Department of Legislative Services

Maryland General Assembly
2004 Session

FISCAL AND POLICY NOTE

House Bill 327 (Delegate Costa)
Health and Government Operations

Health Insurance - Association Health Benefit Plan

This bill requires an insurer, nonprofit health service plan, or HMO (carrier) to offer an association health benefit plan to specified associations.

Fiscal Summary

State Effect: The development of a standard benefit package for an association health benefit plan could be handled with existing Maryland Health Care Commission (MHCC) budgeted resources. Potential minimal special fund revenue increase for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee in FY 2005. The review of annual actuarial certifications could be handled with existing MIA budgeted resources.

Local Effect: None.

Small Business Effect: Potential minimal.

Analysis

Bill Summary: An association: (1) must have been actively in existence for at least five years; (2) must have been formed and maintained in good faith for purposes other than obtaining insurance; (3) must not condition membership on the purchase of association-sponsored insurance; (4) must not condition membership on any health status-related factor; (5) must make health insurance coverage available to all members regardless of any health status-related factor; (6) does not make health insurance coverage available other than in connection with membership in the association; (7) is organized and existing under the laws of the State; (8) must have more than 50 members or employ

more than 50 employees; and (9) must have an affiliation with a profession, industry, or trade, is a chamber of commerce, or is an association of nonprofit entities.

An association may offer the association health benefit plan only to a person that is licensed by or domiciled in the State; an employee, member, or active or retired partner, officer, director, or eligible employee; and their eligible dependents.

MHCC must adopt regulations that specify a uniform set of benefits for an association health benefit plan. MHCC may choose not to include State mandated health benefits or required services. The association health benefit plan must include a pharmacy discount card option and must have uniform deductibles and cost-sharing measures including specified copayments for certain services. A carrier may not limit coverage under the association health benefit plan for a preexisting condition other than those restrictions that may be placed on late enrollees.

A carrier must use a premium rating methodology that is based on the experience of all risks covered by that health benefit plan without regard to health status or occupation. A carrier may adjust the rate only for age, geography, and family composition. By March 15 of each year, a carrier must file an actuarial certification with the Insurance Commissioner.

Current Law: A group health insurance policy may be issued to an association, including a labor union, that has a constitution and bylaws and that is organized and maintained in good faith for purpose other than that of obtaining insurance.

Group health insurance benefit plans, unless they are self-funded, are subject to State insurance laws regarding mandated health benefits and required services.

Background: Association Health Plans (AHPs) have existed for decades, both nationwide and in Maryland. However, while the Employee Retirement Income Security Act of 1974 (ERISA) preempts state regulations for most corporate and union health plans, it does not preempt AHPs, a significant difference that has led to the relative extinction of AHPs. An AHP with members in more than one state would be subject to state insurance laws in each respective state, making these types of health benefit plans difficult to administer in a cost-effective manner. Consequently, as state regulations and mandates across the nation have proliferated in the last decade, AHPs have become increasingly difficult to operate. In 1990, there were more than 1,000 AHPs in the U.S. Currently, there are fewer than 200.

An association health benefit plan permits small businesses that belong to a qualified association to purchase health insurance at rates that are lower than those found in the

small group or individual health insurance markets due to the larger and more predictable risk pool.

The U.S. House of Representatives introduced legislation (H.R. 660 – Small Business Health Fairness Act of 2003) to amend ERISA to improve access and choice for entrepreneurs with small businesses with respect to medical care for their employees. The bill was passed by the House and referred to the Senate on June 20, 2003. No further action has been taken.

Comprehensive Standard Health Benefit Plan (CSHBP): CSHBP was established in 1994 as a result of health care reforms adopted by the General Assembly to provide better access to coverage in the small group market. CSHBP is a standard health benefit package (standard plan) that carriers must sell to small businesses (50 or fewer employees). CSHBP includes guaranteed issuance and renewal, adjusted community rating with rate bands, and the elimination of preexisting condition limitations. In order to maintain affordability, the average CSHBP premium rate per employee must remain below 10% of Maryland's average annual wage.

Multiple Employer Welfare Arrangements (MEWAs): MEWAs are multiple employer arrangements that are not maintained or established pursuant to a collective bargaining agreement and that offer health benefit coverage. In many cases, the coverage is offered to small employers that might not be able to obtain group insurance from commercial carriers.

Small Business Effect: In 2002, approximately 53,000 small businesses provided health insurance coverage to 448,000 covered lives in the small group market. Each policy carried an average 1.835 covered lives.

Small Business Health Insurance Costs: The bill's provisions permitting associations to purchase health insurance would allow an eligible small business to purchase a health benefit plan other than CSHBP. Some small businesses would be offered lower premium rates under an association health benefit plan than they could find in the small group market. To the extent small businesses leave the small group market, premiums in the small group market could increase.

Small Business Pharmacies: There are approximately 1,100 pharmacies in Maryland, one-quarter of which are small businesses. Under a pharmacy discount card option, pharmacies could be required to sell drugs to card holders at a loss. According to a Kaiser Family Foundation report, most discount drug card programs rely on discounts obtained from agreements with pharmacies rather than negotiated discounts or rebates with drug manufacturers.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): *Prescription Drug Discount Programs, Current Programs and Issues* (February 2002), Kaiser Family Foundation; Coalition Supporting Access & Choice through Association Health Plans; U.S. Library of Congress; Department of Health and Mental Hygiene (Maryland Health Care Commission); Maryland Insurance Administration; Department of Legislative Services

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