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March 2, 2018

Joe Canary, Director
Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Attn: Definition of Employer–Small Business Health Plans RIN 1210-AB85

To Director Canary:

The New York Health Plan Association (“NYHPA”) represents over 28 health plans serving eight million New Yorkers in a range of insurance programs. In particular, NYHPA’s membership includes national and regional health plans serving large employers, small employers, individuals, associations, and self-insured entities in New York State.

The proposed Association Health Plan (“AHP”) rule of the United States Department of Labor (“DOL”) seeks to enhance the affordability of small employer and individual health insurance options by permitting sole proprietors and small employers that meet a broadly defined “commonality of interests” test to aggregate together to purchase a single large employer group health plan.

However, NYHPA has concerns about the potential impact the proposed rule may have on the marketplace, including fragmenting the individual and small group markets, resulting in higher health insurance premiums for some consumers and employers.

A threshold issue is the degree to which DOL intends the proposed rule to preempt State law. If the proposed rule seeks to preempt State law, then insured AHPs would not be subject to community rating or essential health benefits requirements otherwise applicable to individuals and small groups purchasing health insurance in New York. While the rule might thereby make coverage more affordable for some small groups and individuals, the proposed rule also may disrupt New York markets and cause a significant spike in prices for many other individuals and small groups. It also may disrupt the New York market because it could result in state regulators seeking to suppress prices that would likely need to rise if the current small group and individual pools are disaggregated, which could in turn destabilize the solvency of some carriers. Ultimately, the final rule must strike a careful balance and result in a level playing field between State regulated products and other products that might be sold if the proposed rule takes effect and is deemed to preempt State law.

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1. DOL should clarify the interplay between the proposed rule and existing state laws

Most fundamentally, the proposed regulation will only enhance the effective operation of the New York market if it is drafted with sufficient clarity to ensure a level playing field for all market participants. As currently drafted, the AHP regulation is unclear as to how the federal rule would interact with state insurance laws governing group size calculations used to determine the applicability of pooling, loss ratio, community rating and essential health benefits requirements.

Specifically, New York has imposed guaranteed issuance and pure community rating on its individual and small group markets for decades. New York’s regulatory infrastructure also addresses association groups and similar group purchasing arrangements by looking to the component membership of the association to determine if individual, small group or large group regulatory requirements apply. For example, if a New York association includes small employer members, New York law requires the insurer to apply small group community rating and include essential health benefits and all other small group consumer protections.

The AHP proposal seeks to permit sole proprietors and small employers to aggregate together to access the enhanced benefit and rating flexibility available in the large group market, while New York State law prohibits this very aggregation in order to avoid fragmentation of the individual and small group markets. Placing the two regulatory approaches in conflict may result in the worst of both worlds – resulting in inconsistency and marketplace disruption for consumers, employers and health plans.

Section 1321(d) of the Affordable Care Act (“ACA”) provides that state laws that do not “prevent the application of” the ACA are not preempted. Some in New York will undoubtedly argue that New York’s laws prohibiting the segmentation of community rated markets do not “prevent the application of” the ACA, but rather serve as a consumer protection that may be applied separate from federal standards. NYHPA’s comments do not seek to litigate complex preemption issues. However, if DOL takes a position that its rule has certain preemptive approaches, NYHPA recommends that it proceed in a nuanced and balanced manner. For example, DOL could conclude that solvency rules, benefit mandates and procedural requirements (such as external appeal rules) are not preempted even if DOL concludes that the federal rule does preempt certain other State rules. Thus, a clear statement as to the preemptive effect of any final rule is critical to avoiding years of uncertainty that will undermine New York’s insurance market.

2. Fragmentation of markets

If the federal rule does preempt certain or many New York rules related to whether individuals and small groups may aggregate and obtain coverage as a MEWA or large group, NYHPA has the following additional comments.

