Association health plans after the final rule

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Introduction

On October 12, 2017, the Trump administration issued the "Executive Order Promoting Healthcare Choice and Competition Across the United States," which sought to provide additional health insurance coverage options for small groups and individuals outside of the Patient Protection and Affordable Care Act (ACA) market.[1] One of the options the executive order addressed directly is the association health plan (AHP) for small groups and certain individuals.[2] On January 5, 2018, the proposed rules for AHPs were issued.[3] In this article, we examine the final rule released on June 21, 2018,[4] evaluate considerations for sponsors of AHPs, and briefly assess the final rule's impact on the small-group health and individual ACA markets.

Key outcomes of the final rule

The final rule continued where the preliminary rule left off and did not substantially change the overall purpose of creating an easier path for associations to become bona fide and offer group health plans as single large-group employers.

Without removing the old path to becoming bona fide, the administration established an additional path that is less arduous and should prove more attractive to currently non-bona fide associations wanting to offer their members major medical coverage under group health plans. Specifically, the final rule on AHPs:

- Retains the prior bona fide qualification process and related rules, in particular allowing associations that meet the stricter prior standard to underwrite specific member groups.
- Establishes an alternative pathway for becoming a bona fide association for purposes of offering a group health plan. That path and its requirements, while still subject to "facts and circumstances," is much clearer than before, making it simpler for existing associations to become bona fide or for new bona fide associations to form. These new requirements do not permit the underwriting of member groups.
- Loosens the commonality of interest test by making either industry or geography sufficient to demonstrate commonality of interest. Previously, both industry and geography were generally necessary, but neither was sufficient to establish commonality on their own.
- Retains similar but somewhat more explicit formal organizational structures and member-control requirements.
- Allows AHPs using the new commonality of interest requirement to enroll working owners, in particular the self-employed and sole proprietors, subject to a minimum-hours-worked threshold.
- Allows AHPs to form for the purposes of offering health coverage to their members, provided they have one other significant reason for forming (for example, furthering industry or professional business goals) that would survive the existence of the health plan.[5] This contrasts with the previous conditions where bona fide associations must exist for purposes *other* than offering health coverage.
- Precludes AHPs from denying member groups coverage or varying premiums based on the health status of the group.
- Retains ACA requirements that apply to group health plans, such as the prohibition on any annual or lifetime dollar limits on essential health benefits (EHBs).

Many, if not most, of the currently existing associations, including local and national chambers of commerce, local or national industry groups, professional groups, and regional interest groups, could fairly easily fulfill all the conditions to become a bona fide association under the latest rules and thereby offer a large-group health plan as an employer. This was not the case prior to Trump's executive order.

1 This executive order is discussed in more detail in our paper "Law and Executive Order," which can be found at http://www.milliman.com/uploadedFiles/insight/2017/law-and-order.pdf.

2 The other options were short-term, limited-duration plans and expanded uses of health reimbursement arrangements (HRAs).

3 The full text of the proposed rules is available at https://www.federalregister.gov/documents/2018/01/05/2017-28103/definition-of-employer-under-section-35-of-erisa-association-health-plans.

4 The full text of the final rule is available at https://www.federalregister.gov/documents/2018/06/21/2018-12992/definition-of-employer-under-section-35-of-erisa-association-health-plans.

5 This is a significant change from the proposed rule, which would have allowed AHPs to form solely for the purpose of offering health coverage.

This does not mean that it would be in the best interest of all associations to offer their own group health plan. In fact, the opposite could be true, if one considers all the costs and benefits as well as the other available options for offering major medical coverage that are available to associations. However, some associations might be well positioned to take advantage of the opportunities presented by the final rule. For example, non-bona fide associations that already have experience offering insured benefits other than major medical, such as critical illness, limited-benefit indemnity plans, or other "branded" offerings such as dental, vision, critical illness, short-term plans, and others, might easily convert to bona fide associations and expand their offerings to include major medical coverage under a group health plan. We discuss the considerations for offering an AHP in more detail below.

