AMERICAN ACADEMY *of* ACTUARIES

April 28, 2003

The Honorable John A. Boehner
Chairman, House Committee on Education and the Workforce
2181 Rayburn House Office Building
Washington, DC 20515-6100

Dear Representative Boehner:

This letter presents the comments of the American Academy of Actuaries'[1] Association Health Plan Work Group regarding the Small Business Health Fairness Act of 2003 (H.R. 660 and S. 545). As you know, these bills would amend ERISA[2] to establish a new "Part 8—Rules Governing Association Health Plans."

H.R. 660 and S. 545 are designed to expand access to affordable health insurance by promoting the use of Association Health Plans (AHPs). We support efforts to increase the availability, affordability, and accessibility of health insurance. While the goals of the legislation are laudable, the bills do not address the core problem, which is the high cost of health care. As currently written, the bills will likely have unintended negative consequences that would hinder the intent of the legislation.

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.

Executive Summary
Some of the unintended negative consequences of the legislation and our related concerns are as follows:

Unlevel Playing Field: The consequence of different rules for AHPs versus state-regulated insured plans is a fragmentation of the market resulting from an unlevel playing field. This is likely to lead to cherry-picking, adverse selection, and increased costs for sicker individuals.

Risk of Insolvency: The proposed rules governing the minimum surplus requirements for AHPs do not account for the growth of the AHP. Historically, there have been many examples of AHP-like organizations becoming insolvent. Following such events, most states enacted solvency standards. To maintain the benefit of these standards to consumers, the surplus standards should be similar to the minimum requirements for Health Risk-Based Capital (RBC) developed by the National Association of Insurance Commissioners (NAIC). Also, the bills at issue rely on affordable reinsurance vehicles that do not currently exist in today's marketplace.

[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.
[2] ERISA refers to the Employee Retirement Income Security Act of 1974.

Unclear Regulatory Authority: Governmental authority for regulating AHPs should be clearly specified. Absent this clarification, it is likely that nobody will be regulating AHPs or that there will be conflicting regulation. When regulatory authority is unclear, consumers have no place to turn for redress.

Unclear State Assessment Authority: The authority to levy assessments will depend on what governmental body has regulatory authority over AHPs. It should be clear what states are allowed to do with assessments generated by AHPs.

Actuarial Certification: The definition of a "qualified actuary" should require membership in the American Academy of Actuaries and should specify that the individual must have pertinent health actuarial expertise.

Other Concerns: Anticipated expense reductions are unlikely to materialize.

Issues Contributing to an Unlevel Playing Field and Subsequent Destabilization of the Small-Group Market

Allowable Rating Practice Differences Contribute to an Unlevel Playing Field

Section 805(a)(2)[3] requires that contribution rates must be nondiscriminatory with regard to individual participants. It also states that contribution rates for any participating small employer must not vary on the basis of any health status-related factor or the small employer's type of business or industry.

However, the term "contribution rates" is not defined. Clarification of whether this refers to a contribution by an individual within a small employer group or the rate an individual employer within an AHP pays is necessary. If this is intended to eliminate the possibility of varying rates for individual small employers by health status, there is a conflict in the language of the paragraphs that follow. The language states that nothing in the bill shall be construed to preclude an AHP from varying contribution rates for small employers to the extent allowed under the state for regulating small group insurance rates. Later in the legislation, it allows an AHP to choose a single state as its "applicable authority" and it need only follow the rating rules of that state for the nationwide plan. If an AHP chooses a state that has no restrictions on small group rates, it seems the limitation on varying contribution rates by health status is not enforceable, thereby resulting in cherry-picking.

This provision would permit an AHP to be exempt 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 are more likely to obtain coverage from the private health insurance market, where rates are limited, than through AHPs, who may not have the same limitations. State small group legislation sought to eliminate this sort of selection in the market by requiring health insurers to put all their small groups in one pool and to limit the premium charged to one employer relative to another. Introducing AHPs that are not required to adhere to the same rating rules brings selection back into the market. The consequence will be that the rates for the two pools will diverge, causing further instability in an already fragile market.

[3] The section references in our comment letter are to those sections of ERISA as amended by H.R. 660 and S. 545.

Lower Solvency Standards Contribute to an Unlevel Playing Field

State-regulated, non-AHP insured plans are subject to state solvency regulation. Ongoing surplus requirements are normally met by risk or profit charges within the premiums or contributions. While this may result in short-term premium savings for the AHPs, the inadequate contributions to surplus likely will contribute to AHP insolvencies, resulting in consumers and providers being responsible for unpaid claims.

Benefit Differences Contribute to an Unlevel Playing Field

AHP groups, according to the bills, will be exempt from state mandated benefits. Healthier groups are less likely to utilize mandates and, therefore are more likely to choose AHP coverage, while groups with higher health risks and higher utilization of these mandated services are more likely to remain in the traditional insured market, thus widening the gap between the two markets. Currently, both high and low utilizers are in the same insured pool and the cost for mandates is spread across a larger pool for a small incremental cost. Splitting the required mandates by market will lower the cost for some, but raise the incremental cost for others.

