

# Federal and State Policy Toward Association Health Plans in Oregon

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in case study states. Reports that have been prepared as part of this ongoing project can be found at [www.rwjf.org](http://www.rwjf.org) and [www.healthpolicycenter.org](http://www.healthpolicycenter.org). The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit [www.rwjf.org/coverage](http://www.rwjf.org/coverage).

## Summary

Before the Affordable Care Act (ACA), some state regulatory approaches created powerful incentives for health insurers to sell through associations to individuals and small employers, largely because they were exempt from key state consumer protections and requirements that would otherwise apply to health insurance sold in the individual and small-group markets. Some experts suggested these regulatory differences allowed for insurers to segment the market by separating healthier individuals and small groups from the less healthy, and provided an opportunity for insurers to offer lower premiums to those in better health status. In some states, many individual and small employers purchased health insurance coverage under associations referred to as Association Health Plans (AHPs). With the passage of the ACA, health insurance sold through an association to individuals and small employers must meet the same insurance standards of coverage sold in the individual and small-group market. There are, however, rare instances in which an association selling health

insurance meets criteria under the Employee Retirement Income Security Act (ERISA) and is referred to as an "ERISA bona fide group or association of employers."<sup>1</sup> In this limited circumstance, the health insurance is treated as a single large-group health plan under ERISA and is not required to meet the ACA protections for small-group markets. Though many believed that the newly level playing field created by the ACA would effectively eliminate the incentive to market and sell health insurance through associations, this paper finds that associations in Oregon offering health insurance are claiming single large-group health plan status under ERISA, thus sidestepping the requirements under the ACA for the small-group market. Through interviews with state regulatory officials, health benefit consultants, association representatives and insurers, this paper examines the experience of the AHP market in Oregon, a state that had a sizeable AHP market before the ACA. We find that the AHP market continues to exist for small employers in Oregon and may be positioned for growth.

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## Introduction

Before the ACA, millions of individuals and small employers bought health insurance through associations, called Association Health Plans (AHPs). Associations, such as professional or trade associations, were often created to further common economic or policy

interests and incidentally offered AHPs as a benefit to their members. Other associations, however, were created solely as a way to market and to sell health insurance.<sup>2</sup>

Some states recognized AHPs as a separate insurance market or part of the state's large-group market and regulated AHPs under regulatory standards distinct from health insurance in the individual and small-group market.<sup>3</sup> Sometimes the standards that applied to AHPs were different than standards in the individual and small-group markets, such as in the areas of underwriting requirements, rate restrictions, portability protections, benefit mandates and rate review and form review requirements.<sup>4</sup> Often these regulatory differences served as powerful incentives for insurers to sell AHP coverage, and they led to a sizable AHP market in some states.<sup>5</sup>

For example, Oregon enacted legislation in 2007 that exempted AHPs from its small employer market rules, including restrictions on rating under certain circumstances.<sup>6</sup> In 2011, there were 23 small employer AHPs covering 10 percent (approximately 35,000 small employer members) of the total small-group market.<sup>7</sup> Other states with similar regulatory exceptions reported large percentages of the individual or small-group market being sold through AHPs.<sup>8</sup> For example, in 2011 more people in Washington received coverage through associations (over 485,000) than in the individual and small-group markets combined (over 472,000).<sup>9</sup>

Under federal law, association coverage does not exist as a distinct category of health insurance, and the general rule is that health insurance policies sold through an association to individual and small employers are regulated under the same federal standards that apply to the individual or small-group market.<sup>10</sup> These standards include guaranteed access to coverage; restrictions on the use of health status, gender and other factors when setting premium rates; coverage of a minimum set of essential health benefits; policies that meet four actuarial value tiers; and a review of rate increases. In addition, insurers are required to maintain one risk pool for each market when setting premiums in the individual and small-group market as well as participate in the ACA's risk and market stabilization programs.<sup>11</sup> These standards and programs were put in place to increase the sharing of health care risk across the individual and small-group markets, thus increasing access and affordability for individuals and small employers with higher-than-average costs.

