AMERICAN ACADEMY *of* ACTUARIES

April 9, 2002

The Honorable J. Dennis Hastert
Speaker of the House
U. S. House of Representatives
H-232 Capitol Building
Washington, DC 20515

Dear Speaker Hastert:

This letter presents the comments of the American Academy of Actuaries'[1] Association Health Plan Work Group (work group) regarding the association health plan (AHP) provisions in Title IV, Subtitle B of the Bipartisan Patient Protection Act (H.R. 2563). As you know, H.R. 2563 would amend the Employee Retirement Income Security Act of 1974 to establish a new "Part 8—Rules Governing Association Health Plans."

These provisions are designed to expand access to affordable health insurance by promoting the use of AHPs. We support efforts to increase the availability, affordability, and access to health insurance. However, as currently written, the AHP language in H.R. 2563 may have unintended negative consequences that would hinder the intent of this legislation.

Summary of Concerns
We note that AHPs can be a viable option to expand access to health insurance. However, the dangers of market segmentation, AHP insolvencies, and avoidance of state and federal market protections are of major concern.

Market segmentation arising from the proposal's implicit incentives for AHPs to select healthy groups could destabilize existing small-group insurance markets in the states. The ability of an AHP to locate in a favorable regulatory jurisdiction could undermine small-group reform laws in other states. Unfortunately, the solvency requirements of the legislation do not increase with AHP growth or medical inflation to protect against solvency risk.

Finally, the AHP provisions of H.R. 2563 create confusion as to which governmental authority, the U.S. Department of Labor (DOL) or state insurance departments, has regulatory responsibility as the "applicable authority" for a particular AHP.

Changes to the AHP language that address the above concerns will allow AHPs to exist in the marketplace without disrupting the current state-based system, thereby creating a new option to expand access to health insurance.

[1] The Academy is the public policy organization for actuaries of all specialties within the United States. In addition to setting qualification and practice standards, a major purpose of the Academy is to act as the public information organization for the profession. The Academy is nonpartisan and assists the public policy process through the presentation of objective analysis. The Academy regularly prepares comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice, and the Code of Professional Conduct for all actuaries practicing in the United States.

Issues Contributing to Increased Market Segmentation in the Small-Group Market

H.R. 2563 contemplates that affordable rates for AHPs will result from volume discounts and increased market clout for the small employers that insure through them. As long as this is true and the small groups that AHPs attract are a cross-section of health risks, the legislation will not lead to increased segmentation in the small-group and individual health insurance markets.

However, AHPs may encourage the splitting of the small-group market into blocks of healthy and unhealthy groups. The bill does attempt to encourage the formation of AHPs that consist of employers from industries normally considered to have higher claims than average. However, not all employers within those classes will have higher-than-average claims. The use of the techniques described below could produce AHP pools composed of those employers with lower expected claims within the higher risk categories, leaving the employers with the higher expected claims within the state regulated insured pools.

States have enacted health insurance reforms that require health insurers to put all their small groups in one pool and limit the premium charged to one employer relative to another. State regulation of small-group health insurance plans generally limits the ability of insurers to selectively attract groups with better risks through selective pricing, product, or marketing techniques. Freed from state regulation, federally qualified self-insured AHPs would have financial incentives to attract healthier small-employer groups through a variety of techniques not allowed under state regulation of fully insured health plans and are not restricted by the proposed legislation. For example, an AHP could require a health questionnaire from each prospective member and then offer reduced premium rates if everyone in a group is in good health, thus minimizing enrollment of individuals in poor health. In groups that include individuals in poor health, the group would be offered a higher premium.

The new section 805(a)(2) established under the bill provides that contribution rates must be nondiscriminatory with regard to individual participants.[2] It also states that contribution rates for any participating small employer must not vary on the basis of the claims experience or the small employer's type of business or industry. An AHP may choose to determine premium rates based on the state's small group reform laws in the jurisdiction where it operates, but it is not required to do so.

This provision would permit an AHP to exempt itself from small-group rating laws, which have been enacted by many states. The AHP could charge small employers with less healthy employees a higher rate than would be permitted for health insurers operating under the small-employer rating restrictions. The result would be that small employers whose employees are greater health risks would be more likely to obtain coverage from the private health insurance market than through AHPs.

Allowing AHPs to rate by health status and attract the healthier groups is likely to result in an increasing proportion of less healthy, higher-cost groups in fully insured plans, which are subject to state solvency regulation and small-group reform laws. Ongoing surplus requirements are normally met by risk or profit charges within the premiums or contributions. The lower surplus requirements for AHPs compared with insured plans are likely to result in lower premiums for AHPs. These lower premiums for AHPs, together with the lower premiums for healthier risks, will further add to the market segmentation.