Considerations for sponsoring an AHP

While many currently existing associations could conceivably offer an AHP under the final rule, it may or may not be in their best interest to do so. Any entry into the major medical market represents a significant undertaking and commitment of resources because healthcare is complicated and costly. Thus, the decision to offer a group health plan product must include a comprehensive evaluation of the association's resources, capabilities, overall mission, and competing priorities. There are business and insurance risks, particularly with alternate funding arrangements, that are not insignificant and that must be considered carefully before committing the association's time and resources. That time and those resources could be otherwise spent furthering other association initiatives rather than taking on many of the responsibilities of a group health plan. Aside from this overarching caution, associations or other parties contemplating forming an AHP should consider the following issues.

OFFERING A GROUP HEALTH PLAN THROUGH AN AHP IS A COST-PLUS GAME…BUT MOST OF IT IS COST

For an AHP to be viable over the long term, it must fund its costs (see funding considerations below) and stay solvent while simultaneously being competitively priced. Although some large employers could be a part of an association health plan, many AHPs will draw the bulk of their membership primarily from the ranks of the small-group market and, to a lesser extent, the individual market. Both markets have shown a high degree of price sensitivity, particularly in the nonsubsidized segment of the individual market (i.e. those individuals with income above 400% of the federal poverty level) who pay full costs with no employer contribution or government subsidy. Low price will still be a key consideration and AHPs will need to have comprehensive strategies that produce the best chance of being competitive with the small-group ACA market as well as with other alternative offerings, such as small group level-funded (self-insured) products.

IS THERE A "PLUS" IN THE AHP STRATEGY?

While low price will be critical, AHPs still have to offer overall compelling product value. In other words, employers will consider price heavily, but features unrelated to price may very well be significant factors in the choice between AHP coverage versus a level-funded product or coverage through the ACA markets. The creative thought in the "plus" part of the equation is what often produces desirable outcomes such as brand loyalty and better retention, which in turn improves risk management, rating, and price competitiveness. The "plus" part of a compelling value proposition can also be heavily influenced by the choice of payer (if fully insured) or third-party administrators (if alternatively funded). Starting an AHP, like starting a new health plan, brings opportunities to be innovative in several different areas of plan operations, such as payment reform, benefits, value-added features, and branding. Choosing a partner that is willing to bring new ideas to the table in these areas could make a big difference when it comes time for employers to choose their coverage.

RISK ADJUSTMENT IS UNAVAILABLE

The final rule clearly establishes that, in the view of the U.S. Department of Labor and the Internal Revenue Service, bona fide associations that offer a group health plan through an association can be treated as large groups for regulatory purposes if the association has sufficient membership. However, treatment of AHPs will ultimately be up to the individual states. Existing treatment of associations varies by state and, in many cases, conforming state legislation will be needed to allow an association to be classified as large-group.

Many states either currently allow or could pass legislation that will allow associations to operate as large employers for purposes of offering a group health plan, which is the intent of the final rule. The large-group market, now potentially available to small businesses and working owners through the AHP, offers certain advantages over the small-group and individual markets. One of those advantages is being able to capture the benefits of favorable risk in its own pricing without having to pay into a risk-adjustment program, as in the ACA. At the same time, the absence of risk adjustment brings a significant risk to the sponsor of an AHP. Risk adjustment in both the small-group and individual ACA markets can be a significant equalizer among market participants, and if done correctly, can also be a source of competitive advantage. In the large-group market there is no risk adjustment and therefore less protection from adverse selection.[6] While single employers often exhibit relatively stable health costs, such that the price of insurance is largely determined by the desired level of benefits rather than any risk of adverse selection, single employers have a key risk-management lever with participation requirements

6 Adverse selection occurs when an entity such as an individual or employer group selects the timing, amount, and price of insurance that is of greatest benefit to them, i.e. when there are significant health needs. Left unchecked, this will lead to higher prices, all else equal.

that AHPs may not.[7] AHPs face the potential for enrollment and cost volatility more consistent with the small-group market and, thus, need to be concerned about the overall risk profile of the association. A risk pool with a significant number of higher-than-average risks will, all else equal, make an AHP's offerings less competitive.