One important but limited exception applies when an association meets a federal standard for being a "bona fide group or association of employers" under the Employee Retirement Income Security Act (ERISA)

(referred hereafter as "ERISA bona fide") and its health coverage is treated as a single group health plan under ERISA.<sup>12</sup> Federal guidance states that this occurs in the "rare instance" where the association of employers is deemed the "employer," and is treated as sponsoring a single group health plan.<sup>13</sup> Under federal law, health coverage under such a situation would be regulated under the standards applicable to the large-group market if there are 51 or more employees of the employers participating in the association claiming "ERISA bona fide" status.<sup>14</sup> In this case, most of the federal market reforms that apply to the small-group market, such as guaranteed issue, would not apply.<sup>15</sup> See Table 1. Associations with individual members generally cannot meet "ERISA bona fide" status because individual members are not employers.<sup>16</sup>

The United States Department of Labor, which has oversight responsibilities over ERISA group plans, may determine upon request whether an association meets criteria to qualify its health plan as a single large-group health plan under ERISA. In general, for an AHP to be treated as a single large-group health plan under ERISA, an association must be a group of employers bound together by a commonality of interest (outside of providing a health plan) with vested control of the association to such an extent that they effectively operate as one employer.<sup>17</sup> This is considered a "difficult standard for most associations to meet"<sup>18</sup> and federal guidance states associations can meet this standard in "rare instances."<sup>19</sup>

Because of the ACA, this exception had little significance because of the lack of federal requirements in the small-group market. Given that the ACA now imposes certain rating and benefit standards and rate review requirements (among others) for the small-group market that are not imposed on the large-group market, an association consisting of small employers has a significant incentive to claim its health coverage as a single large-group health plan under ERISA and be regulated as such under federal law.

Some experts have raised concerns about this incentive and the potential for adverse selection and increased premiums when different regulatory frameworks exist for the same type of health plan purchaser.<sup>20</sup> Because health insurers are generally allowed to adjust premiums based on health status and other permissible factors that apply to the large-group market, small employers with younger, healthier employees may find more competitive

**Table 1. Selective Affordable Care Act Insurance Reforms Effective January 1, 2014**

Market Reform	Description	Applicability to a Small-Employer Purchaser	
		Small-group market	“ERISA bona fide group or association of employers” (sponsoring a single large-group health plan under ERISA)
Guaranteed Issue	Required to accept any small employer who applies for coverage.	Yes	No <sup>a</sup>
Ban on Preexisting Exclusion Periods	Prohibits insurers from imposing preexisting condition exclusions.	Yes	Yes
Essential Health Benefits	Requires coverage of specified benefits defined in the law. <sup>21</sup>	Yes	No
Actuarial Value	Requires insurers to cover at least 60 percent of total costs under each plan; requires plans to meet one of four actuarial-value tiers (bronze, silver, gold, or platinum) as a measure of how the share of costs for covered benefits reimbursed by the plan, on average.	Yes	No
Rating Rules	Requires insurers to vary rates based solely on four factors: family composition, geographic area, age and tobacco use; prohibits insurers from charging an older adult more than three times the rate of a younger person; prohibits insurers from charging tobacco users more than one and a half times the rate of a non-tobacco user.	Yes	No
Single Risk Pool	In setting premiums, requires each insurer to treat all small-group market coverage sold as a single risk pool.	Yes	No
Risk Adjustment	Program that redirects funds from insurers with low-risk participants to insurers with higher-risk participants.	Yes	No
Rate Review	Requires review of proposed increases in health insurance premiums and determine whether such rate increases are reasonable.	Yes	No

<sup>a</sup> Oregon prohibits insurers offering group health plans to associations to decline coverage to any eligible member. Oregon Admin. Rule 836-053-0230.

premiums under health plans regulated under large-group rules.<sup>22</sup> If this was the case, small employer groups with higher risk profiles may have less incentive to purchase AHPs because they would be exposed to higher premiums and larger rate increases and would likely have difficulty finding an AHP providing coverage for essential health benefits. Over time, if healthy groups gravitate toward health insurance coverage through an association claiming that its coverage is regulated under large-group market rules; this could subsequently lead to market segmentation and adverse selection in the plans sold through the small-group market, including the small-group marketplaces.

