

The Other Shoe Drops: Federal Association Health Plan Regulation Is Next Threat to Coverage in New York

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Unable to broker a deal with Congress to repeal and replace the Affordable Care Act (ACA), the Trump administration succeeded in eliminating the individual mandate penalty¹ as part of the tax bill, and it is now pushing to advance its health care policy agenda through a series of regulatory changes that roll back ACA standards. A proposed rule on association health plans (AHPs),² previewed in an earlier UHF *HealthWatch* report,³ presents a real threat to the gains New York has made under the ACA.

In this issue brief, we examine how the regulation could destabilize New York's individual and small group markets by making it easier to organize healthier groups of individuals or small employers into associations treated as a large group, exempt from many state rating and benefit requirements. This dynamic would increase costs for individuals and small groups seeking comprehensive coverage.

AHPs IN NEW YORK

Groups of two or more employers that meet rigorous standards are permitted under New York and federal law to create an association for purposes of offering health coverage, as if they were one large employer. U.S. Department of Labor filings by associations, known as Multiple Employer Welfare Arrangements (MEWAs), offer a window into how the plans operate in New York. About 40 MEWAs reported⁴ being both headquartered in New York and covering New Yorkers in 2017; over 100 additional MEWAs headquartered in other states also covered New Yorkers.

Formed in 1903, the Niagara Frontier Auto Dealers Association (NFADA),⁵ for example, sponsors a health insurance plan for its franchised auto dealers trade association in western New York. According to its 2017 federal "M-1" filing, the NFADA plan covers about 1,500 individuals under a self-funded plan administered by Guardian Life, with heads of local dealerships serving as trustees. The NFADA also helps members

with workers' compensation insurance, safety training, recruitment, and regulatory compliance, and it runs an active charity, which hosts the annual Buffalo auto show.⁶ The tenure and breadth of the NFADA's activities help it qualify as a "bona fide organization," eligible under federal and state rules to provide large group experience rated coverage to its members. Other New York-based MEWAs include plans by the state Bankers Association, the National Hockey League, and Healthy Manufacturers of New York State.⁷

Existing state and federal rules ensure that associations that don't meet standards like the "bona fide organization" requirement, are properly classified, which in turn impacts the rating and benefit rules that apply to coverage offered to association members. This makes it hard for AHPs to skirt benefit requirements and consumer protections, or to cherry-pick lower-risk groups. Under state and federal rules, if an association not meeting the standards includes one or more small groups (1 to 100 employees), then premiums for these groups are based on small group community rates, and any large groups that participate in the association have premiums based on experience rates.

The same "look-through" rules apply to individuals who might be enrolled in groups. Under current law, premiums for individuals and small groups cannot vary based on age, gender, health status, group size, or occupation, and benefits must include all the essential health benefits established by New York. Separate benefit standards apply to fully insured large groups, under which "experience rating" rules do allow premium variations for these different workforce characteristics. Self-funded plans are exempt from most but not all federal and state benefit and rating requirements.

THE TRUMP ADMINISTRATION PROPOSAL

Since the late 1980s, Congress has considered but failed to pass legislation encouraging

the proliferation of AHPs; for the last 18 months, it has tried but failed to pass legislation repealing the ACA. The Trump administration's proposed rule would both greatly enable AHPs and revise important ACA rules and protections designed to stabilize health insurance markets. The proposed rule sweeps away many state and federal Employee Retirement Income Security Act (ERISA) requirements that AHPs must meet to be considered a single employer (embodied in the NFADA plan and others like it). By loosening the rules on what constitutes a "bona fide" organization and "commonality of interest," AHP sponsors could be organized solely for the purpose of offering health coverage, need not be in existence for a minimum period, and could organize entities into associations whose only common thread is operating in the same "trade" or the same geographic location, including metropolitan areas that cover more than one state. In addition, so-called "working owners" or sole proprietors could be covered through AHPs, through an interpretation in the proposed rule that categorizes them as both employers and employees simultaneously, with a low burden of proof to qualify as a working owner.⁸

REACTION TO THE AHP REGULATION

In a sign of its importance, the AHP regulation spurred over 700 formal comments, representing over 900 individuals and organizations from across the country.⁹ Realtors and business groups like the National Federation of Independent Business (NFIB)¹⁰ and the U.S. Chambers of Commerce championed the plan, stressing the advantages of increased competition and greater bargaining power for small businesses. NFIB is one of many organizations that offered association coverage before the ACA reduced its enrollment, which they hope will recover through the proposed AHP rule. The NFIB's website for potential buyers of its "non-Obamacare" individual plans,¹¹ which offer limited benefits and allow discrimination based on pre-existing conditions, is instructive

on the attitude of NFIB on coverage generally, which will surely inform its approach on future AHPs. From the FAQ:

MYTH: If I get sick I'm stuck with this plan.

