Association Health Plan (AHP) Legislation: Myths & Facts

Myth: Proposed AHP bills (S. 406/H.R. 525) will help the uninsured get health coverage.

Fact: S. 406 and H.R. 525 fail to provide meaningful help for nearly any of the 41 million Americans without health insurance. According to the Congressional Budget Office (CBO), only about 600,000 individuals, or less than one percent of the nation’s uninsured, would get new coverage under AHP legislation by the time it is fully implemented in 2008.1 Nearly all of the 7.5 million people who would be covered by AHPs would merely be switching from one type of coverage to another.2 In fact, the CBO estimates that the proposed AHP bills would actually drive up the cost of coverage for 20 million individuals – four out of five small business workers and their families who are now covered under employer-based health insurance plans.3 A study by Mercer Benefits Consulting found that AHPs could increase premiums for small businesses by as much as 23% and result in nearly one million individuals becoming uninsured.4 Instead of making new inroads in covering the uninsured, AHPs would merely “churn” the marketplace and could actually make coverage less affordable for the vast majority of small business workers who now have coverage. Covering substantial numbers of the uninsured should be the goal of any new legislation, and neither S. 406 nor H.R. 525 meets that goal.

Myth: AHP bills will help those who most need health coverage.

Fact: S. 406 and H.R. 525 could actually hurt those who most need health coverage by allowing AHPs to “cherry pick” only the healthiest, cheapest-to-insure individuals to participate in their plans. In order to keep costs low, AHPs would have an incentive to target the people who are the least costly to insure – healthy, young people who rarely access health services. By giving AHPs the power to charge higher premiums for less healthy groups and the discretion to offer narrower benefits, these bills will allow AHPs to deter less healthy groups from enrolling in the AHP. Older, disabled, chronically ill people and those who use more health care services would be marginalized – forced to pay more out-of-pocket or left behind altogether. Those left out of AHP coverage will likely see their premiums increase as the residual state-regulated health insurance market loses its

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3 Id., 15, 17.
healthy risks to AHPs Most states already prohibit this kind of health insurance discrimination, known as “cherry picking,” but AHPs would preempt these anti-discrimination measures in most states, allowing AHPs to discriminate against those who most need coverage.

**Myth: AHP bills would help women.**

**Fact: Women will lose under S. 406 and H.R. 525.** Women are disproportionately likely to own or work for the small firms that are most likely to offer AHPs. Nearly all the firms owned by women in 1997 were small, and most were very small firms with fewer than five employees. Women are also more likely to work for low-wage firms, about three-quarters of which are smaller firms. Women use more health care services than men and often need more expensive services. But under the proposals now pending in Congress, AHPs would likely offer women less generous benefits than are currently mandated by state laws. For example, many states now require insurers to cover maternity benefits, preventive screenings for breast and cervical cancer, mental health services, and contraceptive drugs and devices. Most of these state benefit mandates would be preempted under the proposed AHP bills, and AHPs would have a strong incentive to offer narrower benefits to trim costs. In the end, women would lose: women covered by AHPs would likely pay more out-of-pocket for needed services, and women left out of AHPs could see their premiums increase as they are left to get coverage from a state-regulated pool along with others who need access to more comprehensive coverage. Low-income and low-wage working women, many of whom are single mothers, would be at particular risk, since many lack the resources to purchase additional coverage or pay high out-of-pocket costs. Far from serving the interests of women small business owners and their women workers, S. 406 and H.R. 525 would put women at risk for higher costs or for losing insurance altogether.

**Myth: AHP bills will “level the playing field” between small and large employers.**

**Fact: S. 406 and H.R. 525 would create an uneven playing field by allowing AHPs to opt out of the rules that govern all other health insurers.** Proponents argue that small businesses need AHPs so they can enjoy the same advantages of pooling and preemption that bigger businesses now have under the Employee Retirement Income Security Act of 1974 (ERISA), the federal law that regulates private employer-sponsored health plans. But, rather than create a level playing field, these proposals would create a

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5 In 1997, 98% of the 847,000 women-owned businesses in the U.S. were small firms of fewer than 50 employees. U.S. Census Bureau, 1997 Economic Census: Women-Owned Business Enterprises, March 29, 2001, 167.

6 Lake Snell Perry & Associates, Low Wage Employers and Health Coverage: Findings from a National Survey, January 2003 (Unpublished), 5 (referring to research conducted by Jonathan Gruber, Professor of Economics at Massachusetts Institute of Technology, determining that 73% of employers with at least half of their workers earning $7 or less per hour have fewer than 25 employees.)

set of special rules that only apply to AHPs and give them advantages that neither ERISA nor other health plans now have. Under current law, all health insurers and the majority of employer-based health plans covered under ERISA are subject to state benefit mandates, external review laws and other state oversight and protections. By contrast, AHPs would be mostly exempt from these state requirements and protections; self-insured AHPs would be fully exempt from state regulations; and fully insured AHPs would be subject to limited state protections only in the state where the AHP chose to be licensed. Group health insurers and ERISA plans are also subject to rating restrictions that either limit or bar them from charging individuals more based on health-related factors. However, both S. 406 and H.R. 525 could discriminate against groups, charging them more if they are less healthy or more likely to use health care services. Far from “leveling the playing field,” AHPs would create grossly unfair competition between these new quasi-insurers and traditional health insurers or ERISA plans.

Myth: AHP bills will protect consumers against fraud.

Fact: S. 406 and H.R. 525 will undermine tough consumer protection laws and oversight in all 50 states. Currently, association health plan and insurance fraud, insolvencies, mismanagement, and misrepresentation are being held in check by the states, which now have direct oversight over AHPs and insurance companies. But these proposals would eliminate virtually all of these critical protections for AHPs and replace them with minimal federal protections and inadequate federal oversight under the Department of Labor. For self-insured AHPs, stringent state solvency standards that require associations to maintain surplus reserves adequate to cover the losses they insure and to report to state insurance departments annually would be replaced by weaker federal solvency requirements that would cap surplus reserves at $2 million, regardless of the AHPs’ size, and rely on the AHP’s own actuary to report any solvency problems to the Department of Labor. On-site financial audits and market conduct examinations now conducted by a staff of 10,000 in state insurance departments around the country would be replaced with a federal system that relied on self-reporting of violations and a staff of less than 1,000 to ensure compliance. Far from ensuring tough protections against fraud, these bills could actually exacerbate fraud and abuse in an arena where scams are already rampant. Association health plan fraud has been a national problem for decades, with abuses rising as economic times worsen. In 2003 alone, association health plan scams left over 55,000 workers and their families without health insurance and an estimated $65 million in unpaid medical claims.8 States play a critical role in protecting consumers against these scams and quickly stepping in to stem the tide of losses from insolvency and fraud, but these bills would undermine that role for most AHPs, leaving consumers at the mercy of scam artists and criminals with few protections and minimal assistance at the federal level.

8 Mila Kofman Letter to Senate Small Business Committee, March 5, 2003, 2.