



AMERICAN ACADEMY *of* ACTUARIES

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November 7, 2017

The Honorable Alexander Acosta
Secretary Department of Labor
200 Constitution Ave., NW
Washington, D.C. 20210

The Honorable Eric D. Hargan
Acting Secretary of Health and Human Services
200 Independence Ave., SW
Washington, D.C. 20201

The Honorable Steven Mnuchin
Secretary of the Treasury
1500 Pennsylvania Ave., NW
Washington, DC 20500

Dear Secretaries Acosta, Hargan, and Mnuchin:

On behalf of the Health Practice Council (HPC) of the American Academy of Actuaries¹, I would like to offer input as the Departments of Labor, Treasury, and Health and Human Services consider proposing regulations or revising guidance pursuant to President Trump's Executive Order issued on Oct. 12. The Executive Order focuses on expanding the access to and availability of association health plans (AHPs), short-term limited-duration insurance, and use of health reimbursement arrangements (HRAs).

The HPC encourages the departments to consider the implications of such expanded availability on the stability and sustainability of the existing ACA-compliant individual and small group markets. In particular, to be sustainable, these markets require sufficient enrollment numbers and a balanced risk profile. They also require a stable regulatory environment that facilitates fair competition, with health plans competing to enroll the same participants operating under the same rules. If one set of plans operates under rules that are more advantageous to healthy individuals or groups, market segmentation will result. Individuals and groups will migrate to the plans more advantageous to them. In other words, plans that have rules more amenable to less healthy individuals or groups will suffer from adverse selection. Especially in the absence of an effective risk adjustment program that includes all plans, upward premium spirals could result, threatening the viability of the plans more advantageous to less healthy individuals or groups.

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.

The questions and comments below highlight various issues that would need to be addressed in the rulemaking process and the possible implications for stability of the ACA-compliant markets.

Expanding Access to Association Health Plans

Under current law, regulations, and guidance, fully insured AHPs follow the rules pertaining to the units they are enrolling. In other words, AHPs that enroll small groups must follow the small group ACA rules; AHPs that enroll individuals must follow the individual market ACA rules. These rules include prohibiting coverage denials or higher premiums for individuals or groups with pre-existing health conditions, benefit coverage requirements, and cost-sharing limits. Each market also uses risk adjustment and a single risk pool to help ensure that plans are appropriately compensated for the risks they bear, thereby reducing incentives for insurers to avoid high-risk individuals and groups.

Market segmentation and adverse selection risk for ACA-compliant plans

Large groups are not required to follow all of the benefit requirements applicable to individual and small group coverage. In addition, premiums for large group coverage can vary based on the expected health costs of the group; age factors can exceed the 3:1 limits currently required in the individual and small group markets; and health status factors—prohibited in the individual and small group markets—are allowed in the large group market.² Prior to the ACA, AHPs were allowed to underwrite and set premiums based on the health conditions of the AHP members. If AHPs were allowed to follow the rules applicable to large groups, they could return to their pre-ACA practices and offer lower premiums to healthy and/or young enrollees, but premiums for ACA-compliant plans would increase because their risk pools could deteriorate.³ The extent to which broader access to AHPs could result in market segmentation and adverse selection in ACA-compliant markets depends on many factors, including:

- *Would the exemption from individual and small group ACA rules be only for self-funded AHPs or for fully insured plans as well?* The broader the exemption, the greater the risk of adverse selection to the fully insured, ACA-compliant pool.
- *Would all individuals be eligible to participate in an AHP?* Limiting AHP participation to small groups would mean adverse selection risk and the resulting higher premiums would be limited to the ACA-compliant small group market. Allowing individuals access to AHPs would raise the adverse selection risk in the individual market as well, leading to higher premiums in that market also.
- *Would self-employed individuals be eligible to participate in an AHP?* Allowing individuals to participate in an AHP only if they are self-employed would somewhat limit the adverse

² While rating factors such as age, gender, industry, and health status can be used in the development of large group rates, these factors are aggregated for the group as a whole. Within the group, rates for individual employees rarely vary by age or gender and never vary by an employee's or dependent's health status.

³ Transitional plans (often referred to as “grandmothered plans”) provide an example of what can happen when it becomes advantageous for lower-cost individuals to be covered by noncompliant plans. In states that permitted individuals and small groups to retain their pre-ACA plans, lower-cost individuals and groups were more likely to do so because they could face lower premiums. Higher costs among ACA-compliant plans were the result.

selection risk to the ACA-compliant individual market. Nevertheless, self-employed individuals make up a sizeable share of the individual market;⁴ if healthy self-employed individuals were given the option of a lower-premium AHP, the ACA-compliant individual market could deteriorate, leading to higher premiums.

