Oregon
John A. Kitzhaber, MD, Governor

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January 31, 2013

The Honorable Peter Courtney, Senate President
The Honorable Tina Kotek, Speaker of the House
900 Court Street NE
Salem, OR 97301

Re: HB 3321 (2007) – Report to the Legislature

Dear Senator Courtney and Representative Kotek:

In 2007, the Oregon legislature enacted House Bill 3321 which requires the Department of Consumer and Business Services to monitor association health plan data and report the findings to the legislature. Enclosed is the report, which is also available on the Web site of the Insurance Division at:

http://www.cbs.state.or.us/external/ins/legislature/legislative-reports/2013/2013-ins_legislation-reports_hb3321.pdf

If you have any questions or would like additional information, please feel free to contact me at 503-947-7872, or Insurance Division Administrator Lou Savage at 503-947-7200.

Sincerely,

Patrick M. Allen
Director

Enclosure
cc: Members of the Oregon Legislative Assembly
Legislative Administrator

2013 REPORT OF THE DEPARTMENT OF CONSUMER AND BUSINESS SERVICES ON HOUSE BILL 3321 (2007)

BACKGROUND

Association health plans offer members of an association access to group health insurance coverage. In Oregon, association health insurance is considered group coverage whether purchased by an individual, small employer group, or large employer group. In order for an insurer to offer coverage through an association, the association itself must meet certain standards and must have been formed for purposes other than obtaining insurance.

In 2007, the legislature enacted House Bill 3321[1] to exempt health benefit plans issued to small employer groups through association health plans from the statutes governing small employer group plans, if the association plans meet standards for initial premiums, do not discriminate in membership based on enrollees' health status, and maintain high retention rates. The bill was intended to resolve issues related to how small group laws apply to association health plans.

House Bill 3321 allows insurers writing association group health plans to qualify for an exemption from the small employer rating laws if they meet certain access and retention standards aimed at preventing "cherry-picking" or in other words, providing less-expensive coverage only to the healthiest groups, leaving the less-healthy groups to buy coverage in the general market. This strategy may lead to a less healthy small group market, and to increased general market rates over time. Out-of-state plans are subject to the same requirements as Oregon-based associations.

The bill requires the Department of Consumer and Business Services (DCBS) to monitor association health plans to determine the degree to which the claims experience of non-retained association groups exceeds the claims experience of the association's member groups as a whole and report the findings to the Legislative Assembly by February 1 of each odd-numbered year. This report is provided to the 2013 Legislative Assembly as required.

ASSOCIATION RETENTION DATA

As directed by House Bill 3321, DCBS continues to monitor association health plans to determine the degree to which the claims experience of non-retained association employer groups exceeds the claims experience of the association's member groups as a whole. Continued monitoring of claims experience and of employer group retention rates is designed to identify potential patterns of cherry-picking and to prevent their occurrence.

Association health plans are required under ORS 743.734(7) to maintain an employer group retention rate of 95 percent to qualify for continued exemption from small employer health insurance statutes. In other words, an association health plan may not lose more than five percent of its member employer groups, with certain exceptions. Those that fail to maintain the 95 percent retention rate enter a 12-month correction period during which the association health

[1] 2007 Or Laws ch. 752, codified primarily at ORS 743.734(7) & (8)

plan may correct the retention level before losing the exemption from the requirements of ORS 743.734(1).

A number of association health plans struggled to meet the retention requirement under recent economic circumstances. As a result, ORS 743.734(7) was revised by the legislature in 2010 to allow the department to grant a waiver of the 95 percent retention rate requirement. DCBS implemented rules under which the requirement may be waived. Under the rules, the association health plan insurer may submit a written request for a waiver to the department. To allow the department to make a determination, the request must provide specific information pertaining to each terminated small employer group and the association as a whole, including premium, claims experience, enrollment and employer group retention histories.

In the department's 2009 report to the legislature, we reported that nine of 22 associations failed to meet the 95 percent retention rate during the first year of reporting and had 12 months to correct their retention level before losing their exemption from small employer health insurance laws. Of those nine, four requested an exemption upon implementation of the new legislation in 2010, two were found to have met the retention requirement, one was terminated, and two lost their exemption and are now subject to small employer regulations after being given a year to meet the retention requirements.

In the department's 2011 report to the legislature, we reported that 14 of 23 associations failed to meet the 95% retention rate. Of those 14, nine submitted written requests to waive the 95% retention rate requirement; three met the requirement during subsequent correction periods; and two cancelled coverage.

In 2012, 10 of 26 associations failed to meet the 95% retention rate. Of those 10, eight submitted written requests to waive the 95% retention rate requirement and two are in the 12 month correction period. Six of eight were previously granted waivers from the retention rate requirement.

The department reviewed each request and all accompanying information to ensure no pattern of cherry-picking was evident. Finding no such pattern, the department granted the waivers. Unless otherwise withdrawn by the department, at the expiration of the approved waivers, the association health plans are exempt from small employer statutes only if the health plans then satisfy the requirements of ORS 743.734(7) and (8)(a).

FEDERAL LAW AND ASSOCIATION HEALTH PLANS

Under the Affordable Care Act, rules pertaining to rate review do not recognize associations as a separate market. At the federal level, coverage sold to an association is now generally either group or individual coverage depending upon the purchaser. For example, coverage purchased by an individual (a non-employer) through an association constitutes individual coverage, coverage purchased by an employer with 40 employees constitutes small employer coverage, and coverage purchased by an employer with 51 employees constitutes large group coverage. However, if an association is an ERISA "bona fide group," the association is treated as a single group rather than counted as the separate groups that make up the association.

An ERISA bona fide group is a collection of employers that has such a level of control over the association and a degree of commonality of interest that the group is said to exist at the association level rather than the individual employer level. This is a federal determination and a difficult standard for most associations to meet; however, when an association is a bona fide group and its membership totals 51 or more, it is considered one large group and is not subject to small group rating laws.

In October 2011, the department received a preliminary determination from CMS that, because Oregon law currently exempts some associations from small group rating laws and because Oregon law treats individual coverage provided through an association as group coverage, Oregon does not have an effective rate review program for association coverage sold to individuals and to small groups not rated under the small group rating laws. The federal government has indicated that unless this changes, it could jeopardize Oregon's ability to certify qualified health plans offered through the health insurance exchange in 2014. If the Oregon association exemption is allowed to sunset as the legislature intended, this should not be a concern. Oregon has not received a written final determination from CMS at this time.

In 2014, the Affordable Care Act will require carriers to pool all individual coverage (individual under federal law), including individual coverage provided through an association. It will also require the pooling of all small group coverage, including small group coverage provided through an association. To ensure that Oregon complies with these requirements, the state must modify its association laws so that coverage sold to individuals through an association constitutes individual coverage rather than group coverage.

FUTURE REPORTING

House Bill 3321 sunsets on January 2, 2014.