[2] The section references in our comment letter are to those sections of the Employee Retirement Income Security Act of 1974 amended by Section 421 of H.R. 2563.

This would increase the premiums of those insured groups since there would be fewer enrollees over which the higher claims cost could be spread. This undermines and renders ineffective the state small-group laws.

There is also a question concerning the enforcement of the bill's provisions. It appears that the U. S. Department of Labor (DOL) is given the responsibility to enforce the rating rules, and DOL historically has lacked the funding and staffing needed to effectively regulate AHPs. Lack of effective enforcement could reward those AHPs that do not comply with the spirit of the proposal. In other words, a marketing and rating plan that targets only employers with employees in good health is not in the spirit of this proposal.

Solvency Standards

Solvency standards should include both claim reserves and surplus requirements. The description of claim reserve requirements for AHPs, in Section 806 of the bill, seems adequate. The proposed rules governing AHPs should include ongoing requirements that are similar to the minimum requirements for Health Risk-Based Capital (RBC) developed by the National Association of Insurance Commissioners (NAIC). The start-up capital included in Section 806(b) "Minimum Surplus in Addition to Claims Reserves" does not adjust for future inflation or size of the AHP. Many states had similar minimum surplus requirements that became inadequate until they made legislative changes to increase minimums for inflation.

However, capital requirements also need to increase with the growth of AHP claim volume. Recognizing that capital requirements need to be tied to the size and risk profile of risk-bearing entities, states are now implementing the NAIC Health RBC formula. Under the Health RBC Underwriting Risk Factor, an approximation for surplus would be 8 percent to 10 percent of the total projected claims for the AHP during the year following the evaluation of such claims.

While the requirements for claims reserves, surplus, and other factors may be adequate for the start-up phase of an AHP, they appear inadequate if the total annual claim volume of the AHP exceeds $5 million to $10 million (5,000 to 10,000 individuals). As the AHP gets larger, the total surplus requirement for solvency rises with claim volume. AHPs, which provide coverage for employers in higher-risk industries, may have even larger surplus requirements. Such employers may not have higher initial claims, but due to higher employee turnover they may have higher claims in future years, necessitating larger surplus requirements.

In the Academy's work with the NAIC on the RBC standards, we designed a solvency simulation model that demonstrated the relationship between capital needs and the size of a business. The Academy can make this information available for your consideration in the development of solvency standards for AHPs.

Actuarial Certification

Section 806 of H.R. 2563 provides for the certification of AHP solvency by a qualified actuary. A "qualified actuary," as defined by Section 812(a)(10) of the bill, is "an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the

Secretary [of Labor] may provide by regulation." We recommend that this definition be further strengthened by adding that the individual must also have health expertise.

We agree that the primary definition of a "qualified actuary" should be "an individual who is a member of the American Academy of Actuaries." As the U.S.-based organization with primary responsibility for supporting actuarial professionalism, the Academy staffs and supports the Actuarial Standards Board (which promulgates actuarial standards of practice), the Committee on Qualifications (which develops qualification standards) and the Joint Committee on the Code of Professional Conduct (which develops and maintains standards of conduct for U.S. actuaries).

The Academy also staffs and supports the Actuarial Board for Counseling and Discipline (ABCD), which provides confidential guidance to U.S. actuaries on how to maintain high professional standards in their practice and investigates complaints that may be brought against U.S. actuaries. Academy members who fail to comply with applicable professional standards are subject to public discipline, up to and including expulsion from Academy membership. Thus, Academy membership brings with it the obligation to comply with high standards of conduct, practice, and qualification, and we believe Academy members will satisfy that obligation when making the solvency certification required by Section 806 of H.R. 2563.

However, actuaries who are not members of the Academy or the Academy's sister organizations are not subject to the Academy's professional standards or discipline process. If a situation should arise in which a non-member actuary issued a flawed certification of an AHP's solvency, the Academy would be unable to help monitor the situation.

Given the potentially serious consequences that might ensue from a flawed solvency certification, we think it important that the "reasonable standards and qualifications" for non-Academy members that the Secretary develops under Section 806 be appropriately rigorous and enforceable. The Academy would be pleased to assist the Secretary in defining standards for non-Academy members, independently or through its participation on the Solvency Standards Working Group proposed under Section 806(j) of the legislation.

Applicable Authority
Section 812(a)(5) provides a definition for "applicable authority" that allows DOL to delegate responsibility to enforce federal standards for AHPs to states in certain instances. However, this authority is not universal. The section provides for situations in which there is "joint authority," presumably between the state and federal levels. There are also situations in which the DOL has sole authority over an AHP and state jurisdiction is pre-empted.

