



AMERICAN ACADEMY *of* ACTUARIES

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February 9, 2018

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
U.S. Department of Labor
200 Constitution Ave. NW
Washington, DC 20210

Attention: Definition of Employer—Small Business Health Plans RIN 1210-AB85

Re: Considerations Related to Modeling the Potential Impact of Association Health Plans

To Whom It May Concern,

On behalf of the Individual and Small Group Markets Committee of the American Academy of Actuaries,¹ I would like to offer comments in response to the Department of Labor's proposed rules that would broaden the ability for association health plans (AHPs) to be treated as large groups and for self-employed individuals to be eligible for AHPs. Our comments offer considerations that should be made when analyzing the potential impacts of these more broadly defined AHPs on individuals, employer groups, and the individual and small group health insurance markets. Different stakeholders will be affected differently, depending on allowable rating factors, plan design flexibility, and strategic considerations.

Considerations may differ for fully insured AHPs and self-funded AHPs (e.g., self-funded multiple-employer welfare arrangement (MEWA) plans). The applicability of the Employee Retirement Income Security Act of 1974 (ERISA) and limitations on the ERISA pre-emption for MEWAs, as well as the ability of states to impose their laws and regulations on AHPs due to

¹ The American Academy of Actuaries is a 19,000 member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

such limitations on the ERISA pre-emption, should be considered in developing an analysis of the potential impact of AHPs on the current health plan environment.²

The Academy will be providing more detailed comments on the proposed rules in a subsequent comment letter.

Rating Factor Considerations

If treated as large groups, as proposed, AHPs would be subject to more flexible rating rules compared to Affordable Care Act (ACA)-compliant plans. Due to this increased flexibility, AHPs could offer lower premiums for lower-cost groups and higher premiums for higher-cost groups. As a result, AHPs could benefit from positive selection—that is, they would attract a lower-cost enrollee population. In contrast, ACA plans would be subject to adverse selection—they would attract a higher-cost enrollee population, which would lead to higher ACA premiums.

Age Rating

- Age rating restrictions. The ACA restricts age rating factors used in the individual and small group markets to a 3:1 range for adults, with no variation by gender. Several states have more restrictive allowable age ranges (e.g., New York does not allow premium variations by age). When allowable age rating ranges are more narrow than the actual range in health spending by age, such restrictions result in younger people subsidizing the costs incurred by older people.

Unless limited by state law, AHP issuers can use age ranges based on actuarial experience. The range can vary by plan design and insurer. For instance, high-deductible plans typically exhibit a greater range than lower-deductible plans, but all exceed the 3:1 limit imposed by the ACA. This provides a competitive advantage to the AHP in that it could offer lower premiums to young adults and higher, less attractive premiums to older people.

- Age rating curve. Regulations for the ACA dictate the age-by-age factors that must be used by insurers operating in Federally Facilitated Exchange (FFE) states; most, but not all, other states also use the federal age curve. In contrast, each AHP can determine its own set of age factors, which can vary by plan design and other case characteristics. This flexibility allows AHPs to better target subsets of the population that it would like to attract to its plans. However, rate variations for enrollees age 40 and older must be justifiable by cost data to avoid violating the Age Discrimination in Employment Act.
- Child rating factors. The ACA sets premium factors for children, and the factor for a newborn is identical to those for other children under age 14. An AHP can set its child rating factors based on actuarial expectations. Newborns typically experience health care costs much higher than those of older children.

² Although not discussed in this letter, currently operating AHPs could be using rating practices that would not be allowed under the proposed rules. For instance, they could be using health status as a rating factor. An analysis of the impact of the proposed rules would also need to consider the implications associated with these AHPs.

- Per person rating. The ACA uses an “each person” rating structure, but allows an issuer to charge for only up to three children. That is, additional premiums cannot be charged for the fourth or any additional children. An AHP can use whatever child and family rating structure it wishes. It can charge for each child, irrespective of the number of children (which would make AHPs less attractive for large families) or it can use other family composition rating structures.