Further, health insurers could have incentives to sell plans only through associations claiming “ERISA bona fide” status because the market is more profitable,

allowing insurers to exclude high-cost groups or charge them substantially higher premiums. A similar scenario occurred in Kentucky in the mid-1990s, when the state passed comprehensive health reform including requirements for community rating and standardized benefits in the individual market. However, AHPs were exempted from these requirements, which led to a mass exodus of insurers from the non-AHP market; only two insurers, of the approximately 23 that had been active in the individual market before reform, continued to sell new individual policies outside of the AHP market.<sup>23</sup> One scholar noted that “the association exemption provided a haven for healthy risks in the associations.”<sup>24</sup>

To understand the effect of ACA implementation on the AHP market, we conducted a case study of the AHP market in Oregon, a state in which a sizeable

AHP market existed before the ACA. We conducted in-depth interviews with state regulators and AHP market stakeholders such as health benefit consultants, associations and insurers that participate in Oregon's AHP market. We considered the AHP market before the ACA, changes in how Oregon regulates the AHP market

and whether the AHP market merged into the small-group market, as some experts assumed it would after the ACA was enacted. Lastly, we discuss the future of the AHP market in Oregon now that the ACA market rules are in place.

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## Observations from Oregon

### **Before the ACA, state regulators closely monitored AHPs exempt from Oregon's small-group market rules**

Before the ACA and under Oregon law, AHP coverage was considered group coverage whether it was sold to an individual or a small employer member of an association.<sup>25</sup> Oregon law exempted AHP coverage from the standards that otherwise applied to the small-group market as long as the AHP met certain requirements. Association coverage was exempted from standards such as rating rules that significantly limited premium adjustments based on health status and other factors.<sup>26</sup> To qualify for an exemption, the association had to have been in existence for at least one year and not be organized solely to market health insurance. Insurers were required to submit the by-laws, constitution, and other documentation related to the association when filing for health coverage to be sold to an association.<sup>27</sup>

State regulators closely monitored the status of associations that offered health coverage. Before enactment of the ACA, the state reported between 22 and 26 state-based, small employer associations whose total number varied by year. Most respondents noted that membership in these associations was, for the most part, focused on small employer members of a single industry or trade, such as construction services, and not set up by an insurer "just to sell health insurance." However, many respondents noted that some associations have membership consisting of individuals from multiple industries or trades or including individuals that maintained only a loose affiliation to the association's primary industry of focus, such as industry consultants, legal advisors or others.

### **Oregon eliminated the AHP exemption from the state's small-group market rules, but associations can still claim status under ERISA and have a single large-group plan**

Oregon eliminated the exemption of AHP coverage from the state's small-group market reforms, including the state's rating restrictions, effective in 2014.<sup>28</sup>

In addition, the Oregon Insurance Division (OID) issued guidance explaining that health insurance sold through an association to an individual or small employer must comply with the applicable standards under the ACA that apply to that market except in the "limited circumstances" that an association is considered a "true large-group as defined in federal law" (i.e., ERISA).<sup>29</sup> However, in the same guidance, OID stated that it would not engage in an up-front certification process to determine whether or not an association "qualifies as a true large-group" under ERISA "given the legal complexity and fact-specific nature involved with such an analysis and determination."<sup>30</sup> Instead, OID recommended that insurers or associations interested in "verifying large-group status under ERISA" contact the U.S. Department of Labor. State regulators indicated that the authority to determine whether or not health coverage through an association qualified for ERISA large-group coverage rests with the U.S. Department of Labor, and because it did not have the authority to make such a determination, doubted that any state decision would "carry any weight" in this area.

