

# The Department of Labor

## LACKS THE STAFFING, EXPERIENCE, AND REGULATORY AUTHORITY TO EFFECTIVELY REGULATE ASSOCIATION HEALTH PLANS

by Roderick A. DeArment, Partner, Covington & Burling



CONGRESS IS CONSIDERING LEGISLATION (H.R. 660, S. 545) that would exempt health coverage sold through Association Health Plans (AHPs) from state law and oversight and transfer regulatory authority to the U.S. Department of Labor (DOL).

Proponents of the AHP legislation argue that it is a solution for the problem of the uninsured and the inability of small businesses to obtain affordable health insurance. However, over 1,000 organizations and state and federal policymakers oppose the legislation. Their concerns fall into two categories: (1) that AHP legislation would undermine state consumer protection laws, and (2) that the legislation would increase costs for most small employers by allowing AHPs to siphon off firms with healthier workers from the traditional insurance market.<sup>1</sup>

Less attention has been paid to whether exempting AHPs from comprehensive state regulation and transferring oversight of these plans to the DOL will greatly increase the risks of fraud, plan failure, and other problems for small employers. Certainly, the history of similar plans called Multiple Employer Welfare Arrangements (MEWAs) suggests that these risks are significant.

This article addresses concerns about the AHP legislation, analyzing how effective the DOL is likely to be in protecting small businesses and their workers enrolled in these health plans. As part of this assessment, the article reviews how state insurance commissioners currently regulate health insurance and describes DOL's current enforcement responsibilities and experience with health care and health insurance. The article analyzes the DOL budgetary and staffing capability to handle AHP enforcement, as well as its experience and staff expertise in health insurance regulation. Finally, it compares the state regulatory tools for health insurance with those that would be provided to the DOL under the AHP legislation.

The article concludes that the DOL does not currently have the budget and staff to handle AHP regulation, nor does it have sufficient regulatory experience or staff expertise in health insurance regulation. DOL's considerable experience and skill in ERISA (Employee Retirement Income Security Act) enforcement involves a fundamentally different kind of regulation. Most importantly, the article finds that the AHP legislation deprives DOL of the regula-

tory tools it needs to ensure that small businesses have access to fairly priced and financially sound health coverage.

### How Health Insurance Is Regulated Today

HISTORICALLY, THE FEDERAL GOVERNMENT HAS largely avoided the direct regulation of private health insurance and instead, through the McCarran-Ferguson Act of 1945, deferred responsibility in this area to the states.

The key exception to this deferral of responsibility to the states came with the enactment of ERISA in 1974, which exempted single employer self-insured health plans from state insurance regulation. However, at the same time, ERISA expressly preserved state regulation of health insurance policies offered to employers. ERISA also permits states to regulate health plans offered by MEWAs, since they are essentially engaged in the business of insurance.

The Association Health Plan legislation passed by the House in 2003 (H.R. 660), and its Senate companion (S.545), would overturn this established regulatory structure by giving the federal government (through DOL) the primary responsibility for regulating entities that are acting as insurers. As a result of this legislation, the DOL would regulate AHPs that assume risk from thousands of independent small employers with no common relationship other than participation in a given trade, business, or professional association.

### State Regulation of Health Insurance

The states have more than 125 years of experience in regulating the insurance industry. According to the National Association of Insurance Commissioners (NAIC), state insurance departments nationwide employ over 10,000 regulators, and the combined annual budgets of state insurance departments total more than \$700 million.<sup>2</sup>

State insurance regulation involves constant and regular monitoring of the solvency, finances, rates, claims handling, sales practices, and advertising of *every* insurer within its regulatory reach.<sup>3</sup> It consists of proactive, regular review of *all* regulated insurers.

This state insurance regulatory work is conducted by highly skilled and trained employees, many of whom have specialized education and certification. These employees include actuaries, financial examiners, market conduct examiners, rate/form analysts, spe-

cial computer and data processing personnel, liquidation personnel and consumer benefit representatives, investigators, and attorneys.<sup>4</sup>

States have a number of regulatory tools in their arsenals. Some of the most important tools include the following:

- Market conduct reviews
- Premium/Rate reviews
- Timely and detailed financial reporting
- Financial solvency protections
- Guaranty funds

## MARKET CONDUCT REVIEWS

State insurance laws generally require that insurers file insurance policies, rates and advertising materials, and prohibit false and misleading advertising and marketing. The filed materials help state regulators police proactively the marketing practices of insurers and agents.<sup>5</sup>

State market conduct reviews are often performed simultaneously with financial examinations. The market conduct evaluation focuses on sales, advertising, rating, and handling of claims, and serves a number of pro-consumer functions. First, it ensures company compliance with state laws and regulations. Second, the examiners check to determine that the rates actually charged conform to the rates filed. Third, examiners review advertising material to detect any abuses or any statements that could mislead consumers. Fourth, the examiners review declinations, cancellations, and renewals to make certain that the company is not engaged in unfair discrimination. Findings from the market conduct reviews are documented and corrective actions are recommended to address specific problems identified during the examination.