FACT: You can go back to an Obamacare plan during the next open enrollment season with no medical questions asked.

MYTH: These plans don't cover maternity, mental health, or pre-existing conditions.

FACT: Ok, this one is actually true, but it's not necessarily a bad thing. If you don't need these benefits, why would you pay for them like you will in an Obamacare plan?

MYTH: I have to answer a lot of medical questions.

FACT: You will have to answer some simple medical questions about mostly major conditions like heart disease, cancer, stroke, etc. But if you live a healthy lifestyle, and you qualify, the savings are huge. Plus you can rest easy knowing that you are not just helping to pay for sick people that are in Obamacare plans.

Comments from another supportive business group are enlightening as well, suggesting that AHPs are only sustainable if they screen out higher-risk groups. Although the National Restaurant Association received the necessary approval from federal officials for its own association in November 2017, prior to the release of the proposed rule, it objects to non-discrimination provisions in the proposal. While many consumer groups believe these provisions are too weak to be meaningful (because of the ability of AHP sponsors to tailor benefits and networks to avoid higher-risk groups), the Restaurant Association's comments state that existing non-discrimination provisions in the rule create a duty to offer coverage to "less healthy employees" which would increase costs and "limit the ability of AHPs to attract moderately health groups and eventually making the AHP pricing uncompetitive."¹²

Opponents of the proposal, a group that includes state regulators,¹³ 17 state attorneys

general,¹⁴ actuaries,¹⁵ many provider groups,¹⁶ patient advocacy groups,¹⁷ and consumer advocates,¹⁸ made two main points in asking that the proposed rule be withdrawn—or at the very least that the final rule not preempt state authority. First, given past history, relaxing AHP standards would trigger a new wave of fraudulent associations, which, according to comments by a former U.S. Department of Labor official, would operate like Ponzi schemes and victimize employers, consumers, and providers.¹⁹ Second, opponents argued that the AHP proposal represents an end-run around state insurance regulation and the ACA, making low-benefit coverage available to healthy consumers but drawing healthier individuals and groups from ACA markets to AHPs, which would drive up rates for those who need

comprehensive coverage, a result known as market segmentation.

One recent analysis found that more than 95 percent of “health care organizations”—physicians, nurses, hospitals, and consumer and patient advocacy groups—opposed the AHP plan.²⁰ Health plans took positions on both sides of the issue, perhaps a reflection of whether they are currently engaged in AHP business or not. United Healthcare Group, for example, spoke favorably of the rule, though it sought important clarifications, and the Blue Cross Blue Shield Association opposed it.²¹ All health plans commenting raised concerns with the timing of the proposed rule, worried that it would be out of sync with the cycle for submitting rates for the regular markets. Comments from New Yorkers mirrored those nationally.

NEW YORKERS WEIGH IN ON AHP REGULATION

Reflecting the importance of the AHP regulation, New Yorkers of all stripes have weighed in on the AHP plan. The New York State Association of Realtors²² voiced strong support for the “working owners” provisions, so that independent realtors would not be “forced to purchase in the more costly and volatile individual insurance market.” The New York City Bar Association also supported the rule,²³ suggesting revisions that would make it easier to revive the AHP it formerly offered to members prior to the ACA.

New York Superintendent of Financial Services Maria T. Vullo led the charge against the proposed rule. Like fellow insurance regulators in other states, she stressed the vital importance of maintaining existing state authority over MEWAs and AHPs, “else the Rule would be contrary to law and would have a drastic and catastrophically negative impact on the individual and small group markets in New York.”²⁴ In addition to Superintendent Vullo and the New York State Attorney General, who was part of the coalition of attorneys general voicing opposition to the plan, other government officials opposing the plan included New York City Department of Social Services Commissioners Steven Banks²⁵ and New York State Senator Liz Krueger.²⁶

Some of the companies regulated by Superintendent Vullo made similar comments. The New York Health Plan Association expressed concerns about the proposal “fragmenting the individual and small group markets, resulting in higher health insurance premiums for some consumers and employers,²⁷ but noted that New York policymakers could mitigate the impact by allowing age rating and eliminating benefits. Insurer EmblemHealth worried that the rule, when coupled with the individual mandate penalty repeal, “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.”²⁸

Many provider organizations nationally opposed the rule, and the Healthcare Association of New York State²⁹ is a local example, citing the risk to consumers from low-value coverage, market segmentation, and the risks to providers of a muddled regulatory system. Northwell Health was something of an outlier among providers, as it supported the rule, citing the potential for “fostering choice and innovative plan design.”

