ASSOCIATION HEALTH PLANS: A PRIMER AND KEY CONSIDERATIONS FOR MASSACHUSETTS

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INTRODUCTION

A federal proposal to expand the availability of Association Health Plans (AHPs) could alter the type of health insurance available to small employers,[1] including self-employed individuals (hereafter referred to as sole proprietors); increase costs for some employers and individuals; and leave some residents without important consumer protections.

AHPs — a type of Multi-Employer Welfare Arrangement, or MEWA — are health insurance plans sponsored by an industry, trade, or professional association. In Massachusetts, these arrangements are currently subject to state and federal law, including Massachusetts insurance requirements that apply to individuals and small employer groups (e.g., benefits, what services are covered; member cost sharing, deductibles, co-payments, and out-of-pocket limits; and premiums, how rates are set).

The proposed rule,[2] issued by the U.S. Department of Labor (DOL), would both expand access to AHPs by broadening eligibility for groups and sole proprietors to be covered under an AHP; and by redefining what constitutes an employer, thereby moving many AHPs outside the federal Affordable Care Act (ACA) requirements that apply to health plans offered to individuals and small employers.[3]

While Massachusetts has statutory and regulatory requirements that require AHPs offered to small employers and sole proprietors to comply with the Commonwealth's small group rating rules and regulations,[4] DOL could take action beyond that put forth in its proposed rule to preempt state authority and effectively require states to treat AHPs as a large group for the purpose of insurance rules and regulations. Health plans sold to large groups are not subject to many of the rating rules and benefits standards that apply to the small group market.

There is also concern that AHPs could be established in a state with limited regulatory oversight, perhaps to avoid the Commonwealth's more rigorous insurance standards, potentially enabling employers from any state (including Massachusetts) to obtain coverage through the out-of-state AHP. Massachusetts-based employers could obtain coverage through the AHP without being protected by the access, benefit, and consumer protection standards that apply to coverage issued in Massachusetts, although the Massachusetts Division of Insurance (MA DOI) and the Attorney General's Office (AGO) have authority to enforce Massachusetts laws and regulations applicable to these out-of-state AHPs.[5] This issue brief frames the key issues and potential impacts to consumers that may result from implementation of the proposed AHP rule. There is some ambiguity in the proposed rule. As written, it does not provide authority to override state laws and regulations, but there is language in its preamble that does suggest an intent to provide "relief from State rules."[6] Recognizing that ambiguity, the brief describes the ways in which allowing AHPs to operate according to the proposed

1 For the purpose of health insurance regulations, an employer is considered "small" if it has 50 or fewer full-time equivalent employees.

2 Department of Labor, Employee Benefits Security Administration, 29 CFR Part 2510, "Definition of 'Employer' Under Section 3(5) of ERISA—Association Health Plans," proposed rule, January 5, 2018, www.gpo.gov/fdsys/pkg/FR-2018-01-05/pdf/2017-28103.pdf.

3 Massachusetts is the only state to merge the individual (nongroup) and small group markets. In this report, the term "merged market" refers to the individual and small group markets.

4 Chapter 297 of the Acts of 1996; and 211 CMR 66.00: Small Group Health Insurance.

5 "State Options to Protect Consumers and Stabilize the Market: Responding to President Trump's Executive Order on Association Health Plans," Georgetown University Health Policy Initiative, Center on Health Insurance Reforms, December 2017.

6 Preamble to the proposed rule, Department of Labor, Employee Benefits Security Administration, 29 CFR Part 2510, "Definition of 'Employer' Under Section 3(5) of ERISA—Association Health Plans," proposed rule, January 5, 2018.

rule could impact the scope of benefits, provider networks, and consumer protections available to consumers in plans covered through this arrangement; explains why technical topics such as risk segmentation and rating rules are important in considering the impacts of the proposed AHP rule on consumer access to health coverage; and provides policymakers with options the Commonwealth could consider to protect Massachusetts consumers in response to the federal AHP proposal.

