

Association Health Plans: Issues/Problems

GOAL OF STATE INSURANCE RULES/ PROBLEMS WITH AHPS	SPECIFIC STATE REQUIREMENTS	IS STATE RULE PRE- EMPTED?*	IS THERE NEW FEDERAL RULE?
<p>A. Assure health plans cover certain benefits</p> <p><i>AHP Problems: Adverse Selection</i></p> <ul style="list-style-type: none"> Those who need benefits enroll in state pools AHPs could offer minimal product (e.g., 5 hospital days/physician visits), attracting “healthier” people People could jump back & forth from AHP to state pool, driving up costs of state pool (HIPAA) 	<ul style="list-style-type: none"> Prompt pay requirements Annual and lifetime limits Minimum inpatient hospitalization coverage Mandated benefit requirements Mandated benefit offerings Mandated provider requirements Mandated provider offerings Coordination of benefits rules 	<p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p>	<p>no</p> <p>no</p> <p>no</p> <p>no</p> <p>no</p> <p>no</p> <p>no</p> <p>no</p>
<p>B. Assure reasonable health insurance premium rates</p> <p><i>AHP Problems: Adverse Selection</i></p> <ul style="list-style-type: none"> Premiums in the state regulated market would increase significantly since AHPs could avoid pooling with higher risk groups (CBO: “premiums increase for 4 out of 5 groups”) AHPs would create smaller pools, thereby increasing segmentation in the small group market AHPs would be able to underwrite and exclude individuals in associations; this is especially problematic in guarantee issue states 	<p>Small group market:</p> <ul style="list-style-type: none"> All small business premiums are cross-subsidized (pooled) by carrier Rating limitations based on health, age, or other characteristics of group (excluding claims) Self-employed individuals are rated together with small employers (14 states) Reinsurance programs to help manage the risk of GI requirements (31 states) <p>Individual market:</p> <ul style="list-style-type: none"> Guarantee issue (8 states) Rating rules -- based on relative risk No re-underwriting Assure conversion policy for group to individual <p>Both markets:</p> <ul style="list-style-type: none"> Limits on premium renewal rates Prior review and approval of premiums Public hearing for rate approvals Minimum loss ratio requirements 	<p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p>	<p>no</p> <p>no</p> <p>no</p> <p>no</p> <p>no</p> <p>no</p> <p>no</p> <p>no</p> <p>no</p>

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<p>C. Assure marketing protections</p> <p><i>AHP Problems:</i></p> <ul style="list-style-type: none"> • With no marketing rules or oversight, AHPs would be: <ul style="list-style-type: none"> ➢ Able to use deceptive techniques and misleading information and materials to sell policies consumers do not understand ➢ Permitted to use a variety of marketing techniques to selectively target “healthier” groups and individuals. • Coupled with preemption of mandated benefits and the ability to avoid state rating rules, AHPs will attract much healthier risks, leaving sicker groups and individuals with escalating premiums in the state insured marketplace. 	<ul style="list-style-type: none"> • Mandatory review and/or prior approval of marketing and advertising materials • No false advertising • Requirement to use <u>licensed</u> agents to sell products • Regulation of commissions (e.g. ban lower commissions for high risks) • No “redlining” (i.e., avoiding high cost areas) • Standardized description of covered benefits • Standardized notices of premium increases • Consumer window to cancel contract • Records of marketing and performance • No termination (subject to 5-year ban on market re-entry) 	<p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p>	<p>no</p> <p>no</p> <p>partial (only with insured AHP)</p> <p>no</p> <p>no</p> <p>partial (SPD)</p> <p>no</p> <p>no</p> <p>no</p> <p>no</p>
<p>D. Assure appropriate consumer disclosure</p> <p><i>AHP Problems:</i> Fraud</p> <ul style="list-style-type: none"> • Limited disclosure rules would facilitate the ability of AHPs to mislead consumers by marketing coverage as “comprehensive” even though it lacks critical benefits. 	<ul style="list-style-type: none"> • Disclosure of consumer info (e.g. appeal rights) • Basic info on covered services • Lists of contracting doctors/hospitals • Disclosure of rating practices 	<p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p>	<p>partial (SPD)</p> <p>yes (SPD)</p> <p>yes (SPD)</p> <p>no</p>

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<p>G. Assure appropriate oversight of plans</p> <p><i>AHP Problems:</i></p> <ul style="list-style-type: none"> • Consumers required to call DOL • DOL not staffed (90 years to do baseline review of pension plans) • \$5,000/AHP initial filing fee inadequate • DOL consults with single state per AHP 	<p>Insurance Department:</p> <ul style="list-style-type: none"> • Handles complaints from consumers & providers • Oversees and enforces all rules • Investigates • Resolves issues • Takes appropriate action, including penalties 	<p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p>	<p>no \$</p> <p>no \$</p> <p>no \$</p> <p>no \$</p> <p>no \$</p>
<p>H. Prevent plan insolvency</p> <p><i>AHP Problems:</i></p> <ul style="list-style-type: none"> • \$2 million cap on surplus inadequate for larger plans and not adjusted for medical inflation • No requirement that surplus held in liquid assets • Stop-loss coverage can be substituted for capital • Letters of credit can be substituted for capital • Oversight dependent on AHP self-reporting • Financial reporting only after AHP is on verge of insolvency (AHPs has 180 days after identifying problem to notify DOL) • DOL may place AHP in trusteeship 	<ul style="list-style-type: none"> • Strong (risk-based) capital rules that grow with insurer size • Detailed annual financial reporting requirements; quarterly filings • Triennial on-site exams • State oversees corrective action once entity nears minimum standards • Independent actuarial certification of reserves 	<p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p>	<p>\$2M cap</p> <p>partial</p> <p>no</p> <p>no</p> <p>yes</p>

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<p>I. Oversee financially distressed plans</p> <p><i>AHP Problems:</i></p> <ul style="list-style-type: none"> Assets of sponsoring association/participating employers are not at risk (unlike large employers) Federal AHP “guarantee fund” inadequately financed (\$5,000/AHP); misleading promise to consumers Federal AHP “guarantee fund” used to pay for stop-loss insurance only; no funding available for unpaid claims Federal government likely to become liable for unpaid claims DOL must apply in US Court to place AHP in trusteeship AHP files for bankruptcy, members/providers have same status as other creditors in court proceedings 	<ul style="list-style-type: none"> State typically takes control of insolvent plan State can act quickly to seize assets to pay claims for members and providers before entity leaves state/country States have guaranty funds to pay claims for members Continuation of coverage is provided through arrangements with other insurers 	<p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p>	<p>no</p> <p>no</p> <p>no \$; inadequate protection</p> <p>no</p>
<p>J. Promote access to care for the uninsured</p> <p><i>AHP Problems:</i> Increase Insurance Premiums</p> <ul style="list-style-type: none"> Lack of participation by AHPs in these subsidy programs would make it impossible for states to help the uninsured. 	<p>Rules to ensure participation in initiatives to provide broader access to insurance or health care:</p> <ul style="list-style-type: none"> Subsidies for high risk individuals through administration of state pools Subsidies for uncompensated care Risk adjustment programs “All-markets” rules; encourage individual market offerings Other access initiatives (example: “pay or play” in individual market – New Jersey) 	<p>partial</p> <p>yes</p> <p>yes</p> <p>yes</p> <p>yes</p>	<p>partial (new self-funded AHPs)</p> <p>no</p> <p>no</p> <p>no</p> <p>no</p>

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