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New York's Small Group Market Isn't Feeling Well—and a Trump Administration Proposal May Make Things Worse

December 2017

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United Hospital Fund is an independent, nonprofit organization working to build a more effective health care system for every New Yorker.

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This work was supported by the New York Community Trust.

New York's small group insurance market is showing signs of distress. Enrollment has dropped from about 1.7 million enrollees in 2007 to 1.1 million in 2016,[1] in part because of declining offer rates by smaller private sector employers[2] and likely exacerbated by rising premiums. According to data collected as part of the federal premium stabilization program, New York small group average monthly premiums in 2016 ($600) were 39 percent higher than in 2014, and 35 percent higher than the national average ($440), trailing only Alaska ($669). For the 2017 and 2018 rate years, New York's Department of Financial Services granted average small group rate increases of 8.3 percent and 9.5 percent, respectively.[3]

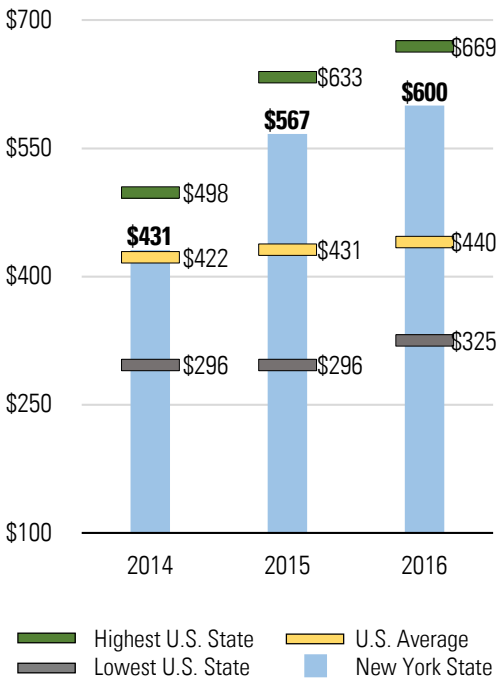
One reason for the spike in small group rates might be the declining health status of the small group risk pool. According to federal data measuring the relative health or sickness of states' small group market risk pools (Figure 2), New York's risk score in 2016 (1.774) was the highest in the nation, well above the national average (1.324), and nearly 50 percent higher than Montana, the state with the healthiest pool (1.081). Even though New York ranked last in both 2015 and 2016, the 2016 risk score actually represents an improvement (from 1.803 to 1.774). This improvement might be due to New York's decision to follow through on an Affordable Care Act (ACA) provision raising the size cutoff for the small group market from 50 to 100 employees, drawing slightly larger and healthier employer groups to the redefined small group pool.[4]

PRESERVING A STABLE SMALL GROUP RISK POOL

In making the decision to implement the group size change, New York policymakers revisited an area that has been a source of regulatory tension for decades. Since 1992, New York's small group market has been community-rated, so rates cannot vary based on the age, sex, occupation or health status of workers and dependents. On the other side of the dividing line, the large group market is experience-rated, with rules that allow rating variation based on these factors. The ACA ushered in community rating for all small group markets nationally, but it also allows rates to vary based on age, up to a 3:1 ratio. When New York adopted community rating in 1992, provisions were included to protect the stability of the small group risk pool[5] by limiting the ways younger or healthier small groups could exit the market for experience-rated coverage through out-of-state plans or self-funded arrangements.

For example, provisions were included that prohibited insurers from selling "stop-loss" coverage to small groups. Typically used in conjunction with self-funded arrangements, stop-loss coverage shields employers from the risk of catastrophic claims, but it can mimic fully-insured coverage if the stop-loss attachment point—the dollar amount beyond which claims are reimbursed by the policy—is close to the deductible on a fully insured plan. When the 1–100 small group size definition was adopted, the prohibition on selling stop-loss coverage moved with it,

Figure 1. Small Group Market Average Premiums, 2014 to 2016



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automatically sealing off a potential loophole. Policymakers, however, have subsequently approved legislation[6] "grandfathering in" existing 50–100 employee groups that already had stop-loss arrangements in place, but pressure remains to eliminate the prohibition entirely.[7]