These provisions create confusion about which regulatory entity has responsibility for oversight of the various functions of AHPs. We welcome the recognition in this legislation of the value of the expertise and resources currently in place at the state level. However, we are concerned that the current language will create situations similar to previously proposed legislation on Multiple Employer Welfare Arrangements (MEWAs) in which the scope of regulatory responsibility over such plans was unclear. As an example, Section 802 of the bill gives certification authority to the Secretary of Labor. It may be difficult for individual departments of insurance to monitor the certification status of AHPs operating within their state. It is critical that the oversight responsibility regarding solvency standards be clear to

avoid situations where AHPs fail because of confusion regarding what entity is to be monitoring and taking action when necessary.

There are a number of specific questions not answered by the language in this bill. For example, does the current language enable individual states to require AHPs operating within their boundaries to abide by all existing insurance regulations, including small-group rating laws and mandated benefits? Or is the scope of states' responsibilities limited to verifying the solvency of an AHP? Can the states require AHPs to meet minimum solvency standards required for insurance companies if those requirements are more stringent than those described in this bill? Thus, it is not clear that states would be willing to effectively regulate these entities if the exemptions are viewed as contrary to the intent of state legislature.

In Section 812(b)(2)(D), it appears that each AHP can identify a single state to act as its "applicable authority." This section further provides that the laws of this single state "supersede any and all laws of any other State in which health insurance coverage of such type is offered." Many states have devoted much time and many resources to developing requirements pertaining to rating, benefits coverage, and consumer disclosures that they believe serve the best interests of their citizens. However, this section would exempt AHPs from having to abide by these laws if the AHP has elected a different state to act as its "applicable authority." This could result in AHPs "shopping" for the state perceived to have the least oversight, effectively negating the existing health insurance laws in most, if not all, states.

The Academy is concerned that by dividing the responsibilities between the state and federal governments, confusion will result regarding which entity has authority over which function. The end result could be no oversight at all.

State Assessment Authority

Section 811 of the legislation allows states to impose assessments on AHPs based on the amount of premiums or contributions received from employers and employees who make up the plan.[3] This provision would presumably give states the ability to use the AHP assessments to fund oversight functions (if the state is the "applicable authority") or to help subsidize the state's "high-risk" pool for uninsured individuals. We support any effort to provide states with additional support for these types of activities. However, it is not clear what states are expected to do with assessments generated by AHPs. It is also questionable whether a state would have the authority to levy such assessments if it defers to the U. S. Department of Labor to regulate its AHPs or if a multi-state AHP is domiciled in another state's jurisdiction.

The states may also have problems enforcing the provision, given the requirement that such assessment, "is otherwise nondiscriminatory . . . ." Section 811 provides that the rate of the assessment cannot exceed premium taxes paid by health insurers or health maintenance organizations (HMOs). In most states, HMOs are not taxed or pay a lower tax than health insurance companies. AHPs might argue that

[3] Section 811 provides for state assessment of "Association Health Plans described in Section 806(a)(2)," which are defined as plans that provide "additional benefit options which do not consist of health insurance coverage . . ." (H.R. 2563, Section 806). Although it is not clear from the language of the section, it is assumed the assessment provision should apply to AHPs defined in both Sections 806(a)(1) and 806(a)(2), since the assessment amounts are based on similar state premium taxes applied to health insurers and health maintenance organizations.

imposing an assessment based on the premium tax rate applied to a health insurer would be discriminatory if a lower rate or no premium tax was applied to HMOs.

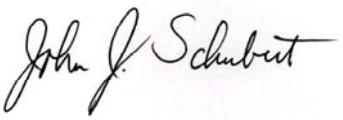
Conclusion

The work group supports efforts to expand access to health insurance and believes that AHPs can be part of the solution if changes are made to address the concerns listed above. We make the following recommendations regarding the AHP provisions in H.R. 2563, which will help avert the potential for adverse impacts on current health insurance markets:

- Minimize the ability for AHPs to avoid small-group health regulation. This will help prevent market segmentation because the ability for plan sponsors to selectively attract groups with better health risks will be limited.
- Adjust claims reserves, surplus, and other solvency factors for future inflation or size of the AHP.
- Specify which government authority — the DOL or a state — has regulatory responsibility as the "applicable authority."
- Clarify what states should do with assessments generated by AHPs and whether states have the authority to levy such assessments if the DOL is the regulating authority or if a multi-state AHP is domiciled in another state's jurisdiction.

Members of the American Academy of Actuaries are available to assist Congress in developing solutions to address the issue of small-employer health insurance reform. If you or your staff would like additional information or assistance, please feel free to contact Holly Kwiatkowski, the Academy's federal health policy analyst, by phone at (202) 223-8196 or by e-mail (kwiatkowski@actuary.org).

Sincerely,



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cc: The Honorable Richard Gephardt
The Honorable Thomas Daschle
The Honorable Trent Lott