"FULLY INSURED" VS. "SELF-INSURED"

"Fully insured" coverage is sold by an insurance carrier to an individual, employer, or other plan sponsor such as a union or group of employers (e.g., a Massachusetts purchasing cooperative). Monthly premiums are charged to the individual or group, and the insurance carrier pays for covered medically necessary services that a member uses (excluding any applicable member cost sharing).

In a "self-insured" arrangement, an employer or union (i.e., plan sponsor) is responsible for paying the cost of claims, excluding member cost sharing. In many cases, the plan sponsor contracts with an insurance carrier or third-party administrator under an administrative-services-only (ASO) arrangement to administer the benefits, adjudicate claims, contract with a provider network, and provide member services.

While the federal Employee Retiree Income Security Act (ERISA) exempts most self-insured health plans from most state insurance laws and regulations,[7] in response to insolvencies and cases of outright fraud involving self-funded MEWAs, Congress amended ERISA to limit its preemptive effect on state law, thereby permitting states to regulate self-funded AHPs / MEWAs.[8] Under current law, self-funded AHPs / MEWAs that attempt to offer coverage in Massachusetts would be required to be licensed and regulated in the same way as any other insurance company.[9] This existing amendment to ERISA means, in practice, that self-funded AHPs may be subject to a greater degree of state oversight than self-funded health plans offered by a single employer. The proposed rule seeks to treat each AHP as a single employer for the purpose of insurance regulation, however, which could adversely affect the state's ability to regulate and oversee these multi-employer health plans.

7 "2015 Employer Health Benefits Survey," Kaiser Family Foundation, September 22, 2015, www.kff.org/report-section/ehbs-2015-section-ten-plan-funding.

8 "MEWAs: The Threat of Plan Insolvency and Other Challenges," The Commonwealth Fund, March 2004.

9 Email to report's author from Deputy Commissioner, Health Care Access Bureau, Massachusetts Division of Insurance, January 2018.

OVERVIEW OF THE PROPOSED RULE

In early January 2018, the DOL issued a proposed rule to broaden the criteria under ERISA for the purpose of determining when separate employers may join together in a group or association and be considered to be one employer under DOL rules when providing health benefits for their collective employees.

The intent of the proposal is to permit more small employers, including sole proprietors, to band together to purchase coverage as a large group, subject to federal large group market insurance rules rather than small group rules. In doing so, the proposal indicates it "could offer small businesses relief from ACA and state rules that restrict issuers' product offerings and pricing in individual and small group markets."[10]

Today, federal rules limit the ability of small employers to band together for the purpose of providing health benefits as a "large group." Employers may join together and be considered a "bona fide" employer group subject to large group insurance regulations only if: (a) the group or association has a purpose and function other than the provision of health benefits; (b) the employers share some commonality of interest and organizational relationship unrelated to the provision of health benefits; and (c) the employers directly or indirectly exercise control of the health benefits.[11]

Based on current rules and guidance issued by the Centers for Medicare and Medicaid Services (CMS),[12] health coverage provided through a trade association, chamber of commerce, or similar organization to small employers or individuals is generally regulated under small group or individual market rules. Instead of viewing the organization as a single large group, the regulations in effect today "look through"[13] the association at the size of each employer participating in the group to determine whether there are individuals or small employers within the association. If there are, then generally the association's health coverage will be subject to small group market rules.[14]

The proposed regulations would allow employers and self-employed individuals to form an association for the sole purpose of providing health benefits, effectively eliminating the "look through" approach. The AHP would be considered a bona fide large group that would not be subject to individual or small group market rules. Members of the association would need only to be in the same industry, trade, or profession; or be located in the same geographic region. The association would no longer be required to have a common purpose or function other than the provision of health benefits. By modifying the "commonality of interest" requirement, the rule intends to permit more small employers, as well as self-

10 Department of Labor, Employee Benefits Security Administration, 29 CFR Part 2510, "Definition of 'Employer' Under Section 3(5) of ERISA—Association Health Plans," proposed rule, January 5, 2018.