Finally, effective market conduct regulation assists in solvency regulation. A recent assessment of market conduct regulations observes:

Because market regulators monitor insurers' prices, products and trade practices, they can alert financial regulators to potential solvency problems. Market regulators can draw attention to several indicators of potential financial trouble, including: inadequate rates; rapid expansion into risky lines or products; a high number of consumer complaints; excessive delays in paying claims; and the lack of good internal controls on underwriting and sales activities. Insurance departments are increasing the coordination of the financial and market regulation units to expand and quicken the detection of potentially troubled insurers.<sup>6</sup>

State officials interviewed for this report stressed that surveillance of market conduct is supported by state insurance departments' knowledge of their local insurance market and ongoing handling of consumer complaints. This local presence helps state

regulators identify warning signals that may trigger market conduct examinations, such as complaints regarding unpaid claims or inappropriate denial of benefits. The goal of this surveillance is to identify and correct problems in order to protect consumers and other purchasers in the state.

## RATE REVIEWS

States generally require insurers to file their rates or premiums, including its actual rate development assumptions and actuarial certifications with the insurance department. Many states require approval of rates by the insurance department before the rates take effect.<sup>7</sup> Other states are "file and use" states, which allow

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insurers to begin using the rates upon filing, however insurance departments may review these rates on an ongoing basis.<sup>8</sup> State regulators review these findings for reasonableness as well as compliance with existing state law. Insurance departments also require the filing and review of contract forms, sales brochures, and other documents necessary to verify the reasonableness of rates.

NAIC's guidance manual for evaluation of insurers' rating methodologies provides information to assist insurance departments when determining if rating factors used by health insurers (such as age, gender, family composition, geography, or health status) are excessive from an actuarial standpoint.<sup>9</sup> Insurance departments may reject proposed premiums that exceed what is deemed reasonable. Importantly, once rates go into effect, states monitor compliance with the rating manual filed with insurance departments, including sampling premiums charged to small employers in the marketplace.

## TIMELY AND DETAILED FINANCIAL REPORTING

State law and regulations generally require that insurers file detailed quarterly and annual financial reports. These reports are then reviewed by expert financial analysts. The resulting reviews enable states to closely monitor the financial health of companies

on an ongoing basis and provide states with a prompt warning of emerging solvency problems. NAIC helps identify problems through computerized review of electronic filings.

Insurance departments also conduct comprehensive on-site financial examinations. Financial examinations are either periodic examinations, which generally occur every three to five years, or targeted examinations, which focus on specific issues. The results of an insurer's examination are documented in a report that assesses the insurer's financial condition along with any "material adverse findings" found during the course of the examination. The report also "may include corrective actions required to be taken by the insurer and/or recommendations for improvements."<sup>10</sup>

### **SOLVENCY PROTECTIONS**

All states have set minimum claim reserve, capital, and surplus requirements, and the vast majority of states set these minimum levels in relation to the amount of financial risk an insurer bears. States require insurers to maintain reserves that are sufficient to cover *expected* claims. The average claim reserve amount for health insurers nationwide was \$5.9 million in 2002, according to the U.S. General Accounting Office (GAO).<sup>11</sup>

In addition, states require insurers to maintain additional capital and surplus to ensure that insurers have a financial cushion to withstand any unexpected losses in excess of the expected loss amount provided via reserve requirements. The average capital and surplus maintained by health insurers reported by states was \$15 million in 2002, according to GAO. Because these requirements typically increase with the risk assumed by an insurer, larger insurers may be required to maintain hundreds of millions of dollars in capital and surplus.



States measure risk in four areas to determine the appropriate level of capital and surplus requirements for an insurer: (1) underwriting risk, (2) asset risk, (3) credit risk, and (4) general business risk. If certain thresholds are not met, the company must file planned corrective actions. Higher thresholds require only corrective actions, whereas lower thresholds may require regulatory oversight by the insurance department or placement in receivership.

Additional protection is provided through limits on the types of investments insurers can make. According to the NAIC, 23 states base their requirements on NAIC models that limit the types of investments insurers can make. For example, NAIC may require reserves or capital to be invested in conservative and secure instruments such as government bonds.<sup>12</sup> States also limit the concentration of assets and prohibit certain investments, and they require higher levels of surplus if higher-risk asset classes (e.g., common stock) are part of a company's asset portfolio. They also increase the amount of capital required when a company has less liquid investments. In addition, certain assets (e.g., those which are not readily convertible to liquid assets) are not recognized on the balance sheet.

State regulators monitor insurers' solvency through regular financial examinations and may take a variety of actions when faced with a solvency problem, including seeking explanations, requiring additional reporting, obtaining a correction plan, or revoking the insurer's certificate of authority.<sup>13</sup> The corrective actions are triggered at levels where default is not yet imminent. State regulators can issue cease-and-desist orders that allow for the immediate shut down of an insurance entity without going to court. When insurers fall below the required capital levels, they are automatically placed into receivership authority, "which is often the only way to take over an authorized company, to stop depletion of assets, and to find assets to pay claims of victims."<sup>14</sup> Moreover, state insurance departments can literally move into an insurer's facilities and oversee business operations, including cosigning checks, when an insurer is on the brink of failure.

