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Submitted electronically at <http://www.regulations.gov>

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

On behalf of EmblemHealth, we appreciate this opportunity to respond to the proposed rule issued by the Department of Labor entitled “Definition of ‘Employer’ Under Section 3(5) of ERISA-Association Health Plans” published in the Federal Register on January 5th, 2018 (83 FR 614). EmblemHealth is the largest community-based nonprofit health plan in the country, and with our subsidiary ConnectiCare, serves approximately 3.1 million individuals who live and work in New York, Connecticut, New Jersey, and Massachusetts. This proposed rule is of critical importance to these individuals and the small and large employer customers whom we serve through a variety of products including HMO, PPO, and self-insured administrative arrangements and who have come to depend on our innovative approach to providing high quality health care services.

GENERAL COMMENTS

This proposed rule was published under an Executive Order directing the Secretary of Labor to promulgate regulations that expand access to Association Health Plans (AHPs) for small employers, thus allowing them to “avoid many of the PPACA’s costly requirements.” While we strongly support initiatives to make coverage more affordable for small employers, we are very concerned that these proposals would make coverage more expensive. In a “worst case” scenario, these rules could permit employers (including those that employ only themselves) to form insurance entities that circumvent state solvency, minimum standards, and consumer protection laws. The result would be skyrocketing costs in the individual and small-group markets and higher burdens on taxpayers to fund a safety net that would likely be stretched by low-income working individuals with high health needs who could face the awful choice of continuing their employment or affording health care for themselves and their families.

We strongly believe this is not the result the Administration would prefer. Below we provide five suggestions for the final rule to support the availability of more affordable coverage options for all Americans, including those we serve in our states.

DETAILED COMMENTS

1. Preserve the Individual Market

Insurance plays a vital role in our nation's health care system. Health care is often expensive. According to the Health Care Cost Institute (HCCI)¹, the average price of an inpatient surgery was more than \$40,000 in 2016. The average price of a brand name prescription drug was \$18 per day, or over \$500 for one month's supply and some new prescription drugs cost upwards of \$100,000 for a course of treatment.

People with comprehensive health insurance coverage almost never see these prices. Instead for a monthly premium, individuals pay only a portion of those costs, which health plans are often able to further reduce by negotiating discounts. The HCCI report finds insurance coverage is effectively playing its role, finding out-of-pocket costs for health care increased more slowly than total spending from 2012 – 2016 and enrollee spending for brand-name prescription drugs ***declined by 26% during this time period***, even though drug manufacturers continued to introduce new drugs with higher and higher prices.

However, a well-functioning health insurance market depends on a balanced and stable risk pool. Consider an example in which a health plan enrolls five people, each with annual costs of \$100,000. The plan would need to charge each person \$100,000 to cover these costs. However, if there are other individuals in the plan that have little or no health care needs, then these costs can be divided among a greater number of people. That is why there is been such a focus on making coverage more affordable for healthier individuals. The only way coverage is affordable for all is if it is affordable for low-risk individuals, so they will be able to get coverage and protect themselves if something happens that increases their needs.

Unfortunately, the proposed rule threatens to take the system in the opposite direction. The regulation may establish AHP options outside of the individual and small group markets that provide minimal benefits. In so doing, AHPs could create benefit packages that will only be attractive to low-risk individuals, raising costs for those that remain in the individual and small group markets and making comprehensive coverage less affordable.

These effects are compounded by the proposed rule's application of large group rules to AHP members regardless of size and redefine "employer" to allow self-employed individuals to gain coverage under an AHP. We do not believe there is a basis in law to justify such a major re-interpretation of "employer". Moreover, the effect on the individual market of such a radical change will be a siphoning of healthy individuals from markets, especially in major metropolitan areas that have a high percentage of self-employed people in the brokerage, financial services, real estate, technology, and arts and entertainment sectors which will be hardest hit by such a change. We strongly urge the Department to reconsider its definition of employer and take the other steps described below to preserve the individual market.

¹ Health Care Cost Institute, "2016 Health Care Cost and Utilization Report" and related tables. Found at <http://www.healthcostinstitute.org/report/2016-health-care-cost-utilization-report/>

2. Preserve State Regulatory Authority

Based on our reading, we believe the proposed rule intends to support state primacy in the regulation of health insurance. However, in the preamble, the Department requests input whether it should consider invoking ERISA law section 514(b)(6)(b) that would allow the federal government to exempt specific classes of non-fully-insured MEWAs (for example AHPs) from state regulation except for specific solvency and contribution requirements.

We strongly recommend that the proposed rule be clarified to assure there is no ambiguity about its intent to recognize the supremacy of states in the regulation of health insurance.

The proposed rule correctly describes AHPs as Multiple Employer Welfare Associations (MEWAs). States have traditionally had a role in regulating these entities, which is the outgrowth of developments in insurance markets during the 1970s and '80s when MEWAs were allowed to skirt state insurance regulations. Once free of these requirements, MEWAs could set meager benefit levels that only appealed to healthier individuals. The result was increased costs for those with higher health care needs, which led to bipartisan Congressional actions in 1982 and 1994 that reformed MEWA laws to mitigate the damage that had been caused. Actions by the Department to threaten state authority would undermine those carefully crafted laws.

