



AMERICAN ACADEMY of ACTUARIES

May 4, 2006

The Honorable William Frist
Majority Leader
United States Senate
Capitol Building, S-230
Washington, DC 20510

The Honorable Harry Reid
Minority Leader
United States Senate
Capitol Building, S-221
Washington, DC 20510

Dear Majority Leader Frist and Minority Leader Reid:

This letter presents the comments of the American Academy of Actuaries'ⁱ Small-Group Market Task Force (with input from the Individual Medical Market Task Force) regarding S. 1955, the *Health Insurance Marketplace Modernization and Affordability Act of 2006*. Our comments are based on an objective actuarial review of the version of S. 1955 that was reported out of the Senate Health, Education, Labor, and Pensions Committee on March 15, 2006. Any subsequent changes to the proposed legislation could alter the direction and interpretation of our comments.

The stated purpose of S. 1955 is to amend the *Employee Retirement Income and Security Act* (ERISA) and the *Public Health Service Act* to expand health care access and reduce costs by creating small business health plans (SBHPs) and modernizing the health insurance marketplace. While this letter focuses on the potential effect on the small-group market as defined by the *Health Insurance Portability and Accountability Act* (HIPAA) (2 to 50 lives), we have tried to consider how it affects the individual market, without reference to specific states or their laws.

Executive Summary

The Academy has previously provided comments on legislation governing the creation of association health plans (AHPs).ⁱⁱ Like SBHP legislation, AHPs are intended by its sponsors to expand access to affordable health insurance, particularly in the small-group market.ⁱⁱⁱ S. 1955, however, goes beyond AHP legislation by proposing the development of uniform regulatory standards to achieve more effective state regulation and a more efficient health insurance marketplace.

S. 1955 would address many of the negative consequences that members of the task force believe would likely result from previous AHP legislation. While S. 1955 is intended to encourage competition and reduce administrative costs through market reforms, it does not, however, significantly address the core issue of health insurance affordability.

Members of the task force support further efforts to increase the availability, affordability, and accessibility of health insurance. We are available to assist Congress in analyzing solutions to address the issue of small-employer health insurance reform.

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As S. 1955 moves through the Senate and potentially into conference with House AHP legislation, it is imperative, from an actuarial perspective, that the following issues, many of which have been addressed in previous Academy analyses, be considered:

Maintain/create a level playing field: The same rules should apply to all health insurance providers to help create and maintain stable markets.

Solvency requirements should be adequate and consistent: Allowing multiple employer health insurance purchasing pools to offer only fully-insured health plans is key to retaining adequate and consistent solvency requirements.

Regulatory authority should be clear and consistent: Regulatory authority should be well defined.

Qualified actuarial certifications should be required: Actuarial certifications should only be signed by qualified actuaries who have pertinent health actuarial expertise.

Market stability and consumer impact should be considered: Changes in the status quo affect the market. Some small employers in states whose rating rules are less flexible than the federal rating rules proposed in S. 1955 could experience significant rate increases as a result of the more flexible rules, causing some groups to drop coverage. Even among groups that retain coverage, some individual employees may drop coverage if their premiums become too expensive. Other small employers in these same states could experience significant rate decreases, enabling previously uninsured groups to purchase insurance. Individual employees who may have declined coverage before may opt to participate if their premiums decrease substantially. States will need to monitor transition rules if they want to identify the impact on current consumers. Some states may want to establish a safety net for those who would be disadvantaged by S. 1955. We are available to assist Congress and/or the states in analyzing impacts on market stability and consumers.

Comparison of AHPs v. SBHPs

The following table compares our analysis of the potential intended or unintended consequences and other concerns regarding SBHP legislation with those previously identified by the Academy regarding AHPs.