Oregon does not require that insurers obtain from an association a Department of Labor determination that its health coverage can be treated as a single large-group health plan under ERISA before issuing large-group coverage to an association. Instead, because OID's authority extends to the insurer and not the association, OID requires insurers to attest that the association meets "ERISA bona fide" status before the issuer provides a large-group plan to that association.<sup>31</sup> Some respondents questioned OID's reliance on an attestation, but state regulators pointed out its plan to closely monitor insurer compliance with the law and subject outliers to further scrutiny.<sup>32</sup> State regulators noted that an insurer found to be making a false attestation faces "serious

administrative penalties.” Respondents indicated that Oregon’s approach contrasts with the approach of other states, such as Nevada and Montana, which require a determination from the Department of Labor that the association meets “ERISA bona fide” status *before* an issuer can provide a large-group policy to an association.

Overall, most respondents dismissed the practicality of getting an official advisory opinion from the Department of Labor that an association meets “ERISA bona fide” status so that its health coverage qualifies for large-group status under ERISA. One insurer noted “getting an opinion out of the Department of Labor could take a year or more, and we didn’t have time for that.” Indeed, state officials recognized this timing issue and noted that it contributed to OID’s decision to accept from an insurer an attestation that an association meets “ERISA bona fide” status instead of requiring an upfront determination from the Department of Labor. One state regulator pointed out that the alternative option—requiring associations to go through the Department of Labor determination process—had the potential of “leaving significant numbers of consumers [association members] in a lurch and disrupting markets further.” Consequently, most insurers have simply asked the association to produce a legal opinion that it meets the criteria for “ERISA bona fide” status, allowing the insurer to provide a single large-group health plan.

### **Respondents report many existing associations are claiming to qualify under ERISA and obtaining large-group coverage, sidestepping ACA market reforms for the small-group market**

As noted above, depending on the year, 22 to 26 small employer associations offered AHP coverage before the ACA in Oregon. Respondents suggested that many (if not most) of these associations are now claiming “ERISA bona fide” status, effectively making their health coverage a single large-group plan under ERISA and thus not subject to the ACA requirements for the small-group market. Most, if not all, of these associations had been established before the ACA and had been offering health coverage as a benefit to their members. Respondents indicated that these associations are planning to continue offering AHP coverage to small employer members.

Under Oregon’s framework, the self-attestation has led to insurers and associations working together to pursue “ERISA bona fide” status. According to one insurer, “we put [the ERISA status determination] back on [the]

association, but we give them guidance on steps they need to pursue to become a bona fide association.” Although all insurers we contacted asked the association to provide a legal opinion supporting its status as “ERISA bona fide,” insurers’ approaches varied. Some insurers simply required the association to provide an independent legal opinion; others required more support for the association’s “ERISA bona fide” status claim. One insurer stated, “it is supposed to be a hard test but everyone thinks they’re bona fide [under ERISA].” According to respondents, one particular Chamber of Commerce association had previously requested an advisory opinion from the Department of Labor. They noted that the Department of Labor found that the chamber did not meet the factors for “ERISA bona fide” status because it was made up of various industry employers. Respondents indicated that the chamber subsequently reorganized into multiple industry-specific associations that are now each claiming “ERISA bona fide” status.

Although it was noted that OID has authority only over insurers, one insurer pointed out the difficulty of requiring the insurer to attest that an association qualifies for a large-group plan under ERISA, stating insurers are then in the position of “telling [their] own customer that they can’t have what they want,” especially when “they could walk across the street and find an [insurer] that is more accommodating.” However, as noted above, state regulators indicate that insurers will be kept from making false attestations through monitoring insurer compliance with the law, further scrutinizing outliers and the levying the possibility of “serious administrative actions.”