11 "Association Health Plan Proposed Rule: Summary and Implications for States," Center on Health Insurance Reforms, Georgetown University, January 2018.

12 www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf.

13 The "look through" provision determines whether the AHP is subject to small group regulations by examining each entity that participates, rather than evaluating the AHP as a whole. For example, an AHP comprising 100 employers, each employing less than 50 employees, would be subject to small group rules based on the size of each entity; even though the total number of employees covered by the AHP exceeds 50.

14 "Association Health Plans—Can the Trump Administration Expand Access Without Congress?" Alden Bianchi and Edward Lenz, October 11, 2017.

employed individuals, to form AHPs that would be subject to federal insurance regulations applicable to a large employer rather than insurance rules governing small employers.

It should be noted that Massachusetts law treats each member of an association as "a separate group health plan with respect to each employer maintaining the [AHP] arrangement."[15] And the proposed federal rule, in its preamble, does not override a state's ability to apply small group rules to an AHP comprising small employers. However, the preamble to the proposed rule also states:

> *"As large groups, AHPs might offer small businesses some of the scale and efficiency advantages typically enjoyed by large employer plans. They additionally could offer small businesses relief from ACA and State rules that restrict issuers' product offerings and pricing in individual and small group markets."*[16]

This suggests an intent to apply large group rules to AHPs. Therefore, although the proposed rule as written does not provide authority to override Massachusetts state laws and regulations, to the extent that it is ambiguous, it suggests various ways in which AHPs could affect the Massachusetts health insurance market. These are described in the following section.

POTENTIAL IMPACTS OF THE PROPOSED RULE

Permitting small employers and self-employed individuals to purchase health coverage through an AHP could directly affect the broad range of health benefits that employees are provided today and change the way an employer's premiums are determined. Health plans sold to Massachusetts-based employers by an AHP established outside the Commonwealth could, without further legislation or regulatory changes, potentially limit Massachusetts' ability to enforce consumer protections.

Indirectly, without active state regulatory oversight, if AHPs gain sufficient traction and attract organizations whose employees are relatively young and healthy while a disproportionate share of older and less healthy individuals remain covered through the existing merged market, premiums in the merged market would increase. The Commonwealth recently engaged an independent actuarial firm to evaluate the premium impact on the merged market if AHPs are not subject to state regulation. The results indicated that if state action is not permitted in the final regulation, premiums in the merged market could rise by over 10 percent in 2019 due solely to the introduction of AHPs, with additional premium increases in later years.[17]

15 Mass. General Laws, Chapter 176J, § 1.

16 Preamble to the proposed rule, Department of Labor, Employee Benefits Security Administration, 29 CFR Part 2510, "Definition of 'Employer' Under Section 3(5) of ERISA—Association Health Plans," proposed rule, January 5, 2018.

17 Massachusetts Division of Insurance and Massachusetts Health Connector comments submitted to DOL re proposed AHP rule, March 6, 2018, www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00600.pdf.

BENEFITS AND COST SHARING

The Affordable Care Act introduced several benefit and cost-sharing standards, such as Essential Health Benefit (EHB) requirements and limitations on deductibles and out-of-pocket maximums. The majority of these market reforms, however, apply to the nongroup and small group markets but do not apply to coverage sold in the large group market. One consequence of the proposed federal rule is that AHPs, if subject to large group rules, could have higher up-front deductibles, larger co-pays, greater co-insurance, and/or more limited benefits.

In the small and nongroup markets, federal EHB standards require health plans to cover services under ten categories of care:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

In contrast, large group health plans are not required to cover all EHB categories. While most large employer health plans provide comprehensive coverage, they are not required to do so. By definition, large employer health plans are deemed by federal statute to be compliant with the ACA's minimum essential coverage (MEC) standards. This distinction could, without further legislation or regulatory intervention, open the door for AHPs to offer less robust coverage than is required for health plans sold to individuals and small groups.

