HMA

HEALTH MANAGEMENT ASSOCIATES

New York Insurance Markets and the Affordable Care Act

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New York's Small Group Market

Enrollment and Market Concentration - EPO (Exclusive Provider Organization) plans were the most common product type in the small group market in New York, comprising more than one-third of total enrollment. Downstate employers preferred EPO products, while small employers in upstate New York were more likely to select PPO products

Cost Sharing - While enrollment is clearly concentrated by product type, the small group market offers a wide range of benefit plan designs with a significant number of cost-sharing combinations, especially in upstate New York.

Actuarial Value – The ACA requires that health plans (including both small group and individual plans) offered through the Exchange must comply with actuarial value ranges. Most small employers have selected plans that, if sold in 2014, would comply with the actuarial value requirements.

Distribution Channels - All carriers reported selling group policies through a combination of brokers, chambers of commerce and associations, and the carriers' direct sales force. Brokers are the most common distribution channel reported by the carriers. As part of designing its exchange, New York has determined that brokers will be allowed to assist consumers in both the individual and SHOP exchanges to purchase coverage. As a way of limiting selection bias, New York will require that commissions on policies offered inside the Exchange are the same as those on policies offered outside the Exchange.

New York's Individual Market

Enrollment - Healthy NY plans, which restrict enrollment to low-income individuals and subsidize premiums through a state-funded reinsurance pool, play a significant role in New York's individual market. Healthy NY with Rx is the most common product type, in terms of enrollment, and more than half of the total market, and 75 percent of the non-grandfathered market, is enrolled in Healthy NY plans.

Distribution Channels - Producers play a lesser role in the individual market compared to the small group market. Producer participation can provide significant value to both consumers and carriers as they provide expertise and experience that some navigators may not immediately possess. However, commission rates and commission variations among certain products may enhance the risk of adverse selection. To minimize these opportunities, the state is requiring that the calculation of commissions for all products be the same inside and outside the Exchange.

Section Two: ACA Changes to Markets and Market Rules

ACA Market Rules Already in Effect

Medical Loss Ratio - Beginning in 2011, plans are subject to a medical loss ratio (MLR) requirement of 80 percent in the individual and small group markets and 85 percent in the large group market. New York had MLR standards in place for its community rated products prior to the enactment of the ACA, and so this change has had little impact on New York's insurers.

Federal Rate Review - The ACA grants the HHS Secretary the authority to conduct an annual review of health plan rate filings in the individual and small group markets in partnership with the states. Rate increases of 10 percent must be reviewed by the state or HHS, and plans are required to provide detailed justification for proposed increases. In New York, the Department of Financial Services (DFS) has broad rate review authority. In June 2010, New York enacted legislation that re-introduced rate regulation. The law, which applies to all community-rated policies, provides the Department of Insurance (now DFS) the authority to review and approve health insurance premium rate increases on existing policies.

Internal Appeals Process - An insurer offering individual or group health insurance is required to implement an internal claims appeals process. Enrollees must be able to review their files, submit written comments, documents, records and other information relating to the claims for benefits as part of the appeals process. New York has had a fairly progressive managed care bill of rights since 1996. The law gives any insured or enrollee subject to utilization review the right to seek an appeal of a utilization review decision that denies medical care on medical necessity grounds.

External Review - Under the ACA, states that had enacted external review laws and met the minimum consumer protection standards of the National Association of Insurance Commissioners Uniform External Review Model Act (NAIC Model Act) were deemed to be applicable and enforceable for all health plans in that state. New York's external review law establishes a process and timeline for all health care services denied on the grounds that the service was not medically necessary. The law also establishes an external review process for patients with life-threatening or disabling conditions seeking investigational or experimental treatment. Upon review by HHS, New York's external appeals process was deemed adequate to meet the ACA requirements.

Dependent Coverage - Health plans and products that provide dependent coverage of children are now required to extend coverage to children up until age 26. In addition, plans are now prohibited from excluding coverage for pre-existing conditions for enrollees under age 19. New York's 2011 ACA-related legislation establishes dependent coverage up to age 26. In addition, New York had already enacted legislation that allows for coverage of dependents through age 29, although through a different actuarial and financing mechanism. The 2011 legislation also eliminated pre-existing condition clauses for children's coverage.

Lifetime and Annual Dollar Limits - The ACA prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from imposing lifetime limits on the dollar value of health benefits in any health plan or insurance policy issued or renewed on or after September 23, 2010. Annual limits also are prohibited, but the statute includes a phase-in of this provision. For

plans issued or renewed beginning January 1, 2014, all annual dollar limits on coverage of essential health benefits will be prohibited; however, health plans may place limits on benefits that are not part of the state's defined essential health benefits. New York's ACA implementation legislation incorporates these changes into insurance law.

Direct Access and Prior Authorization - The ACA establishes numerous patient protections under a Patient's Bill of Rights. Enrollees are guaranteed the right to choose any primary care provider in the plan's provider network. For enrollees requiring emergency care, the ACA prohibits plans from requiring prior authorization of emergency room services, limiting emergency services to in-network providers, or imposing higher cost-sharing for emergency services for out-of-network care than for in-network care. Finally, health plans may not require authorization or referral for enrollee access to obstetrics-gynecological (OB-GYN) services. New York's ACA implementation legislation incorporates these changes into insurance law.

High-Risk Pool - A national high-risk pool, established almost immediately after the ACA's enactment, is currently providing coverage to the medically uninsurable who have not had creditable coverage for at least six months prior to application. The federal high-risk pool, known as the Pre-existing Condition Insurance Plan (PCIP), is available until Exchange coverage begins in 2014 with the requirement that all plans must issue coverage regardless of an individual's health status. New York established its own pre-existing condition plan, the NY Bridge Plan, administered by GHI, an EmblemHealth company.

Preventive Services - An ACA provision that took effect in 2010 requires that health plans cover evidence-based preventive services and eliminate cost-sharing for preventive care provided by an in-network provider. New York's ACA implementation legislation incorporates these changes into insurance law.

ACA Rules in Effect Starting January 1, 2014

Guarantee Issue/Preexisting conditions - Starting on January 1, 2014, all group health plans and individual health insurance products will be required to accept every employer and individual in the state applying for coverage. Plans are also prohibited from imposing any pre-existing condition exclusions on coverage and will be required to continue offering renewals or continuation of coverage at the option of the plan sponsor (employer) or individual. Lastly, plans will not be allowed to establish waiting periods for eligibility that extend beyond 90 days. The New York insurance market already requires guarantee issue in both the small employer and the individual markets. New York law currently allows pre-existing condition exclusions of up to 12 months in both small employer and individual policies. To be compliant with the ACA, amendments to the pre-existing conditions exclusions were included in the 2011 legislation that prohibit insurers from imposing pre-existing conditions exclusions in any individual or group policy beginning January 1, 2014.

Premium Variance/Rating Provisions - After January 1, 2014, premium rates for group and individual health insurance may vary only with respect to the particular plan or coverage and only by: family structure or size, rating area, and age or tobacco use.

- For New York, these provisions are not applicable since the state has already determined the rating structure for the individual and small group markets.
- Under the ACA, states that do not already have defined rating areas must create them and submit them to the HHS Secretary for adequacy. New York does not have standardized geographic rating areas and will have to create them.
- New York prohibits plans from using age bands in establishing premiums. While this prohibition could be re-considered, the ACA does not preclude New York from maintaining that prohibition.

Clinical Trials - In 2014, plans will be prohibited from denying an individual the ability to participate in a clinical trial, including a clinical trial conducted outside of the state in which the individual lives.

Multi-State Plans - The ACA requires that among the qualified health plans (QHPs) offered, every state exchange must offer at least two Multi-State Plans (MSPs), which must offer the Essential Health Benefit. The MSPs will be licensed by states but regulated by the federal Office of Personnel Management (OPM). While OPM will negotiate premiums, set rates, establish MLRs and certify plans as QHPs, the MSPs must be licensed in each state and meet any state-specific QHP requirements. Concerns have been raised that MSPs could create adverse selection. Recently released rules articulate provisions to create a "level playing field" among the QHPs, including requirements that the MSP follow all state laws in 13 categories.