### **Small employers buying health insurance coverage through associations claiming ERISA status are missing out on important ACA protections**

In Oregon, many respondents noted that part of the motivation for associations to seek health coverage as a large-group under ERISA is to avoid the small-group market reforms required under the ACA, specifically the rating reforms and essential health benefits requirements. In addition, state regulators pointed out that the large-group rates are not subject to state review and approval. One respondent made clear that seeking large-group coverage is mostly about “avoiding fully adopting small-group reforms of the ACA.”

Though associations in Oregon are claiming “ERISA bona fide” status so that their health coverage is treated as a single large-group, it appears that each small employer

member is still treated separately for premium setting. For example, although it was stated that health status was not used to set initial premiums, insurers noted that they consider the specific claims experiences of a small employer member group in setting rates at renewal. This practice is not permissible under the rating rules of the ACA for the small-group market, and because large-group rates are not subject to rate review or approval under Oregon law, the accompanying rates are not reviewed or approved by state regulators. In addition, insurers reported using a full range of other factors to set initial and renewal premiums for health coverage of each small employer member in an association claiming “ERISA bona fide” status. Some factors, such as gender and industry, similar to health status, would otherwise not be permitted in setting premiums for a small employer under the ACA. Other factors, such as age and geography, are also being used to set rates and at ranges well beyond the limits permitted by the ACA for small groups. For example, whereas under the ACA, an individual within a small employer group could only be rated up on a 3:1 ratio for age, one insurer told researchers they were setting premiums for each individual within a small employer of an association claiming “ERISA bona fide” status on a 4:1 or 4.5:1 age ratio. Another respondent, a health benefits advisor to an association, suggested that insurers could go even higher on rating-up based on age and pointed out an association where the insurer considered 8:1 age bands when setting rates for each small employer member. As one insurer noted, exemption from the ACA market rules allowed associations to offer some small employers “more competitive rates than the overall small-group market pool.”

In addition, respondents also told us that some associations are taking advantage of their self-attesting status as “ERISA bona fide” to design benefit plans that are responsive to their employees and not constrained by the essential health benefits requirement of the small-group market, such as by not offering pediatric dental or vision.

### **With the current regulatory approach, some predict a growth in the Oregon AHP market, especially after 2016**

When asked about the future of AHPs in Oregon, industry respondents agreed they would likely continue given that associations could attest to meeting “ERISA bona fide” status and obtain single large-group coverage. Respondents, however, projected different amounts of growth. One respondent projected that the growth of AHPs would depend on how competitive these health plans could be compared to the overall market. The same respondent, however, stated that AHPs had the potential for growth because insurers already providing AHPs had a year of ACA experience behind them and they were more comfortable partnering with associations to formulate new AHPs. Another respondent predicted growth because no restrictions on rating apply to AHPs and the “value proposition” of the rating model gives AHPs a competitive edge compared to small-group plans under ACA rating restrictions, particularly with healthy small groups.

One respondent noted that in 2016, when the definition of “small group” expands to include businesses with 51 to 100 employees, these mid-size employers may look to associations as an alternative to either purchasing health insurance coverage that meets the small-group market requirements for health plans or self-insuring. Because groups in the 51 to 100 size category are currently considered large-groups and insurers apply experience-rating to them, healthier and younger groups may face increased premiums once they are recategorized under the ACA's rating for small groups in 2016. The same respondent noted these employers (51 to 100 employees) “won't take a rate hit in an AHP.”

Lastly, some respondents noted that associations claiming “ERSIA bona fide” status is not unique to Oregon and suggested that associations in other states, such as Washington, were pursuing similar avenues in order to escape the ACA's small-group market reforms.