Issue	AHP Legislation	SBHP Legislation
Unlevel playing field among plans	The consequence of creating different rules for AHPs through self-funded associations or state domiciled rules versus local state-regulated insured plans is a fragmentation of the market, resulting in an unlevel playing field. This is likely to lead to cherry-picking, adverse selection, and increased costs for sicker individuals.	<p>SBHP legislation would establish federal rating rules. Insuring entities could choose to follow either the federal rating rules or the state-specific rating rules. Insuring entities in states with rules that are more restrictive than the proposed federal rating rules will, for all practical matters, be forced to choose the more liberal federal rules to be competitive with SBHPs.</p> <p>SBHP legislation would also allow insuring entities to offer coverage that differs from state insurance mandated benefit requirements, as long as they also offer an enhanced plan that covers the benefit requirements of a state employee plan in one of the five most populous states.</p> <p>Enabling all insuring entities to follow common rating rules and benefit package requirements appears to address the unlevel playing field problem.</p>
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 consumer benefit of these surplus standards, they 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.	<p>SBHPs could not be self-funded. Only state-licensed insuring entities could market them. Therefore, the insuring entities would have to meet the solvency requirements required in each state.</p> <p>S. 1955 would address the Academy's concern that solvency requirements for self-funded AHPs would be inadequate.</p>
Unclear regulatory authority	Governmental authority for regulating AHPs should be clearly specified. Without this clarification, it is likely that nobody will be regulating AHPs or that regulations will conflict. When regulatory authority is unclear, consumers have no place to turn for redress.	Although S. 1955 is clear in many areas, there are some instances, such as the regulatory environment in non-adopting states, in which clear and careful regulatory language would be needed.
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	Since SBHPs could only be marketed through licensed insuring entities, which are subject to state assessment authority, this would no longer be a concern.
Qualified actuarial certifications	Proposed AHP legislation defines a "qualified actuary" as a member of the American Academy of Actuaries. The definition could be strengthened to specify that the individual must have pertinent health actuarial expertise.	Since all SBHPs would be required to be fully-insured, individual state definitions of "qualified actuary" would apply.
Other concerns	<p>Anticipated administrative expense reductions are unlikely to materialize.</p> <p>Insurers currently pass on to small-employer groups the results of their buying powers in provider negotiations. It is unlikely that the introduction of AHPs would materially change these discounts.</p>	<p>While there is a potential for multi-state insuring entities to reduce expenses, some companies operating in states that currently prohibit medical underwriting could experience an increase in administrative costs.</p> <p>Insurers currently pass on to small-employer groups the results of their buying powers in provider negotiations. It is unlikely that the introduction of SBHPs would materially change these discounts.</p>

New Issues for Consideration under S. 1955

Benefit package requirements

S. 1955 proposes a new approach to solving the long-running debate over the appropriate level of benefits, services and/or category of provider mandated by state legislation. S. 1955 offers an

approach that would let the marketplace develop a minimum coverage level for consumers (a “basic” plan) as long as an “enhanced” option is also available.

A health insurance issuer in a state would be allowed to offer a basic plan or plans that do not comply with one or more state mandates regarding covered benefits, services, or category of provider as long as that issuer also offers an enhanced option. The enhanced option must include the minimum covered benefits, services, and provider categories that are covered by a state employee health plan in one of the five most populous states. The Secretary of Labor must establish such covered benefits, services, and categories of providers on the first day of each calendar year.

Key issues for consideration regarding benefit requirements under S. 1955:

- The definition of benefits should be clarified, e.g., whether to include cost sharing requirements.
- If the definition of the enhanced benefit plan is changed annually, as provided for in the bill, there will very likely be increased administrative expense for any SBHP choosing to offer a basic plan. The expense arises from implementing annual changes to the enhanced benefit plan. Implementing changes less frequently — every three years, for example — could avoid some administrative expense and customer confusion.
- Deciding what constitutes an enhanced plan could be difficult. A health maintenance organization (HMO) plan, for example, has very rich benefits in-network but zero benefits out of network. In this case, the cost sharing provisions could be considered enhanced but network access could be fairly limited.
- Imposing a network requirement on the enhanced plan could prove difficult or impossible on a statewide basis.
- In lieu of the enhanced and basic plan approach, another option might be to explore concepts that would ensure a floor of mandated benefits for all plans. An example might be the original 45-state rule (or some other threshold representing a significant majority of the state markets) that requires any insuring entity to include those mandates passed by 45 states. In considering this type of approach, it is important to consider the balance between mandating benefits and allowing lower-cost benefit packages.
- The treatment of plans in the individual market is not clear. The effect of S. 1955 could be different on the individual market than on the small-group market. We recommend clarifying language in the relevant sections of the legislation, or flexibility in drafting regulations, to avoid unintended consequences in the individual market.