Consumer Operated and Oriented Plan (CO-OP) Program - The ACA allows for the creation of qualified non-profit, consumer-governed health insurers to offer products in the individual and small group markets. As of August 2012, 20 non-profit organizations offering coverage in 20 states have been awarded federal loans to support the creation of eligible CO-OP, including one New York-based organization. Freelancers Union was awarded a loan of $174,445,000 to sponsor a CO-OP program in New York.

Section Three: Adverse Selection and Options to Mitigate in New York State

1. Adverse Selection Between and Within the Exchange and External Markets

Adverse selection will be minimized if the Exchange and the external markets use the same rules regarding enrollment, rating, and switching of plans. Whatever is done with regard to these factors inside the Exchange should also be done outside the Exchange.

Rating Rules - A major potential source of adverse selection in New York is the use of different risk rating rules inside and outside the Exchange. If one market uses full community rating while another market uses adjusted community rating following the ACA (a limit of three to one on age, and 1.5 to 1 on tobacco use), the market with full community rating would become the victim of adverse risk selection as sicker people move toward the market where they do not pay anything extra for their poor health status and healthier people choose the market that uses the ACA-stipulated degree of risk rating. The ACA requires that insurers charge the same prices for the same products inside and outside the

Exchange. Since New York has decided to retain full CR in the external markets, we recommend that New York use full CR in the Exchange to mitigate adverse selection.

Open Enrollment - Currently, New York allows continuous "open enrollment" in the individual and small group markets. Individuals and employers are not bound by the time frame of an open enrollment period commonly used in private insurance markets around the country. The ACA requires a limited period for plan selection in the Health Benefits Exchanges for individuals, and does not allow enrollees to sign up for health coverage during the year. We recommend that New York change its open enrollment period policy in the external markets to synchronize with ACA rules.

Plan Switching - Adverse risk selection can occur if people can switch health plans at any time and with no limits. This allows people to take a plan with high cost sharing when they are healthy and immediately switch to one with lower cost sharing when they get sick. New York should have the same plan switching rules inside and outside the Exchange, and should consider limiting plan switching to specified enrollment periods and placing some limits on the number of tiers that people can "jump" in any one enrollment period.

Plan offerings Inside and Outside the Exchange - Another possible source of adverse selection can occur if some plans are offered inside the Exchange but not outside the Exchange, or at different prices. Insurers are not required to participate in the Exchanges, opening up the possibility for healthy individuals or small employers to purchase minimum coverage outside the Exchanges. New York should consider adopting strategies related to plan offerings to limit risk selection across the boundary between the Exchange and the external Markets.

2. Should the Exchange Constitute the Entire Market for Individuals and Small Groups?

One way to avoid adverse selection against the Exchange is by having all private individual and small group health insurance coverage sold through the Exchange. In effect, the Exchange would become the private market for health insurance for the non-group and small group markets. While it is possible that bringing the small-group market into the Exchange might mitigate selection issues, this advantage would be offset by forcing too many plan designs into the Exchange, which could raise administrative costs and confuse consumers. Another unfortunate outcome could be the elimination of some of the varying plan designs that contribute to the current vibrancy of New York's current small group market. The same considerations do not apply to New York's individual market.

Therefore, we recommend preserving the small-group market, and transitioning the non-group market into the Exchange.

Continue to Prepare for Risk Adjustment and Reinsurance Mechanisms

The ACA contains three mechanisms to correct for the effects of adverse risk selection—risk adjustment, reinsurance, and risk corridors. Under the ACA New York may choose between establishing its own risk-adjustment program or using one being constructed by the federal government. Risk adjustment is a permanent program created by the ACA that aims to eliminate, or at least substantially reduce,

premium differences across plans based solely on favorable or unfavorable risk selection. New York operates several risk adjustment and reinsurance programs.

The ACA's risk adjustment requirements would shift more money across insurance plans than is now the case under the state's own programs. New York should consult with both in-house actuaries and obtain outside actuarial advice on how to make this transition.

3. Association Health Plans (AHPs) and Professional Employer Organizations (PEOs)

Association Health Plans (AHPs)

Various purchasing entities known as Association Health Plans (AHPs)have formed over the years to enable small firms to obtain some of the advantages in purchasing health insurance normally enjoyed by larger firms. Under AHPs, an insurance policy is held by the organization to cover all of its members, or the association self-insures for the benefits of its members who could not do so on their own. Many AHPs provide helpful services to their members, offering economies of scale and enhanced bargaining power by pooling individuals and small companies. But AHPs have a history of market place disruptions, particularly in guaranteed issue, community rated markets. They can also foster adverse risk selection by marketing their products to low-risk individuals and groups, while leaving the sicker people with higher risks in more traditional markets.

New York should maintain a vigilant and active position in monitoring how the activities of AHPs and MEWAs might lead to adverse selection against the Exchange. A range of federal and state laws set strict limits on the ability of these organizations to aggregate smaller groups into larger groups in ways that would allow them to escape insurance regulations and engage in risk selection. If these laws are effectively enforced, this risk selection should be minimal. If they are not, there is a potential for AHPs to siphon off the youngest and healthiest individuals and small groups into phony large groups, and leave an older and sicker population in the Exchange and the existing individual and small-group markets.

Professional Employer Organizations (PEOs)

Professional Employer Associations (PEOs) offer a wide range of products to employers, particularly small firms, including health insurance, Workers' Compensation, and disability insurance. PEOs claim to "co-employ" the workers of a firm that contracts with them. But the US Department of Labor has determined that PEOs do not qualify as ERISA plans. Since PEOs provide a service that many small firms value, they should be permitted to make their insurance coverage ACA-compliant and consistent with the rules for exchange-based coverage.

New York should prepare a vigilant and active stance to assure that PEOs do not lead to adverse risk selection against the Exchange. PEOs cannot meet federal government tests of being employers or "co-employers," and New York may want to take regulatory actions that reinforce federal policy, to help assure that PEOs should not be allowed to carry small firms into some type of "phantom" large

firm that avoids the protections afforded to small firms by the ACA and by New York's community rating and open enrollment requirements.

4. "Employee Choice" Model for Small Firms in the Exchange

Under the ACA, states have a choice as to whether to follow the "employee choice" model for small groups entering the Exchange—so that individual employees can choose any plan offered through the Exchange—or to follow the alternative model under which the small employer chooses one or more plans for its employees. A strong rationale for Exchanges is to create a more consumer-centric experience and to thereby enhance competition among health plans. Having a broad and meaningful choice of plans is essential for this vision

We recommend that New York use the Employee Choice model for plan selection in the SHOP Exchange.

5. Minimum Participation Rule

Current law in New York requires that insurers, when signing up small groups in the private market, assure that at least 50% of the employees of the company actually enroll in the plan. This 50% minimum participation rate is well below what most US insurers require. The purpose of the minimum participation requirement is to reduce the degree of adverse risk selection. HMOs in New York are not permitted to apply minimum participation requirements, ensuring all applicants access to a form of health insurance coverage.

Establishing a minimum participation rate in the small employer (SHOP) portion of the Exchange that New York is designing could help reduce adverse selection. Adverse selection could occur if participation requirements are different between the small-group market and SHOP portion of the New York Exchange.

6. Changing the Small-Group Market Definition

The ACA stipulates that the states must define small employers as firms with 100 or fewer employees by 2016, but allows states the option to expand the definition of small firms prior to 2016 and as early as 2014. Changing the definition of small groups from 100 or fewer workers to 50 or fewer has relatively little impact on the proportion of people covered in New York State.

Since groups of more than 50 employees are not subject to the law prohibiting insurers from selling stop-loss coverage to small groups, medium-size firms with healthier work forces may be encouraged by some insurers to self-insure and combine this with the purchase of stop-loss coverage, or reinsurance. **New York should consider prohibiting insurers from selling stop-loss insurance to firms with fewer than 100 workers at the time when the state goes from 50 to 100 employees as the cutoff point for entry of small firms into the Exchange.**

It would be a mistake to increase the pool of eligible Exchange enrollees by expanding the definition of small employers in 2014 before the state gets a chance to gain experience with the more limited base of

individuals and smaller companies. In 2016, the Exchange will have a better sense of how to avoid risk selection and manage employee choice and health plan performance in this new environment.

We recommend that New York postpone expanding the definition of the small group market from 50 or fewer employees to 100 or fewer employees until 2016. New York has made this decision, as indicated in the Blueprint.

