain subject to state law.

AHPs consist of groups of small firms and businesses that have banded together as trade associations to offer health insurance plans for their members and employees. The associations can be based on professional or trade associations (generally with membership limited to a specific trade or business), or can simply be a broad association for small employers who share common personal interests.

AHPs are regulated primarily by the states, although some plans must also comply with federal requirements. Recently, however, there have been efforts in Congress to transition regulatory authority from the state to the federal government. In the 111th Congress, several bills regarding AHPs were introduced to change the current regulatory structure, but little to no action was taken on these bills. During the last year, Congress focused its efforts on changes to reform the existing health care system, but discussion about AHPs was limited.

VIRGINIA LIAISON OFFICE

2010 Annual Report on Federal Legislation Pertaining to Association Health Plans

It is the Commonwealth of Virginia's official public policy to encourage pooling of health insurance efforts by small businesses, and to support federal legislative efforts that facilitate this pooling. Virginia's policy is codified at Virginia Code § 2.2-302.1, which reads:

Support for enactment of pooled purchasing of health insurance efforts. It is the public policy of the Commonwealth to support federal efforts to encourage pooling of health insurance by small businesses, provided any such health insurance plans remain subject to state law. [2]

The Virginia Liaison office has been tasked with writing the following report:

"[An] annual report that summarizes the status of the development, support, and federal legislation that provides for the establishment and governance of group health plans sponsored by trade, industry, professional, chamber of commerce, or similar business associations, which are referred to as association health plans [AHP], provided that such plans remain subject to the laws of the Commonwealth and activities by the Office."[3]

In accordance with the above directives, the following report details Association Health Plans (AHPs) and current federal legislative attempts to bring regulation under the authority of the federal government.

Association Health Plans

AHPs consist of groups of small firms and businesses that have banded together as trade associations to offer health insurance plans for their members and employees. The associations can be based on professional or trade associations (generally with membership limited to a specific trade or business), or can simply be a broad association for small employers who share common personal interests.

Small employers are less likely than larger employers to provide health insurance to their employees for a number of reasons including the high cost of plans, limited options, administrative burdens of providing benefits, and the high turnover of employees. Proponents of AHPs argue that pooling the insurance risk of small businesses together increases the bargaining power to negotiate contracts with insurers and share administrative functions, resulting in lower premium costs and additional health insurance options for the small employer. As a result, more businesses could offer their employees access to health insurance.

Opponents of AHPs argue that AHPs increase the risk segment for insurance by only covering healthy groups and leading to instability and higher premiums for small employers who offer coverage outside of AHPs.

[2] Va. Code Ann. § 2.2-302.1 (2006)

[3] VA S.B. 487.

State vs. Federal Regulation of Association Health Plans

Under current law, association health plans are regulated by states but requirements vary widely among and even within states. The authority for state regulation is clarified in the Multiple Employer Welfare Arrangement (MEWA), a provision of the Employee Retirement and Income Security Act (ERISA). ERISA defines MEWAs as arrangements through which two or more employers and self-employed individuals obtain health insurance coverage. AHPs are considered MEWAs and thus are subject to state regulation (this is true even when those associations are self-funded.)

One of the recurring debates in Congress related to AHPs has been regarding regulation of the plans. Over the years, proponents of AHPs have called for creating federal standards to make uniform regulations to which AHPs are subjected. It is their belief that preemption under ERISA would avoid costly benefits mandated by state law. Proponents also call for the ability of AHPs to self-insure, which avoids additional costs due to state regulation (such as premium taxes). By eliminating state regulation, AHPs could cross state lines without costly duplicative regulatory requirements or the burden of meeting many states' varying regulations. In short, proponents believe a federal regulatory system would reduce administrative burdens and increase variation in benefit packages being offered by AHPs, resulting in more employees with access to health benefit packages.

Opponents of transferring regulatory authority of AHPs to the federal level have argued that such action will lead to lack of oversight, increased fraud and the potential for rate increases. Should this occur, it is their belief that fewer employees will have access to health care insurance coverage. Through the discussion of the role of AHPs, states have been concerned that the loss of state regulation and consumer protections within could jeopardize state efforts to address issues related to health insurance access and the uninsured.

