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The Honorable Harris W. Fawell
Chairman, Subcommittee on
Employer-Employee Relations
Committee on Economic and
Educational Opportunities
House of Representatives

Dear Mr. Chairman:

Your Subcommittee is considering legislation that would provide for consistent regulatory treatment of all small employer health plans within a uniform national framework, including association health plans. Association health plans are plans purchased by trade or business associations (for example, a local chamber of commerce or automobile dealers' association) for their multiple small employer or individual members. To assist your Subcommittee in its deliberations, you asked us to provide information on

- their market penetration,
- how they are regulated, and
- any regulatory concerns or other issues that have surfaced.

To answer these questions, we relied primarily on previous work we conducted for your Subcommittee.[1] We supplemented this information through follow-up discussions with insurance regulators from seven states, selected judgmentally based on prior knowledge of their regulatory treatment of association plans. The states are Illinois, Louisiana, Minnesota, Montana, New York, Ohio, and Vermont. Our work was conducted from July through November 1995 in accordance with generally accepted government auditing standards.

[1]Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms (GAO/HEHS-95-161FS, June 12, 1995).

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In summary, we found that clearly identifying the types of association health plans that exist is difficult because no common definition is used by the industry or regulators. State statutory definitions for association health plans, to the extent they exist, differ from one another and often use broad language that leaves much open to interpretation. Nonetheless, limited data suggest that association health plans and similar pooled purchasing arrangements may account for about 17 percent of the small employer insurance market nationally. In the states we contacted, regulators estimated that from about 5 percent to over 50 percent of the small employer insurance market is comprised of such plans, depending on the definition used for an association health plan.

While not explicitly subjecting association health plans to state regulation, small employer reform statutes in 27 states contain broad language that may be interpreted as applying some state regulations to them. However, conflicting interpretations about how a particular association plan should be categorized can lead to regulatory confusion within a state. Among the complex issues that states must assess in determining how the plans are to be regulated are

- whether associations provide coverage to individuals as well as small firms,
- whether the plans are fully insured or self-funded, and
- whether states consider self-funded plans to be multiple employer welfare arrangements (MEWA)[2] that are subject to state regulations or Employee Retirement Income Security Act (ERISA)[3] plans that are largely exempt from state regulation.

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[2]An MEWA is defined by federal law as an employee welfare benefit plan or similar arrangement, including a health plan, established or maintained for the purpose of offering or providing benefits (other than pensions) to employees of two or more employers.

[3]ERISA is a federal statute enacted to protect the rights of employer pension plan beneficiaries. The statute applies to all employee benefit plans, including health plans, and explicitly preempts state laws that relate to them. States retain authority to regulate only traditional insurance carriers. For more information on ERISA, see Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA (GAO/HEHS-95-167, July 25, 1995).

Finally, some state regulators are also concerned about the applicability of state laws to association plans domiciled in one state but operating in several others. More specifically, some state regulators indicated to us that some associations may have used this definitional and regulatory ambiguity to avoid state regulation.

DEFINITIONS FOR ASSOCIATION HEALTH PLANS VARY

No common definition for an association health plan is used within the industry or among state regulators. Consequently, a variety of funding arrangements offered by an assortment of organizations may be considered to be association health plans. Association health plans are often offered by a trade or business association. However, these plans as well as health plans provided by other entities, such as fraternal benefit societies, multiple employer trusts, MEWAs, and purchasing alliances or coalitions, are sometimes characterized as association health plans. The plans may be fully insured, or self-funded. The membership of the association may consist of individuals, small employers, or larger employers.

States often have no explicit statutory definition for an association health plan. Among those that do, the definitions vary and are often nonspecific regarding the types of health plans that are included. For example, in Maine, an "eligible subgroup" is subject to the state's small employer statute. An eligible subgroup is defined as an employer with fewer than 25 employees that is part of an association, multiple employer trust, or a similar larger group covered by a single group health contract. Minnesota and Vermont explicitly define associations within their small employer statutes. In Minnesota, an association must have at least 100 members and derive no more than 20 percent of its income from the health plan. In Vermont, the statute requires an association to have at least 25 members, but includes no restrictions on funding and specifically includes MEWAs within the definition.

MARKET PENETRATION VARIES AND COULD BE INCREASING

One nationwide survey conducted in 1993 estimates that 17 percent of small employers that offer insurance do so

through "a local business association, trade group, employer coalition, or some other group of small purchasers."[4] Fifty-nine percent of the small employers offering insurance had considered purchasing insurance through associations. Some insurance regulators suggest that the association health plan share of the small employer group market is growing.

Officials from five of the seven states we contacted provided rough estimates of association health plan market share, which varied. In Minnesota, state regulators estimated that only 5 percent of the health plans in the small employer group market are issued by or through associations. In Montana, a regulator suggested that association health plans comprise about 15 percent of the small employer group market. Officials in Louisiana, Ohio, and Vermont estimated penetration at about 50 percent or more of the small employer market.

The varying market penetration estimates may be due in part to the different definitions of an association health plan used by regulators. Montana regulators did not include self-funded association health plans (which the state considers to be MEWAs), fraternal benefit society plans, or coalitions in their estimate, while officials in Louisiana and Ohio included all of the above-mentioned types of plans in their estimates.