7. Large Employer Groups and the Exchange

Beginning in 2017, the ACA allows states to expand Exchanges to include groups of more than 100 employees. In a state the size of New York, the Exchange is expected to have a sufficiently large number of enrollees in the individual and small group market to provide a stable risk pool. Inclusion of large employers creates some challenges given the unique nature of their risk and the differences in how this market traditionally operates compared to that of small groups. Large employers are not subject to certain ACA requirements. While all small group and individual plans must comply with essential benefit requirements, only large employer plans purchased through the Exchange must include the benefits. Large employer plans sold outside the Exchange also are not restricted to the precious metal tier requirements.

The biggest concern with accepting large employer groups is the risk of adverse selection associated with the ability to enroll in the Exchange at any time. Groups most likely to enter the Exchange are those who cannot get favorable rates outside the Exchange and those who find the risk for their enrollees has increased to the point that self-insuring is not financially logical. Large employers are generally much more sophisticated purchasers than are small groups and will use their expertise to determine the most financially beneficial solution for their business, but not necessarily for the Exchange.

Allowing larger firms to participate in the Exchange has advantages and potential disadvantages. We suggest that the state delay a decision regarding the inclusion of large employers until after the Exchange has been operational and instead focus on the immediate issues related to getting the Exchange implemented by 2014. Given that the insurance market will experience dramatic changes in 2014 -2016, we recommend that New York conduct an actuarial impact study to evaluate the impact of extending coverage to large employers under the market conditions that exist at that time.

Introduction: New York State's Small Group and Individual Insurance Markets and the ACA

The Affordable Care Act (ACA) includes significant insurance reforms designed to improve fairness, assure full transparency of prices and quality measures, and make health coverage more accessible and affordable. A key thrust of the ACA is to foster competition among health plans, improving quality and reducing costs, and to reduce discrimination within the health insurance market. The idea of increasing competition based on lowering the underlying cost of care, rather than selecting the best risks or cost shifting, is designed to drive improvements in care delivery and health outcomes.

Essential to these efforts are insurance reforms that create uniform national standards and rules that change the way health insurers operate, and dramatically alter the dynamics of the current voluntary insurance market. While many reforms apply broadly to the entire health insurance market (including self-funded plans and large employer group plans), they most directly affect those who purchase insurance through the individual and small group markets.

This report reviews the state of the current New York insurance market, with a focus on individual and small group insurance plans. The first section of the report summarizes information collected by the New York State Department of Financial Services (DFS) earlier this year and provides information about market concentration, actuarial value, geographic distribution and cost-sharing arrangements exhibited in the current insurance markets. The second section describes changes to insurance market rules required by the ACA. It includes an overview of how New York implemented the initial ACA market reforms that took effect in 2010, and reviews the potential impact of changes that are scheduled to occur in 2014. The final section of the report discusses the potential for adverse risk selection related to the development of the insurance exchange, and suggests ways of minimizing adverse selection. It includes a detailed examination of the types of risk selection that could be expected to occur between the external market (individual and small group markets only) and the Exchange.

In reading this report, it is important to keep in mind the significant insurance reforms enacted by New York in the mid 1990's, some of which are key provisions of the ACA reforms (including community rating and open enrollment, guarantee issue, the inclusion of comprehensive benefits, and premium assistance for low-income individuals and families). In fact, the stated goals of New York's insurance market reforms sound remarkably similar to those underlying the ACA: "to facilitate access to health insurance by all New York residents who wish to obtain it directly or as members of small groups; and to promote competition among insurers and health maintenance organizations on the basis of efficient claims handling, ability to manage health care services, consumer satisfaction, and low administrative costs; rather than on the basis of differing underwriting and rating practices which allowed some insurers to exclude higher risk applicants from coverage and cause unaffordable premium rates to those unable to meet selection standards."[1]

[1] New York Insurance Law Regulation 145 of 11 NYCRR 360.1 - Rules to Assure an Orderly Implementation and Ongoing Operation of Open Enrollment and Community Rating of Individual and Small Group.

Some critics argue that high premiums in New York's small group and individual markets are partially attributable to these reforms, and observe that a "death spiral" associated with higher premiums and lower enrollment in the individual market is the most significant consequence of requiring open enrollment and community rating without an individual mandate. Enrollment in the individual market has declined markedly, from over 100,000 in 2000 to 17,795 in 2012, while premiums have tripled. As New York faces the significant challenges of designing a successful exchange, the experience of these past reforms provides useful guidance as the state evaluates how to ensure affordable coverage for all New Yorkers.

Section One: Overview of New York State's Current Small Group and Individual Insurance Markets

This section of the report provides information on the current New York State small group and individual markets. The information and analysis are based primarily on data from the "standardization data call" conducted by the state earlier this year. The survey issued by the Department of Financial Services (DFS) was distributed to insurers covering 80% of the 2009 enrollment in the small group and individual markets.

1. New York's Small Group Market

The DFS survey was distributed to nine licensed insurers who hold a total of 16 licenses. These insurers offer a range of products, including HMO (Health Maintenance Organization) plans, PPO (Preferred Provider Organization) plans, POS (Point of Service) plans, EPO (Exclusive Provider Organization) plans, and indemnity plans.[2]

Enrollment and Market Concentration

As shown in Table 1 below, EPOs were the most common product type in the small group market in New York, comprising more than one-third of total enrollment.[3] The remaining statewide small group enrollment is spread fairly evenly among HMOs, PPOs and POS plans, which account for 16 percent, 18 percent and 22 percent of enrollment, respectively. Less than 13,000 people enrolled in indemnity plans, and the majority of those individuals resided in upstate New York. By region, however, selection of products varied significantly. While downstate employers preferred EPO products (53 percent of enrollment), followed by POS plans (24 percent), small employers in upstate New York were more likely to select PPO products (39 percent enrollment), followed by EPO plans (26 percent). Only six percent of downstate small employers selected PPO products. The differences in the type of benefit plan selection suggest variations in preferences that Wakely concludes is an indication the state needs to consider allowing different QHP offerings to small employers for downstate and upstate regions.[4]

[2] Wakely Consulting Group. "Benefit Standardization Study for the State of New York." June, 2012.
[3] Since the survey was issued, Empire Blue Cross and Blue Shield discontinued offering Empire Prism and Empire HSA plans, which may impact overall enrollment trends by type of plan for the small group market.
[4] Wakely Consulting Group, pg. 7.

Table 1: Small Group Enrollment by Product Type
(January – June 2011)

Product Type	Enrollment			% of Enrollment		
	Downstate	Upstate	Total	Downstate	Upstate	
HMO	153,826	76,188	230,014	16%	15%	16%
PPO	57,444	194,272	251,716	6%	39%	18%
POS	221,672	88,125	309,797	24%	18%	22%
EPO	500,381	130,935	631,316	53%	26%	44%
Indemnity	3,342	9,098	12,440	0%	2%	1%,
Total	***936,665***	***498,618***	***1,435,283***	***100%***	***100%***	***100%***

Enrollment distribution indicates strong preferences of consumers and strategic business decisions by New York health plans. Of the 16 small group companies surveyed, twelve offer EPO products. EPOs are appealing to carriers because they provide the opportunity to offer an HMO-like product (i.e., except for emergency care, enrollees are restricted to in-network providers and services) without the requirement to obtain a separate HMO license and establish the administrative and organizational structure required of HMOs. Although we did not review premium rates, the in-network restriction generally enables EPOs to offer lower premiums than PPO plans, which include coverage for out-of-network providers. It is easier for plans to negotiate reduced reimbursement rates in a closed, network-only environment, as providers are less likely to opt out if no out-of-network reimbursement is available. Yet consumers show a preference for plans that offer an out-of-network option, and it is not surprising that EPO enrollment is high.

Cost Sharing

While enrollment is clearly concentrated by product type, the small group market offers a wide range of benefit plan designs with a significant number of cost-sharing combinations. Surveyed insurers reported a total of 14,999 different plan options, based on plan benefits and cost-sharing combinations. Of those plans, 97% (14,577 plans) enrolled less than 500 lives each. The 97 plans with the largest enrollment (at least 2,500 lives each) provide coverage to approximately 52% of the market. Employers in upstate New York enrolled in 11,485 different plans. By comparison, downstate employers enrolled in only 3,514 plan variations and had an average enrollment of 254 members.