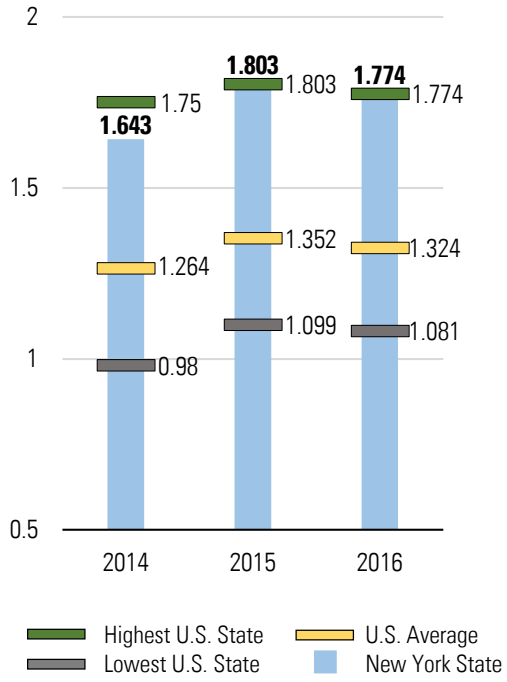
ASSOCIATION HEALTH PLANS

Stop-loss coverage is just one of the hot spots that regulators face as they try to preserve the stability of the small group market; association health plans (AHPs) are another. Sponsors of AHPs bundle multiple small groups together to reduce costs by accessing the self-funded or large group market. Despite persistent problems with fraudulent AHP sponsors that have left policyholders responsible for millions in claims,[8] the arrangements have strong supporters among business groups[9] (which often offer coverage through these arrangements to their membership) and in Congress.[10] Proponents tout the benefits of giving small groups the same bargaining power as large groups,[11] but many believe the cost savings are a result of rates based on age, sex, health status, and occupation—which tends to benefit younger, predominantly male, and healthier groups in lower-risk fields—and AHPs' ability to avoid state benefit requirements and consumer protections.[12]

As was the case with the stop-loss requirements, New York policymakers included statutory and regulatory provisions to prevent AHPs from avoiding small group requirements. For example, insurers could not do business with association plans formed just for the purposes of getting coverage,[13] and if the association had one small group member, premiums had to be set for the whole association using community-rating rules. ACA guidance generally affirmed and strengthened these standards.[14]

But state and federal regulations on group insurance are both grounded on the

Figure 2. Small Group Market Risk Scores, 2014 to 2016



Source for Figures 1 and 2: Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight. Summary Reports on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for Benefit Years 2014, 2015, and 2016. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/

complicated federal Employee Retirement Income Security Act, which governs all group health insurance arrangements and defines important terms like bona fide association group, Multiple Employer Welfare Associations (MEWA), and single large group employer. The U.S. Department of Labor provides ongoing guidance through regulations and advisory opinions, looking at a range of factors to determine how associations fit into the complicated state and federal regulatory scheme—such as how much control individual employers have over the association and how it's governed, the commonality of interest among members, and other activities the association undertakes on behalf of members.[15] The discretion federal regulators appear to have in this area is why

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many observers are worried about the recent Trump administration executive order on AHPs, and its potential to undermine state regulation of small group markets.[16]

THE EXECUTIVE ORDER

The Trump administration's executive order[17] of October 12, 2017, expressly seeks to "facilitate the purchase of insurance across State lines" and outlines a regulatory path for federal agencies to expand access to AHPs by loosening current definitions of what constitutes a large group employer under federal law, which could preempt state small group rating and benefit laws. In many ways, a broad interpretation of what constitutes an employer would be analogous to the current regulatory treatment of Professional Employer Organizations (PEOs) operating in New York and across the country, which many believe are draining healthier and younger employer groups from New York's small group market. PEOs (also known as employee-leasing organizations), on the basis of a New York State Labor Law definition of employer,[18] are able to package the employees of small and large groups together in a shell corporation in order to obtain large group health coverage exempt from small group rating requirements.

Some legal experts in employment and benefits believe the Trump administration has sufficient authority to move forward with the plan.[19] Another respected analyst has agreed, arguing that expanded access to AHPs "could finish the ACA-compliant small group market off."[20] For the American Academy of Actuaries, problems crop up when health plans competing to enroll the same participants don't operate under the same rules, which can "fragment the market as lower-cost groups and individuals would move to establish an AHP, and higher-cost groups and individuals would remain in traditional insurance plans."

New York policymakers, regulators, health plans, and employers appear to have a small group market on their hands that is already leaking healthier small employer groups, based on the 2016 risk score. In November 2017, DFS cracked down on an insurer that sought to do an end-run around New York small group regulations under existing law by signing up employers located in New York but incorporated out of state, for both self-funded and fully-insured coverage that did not meet New York requirements.[21] New York's rating rules and strong benefit standards make it a target-rich environment for entrepreneurs looking to market out-of-state or self-funded coverage in New York though AHPs, so all eyes here will be on the upcoming Trump administration AHP regulation, which could come by mid-December.