The variation in market share may also be due in part to the different regulatory treatment of association health plans among states. Association health plans in Vermont and Montana are exempt from the rating requirements of their respective small employer group reform statutes. Associations may, therefore, base their health plan rates on the experience of their members only, rather than the small employer group pool at large. Consequently, associations with younger, healthier members can offer very competitively priced products and gain further market share. In contrast, regulatory treatment of association plans in Minnesota and Louisiana is less favorable. Minnesota requires associations to meet strict statutory requirements before they can provide health insurance, and exemptions from the state's small group reforms are limited. An official in Louisiana said that because the

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[4]Michael A. Morrisey, Gail A. Jensen, and Robert J. Morlock, "Small Employers and the Health Insurance Market," Health Affairs, Winter (1995), p. 156.

state's small group reforms now explicitly include association health plans, the historic pricing advantage they have enjoyed over other small group plans should diminish.

TREATMENT OF PLANS IN SMALL EMPLOYER REFORM STATUTES IS UNCLEAR

The regulatory treatment of association health plans in small employer group statutes also varies among states. While not explicitly including association health plans by name, the small employer group reform statutes of 27 states contain broad language that could be interpreted as doing so. The language of the various acts generally states that any health plan offered to small employers by any entity is subject to the act. However, we found that some regulators were uncertain as to how their statute applies in certain circumstances, if at all.

Uncertainty can result because associations can have mixed membership--that is, the membership may include individuals as well as both small and large employers. Health insurance for small employers is typically regulated pursuant to a small employer insurance statute. Consequently some regulators continue to question the applicability of these statutes to the association plan when the plan also covers individuals and large employer groups. In Louisiana, regulators require that any health plan issued to a small employer group must comply with the small employer group statute, regardless of the association's composition. However, they acknowledge the difficulty of regulating portions of one insurance contract pursuant to two or more different statutes. A New Mexico regulator said that his office has historically subjected all association health plans to the state's large employer group statute because, although the plans cover small employers, their collective numbers are usually large. His office has recently come to question the applicability of the small employer group statute to association plans and has requested a meeting with the National Association of Insurance Commissioners (NAIC)[5] to help clarify the matter.

Small employer group reform statutes in at least 15 states explicitly include association health plans, and 10 of

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[5]NAIC is a voluntary association comprised of the heads of the insurance departments of each state, the District of Columbia, and four U.S. territories.

these statutes provide special exemptions to association plans, sometimes as a result of the lobbying efforts of association groups, according to regulators. For example, in California, the small employer group reform legislation permits associations to offer nonstandard products to members and permits individuals and employer groups of greater than 50 to participate in the small employer group market through association health plans. In Montana, New York, and Vermont, small employer group reform statutes exempt association health plans from rating or other requirements if the association guarantees to issue health plans to all members who apply. However, New York granted this exemption to only a limited number of associations and placed strict limits on the growth of their health plans so that the plans would not become a regulatory "escape hatch." In doing so, regulators addressed concerns that certain associations with healthy members would underprice products available to the community at large, thus drawing from the community pool many healthy, lower risk individuals.

The regulation of self-funded association health plans is even more ambiguous. Based on limited information, states apparently treat them either as MEWAs subject to state regulation; or as an ERISA plan that is exempt from most state regulation. For example, Ohio, Minnesota, and Montana treat self-funded association health plans like an MEWA and subject them to separate MEWA statutes. Illinois and Louisiana consider self-funded association health plans to be ERISA plans that are exempt from most state regulations.

REGULATORY UNCERTAINTY RAISES OTHER CONCERNS

Among states, confusion sometimes exists as to whether an association must comply with the regulations of each state in which it operates or only to the laws of the state where it is domiciled. For example, a Louisiana regulator said that an Illinois-domiciled association, which markets a health plan to Louisiana residents, claims that it does not have to comply with Louisiana's small employer group reform laws because it is not domiciled there. On the other hand, the regulator's interpretation is that any insurance product marketed or sold to a Louisiana resident is subject to the state's regulation. In contrast, a regulator in Illinois said that associations domiciled in other states do not have to comply with Illinois' small employer group reform law.

Association health plans that obscure the identity of the true purchaser of the product or use other methods to circumvent regulation are also a challenge to various state regulators. For example, an association of independent farmers in Minnesota claims that its members purchase insurance as individuals and, consequently, the association's health plan should be regulated under the individual statute rather than the (more restrictive) small employer group law. The state disagrees, contending that because each farm is a small business, coverage should be regulated under the small employer group statute. In Montana, an indemnity insurance carrier is trying to avoid compliance with the small employer group statutes by creating a trust, which the insurer claims is an MEWA, and through which it markets small employer group insurance products. Currently, Montana has an administrative action pending, asserting that a trust is a small employer carrier and therefore its products should be subject to small employer group regulation.

Officials in New York and Vermont said that association health plans can be used by small businesses as a vehicle to avoid reform requirements. A Vermont insurance regulator suggested that associations, exempt from small employer group rating requirements, might attempt to offer coverage only to healthier, lower risk groups, thereby creating the same risk selection problems that initiated small employer group reform efforts in the first place.

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This information was developed under the guidance of Michael Gutowski, Assistant Director. Other major contributors include Randy DiRosa and Susan Thillman. Please call me or Mr. Gutowski at (202) 512-7119 if you or your staff have any questions concerning this letter.

Sincerely yours,

Mark V. Nadel

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