

July 20, 2011

Honorable Kathleen Sebelius
Secretary
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Madam Secretary:

On May 23, 2011, the Department of Health and Human Services (HHS) published the Rate Review regulation. As part of the regulation, HHS requested specific comments on how associations should be treated under the rate review process:

“Comment Subject Areas: We will consider comments on how individual and small group coverage sold through associations should be treated under the rate review process as discussed in this final rule with comment period that are received by the date and time indicated in the DATES section of this final rule with comment period.”

The National Association of Insurance Commissioners (NAIC) provides the following comments to HHS regarding associations, including answers to the six specific questions asked in the regulation. These comments are based on our experience as regulators of health insurance, survey responses from 31 states (including 4 of the 5 most populous states) providing answers to the six questions listed below, and interviews with representatives of six organizations that sell medical coverage through association or trust vehicles.

In summary, we make the following two recommendations:

- The rate review requirements in the law for individual/family coverage apply to every block of association or trust coverage that is individually underwritten or rated (applicants provide health information to determine eligibility for coverage or to determine a rate level),
- The rate review requirements in the law for small group coverage apply to every block of association or trust business that covers small group employees through their employer.

Please note that the information used, in part, to formulate these recommendations was obtained through NAIC surveys of the states and interviews with representatives of six organizations that sell medical coverage through association or trust vehicles. The survey and interviews were somewhat informal and were conducted over a limited time period. HHS may want to collect additional information directly from the organizations that sell this coverage and from the insured persons who have purchased the coverage before making a final determination of how the rate review requirements in the Affordable Care Act apply to this type of medical coverage.

The following summarizes information drawn from the interviews:

Distinctions among types of associations and types of coverage

There are several distinctions that should be made to understand the association market for medical insurance. These are relationship to the insurer, who is eligible (individual member, family members, enrolled student, or

employee), underwriting level, rating factors, comprehensive or limited benefits, and commissions to a sales force or the association.

Some associations like AARP, the NFIB, or colleges are large and independent and negotiate with different insurers to offer medical coverage to their members. These insurance plans can be a significant revenue source for the association. Although colleges are not technically associations, the plans they offer to students are substantially similar to association plans. Other associations, such as some trade associations or chambers of commerce, are smaller and may be in a restricted geographic area, and have an ongoing relationship with one insurer. Still other associations are set up and controlled by the insurer who offers coverage to the members. Each state defines the words “association”, “trust”, and “group insurance” in their state law, and these typically differ from state to state.

Some associations offer coverage to individual members and their families. Other associations have small employers as members, and offer coverage to the employees of each small employer that is a member. Some offer coverage both to individual members and to employer members to cover their employees.

Some associations offer coverage with limited underwriting, accepting all or almost all member applicants. Typically these are associations that have a strong connection to their members, which results in high participation in the coverage. This high participation helps to reduce adverse selection. An example might be a trade association such as a state banker’s association or an association of optometrists or trial lawyers. Another example is a student plan offered to students enrolled in a college. Other associations apply full underwriting, similar to the underwriting of individual medical insurance applicants.

Some associations offer community rating, varying rates only by geographic area and different plan of benefits or network. Others vary the rates by many other factors, including age, gender, occupation, duration of coverage, claim experience, and health status.

Some associations offer medical benefits that are very comprehensive, covering inpatient and outpatient care along with prescription drugs with a deductible and copayment and a high annual or lifetime limit on benefit payments. Other associations offer benefits that cover limited procedures, limited dollar amounts per procedure, a low annual or lifetime limit on benefit payments, or limited causes such as accident-only coverage.

Commissions paid by the insurer to an agent or broker typically are between 3% and 10% of premiums. If the coverage is primarily sold by mass marketing, the cost of marketing replaces some or all of the commissions. Some associations who do the marketing to their members receive royalties from the insurer. This is not generally reported as commissions, but as general administrative expense. Some associations are able to charge higher membership dues due to the availability of medical insurance, and those dues do not appear on the records of the insurer. Note that some carriers market association medical insurance on ehealthinsurance.com, and even offer membership and bill the association dues with the insurance.

How Carriers Comply with Financial Reporting and Rate/Form Filing Laws

Most carriers indicated that they report their association medical business on line B02 (Group Business, Comprehensive Major Medical, Multiple Employer Associations and Trusts) of the NAIC Annual Statement Accident and Health Policy Experience Exhibit for employer business and B03 (Group Business, Comprehensive Major Medical, Other Associations and Discretionary Trusts) for individual membership business. Other carriers report their association medical business in line B01 (Group Business, Comprehensive Major Medical, Single Employer) for employer business along with single-employer policies, and in line A01 (Individual Business, Comprehensive Major Medical) for individual membership business. For the carriers that lump the association business together with the directly issued policies in this way, there is no way to determine how much association business they have. These carriers did not answer the question about how much association business they have. All carriers indicated that for the NAIC Annual Statement Supplemental Health Care Exhibit they allocate their

association employer business to the small or large employer categories, and their association individual business to the individual category, in conformance with federal law and the NAIC instructions.

