North Carolina Center for Nonprofits
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Comparison of House and Senate Association Health Plan Legislation

Revised: August 9, 2019

Issue	Original Senate bill (S.86)	House bill (H.B. 464)	Legislative compromise (S.86)	Nonprofit considerations
Associations that can offer plans	• Must be nonprofit having operated for at least two years with at least one substantial business purpose unrelated to offering health insurance. • All members of the association must be in the same trade, industry, line of business, or profession (note: nonprofits would meet this test) OR be located in the same region or metropolitan area (even if they employers are different types of businesses/nonprofits). • All board members must represent member employers unless approved by the NC Department of Insurance. • The governing board must be elected by the association's members.	• Must be nonprofit having operated for at least five years with at least one substantial business purpose unrelated to offering health insurance.. • All members of the association must be in the same trade, industry, line of business, or profession (note: nonprofits would meet this test) OR the organization must be a statewide association of North Carolina-based employers (*i.e.* a local or regional group). • Board members must represent member employers.	• Must be nonprofit having operated for at least three years with at least one substantial business purpose unrelated to offering health insurance. • All members of the association must be in the same trade, industry, line of business, or profession (note: nonprofits would meet this test) OR the organization must be a statewide association of North Carolina-based employers (*i.e.* a local or regional group). • At least one board member must represent a member employer.	• By allowing for regional plans for employers without a commonality of interest, the original Senate plan may have create a system with association health plans in large metropolitan areas without options for nonprofits (or businesses) in other parts of the state. • The board provisions in the final legislative compromise would prevent potential nonprofit governance and fiduciary duty issues that could have arisen in the two original plans.
Minimum number of participants in association health plan	• 500 participants.	• 500 participants.	• 500 participants.	• Nonprofit associations will need to have at least 500 covered individuals to offer an association health plan. From a practical perspective,

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				this is need to form a viable plan.
Types of members allowed	• Businesses and nonprofits with one or more employees can be members. • Sole proprietors and self-employed individuals can also be members.	• Businesses and nonprofits with one or more employees can be members. • Sole proprietors can also be members.	• Businesses and nonprofits with one or more employees can be members. • Sole proprietors can also be members.	• Potentially, this could create more health insurance options for small nonprofits, including those with a single employee.
Solvency requirements	• Plans must cover at least 500 participants and association must have been in existence for at least two years.	• Plans must cover at least 500 participants and association must have been in existence for at least five years. • Plans must have provisions to prevent members from terminating coverage early. • Plans must maintain have financial and other resources in place to ensure solvency.	• Plans must cover at least 500 participants and association must have been in existence for at least three years. • Plans must have provisions to prevent members from terminating coverage early. • Plans must maintain have financial and other resources in place to ensure solvency.	• These requirements should help assure nonprofits that any AHP they may join will remain in place during the term of their health coverage.
Membership commitment	• None.	• Association members must commit to remaining association members and AHP participants for two years.	• Association members must commit to remaining association members and AHP participants for at least 12 months.	• Nonprofits considering joining AHPs should be aware that they are committed for at least 12 months.
Nondiscrimination requirements	• None.	• Plans may not discriminate based on health status, medical condition (physical or mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or preexisting conditions. • Plans may make rate distinctions among members based on other factors.	• Plans may not discriminate based on health status, medical condition (physical or mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or preexisting conditions. • Plans may make rate distinctions among members based on other factors.	• While the nondiscrimination provisions in the final version are an improvement, it is still possible that some AHPs could charge much higher rates to some nonprofits based on other factors related to their workforce or location.
Minimum coverage requirements	• None.	• Plans must provide coverage for hospital and physician services. • Plans must provide a level of coverage equal to or greater than 60% of the actuarial	• Plans must provide coverage for hospital and physician services. • Plans must provide a level of coverage equal to or greater than 60% of the actuarial	• The original Senate bill would have allowed for very skimpy plans with minimal levels of health coverage.

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		value of allowed costs for covered benefits. • Plans are required to provide the 10 essential health benefits that apply to Affordable Care Act (ACA) compliant health plans. These include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventative and wellness services/chronic disease management, and pediatric services (including oral and vision care).	value of allowed costs for covered benefits. • Plans are ***not*** required to provide the 10 essential health benefits that apply to Affordable Care Act compliant health plans.	• While the final version has some minimal coverage requirements, there are concerns that some AHPs won't offer some of the ACA's essential health benefits, like maternal care, mental health care, or prescription drugs, which could significantly increase out-of-pocket expenses for individuals covered by these plans.

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