The state survey instructed carriers to categorize all enrollments in 28 separate plans that varied primarily based on the annual deductible and out-of pocket maximum. Deductibles ranged from $0 to more than $5,000; out-of-pocket maximums ranged from $2,000 or less up to no maximum limitation. Using this process, carriers reported enrollment for the 28 variations for 2009 and 2011.

The data are striking and illustrate that both deductibles and out-of pocket maximums increased significantly for many enrollees within the short time period covered by this survey. In 2011, 29.6 percent of enrollees in single policies reported annual out-of-pocket maximums above $6,000, compared to only 11.1 percent in 2009. Deductible values saw a similar increase. In 2009, 79 percent of enrollees were in plans with a deductible of $2,000 or less; by 2011, the percentage declined to 62.7 percent. During the same time period the percentage of enrollees with a deductible of $6,000-$9,999

increased from 6.7 percent to 21.0 percent. The percentage of enrollees with deductibles above $10,000 nearly doubled from 4.4 percent to 8.6 percent. These data indicate that many of the existing plans will not comply with the ACA limits on deductibles ($2000 for individuals and $4,000 per family) and out-of-pocket maximums (approximately $6,000 per individual and $12,000 per family) for minimum essential coverage under the ACA.

All of these data have important implications for Exchange planning purposes. In determining the criteria for Exchange participation, the state will want to consider how carrier participation, plan benefit and cost sharing requirements, and enrollment provisions might affect certain types of products differently. These requirements will likely impact carriers' decisions regarding whether they will participate in the Exchange, or only offer products outside the Exchange. Unlimited choice of plans can be overwhelming to employers, particularly if the differences between plans are not meaningful. Nonetheless, New York's current market data suggests that small employers enjoy having a wide range of choices. Limiting the range of options within the Exchange, while allowing unlimited choice outside the Exchange, may impact employers' decisions on whether to participate in an exchange plan. While this may or may not create adverse selection risks depending on the plans and the risk characteristics of the enrollees, the fact that the potential exists warrants careful consideration by the state.

Actuarial Value

Another ACA provision that will likely result in changes to at least some current small employer plans is the requirement that health plans (including both small group and individual plans) offered through the Exchange must comply with actuarial value ranges. To determine the actuarial value of current benefit plans compared to those required in 2014, the DFS survey directed carriers to report the percentage of their small group enrollment across the following categories:

- Platinum (defined as an actuarial value between 88-92 percent);
- Gold (actuarial value between 78-82 percent);
- Silver (actuarial value between 68-72 percent);
- Bronze (actuarial value between 58-62 percent); and
- Actuarial value less than 58 percent.

Plans that provided the information reported that approximately 48 percent of enrollees fall within one of these specific tiers. Another 46 percent of enrollees are in plans that have values that fall between the tiers identified. Carriers estimate that only seven percent of enrollees are in plans below the actuarial value of 58 percent. Enrollment also varied by region, with enrollees in upstate plans showing a much higher enrollment in Platinum plans than enrollees in downstate New York. At the other end of the spectrum, 8 percent of enrollees in downstate NY were enrolled in plans that fell below the 58 percent minimum compared to only 4 percent of upstate enrollees.

These survey results provide valuable insight into the type of benefit plans to which current small business owners are most attracted. Based on actuarial value alone, the data indicates that most small employers selected plans that, if sold in 2014, would comply with the actuarial value requirements.

Using State Specific Data Sets to Calculate Actuarial Value

As proposed, the population data on which the AV calculations will be based does not take into account regional variations in health spending, utilization patterns, or health care costs. To address this concern, beginning in 2015 HHS proposes to allow states to substitute the national data with state-specific data under certain conditions. States will be able to substitute a state-specific data set in place of the standard population continuance tables used in the calculator, while still using the AV calculator logic. If a state chooses this alternative option, the substitute data must be approved by HHS and meet the following requirements:

- Support the calculation of AVs for the full range of health plans available in the market, meaning that the structure and definition for the data set must be standardized and clearly documented;
- Data must be derived from the non-elderly population likely to be covered by plans in the 2014 market and beyond (i.e., the small group and individual market enrollees at the time, and not the Medicaid or Medicare population);
- Must be large enough to ensure that demographic and spending patterns are stable over time, and include a substantial majority of the state's insured population;
- If a state intends to reflect geographic differences within the state, the data set must be "statistically reliable and stable;" and
- The data set must capture the range of health care services typically offered, including those that fall within the Essential Health Benefit requirements and are at the time of submission offered in a typical employer plan.

States that decide to submit state-specific data will be required to provide information in a format that will be developed by HHS. HHS expects submissions will be due in the second quarter of the year prior to the benefit year for which the AV values are proposed to be applicable. In the preamble, HHS also notes that the decision to allow state-specific data was supported in comments on a previously issued AV/CSR Bulletin, and is based on recommendations from the American Academy of Actuaries.[5] HHS notes that, under this proposed rule, they request additional comments on the option of state flexibility to provide state-specific data, and also whether HHS should consider including up to three regional adjustments for geographic price differences.

Actuarial Value and Annual Deductibles

Federal regulations limit the maximum deductible for health plans in the small group market. However, HHS is proposing to allow a plan to exceed the annual deductible limit if the plan cannot "reasonably" meet the AV requirements for a particular metal level. HHS also notes this issue in the draft regulations, and proposes that a plan will be deemed as meeting a particular metal level if its AV is within 2 percentage points of the standard (i.e., 2 points above or below the AV target requirement for a specific

[5] http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf

level). For example, a silver plan would comply as long as the AV value is between 68 and 72 percent. The rule also proposes to allow issuers in the small group market to exceed the annual deductible limits if necessary to achieve a particular metal level.

To more completely understand where plans stand today and what is driving employer's decisions, we suggest that the state consider a supplemental data call to obtain a more complete assessment of AV for current plans. With the release of the draft regulations for AV calculations and essential health benefits, health plans should soon be in a position to provide more relevant data that may prove useful in predicting how the new regulations will impact existing plan designs as well as premium costs. The state may also want to request data on how many small group plans have retained their grandfather status to date. With the richer benefits that will be required in 2014, some grandfathered plans may have significantly lower premiums, which may discourage some employers from moving into the Exchange. This factor may have an impact on adverse selection depending on the risk characteristics of the employees that remain in the grandfathered plans and those that move into the Exchange.

Distribution Channels

While most health insurance plans sold today are sold through producers, the Exchange will offer consumers the opportunity to purchase plans directly from a carrier. Other consumers will continue to use the services of a producer, but their role in the market will almost certainly be affected. To better understand the role of producers and how small employers shop for coverage today, the DFS survey asked carriers to report the method through which health plans are sold. Carriers were asked to provide the percentage of policies sold by producers, those sold by associations or chambers of commerce, and those sold by a carrier's direct sales force.

All carriers reported selling group policies through a combination of brokers, chambers of commerce and associations, and the carriers' direct sales force. Ten carriers also sell policies through general agency agreements. Brokers are the most common distribution channel reported by the carriers; 13 carriers indicated that at least 70 percent of policies are sold through brokers. Thirteen carriers indicated selling less than 10 percent of policies through chambers of commerce or associations, no carrier reported more than 27 percent of policies are sold through these channels.

As part of designing its exchange, New York has determined that brokers will be allowed to assist consumers in both the individual and SHOP Exchanges to purchase coverage. Given the significant role that brokers currently play in the small group market, this decision will have a significant impact on the broker community.

States are considering various options for how brokers will be paid for plans sold through the Exchange, including alternatives to the widely prevalent percent of premium (e.g. 3 percent) commonly used in today's market. Because premiums increase with medical inflation and at a rate that exceeds standard inflation, the real dollar value of broker payments based upon a percent of premium also grows at a rate that exceeds inflation. Some states are considering a flat "fee-for-service" approach under which brokers serve as vendors who perform certain services for a pre-determined fee. The state needs to not only weigh the impact of this decision on the broker community, but also define what roles brokers and agents will play—particularly in light of the navigator function. When New York adopted community

rating in 1992 it established a regulatory framework to ensure consistency in the payment of commissions. The state does not fix the percentage that producers are compensated, and has indicated that will not change when the Exchange begins operations in 2014. As a way of limiting selection bias, New York will require that commissions on policies offered inside the Exchange are the same as those on policies offered outside the Exchange. The state has also indicated that it does not intend to act as an intermediary, and that plans will have to negotiate and pay producer commissions directly.