### **GUARANTY FUNDS**

Most states maintain a broad-based guaranty fund, which can be accessed to pay policyholder claims in the event of health insurer default. Where a failing insurer's funds are insufficient, states generally require solvent insurers to contribute to the fund in order to ensure that claims are paid. State guarantee funds ensure that consumers will not be responsible for unpaid claims.

## **How AHP Legislation Would Change The Regulation Of Health Insurance**

### **New DOL Regulatory Responsibilities under Proposed AHP Legislation**

Association health plans exist today, but are regulated by the states and are required to meet all state rules. As noted earlier, H.R. 660 and S. 545 would exempt self-insured AHPs from all

state laws and oversight and give to DOL the responsibility for regulating the new federally certified insurance companies. The specific tasks assigned to DOL by the legislation fall into two main categories: (1) ensuring compliance with the general requirements set forth in the legislation, and (2) oversight of financial solvency for self-funded AHPs.

(1) **Compliance.** DOL is directed to certify any AHP that meets the qualifications set forth in the bill, including sponsorship by a *bona fide* association in existence for at least three years with a bonded fiduciary Board of Trustees. DOL must ensure that each AHP complies with coverage requirements, including the requirement that all covered employers are members of the association sponsoring the plan and the individuals covered are owners or employees of a participating employer, self-employed, or otherwise eligible to participate. DOL also must ensure compliance with HIPAA and other federal health mandates, rules against nondiscrimination in plan participation, and rules against varying contribution rates for the AHP based on the type of business or industry or any health status-related factors, except as permitted under state-passed rating laws.

(2) **Solvency.** DOL also has authority under the legislation to: review annual reports from AHPs that provide actuarial certifications on the adequacy of reserves and contribution rates and on current and projected values of assets and liabilities; ensure that an AHP meets surplus and capital requirements (up to a maximum \$2 million) and have stop loss and indemnification insurance; handle voluntary and mandatory plan terminations, including acting as trustee for insolvent plans; establish and maintain an Association Health Plan Fund to cover lapse, stop loss and indemnification insurance for failed self-insured AHPs; and investigate, and bring enforcement actions (including individual sanctions for willful misrepresentation for noncompliance with the AHP rules, with court approval).

Clearly, the regulatory authority provided to DOL over self-insured AHPs under the legislation falls far short of the authority that states currently exercise over state-regulated health insurance plans. Even though these AHPs would be in the business of insurance, their exemption from state regulation means they would be subject to far fewer requirements and far less stringent regulation than state-regulated plans.

The regulatory picture for insured AHPs that operate in multiple states is even worse. Such AHPs could select the state with the most lenient insurance laws to file and receive approval of their policy forms, and then offer coverage under that same policy in all of the states in which they operate. Regulators in other states may have no authority to oversee/enforce their state's insurance laws with respect to such AHPs. Thus, multi-state insured AHPs would appear to exist in a regulatory vacuum; DOL would have no authority over them, and the law could be interpreted to prevent regulatory oversight by most states in which they do business.

## The Department Of Labor's Capability To Handle These New Responsibilities

### DOL'S Current Health Care Responsibilities

#### IN GENERAL

The Department of Labor, through its Employee Benefits Security Administration (EBSA), has regulatory responsibility for six million single and multi-employer health and welfare plans. EBSA enforces Title I of ERISA, which principally involves enforcing compliance with the fiduciary, reporting, and disclosure requirements. EBSA's role as an enforcement agency in the health arena involves promulgation of rules and regulations, compliance assistance and education, handling complaints, investigating alleged fiduciary breaches, and bringing enforcement actions. EBSA's main enforcement tool is the use of highly targeted investigations.

EBSA has never had the resources to audit compliance of each plan under its ERISA regulatory umbrella. According to a 2002 GAO report, the Pension Welfare and Benefits Administration (PWBA, now renamed EBSA) has "not systematically estimated the nature and extent of employee benefit plan non-compliance with ERISA provisions. Therefore, PWBA cannot ensure that it is accurately identifying the areas in which it needs to focus to most efficiently and effectively allocate its limited resources." Indeed, in 2000, the agency estimated it would take its full investigative staff 90 years to assess baseline noncompliance of just the pension plans under its responsibility.<sup>15</sup>

EBSA has jurisdiction over only 750,000 pension plans, compared with 6 million health plans. Former Assistant Secretary Olena Berg testified that based on DOL's investigative experience, it would take 300 years to review once every benefit plan under its jurisdiction.<sup>16</sup>

EBSA is also responsible for enforcing a number of specific federal coverage mandates and limited eligibility (i.e., nondiscrimination) rules. Thus, EBSA enforces the continuation of health benefits under COBRA<sup>17</sup> and the consumer protection requirements of HIPAA,<sup>18</sup> and has concurrent jurisdiction over the provisions of the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act of 1996, and the Women's Health and Cancer Rights Act.