Notes

1 UHF analysis of health plan small group rate filings for 2017 and 2018 with the New York State Department of Financial Services, available at https://myportal.dfs.ny.gov/web/prior-approval/rate-applications-by-company; and Gorman Actuarial, LLP. October 2008. *Merging the Markets: Combining New York's Individual and Small Group Markets into Common Risk Pools*. United Hospital Fund, https://uhfnyc.org/publications/711071

2 The offer rate by New York private employers with less than 50 employees was 49.4 percent in 2008 and 32.4 percent in 2016. Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Surveys for 2016 and 2008. https://meps.ahrq.gov/data_stats/quick_tables_search.jsp?component=2&subcomponent=2

3 Figures are weighted averages. New York State Department of Financial Services press releases, August 15, 2017, DFS Announces 2018 Health Insurance Rates in a Continued Robust Market, http://www.dfs.ny.gov/about/press/pr1708151.htm; and August 5, 2017, Department of Financial Services Announces 2017 Health Insurance Rates, www.dfs.ny.gov/about/press/pr1608051.htm

4 New York State Department of Financial Services. FAQs for Small Group Expansion to 1-100 Employees. http://www.dfs.ny.gov/insurance/health/faqs_sm_grp_expansion_1to100.htm

5 New York Insurance Law sections 4317(d) and (e), and New York Codes, Rules and Regulations, Part 11, sections 360.8 and 360.9.

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6 Chapter 370 of the Laws of New York, 2017.

7 Clukey K and N Niedzwiadelc. October 25, 2017. Education Groups Call for Permanent Solution. October 25, 2017. *Politico New York*.

8 U.S. General Accounting Office. 2004. *Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entities Selling Coverage*. Pub. No. GAO 312. http://www.gao.gov/products/GAO-04-312

9 National Federation of Independent Businesses. October 12, 2017. Small Business Group Applauds Order to Remove Onerous Regulations (press release). http://www.nfib.com/content/press-release/healthcare/nfib-reacts-to-trump-executive-order-on-healthcare/

10 For example, the Small Business Health Fairness Act of 2017 (H.R.1101) passed the U.S. House of Representatives on March 22, 2017. https://www.congress.gov/bill/115th-congress/house-bill/1101. https://www.congress.gov/bill/115th-congress/house-bill/1101

11 Talent J. October 17, 2017. The Promise of Association Health Plans. October 17, 2017. *National Review*. http://www.nationalreview.com/article/452746/trump-association-health-plans-high-potential

12 Kofman M, K Lucia, E Bangit, and K Politz. 2006. Association Health Plans: What's All the Fuss About? *Health Affairs* 25(6): 1591–1602; http://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.25.6.1591

13 NY Insurance Law Section 4235 sets out the types of groups that are eligible for coverage, such as employers, unions, and associations, and the conditions that must be met before an insurer can provide coverage.

14 Centers for Medicare & Medicaid Services. September 1, 2011. *Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through Associations*. Bulletin. https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf

15 See, for example, U.S. Department of Labor Employee Benefits Security Administration advisory opinions: Adv. Op. 2008-07A, https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/2008-07a; Adv. Op. 2001-04A, https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/2001-04a; and Adv. Op. 2003-13A, https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/2003-13a.

16 Lucia K and S Corlette. October 10, 2017. *President Trump's Executive Order: Can Association Health Plans Accomplish What Congress Could Not?* The Commonwealth Fund, To the Point. October 10, 2017. http://www.commonwealthfund.org/publications/blog/2017/oct/association-health-plans-executive-order

17 Presidential Executive Order Promoting Healthcare 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

18 Newell P. April 2015. *Larger Small Groups: Challenges to Bolstering New York's Small Group Market*. United Hospital Fund. https://uhfnyc.org/publications/881053

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20 Jost T. October 12, 2017. Trump Executive Order Expands Opportunities for Healthier People to Exit ACA. *Health Affairs Blog*. https://www.healthaffairs.org/action/showDoPubSecure?doi=10.1377%2Fhblog20171022.762005&format=full

21 New York Department of Financial Services. November 14, 2017. DFS Superintendent Vullo Announces $2 Million Fine Against CIGNA for Violation of New York Insurance Law (press release). November 14, 2017. http://www.dfs.ny.gov/about/press/pr1711141.htm