The Commonwealth has its own coverage requirements stemming from the health care reform law of 2006.[18] The Commonwealth's Minimum Creditable Coverage (MCC) standards — as determined by the Massachusetts Health Connector Board of Directors[19] — require most adults to be covered by a health plan that provides coverage for a "broad range of medical services," including:

- Inpatient acute care services
- Maternity and newborn care
- Diagnostic tests and procedures
- Medical/surgical care, including preventive and primary care services
- Mental health and substance use disorder services
- Radiation therapy and chemotherapy
- Outpatient care
- Prescription drugs

18 Chapter 58 of the Acts of 2006, https://malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter58.

19 Minimum Creditable Coverage regulation, www.mahealthconnector.org/wp-content/uploads/rules-and-regulations/956CMR5.00.pdf.

The MCC standards prohibit annual limits on coverage of "core services,"[20] limit the up-front deductible before the plan begins to pay for coverage, and place an annual cap on the maximum amount a consumer is required to pay out-of-pocket (i.e., co-payments, co-insurance, and deductibles).

MCC standards apply to individuals and specify the level of benefits and cost-sharing protections individuals must have in their health insurance plans to satisfy the state's individual mandate. While MCC standards do not directly apply to health insurance plans or employers, this policy approach has the intentional effect of influencing the types of health plans — including the scope of benefits and cost-sharing designs — offered by insurers and employers.

It is worth noting that the Commonwealth's health reform law does not prohibit insurers from selling policies that do not meet MCC standards, although the MA DOI requires insurers to notify consumers whether their health plan meets — or does not meet — MCC standards.[21]

An AHP that offers coverage to small employers, if treated as a large group, would be exempt from certain MA DOI review and approval requirements. The AHP could exclude coverage of certain services (e.g., mental health, maternity, prescription drugs), or member cost sharing could exceed the cost-sharing limits placed on health plans available in the state's small group market.

In this case, AHP members could be covered by a health plan with limited benefits and large out-of-pocket exposure. And because the state's individual mandate remains in effect, AHP members whose health plan does not meet the state's MCC standards may be subject to a state tax penalty.

PREMIUMS AND RATING RULES

As noted above, Massachusetts law requires that each employer member of an AHP be treated as "a separate group health plan with respect to each employer maintaining the [AHP] arrangement." As a result, under current state law, small employers joining AHPs in Massachusetts would still be subject to state rating rules that apply to small groups. However, if that law is preempted, as seems possible in light of language in the proposed rule suggesting an intent to treat members of AHPs as large groups, this will have important implications.

There are significant differences in the way insurers are allowed to establish premiums, or rates, in the merged market vis-à-vis the large group market, as well as material differences in the review and approval of rates by the MA DOI across these market segments.

In the merged market, carriers establish premiums based on the claims experience and projected expenses of all people covered by the insurance carrier in that market segment (also referred to as the use of a "single risk pool"). That is, the experience of all groups and individuals in the merged market — not the experience of any particular group or individual — forms the basis of each carrier's rate development.

Premiums for a given group can vary based on the composition of the group, but only through the use of a limited set of rating factors. The rating factors that are permitted in the merged market include

20 Core services include physician services, inpatient acute care services, day surgery, and diagnostic procedures and tests.

21 MA DOI Bulletin 2010 – 07, www.mass.gov/files/documents/2017/11/22/Bulletin%202010-07.pdf.

geographic location of the group, age of the group's members,[22] rate basis type (e.g., individual, family, employee + spouse), and tobacco use. In addition, Massachusetts is permitted under a special exemption granted by CMS to permit limited use of the following rating factors for coverage issued or renewed through the end of 2019: industry, size of the group (e.g., number of employees), participation rate of employees in the employer health coverage, and coverage obtained through intermediaries or group purchasing cooperatives. Carriers are not permitted to use health status or gender in setting rates in the merged market.