Many New York patient advocacy groups made their voices heard through their national associations,³⁰ but local groups like the Health Care for All New Yorkers³¹ coalition and New Yorkers for Accessible Health Coverage,³² opposed the rule, citing market segmentation and benefits issues, as did the Medicare Rights Center, which focused on the potential harm to older New Yorkers and fallout from increased fraud.³³ Two New York non-profit health care organizations highlighted the potential damage from the rule, the New York State Health Foundation³⁴ and the United Hospital Fund.³⁵

AHPs AND THE INDIVIDUAL MARKET

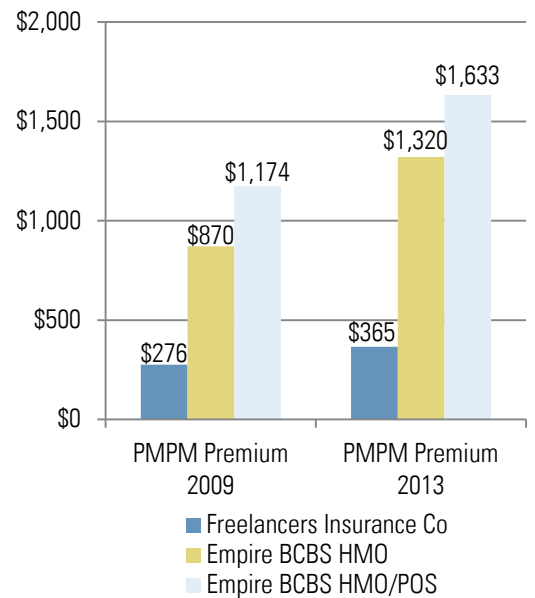
One unexpected provision of the proposed AHP regulation, since it was not raised in the Trump administration executive order announcing the AHP plan,³⁶ is the establishment of another eligible category of people who are not part of an employer group, so-called “working owners.” But this issue is not new to New York, which has grappled with what coverage options should be available for “sole proprietors” or “groups of one” for over 25 years. New York’s experiment to allow the creation of an association plan exclusively for “freelancers” or “independent workers” in certain industries helps explain this approach’s appeal, as well as its tradeoffs and potential consequences.

Originally known as Working Today, the Freelancers Union was established to organize and aid independent workers. Freelancers Union leadership made the case that, with the onset of the growing “gig economy,” independent workers needed a mechanism to access coverage, because it was not available through an employer, and because coverage in New York’s individual market was very expensive. In 2000, the New York State Department of Financial Services (DFS) used its statutory discretion to grant the Freelancers Union association status,³⁷ and the organization began arranging coverage for members who worked as freelancers in technology jobs—“everything from software development to online journalism”—according to one account of its early history.³⁸ At first, members purchased coverage through Health Insurance Plan of Greater New York (HIP) and then later Empire Blue Cross Blue Shield, but in 2008, the organization launched a for-profit accident and health insurer, Freelancers Insurance Company, Inc. (FIC), solely for its members.³⁹ Eligibility for FIC was expanded beyond independent workers in technology, to other fields and occupations as well: arts, design, and entertainment; domestic child care; financial services; nonprofits; skilled computer users; and

traditional or alternative health care providers. Legislation enacting a special demonstration program tailored to the Freelancers Union’s activities provided a statutory underpinning for its unusual status.⁴⁰

Over time, enrollment grew steadily for the Freelancers Union, starting with about 1,000 members in 2000, to nearly 26,600 members in 2013,⁴¹ more than in the individual market for comprehensive coverage statewide.⁴² A comparison of FIC rates to those in the standardized market for individual comprehensive coverage explains the reason for that growth. Figure 1 compares per-member per-month (PMPM) premiums reported in 2009 and 2013 by FIC for its Preferred Provider Organization (PPO) product, to two Empire Blue Cross Blue Shield (EBCBS) individual market products, an in-network only plan (HMO) and a plan with out-of-network benefits (HMO/POS).

Figure 1. PMPM Premiums for Freelancers Insurance Company, Empire BCBS HMO, and Empire BCBS HMO/POS, 2009 and 2013



Source: UHF analysis of NAIC Annual Statements and New York Supplements for Freelancers Insurance Company and Empire BCBS, for calendar years 2009 and 2013.