#### CURRENT RESPONSIBILITIES WITH REGARD TO HEALTH PLANS

Consistent with its regulatory duties, EBSA seeks to ensure that federally mandated benefits or protections are included in health insurance plans. However, DOL has no systematic data on all employer-based plans to help them identify instances of non-compliance. Instead, EBSA generally uses "soft enforcement" like voluntary surveys inquiring whether insurance companies are in compliance. DOL generally will not seek a court

order to enforce standards, unless it finds a pattern and practice of illegal action.<sup>19</sup> Thus, complaints from individual participants may go unanswered.

EBSA becomes directly involved with health insurers when they function as ERISA fiduciaries. For example, EBSA initiated multiple investigations of health insurers for failure to pass through provider discounts in an administrative-services-only arrangement. Otherwise, EBSA does not have regulatory responsibility for health insurance companies. It has never had responsibility for regulating health insurance premiums, the safety and soundness of insurers, or other aspects of insurance regulation. This has been exclusively handled by the state insurance commissioners. Section 502(b)(3) of ERISA expressly precludes DOL enforcement of the group health plan requirements against health insurers.

**“Without the funding, staff expertise, or regulatory tools currently available to state regulators, the DOL would be unable to extend the protection that consumers have come to expect from state regulated insurance.”**

### **MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs)**

When ERISA legislation passed in 1974, many operators of business associations and Multiple Employer Welfare Arrangements (MEWAs) argued that their plans were exempt from state regulation under ERISA. In 1983, Congress clarified that states could regulate MEWAs in response to mounting problems involving fraud and insolvency among these plans. However, MEWA operators continued to take advantage of regulatory ambiguity to circumvent state regulation. As documented in a 1992 report by the GAO, between January 1988 and June 1991, "MEWAs left at least 398,000 participants and their beneficiaries with over \$123 million in unpaid claims."<sup>20</sup>

Since that time, EBSA has worked with state regulators to combat MEWA fraud. EBSA's role has been to require registration of MEWAs, to clarify the state regulatory authority over MEWAs, and to shut down fraudulent MEWAs through fiduciary breach enforcement. While EBSA has pursued some successful criminal and civil actions involving MEWA fraud, EBSA has left the insur-

ance regulation of MEWAs to the states. EBSA itself describes the separate roles of DOL and the states as follows:

[W]hile the Department may pursue enforcement actions with respect to MEWAs, such action is considerably different from, and often more limited than, the remedies generally available to the states under their insurance laws. In this regard, it is important to note that, in many instances, states may be able to take immediate action with respect to a MEWA upon determining that the MEWA has failed to comply with licensing, contribution or reserve requirements under state insurance laws, whereas investigating and substantiating a fiduciary breach under ERISA may take considerably longer.<sup>21</sup>

### **DOL Lacks the Capacity to Handle the Regulatory Tasks**

#### **DOL DOES NOT HAVE ADEQUATE STAFFING TO HANDLE AHP REGULATION**

Adding regulatory responsibility for federally certified AHPs would considerably expand EBSA's mission and would require significant additional staffing and resources as well as different expertise than DOL currently possesses. It is not true, as some AHP proponents have stated, that EBSA can simply "allocate" the money for AHP enforcement from EBSA funds.

EBSA is already requesting an increase in budget and personnel in order to meet its existing enforcement duties and to handle new responsibilities under the Sarbanes-Oxley Act.<sup>22</sup> Moreover, more than half of EBSA's senior management staff will be eligible to retire in the next five years, which according to the GAO, "could undermine the continuity and effectiveness of its enforcement program." No funds for regulation of AHPs were provided in the FY 2004 budget.<sup>23</sup> Thus, since the 930 new staff positions EBSA had hoped for in the FY 2004 budget were not provided, EBSA would not have the staff or resources to regulate AHPs without sacrificing its other ERISA enforcement functions.

The Congressional Budget Office (CBO) estimated that regulation of AHPs would require an additional 150 staff members and a budget of \$138 million over the period from 2004-2013 (assuming the appropriation of the necessary amounts).<sup>24</sup> However, this may significantly underestimate the true regulatory costs if EBSA were to replicate the comprehensive regulation performed by state insurance departments. An analysis by Bill Custer and Martin S. Grace at Georgia State University predicted federal regulatory costs of between \$331 million and \$2.4 billion over a seven year budget period, assuming that DOL performs the type of regulatory activities that state insurance departments currently perform.<sup>25</sup>

## **DOL DOES NOT NOW HAVE THE EXPERIENCE OR STAFF EXPERTISE TO HANDLE AHP REGULATION**

Proponents of the AHP legislation often point to EBSA's existing regulatory responsibilities as equipping the agency to handle the regulation of AHPs. This reliance is misguided. EBSA effectively investigates and prosecutes fraud and fiduciary violations in health plans when they identify them, but AHP legislation would dramatically expand EBSA's existing regulatory responsibilities to include those required in the specialized business of insurance regulation.