## Conclusion

In-depth telephone interviews with state regulatory officials and AHP stakeholders, such as health benefit consultants, representatives of associations and insurers that participate in the AHP market revealed that small employers in Oregon continue to have access to an AHP market that is similar to the one that existed before the ACA. With minimal upfront regulatory oversight at the state and federal level, respondents report many of the associations that offered AHP coverage before the ACA in Oregon are now claiming “ERISA bona fide” status so that its AHP is treated as single large-group coverage. Under federal law, coverage sold to a small employer member of an association claiming “ERISA bona fide” status is not required to meet the ACA standards applicable to the small-group market, such as guaranteed issue, modified community rating, coverage of essential health benefits, specified actuarial-value requirements (i.e. metal levels) and many other standards. This trend appears to be occurring despite federal guidance noting that it is in the “rare instance” that an association of employers is sponsoring a large-group health plan because it meets “ERISA bona fide” status.

After years of regulatory uncertainty related to AHPs, there appears to be growing confidence among AHP stakeholders in Oregon that the AHP market has the potential to expand in the upcoming years, especially after 2016, when the definition of small employer

expands from groups of 50 or fewer employees to groups as large as 100 employees. Though respondents noted the potential for abuse, the number of associations claiming “ERISA bona fide” status may very well depend on how closely Oregon continues to monitor this market. And though Oregon has taken one approach, other states require an up-front determination from the Department of Labor that an association meets “ERISA bona fide” status before its health coverage can be treated as a large-group plan under ERISA.

The exemption for policies under an association claiming “ERISA bona fide” status and the lack of upfront regulatory oversight at the state and federal level has created the potential for adverse selection in the remaining small-group market in Oregon. If the AHP market expands in future years, there is the possibility of increased market segmentation by health status relative to the more unified market conceptualized by federal law designers. To avoid the long-term consequences of this scenario, states may be looking to the U.S. Department of Labor for a collaborative, streamlined process to more readily assess whether or not associations claiming “ERISA bona fide” status actually meet standards under federal law that allow them to be treated as a single large-group plan thus avoiding the ACA requirements for the small-group market.