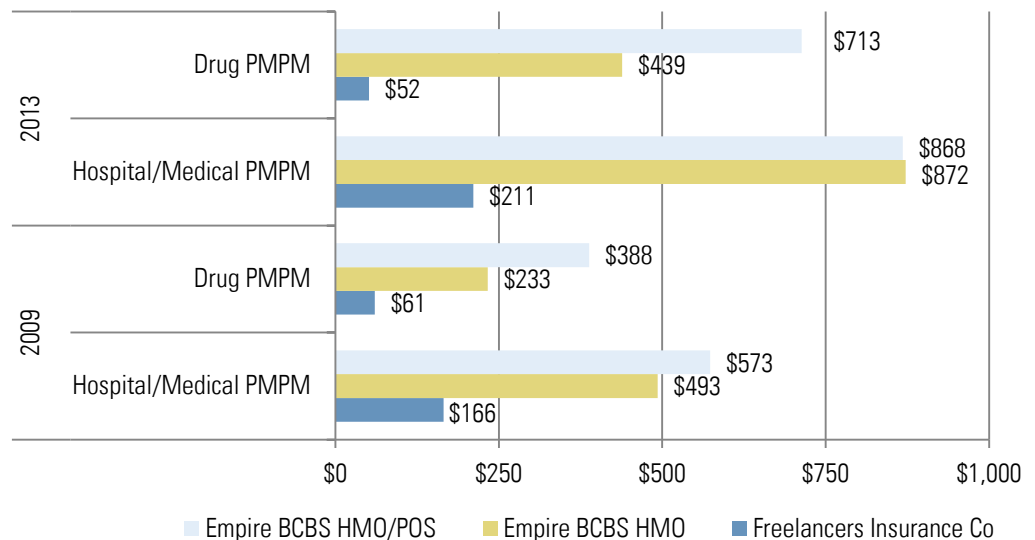
FIC’s members enjoyed a huge discount compared to the standardized individual products offered by EBCBS. In 2009, FIC’s reported monthly premiums (\$276) amounted to about 30 percent of premiums reported by EBCBS for its HMO (\$870), and less than 25 percent for the EBCBS HMO/POS plan (\$1,174).⁴³ Although premiums rose for all three products by 2013, premiums for the EBCBS plans rose at a higher rate and FIC members achieved roughly the same savings over time, paying about 27 percent (\$365) of the cost of the Empire HMO plan (\$1,320), and 23 percent of the Empire HMO/POS plan (\$1,633).

Why were the FIC rates so much lower than EBCBS? Sometimes the size of provider networks can affect premiums, but since FIC relied on the EBCBS network, that can be ruled out here. The level of benefits can also raise or lower premiums, but that also does not appear to have been an issue; FIC enrollment was initially categorized as a large group—not subject to individual benefit requirements—but it appeared to provide most benefits required for the individual market.⁴⁴ Cost sharing certainly was a factor.

Only copays were allowed in the EBCBS individual coverage, with no in-network deductibles and an out-of-pocket maximum of \$1,500 for individuals / \$3,000 families, and, for out-of-network services, a deductible of \$1,000/\$2,000, and maximum out of pocket of \$3,000/\$5,000. In contrast, FIC coverage under its most comprehensive plan included deductibles of \$1,500/\$3,000 and out-of-pocket maximums of \$6,000/\$12,000, with higher cost-sharing options available. All FIC options capped annual benefits at \$2,000,000.

But the overriding reason why FIC premiums were far less costly appears to be that its members were so much healthier than EBCBS enrollees (Figure 2), based on reported PMPM expenses for hospital/medical care and drugs. FIC’s association status allowed it to effectively start its own risk pool outside of New York’s pre-ACA individual market—which was very much *in extremis* at that point, after years of adverse selection that drove rates up and drove healthy individuals out of the market. FIC-reported PMPM expenses for hospital/medical expenses in 2009 (\$166) were a small fraction of the expenses EBCBS reported for those services (\$493 and \$573),

Figure 2. PMPM Hospital/Medical and Drug Expenses for Freelancers Insurance Company, Empire BCBS HMO, and Empire BCBS HMO/POS, 2009 and 2013



Source: UHF analysis of NAIC Annual Statements and New York Supplements for Freelancers Insurance Company and Empire BCBS, for calendar years 2009 and 2013.

about 33 percent and 29 percent, respectively. For the same year, the differences between FIC's drug expenses (\$61) and those of EBCBS (\$388 and \$439) were even starker, with FIC expenses amounting to about 16 percent and 14 percent of EBCBS's drug expenses. The same pattern held true in 2013 as well.⁴⁵

Certainly, one factor in the disparity in health status between FIC and EBCBS individual market coverage was the status of New York's individual market risk pool at the time. Other factors may have contributed to the size of the disparity, including characteristics allowed in large group underwriting such as age, gender, and occupation. There is some evidence that the freelance workforce is "skewed" toward younger and male workers,⁴⁶ and occupation has long been a part of how health plans develop experience rates for large groups.