We are surprised this Administration would consider strategies for federal preemption given the deference it has provided to state authority. As Seema Verma, the Administrator of the Centers for Medicare & Medicaid Services (CMS) recently wrote in the context of Medicaid program design, “Each state is different, and states are in the best position to determine which approaches are most likely to succeed, based on their specific populations and resources”.² We are unclear why this same principle does not apply to insurance markets, where the authority of state insurance commissioners has been recognized by Republicans and Democrats. We urge the Department to continue to affirm state authority to determine the rules of local insurance markets consistent with this principle.

We also strongly recommend the final rule clarify that AHPs in a metropolitan area will not be allowed to cover lives across state lines. While some suggest permitting the sale of insurance products across state lines is a panacea, doing so would undermine the competitive market by subjecting different plans in the same service area to different rules. These rules have been carefully crafted by states to reflect the unique needs and wishes of their residents. Federal requirements that muddy state authority will only increase confusion for consumers and apply inconsistent protections based upon where the product originated. This is not a prescription for the transparency and consumer empowerment strategies promoted by the Administration.

In a similar vein, we strongly recommend that states be provided the authority to establish the effective date of the final rule, but in no case earlier than for 2020. Health insurers in New York, Connecticut, and other state-based Exchange states will be required to submit rates in the early spring. Any changes announced much later than the early March comment deadline for this proposed rule will be extremely disruptive to our development of affordable coverage and state review of these proposals.

² CMS Letter to State Medicaid Directors, “RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries”. SMD 18-002 (January 11, 2018)

3. Protect Consumers

The final rule should ensure the chaos of the 1970s and 1980s is not repeated by confirming AHPs are subject to the federal and state laws that were developed to prevent fraud and establish fiscal solvency requirements. We recommend the Department make clear in the final rule that AHPs are subject to ERISA section 514(b)(6) in the following manner:

- For self-insured AHPs, state large group requirements that are not inconsistent with Title I of ERISA should be applied directly to the MEWA including solvency, minimum contribution, and minimum standards;
- For fully-insured AHPs, state reserve and contribution level requirements should be applied to the AHP, and state large group requirements can be applied to the insurer underwriting the risk of the AHP.

Reaffirming the authority of these federal and state rules will ensure beneficiaries are protected from disruption and other harms caused when insuring entities are not in compliance with solvency requirements. We urge the Department to take this step.

4. Maintain the “Commonality of Interest” Requirement

The proposed rule would allow an AHP to either form as a nationwide entity offering membership to employers participating in a specific industry or trade, or on a statewide or metropolitan area basis to a broader membership of employers. These changes would allow an AHP to form solely for the purpose of offering health coverage.

We strongly recommend the Department reverse this approach. Allowing an AHP to enroll individuals or organizations without a specific common work-related interest or relationship will hasten the market instability that will inevitably result from this expansion of the AHP definition. One of the most destructive aspects of the MEWA expansion of the 1970s and 80s was the creation of “Air Breather” associations of members that had nothing in common except their existence. These associations became unregulated insurers that raided markets pulling healthy risk out and leaving their membership with inadequate coverage and little recourse through the consumer protection channels that are the responsibility of state regulators.

5. Strengthen the Non-Discrimination Restrictions

Finally, the rule would impose specific non-discrimination requirements on AHPs in order to decrease the likelihood of risk selection or “cherry-picking” of only healthy individuals and groups. We strongly support this approach and urge the Department to provide more clarity in the final rule. Non-discrimination restrictions should prohibit AHPs from limiting membership

based on any health factor including age, health status, medical condition including mental health, claims experience, receipt of healthcare services, medical history, genetic information, evidence of insurability, or disability. We also recommend that the rule prohibit an AHP from charging different rates to the groups within its membership based on health status, or charging different rates based on age, except within the current rating bands applied to the individual market in most states.

Conclusion

EmblemHealth recognizes that insurance costs in existing markets are too high and have provided recommendations to the Administration on several occasions to make coverage more affordable. Several of these recommendations have been consistent with Administration actions. For example, we have appreciated Administration's consideration of changes that reduce regulatory burdens, reform the SHOP exchange, and support state efforts to modify the small group risk adjustment redistribution formula in response to local market factors. We have also suggested other ideas to protect the system from the increasing underlying costs of care documented by HCCI, including those that are the result of drug manufacturer pricing practices, which we hope the Administration and Congress will act on to make coverage more affordable.

However, the approaches suggested in this proposed rule are not the answer. We are very concerned that unless state authority to regulate markets is preserved and the other issues noted above are addressed, this proposed rule in combination with the repeal of the individual mandate would create a bifurcated health care system where the healthy can afford insurance and the sick will need to deplete assets to qualify for federal low-income subsidies and/or Medicaid to get the comprehensive coverage they need. While we are strong supporters of safety net programs, these results seem inconsistent with the Administration's goals to reduce public program spending and increase the role of the market in the health care system. Instead, we should be working to support the individual and small group markets and allow private plans to use market forces and innovation to provide affordable coverage to all.

We appreciate this opportunity to respond to the proposed rule. Please contact Howard Weiss at 646-447-1074 or hweiss@EmblemHealth.com if you would like to discuss the issues we have raised.