Complicating matters is the treatment of large groups. While most large groups will likely see relatively little incentive to enroll in AHP coverage, any large group that is eligible to join the association and has a risk profile worse than average could elect to join the association to obtain risk pooling benefits that are unavailable to them in the large-group market, where they would be partially or completely rated on their own experience. If this group's risk profile is sufficiently worse than other AHP member groups, then its enrollment could increase rates for small employer members beyond what is competitive. It may be possible for the association to vary rates and product offerings based on employer size, subject to state restrictions. AHPs should be aware of this possibility.

At the same time, many associations could have built-in advantages when it comes to attracting a competitively advantageous risk pool. For example, the AHP formed by, say, the Association of People Doing Dangerous Things might be challenged to enroll members with lower healthcare costs than the Association of People Who Never Take Risks. That said, there is also no guarantee that the members of a relatively healthier association, *when considering its entire membership base*, will succeed in enrolling a balanced cross-section of its membership. In other words, who participates matters. Moreover, AHPs, once formed, might seek to expand their membership bases in ways that are consistent with their purposes but give them a broader potential market. This expansion makes it even more challenging to understand and predict the overall resulting morbidity of an association's risk pool.

WILL THE AHP BE WILLING AND ABLE TO MANAGE RISK?

With risk adjustment unavailable, membership participation critical, and price an important determinant of success in the AHP market, associations will need to pay close attention to the risk-management levers at their disposal. Poor risk management will lead to an uncompetitive offering, which could lead to lower membership volume and adverse selection that leads to higher prices. Careful eligibility and benefit design strategies will be critical in this regard, as will marketing, pricing structures, provider contracting, medical management, and financial risk arrangements such as reinsurance. AHPs that rely solely on the hope that their membership is and will remain healthier than average could find themselves out of the market in a few years, as their rates approach or exceed the ACA small-group risk pool, or they could lose money, or both.

7 AHPs could require and enforce group-level participation requirements as well as implementing incentives for association member groups to join the AHP.

IS THERE CRITICAL MEMBERSHIP VOLUME AVAILABLE?

Potential membership volume is an important determinant in an AHP's long-term success. At a minimum, associations will need at least 51 members to qualify as a large employer. Beyond this, a large volume of membership will reduce monthly and annual claims volatility. It can also improve rate stability, reduce administrative fixed costs on a per-member basis, improve the chances of obtaining a balanced, competitive risk profile, and make the AHP more attractive to payer and provider partners.

Associations with narrow eligibility criteria may struggle in this regard. For example, a regional association offered to a specific profession may benefit from either expanding its service region to an entire state or broadening its membership base by expanding to related industries or peripheral businesses related to its primary industry.

Associations themselves may also have an opportunity to band together behind the scenes for purposes of risk pooling and increased volume, while still retaining their branded offerings and market distinctions.

WILL ALL THE PURPORTED BENEFITS OF AHPS BE REALIZED?

AHP proponents tout the advantages of being in the large-group market (if allowed by states). However, AHPs should be realistic when evaluating their strategies and chances of success. For example, it seems unlikely that any one association could have enough membership volume in a geographic coverage area to command unit-price concessions from providers that would be significantly greater than what incumbent mainline carriers and third-party administrators (TPAs) have negotiated for their ACA products. It is certainly possible that an AHP's administrative costs could be lower but, given that those costs are only about 15% of the total cost in the small-group market, reductions here can only go so far in delivering lower premiums.[8] Depending on how states proceed and the choice of funding by an AHP, there may or may not be savings associated with taxes or mandated benefits. One thing is certain: if the AHP is classified as large group in a state, it will have significantly more flexibility in benefit design and rating relative to ACA markets, which are heavily restricted. In particular, the requirement to cover essential health benefits, the 3-to-1 age band restriction, and the ACA's metallic tier requirements will not apply in the large-group market.[9]

8 A typical large group expense ratio is closer to 10% of total cost, resulting in a maximum 5% savings.

9 While large-group markets technically do not have an actuarial value requirement, large employers that do not provide coverage that meets minimum value (paying at least 60% of typical healthcare costs) may be liable for the employer mandate penalty, which effectively forces a minimum level of benefit in the large-group market. However, small employer members of an AHP would not be liable for this penalty, and so could purchase leaner coverage than would typically be available without fear of that enforcement mechanism.