Experience-rating formulas used by health plans start with a base rate, which is then adjusted based on an age/sex factor of members. With 1.0 serving as the average risk, 25- to 29-year-old males, for example, are assigned a factor of 0.461, and 25- to 29-year-old females are assigned a factor of 0.790.⁴⁷ After adjusting rates based on the age and gender of a company's employees, health plans further adjust the base rate using "standard industrial classification" codes, which are predictive of risk. An EBCBS rating manual in effect at the time for one of its group products provided modest discounts on rates for computer programmers, depository institutions, and communications services, and added a surcharge on rates for drinking places, taxicabs, and eating and drinking places. A current rating manual for upstate insurer Capital District Physicians' Health Plan provides discounts for communications and professional services (accounting, engineering, architecture), and charges higher rates for eating and drinking places, forestry, hotels, and hospitals. An HIP rating manual provides a discount for electrical and electronic equipment, printing and

publishing, and financial and business services, and adds a surcharge to health services, eating places, and passenger transit.⁴⁸

FIC rates likely reflected favorable demographic factors and a higher proportion of lower-risk occupations, due to Freelancers Union eligibility standards. Medical expenses were not only lower than individual market expenses, but also compared favorably to EBCBS small group expenses at the time, which is very unusual.⁴⁹ (Typically, small group risk profiles are healthier than individual market enrollees.) And the FIC experience contrasts with the track record of another group of individuals allowed to join associations, sole proprietors. When New York mandated that Chambers of Commerce offering pre-ACA AHP coverage to small groups also offer it to sole proprietors, it allowed health plans providing the coverage to charge a 15 percent surcharge, due to expected higher claims experience among these individuals.⁵⁰

Certainly coverage through the Freelancers Union was a boon to members, providing coverage that many could not otherwise afford, but the opportunity was not available for individuals who did not meet Freelancers Union eligibility criteria, or for workers at small or large employers not offering coverage.⁵¹ The ACA provided a market-wide approach, with individual responsibility provisions to encourage healthier people to buy coverage, and premium and cost-sharing subsidies to make coverage affordable for lower-income enrollees, both of which helped stabilize the individual market risk pool. New York State of Health, the new ACA Marketplace, provided technology, structure, and resources to make shopping for coverage easier. In 2015, FIC announced that it would opt out of the individual market, but undoubtedly, the shift of some of its members to Marketplace coverage contributed to the more stable risk pool, and thus lower rates.⁵²

While New York's individual market is in far better shape now than in 2013, working owner associations could be structured around low-risk occupations or younger age groups to siphon off healthier risks through cheaper premiums. One recent study⁵³ contained a "low-range" estimate that three percent of individual market members nationally might leave for AHPs under the proposed rules, and those enrollees would be 62 percent healthier than the remaining members on average. The "high-range" scenario arrived at an estimate of 10 percent leaving the marketplace, who would be 54 percent healthier. A shift in enrollment from the individual market to association plans would also result in less funding for the risk-adjustment mechanism that helps offset the costs of health plans with a disproportionate share of higher-risk individuals, while the overall risk profile of the pool might be deteriorating because of the loss of healthier individuals.

AHPs AND SMALL GROUPS

The AHP proposal presents the same threats to the small group market discussed above for the individual market—age, gender, occupational underwriting, limited benefits (prescription drugs are not a required large group benefit in New York, for example)—and increased cost sharing could help AHP sponsors produce lower premiums than available in the small group market. With large enough numbers, AHP sponsors could seek to establish self-funded AHPs, leaving the regulated market entirely.

Opponents of the AHP proposal have plenty of real-life examples of the dysfunction of markets in which participants play by two sets of rules. In Tennessee, the ability of that state's Farm Bureau to market non-compliant plans to farmers, non-farmers, and individuals has made the ACA market among the most inhospitable in the nation, with high premiums and low health plan participation.⁵⁴ In Kentucky, a crisis was precipitated in the 1990s when health plans playing by modified

community rating rules could not compete with health plans not subject to underwriting restrictions because they enrolled groups through AHPs.⁵⁵ In comments on the AHP regulation, Washington's Insurance Commissioner cited a study finding that premiums for AHPs averaged \$278 per month in 2010, compared to \$382 for the community-rated market. He noted that "this inexpensive alternative for small employers appeared to come at a cost to the community-rated small group market, which skewed toward markedly older and sicker enrollees and had more female enrollees. We concluded, therefore, that AHPs were able to identify and enroll those small employers with lower health risk, thus making the community-rated small group market more costly, less attractive to issuers, and less stable."