2. New York's Individual Market

The DFS survey collected data from twelve carriers who issue coverage in New York's individual market. Coverage in the individual market is limited to two standardized HMO and POS products, coverage for qualifying enrollees through the Healthy NY program and coverage through limited benefits health insurance contracts.

Enrollment

The individual market includes two standardized HMO and POS benefit plans in addition to a limited number of other product options. Carriers were asked to report on enrollment for eight product variations, see Table 2.

A large number of enrollees are in plans about which we have no information from the data call, which includes all pre-1996 non-standard medical/surgical products in the individual market that are still in force. When those individuals are removed from the totals, the importance of Healthy NY is striking. Healthy NY with Rx is the most common product type, in terms of enrollment, with more than one-third (36.3 percent) of total enrollment, and almost 55 percent when grandfathered plans are removed. More than half of the total market, and 75 percent of the non-grandfathered market, is enrolled in Healthy NY plans, which restrict enrollment to low-income individuals and subsidize premiums through a state-funded reinsurance pool. Hospital-only plans, which are lower-cost plans, will not qualify as QHPs beginning in 2014, as plans offering medical-only or hospital-only coverage are not considered QHPs under the ACA.

Table 2: Individual Enrollment by Product Type (January – June 2011)

Product Type	Total Member Months[6]	% of Total	% of Total (excluding pre-1996 non-standard plans)
Standard HMO	60,594	7.3%	10.9%
Standard HMO with POS	28,425	3.4%	5.1%
Hospital Benefit Only	93,968	11.3%	17.0%
Healthy NY with Rx	302,306	36.3%	54.5%
Healthy NY without Rx	112,927	13.6%	20.4%
Healthy NY HDHP with Rx	15,413	1.9%	2.8%

[6] The survey requested enrollment for member months rather than number of total enrollees. Member months reflect the total number of months all enrollees had coverage for the reporting period. For example, 10 people enrolled for a full calendar year of 12 months equal 120 member months (10x12).

Healthy NY HDHP without Rx	29,649	3.6%	5.3%
Pre-1996 Non- Standard	190,072	22.8%	0.0%
Total[7]	***833,354***	***100%***	***100%***

Similar to the small group market, New York's individual market enrollment is rather concentrated. Of the 12 carriers that offer coverage, half of all reported member months belong to two plans, and 66 percent of reported enrollment belongs to just three plans.

As with the small group market, New York consumers have a range of carriers and benefit plans from which to select. Given the increased business opportunities the Exchange provides, the demand for coverage is likely to be significant beginning in 2014. The state will need to determine whether the existing carriers are sufficient to handle the anticipated increase in enrollment, or whether the state needs to take steps to attract additional carriers. New York will also want to ensure consumers have a sufficient choice of health plans' product types in the Exchange and will need to work closely with carriers to ensure their participation.

Access to a range of products will be an important factor in the success of the Exchange. With the availability of subsidies, the potential for significant enrollment, and a relatively strong commercial market, the state is in a good position to attract carriers to the Exchange. However, carriers will also be sensitive to the uncertainties that accompany the implementation of the Exchange, including the many operational and participation decisions the state will make. At least some carriers may be tempted to delay Exchange participation until after the initial enrollment, which is likely to attract some of the highest risk individuals who need immediate health care services. Other carriers may prefer to focus on the market outside the Exchange in an attempt to provide lower cost products that will attract better risks. As a way to prevent this type of risk avoidance New York plans to control the opportunity to participate in the Exchange, so plans that do not join the initial participation in 2013 (for plan year 2014) may not have another opportunity to participate until 2015 (for plan year 2016).

Geographic Distribution of Carriers

In the individual market only one carrier operates statewide, while the remaining carriers operate on a regional basis. All counties have at least two plans providing coverage to local residents. Five carriers offer coverage in New York City.

Distribution Channels

An additional market characteristic is the method by which purchasers obtain coverage in the individual market. The vast majority of individual market coverage is sold directly through the carriers. Eight carriers reported that all individual coverage is sold directly. Of the remaining carriers, three reported that over 85 percent of policies are purchased through direct-sales, with the remainder sold through brokers or other intermediaries (referred to collectively as producers). One carrier reported that 50 percent of individual policies were sold directly and 50 percent were sold through producers.

[7] The total member months reported by the carriers do not equal total enrollment in the individual market as some carriers offer products in addition to those specified in the data call.

As noted earlier, New York has determined that producers will be allowed to assist consumers in the Exchange. While producers play a lesser role in the individual market compared to the small group market, their participation (both inside and outside the Exchange) might have significant impact. Under the best scenario, producer participation can provide significant value to both consumers and carriers as they provide expertise and experience that some navigators may not immediately possess. To the extent that consumers are not adequately informed or prepared to make decisions, or if the number of navigators is insufficient to meet the demand, their importance will be enhanced. However, commission rates and commission variations among certain products – both within and outside the Exchange – can encourage producers to direct consumers to certain products, which may result in poor purchasing decisions by consumers and enhance the risk of adverse selection. To minimize these opportunities, the state has created a level playing field by requiring that the calculation of commissions for all products be the same inside and outside the Exchange. The state may also want to consider requiring a flat "enrollment fee" rather than commissions for all individual sales, regardless of the market, to eliminate the risk of producers advising consumers to purchase higher cost products for the purpose of increasing commissions.

Section Two: ACA Changes to Markets and Market Rules

The ACA made sweeping national changes to the health insurance industry – which has historically been regulated by state insurance commissioners and governed mainly by state law. While some states, such as New York, have previously required health insurance plans to offer coverage to state residents on a "guarantee issue" basis, plans in all states will be required to offer and provide coverage to all individuals and groups after January 1, 2014.This change, coupled with the prohibition on rescinding coverage (except in cases of fraud or intentional misrepresentation) and preexisting condition exclusions and waiting periods will significantly alter the national health insurance market dynamics that have traditionally focused on avoiding risk and limiting coverage based on health status. The ACA has already led to some immediate market rule changes, while others will not be implemented until January 1, 2014. New York State has pursued comprehensive insurance regulatory reforms over the years, and the market and rating rule changes implemented by the ACA will have less of an effect in New York compared with other states. Many of these rules were implemented in 1992 as part of the regulatory changes associated with New York's community rating law. New York enacted further legislation in 2011 in response to the ACA that was designed to bring New York insurance law and public health law into compliance with specific ACA requirements.[8]

1. ACA Market Rules Already in Effect

Medical Loss Ratio

Beginning in 2011, plans are subject to a medical loss ratio (MLR) requirement of 80 percent in the individual and small group markets and 85 percent in the large group market. The MLR provisions also apply to grandfathered plans. Plans are required to pay rebates to enrollees if they fail to meet this requirement. States have discretion to increase these thresholds. In addition, the HHS Secretary is permitted to adjust the MLR threshold for a state if the Secretary determines that the application of the requirement could destabilize the individual market in that state.[9] It excludes federal and state taxes and fees from the calculation of non-claims costs. The MLR provision is permanent and does not sunset.

New York had MLR standards in place for its community rated products prior to the enactment of the ACA, and so this change has had little impact on New York's insurers. Under the prior approval law enacted in 2010, the expected MLR for a given policy in the individual and small group markets must be at least 82 percent. Furthermore, if the MLR falls below 82 percent DFS can require that the plan provide refunds to policy-holders. (NY Insurance §3231 and §4308). Prior to 2011 large group products had a very low MLR standard, so the 85 percent requirement had a more significant impact on those plans.

Federal Rate Review

[8] A.8460/S.5800: Relates to implementation of the Affordable Health Care Act, Chapter 219 of the laws of 2011.
[9] To date, the Secretary has granted seven waivers, denied 10, and determined that one (Guam) was not necessary as all insurance issuers are presumed to meet or exceed the 80 percent threshold.

The ACA grants the HHS Secretary the authority to conduct an annual review of health plan rate filings in the individual and small group markets[10] in partnership with the states. Under this provision, which took effect on September 1, 2011, rate increases of 10 percent must be reviewed by the state or HHS, and plans are required to provide detailed justification for proposed increases. Forty-four states, including New York have created programs for performing rate reviews.[11] Beginning in 2014, states and the federal government will monitor premium increases for plans selling coverage in and outside of the health exchanges.

