Department of Legislative Services
Maryland General Assembly
2005 Session

FISCAL AND POLICY NOTE

House Bill 52 (Delegate Boschert)
Health and Government Operations

Maryland Association Health Plan Act

This bill establishes an association health benefit plan that an association or consortium of associations may offer to an employee; member; active or retired partner, officer, or director, or eligible employee of a participating employer; and their eligible dependents.

Fiscal Summary

State Effect: Potential minimal special fund revenue increase for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee in FY 2006. 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: In order to offer an association health benefit plan, an association must: (1) have been actively in existence for at least three years; (2) have been formed and maintained in good faith for purposes other than obtaining insurance; (3) not condition membership on the purchase of association-sponsored insurance; (4) not condition membership on any health status-related factor; (5) make health insurance coverage available to all members regardless of any health status-related factor; (6) not make health insurance coverage available other than in connection with membership in the association; and (7) have an affiliation with a profession, industry, or trade; a chamber of commerce; or an association of nonprofit entities.

An association health benefit plan may exclude health benefits and reimbursements mandated by State law. The bill also prohibits denial of coverage or coverage limitations for certain preexisting conditions such as pregnancy, other than those restrictions that may be placed on certain late enrollees.

A health insurer, nonprofit health service plan, or HMO (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 and geography. A carrier may adjust rates based on family composition as approved by the Insurance Commissioner. 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 a purpose other than that of obtaining insurance.

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.

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.

Limited Benefit Plan (LBP): LBP was established in 2004 as an alternative to CSHBP for certain small businesses. It offers a minimal benefit package to small businesses that have not offered CSHBP to employees within the past 12 months and whose employees earn 75% or less of the State'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 2003, approximately 51,000 small businesses provided health insurance coverage to 452,000 covered lives in the small group market. Each policy carried an average 1.789 covered lives.

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

Additional Information

Prior Introductions: A similar bill, HB 327 of 2004, was reported unfavorably by the Health and Government Operations Committee.

Cross File: None.

Information Source(s): *Annual Review – Comprehensive Standard Health Benefit Plan, September 2004*, Maryland Health Care Commission; Maryland Insurance Administration; Kaiser Family Foundation; Coalition Supporting Access & Choice through Association Health Plans; U.S. Library of Congress; Department of Legislative Services

Fiscal Note History: First Reader - January 27, 2005
ncs/jr

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