In the 111th Congress, several bills were introduced to transfer the regulation of association health plans to the federal government. In some of the bills, associated health plans are the primary subject for the bill, but for most bills listed in this report it is just one component of broader legislation dealing with health care access issues. All of the bills listed call for federal rules governing AHPs, including certification; sponsors and boards of trustees; participation and coverage; nondiscrimination; contribution rates; notice of voluntary termination; correction actions; and mandatory termination. These bills all require AHPs to have an indemnified back-up plan in order to prevent unpaid claims in the event of plan termination; to undergo independent actuarial certification for financial soundness on a quarterly basis; and to maintain surplus reserves of $2 million in addition to normal claims reserve. In addition, all of the bills allow states to impose a contribution tax on associated health plans that commence operations after the enactment of the bill. (H.R. 2607, H.R. 3400, H.R. 3713, H.R. 3889, H.R. 4038, H.R. 4529).
In addition, H.R. 4038, the Common Sense Health Care Reform and Affordability Act, would also permit an insurer licensed in one state to sell insurance across state lines.

Despite the introduction of these bills, provisions related to AHPs were not included in the health care reform legislation passed by the 111th Congress and signed into law by the President (Patient Protection and Affordable Care Act -PPACA). Soon after becoming law, new legislation was introduced in Congress to repeal PPACA. This repealing legislation also includes provisions calling for federal governance of association health plans similar to bills described earlier in this report (H.R. 4910, H.R. 4944, and H.R.5421).

Health Care Reform – Where does it leave Association Health Plans?

The Patient Protection and Affordable Care Act (PPACA) was passed by Congress and signed into law on March 23, 2010. Along with the Health Care and Education Reconciliation Act of 2010 (signed on March 30, 2010), these two acts comprise the health care reform efforts of the 111th Congress and President Obama. While neither of these bills identify or address the role of AHPs, there are questions as to whether associated health plans could exist within the new health care framework of PPACA and whether the need for AHPs still exists.

Access to health care

Legislation supporting AHPs proposed to develop greater access to health care insurance for employers through the private market. Through increased membership through pooling, AHPs could better negotiate with a number of insurance plans – thereby increasing access and reducing costs to health insurance plans and sharing that with its members.

Healthcare reform legislation passed by Congress (hereafter referred to simply as ACA or Affordable Care Act), on the other hand, requires individuals to obtain and maintain health insurance coverage through several means. The law requires states to expand Medicaid coverage to newly eligible individuals by 2014, calls for the creation of a high risk pool in each state for high risk individuals, and requires individuals to obtain insurance coverage and employers to provide health insurance to employees or face fines. The bill does include changes to the small group and individual insurance market in order to make coverage more accessible such as requirements for guaranteed issue and renewability; a prohibition on pre-existing conditions; and rating bands that at the minimum include age, family structure, geography, actuarial value of the benefit and tobacco use.

Under ACA states are called on to establish health insurance exchanges by 2014. Exchanges will not be insurers, but will provide qualified individuals and small businesses with access to insurers' qualified health plans in a comparable way. Initially, exchanges will be open only to individuals who work at companies with no more than 100 employees or that do not provide insurance, the self-employed and unemployed, non-Medicare-covered retirees, and small businesses. The Congressional Budget Office has estimated that that approximately 24 million people would purchase their own coverage through the new exchanges. CBO also predicts that

the number of people purchasing individual coverage outside the exchanges will decline and the number of people obtaining coverage through their employer will decline.[4]

However, plans entering the exchange must meet certain requirements, and there is no guarantee as to the number of plans in the exchange, the variations in the plans, or the cost of the plans. At this point, it is simply unclear whether individuals would have a greater variety of affordable plans under an AHP scenario or the exchange to be developed under requirements of ACA. While an AHP could be part of an exchange, it would have to voluntarily meet the federal and state standards within the exchange and some feel that participation of an AHP in an exchange is unlikely.

Future Outlook for Association Health Plans

The outlook for AHPs is unclear at this juncture. Participation of AHPs within the ACA structure is uncertain and the U.S. Department of Health and Human Services continues to provide guidance to states and other stakeholders on expectations and required changes to the individual market, as well as state run Medicaid programs. In addition, state lawsuits against ACA continue to proceed and the resulting impact of such decisions could change how Congress, HHS, and states address health care reform.

The Virginia Liaison Office remains available to discuss existing federal efforts on the health care front, including AHPs.

[4] March 20, 2010 CBO letter to House Speaker Nancy Pelosi.