All carriers indicated a familiarity with the different form filing and rate filing requirements of the different states. They tailor the benefits and rating factors to each state's requirements to the extent that the state requirements apply to association/trust business. In other words, if state rating rules for individual or small employer business do not apply to association group business, some carriers rate for age without limits, for gender, for geography, and for health status.

In addition to information drawn from the interviews, please find attached a survey (*Association Health Plan Survey Results.doc*) conducted at the request of the Washington State Office of the Insurance Commissioner in November, 2010.

Excerpt from the Final HHS Rate Review Regulation Preamble:

“In addition, we are seeking comments to address the following questions:

- 1. Do States currently review rate increases for association and out-of-State trust coverage sold to individuals and small groups, regardless of whether the policies are situated in or outside of their States?**
- 2. How many such rate filings do States receive for association and out-of-State trust coverage?**
- 3. How prevalent are association and out-of-State trust coverage arrangements? What percentage of individual market and small group market business is sold through associations and out-of-State trusts?**
- 4. In which States is association and out-of-State trust coverage commonly purchased by individuals and small groups? Where are out-of-State trusts typically situated?**
- 5. Why do some individuals and small employers purchase coverage through associations and out-of-State trusts rather than the traditional markets? Are there particular groups of individuals or types of small employers that typically purchase coverage through associations and out-of-State trusts? What organizations (other than issuers) typically sponsor, endorse, or market association and out-of-State trust arrangements?**
- 6. How do rate increases for association and out-of-State trust coverage sold to individuals and small groups compare to rate increases in the traditional market? What explains the differences (if any) between rate increases for association and out-of-State trust coverage and traditional market coverage?”**

Summarized Answers to HHS Questions Regarding Health Coverage through Associations
(answers from each state are attached – please see *State Survey Comments on Final Reg.xlsx*)

1. Do States currently review rate increases for association and out-of-State trust coverage sold to individuals and small groups, regardless of whether the policies are situated in or outside of their States?

Answer: Twenty of the thirty-one states that responded review rate increases for association and out-of-State trust coverage sold to individuals and/or small groups in their states, without regard to the situs of the trust.

2. How many such rate filings do States receive for association and out-of-State trust coverage?

Answer: Many states were unable to answer this question. Of those which did answer it, the numbers ranged from 0 to 84 rate filings in 2010.

3. How prevalent are association and out-of-State trust coverage arrangements? What percentage of the individual and small group market business is sold through associations and out-of-State trusts?

Answer: Many states were unable to answer this question. Of those which did answer it, the percentages ranged from 1% to 66% for small group coverage, and from 1% to 72% (measured by number of people covered) for individual coverage. In summary, the answer to this question varies dramatically by state.

4. In which States is association and out-of-State trust coverage commonly purchased by individuals and small groups? Where are out-of-State trusts typically situated?

Answer: The states in which association and out-of-State trust coverage is most commonly purchased by individuals appear to be Florida, Illinois, Ohio, Virginia, and Wisconsin. The states in which association and out-of-State trust coverage is most commonly purchased by small groups appear to be Illinois, Kentucky, Montana, and Washington.

Out-of-State trusts appear to be situated most commonly in Delaware, Illinois, and Washington DC.

5. Why do some individuals and small groups purchase coverage through associations and out-of-State trusts rather than the traditional markets? Are there particular groups of individuals or types of small employers that typically purchase coverage through associations and out-of-State trusts? What organizations (other than issuers) typically sponsor, endorse, or market association and out-of-State trust arrangements?

Answer: It is difficult to generalize why individuals and small groups purchase coverage through associations and out-of-State trusts rather than the traditional markets, and the answers are somewhat speculative. Among the reasons believed to be motivating such purchase decisions are aggressive sales tactics, avoidance of state regulations, perceived lower price, less restrictive underwriting/greater accessibility, and reduced administrative burdens.

No pattern of typical types of purchasers was observed.

Typical sponsoring organizations include professional associations, alumni associations, AARP, and large retail chains such as Costco.

6. How do rate increases for association and out-of-State trust coverage sold to individuals and small groups compare to rate increases in the traditional markets? What explains the differences (if any) between rate increases for association and out-of-State trust coverage and traditional market coverage?

Answer: Most states were unable to answer these questions. Three states did provide answers, essentially as follows:

- The rate increases for associations tend to be in line with rate increases from smaller carriers, which typically issue association plans. Smaller carriers tend to have higher rate increases than the market average so the overall rate increases for associations tend to be higher than the market average.
- Higher rate increases after issuance. Some associations and trusts appear to attract health insurance buyers by offering lower premiums at issuance. However, at renewal, increases in

rating factors tend to drive up premium rates in later years more quickly than in traditional markets

- For individual coverage via non-employer association group contracts, renewal underwriting and re-rating is allowed each year without a rate increase filing. Traditional individual insurance policies do not allow renewal underwriting and require rate increases to be implemented via rate filings (except for changes in age, area, or family structure). Due to this difference in rating, rate increase filings should be lower for individual coverage via non-employer group contracts than for traditional individual insurance, even though premium rate increases that include renewal underwriting/re-rating may be higher .

Sincerely,



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