As noted in the earlier *Health Watch* brief, New York would be a target-rich environment for entrepreneurs seeking to organize AHPs.⁵⁶ Because New York does not allow any variation in community-rated premiums (the ACA permits states to set up to a 3:1 ratio for premiums based on age), employers with younger employees or more men might find an AHP attractive. Also, New York is one of only four states that define small groups as between 1 to 100 employees,⁵⁷ so groups of 51-100 employees may also meet new suitors in the market with an AHP scheme in place, offering experience rates. Finally, the fact that New York's small group risk pool is among the "sickest" in the nation, based on 2016 federal risk-adjustment data, enhances the ability of AHP sponsors to use tools like reduced benefits, age, gender and occupation rating to offer competitive rates to target lower-risk employer groups, as was the case in Washington.

In its comments, United Healthcare Group sought clarification on an important issue left unsettled in the regulation: whether AHP sponsors could price coverage at the "employer level" (a separate rate for each employer group participating in the

association), or based on the experience of the whole group. Employer-level rating would make it very easy to cherry-pick healthier small groups.

AHPs—THE OTHER SHOE DROPS

If the repeal of the individual mandate penalty—responsible for roughly half of the weighted average 24 percent individual market rate increase New York health plans are seeking for 2019⁵⁸—was the first shoe dropping, then a final AHP regulation, which could be issued as early as June, could be the second.

In comments on the AHP regulation, DFS Superintendent Vullo noted that “any preemption of state regulation would be a disaster.” Although parts of the preamble to the proposed regulation affirm state regulation of MEWAs, including provisions⁵⁹ that allow states to regulate MEWAs that are self-funded, the regulation also invites comments on whether the U.S. Department of Labor should craft exceptions to state authority. Without preemption, states could revisit existing AHP-related provisions and look-through rules, align benefit requirements across markets, identify best practices from other states, and seek creative ways to keep individual and small group risk pools intact. This is particularly important given the expansion of AHPs to include any employer “in the same trade, industry, line of business or profession,”⁶⁰ or in geographic areas covering more than one state, both of which invites sales of insurance “across state lines,” another stated goal of the Trump administration.

With preemption, a final AHP rule would unleash market forces that make it very difficult to sustain stable insurance markets, particularly for small businesses and individuals ineligible for subsidies. With the stakes so high, litigation is a strong possibility; many have questioned the legality of both

the working owners’ provisions⁶¹ and the proposed rule overall. Comments from the 17 opposing states attorney general, for example, called the proposal “an unlawful attempt to accomplish by executive rulemaking changes in law and policy that lie within the power of Congress—and that Congress has refused or failed to adopt.”

CONCLUSION

The AHP regulation is certainly not the only example of the Trump administration’s efforts to alter ACA provisions through regulation rather than through statutory changes. Most recently, the final Notice of Benefit and Payment Parameters,⁶² for example, makes it easier for states to exempt health plans from minimum medical loss ratios and reduce essential health benefits, but it does not prevent New York from maintaining its own standards. Another pending regulation⁶³ seeks to expand the availability of so-called short-term limited duration insurance (STLDI), which allows discrimination based on pre-existing conditions, and typically excludes mental health, maternity, and prescription drug benefits, but these products are currently prohibited in New York.⁶⁴ But the AHP rule could be structured to sharply limit state discretion.

With the final AHP rule expected imminently, watchers will be on the lookout for big and small differences between the proposed and final rule, including whether working owners will be allowed to join AHPs and under what terms, potential grandfathering in of existing AHPs, the possible weakening of anti-discrimination standards, the timing of the rule’s implementation, and the question of employer-level or large group rating. But by far, the key element that has ACA supporters concerned is state preemption, and how tightly the final regulation will tie states’ hands.