The age bands used in Massachusetts limit the variance in age rating to no more than a 2-to-1 ratio. That is, for each health plan, an employer with older employees can be charged no more than twice the rate charged to a similarly-situated employer with younger workers. For example, if an insurer charges a small employer whose employees are 20-year-olds an average premium of $200 per employee per month for a particular health plan, the most it can charge a similarly situated small employer with older employees for the same health plan is an average premium of $400 per employee per month.

These rating rules do not apply to coverage sold in the large group market. Carriers are allowed to set rates for large groups based on each group's claims experience, and there are no explicit limits to the rating factors a carrier can utilize.[23] In contrast to the merged market, the large group market permits using gender as a rating factor.[24]

An American Academy of Actuaries report noted that "insurers' age rating factors [in the large group market] reflect up to a 5-to-1 ratio or higher."[25] If a 5-to-1 age rating factor is applied to AHPs, this could result in premiums for older AHP members being five times the amount charged to younger members. In this scenario, older groups and individuals would be less likely to enroll in an AHP while younger members would be incented to join the AHP.

This is where the "AHP is a large group" premise falls short. Large employer health insurance rates are based on the group as a whole. The rate for each department or unit within the large employer is not set based on the demographic profile (e.g., age, gender) of the department or unit. In contrast, under an AHP, each group that participates in the AHP is charged a rate based on its own demographic profile.

While carriers can use the health status or health claims experience of the group as a rate factor in setting premiums for a large employer, the proposed AHP regulation would prohibit AHPs from doing the same thing when setting premiums for members of the AHP. Specifically, DOL is proposing that AHPs cannot take health status into account when determining membership, eligibility for benefits, benefit designs, and premiums.

Under the proposed rule, AHPs would be permitted to use gender and other non-health-based rating factors in setting premiums. For example, AHPs could refuse coverage or charge significantly higher rates to employers in certain industries. They could apply a premium surcharge based on the region of

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22 The state's age rating limit of 2-to-1 is narrower than the 3-to-1 limit under the ACA.

23 The federal Health Insurance Portability and Accountability Act (HIPAA) prohibits discrimination within a group of similarly situated individuals.

24 Employment discrimination laws prohibit employers from charging different rates to male and female employees within a firm. However, insurers are permitted to charge different rates based on the gender mix of each group.

25 "Potential Implications of the Small Group Definition Expanding to Employers with 51–100 Employees," American Academy of Actuaries, March 2015, www.actuary.org/files/Small_group_def_ib_030215.pdf.

the Commonwealth in which the employer is located or exclude serving certain high-cost areas of the Commonwealth. These and other types of discriminatory rating practices would be permitted under the proposed rule, although they are not under Massachusetts state law.

RISK SEGMENTATION

Through the use of the rating factors discussed above or through benefit design (i.e., deductibles and other cost sharing for services), AHPs could segment the market by attracting healthier groups and healthier individuals *within* groups, while the existing merged market would be left to cover relatively higher cost groups and individuals. An AHP could also structure coverage of benefits in a way that meets the needs of healthier workers and families but discourages enrollment by people with more medical needs. For example, AHP coverage might exclude maternity care, or a prescription drug benefit might exclude coverage of medications for chronic conditions.

For example, the Tennessee Farm Bureau, an AHP that covers approximately 75,000 residents of Tennessee (not just farmers), covers maternity care only after nine consecutive months of coverage under a family policy. Maternity care is not a covered benefit under an individual policy sold by the Farm Bureau.[26] Under these plans, pregnancy is a preexisting condition and maternity care is not a covered benefit.