Individual and employer mandate requirements

The individual mandate is an integral component of the law, especially given current law provisions that prohibit insurers in the ACA-compliant markets from denying coverage or charging higher premiums based on pre-existing health conditions. In addition, the employer mandate, applicable to employers with 50 or more workers, encourages employers to offer coverage that meets affordability and minimum value requirements.

- *Would AHP coverage count toward meeting the individual mandate?* If AHP coverage abides by current large group requirements, then it would satisfy the individual mandate. Large groups may currently offer plans with benefits and cost-sharing requirements that do not meet minimum value requirements (i.e., are less generous than ACA-compliant plans), but are still considered minimum essential coverage for the individual mandate. Further market segmentation and adverse selection in the ACA-compliant markets could result if healthy individuals and groups opt for less generous AHP coverage.
- *How would the employer mandate rules apply to an AHP?* Large employers are subject to a financial penalty if workers do not have access to employer coverage that meets the affordability and minimum value requirements and instead obtain subsidized coverage in the individual market. How would the employer mandate rules apply to employers providing coverage through an AHP?

Timing of AHP expansions

Premiums for 2018 ACA-compliant plans are finalized and open enrollment began on Nov. 1. These premiums were developed assuming current AHP rules. If access to AHPs is expanded at any time during 2018, premiums for ACA-compliant plans could be understated to the extent that AHPs attract a healthier enrollee population, worsening the risk profile of the ACA-compliant markets.

- *Would insurers be allowed to submit mid-year premium changes for the individual market? Would insurers also be able to modify small group rates mid-year for groups that enrolled earlier in the year?*⁵ Insurers are already beginning the process of developing ACA market premiums for 2019; initial rates will likely need to be filed during the spring of 2018. Resource constraints for insurers and regulators could make it difficult to simultaneously develop and approve revised rates for 2018, especially on a condensed timeline, alongside

⁴ Emilie Jackson, Adam Looney, and Shanthi Ramnath, "[The Rise of Alternative Work Arrangements: Evidence and Implications for Tax Filing and Benefit Coverage](#)," Department of Treasury, Office of Tax Analysis Working Paper 114, January 2017.

⁵ Insurers can already change small group rates quarterly for new business and renewal business. Therefore, for any new or renewal group business beginning after a change to AHP rules, the change can be incorporated into the rates as long as the changes are known far enough in advance.

the 2019 rates. In addition, laws and regulations in many states require rates and coverage to be effective for a period of 12 months.

- *If mid-year rate changes are allowed, would a mid-year open enrollment period be held so that individuals could reassess their options?* If rates change for ACA-compliant plans mid-year, it may be appropriate to consider holding a new open enrollment period or at least a special enrollment period for those whose rates increase.

Solvency and Consumer Protections

Self-funded AHPs face increased insolvency risk without clearly defined regulatory authority. In addition, all AHPs, both self-funded and fully insured, would need to be subject to state-level consumer protection laws.

- *What entity would be responsible for solvency authority for self-funded AHPs?* To ensure plan solvency in the event that plan expenditures exceed premiums due to adverse experience, insurers are required to meet state-regulated solvency requirements based on risk-based capital (RBC) formulas. Self-funded AHPs face increased insolvency risk without clearly defined regulatory authority. Absent such authority, it is likely that no entity will bear the sole responsibility for regulating AHPs or that there will be conflicting regulation. Self-funded AHPs could suffer the same fate as previous multiple employer welfare arrangements (MEWAs), many of which experienced bankruptcies and left consumers with limited avenues for redress. MEWA rules have clarified that states have regulatory authority over MEWAs. To avoid insolvency risks to AHPs, surplus requirements for self-funded AHPs should be similar to the minimum requirements for health RBC developed by the National Association of Insurance Commissioners.
- *What entity is responsible for overseeing consumer protections?* It is important to recognize the need for AHPs to abide by state-level consumer protection laws, including but not limited to network adequacy requirements and appeal processes for denied services.

Expanded Availability of Short-Term Duration Insurance

Short-term duration insurance plans are currently capped at three months, down from the 12 months allowed prior to 2017. Although currently a relatively small share of the market, enrollment in short-term plans has been growing, and could grow faster if the rules expand availability further. Short-term plans are not required to follow ACA issue and rating rules or benefit coverage requirements and typically exclude coverage for pre-existing conditions. Although coverage can be somewhat comprehensive, it usually excludes or limits coverage for certain benefit categories, such as maternity care, physical therapy, and mental health and substance abuse treatment. Short-term plans also usually have overall coverage limits, for instance \$1 million. Typically, plans can be renewed once (or more than once by switching to another insurer), but are not guaranteed renewable. Pre-existing condition exclusions begin again upon renewal, meaning any conditions that began in the prior coverage period would not be covered in the next period. Short-term coverage does not satisfy the requirement for meeting the individual mandate.