Notes

- 1 Part VIII of the Tax and Jobs Act (H.R.1 of 2018) reduced the individual responsibility penalty from 2.5 percent of income or \$695 to \$0 after December 31, 2018. <https://www.congress.gov/115/bills/hr1/BILLS-115hr1enr.pdf>
- 2 Proposed Rule on Definition of “employer” Under Section 3(5) of ERISA—Association Health Plans. U.S. Department of Labor, Employee Benefits Security Administration. January 5, 2018. <https://www.federalregister.gov/documents/2018/01/05/2017-28103/definition-of-employer-under-section-35-of-erisa-association-health-plans>
- 3 Newell P. *New York’s Small Group Market Isn’t Feeling Well—and a Trump Administration Proposal May Make Things Worse*. December 2017. United Hospital Fund. <http://uhfnyc.org/publications/881265>
- 4 US DOL M-1 online search, at <https://www.askebsa.dol.gov/epds/>
- 5 NFADA M-1 Filing available at <https://www.askebsa.dol.gov/mewaview/View/Index/6109>
- 6 For background, see NFADA website at <http://www.nfada.com/>
- 7 Healthy Manufacturers of New York State M-1 filing for 2017. <https://www.askebsa.dol.gov/mewaview/View/Index/5691>
- 8 Section 25103-5(e)(2) of the proposed regulation allows working owners to qualify by notifying AHP sponsors in writing that they meet the eligibility requirements for working owners.
- 9 All comments are available on the Employee Benefit Security Agency’s comment page, <https://www.dol.gov/agencies/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85>. The Georgetown University Health Policy Institute’s Center on Health Insurance Reforms prepared a through summary on the comments, based on five categories of interest groups. <http://chirblog.org/future-affordable-care-act-president-trump-stakeholders-respond-proposed-association-health-plan-rule-part-v-departments-insurance/>
- 10 National Federation of Independent Business and U.S. Chamber of Commerce
- 11 NFIB website. <https://www.nfib.com/content/news/healthcare/non-obamacare-health-insurance-plans-myth-vs-fact-73679/>. Accessed May 20, 2018.
- 12 National Restaurant Association
- 13 National Association of Insurance Commissioners and The Center for Insurance Policy and Research
- 14 17 State Attorneys General
- 15 American Academy of Actuaries and American Academy of Actuaries Individual and Small Group Markets Committee
- 16 American Medical Association, Federation of American Hospitals, American Academy of Family Physicians, American Hospital Association and American Academy of Pediatrics
- 17 American Cancer Society Cancer Action Network
- 18 Consumers Union, Families USA
- 19 Marc I. Machiz
- 20 Levey N. May 30, 2018. Trump’s new insurance rules are panned by nearly every healthcare group that submitted formal comments. *Los Angeles Times*. <http://www.latimes.com/politics/la-na-pol-trump-insurance-opposition-20180530-story.html>
- 21 United Healthcare Group and Blue Cross Blue Shield Association
- 22 New York State Association of Realtors
- 23 The Association of the Bar of the City of New York
- 24 New York State Department of Financial Services
- 25 City of New York Department of Social Services

- 26 [New York State Senator Liz Krueger](#)
- 27 [New York Health Plan Association](#)
- 28 [EmblemHealth](#)
- 29 [Healthcare Association of New York State](#)
- 30 [Coalition of 15 Organizations, including: American Cancer Society, Cancer Action Network, American Heart Association, American Liver Foundation, American Lung Association, Autism Speaks, COPD Foundation, Crohn's & Colitis Foundation, Cystic Fibrosis Foundation, Epilepsy Foundation, Futures without Violence, Leukemia & Lymphoma Society, Lutheran Services in America, Muscular Dystrophy Association, National Multiple Sclerosis Society, National Organization for Rare Disorders](#)
- 31 [Health Care for All New York](#)
- 32 [New Yorkers for Accessible Health Coverage](#)
- 33 [Medicare Rights Center](#)
- 34 [New York State Health Foundation Sandman](#)
- 35 [United Hospital Fund](#)
- 36 [Presidential Executive Order Promoting Health Care Choice and Competition Across the United States. October 12, 2017.
<https://www.whitehouse.gov/the-press-office/2017/10/12/presidential-executive-order-promoting-healthcare-choice-and-competition>](#)
- 37 [NY Insurance section 4235\(c\)\(M\) allows the superintendent the discretion to recognize associations which do not meet other statutory requirements.](#)
- 38 [Strom S. October 2, 2002. Health Insurance for Freelancers; A New Group Focuses on an Overlooked Group of Workers. *New York Times*. For additional background on Freelancers Union, see: Laskow S and S Greenhouse. January 27, 2007. Labor Union, Redefined for Freelance Workers. *New York Times*.](#)
- 39 [New York State Department of Financial Services. Report on Organization, Freelancers Insurance Company, Inc. October 23, 2008. \[https://www.dfs.ny.gov/insurance/exam_rpt/freeoo08.pdf\]\(https://www.dfs.ny.gov/insurance/exam_rpt/freeoo08.pdf\); and Report on Examination, Freelancers Insurance Company, Inc. June 27, 2013. \[https://www.dfs.ny.gov/insurance/exam_rpt/13564c09.pdf\]\(https://www.dfs.ny.gov/insurance/exam_rpt/13564c09.pdf\)](#)
- 40 [NY Insurance Law, section 1123, repealed in December 2014.](#)
- 41 [Freelancers Insurance Company, Inc., New York Supplement for calendar year 2013.](#)
- 42 [Newell P. Rewind: New York State Faces Familiar Issues and New Challenges in the "Repeal and Replace" Era. June 2017. United Hospital Fund. <https://uhfnyc.org/publications/881214>](#)
- 43 [Oxford Health Plans \(OHP\) and EBCBS were the leading individual market health plans in 2009 and 2013 in terms of market share.](#)
- 44 [UHF analysis of FIC certificates of coverage, rating manuals and other documents filed with the Department of Financial Services, and statutory provisions for individual coverage in NY Insurance sections 4321 and 4322.](#)
- 45 [OHP reported either comparable or higher PMPM premiums, hospital/medical and drug expenses than EBCBS. In 2013, for example, Oxford reported PMPM premiums of \\$1,891 \(HMO/POS\) and \\$1,292, \(HMO\), hospital/medical expenses of \\$869 and \\$1674, and drug expenses of \\$612 and \\$1,104.](#)
- 46 [A December 2017 survey by NPR and the Marist Poll found that 65 percent of contract workers were male, and 62 percent are under age 45. NPR. Special Series: The Rise of the Contract Workforce. January 22, 2018. Video, audio and transcripts available at <https://www.npr.org/series/579833363/the-rise-of-the-contract-workers> and <https://www.npr.org/2018/01/23/579690595/the-mystery-of-contract-work-why-so-many-guys>. Underlying poll available at <http://maristpoll.marist.edu/nprmarist-poll-results-january-2018-picture-of-work/>. An annual survey commissioned by Upwork and Freelancers Union found in 2015 that "men tend to freelance more than women" \(60% to 40%\), though the 2016 survey found that the](#)