Industry/Occupation

The ACA does not allow premium variations by industry or occupation for any group or individual. Unless prohibited by state regulation, an AHP could vary its rates based on the industry or occupation of the applicant. Industry rating is common in the large group market and was common in the small group market prior to the ACA. Some states limit the percentage differential that can be used for groups, but not all have such restrictions.

Being able to charge higher rates to groups operating in industries that tend to have higher health costs and lower rates to groups in lower cost industries provides a key rating advantage to AHPs over plans subject to ACA restrictions.

Geographic Area

Under the ACA, geographic rating zones are determined through federal regulation with input by the states. All insurers within a state must set their premiums using identical rating zones, although they can vary the area factor used for each pre-established zone to reflect cost differences, but not morbidity differences, by zone. Some states set their ACA zones such that a mix of higher-cost and lower-cost areas were included in a zone so as to help limit rates that otherwise would be charged in the higher-cost area of the zone.

Subject to state regulations, an AHP can determine its own rating zones as well as its geographic area factors by zone. This allows it a strategic advantage over an ACA issuer that operates in multiple zones within a state. For instance, an AHP could split an ACA geographic zone into two rating areas in order to be more competitive in the lower-cost area and charge higher rates in the higher-cost area. It could also choose not to market in the higher cost area.

Gender Rating

The ACA prohibits varying rates based on gender for plans issued in the individual and small group markets. Rating by gender in the small group and individual markets was commonplace prior to the ACA. If gender rating is not prohibited, AHPs could vary rates by gender, at least at the participating group level; small groups would not be allowed to pass along gender-specific premiums to their members. Females at younger ages exhibit health care costs well in excess of males of the same ages. Gender rating would allow AHPs the ability to rate the small groups that comprise its membership more accurately, minimizing the gender rating risks that are faced by ACA issuers. As a result, AHPs could be more attractive to small groups comprised of younger men.

Group Size

The ACA prohibits varying premiums based on the size of the small employer group. Group size rating was widely used by small group insurers prior to the ACA, although many states limited the rating variation that could be applied, typically to no more than 20 percent.

If group size rating is allowed for AHPs, this rating factor would likely be employed for competitive positioning. Historically smaller groups tend to have higher costs than larger groups, all other things equal. This is particularly true of groups of fewer than 10 employees, especially if sole proprietors are eligible to join an AHP. By using group size rating factors, AHPs could offer more attractive premiums than ACA plans for what are typically more desirable small groups with more than 10 (or 20) employees and less attractive rates for the “micro groups” of fewer than 10 employees and sole proprietors.

Single Risk Pool

The ACA requires rating using a single risk pool. Subject only to allowing rating variations based on age, locality, family composition, and tobacco use, each ACA insurer must determine its rates based on the combined experience of all of its members within each state market (i.e., individual, small group). Through required participation in the ACA risk adjustment program, this essentially becomes a statewide single rating pool, encompassing all insurers in the market. As such, premium rates need to reflect the expected morbidity level of the entire state for the small group market and for the individual market.

AHPs set rates based on the expected experience of all their members, but are not subject to the ACA risk adjustment program. Therefore, AHP rates do not have to incorporate the expected experience of ACA compliant competitors. Given the various rating factor advantages that it has, as described above, an AHP may attract healthier-than-average groups. Such a bifurcated situation could lead to potential rate spirals in the ACA markets as healthier groups move to the AHP market, leaving less-healthy groups in the ACA market.

Plan Design Considerations

When treated as a large group, AHPs would be regulated by more flexible rules regarding benefit and cost-sharing requirements compared to ACA-compliant plans. AHPs could lower premiums by offering less-comprehensive plans than ACA plans. Similar to more flexible rating rules, more flexible benefit rules could allow AHPs to create plans more attractive to lower-cost groups, resulting in positive selection (and lower premiums) for AHPs and adverse selection (and higher premiums) for ACA plans.

Covered Services

ACA issuers in both the individual and small group markets must provide coverage for 10 essential health benefits (EHBs). Although large groups are not required to provide such coverage under the ACA, most provide comprehensive coverage, although not necessarily to the same extent as required for ACA individual and small group health plans.