Opinions differ considerably regarding the potential impact of allowing the market to define the minimum benefits offered as opposed to requiring a minimum, federally defined benefit plan (e.g. covered services and providers). There are many complex behavioral factors that interrelate

in a health insurance marketplace. Some states currently allow the marketing of plans that do not contain all of the state-specific mandated benefits. To date, employer acceptance of these products has been limited. Based on this experience, many actuaries expect employers will demand at least some of the benefits already mandated by the states, and insurers will need to provide these if they are to be successful in the marketplace. Other actuaries contend that it was the lack of coverage of certain benefits that drove states to mandate benefits to begin with, implying that removing the mandates would cause insurers to drop those benefits.

The task force is also concerned that consumers may not fully understand that plans exempted from state mandates may not contain all the consumer protections that state-mandated plans would provide. Complete and thorough disclosure will be necessary for groups moving from coverage containing a state's mandates to coverage without such mandates. This disclosure must happen at the point of sale and enrollment and not at the point of claim.

Whenever there is choice, there is the potential for selection. If basic benefit plans are offered alongside enhanced plans that cover a wide range of benefits, those groups who are more likely to need the additional benefits are more likely to choose the enhanced plans. Groups not needing those benefits are more likely to choose the basic plans. Unlike the AHP legislation, however, S. 1955 would require that all policies, enhanced as well as basic benefits, be pooled into a single small-employer group pool. The pool would be subject to the rating laws contained in the NAIC's 1993 model bill, which precludes pricing benefit plans for selection. This combination of a single pool and the inability to price benefit plans based on selection lowers the potential for selection.

As with our analysis of AHP legislation, we assume S. 1955 would not relieve companies from federally mandated benefits, or provisions under ERISA or HIPAA, nor preclude continued coverage of existing multiple employer welfare arrangements (MEWAs) eligible under ERISA.

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, an HMO, or a self-funded AHP. S. 1955 would appear to do this.

Applicable authority

S. 1955 would retain oversight responsibilities at the state level in the small-group market. Some state authorities will be required to oversee rating regulations different from those that exist today. S. 1955 could complicate the oversight of compliance with state-mandated benefits if any insuring entities choose to remain in the state-regulated market and/or offer state-mandated benefits. State authorities will need to be apprised of the benefits required in the enhanced plans as provided by the bill. As mentioned, it is unclear how a non-adopting state would regulate a plan being offered with federal provisions, or what would happen if the state refuses to approve such policies. The treatment of individual market policies under S.1955 would also have to be clarified.

Administrative expenses

There is a potential for expense reductions for insuring entities operating in multiple states if the “harmonization” provisions of S. 1955 result in standardization of specified filing, reporting and operational functions, and/or rating laws and mandated benefits. Some companies operating in states that currently prohibit medical underwriting, however, could experience an increase in administrative costs.

Provider discounts

Insurers currently pass on to small-employer groups the results of their buying powers in provider negotiations. It is unlikely that the introduction of SBHPs would materially change these discounts.

Transition rules

The uniform rate and benefit provisions for SBHPs in S. 1955 would help create a level playing field for plans in the small-group market. Given the current variation of state rules and regulations, however, the transition would have to be done very carefully, and with great flexibility, to avoid adversely disrupting the existing small-group market. Transition rules would be needed to prevent existing insuring entities from exiting the market without an entry of new carriers. This has occurred in states when significantly different rating and underwriting rules were implemented, so it is very possible for such situations to be replicated. Other considerations regarding the transition period include:

- In states with underwriting and rating rules that are more restrictive than the proposed federal standards, some insured groups currently pay premiums higher or lower than premiums calculated under the proposed SBHP rules. Groups with a lower risk profile (e.g., by age) that are currently paying higher premiums would want to move to the lower premiums as soon as possible. Some groups in this category may have been precluded from entering the insurance market because the premiums were high relative to their actual risk profiles. In contrast, groups that have been enjoying subsidized premiums based on their risk profiles may face increased premiums and will have incentives not to move to the new system until absolutely required to. In order to maintain a viable pool, the changes in premiums for these different types of groups should be phased in over several years. At a minimum, the transition rules for existing groups and new groups need to be the same.
- The small-employer block of business (pool) for existing carriers in these highly regulated states may be skewed toward higher-risk groups because of the subsidies associated with the underlying rating and underwriting rules. A carrier new to a market with no existing pool does not have these higher-risk groups and is likely to attract groups with lower risk profiles because they can start an entirely new pool. The rules in effect during the transition period must be designed to ensure that carriers new to a market do not have a pricing or marketing advantage over existing carriers. Carriers with existing blocks of business need to be able to market to the uninsured and to favorable risks within their own existing blocks in a manner that will allow them to compete equally with new carriers. This may require that transition rules in some states allow existing carriers to set up separate pools and/or suspend some of

the rate factor restrictions, such as the 20 percent maximum for class differences, during the transition period. States may also consider developing safety net provisions to protect both carriers and consumers. The guarantee-issue provisions of HIPAA require all carriers to accept all small groups in the market, which should help minimize the potential antiselection against existing carriers, especially after the first renewal cycle during the transition period.