- gap had narrowed to 54% to 46%). The 2016 survey found that “more millennials and members of Gen Z are freelancing than any other age group” and the 2017 survey found that “younger generations are driving the acceleration in freelancing.” 2017 Results Deck <https://www.slideshare.net/upwork/freelancing-in-america-2017/1>; 2016 Results Deck: <https://www.slideshare.net/upwork/freelancing-in-america-2016/1>; 2015 Results Deck: <https://www.slideshare.net/upwork/2015-us-freelancer-survey-53166722/1>. A recent federal survey on “contingent workers” found that men made up 64 percent of the 10.6 million “independent contractors” estimated nationally, with 44 percent of all independent contractors under the age of 44, and 47 percent between the ages of 45 and 64. Contingent and Alternative Employment Arrangements. May 2017. Bureau of Labor Statistics, U.S. Department of Labor. News Release. June 7, 2019. <https://www.bls.gov/news.release/conemp.nr0.htm>
- 47 Health Insurance Plan of Greater New York Large Group Experience Rating Formula, filed February 2, 2013.
 - 48 The experience rating formulas typically assign average risk industries the value of 1.0, with riskier occupations at greater values, and lower-risk industries with lower values. HIP’s rating manual, for example, includes a formula assigning “nondepository credit institutions” a value of 9.25, “communications” a value of 9.50, “hotels, rooming houses, camps and other lodging places” a value of 1.125, and “health services (nursing homes and hospitals)” a value of 1.150. Other rating manuals used were EBCBS 2009 for its Prism product, and a 2015 large group rating manual for Universal Health Benefits, Inc., an article 43 nonprofit insurer within the CDPHP holding company.
 - 49 In 2013, EBCBS HMO reported \$86 PMPM in drug expenses, and \$379 PMPM in hospital/medical expenses for its small group business; FIC reported \$52 PMPM and \$211 PMPM, respectively. A leading small group insurer, Oxford Health Plans, reported \$45 PMPM for drugs and \$288 PMPM for hospital/medical for its HMO small group business in 2013.
 - 50 NY Insurance Law section 4317(f).
 - 51 In 2016, 54.5 percent of employees worked at private sector establishments with 50 or fewer employees that offered health insurance. Table II.B.2 Percent of private-sector employees in establishments that offer health insurance by firm size and State: United States, 2016. Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2016 Medical Expenditure Panel Survey-Insurance Component. https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2016/tiib2.pdf. More than 700,000 New Yorkers were employed but lacked coverage in 2016, according to the American Community Survey. https://factfinder.census.gov/faces/nav/jsf/pages/guided_search.xhtml.
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 - 57 National Conference of State Legislators. Small and Large Business Health Insurance: State and Federal Roles. January 2017. <http://www.ncsl.org/research/health/small-business-health-insurance.aspx>
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- 59 The 1983 Erlenborn-Burton amendment to ERISA added a new section 3(40) giving states authority to regulate MEWAs, in response to the fallout from a number of fraudulent and incompetent associations that failed.
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- 62 HHS Notice of Benefit and Payment Parameters for 2019. U.S. Department of Health and Human Services. April 18, 2018. <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-07355.pdf>
- 63 Proposed Rule on Short-term Limited Duration Insurance. U.S. Department of Labor, U.S. Department of the Treasury, U.S. Department of Health and Human Service. February 21, 2018. <https://www.federalregister.gov/documents/2018/02/21/2018-03208/short-term-limited-duration-insurance>
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