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Association Health Plans Put Patients, Workers, and Insurance Markets At Risk

Senate Bill 86 could lead to race to the bottom on consumer protections

NC JUSTICE CENTER FACT SHEET

Under Senate Bill 86, Association Health Plans (AHPs) can avoid rules governing small group and individual market coverage, enabling them to siphon off lower-risk enrollees from the regular small group and individual markets. But any reduction in premiums that SB 86 may offer to some small businesses and individuals come only at the expense of others who would have to pay higher costs.

Association Health Plans' promise of lower premiums rests on skirting consumer protections and cherry picking enrollees via benefit design and premium practices.

AHPs can vary premiums for small businesses in ways that benefit the healthy but put less healthy and older firms at a disadvantage. They can:

- Charge workplaces with older workers higher rates than the 3:1 age rating cap in other markets.
- Vary rates by gender, making coverage unaffordable for workplaces with higher rates of women, especially younger women who may seek maternity and newborn care.
- Practice redlining, by up-charging or avoiding areas of the state with worse health care outcomes, higher health costs, lower incomes, and greater populations of communities of color.
- Avoid covering or charge higher premiums to workers in industries and occupations that might be seen as higher risk of significant medical costs.
- *Set employer premiums based on health status* and pre-existing conditions at a small business (if they form under a pre-existing federal pathway not subject to a prohibition on this practice).

AHPs can offer bare-bones coverage with high out-of-pocket costs.

- AHPs are not required to cover the Essential Health Benefits (EHBs) package, meaning they could refuse to cover maternity and newborn care, mental health and substance use disorder treatment, prescription drugs, and other critical services.
- Without EHB coverage, AHPs' other consumer protections, including the annual out-of-pocket limit and prohibitions on lifetime limits and annual caps on coverage, provide little value.
- AHPs can offer bare bones coverage with sky-high deductibles because they are not required to meet the Minimum Value standard. Even if they did cover EHBs, coverage could be nominal, leaving patients responsible for massive out-of-pocket costs when they seek treatment.

AHPs primarily reduce premiums (for some) by segmenting the market, *not* through economies of scale, administrative efficiencies, or increased negotiating power.

- Experts have found no evidence that AHPs reduce underlying administrative or medical costs, and even if they did, reducing administrative costs offers limited cost savings potential.
- AHPs are highly unlikely to do any better at negotiating lower rates with providers than large insurance companies do (Milliman, American Academy of Actuaries, Mark Hall).
- AHPs will have an incentive to avoid high-risk, high-cost enrollees, as they operate in a separate risk pool and lack the safety net of participating in a risk adjustment program.

Contact: Brendan Riley at Brendan@ncjustice.org or 919-861-2074

Senate Bill 86 would let AHPs benefit from an unlevel playing field and put small businesses and individuals who buy their own coverage at risk.

- S.B. 86 creates a Commonality of Interest standard that is too broad, allowing for self-insured and fully insured AHPs to be formed for small groups that lack a legitimate commonality. This allows these plans to be treated as Large Group market health insurance plans and thereby skirt the important protections in the individual and small group markets. The proposed commonality based merely on geographic location raises particular concerns.

  (Part 1, Section 1(b)(h): *A MEWA will be treated as having a commonality of interest if either of the following is true: (1) It is established by a group of employers under an association in the same trade, industry, line of business, or profession. (2) It is established by employers under an association in the same region or metropolitan area, provided that region or area is contiguous to the State and includes the State*.)
  (Part 2, Section 2(a)(1a-1b))
- S.B. 86 rewrites the definition of "employer" to include "sole proprietors and self-employed workers" who do not have any employees (Part 1, Section 1(c)(f)). This opens the doors to AHPs actively poaching low-risk enrollees from the individual market, especially given their ability to offer lower premiums than the individual market to certain people or design narrow benefit packages. Membership in an AHP should be limited to employers with at least one employee to ensure the integrity of the AHP and stability of the individual market.

If AHPs expand, people with pre-existing conditions and serious health needs will suffer from higher premiums.

- Because AHPs are not subject to the single risk pool requirement, small business workers and people who buy their own coverage on the individual market are likely to face increasing affordability barriers as a result of the changes in SB 86.

  > *[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

- Avalere Health projected that AHPs would increase premiums in the small group and individual markets and increase the number of uninsured people beyond federal government projections.

AHPs raise additional consumer protection concerns.

- Association Health Plans have a long history of fraud, financial instability, and insolvency.
- AHPs domiciled in other states have historically raised concerns and confusion about states' ability to regulate and oversee them.

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