In New York, the Department of Financial Services (DFS) has broad rate review authority. In June 2010, New York enacted legislation that re-introduced rate regulation. The law, which applies to all community-rated policies,[12] provides the Department of Insurance (now DFS) the authority to review and approve health insurance premium rate increases on existing policies. The rate applications are reviewed by the department, and can be approved, modified or disapproved. The process is meant to be transparent, and rate increase applications are posted on the DFS web site so that policy holders and other stakeholders can comment on the applications before the department issues its decision. (NY Insurance §3231 and §4308).

Internal Appeals Process

An insurer offering individual or group health insurance is required to implement an internal claims appeals process. The plan must provide notice to enrollees of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman. Enrollees must be able to review their files, submit written comments, documents, records and other information relating to the claims for benefits as part of the appeals process. Additionally, plans may not terminate or reduce an approved ongoing course of treatment without notifying the claimant sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination. These provisions were implemented in federal regulations published in July 2010.[13]

New York has had a fairly progressive managed care bill of rights since 1996. The law gives any insured or enrollee subject to utilization review the right to seek an appeal of a utilization review decision that denies medical care on medical necessity grounds.

External Review

[10] Note that the rate review provision only applies to new plans; grandfathered plans (i.e., those that were in existence on March 23, 2010) are exempt.
[11] For an overview of the rate review process, please see: http://www.healthcare.gov/law/resources/reports/rate-review09112012a.html.
[12] The law applies to individual, small group, large group community rates, Healthy New York and Medicare Supplemental policies. It does not apply to experience-rated large groups or self-insured health plans.
[13] U.S. Departments of Treasury, Labor and Health and Human Services, "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act." July 23, 2010.

Under the ACA, states that had enacted external review laws and met the minimum consumer protection standards of the National Association of Insurance Commissioners Uniform External Review Model Act (NAIC Model Act) were deemed to be applicable and enforceable for all health plans in that state. The ACA also made determinations by an external review entity binding on plans. In states without external review laws, and for self-funded plans (not subject to state laws), the Secretary was required to develop an effective external review process similar to the NAIC Model Act.[14]

New York's external review law establishes a process and timeline for all health care services denied on the grounds that the service was not medically necessary. The law also establishes an external review process for patients with life-threatening or disabling conditions seeking investigational or experimental treatment. The state requires independent health care professionals with no ties to the health plan to conduct the reviews.[15] The 2011 law added a number of requirements to its external review rules, including accreditation of organizations conducting external appeals, changes to time lines and fees, and expanding reviews for experimental treatment to all enrollees, to align New York's external appeals rules with the ACA. Upon review by HHS, New York's external appeals process was deemed adequate to meet the ACA requirements.

Dependent Coverage

Health plans and products that provide dependent coverage of children are now required to extend coverage to children up until age 26.[16] Since this provision took effect, an estimated 3.1 million individuals have been covered.[17]

In addition to extending coverage to dependents up to the age of 26, plans are now prohibited from excluding coverage of pre-existing conditions for enrollees under age 19. Under the ACA and detailed in final regulations,[18] plans that cover children can no longer exclude, limit, or deny coverage to a child under age 19 solely based on a health problem or disability that the child developed before the family applied for coverage.

New York's 2011 ACA-related legislation establishes dependent coverage up to age 26. In addition, New York had already enacted legislation[19] that allows for coverage of dependents through age 29, although

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[14] Ibid.

[15] NY Public Health Law §4910 and Insurance Law §4910

[16] These changes were implemented in the following federal regulations: U.S. Departments of Treasury, Labor, and Health and Human Services, "Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule," July 23, 2010.

[17] Benjamin D. Sommers, "Number of Young Adults Gaining Insurance Due to the Affordable Care Act Now Tops 3 Million," Issue Brief, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, June 19, 2012.

[18] U.S. Departments of Treasury, Labor, and Health and Human Services, "Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule," June 28, 2010.

[19] A.9038/S.6030: Relates to the provision of health insurance coverage to the unmarried child of an insured through the age of 29 years. Chapter 240 of the laws of 2009.

through a different actuarial and financing mechanism. Group and individual policy holders are permitted to purchase a rider to their contract allowing for dependents to remain covered as dependents through age 29. For group contracts that choose not to purchase the dependent coverage to age 29, the young adult dependent has the right to purchase coverage at the individual rate through the group contract. The state law remains in effect, providing an additional coverage option for individuals 26-29 years. The 2011 legislation also eliminated pre-existing condition clauses for children's coverage.

Lifetime and Annual Dollar Limits

The ACA prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from imposing lifetime limits on the dollar value of health benefits in any health plan or insurance policy issued or renewed on or after September 23, 2010. Annual limits also are prohibited, but the statute includes a phase-in of this provision before January 1, 2014, that allows plans and issuers to impose "restricted annual limits, outlined in federal regulations published in June 2010.[20] For plan years starting between September 23, 2010 and September 22, 2011, plans could not limit annual coverage of essential benefits (such as hospital, physician and pharmacy benefits) to less than $750,000. The restricted annual limit increased to $1.25 million for plan years starting on or after September 23, 2011, and to $2 million for plan years starting between September 23, 2012 and January 1, 2014. For plans issued or renewed beginning January 1, 2014, all annual dollar limits on coverage of essential health benefits will be prohibited; however, health plans may place limits on benefits that are not part of the state's defined essential health benefits.

New York's ACA implementation legislation incorporates these changes into insurance law.[21]

Direct Access and Prior Authorization

The ACA establishes numerous patient protections under a Patient's Bill of Rights that apply to health coverage starting on or after September 23, 2010. Under the ACA, individuals enrolled in a health plan that requires them to designate a specific primary care provider are guaranteed the right to choose any primary care provider in the plan's provider network. For enrollees requiring emergency care, the ACA prohibits plans from requiring prior authorization of emergency room services, limiting emergency services to in-network providers, or imposing higher cost-sharing for emergency services for out-of-network care than for in-network care. Finally, health plans may not require authorization or referral for enrollee access to obstetrics-gynecological (OB-GYN) services.

New York's ACA implementation legislation incorporates these changes into insurance law.[22]

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[20] U.S. Departments of Treasury, Labor and Health and Human Services, "Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections." June 28, 2010.

[21] A.8460/S.5800: Relates to implementation of the Affordable Health Care Act, Chapter 219 of the laws of 2011, §10, §42.

[22] The direct access provisions are addressed in §9, 41 and 59; the emergency room changes are addressed in §3, 13 and 25; direct access to OB-GYN care is addressed in §8, 40 and 60. Note that, in each case, the legislation requires three separate sections to address insurance companies licensed under three different provisions of insurance law. The language in each case describing the statutory changes is identical.

High-Risk Pool

A national high-risk pool, established almost immediately after the ACA's enactment, is currently providing coverage to the medically uninsurable who have not had creditable coverage for at least six months prior to application. The federal high-risk pool, known as the Pre-existing Condition Insurance Plan (PCIP), is available until Exchange coverage begins in 2014 with the requirement that all plans must issue coverage regardless of an individual's health status.[23] As of July 31, 2012, there were 82,000 PCIP enrollees nationwide.[24]

New York established its own pre-existing condition plan, the NY Bridge Plan, administered by GHI, an EmblemHealth company. The plan is an Exclusive Provider Option (EPO), which means that members must use doctors and health care providers who are in the GHI EPO network, except in cases of emergency or when care is not available through a participating provider. Premiums are substantially lower than those available in the individual market. The downstate premium is $421 per month; the upstate premium is $362. This compares with rates upwards of $1,300 in the individual market. The benefit package is generous, and cost-sharing is limited. Enrollment, which began in October 2010, has reached about 3,400 individuals. New York's existing enrollment levels will exhaust available federal funds, and the state has submitted a request for additional funds to the federal government.

Preventive Services

Another key ACA provision that took effect in 2010 requires that health plans cover evidence-based preventive services and eliminate cost-sharing for preventive care provided by an in-network provider. This provision applies to all non-grandfathered group health plans, small group and individual health insurance issuers, and these plans must cover 16 preventive services for adults (e.g., blood pressure screening, recommended adult immunizations, cholesterol screening), 22 preventive services for women (e.g., mammograms for women over age 40, osteoporosis screening, well-woman visits for women under age 65), and 27 preventive services for children (e.g., autism screening for children at 18 and 24 months, recommended childhood immunizations, lead screening, newborn hearing screening).