As noted earlier, ERISA expressly preserves state regulation of health insurance policies offered to employers. ERISA also permits state regulation of health plans offered by multiple employer welfare arrangements, since MEWAs are engaged in the business of insurance when they self-fund. AHP legislation would overturn this established regulatory structure by giving DOL primary responsibility for regulating entities that act as insurers.

AHPs are fundamentally different from the employer plans DOL has traditionally overseen. These AHPs would assume risk from thousands of independent small employers with no common relationship other than participation in a given trade, business, or professional association. AHPs could assume all functions that insurance companies now perform for small employers including marketing and underwriting health products, collecting premiums, managing risk, ensuring solvency and paying claims.

EBSA has no experience in regulating traditional insurance functions, such as marketing, rating methods, or solvency on a proactive basis. EBSA's involvement with health plans tends to be episodic and reactive to problems identified by EBSA-targeted enforcement or complaints. As previously noted, it would take EBSA hundreds of years to examine each benefit plan even once. Thus, DOL is most likely to get involved in the clean-up after major problems have developed, rather than proactively monitoring AHPs to prevent problems before they occur.

While EBSA lacks the experience and skilled staff necessary to regulate AHPs, over time they could hire employees with those specialized skills, probably from state insurance departments. Nevertheless, it would take years for EBSA to obtain adequate funding for such an expansion, to locate, recruit, and train the needed expert staff, and to form a functional regulatory team that sufficiently integrates the required component parts. It is unlikely that DOL could build this enforcement capacity within the year timeframe the legislation specifies for promulgating implementing regulations. Moreover, DOL could not replicate the local presence of state insurance departments, which insurance commissioners interviewed for this paper cited as critical in their market surveillance and consumer protection activities.

## **RELIANCE ON A "BONA FIDE ASSOCIATION" REQUIREMENT WOULD NOT LESSEN DOL'S REGULATORY BURDEN**

Proponents of AHP legislation emphasize the requirement that AHPs can be offered only through "*bona fide* associations":

"To ensure that unscrupulous promoters would not operate AHPs, only bona fide trade or industry associations that have been in operation for at least three years will be allowed to sponsor these arrangements."<sup>26</sup>

This reliance on the "*bona fide* association" requirement for providing protection against fraud or incompetence is ill-advised in light of DOL's experience with MEWAs and the states' experience with regulation of association health plans.

The states once shared the same view about *bona fide* association health plans and learned from experience that association status is no substitute for proper regulation.

Until recently, regulators paid little attention to this market because they believed the associations would be looking out for members who purchased health insurance. An individual or family typically must join an association to purchase a policy. Many states exempt these policies from many regulations, especially regarding rates. The associations are generally nonprofit groups, with dues-paying members receiving various benefits.

In return, most states require that an association offering policies be formed and maintained for purposes other than the sale of insurance - as in the case of professional groups serving farmers or photographers, for instance. But in many cases the nonprofit groups - which generally portray themselves as representing consumers - appear to be little more than marketing arms for insurers or insurance agencies. . . .

John Garamendi, California's insurance commissioner, said his agency will 'review the whole association health marketplace as to its legality, its business practices, and appropriateness under law. He said the action was prompted by a significant number of consumer complaints. . . . "It concerns me that people are brought in on a false understanding of what the association is."<sup>27</sup>

Many MEWAs that have experienced difficulties have been sponsored by *bona fide* associations. In some instances, the MEWA's problem is not fraud, but financial mismanagement or incompetence; however, the losses to the participants are the same. For example, the citrus growers cooperative Sunkist Growers, Inc.

sponsored a self-insured MEWA health plan that collapsed in late 2002, leaving \$10 million in unpaid claims.<sup>28</sup> There is no doubt that Sunkist, a long-established citrus cooperative, would qualify as a "bona fide association" and would be eligible for DOL certification. The same would be true of the New Jersey Automobile Wholesalers Association Insurance Trust, a self-insured MEWA for automobile dealers, which collapsed leaving \$13 million in unpaid claims.<sup>29</sup> Another example is the Indiana Construction Industry Trust, which left 21,000 people with \$7 to \$8 million in unpaid claims.<sup>30</sup>

### **DOL WOULD NOT HAVE THE TOOLS NECESSARY TO REGULATE AHPs EFFECTIVELY**

H.R. 660 and S. 545 would assign a limited regulatory role to DOL and would, to a large extent, rely on AHPs to regulate themselves with respect to rules governing solvency, rate setting, plan design and market conduct. Unlike state insurance regulators, DOL is not given the regulatory authority used by most states to protect consumers from non-compliance with insurance laws or plan insolvencies. There are a number of significant gaps in the regulatory authority given DOL under the bill that would cripple its ability to effectively regulate AHPs.

### **DOL IS NOT AUTHORIZED TO REVIEW MARKET CONDUCT**

As previously noted, state insurance laws generally require the filing of insurance policies, rates and advertising materials, which helps state regulators proactively police insurers' marketing practices.<sup>31</sup> The AHP legislation requires no such filings, and does not empower DOL to undertake market conduct reviews.

