AMERICAN ACADEMY *of* ACTUARIES

October 5, 1998

The Honorable Harris W. Fawell, Chairman
Subcommittee on Employer-Employee Relations
2368 Rayburn House Office Building
Washington, DC 20515-1313

Dear Representative Fawell:

This letter presents the comments of the American Academy of Actuaries, Association Health Plan Work Group regarding the "Health Coverage for Employees of Small Businesses" provisions in Title I (Subtitle D) of the Patient Protection Act of 1998 (H.R. 4250). The Academy is the public policy organization for actuaries of all specialities 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.

The intent of H.R. 4250 is to improve the access of small employers to affordable health insurance by promoting use of association health plans (AHPs). An AHP offers medical coverage to members of an organization that does not exist exclusively to obtain or offer medical care insurance. However, as written, the current AHP legislation may have unintended consequences.

Summary of Concerns

The Academy notes that recent changes to the proposed legislation have decreased the potential for negative side effects to the consumer. However, the dangers of market segmentation, AHP insolvencies, and the avoidance of state and federal market protections are still present in the bill. Market segmentation arising from the law's implicit incentives for AHPs to select healthy groups could destabilize small group insurance markets. The ability of an AHP to locate in a favorable regulatory jurisdiction could undermine small group reform laws in other states. The solvency requirements of the legislation do not increase with AHP growth to protect against solvency risk. Finally, the provisions of H.R. 4250 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."

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

H.R. 4250 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 could encourage the splitting of the small-group market into blocks of healthy and unhealthy groups.

State regulation of small group health insurance plans generally limit the ability of plan sponsors 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 which are 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.

Section 805(a)(2) of the bill provides that contribution rates must be nondiscriminatory.[1] It also states that contribution rates for any participating small employer must not vary on the basis of the claims experience or the type of business or industry of the small employer. 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 association health plan could charge small employers with less healthy employees a higher rate than what would be permitted for health insurers operating under the small employer rating restrictions. The result would be that small employers that have employees with health risks would be more likely to obtain coverage from the private health insurance market rather 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. 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 provisions of the bill. It appears that the Department of Labor (DOL) is given the responsibility to enforce the rating rules, and DOL

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[1]The section references in our comment letter are to those sections of the Employee Retirement Income Security Act of 1974 amended by Section 1302 this legislation.

historically has not had the complete infrastructure to do so. Lack of effective enforcement could reward those AHPs that do not comply with the spirit of the law. In other words, a marketing and rating plan that targets only employers with employees in good health is not in the spirit of this law.

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 quite adequate. The proposed rules governing AHPs have certainly improved the minimum solvency standards for new plans as far as initial surplus requirements are concerned. These requirements are similar to the minimum requirements for Managed Care Organizations' Risk Based Capital (MCO RBC) developed by the National Association of Insurance Commissioners (NAIC). This start-up capital is included in Section 806(b) "Minimum Surplus in Addition to Claims Reserves."

However, capital requirements need to increase with the growth of AHP claim volume. Under the latest version of the MCO RBC Underwriting Risk Factor, an approximation for surplus would be 10 percent of the total projected claims for the AHP during the year following the evaluation of such claims. While the requirements for reserves for claims and other factors and for surplus 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 to $10 million (5,000 to 10,000 individuals). As the AHP gets larger, the total surplus requirement rises with claim volume.

In the Academy's work with the NAIC on the RBC standards, we designed a solvency simulation model that demonstrated the relationship of capital needs with 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. 4250 provides for the certification of AHP solvency by a qualified actuary. A "qualified actuary," as defined by Section 813 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 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. 4250.

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 Negotiated Rule Making Committee proposed under Section 806(j) of the legislation.

Applicable Authority

Section 813(a)(5) provides a definition for "applicable authority" that allows states to assert jurisdiction over Association Health Plans. However, this authority is not universal. The section provides for situations where there is "joint authority," presumably between the state and federal levels. There are also situations where the DOL has sole authority over an AHP and state jurisdiction is pre-empted.

These provisions create confusion as to which regulatory entity has responsibility for oversight of the various functions of AHPs. The Academy welcomes the recognition in this legislation of the value of the expertise and resources currently in place at the state level. However, the Academy is concerned that the current language will create situations similar to previously proposed MEWA legislation where the scope of regulatory responsibility over such plans was unclear.

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 responsibilities of the states 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?

In Section 813(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 resources in 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 which is perceived to have the least oversight to become their applicable authority, effectively negating the existing health insurance laws in most, if not all, the states.

The Academy is concerned that by dividing the responsibilities between the State and the 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 Association Health Plans based on the amount of premiums or contributions received from employers and employees who make up the plan.[2] 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. The Academy supports 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 association plans. It is also questionable whether a state would have the authority to levy such assessments if it defers to the Department of Labor to regulate the AHPs in its states, or if a multi-state association plan is domiciled in another state 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 can not exceed premium taxes that are paid by health insurers or health maintenance organizations. In most states, HMOs are not taxed, or pay a lower tax than health insurance companies. Association plans 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.

Conclusion

Overall, H.R. 4250's provisions for AHPs may:

- Destabilize the small-group insurance markets through greater market segmentation because of the law's implicit incentives for AHPs to select healthy groups and favorable regulatory jurisdictions. This would undermine the small group reform laws of most states.

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[2] 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 . . . ." (HR4250, 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.

- Increase solvency risks unless those solvency requirements are increased as the AHP grows.
- Create confusion, as to which government authority, the DOL or a State, has regulatory responsibility as the "applicable authority."
- Raise very difficult issues regarding the use of state assessments for high risk pools, premium taxes or other purposes.

We recommend that these issues be considered carefully because of the potential significant adverse impacts on current insurance markets. The Academy is available to assist Congress in addressing solutions on the issue of small employer health insurance reform. If you, or your staff need further clarification on parts of the bill or have any questions, please contact Tom Wilder or Alison Kocz at the American Academy of Actuaries at (202) 223-8196, and they can put you in contact with me.

Sincerely,

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Other Academy members contributing to this letter are: David J. Bahn, FSA, MAAA; Karen Bender, ASA, MAAA; Richard Niemiec, MAAA; Donna C. Novak, ASA, MAAA; Peter Perkins, FSA, MAAA; Harry Sutton, Jr., FSA, MAAA; and David Wille, FSA, MAAA.

cc: The Honorable Trent Lott
The Honorable Thomas Daschle
The Honorable James M. Jeffords
The Honorable Edward M. Kennedy
The Honorable Newt Gingrich
The Honorable Dick Gephardt