



New Yorkers For Accessible Health Coverage

Member Organizations

American Association of Kidney Patients,
New York chapter
American Cancer Society
American Diabetes Association
Brain Tumor Foundation
Cancer Care
Care for the Homeless
The Center for Independence of the Disabled, NY
Cystic Fibrosis Foundation, Greater New York
chapter
Disabled in Action of Metropolitan New York
Epilepsy Foundation of Greater New York
Gay Men's Health Crisis
Hemophilia Association of New York
Huntington's Disease Society of America, New
York and Long Island chapters
Interagency Council of Mental Retardation and
Developmental Disabilities
Leukemia & Lymphoma Society, New York City
chapter
Mental Health Association of New York City
Mental Health Association of Westchester County
National Alliance for the Mentally Ill –
New York State
National Aphasia Association
National Marfan Association
National Multiple Sclerosis Society, Capital,
Long Island, New York City, Southern,
and Upstate chapters
New York AIDS Coalition
New York Association of Psychiatric
Rehabilitation Services
SHARE: Self-Help for Women with Breast and
Ovarian Cancers
SLE Foundation
West Islip Breast Cancer Coalition for Long Island

Cooperating Organizations

Alliance of Resident Theaters of New York
Brooklynwide Interagency Council of the Aging
Citizen Action of New York
Commission on the Public's Health System
Community Healthcare Network
Community Service Society
Dance Theater Workshop
Greater New York Labor-Religion Coalition
Institute for Puerto Rican and Hispanic Elderly
Joint Public Affairs Committee for Older Adults
Lambda Legal Defense and Education Fund
Long Island Progressive Coalition
Medicare Rights Center
Metro New York Health Care for All Campaign
National Association of Social Workers,
New York City chapter
New York State Health Care Campaign
New York State Nurses Association
New York State Psychological Association
New York Statewide Senior Action Council
Senior Services
Society for Hospital Social Work Directors,
Metropolitan New York chapter
South Fork Community Health Initiative
William F. Ryan Community Health Center

March 6, 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::

New Yorkers for Accessible Health Coverage (NYFAHC) is a statewide coalition of 53 voluntary health organizations and allied groups who serve and represent people with chronic illnesses and disabilities including cancer, HIV/AIDS, cognitive impairments, multiple sclerosis, lupus and bleeding disorders. Because the conditions affecting the individuals and families we represent do not discriminate between rich and poor, we advocate for accessible, affordable, comprehensive and accountable health insurance for the privately insured, as well as those in need of access to public insurance programs.

We appreciate the opportunity to comment on the notice of proposed rulemaking (NPRM) on the Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans.

The Department of Labor has proposed to expand the definition of an employer, allowing more small businesses and self-employed individuals to join together for the sole purpose of offering health insurance. We believe that the proposed changes would negatively impact access to quality, affordable care for consumers, disrupt the individual and small business marketplace, and further strain the limited resources of state regulators. The loosely affiliated small businesses joined together as AHPs would be exempt from many of the consumer protections created by the Affordable Care Act (ACA), including insurance standards such as Essential Health Benefits, premium rating rules, and risk pooling. As was seen in the past with AHPs, fraud, abuse, and plan solvency present potential concerns, especially as oversight and regulatory authority remains in question.

We are particularly concerned that Association health plans will use various practices to discriminate on the basis of health status and will segment the market making the ACA compliant market, that the people we serve now enjoy, into a high risk pool that will become unaffordable to them.

March 6, 2018

DOL is proposing to apply the nondiscrimination rules to ERISA AHPs to prohibit AHPs from discriminating against employer members or employers' employees or dependents based on health status related factors (health factors) (29 CFR 2590.702). As proposed, this would prevent AHPs from using health factors to determine eligibility for benefits or in setting premiums. Health factors include: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. The nondiscrimination standards have applied to group health plans since 1996 and were added to ERISA by the Health Insurance Portability and Accountability Act (Part 7 of Title 1 of ERISA). We applaud this proposal, as it is essential to help protect both employers and their employees from discrimination based on health status.