In the absence of an affirmative requirement to regulate market conduct, DOL would not have the authority or staffing to ensure that AHPs comply with existing laws and regulations, or that AHPs are actually charging the rates that they file. Nor would DOL be able to detect any abuses or misleading information in AHPs' marketing materials. Finally, DOL would be unable to review AHPs' declinations, cancellations, and renewals - rendering them unable to protect consumers against violations of law.

Clearly, the lack of authority for market conduct reviews would deprive DOL of a major tool used by state regulators to protect consumers from misleading activity and other unlawful market misconduct and to enable the early detection of solvency problems. Without proactive monitoring of market conduct, DOL would be blind to emerging problems until they have reached the crisis stage.

### **DOL IS NOT AUTHORIZED TO REVIEW RATES**

States generally require that rates, including actual rate development assumptions, are filed with the insurance department - and sometimes require regulatory approval when the rates goes into effect.<sup>32</sup> The AHP legislation does not require AHPs to file rates with DOL either before or after putting the rates in effect. The review of the adequacy of rates to support the payment of obligations and compliance with nondiscrimination rules is left to self-certification in an actuarial opinion.

As a result, DOL would have no independent basis for determining whether rates are reasonable. DOL would have to demand such information on a case-by-case basis or respond after a problem has resulted in complaints or losses to covered employees. This is yet another instance in which DOL is not given the tools to prevent injury to consumers.

### **DOL IS NOT AUTHORIZED TO REQUIRE TIMELY FINANCIAL REPORTING**

State laws generally require that insurers file detailed quarterly and annual financial reports, which enables regulators to closely monitor the financial health of companies and to have reasonably prompt warning of an emerging solvency problem. Where regulators are concerned about a company's financial condition, they can take prompt action, including even revoking the insurer's certificate of authority.<sup>33</sup>

In contrast, H.R. 660 and S. 545 would generally require only that self-insured AHPs file regular financial reports, and those reports would be only required annually, 90 days after the close of the plan year.<sup>34</sup> Much of the financial report consists of actuarial certificates, which would require a regulator to obtain additional information in order to verify with confidence the financial condition of the self-insured AHP. This means that, as a regulator, EBSA would rely on self-reporting by AHPs and would not have current information on AHPs, nor would it have sufficient information to independently verify the conclusions about the financial health of AHPs. Thus, to a large degree, DOL would be flying blind until a major financial problem has already manifested, such as the AHP ceasing to pay claims.

Additionally, once DOL had enough information to determine that a particular AHP was at risk of insolvency, it could not move as quickly as states to close down the AHP's operations because it would first have to file suit in federal court. States, on the other hand, have authority to issue cease-and-desist orders and shut down troubled insurers immediately.



## **DOL IS NOT AUTHORIZED TO REQUIRE ADEQUATE SOLVENCY PROTECTIONS**

Nearly all states have larger minimum capital surplus requirements than those included in the AHP legislation as well as having the authority to set the surplus and capital requirements in relation to the size of the risk it is backing.<sup>35</sup> For example, Oregon has a \$2.5 million minimum and Iowa a \$5 million minimum.

In contrast, while H.R. 660 and S. 545 require a minimum surplus in addition to claims reserves, the bills cap that minimum at \$2 million. DOL is given no discretion beyond the cap to require that capital be commensurate with the size of the plan's risk. While \$2 million surplus might be adequate for a very small plan, it can obviously be inadequate for most plans of any other size, and it could be easily exhausted by a few adverse claims. As a result, AHP participants would face the same risk as participants in many MEWAs. As EBSA described, "a number of MEWAs have been unable to pay claims as a result of insufficient funding and inadequate reserves."<sup>36</sup>

The American Academy of Actuaries, which represents the actuaries that would certify the financial health of AHPs, has also concluded that the proposed financial standards for AHPs are "inadequate if the total annual claims volume of the AHP exceeds \$5 million to \$10 million (5,000 to 10,000 individuals)."<sup>37</sup> A 2003 GAO report found that the median capital and surplus required for health insurers was \$15 million, more than seven times the maximum amount that DOL could impose upon self-insured AHPs.<sup>38</sup>

## **DOL IS NOT AUTHORIZED TO ENSURE ADEQUATE GUARANTY FUNDS FOR AHPs**

Most states have established broad-based guaranty funds to pay policyholder claims in the event of insurer insolvency. While the AHP legislation creates a federal AHP guaranty fund, it falls far short of most state guaranty funds.

First, the fund would be available for paying stop-loss and indemnification insurance premiums, not for the payment of all unpaid claims. While participants in the plan are ultimately responsible for claims, these insurance arrangements might provide some protection in the event of catastrophic claims or termination of the plan. However, they are not an adequate substitute for strong capital requirements or state-established guarantee funds.