AHPs would not need to meet the EHBs or state-benchmark requirements under the ACA. This would provide AHPs some flexibility in its plan benefit designs that could result in lower premiums and make them less attractive to higher-cost groups and individuals. For example, benefits that might be covered to a lesser extent in an AHP include rehabilitative and habilitative services (including chiropractic, physical therapy, and other therapies) and behavioral health services. AHPs that include prescription drug coverage might have narrower formularies than ACA-compliant plans.

Cost-Sharing Provisions

Under the ACA, individual and small group health plans must meet actuarial value (AV) requirements for the various metal tiers—60 percent AV for bronze plans, 70 percent AV for silver plans, 80 percent AV for gold plans, and 90 percent AV for platinum plans.³ ACA plans also have maximum out-of-pocket limits and cannot impose annual lifetime benefit limits. To avoid employer-shared responsibility penalties, large group plans must meet at least a 60 percent minimum value (akin to an actuarial value, but using a different federal calculator) with at least one of the plans that is offered to its employees. Unlike small employers, large employers can also offer plans with AVs lower than 60 percent and are not restricted to the metal level tiers, making plan design much more flexible.

AHPs have much more flexibility in their plan benefit designs and cost-sharing provisions. In particular, the ability to offer plans with AVs less than 60 percent could be attractive to many groups, as they are not subject to the shared responsibility provisions of the ACA. This could lower premiums for AHPs compared to small group ACA-compliant plans.

Provider Network Considerations

The ACA statute and regulations impose certain requirements on the makeup and accessibility of the health care provider networks being used for an ACA-compliant health plan. In addition to assuring access to primary care, specialty care, and hospital care, ACA plans must include at a minimum a specified percentage of certified community health centers in their networks.

Unless required by state law, an AHP will have more flexibility than an ACA-compliant plan in constructing its health care provider networks. However, it may be difficult for an AHP to secure the same level of negotiated reimbursement arrangements (i.e., provider discounts) as many of the ACA plans, particularly those with large blocks of business in a state or locality. If an AHP uses an administrator that can provide net discounts similar to the ACA competition, its advantage of having more flexible design options would be meaningful. However, “rent-a-network” arrangements generally do not produce discounts as large as those that major ACA players and many local HMO plans are able to secure from their provider networks.

³ Although catastrophic plans in the individual market are not subject to AV requirements, the AV of catastrophic plans is similar to that of bronze plans.

Other Key Modeling Considerations

Regulatory Environment

Insurance laws and regulations vary by state, and AHPs would likely carefully consider the regulatory environment before determining whether to enter a state market. AHPs would need to consider the rules of the AHP state of domicile as well as any applicable rules in the other states in which the AHP wants to participate.

As noted earlier, some states like New York require pure community rating. States with strict rating rules are less desirable candidates for an AHP's state of domicile, because the state rules would limit their rating flexibility and thus their potential advantage over ACA plans. However, states with strict rating rules would be good candidates for states in which an AHP might choose to market—AHP rating flexibility would allow them to offer more attractive premiums for younger adults, for instance. AHPs might be less inclined to market coverage in states that allowed individuals to keep their prior non-ACA-compliant coverage (i.e., so-called “transition” or “grandmothered” plans); in these states lower-cost individuals and small groups may already have plans with more rate flexibility than ACA plans.

The applicability of state laws regarding MEWAs based in other states will be a key determinant of how effectively AHPs can compete, particularly in the event such laws subject the AHP to many, if not all, of the rating and underwriting requirements the state has in place for its ACA business.

Competitive Considerations

Some issuers have more market power than others. This can be due not only to having more competitive rates, but also to other characteristics that are more difficult to measure and model. Some of these characteristics include insurer reputation, plan structure (e.g., HMO, PPO), provider networks, care management, and administration. How an AHP compares to competing plans across these characteristics can affect its potential market share.

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We appreciate the opportunity to provide these comments and would welcome the opportunity to speak with you in more detail and answer any questions you have. If you have any questions or would like to discuss further, please contact David Linn, the Academy's senior health policy analyst, at 202.223.8196 or linn@actuary.org.

Sincerely,

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American Academy of Actuaries