If an AHP does not meet the state's MCC requirements, employees could seek coverage through the individual market and could be eligible for subsidized coverage through the Massachusetts Health Connector. AHPs that siphon off "good risk" individuals and shift less healthy ones to the merged market could impact the merged market's risk pool, leading to an increase in premiums for those who remain in the individual and small group market. As noted in a February 2017 report by the American Academy of Actuaries:

> *"A key to sustainability of health insurance markets is that health plans competing to enroll the same participants must operate under the same rules. Although AHPs would be offered in competition with other small group and individual market plans, they could operate under different rules. In particular, if an AHP is allowed to follow the issue, rating, and benefit rules of a single state nationwide, or be pre-empted from state regulation by being self-insured, it would impose different rules on insurance providers offering coverage in the same market. The viability of many state-based markets would be challenged as a result."* [27]

Because health plans available in the merged market must be offered on a guaranteed issue / guaranteed renewal basis, small groups or sole proprietors that find they need a richer benefits package or coverage of services that may not be offered by the AHP can drop their AHP coverage and purchase coverage in the merged market. Because the Commonwealth's laws do not limit when employer groups (small and large) may purchase coverage, and insurers allow employer groups to enroll at any time

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26 www.fbhealthplans.com/SiteMedia/Documents/Schedule_of_Benefits/Major-Medical.pdf.

27 "Association Health Plans," Issue Brief, American Academy of Actuaries, February 2017, www.actuary.org/files/publications/AssociationHealthPlans_021317.pdf.

during the year, these groups and sole proprietors can then purchase coverage from insurers operating under the state's small group rules, which require insurers to meet federal and state benefits standards.

If not rigorously enforced, this type of adverse selection, in which groups or individuals purchase insurance in the merged market when they need coverage for certain services that are not covered by an AHP, could lead to premium increases in the merged market.

PROVIDER NETWORKS AND MEMBER ACCESS

The depth and breadth of a provider network sufficient in size and scope to serve an AHP's members is another important consideration. Unless an AHP is offered by an insurance carrier currently operating in Massachusetts or otherwise has access to a Massachusetts insurance carrier's provider network, the AHP will need to develop or "rent" a provider network.

However, some rental networks are designed to complement an insurer's existing provider network rather than serve as the primary provider network. Insurers often use these networks to provide members who live out of state with access to a minimal number of "in-network" providers and facilities.[28] They are not intended to serve as the health plan's principal provider network. If a given AHP's provider network is not sufficiently comprehensive, members may have difficulty accessing care from in-network providers.

An AHP with far fewer members than a well-established insurance carrier may find it difficult to establish a provider network to adequately serve its members, potentially resulting in members being unable to access care or members being forced to seek care from costlier out-of-network providers. In addition, there are no network adequacy standards that apply to the large group market.

CONSUMER PROTECTIONS

Massachusetts has in place a number of consumer protection provisions, along with oversight and enforcement agencies, to ensure that consumers are treated fairly by insurance carriers offering coverage in the Commonwealth. Some protections, such as prospective rate review and approval of health plans, and requirements that carriers make refunds to covered groups and individuals when their medical-loss ratios fall below 88 percent, are specific to merged market plans, while other provisions apply to all insured products that are offered, issued, or renewed in Massachusetts. These include an independent external appeals process for coverage denials, market conduct examinations to determine whether insurance carriers are operating according to applicable statutory and regulatory requirements, and financial solvency standards for insurers. The table below describes different types of consumer protections and the market segments to which they apply under current law.

28 For example, Multiplan is a national preferred provider organization (PPO) network that health insurers often contract with to complement their provider networks by giving health plan participants access to in-network providers in areas of the state or country where the health plan's own provider network is spotty or nonexistent.