A. New York’s individual market

The AHP proposal would permit AHPs to extend coverage to sole proprietors. While sole proprietors who are eligible for an advanced premium tax credit (“APTC”) may continue to purchase coverage through the Exchange, relatively healthy sole proprietors at or above 400% FPL may choose to join AHPs to access more affordable options with less comprehensive benefits. At the same time, those sole proprietors that leave the individual market will no longer contribute to risk adjustment mechanisms. These factors could result in anti-selection and higher prices in the individual market.

Given the vulnerability of the individual market – and New York’s past experience with a broken individual market – DOL should consider pairing the AHP proposal with a federally supported high risk pool or other reinsurance mechanism to provide financial support to the individual market. Further, as the individual market diminishes in size, state mechanisms to encourage or force health plan participation in the individual market must be re-examined. For example, New York law currently requires all health maintenance organizations (“HMOs”) to participate in New York’s individual market. Similarly, a New York Executive Order prevents health plans from withdrawing from New York’s individual exchange by threatening the health plan with the loss of all State contracts, including contracts related to federally funded programs (e.g. Medicaid Managed Care, Child Health Plus, etc.). Such mandates force health plans to maintain an individual market infrastructure without regard to the size of the market or the financial viability of the product, driving up systems costs that are ultimately borne by consumers and the federal government in the form of higher APTCs.

NYHPA recognizes that DOL’s proposed prohibition on discrimination based on health status is intended to prevent adverse selection. However, the effect of the anti-discrimination provision is speculative, and the prohibition will be difficult to prove and enforce. As a result, if better risk sole proprietors move to AHPs but sicker sole proprietors and individuals remain in the individual pool, it will result in an individual pool with worse risk necessitating price increases.

NYHPA is concerned that proposed premium rate increases will cause State regulators to suppress prices, which has occurred in the past. New York requires prior approval of rates with the Superintendent of Financial Services responsible for approving rates. While the rate process has been reasonably fair in some years, in other years it has been infused with political considerations resulting in rates that were not actuarially sound. Such suppression is damaging not only to health plans but also to consumers who must later absorb even larger rate increases to stabilize previously underpriced products.

In response to the final regulations, New York could take other steps to make individual and small group coverage more affordable, including adopting modified community rating similar to most other states, eliminating unnecessary mandates, allowing for more product flexibility and eliminating unnecessary regulatory burdens. Moreover, if the federal government provided funding to mitigate the impact on the individual market, it would minimize the possibility of disruption.

B. New York’s small group market

The AHP proposal allows small employers to join AHPs and access the advantages of large group rating and more flexible benefit designs that do not include essential health benefits. If New York State laws are preempted, the AHP proposal is likely to cause small employers to exit New York’s small group market (i.e. further diminishing its size). Additionally, there are features of the AHP proposal that make it more likely that relatively healthy small employer groups will join AHPs, while those with relatively unhealthy employees may not. For example, AHPs may limit their membership to relatively healthy occupations or trades, and AHPs may offer less comprehensive benefit packages without essential health benefits that are more likely to be attractive to relatively healthy employer groups. At the same time, any cross subsidy flowing through risk adjustment from relatively healthy groups that join AHPs would no longer be available to support traditional small group premiums. While small employers would have more options, premiums in the traditional small group market could potentially increase as a result of anti-selection.

In addition, NYHPA has the same concerns regarding price suppression as exist for the individual market.

As with the individual market, New York could take steps to make its small group market more affordable. Similarly, the AHP proposal would avoid certain of this disruption if it was paired with a federally supported high risk pool or other mechanism to strengthen the viability of the small group market.

C. Effective Date and the Accuracy of Individual and Small Group Rates for 2019

NYHPA expects that, if adopted, the AHP proposal will have significant implications for individual and small group premium rates in New York. However, New York's deadline for filing individual and small group products for 2019 will likely be set for no later than mid-May (preceding the federal marketplace deadline by five to six weeks). This means that health plans have already started to develop rates for the 2019 year. Because of uncertainty as to what a final AHP rule will be, as well as the New York State regulatory response if DOL takes the position that the rule preempts State law, health plans are not able accurately to price their 2019 products.