While we strongly encourage DOL to retain this requirement in final rules, we note that the 1996 nondiscrimination standards alone are insufficient. Other practices including benefit design, rating, geographic location, and industry will result in discrimination against people with medical needs. An AHP can attract healthier groups by offering coverage without maternity, mental health benefits, and expensive prescription drugs. People who need such coverage would not enroll in AHP coverage. Also, an AHP could discriminate in rates, charging women higher rates than men, charging smaller businesses higher rates than larger businesses, charging businesses in certain industries higher rates, and charging older people higher rates. AHPs using these rating practices would attract healthier and younger groups because groups rated up would remain in the state regulated markets. Furthermore, an AHP could engage in marketing practices targeted at attracting healthier people. An AHP could restrict membership to a geographic area that avoids high incidents of cancer rates, heart disease, and diabetes and thereby avoiding covering sicker populations. Its geographic location can also be used to engage in redlining practices. All of these and other discriminatory practices would be allowed because AHPs would be exempt the ACA standards that prohibit such discrimination.

To ensure that AHPs are not engaged in discriminatory practices, in addition to the proposed non-discrimination standard, the final rule should apply ACA EHB, rate reforms, guaranteed issue (which includes marketing standards) and single-risk pool requirements. The single-risk pool requirement is an important way to ensure that AHPs where they exist do not segment the market. Under current law, these requirements apply. Failure to continue to apply these requirements to AHPs will expose employers and their employees to discrimination. Failure to apply these requirements will also place the regulated health insurance markets in jeopardy, as AHPs would cherry pick healthy consumers out of the regulated markets, leaving those markets to fail as the risk pool worsens and premiums spiral out of control.

We share the concern held by many others that freer availability of AHPs will lead to adverse selection. AHPs have a history of harming regulated markets through risk segmentation, and risk segmentation is virtually inevitable, for the following reasons. Due to the well-documented concentration of medical expenses in a small percentage of the population, avoiding even just the top 1 percent of medical spenders can save almost 25 percent of total costs, in any given health risk pool.¹ Thus, like any risk pooling mechanism, AHPs have a great deal more to gain by avoiding a few very high cost subscribers than by including features that are attractive to a broader swath of the population.

This iron law of health care expenditures means that it is highly likely that AHPs will take every opportunity to tailor their coverage and their membership criteria to attract better risks and avoid worse risks. And doing that will leave the regular individual and small-group markets to absorb a greater share of these much-higher-cost patients, threatening their basic stability.

Despite the obvious potential of AHPs to segment better from much worse risks, the proposed rule speculates that this will not happen because unhealthy people have just as much reason to seek the advantages of AHPs as do healthy people. The issue of risk segmentation arises because healthy people are seeking the additional advantages of the costs they can save if they can get into an AHP that has very few unhealthy people. Unhealthy people might, hypothetically, have some interest in joining a particular AHP, but they won't, if they're smart shoppers, have any interest in signing up for an AHP with a low actuarial value, or one that fails to cover the particular costly drugs and treatments that their condition requires. This makes that particular AHP even more attractive to healthy people than it already was. One of the stated goals of the program is to provide a less expensive alternative to plans that must meet minimum actuarial value requirements (56% under the latest regulations) and provide all benefits that have been determined to be "essential." It is certain that healthy people will leave regulated "more expensive" coverage. And that's what risk segmentation is all about. If AHPs are not intended to be a vehicle for skimpy coverage, then the Proposed Rule should be revised to prevent them from selling skimpy coverage.

¹ See Tom Miller, The Concentration And Persistence Of Health Care Spending, 40(4) Regulation 28 (Dec. 2017).

As a result, Avalere has estimated that the impact of the proposed rule will be higher premiums in both the individual (2.7% - 4%) and small-group (.1 -1.9%) markets on top of the premium increases that will be caused by the disappearance of the individual mandate penalty, the short term policy expansion, and any other administrative changes that could influence these markets. There will also be an increased number of uninsured Americans.

The New Yorkers we represent have experienced the spiral of adverse selection. Our individual market had dwindled to 19,000. We now have more than 900,000 people enrolled in Qualified Health Plans and the Essential Plan in New York. Premiums are also significantly lower in the exchange relative to the 2013 individual market plans. The expansion of Association Health plans could do serious damage to this progress and so we urge that these regulations be withdrawn and revised.

If you have questions about these comments, please contact Heidi Siegfried at hsiegfried@cidny.org or 646.442.4147. Thank you for your consideration of our comments.

Sincerely,

Heidi Siegfried, Esq.
Project Director

March 6, 2018