KEY CONSUMER PROTECTIONS BY MARKET SEGMENT

CATEGORY	DESCRIPTION	MERGED MARKET	LARGE GROUP MARKET
Benefits and Member Cost Sharing	MA DOI reviews and approves the services covered and member cost sharing of each health plan (i.e., deductibles, co-payments, co-insurance, out-of-pocket maximum).	Yes	Yes
Essential Health Benefits	Health plans must provide coverage of 10 categories of benefits.	Yes	No
Actuarial Value	Health plans must cover, on average, at least 60 percent of expected medical expenses for covered services.	Yes	No
Single Risk Pool	Health plans must consider claims experience of all members across all plans within the market segment when setting premiums.	Yes	No
Rating Factors	Health plans are limited to the use of standard rating factors, and age factor band is limited to 2:1 (i.e., assuming similarly situated groups with identical coverage, the average premium for groups with the oldest members can be no greater than two times the premium for groups with the youngest members).	Yes	No
Health Status Adjustment	Health plans are prohibited from adjusting rates for a group based on the group members' collective health status or claims experience.	Yes	No
Risk Adjustment	Within the market segment, premium revenue is transferred from health plans with relatively low-risk enrollees to those with relatively high-risk enrollees.	Yes	No
External Appeals	Insurers' benefit coverage decisions are subject to an external appeals process (e.g., whether a service is covered by the health plan).	Yes	Yes

PAST EXPERIENCE OF ASSOCIATION HEALTH PLANS

The concerns raised in this issue brief are reinforced by the past experience of some AHPs. As a former DOL insurance investigator commented, AHPs "operate in a never-never land between the Department of Labor and state insurance regulators."[29] AHPs have a checkered record, with a lengthy list of instances of fraud and abuse that have left some employers and employees without coverage and with millions of dollars of unpaid medical bills.

- In 2001 and 2002, two nationwide AHPs were shut down — Employer Mutual and American Benefit Plans — leaving 70,000 workers and their dependents with an estimated $70 million in unpaid medical bills.[30]
- Sunkist Growers, a California MEWA, filed for bankruptcy in 2001, reporting $11 million in outstanding medical claims and leaving 23,000 people without coverage.[31]
- In 2002, New Jersey's Coalition of Automotive Retailers, a MEWA covering 20,000 members, became insolvent, leaving $25 million in unpaid medical bills.
- The Indiana Construction Industry Trust, a MEWA with over 22,000 members, became insolvent in 2002, leaving $15 million in outstanding medical bills.[32]

In these instances, important state insurance rules did not apply to the AHPs. Consumer protection laws — in particular creating a state guaranty fund that typically covers outstanding medical bills in the event of an insurance carrier's insolvency — did not extend to these arrangements. As a result, employees and employers found themselves responsible for millions in unpaid medical bills, and clinicians and facilities that provided care were left with significant amounts of bad debt.

IMPORTANT CONSIDERATIONS FOR MASSACHUSETTS

Massachusetts has an established infrastructure and a common set of rules that help protect consumers from predatory practices and promote a level playing field for insurers. The insurance market and the policies and procedures that govern it were developed over time, with a strong focus on improving access to health coverage.[33] It is crucial that the Commonwealth not revert to a time when insurers were held to different standards, were allowed to avoid enrolling less healthy residents, and offered limited benefits coverage.[34]

29 "Cheaper Health Plans Promoted by Trump Have a History of Fraud," New York Times, October 21, 2017.

30 "Group Purchasing Arrangements: Implications of MEWAs," California Health Care Foundation, July 2003.

31 Ibid.

32 "MEWAs: The Threat of Plan Insolvency and Other Challenges," The Commonwealth Fund, March 2004.

33 Carey, R. (2018). A History of Promoting Health Coverage in Massachusetts. The Blue Cross Blue Shield of Massachusetts Foundation, https://bluecrossmafoundation.org/sites/default/files/download/publication/History_Health_Coverage_MA_FINAL.pdf.

34 Ibid.

Listed below are ways in which the Commonwealth could reinforce well-established rules that have shaped our market. Applying these rules to all market participants, including AHPs that wish to offer coverage in the Commonwealth, could mitigate the destabilizing impact that AHPs may otherwise bring to the Massachusetts health insurance market.

Licensing — The Commonwealth's small group health insurance statute[35] requires self-insured MEWAs (i.e., AHPs) to be licensed by the MA DOI in order to offer coverage in the Massachusetts small group market. Rigorous enforcement of this statute will ensure that self-funded AHPs meet the same licensing standards as other insurance carriers, including financial solvency oversight requirements.

