March 2, 2018

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

ATTN: Definition of Employer—Small Business Health Plans RIN 1210-AB85

Dear Mr. Canary:

On behalf of the New York State Health Foundation (NYSHealth), I am writing to provide comments on the Department of Labor (DOL) proposed rule for broadening the availability of health insurance coverage—called Association Health Plans (AHPs)—sold through associations of employers. In particular, the proposed rule would expand the conditions under which associations of small employers and self-employed individuals could join together to be considered a single employer under the Employee Retirement Income Security Act (ERISA). ERISA status would allow the AHPs offered by such employer groups to be regulated under federal law as large-group coverage.

The proposed rule has potential to erode consumer protections, destabilize insurance markets, promote adverse selection, and raise prices for Americans.

Proponents of AHPs contend they can help reduce costs of health insurance by giving groups of employers increased purchasing power vis-à-vis hospitals, doctors, and other health care providers, as well as potentially creating administrative efficiencies. Also, by virtue of being regulated by federal law rather than state regulations, AHPs may have more freedom to customize plan offerings to the specific populations they serve. Freedom from certain state regulations, such as mandated essential health benefits, also allows AHPs to reduce premiums for their customers by offering fewer benefits. Supporters further assert that AHPs can offer coverage to individuals who do not receive insurance through their employer, and would otherwise be in the individual market. Thus, AHPs would give these employees another coverage option for themselves and their families.

At NYSHealth, we are sympathetic to the challenges small businesses and sole proprietors face in obtaining health care insurance coverage, and supportive of efforts intended to bring comprehensive and affordable coverage to everyone. To that end, we have a history of funding freelancer organizations, chambers of commerce, business associations, retail worker organizations, restaurant worker organizations, and even dairy farmers to grow and improve health insurance coverage among economic sectors struggling with costs. However, we are concerned that this proposal will actually make it harder for many working Americans—particularly those most in need—to obtain affordable health insurance coverage and that AHPs may fail to adequately cover their members for critical health care services.

AHPs may induce and perpetuate "death spirals" by attracting younger, healthier individuals and leaving a smaller, sicker pool in the small group and individual markets, forcing insurers to raise premiums for all those enrolled. The history of New York State's individual and small group health insurance markets provides relevant insight for what can happen when risk pools are oversaturated with sicker and more expensive enrollees. Prior to the enactment of the Affordable Care Act (ACA), New York's individual market premiums were among the highest in the nation, thanks to a "Guaranteed Issue" state policy and pure community rating. These laws prohibited insurer discrimination based on health status, age, or a number of other factors. These policies led to an older, sicker, and higher-cost individual market when compared to other states, which resulted in higher premiums and limited enrollment. Prior to the implementation of the ACA, a mere 17,000 people were covered by individual insurance plans in New York State. As of 2017, there were more than 900,000 people enrolled in Qualified Health Plans (QHPs) and the Essential Plan in New York. Premiums were also significantly lower in the exchange relative to 2013 individual market plans.[1,2]

There are additional concerns involving the expanded use of AHPs. As acknowledged throughout the DOL proposed rule preamble, the history of plans like AHPs has been fraught with fraud and abuse. This was particularly the case before the ACA fortified states' ability to oversee AHPs and when there was only minimal federal oversight. Many AHPs became insolvent, leaving consumers and health care providers stuck with the bill. Moreover, reduced oversight of AHPs would result in fewer state protections for patients, such as laws that require coverage for emergency care and certain specialists; mandatory grievance procedures; and review of denied medical claims.

Should DOL proceed with expanding AHPs, we suggest the adoption of these actions and policies:

Clarify and Ensure State Authority over AHPs. In the proposed rule, DOL expresses that there would be "limited" effect on state regulation of AHP plans, both self-insured and fully-insured. However, it also raises questions about the extent of state authority to assess whether AHPs meet the new tests for single-employer status, whether to subject AHPs to traditional individual and small group marketplace rules, and whether the future federal rules could pre-empt state regulation of AHPs. In general, we oppose any attempt by DOL to pre-empt state authority to regulate AHPs.

We encourage DOL to solidify and fortify the language in the rule providing states with enforcement authority to protect their residents. Under current law, state insurance regulators can require AHPs to: be state-licensed insurers; meet minimum financial solvency standards; cover state-mandated benefits (e.g., maternity care) and meet other state insurance standards (e.g., rating rules); and acquire pre-approval of marketing materials to consumers. With such authority, states can limit potential risks of AHPs, including fraud, insolvency, and adverse insurance market distortions. Furthermore, DOL should also clearly state that AHPs covering people in more than one state would have to comply with all state laws in states in which they operate and continue to be subject to state oversight and regulation.

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[1] Rabin, Roni Caryn and Reed Abelson. "Health Plan Cost for New Yorkers Set to Fall 50%." The New York Times, July 16, 2013. http://www.nytimes.com/2013/07/17/health/health-plan-cost-for-new-yorkers-set-to-fall-50.html?mcubz=0, accessed January 2018.