Market segmentation and adverse selection risk for ACA-compliant plans

Because of the pre-existing condition exclusions, premiums for short-term plans can be considerably lower than ACA-compliant plans and can be more attractive to individuals who are healthy. The more available short-term plans are and the more attractive they become to healthy individuals, the greater the risk for market segmentation and adverse selection, and therefore higher premiums, in the ACA-compliant individual market.

- *Would short-term coverage count toward meeting the individual mandate?* Short-term coverage would be more attractive to individuals if it met the individual mandate requirement. That could worsen the deterioration of the individual market, by further siphoning off healthy individuals.
- *Would coverage be guaranteed renewable?* Allowing short-term plans to be guaranteed renewable could make them more attractive to people who are currently healthy, because any new health conditions that arise would not be subject to pre-existing condition exclusions upon renewal. However, premiums would likely increase with policy duration to reflect this increased protection.

Timing of expansion of short-term plan availability

Premiums for 2018 ACA-compliant plans are final and open enrollment began on Nov. 1. These premiums were developed assuming current short-term duration insurance rules. If access to short-term plans is expanded at any time during 2018, premiums for ACA-compliant plans could be understated to the extent that short-term plans attract a healthier enrollee population, worsening the risk profile of the ACA-compliant markets.

- *Would insurers be allowed to submit mid-year premium changes for the individual market?* Insurers are already beginning the process of developing ACA market premiums for 2019; initial rates will likely need to be filed during the spring of 2018. Similar to the situation if AHP availability is expanded, resource constraints for insurers and regulators could make it difficult to simultaneously develop and approve revised rates for 2018, especially on a condensed timeline, alongside the 2019 rates. In addition, laws and regulations in many states require rates and coverage to be effective for a period of 12 months.
- *If mid-year rate changes are allowed, would a mid-year open enrollment period be held so that individuals and groups could reassess their options?* If rates change for ACA-compliant plans mid-year, it may be appropriate to consider holding a new open enrollment period or at least a special enrollment period for those whose rates increase.

Expanded Availability and Permitted Use of Health Reimbursement Arrangements

Although the 21st Century Cures Act (PL 114-255) allows small employers to use HRA contributions toward individual market premiums, large employers are prohibited from doing so. Extending the ability to large employers could increase the adverse selection risk in the individual market if less healthy workers are disproportionately encouraged directly or indirectly to use their HRAs for coverage on the individual market. For instance, large employers with a greater share of less healthy employees could be more likely to offer HRAs toward individual

market premiums than employers with healthier employees. In addition, when provided an HRA, less healthy individuals might prefer to use the HRAs to obtain ACA-compliant individual market coverage, whereas healthy individuals might prefer to use the HRAs to cover out-of-pocket spending or for non-compliant coverage. Adverse selection could also be a problem if employers could target their less healthy workers or classes of workers for individual market coverage, while offering group coverage to their healthy workers.

On the other hand, many large employers are interested in transitioning to a defined contribution approach of providing employer-sponsored health benefits. Allowing HRAs to be used to purchase individual market coverage could facilitate such a trend and could improve the individual market risk pool if a broad cross section of employers, as opposed to solely those with employees with high health costs, move in this direction. Nevertheless, employers would be hesitant to use this approach if they consider the individual market to be unstable and not offering adequate choices to their employees.

- *If large employers offer HRA contributions, would these contributions meet the large group affordability and other requirements?*
- *If individuals use these tax-advantaged HRA funds to purchase individual insurance in the ACA market on exchanges, would the HRA be counted as income in the determination of any potential subsidies?*

We appreciate the opportunity to provide these comments. If you have any questions or would like to discuss further, please contact David Linn, senior health policy analyst, at linn@actuary.org or 202-785-6931.

Sincerely,

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Vice President, Health Practice Council
American Academy of Actuaries

For more information, see related publications from the American Academy of Actuaries:

[*Risk Pooling: How Health Insurance in the Individual Market Works*](#) (July 2017)

[*Association Health Plans*](#) (February 2017)

[*Selling Insurance Across State Lines*](#) (February 2017)

[*How Changes to Health Insurance Market Rules Would Affect Risk Adjustment*](#) (May 2017)