Extraterritorial Authority — To head off any ambiguity regarding the ability of the MA DOI to regulate out-of-state AHPs that sell into Massachusetts, the Commonwealth could issue a bulletin or guidance to reinforce the requirement that an insurer or AHP must file and obtain approval from the MA DOI before providing coverage to a group or sole proprietor whose principal work location is in Massachusetts.[36]

State Guaranty Association — Commercial insurance companies offering fully insured health coverage in the Commonwealth are statutorily required[37] to participate in the Massachusetts Life & Health Guaranty Association.[38] In the event a member insurance company is found to be insolvent and ordered to be liquidated by a court, the Guaranty Association protects Massachusetts residents who are holders of health insurance policies with the insolvent insurance company. AHPs wishing to enter the Massachusetts market and offer fully insured coverage could be required to participate in the Guaranty Association in order to protect consumers and health care providers in the event of an insolvency.[39]

Rate Filing / Rate Review and Approval — The Commonwealth's small group regulations[40] require insured plans that are made available to small employers to comply with small group rules based on the "look through" standard (i.e., each employer within the association is considered a separate group). The MA DOI could consider amending these regulations where necessary to clarify that AHPs are required to comply with the Commonwealth's small group rating rules, which limit the factors used to develop rates and require insurers to submit rates for review and approval by the MA DOI prior to offering coverage to small employers.

Benefits (Form Filing Review) — Just as the Commonwealth could take steps to require AHPs to follow small group rating rules, the Commonwealth could consider requiring AHPs to submit a schedule of benefits (i.e., details of covered services), including member cost sharing, for each policy offered in the Commonwealth. This currently existing critical consumer protection ensures small employers and individuals are offered comprehensive health coverage, while verifying that the same standards apply to all insurers.

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35 Mass. General Laws, Chapter 176J, Section 1, https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176J/Section1.

36 See this New Hampshire Insurance Department bulletin, for example: www.nh.gov/insurance/media/bulletins/2008/documents/ins_08_014ab.pdf.

37 Mass. General Laws, Chapter 175, Section 146B, https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter175/Section146B.

38 www.malifega.org.

39 Pursuant to state law, managed care companies (i.e., Health Maintenance Organizations [HMOs]) are not required to participate in the state's Guaranty Association.

40 211 CMR 66.00: Small Group Health Insurance, www.mass.gov/files/documents/2017/11/08/211-66.pdf.

Financial Reporting — Consistent with requirements that apply to all licensed insurance carriers operating in the Massachusetts market, the Commonwealth could consider taking steps to require AHPs to file quarterly and annual financial statements with the MA DOI. Such statements provide the MA DOI with regular updates on the financial condition of insurers, including detailed information on revenue and expenses, liabilities, capital, reserves, membership, utilization, premiums, and other key indices of financial performance.

Consumer Disclosure Standards — The Commonwealth could consider taking appropriate steps so that AHPs are held to the same standards as other insurers in the market with regard to consumer disclosure and marketing materials. Clear and concise information at a reading level appropriate for consumers will ensure that residents are provided with the necessary information to make an informed choice. The information could also include disclosure as to whether the plan meets the Commonwealth's MCC requirements for purposes of satisfying the Commonwealth's health coverage mandate.

CONCLUSION

The potential introduction of AHPs to the Massachusetts market raises important considerations for the Commonwealth. As described above, these types of arrangements could undermine the considerable progress the Commonwealth has made in establishing a market for health coverage that promotes access to robust and comprehensive health insurance coverage, without regard to an individual's underlying health status; that limits risk segmentation and the ability of insurers to selectively choose members to enroll (i.e., cherry-pick) through the use of discriminatory rating practices; and that provides diverse and meaningful protections for consumers. In an effort to maintain its longstanding commitment to promoting access to health coverage, the Commonwealth could consider any or all of several measures, ranging from licensing enforcement to consumer disclosure standards, to protect consumers and employers from these potential impacts.

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