[2] Norris, Louise. "New York health insurance marketplace: history and news of the state's exchange" https://www.healthinsurance.org/new-york-state-health-insurance-exchange/, accessed January 2018.

Limit Ability to Discriminate Based on Geography. DOL is proposing to prohibit AHPs from discriminating based on health status related factors. We encourage DOL to retain this requirement in the final rule and ensure that it apply to all AHPs. However, there are concerns that other aspects of the proposed rule will result in discrimination against people with medical needs, including how DOL proposes to expand the "commonality" criteria for the purpose of employers to form an AHP. That is, to be considered a single-employer AHP, members could be either in the same industry or have their principal place of business in the same geographic region. Both criteria lend themselves to potentially creating disparities in options for coverage based on health-related factors. DOL should consider ways to mitigate that potential and explicitly detail them in the final rule.

For example, health care costs and utilization can vary widely depending on geographic location, even within the geographic boundaries of a county or metropolitan statistical area. This may create incentives for AHPs to "carve out" portions of areas associated with relatively higher costs. Evidence for this occurred in the Medicare Part C program. While county boundaries are used to designate plan service areas under Part C, plans were able to "carve out" areas within the county from their service area. This meant that plans may have been less motivated to develop adequate networks in certain ZIP codes, which are often those with a disproportionate share of low-income and otherwise vulnerable populations. The Medicare Part C program also exhibits the difficulties in encouraging plans to offer services in less populated rural areas. For years, the Part C program has built in overpayments to provide incentives to plans to participate in rural areas. To encourage innovation in these areas and to help ensure equal options to care for all Americans, DOL should consider requiring "commonality" definitions of geographic areas that are inclusive of rural and less populated areas. Further, DOL should prohibit the ability to "carve out" areas within markets.

Every state already has a set of geographic rating areas that issuers must use to set rates. Smaller states may have only one rating area, while larger states tend to have more. These areas are generally the size of metropolitan statistical areas, or larger to include adjacent rural areas. Thus, these rating areas are designed to be reasonably economically diverse.[3] DOL should consider these areas for AHP "commonality" purposes, which may also have the benefit of having consistency across various insurer market and service area designations.

Transparency of AHP Benefits and Consumer Protections. AHP plans should be required to affirmatively inform members and prospective members that they are not receiving specific consumer protections or benefits that they would have otherwise received under the traditional state-regulated individual and small group markets. These would include detailing deviations from the essential health benefits and whether dollar limits apply to any benefits. Further, disclosure requirements should be in place regarding the factors such as full-time or part-time employment or occupation type that influence premium levels, benefits provided, and membership status.

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[3] The Center for Consumer Information and Insurance Oversight, "Market Rating Reforms," https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/state-gra.html, accessed January 2018.

Clarify Eligibility for ACA Coverage if also Offered AHP Coverage. It may be possible that employees who are eligible for subsidies to buy insurance in the individual or small group marketplace may also be offered insurance through their employer's AHP membership. Moreover, the AHP coverage may have non-equivalent benefits relative to the essential benefits required with individual or small group marketplace coverage. Under such a scenario, the employee should maintain the ability to acquire the subsidized coverage. DOL should clarify in the final rule language that AHPs and participating employers have the same obligation as all other employers to provide employees with an annual notice of the availability of marketplace coverage, with financial help for those that qualify.

Ensuring Access to Data for Research and Policymaking. After the Gobeille v. Liberty Mutual Insurance Co. decision, there has been greater interest in how to revisit ERISA rules to ensure a level playing field for what health care data is available for research and policymaking. Post-Gobeille, ERISA plans are no longer subject to state all-payer claims database (APCD) reporting requirements, depriving states of essential information on health care utilization, pricing, and quality in the state. AHPs can further exacerbate this imbalance as to the health care data available to inform policy decisions and analysis. We suggest that DOL take this opportunity, as it considers how to create a pathway for reporting of self-funded data, to also ensure data from AHPs will be available to state APCDs. Previous comments from national and state stakeholders lay out how APCDs can assist DOL in meeting its responsibility to oversee cost and quality in employer-sponsored health plans.[4] This responsibility will only be greater should AHPs, both self-insured and fully-insured plans, substantially expand their enrollment.

AHPs could undermine coverage, erode consumer protections, and raise costs for Americans. Should DOL expand their availability, the policies described above would lessen negative consequences. Thank you for the opportunity to provide input on this important matter.

Respectfully submitted,

David Sandman, Ph.D.
President and CEO
New York State Health Foundation
1385 Broadway, 23rd Floor
New York, NY 10018
sandman@nyshealth.org
212-584-7690

[4] National Academy for State Health Policy, Comments on Department of Labor Notice of Proposed Rulemaking. Available at: https://nashp.org/next-steps-for-apcds-us-department-of-labor-dol-rulemaking/.