"Bona fide" before and after the final rule

Prior to the release of the final rule, associations did not have a well-defined pathway to being determined bona fide. Rather, each association's facts and circumstances were evaluated against three broad issues:

1. Does the association exist for a purpose other than providing benefits?
2. Do employer members of the association have a close enough relationship to be essentially a single common entity?
3. Do employer members control the health plan in form and substance?

The second criteria often presented a challenge to associations, as the required economic and representational relationship between association members was typically only satisfied by associations with narrow membership requirements.

With the new pathway identified in the June 18 final rule, the second criteria is made much more explicit, and can be satisfied by demonstrating that association members share a common industry or geography.

Qualifying as bona fide allows an association to be viewed, in essence, as the employer of association members' employees and its group health plan can be regulated as a part of the large-group market.

WHAT ABOUT FUNDING?

An AHP will need to make a critical decision early in its strategic evaluation process on how to fund the plan. It is beyond the scope of this paper to fully evaluate all these options, but a starting point might be the decision to either purchase health insurance collectively on a fully insured or partially insured basis from an established carrier or to arrange self-insured coverage with either a carrier or a TPA. Each of these options has advantages and disadvantages and can differ based on an association's mission, resources, target membership, geographic presence, and internal capabilities. For example, a carrier-based fully insured or administrative services organization (ASO) offering will bring value through its turnkey, end-to-end solution, which includes established networks, negotiated pricing, administration, and strategy. TPAs, on the other hand, might bring additional flexibility, lower cost, and innovative solutions. In any case, the funding options available as a result of this decision will also vary. Funding options considered by AHPs often range from a standard fully insured scheme, to minimum premium arrangements, and even to more exotic options, such as forming their own captive insurers as well as other alternative funding options. State law is a heavy determinant in this decision as certain states do not allow self-funding or its variants due to past challenges, particularly with multiple employer welfare arrangements (MEWAs).

AND WHAT ABOUT OTHER FIDUCIARY REQUIREMENTS?

AHPs are a type of group health plan and, as such, plan trustees and certain vendors face strict fiduciary requirements. While single-employer group health plans face this cost, they receive preemption from many state laws in return, trading one set of compliance issues for another. AHPs (and other MEWAs) face both compliance situations—they must comply with ERISA's fiduciary requirements and with a much broader slate of applicable state laws. The need for this compliance could complicate AHP offerings, particularly for industry-based associations that seek to offer coverage in multiple states. Furthermore, it may be challenging for a new market entrant to locate and ensure compliance with all applicable rules and regulations. These additional compliance costs could impact the competitiveness for associations, particularly those without significant volume, making an AHP's coverage less competitive.

Impacts to small-group and individual ACA markets

The impact to the ACA risk pools is largely dependent on how many existing non-bona fide associations make the leap to bona fide status and how many new associations will form as bona fide under the latest rules. The number of AHPs that ultimately form will likewise be dependent on each association's evaluation of the considerations we outline above as well as many other factors.

AHPs have long been among the array of possible vehicles for providing employee benefits to small businesses,[10] but their usefulness was significantly curtailed by the market reforms of the ACA.[11] Following the U.S. Congress' failed attempt to "repeal and replace" the ACA,[12] AHPs returned to the spotlight as one of the only substantial policy changes affecting health insurance markets that could be potentially implemented without requiring Congress to pass new legislation.

10 AHPs are a form of multiple employer welfare arrangements (MEWA) and have been part of the benefits landscape since the passage of ERISA in 1974, though they did not gain significant traction until the 1990s.

