Opening Statement
Mike Sturm, Milliman, Inc.
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My name is Mike Sturm, and I am a Consulting Actuary with Milliman. I am 30 years into my career with 27 of them spent in health care.

Milliman serves a variety of clients in the health care market, including health insurers, health systems, pharmaceutical manufacturers, employers, and many others. One of the reasons these diverse clients look to us for advice is because we are independent (i.e., we are wholly owned by our employees). This independence is very important to us because it allows us to advise our clients without the influence of outside interests. As such, we are not required to (nor do we) take political positions on any topic, including healthcare legislation. I am not here to convince you the proposed Association Health Plan rule should or should not be implemented. Rather, my goal is to provide unbiased, fact-based information to help inform the discussion with the hope that it will improve our health care financing system.

Association Health Plans have the potential to change the healthcare marketplace. As with most regulatory actions, there are advantages and disadvantages, there will be intended and unintended consequences, and there will be those who are financially better off and those who are not. This is the also the case with the AHP proposed rule.

One needs to consider a number of factors when thinking about whether AHPs will achieve the administration's stated goals of creating stable risk pools for small employers and the ability for consumers to purchase policies at prices similar to the large group market without adversely impacting the current healthcare market.

These factors include, but are not necessarily limited to:

- How rating rules for AHPs vary from current rating rules. Different rating rules create the possibility of risk pool segregation between more expensive and less expensive members in a given market. The proposed rule as written appears to allow (and in some cases require) AHPs to vary rates differently than allowed in the current healthcare market. For example, AHPs appear to be allowed to rate differently for:
  - Age
    - AHPs appear to be able to use age relativities wider than the 3:1 restriction in the individual and small group markets
  - Geography
    - AHPs appear to have more flexibility in both area factors and the area definitions themselves than is present in the individual and small group markets
  - Family composition
    - The ACA requires carriers to consider at most the three oldest dependent children when determining individual and small group premiums
  - Gender
    - AHPs appear to be able to vary premiums by gender
  - Group size (e.g., 1-5, 6-10 vs. 11-50)
    - The current market requires self-employed individuals to participate in the individual market, while premiums cannot vary by group size for other small employers
  - Health status
    - AHPs appear to be able to experience rate based on the aggregate risk of the association, while the current market requires rating for market average risk for small employers and the experience of the specific employer in the large group market

– Benefits

AHPs appear to have more flexibility in benefits, as the current market prevents small employers from purchasing coverage leaner than bronze / coverage that does not provide EHBs.

– Avoidance of risk adjustment mechanism in the current market

All of these differences lead to the potential for segregation of the current risk pool. With that said, it is difficult to determine the extent of the segregation that might occur.

In addition, given AHPs will be allowed to form around industry, it is likely that morbidity differences by industry will further segregate the risk pool between healthy and less healthy populations. The younger and healthier industries will likely find AHPs attractive and the older and less healthy industries are unlikely to find AHPs attractive.

Other factors to consider whether AHPs will meet their stated goals, include:

- How much savings are achievable and at what cost. Savings will depend on whether the AHPs are fully insured or self-funded. Fully insured plans might be able to achieve some small administrative savings and possibly benefit limitations. Self-funding will likely generate greater administrative savings, but will likely require the AHP to raise a significant amount of (what we refer to in the industry as) risk based capital, to achieve the savings.

  Allowing AHPs to offer “less than EHB” coverage will generate additional savings if they so choose to do so. One benefit they might not offer is maternity given its elective nature. However, I can tell you that most large employers cover all the EHBs, including maternity.

- Will the fact that AHPs are subject to state laws create a regulatory compliance scenario so onerous such that it limits the formation of new AHPs?

- The health insurance expertise of the AHP’s leadership will likely play a large part in whether the association will succeed long-term and protect its members.

- Regarding stable risk pools, insurance companies and at least one current AHP I am aware of have stable pools. It may be difficult for new AHPs to garner enough members to create a stable pool in the first few years. Much of this will depend on whether they can get historical data on new association members to rate them accurately. A less stable risk pool could result if AHPs cannot gain access to this data. With that said, if AHPs are fully insured, the insurance carrier they select may already have the data needed to estimate an accurate rate.

- In my experience, trust is an important factor in consumers' purchasing decisions. AHP members may prefer to buy from their industry leaders (given they have common goals) whether or not the AHP is a more efficient funding vehicle than their current health care payer.

- What will the role of insurance companies be in an AHP? I suspect insurance companies will have much to offer AHPs given their deep provider discounts, current abilities to administer health care claims, and large amounts of reserves to protect a new AHP.

I look forward to discussing these issues and others as we work together today to improve our healthcare financing system.