# ENDNOTES

1. Employee Benefits Security Administration. *Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation*. Washington: U.S. Department of Labor, 2013. <http://www.dol.gov/ebsa/Publications/mewas.html> (accessed September 2014). Note that status as a “bona fide group or association of employers” under ERISA is distinct from a “bona fide association” under HIPAA. For a full analysis of the regulation of health insurance sold through associations under federal law, see Jost T. “Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them.” *Saint Louis University Journal of Health Law & Policy* 27(5), 2011.
2. Kofman M, Lucia K, Bangit E and Pollitz K. “Association Health Plans: What’s All the Fuss About?” *Health Affairs* 26(6): 1591–1602, 2006; Kofman M, Lucia K, Bangit E and Pollitz K. “Association Health Insurance: Is it Time to Regulate This Product?” *Journal of Insurance Regulation* 24(1), 2005; Hall M. “The Geography of Health Insurance Regulation.” *Health Affairs* 19(2): 173–184, 2000.
3. Kofman M, Lucia K, Bangit E, and Pollitz K. “Association Health Plans: What’s All the Fuss About?” Kofman M, Lucia K, Bangit E, and Pollitz K. “Association Health Insurance: Is it Time to Regulate This Product?” Hall M. “The Geography of Insurance Regulation.”
4. Kofman M, Lucia K, Bangit E, and Pollitz K. “Association Health Plans: What’s All the Fuss About?” Kofman M, Lucia K, Bangit E, and Pollitz K. “Association Health Insurance: Is it Time to Regulate This Product?” Hall M. “The Geography of Insurance Regulation.”
5. Kofman M, Lucia K, Bangit E, and Pollitz K. “Association Health Plans: What’s All the Fuss About?” Kofman M, Lucia K, Bangit E, and Pollitz K. “Association Health Insurance: Is it Time to Regulate This Product?” Hall M. “The Geography of Insurance Regulation.” See also National Association of Insurance Commissioners, “Rate Review Comment Letter on Associations and Survey Responses,” July 20, 2011, [http://www.naic.org/documents/committees\\_b\\_rate\\_review\\_reg\\_comments\\_associations.pdf](http://www.naic.org/documents/committees_b_rate_review_reg_comments_associations.pdf); and “Rate Review Regulation State Survey Responses.” National Association of Insurance Commissioners, [http://www.naic.org/documents/committees\\_b\\_rate\\_review\\_reg\\_state\\_surveys.pdf](http://www.naic.org/documents/committees_b_rate_review_reg_state_surveys.pdf) (accessed September 2014).
6. Oregon HB 3321 (2007).
7. Department of Consumer and Business Services. *Report of the Department of Consumer and Business Services on House Bill 3321*. Oregon Department of Business and Consumer Services, 2007, [http://www.oregon.gov/DCBS/insurance/legal/legislation/Documents/Reports/2013-ins\\_legislation-reports\\_hb3321.pdf](http://www.oregon.gov/DCBS/insurance/legal/legislation/Documents/Reports/2013-ins_legislation-reports_hb3321.pdf) (accessed September 2014). See also Wakely Consulting Group. *Actuarial Analysis: Impact of the Affordable Care Act (ACA) on Small Group and Individual Market Premiums in Oregon, Prepared for the State of Oregon*. Salem, Oregon: The State of Oregon, 2012, [http://www.wakely.com/wp-content/uploads/2012/10/OR\\_ACA\\_Market\\_Premium\\_Impact\\_wletter\\_20120731.pdf](http://www.wakely.com/wp-content/uploads/2012/10/OR_ACA_Market_Premium_Impact_wletter_20120731.pdf) (accessed September 2014).
8. National Association of Insurance Commissioners, “Rate Review Comment Letter on Associations and Survey Responses,” and National Association of Insurance Commissioners, “Rate Review Regulation State Survey Responses.” Also consider the AHP experience in Washington State. Beginning in 1995, Washington has exempted AHPs from rate restrictions that otherwise apply to these markets. Since then, there has been a steady growth in the number of individual and small employers purchasing health insurance through associations, with the Department of Insurance in Washington reporting a greater concentration of healthy risk in AHPs. In 2010, approximately 35 percent of insured residents were enrolled in AHP. See Chollet, Nysenbaum, Barrett, et. al. Association Health Plans and Community-Rated Small Group Health Insurance in Washington State Final Report. Mathematica Policy Research, 2011, <http://www.mathematica-mpr.com/our-publications-and-findings/publications/association-health-plans-and-community-rated-small-group-health-insurance-in-washington-state> (accessed September 2014).
9. National Association of Insurance Commissioners, “Rate Review Comment Letter on Associations and Survey Responses,” and National Association of Insurance Commissioners, “Rate Review Regulation State Survey Responses.”
10. Cohen G. *Insurance Standard Bulletin Series-Information: Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage is Sold to, or through, Associations*. Baltimore: Centers for Medicare and Medicaid Services, 2011, [https://www.cms.gov/CCIIO/Resources/Files/Downloads/association\\_coverage\\_9\\_1\\_2011.pdf](https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf) (accessed September 2014).
11. Issuers must have single risk pools for each of the individual and small-group markets, or a single merged risk pool, if a state so elects, which will include all individuals enrolled in nongrandfathered plans in the applicable market (the single risk-pool requirement). HHS, Final Rule, Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 78 Fed. Reg. 13406, 13431 (Feb. 27, 2013).
12. Status as a “bona fide group or association of employers” under ERISA is distinct from a “bona fide association” under HIPAA. For a full analysis of the regulation of health insurance sold through associations under federal law, see Jost T. “Loopholes in the Affordable Care Act.”
13. Cohen G. *Insurance Standard Bulletin Series-Information*.
14. Under the ACA, a large-group will be defined as 101 employees or more in 2016 and after. Sec. 1304 of The Patient Protection and Affordable Care Act (codified at 42 U.S.C. § 18024).
15. Federal law and guidance provides that states can “apply and enforce their State insurance laws with respect to the plan to the extent provided by ERISA Section 514(b)(6)(A)” to ERISA plans that are multiple employer welfare arrangements (MEWAs). U.S. Department of Labor, See Employee Benefits Security Administration. *Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation*, rev. August 2013, available at <http://www.dol.gov/ebsa/Publications/mewas.html>.
16. Employee Benefits Security Administration. *Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act*.
17. The U.S. Department of Labor provides the following factors it considered when determining whether an association is bona fide under ERISA: the manner in which members are solicited; eligibility to participate and actual participations, the process by which the association was formed and for what purpose, and whether there were pre-existing relationships among the members; the scope of power, rights, and privileges of employer members; the identify of parties who control and direct activities of the association and health plan; and the level of direct or indirect control that employers have over the health plan. See Employee Benefits Security Administration. *Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act*.
18. Oregon Insurance Division. “Oregon Insurance Division Bulletin Ins 2013-3.” Oregon Dept. of Consumer and Business Services, <http://www.oregon.gov/DCBS/insurance/legal/bulletins/Documents/bulletin2013-03.pdf> (accessed September 2014).
19. Cohen G. *Insurance Standard Bulletin Series-Information*.
20. Jost T, *Implementing Health Reform: Association Health Plans*,