Second, even if it were available for payment of unpaid claims, the fund would be severely under-funded. Its funding would consist of annual payments of \$5,000 by self-insured AHPs and by any late payment charges. Assuming that one-thousand AHPs are self-insured, and therefore contributing to the AHP fund, the fund would collect about \$5 million a year. This would easily be consumed by just one failure the size of the Sunkist plan failure, which left \$10 million in unpaid claims.

## **DOL IS NOT GIVEN ADEQUATE TOOLS TO PREVENT "CHERRY PICKING"**

One criticism of AHPs is that they would drive up health costs for small businesses that are insured through the state-regu-

lated market by "cherry picking" the good health risks and avoiding pooling with higher risk groups. A CBO study concluded that AHPs would cause premiums to increase for many businesses with traditional coverage and that some high-cost firms would drop coverage.<sup>39</sup>

Proponents of H.R. 660 argue that protections against cherry picking are built into the bill. First, the bill would prohibit the exclusion of high-risk individuals or firms from an AHP's coverage. Indeed, all AHP member firms must be eligible to participate in the geographic areas where the health plan is made available. Second, the bill requires a self-insured AHP to have at least 1,000 lives[LED3]. Third, the bill prohibits charging higher rates based on direct health status related factors, except as permitted under state law. Under HIPAA, health status related factors refers to health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability. However, AHPs could use proxies for health status (such as age, gender, and certain demographic factors) to increase premiums for older and sicker groups without limitation. These provisions are helpful in preventing outright denial of coverage, but experience suggests that cherry picking could be accomplished through a variety of subtle measures that DOL does not have the regulatory authority to address. For example, one technique to limit servicing in high-cost geographical areas is to effectively redline areas where an AHP fails to build a provider network. Such network gaps would make the AHP unattractive to employers in those areas because their employees would not be able to obtain convenient health care or would have higher co-pays to do so (because they would have to pay for out-of-network providers). EBSA would have no ability to detect these problems because DOL is not authorized to perform market conduct review.

A second technique would be either to set brokers' commissions higher for signing healthy groups or to direct brokers to market in some geographic areas and not in others. Such practices would provide direct incentives to acquire healthy groups and disincentives to sign higher-cost groups.

A third technique would be to use age aggressively in setting rates for older groups. Older workers tend to have higher health costs; therefore, age-skewed rates for older groups could make coverage through the AHP prohibitively expensive. Nothing in the AHP legislation would prohibit the aggressive use of age as a rating factor and DOL would not even have rating information filed with it to detect this problem. AHPs could also use the rating to increase premiums for groups in higher cost geographical areas to discourage their participation.

A fourth technique would be to use a plan designed to discourage higher-cost groups from participating in an AHP. Because self-insured AHPs are exempt from state benefit mandates, AHPs could exclude benefits that might attract higher-risk groups, such as coverage for clinical trials, fertility services, or maternity benefits.

While there are limits to the benefits an AHP could exclude and still have a product with broad-market acceptability, many high-cost services might be excluded or caps placed on total benefits. This might not deter younger, healthier groups from purchasing this coverage, but it would weed out older, more costly groups. Section 805(b) of the legislation expressly gives AHPs' "sole discretion" in benefit design (i.e., selection of covered items and services) so long as specific diseases or federally mandated benefits are not excluded.

These are just a few of the techniques that AHPs could employ with almost complete impunity since DOL is not provided with the regulatory tools necessary to detect most of this conduct or to deal with the abuses if they were detected.

## Conclusion

WITHOUT THE FUNDING, STAFF EXPERTISE, or regulatory tools currently available to state regulators, the DOL would be unable to extend the protection that consumers have come to expect from

state regulated insurance. Instead, consumers would be forced to rely on an insufficient number of inexperienced federal regulators who would be unable to ensure that AHPs comply with federal requirements, charge fair rates for coverage, market coverage appropriately, or detect potential solvency problems in time to protect consumers from plan failure and resulting unpaid medical bills. Nor would DOL have the ability to protect consumers from the results of "cherry picking" by AHPs. In sum, DOL regulation of association health plans would fall far below the standards state regulators have set to ensure access to fairly priced and financially sound health coverage.

BLB

*Rod DeArment is a partner with Covington & Burling in Washington D.C. Rod served as Deputy Secretary of Labor in the first Bush Administration (1989 to 1991) and served as Chief Counsel and Staff Director of the Senate Finance Committee and Chief of Staff to Majority Leader Bob Dole. Rod received a JD degree from the University of Virginia School of Law in 1973 (Order of the Coif and Virginia Law Review editor) and BA degree with honors from Trinity College in 1970 (Phi Beta Kappa).*

## ENDNOTES: Roderick A. DeArment

<sup>1</sup> The independent Congressional Budget Office concluded that AHPs would actually increase costs for three-quarters of small employers by attracting relatively healthy workers and leaving sicker workers in the traditional health insurance market. See Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plan and Healthmarkets* (Jan. 2000).