In summary, market destabilization is a likely result of the proposed AHP legislation, as currently written, because of the disparity in allowable rating practices and solvency standards, which would be compounded by benefit differentials. The only way to maintain a level playing field is to have a common set of rating rules and consumer protection laws for every entity, whether it is an insurance company, health maintenance organization (HMO), or a self-funded AHP.

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 bills 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 of surplus for many entities would be a minimum of eight percent to 10 percent of the total projected claims for the AHP during the year following the evaluation of such claims. The minimum surplus is adjusted to reflect the purchase of stop-loss reinsurance and other types of reinsurance.

While the requirements for claim reserves, surplus, and other factors may be adequate for the start-up phase of an AHP, they appear inadequate if the total annual claims 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 that 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.

Actuarial Certification
Section 806 of the bills provides for the certification of AHP solvency by a "qualified actuary." The work group wishes to stress the importance of defining that term as "an individual who is a member of the American Academy of Actuaries," and they further recommend that the definition be strengthened by requiring pertinent health actuarial expertise.

It is important that the 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 promoting 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 actuaries).

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

Actuaries who are not members of the Academy, or one of the other U.S.-based actuarial organizations, are not subject to the professional standards and discipline process just described. Therefore, in a situation where a non-member actuary had issued a flawed certification of an AHP's solvency, the Academy would be unable to help monitor the situation.

Applicable Authority
Section 812(a)(5) provides a definition for "applicable authority" that allows the U.S. Department of Labor (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 preempted.

These provisions create confusion about which regulatory entity has responsibility for oversight of the various functions of AHPs. We make note of the bills' recognition 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 bills gives certification authority to the secretary of labor. It may be difficult for an individual department of insurance to monitor the certification status of AHPs operating within their state. It is crucial 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 this language in the bills. 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 these bills? 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 the state legislature.

Section 812(b)(2)(D) establishes 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, benefit 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 states. In some states with small employer regulations that significantly increase the cost of health insurance, all of the small employers could migrate to AHPs, resulting in federalization of the state's small group market.

In addition to rating and benefit regulations, provider and claim payment laws add further complexity to this issue. These include, but are not limited to: any willing provider laws, prompt payment rules, privacy and patient protection laws, and regulations regarding assignment of claims.

The work group is concerned that by dividing the oversight responsibilities between the state and federal governments, confusion will result regarding which entity has authority over which function. The end result could be either overregulation to the point that AHPs cannot operate, or underregulation. When regulatory authority is unclear, consumers have no place to turn for redress.

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.[4] Many states use assessments to subsidize "high-risk" pools for uninsured individuals. However, it is questionable whether a state would have the authority to levy such assessments if it defers to the DOL to regulate its AHPs or if a multi-state AHP is domiciled in another state's jurisdiction.

The states also may 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 HMOs. In most states, HMOs are not taxed or pay a lower tax than health insurance companies. AHPs might argue that 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. The work group recommends that the legislation clearly delineate where assessment authority will be placed, at the state or federal level, and what the provisions of the assessments will be.

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[4] 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. 660/S. 545, 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.

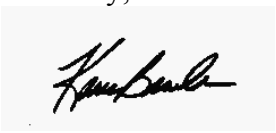
Other Concerns
Expense reductions are not likely to materialize. Administratively, each employer group will require the same amount of underwriting, enrollment, mailings, and customer support as they currently do in the small group insurance market. It is unlikely that the AHPs will have more buying power than the insurers that represent small employers today.

Conclusion
The work group supports efforts to expand access to health insurance. However, H.R. 660 and S. 545 can have many unintended negative consequences. These include:

- An unlevel playing field, leading to market destabilization and higher rates for sicker individuals;
- Potential AHP insolvencies, resulting in unpaid claims for consumers and providers;
- Unclear regulatory responsibility;
- Unclear directives relating to assessments; and
- A promise of expense reductions that are unlikely to materialize.

Again, 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 senior health policy analyst (federal), by phone at (202) 223-8196 or by e-mail at kwiatkowski@actuary.org.

Sincerely,



Karen Bender, ASA, MAAA, FCA
Chairperson, Association Health Plan Work Group
American Academy of Actuaries

Other Academy members contributing to this letter are: Michael S. Abroe, FSA, MAAA; David J. Bahn, FSA, MAAA; Jennifer J. Brinker, FSA, MAAA; Michael L. Burks, MAAA; James E. Drennan, FSA, MAAA, FCA; Richard M. Niemiec, MAAA; Donna C. Novak, ASA, MAAA, FCA; John R. Parsons, MAAA, FCA; John J. Schubert, ASA, MAAA, FCA; David A. Shea, Jr., FSA, MAAA; Mark Wernicke, FSA, MAAA; and Jerome Winkelstein, FSA, MAAA.