Health Affairs Blog, September 1, 2011, <http://healthaffairs.org/blog/2011/09/01/implementing-health-reform-association-health-plans/> (accessed September 2014).

21. Under the ACA, policies sold in the individual and small-group market must include the following 10 categories of defined benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. 45 C.F.R. § 147.150.
22. When adjusting premiums, large-group issuers must comply with nondiscrimination and wellness program requirements under HIPAA (as amended under the ACA). See 42 U.S.C. § 300gg-4, 45 C.F.R. § 146.121.
23. Kirk A. "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts." *Journal of Health Politics, Policy and Law* 25 (1), 2000.
24. *ibid.*
25. Oregon Insurance Division. "Oregon Insurance Division Bulletin Ins 2013-3."
26. Along with the exemption for AHPs from the small-group market rules, Oregon House Bill 3321 also included many requirements to prevent the segmentation of risk between the AHP market and the traditional small-group market. To get the exemption, an AHP was not allowed to use health status as a determining factor for membership and had to maintain a 95 percent retention rate. In other words, in an attempt to avoid adverse selection against the fully insured small-group market, AHPs could generally not lose more than 5 percent of its member employer groups. In 2010, the state legislature revised state law to allow the Oregon Insurance Division to grant a waiver of the 95 percent rate requirement and, in subsequent years, many associations requested and received a waiver from the retention rules. For example, in 2012, 10 of 26 associations failed to meet the retention requirements. Of those 10, eight requested and received waivers. See Department of Consumer and Business Services. *Report of the Department of Consumer and Business Services on House Bill 3321*.
27. Oregon Rev. Stat. § 731.987. See also Oregon Insurance Division. "Transmittal and Standards Form for Group Health Coverage to be Issued to an Association, Union Trust, Trust Group or Credit Union." Form 440-2441A (11/11/INS). Oregon Department of Consumer and Business Services (undated).
28. Oregon Insurance Division. "Oregon Insurance Division Bulletin Ins 2013-3."
29. *ibid.*
30. *ibid.*
31. *ibid.* See also Oregon Insurance Division. *ACA Policy, Form, Plan and Rate Development Questions, Answers and Clarification*. Oregon Department of Consumer and Business Services, revised May 5, 2014, <http://www.oregon.gov/DCBS/insurance/insurers/other/Documents/regulatory-guidance/questions-answers-clarifications.pdf> (accessed September 2014).
32. Oregon Insurance Division. "Oregon Insurance Division Bulletin Ins 2013-3." and Oregon Insurance Division. "Transmittal and Standards Form for Group Health Coverage."

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