For these and other reasons, if DOL moves forward with the rule, then NYHPA recommends that AHPs not be permitted to sell coverage that would take effect prior to January 1, 2020. This effective date will reduce – but not eliminate – the disruption that might otherwise ensue and allow health plans, state regulators, AHP sponsors and consumers a more reasonable period of time to react to a new rule. It also will allow for more accurate pricing as to the impact of the rule on the current risk pools.

D. Broader implications for New York's insured markets

With respect to insurance sales across state lines, the federal proposal appears to allow AHPs made up of single trade groups or groups located in a single metropolitan region to operate across state lines. This in turn may result in impacts on existing state markets – e.g. will this cause insurance policies to be situated in the state with the fewest regulatory requirements. States such as New York might seek to amend their statutes to assert regulatory jurisdiction over AHPs covering state residents on an insured basis. Consistent with the general comments set forth above, to ensure a level playing field and functioning markets, NYHPA requests that DOL clarify how the AHP proposal would interact with state laws, particularly when the AHP operates across state lines in two or more states.

Similarly, the commentary to the AHP proposal acknowledges that states have jurisdiction over Multiple Employer Welfare Arrangements (“MEWAs”) that self-insure, but that DOL has the ability to “exempt” such MEWAs from most state regulations (with the exception of regulations related to solvency or contributions). Given that state insurance requirements would not apply to self-insured plans if such exemptions were to be granted, the exemption process has the potential to create market disruption. For example, if MEWAs are permitted to operate on a self-insured basis outside of state regulation, insurers that must comply with extensive regulatory requirements may be at a disadvantage. NYHPA recommends that there be a clear statement as to whether DOL will grant exemptions and, if so, on what grounds. In addition, any proposed exemptions should themselves be subject to public comment.

3. Additional considerations

A. DOL Requests for Input

DOL's commentary seeks input on a number of additional issues including: whether more or different parameters should be used to determine commonality of interest among employers; whether there is reason for concern that associations may manipulate geographic classifications to avoid covering employers expected to incur more costly health claims; whether more clarification would be helpful regarding the definition of a metropolitan area; and whether there should be a special process to obtain a DOL determination that an association's members have a principal place of business in a metropolitan area.

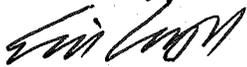
The issues DOL identified do not lend themselves to one-size-fits-all answers. For example, defining a Metropolitan Region raises significant issues in the downstate New York region as to whether such a region should be limited only to New York City; include Long Island and/or Westchester and other lower Hudson Valley counties; include northern New Jersey; and/or include southwestern Connecticut. In addition, the approach adopted for downstate New York may vary from the approach that might exist in other New York areas where AHP members may live in different states. Similarly, if eligibility turns on the existence of a principal place of business in a given region, at a minimum, the definition of "principal place of business" should be clearly defined. Also, state regulators in bordering states may need to adopt similar regulatory approaches. Otherwise the rules of one state may be inconsistent with the rules of the neighboring state making it impossible to administer an AHP or putting other health plans and employers of one state at a disadvantage.

B. AHPs and Guaranteed Issuance

NYHPA also seeks clarification regarding how the AHP proposal meshes with guaranteed issuance requirements in the large group marketplace. For example, will AHPs be required to accept all groups or individuals that self-identify as satisfying the commonality of interest? Also, what will the enforcement standard be for the AHP and will States be permitted to impose their own enforcement standards?

Thank you for the opportunity to provide these comments. NYHPA welcomes any questions you may have regarding these comments. Please free to contact me at (518) 462-2150 or elinzer@nyhpa.org.

Sincerely,



Eric Linzer
President & CEO