New York's ACA implementation legislation incorporates these changes into insurance law.[25]

2. ACA Rules in Effect Starting January 1, 2014

Guarantee Issue/Preexisting conditions

Starting on January 1, 2014, all group health plans and individual health insurance products will be required to accept every employer and individual in the state applying for coverage. These plans will be prohibited from establishing any rules for eligibility based on the following health-related factors:

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[23] Patient Protection and Affordable Care Act: Pre-Existing Condition Insurance Plan Program. Interim Final Regulation, July 30, 2010.

[24] Center for Consumer Information and Insurance Oversight, "State-by-State Enrollment in the Pre-existing Condition Insurance Plan, as of July 31, 2012," posted September 14, 2012.

[25] A.8460/S.5800: Relates to implementation of the Affordable Health Care Act, Chapter 219 of the laws of 2011, §10, §42.

- Health status;
- Medical condition (including both physical and mental);
- Claims experience;
- Receipt of medical care;
- Genetic information;
- Evidence of insurability;
- Disability; and
- Any other health status-related factor determined as appropriate by the HHS Secretary.

In addition to requiring all plans to accept enrollees regardless of their previous or current health status, plans are also prohibited from imposing any pre-existing condition exclusions on coverage and will be required to continue offering renewals or continuation of coverage at the option of the plan sponsor (employer) or individual. Lastly, plans will not be allowed to establish waiting periods for eligibility that extend beyond 90 days.

The New York insurance market already requires guarantee issue in both the small employer and the individual markets. New York established community rating and open enrollment in 1992. Insurers must accept any individual for medical coverage, at any point during the year, and once accepted, they cannot be terminated based on claims experience.[26] New York law currently allows pre-existing condition exclusions of up to 12 months in both small employer and individual policies. To be compliant with the ACA, amendments to the pre-existing conditions exclusions were included in the 2011 legislation (sections 23 and 43) that prohibit insurers from imposing pre-existing conditions exclusions in any individual or group policy beginning January 1, 2014.

Premium Variance/Rating Provisions

After January 1, 2014, under federal law, premium rates for group and individual health insurance may vary only with respect to the particular plan or coverage and only by: family structure or size, rating area, and age or tobacco use. For states like New York that have community rating, these provisions are not applicable since the state has already determined the rating structure for the individual and small group markets.

Under the ACA, states that do not already have defined rating areas must create them and submit them to the HHS Secretary for adequacy. New York does not have standardized geographic rating areas; instead, each insurer is free to define their rating areas as long as they are larger than a single county. Additionally, insurers can define regions based on where enrollees live, where they receive care, or where their employer is located. New York will have to create standardized rating areas. The ACA allows states to establish a single geographic rating area for the entire state.

New York prohibits plans from using age bands in establishing premiums. While this prohibition could be re-considered, the ACA does not preclude New York from maintaining that prohibition.

Clinical Trials

[26] NY Insurance §3231 and §4317

In 2014, plans will be prohibited from denying an individual the ability to participate in a clinical trial, including a clinical trial conducted outside of the state in which the individual lives. This prohibition will also include the discrimination of, or denying, limiting or imposing any additional conditions on the coverage of routine patient costs for items and services furnished in connection with the clinical trial.

Multi-State Plans

The ACA requires that among the qualified health plans (QHPs) offered, every state exchange must offer at least two Multi-State Plans (MSPs). Unlike other QHPs, the MSPs will be licensed by states but regulated by the federal Office of Personnel Management (OPM), which also operates the Federal Employees Health Benefit Plan (FEHBP). OPM must ensure that at least one is a non-profit plan, and that one does not provide abortion coverage. The intent of the MSP provision is to increase consumer choice within the state's exchange. MSPs, like the Consumer Oriented and Operated Plan (CO-OP) Program discussed below, are designed to offer competition for traditional insurance issuers, which, if successful, should lead to some combination of lower premiums and better quality. MSPs must offer the Essential Health Benefits. While OPM will negotiate premiums, set rates, establish MLRs and certify plans as QHPs, the MSPs must be licensed in each state and meet any state-specific QHP requirements. A health insurance issuer may work with other regional (or sub-regional) issuers to offer an MSP. The ACA also provides that a group of insurance companies can be considered a single insurer for the purpose of creating an MSP if they have common ownership and control or operate under a nationally-licensed service mark.

OPM released proposed rules for the MSP program on November 30, 2012.[27] The proposed rule clarified some questions about MSPs, but some concerns remain.

- Under the ACA, MSPs are deemed eligible to participate in each state's exchange, which raises concerns about states' ability to use the exchanges to drive value-based purchasing. Because their premiums and MLRs are established by OPM and not by the individual state, MSPs will be held to a different standard, potentially creating market segmentation. The concern is that MSPs limit the ability of a state to design an exchange that is an active purchaser, as the MSPs must be offered within the exchange even if they do not meet the state's value-based purchasing standards.
- Concerns have been raised that MSPs could create adverse selection. The recently released rules articulate provisions to create a "level playing field" among the QHPs, including requirements that the MSP follow all state laws in 13 categories (guaranteed renewal; rating; preexisting conditions; non-discrimination; quality improvement and reporting; fraud and abuse; solvency and financial requirements; market conduct; prompt payment; appeals and grievances; privacy

[27] Office of Personnel Management. "Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges; Proposed Rule." Federal Register / Vol. 77, No. 234

and confidentiality; licensure; and benefit plan material or information). It remains to be seen whether that is sufficient to prevent adverse selection.[28]

Consumer Operated and Oriented Plan (CO-OP) Program

In addition to MSPs, the ACA allows for the creation of qualified non-profit, consumer-governed health insurers to offer products in the individual and small group markets if the state allows for the licensure of such entities. The HHS Secretary issued final federal regulations on the CO-OP model in December 2011. [29] For the purposes of the CO-OP Program, "qualified nonprofit health insurance issuers" are required to:

- Be organized as a nonprofit, member corporation under state law;
- Not be an existing organization that provided insurance as of July 16, 2009, and not be an affiliate or successor of any such organization;
- Have governing documents that incorporate ethics and conflict of interest standards protecting against insurance industry involvement and influence;
- Not be sponsored by a state or sub-state government;
- Have substantially all of its activities involve the provision of health coverage;
- Have a strong consumer focus;
- Meet solvency and licensure requirements, follow rules on payments to providers, and comply with network adequacy rules, rate and form filing rules and any state premium assessments;
- Only offer a health plan after the state has in effect, or the Secretary has implemented, the market reforms described by the ACA; and
- Use profits to lower premiums, improve benefits or improve the quality of health care.

As of August 2012, 20 non-profit organizations offering coverage in 20 states have been awarded federal loans to support the creation of eligible CO-OP, including one New York-based organization. Freelancers Union was awarded a loan of $174,445,000 to sponsor a CO-OP program in New York. Freelancers Union was established in 2001 to provide benefits to individuals in non-traditional employment such as freelancers, consultants, independent contractors, and the self-employed who do not have access to employer-based insurance. They have created a portable benefits delivery system, linking benefits to individuals rather than to employers, so independent workers can maintain benefits as they move from job to job and project to project. Freelancers Union launched its own insurance plan in 2009, which currently provides coverage to 23,000 individuals, and expect their CO-OP will cover 100,000 individuals within seven years.

[28] For more information about MSPs, please see: T. Riley and J. Thorpe, "Multi-State Plans Under the Affordable Care Act," George Washington University, March 2012.
[29] U.S Department of Health and Human Services, "Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program." December 13, 2011.

Section Three: Adverse Selection and Options to Mitigate in New York State

The purpose of this section of the report is to highlight the varied sources of possible adverse risk selection related to the development of the Insurance Exchange in New York State, and to recommend policy strategies to minimize adverse risk selection. We focus particular attention on the types of risk selection that could be expected to occur between the external market (individual and small group markets only) and the Exchange, but we also include other types of risk selection. These include the practices of various types of organizations that could aggregate individuals and small groups into larger entities in ways that might remove significant numbers of younger and healthier people from the scope of federal and state insurance regulation and lead to adverse selection against the Exchange.

Background

A key thrust of the Affordable Care Act (ACA) is to foster competition among health plans/care systems based on their ability to drive improvements in care delivery and health outcomes and to discourage competition based on cherry-picking the best risks and cost-shifting. The expected outcomes are reduced total spending and better quality of care. The Affordable Care Act (ACA) also includes important provisions designed to limit adverse risk selection or mitigate its adverse impact. These include insurance market rules discussed in Section Two; the individual mandate to obtain coverage; risk adjustment of premiums; and reinsurance.