11 In particular, the ACA required that non-bona fide associations follow the rules of the market based on the rules that otherwise apply to the purchaser (whether individual, small-group, or large-group), which forced these associations to comply with the ACA's individual and small-group market reforms. Bona fide associations can offer a single-group health plan based on the overall size of the association and are only subject to those reforms that apply to the large-group market or to self-insured plans.

12 Haberkorn, J. et al. (September 27, 2017). Inside the life and death of Graham-Cassidy. Politico. Retrieved August 15, 2018, from **https://www.politico.com/story/2017/09/27/obamacare-repeal-graham-cassidy-243178**. This news article addresses the failure of Graham-Cassidy and other ACA repeal efforts.

The ACA's regulatory impact on non-bona fide AHPs was beneficial to ACA markets. By imposing greater restrictions on non-bona fide associations without simplifying the requirements and process of becoming bona fide, the membership of most association health plans was incorporated into the ACA single-risk pools in both the individual and small-group markets. The recent final rule does not modify treatment of associations that are not bona fide, but it does simplify the process and loosen the criteria by which an association is determined to be bona fide. Subject to how states choose to regulate AHPs, bona fide AHPs with more than 50 total lives will be a part of the large-group market. Thus, as non-bona fide associations become bona fide, there will most likely be a detrimental impact on both the small-group and individual ACA markets' membership.

Critics of AHPs[13] cite any number of negative impacts but, arguably, chief among them is the membership attrition and resulting ACA risk-pool destabilization. By attracting the healthier risks with lower prices and potentially leaner benefits, critics contend that the ACA risk pools will experience adverse selection and incremental price increases. Prior to the issuance of the final rule related to AHPs, the Congressional Budget Office (CBO) estimated that approximately four million people would obtain coverage through AHPs by 2023 and that most (90%) would come from the existing small-group and individual ACA markets. The exit of this presumably healthier population was estimated to have a 2% to 3% impact on the small-group market.[14] Proponents counter this by noting that increased competition, lower prices, innovation, and more choices are precisely what health insurance markets need and will serve to improve the long-term health of these markets. They argue that the higher prices in the ACA markets are not due to the presence of competing products, such as AHPs, but rather to poorly functioning markets, excessive benefits, and a lack of incentives to control costs and promote member health and wellness.

Critics also cite the history of fraud and abuse[15] with MEWAs, claiming that simplifying the process of forming AHPs will naturally resurrect these behaviors and even expand upon them. Proponents counter that state oversight of AHPs and the limited preemption of ERISA that has applied to MEWAs since the early 1980s[16] will prevent this from reoccurring.

Finally, critics also argue that benefits will be leaner under AHPs and that AHPs will take advantage of rules stacked in their favor and against ACA markets (e.g. no EHB requirements, wider age rating bands to attract younger enrollees, etc.). Proponents argue that employers will want to offer competitive benefit packages, making a race to the bottom of the benefit richness scale unlikely and that AHPs will primarily serve groups that are negatively impacted by the ACA as well as those who may not have insurance, many of whom are younger.

Conclusion

Like any other significant change in market structure, the executive order related to healthcare choice and competition and the final rule that implements the goals of this executive order will bring opportunities and risks for all involved in the healthcare ecosystem. Carriers involved in the ACA market will need to monitor and evaluate emerging AHP impacts on enrollment and morbidity in the states where they participate in the ACA market. Payers will need to evaluate the viability of AHPs approaching them for partnerships and balance strategies that potentially cannibalize existing membership in other markets. And associations will need to carefully and realistically evaluate whether it makes sense for them to enter the AHP space, with a keen eye on how to effectively manage risk and compete over the long haul.

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13 And there are many—95% of groups commenting on the final rule had negative views of the proposal.

14 The CBO report can be found at https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53826-healthinsurancecoverage.pdf.

15 Fraud and abuse includes, but is not limited to, financial mismanagement, not paying benefits, using unlicensed agents or brokers, and misrepresentation.

16 For an interesting discussion of this, see page 4 of this 2000 paper by the American Bar Association, available at https://apps.americanbar.org/labor/lel-aba-annual/papers/2000/paris.pdf.