- A goal of S. 1955 is to increase the number of insured groups by improving affordability. Some groups in some states could face increased premiums under the proposed federal rate structures. Other groups in these states, however, could have the benefit of lower premiums. A multiyear phase-in may be required to permit groups and carriers to adjust to the new rate structures.
- In states with existing underwriting and rating rules that are more restrictive than the proposed federal standards, insurers would be forced to adopt the proposed federal standards if they are to survive. It is not possible in the long run to have two different rating methods — one significantly more restrictive than the other — coexisting in the same market without sustaining significant adverse selection for the more restrictive insurers. The transition rules should apply to both current insurers and those entering the marketplace.

Health actuaries have had years of experience administering significant regulatory transitions. Their experience can be a source for developing transition rules that will help realize the goals of this legislation.

Effects on states with different rating requirements

Insurers in states with the most restrictive rating rules (pure community rating) would most likely adopt the federal minimum rating rules (the NAIC's 1993 model bill), so the impact on rates, enrollment, and administrative costs could be dramatic. Insurers in states with rating rules similar to or more liberal than the federal minimum would likely not change, so there would be no impact in these states.

Without complex modeling and myriad assumptions, it is extremely difficult to gauge the financial and enrollment impact of the rating rule changes on an individual state-by-state basis.

Conclusion

S. 1955 would address many of the concerns raised in the past regarding proposed AHP legislation. One of the crucial elements S. 1955 would address is maintaining a level playing field in the small-group market. Enabling all insuring entities to follow common rating rules and benefit package requirements along with the exclusion of self-funded AHPs has been instrumental in achieving this. Any legislation that reintroduces self-funded AHPs, without clear rating rules and adequate capital requirements, would eliminate the level playing field and would likely result in market destabilization, higher rates for sicker individuals or employers with sicker employees, and insolvencies.

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More clarification is needed on issues such as benefit package requirements and what transition relief will be provided to fully evaluate and understand potential consequences. Opinions differ on the potential impact of allowing the market to define the minimum benefits offered as opposed to requiring a minimum, federally defined benefit plan (e.g. covered services and providers). It is clear, however, that while some people may see premium reductions, others will see increases; and for states that currently have more restrictive rating rules than the proposed federal rules, the transition will be more difficult.

Again, we thank you for the opportunity to present our analysis. Members of the task force are available to assist Congress as it develops 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,

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cc: Members of the Senate

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ⁱ The American Academy of Actuaries is a national organization formed in 1965 to bring together, in a single entity, actuaries of all specializations within the United States. A major purpose of the Academy is to act as a public information organization for the profession. Academy committees, task forces and work groups regularly prepare testimony and provide information to Congress and senior federal policy-makers, comment on proposed federal and state regulations, and work closely with the National Association of Insurance Commissioners and state officials on issues related to insurance, pensions and other forms of risk financing. The Academy establishes qualification standards for the actuarial profession in the United States and supports two independent boards. The Actuarial Standards Board promulgates standards of practice for the profession, and the Actuarial Board for Counseling and Discipline helps to ensure high standards of professional conduct are met. The Academy also supports the Joint Committee for the Code of Professional Conduct, which develops standards of conduct for the U.S. actuarial profession.

ⁱⁱ The Academy published a comment letter on the *Small Business Health Fairness Act of 2003* (H.R. 660 and S. 545), which is available on the web (http://www.actuary.org/pdf/health/ahp_042803.pdf). In 2005, the Academy published the issue brief *FAQs on AHPs*, in response to current AHP legislation (H.R. 525 and S. 406). The issue brief is also available on the web (http://www.actuary.org/pdf/health/ahp_mar05.pdf).

ⁱⁱⁱ S. 1955, however, does not appear to increase the availability of coverage to the uninsurable self-employed.