<sup>2</sup> *The Small Business Health Care Crisis: Possible Solutions Before The Senate Small Business and Entrepreneurship Committee*, 108th Cong. (Mar. 2003) (testimony of the National Association of Insurance Commissioners).

<sup>3</sup> National Association of Insurance Commissioners, *Health Finance Analysis Handbook* 4-9 (Dec. 2003).

<sup>4</sup> NAIC, *2000 Insurance Department Resource Report* (2001).

<sup>5</sup> Klein & Schacht, *An Assessment of Insurance Market Conduct Surveillance*, 20-1 J. Ins. Reg. 51 (2001).

<sup>6</sup> *Id.*

<sup>7</sup> NAIC, *Health Financial Analysis Handbook*, *supra* note 3 at 6.

<sup>8</sup> *Id.*

<sup>9</sup> NAIC, *Guidance Manual in the Evaluation of Rating Manuals and Filings Concerning Small Employer and Individual Health Insurance* (Dec. 2002).

<sup>10</sup> *Id.* at 5.

<sup>11</sup> U.S. General Accounting Office, *Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses*, GAO-03-1133 at 29 (Sept. 2003).

<sup>12</sup> *Id.*

<sup>13</sup> NAIC, *Health Financial Analysis Handbook*, *supra* note 3 at 5.

<sup>14</sup> Kofman, et al., *Health Insurance Scams: How Government is Responding and What Further Steps Are Needed*, The Commonwealth Fund Issue Brief 7 (Aug. 2003).

<sup>15</sup> GAO, *Pension and Welfare Benefits Administration: Opportunities Exist for Improving Management of the Enforcement Program*, GAO-02-232 at 18 (Mar. 2002).

<sup>16</sup> *Expansion of Portability and Health Insurance Coverage Act: Hearings on S. 729 Before the Senate Labor and Human Resources Comm.*, 105th Cong. 6 (Oct. 1997) (testimony of Olena Berg, Assistant Secretary of Labor Pension and Welfare Benefits Administration).

<sup>17</sup> Consolidated Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509 (1986).

<sup>18</sup> Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (1996).

<sup>19</sup> Kofman, et al., *Health Insurance Scams: How Government is Responding and What*

*Further Steps Are Needed*, The Commonwealth Fund Issue Brief, 6 (Aug. 2003).

<sup>20</sup> GAO, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*, GAO/HRD-92-40 at 2 (Mar. 1992).

<sup>21</sup> U.S. Department of Labor, Pension and Welfare Benefits Administration, *Multiple Employer Welfare Arrangements under ERISA: A Guide to State and Federal Regulation* 24 (Sept. 2002).

<sup>22</sup> DOL, *Final FY 2004 Annual Performance Plan* 6 (Feb. 2003).

<sup>23</sup> DOL, Budget For Fiscal Year 2004 656-657 (2003).

<sup>24</sup> Ahlstrom, Alexis et al. "CBO Cost Estimate of H.R. 660: Small Business Health Fairness Act." *U.S. Congressional Budget Office*; July 11, 2003.

<sup>25</sup> Custer & Grace, *Regulatory Burden and Market Effects Under Association Health Plan Legislation*, Center for Risk Management and Insurance Research, Georgia State University (June 1999).

<sup>26</sup> *Association Health Plans: Hearings Before the Subcomm. on Employer-Employee Relations Committee on Education and the Workforce*, 108th Cong. 8 (Mar. 2003) (testimony of Ann L. Combs, Assistant Secretary of Employee Benefits Security, Department of Labor).

<sup>27</sup> Terhune, *States Probe Health-Policy Sales Promoted Through Associations*, Wall St. J., Feb. 25, 2003, at A3.

<sup>28</sup> Fulner & White, *Sunkist's Health Plan Collapses*, LA Times, Jan. 4, 2002, at C1.

<sup>29</sup> Fitzgerald, *Car Dealers Health Insurance Trust Goes Under*, Newark Star-Ledger, Feb. 24, 2002, available at <http://www.nj.com/business/ledger/index.ssf?base/business-0/1014545402286004.xml>.

<sup>30</sup> Swiatek, *State Takes Reins of Troubled Insurer*, Indianapolis Star, July 20, 2002, available at 2002 WL 23905704.

<sup>31</sup> Klein, *supra* note 5.

<sup>32</sup> NAIC, *Health Financial Analysis Handbook*, *supra* note 3 at 6.

<sup>33</sup> *Id.* at 5.

<sup>34</sup> H.R. 660, 108th Cong. § 807(e) (2003).

<sup>35</sup> Halvorson & Keizur, Milliman & Robertson Inc., *Risk-Based Capital Requirements for Managed Care Organizations* 2 (1998).

<sup>36</sup> DOL, Pension and Welfare Benefits Administration, *supra* note 20 at 3.

<sup>37</sup> Letter from American Academy of Actuaries to the Honorable John A. Boehner, Chairman, House Committee on Education and the Workforce 3 (April 28, 2003).

<sup>38</sup> GAO, *Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses*, *supra* note 11.

<sup>39</sup> Congressional Budget Office, *supra* note 1.