New York has full community rating (CR) in the individual and small group markets, and this substantially increases the incentives for health plans to cherry pick good risks or subtly avoid higher-risk individuals or groups. Under full community rating, insurers cannot "rate higher-risk people or groups up," so they may try very hard to find ways to attract younger and healthier people and avoid older and less healthy people. New York faces challenges to minimize adverse selection in both the Exchange and the external market, and between the external markets and the Exchange.

Our working assumptions for this analysis are as follows:

- New York will develop a single Insurance Exchange governance structure that incorporates both an Exchange for individuals and a SHOP Exchange.
- The Exchange will maintain separate risk pools for the small group and non-group markets.
- The Exchange will operate as part of an existing state government agency.

The individual mandate is very important in New York because of pure community rating. Pure community rating creates a situation where young and healthy people have to pay premiums that are much higher than their expected claims cost; that is, they face a particularly large gap between the actuarial value of their coverage and the full CR rate that they have to pay for coverage. Under the ACA, the gap in New York will be larger than will be the case in others states, since the ACA allows a 3:1 rate variation for age, and virtually all states that are designing exchanges plan to allow that degree of rate variation, whereas New York plans to use full CR in both the Exchange and the individual and small-group markets. Coupled with New York's continuous open enrollment provisions under which people can sign up for health coverage at any point during the year, this gap between the premiums and the

actuarial value of coverage provides a strong inducement for healthier people to stay uninsured until they get sick and then, when they do, obtain health coverage without having to worry about exclusions for pre-existing conditions, which will not be allowed under ACA. Offsetting this inducement is the availability of premium subsidies for many who would enter the Exchange, depending upon their income, as well as the penalty that people would pay if they remain uninsured.

Yet, for many younger and healthier people, this penalty could be substantially less than the actuarial cost of coverage. Counter-balancing this effect is the advantage that older and sicker people receive from full CR as the actuarial value of their coverage substantially exceeds the community rate. The bottom line is that compared to other states, younger and healthier people in New York have a stronger financial incentive to avoid buying coverage because of the higher cost. Further, to the extent that these younger and healthier people stay on the sidelines, this raises the cost of coverage for those who do participate.

The mandate implemented in 2014 will induce many younger and healthier residents of New York who have been uninsured to obtain health coverage, and this will reduce the average level of premiums. To understand the magnitude of the likely impact of the individual mandate, we highlight the important findings in a recent Urban Institute report on New York. This report includes estimates that when the ACA is fully implemented, the size of the individual market would increase dramatically, in fact, six-fold. Further, they estimate that average premium in the individual market, excluding the Healthy NY population, would fall by 70 percent.[30]

Moreover, experience in Massachusetts shows that the size of the individual market grew substantially after the state's health reform, which included major new subsidies and an individual mandate. Enrollment in the individual market more than doubled over the 2006-2008 period.[31] It is important to note, however, that one of these estimates covers an earlier period (Massachusetts example) while the other assumed full implementation of ACA in 2011 (Urban Institute study of New York). With actual implementation of the Exchange in 2014, the magnitude of the change in premiums could be somewhat different.

1. Adverse Selection Between and Within the Exchange and External Markets

Adverse selection will be minimized if the Exchange and the external markets use the same rules regarding enrollment, rating, and switching of plans. Whatever is done with regard to these factors inside the Exchange should also be done outside the Exchange.

[30]Fredric Blavin, Linda J. Blumberg, Matthew Buettgens, and Jeremy Roth, "The Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State." Urban Institute, March 31, 2012. http://www.urban.org/publications/412534.html

[31]Dianna K. Welch and Kurt Giesa, "Analysis of Individual Health Coverage in Massachusetts Before and After the July 1, 2007 Merger of the Small-Group and Non-Group Health Insurance Markets." Oliver Wyman Company, June 2010.

Rating Rules

A major potential source of adverse selection in New York is the use of different risk rating rules inside and outside the Exchange. If one market uses full community rating while another market uses adjusted community rating following the ACA (a limit of three to one on age, and 1.5 to 1 on tobacco use), the market with full community rating would become the victim of adverse risk selection as sicker people move toward the market where they do not pay anything extra for their poor health status and healthier people choose the market that uses the ACA-stipulated degree of risk rating. The ACA requires that insurers charge the same prices for the same products inside and outside the Exchange.

We believe that average premiums in New York would be decreased by adopting the ACA rating rules that include a 3 to 1 limit on age rating and a 1.5 to 1 limit on tobacco products use rating, and then modifying the full CR rating rules in the external markets to make them the same. We think that this would reduce the incidence of younger and healthier people deciding to remain uninsured and paying the penalty for non-compliance with the individual mandate, and that this would lower costs. However, this policy choice would be a significant policy change for New York, which requires that all individuals and small groups be charged the same premium rate without regard to age, sex, health status or occupation. Most significantly, reintroducing age and tobacco rating would significantly increase premiums for older New Yorkers and those impacted by tobacco addiction.

We recognize that New York has decided to retain full CR in the external markets. Given this decision, we recommend that New York use full CR in the Exchange to mitigate adverse selection.

Open Enrollment

Currently, New York allows continuous "open enrollment" in the individual and small group markets. This means that people can enroll in insurance at any time during the year. Individuals and employers are not bound by the time frame of an "open enrollment period" of six or eight weeks, commonly used in private insurance markets around the country. Under prevalent arrangements in other states, enrollees make a choice during a fixed enrollment period that they must stick with until the next open enrollment period, subject to triggering events noted below. Open enrollment is only applicable to new enrollment in individual and small group policies and does not apply to employees enrolling in employer-sponsored plans.

In contrast to current practice in New York, the ACA requires a limited period for plan selection in the Health Benefits Exchanges for individuals, and does not allow enrollees to sign up for health coverage throughout the year. For example, regarding coverage in the first year of the Exchange, 2014, there is a six-month enrollment period, beginning on October 1, 2013 and extending through March 31, 2014. The intent is to get an early start on the first calendar year of the Exchange program and spread the work of the initial enrollment, while allowing flexibility for those who might find out about the Exchanges for the first time in the early part of 2014.

For subsequent years, however, the annual enrollment period will run from October 15th through December 7th. The ACA also offers a number of "triggering events" permitting people to enroll in or switch their Exchange coverage during a "special enrollment period" outside of the annual open enrollment period. People who lose job-based insurance, or lose Medicaid because of an increase in income may enroll in Exchanges, and other triggering events include marriage, divorce, and the birth or

adoption of a child.[32] It is important to note that these fixed enrollment periods apply to the Health Benefits Exchanges in which individuals enroll, not the Small Business Health Options Program (SHOP) through which small firms enroll. Small firms can join the SHOP Exchanges throughout the year.

Massachusetts also provides an example of the use of fixed rather than open enrollment periods. In 2010 Massachusetts moved from open enrollment throughout the year to two six-week enrollment periods in private insurance markets, including the Connector.[33] For 2012, the state brought this down to one open enrollment period (July 1-August 15) under Comm Choice, the unsubsidized program for people enrolling in the Connector. [34] Massachusetts also required insurance carriers to merge their individual market and small group market enrollees into a single pool, using the same rating methodologies for the entire population.[35]

We recommend that New York change its open enrollment period policy in the external markets to synchronize with ACA rules. Thus, for individual plans, enrollment would begin on October 1, 2013, but only through the end of March 2014. The next open enrollment period would begin on October 15, 2014 and run through December 7, 2014, with the same period in subsequent years. Small employers purchasing coverage in the external markets would be permitted to continue to enroll on a monthly basis, consistent with ACA requirements applicable to the Exchange. Otherwise, the market outside the Exchange will likely be the victim of adverse selection as younger and healthier people will have an incentive to remain uninsured and then go into the external market as soon as they see a need for a substantial amount of medical care. They would have to pay the ACA-required penalty for remaining uninsured, but in 2014, that will only be $95, or 1 percent of their income, whichever is higher, rising in stages to $695, or 2.5 percent of income in 2016. This amount is far below the cost of insurance, particularly in New York. If younger and healthier people stay on the sidelines, both the Exchange and the external markets would have higher costs than if these individuals got health coverage (the insurance market as a whole is "selected against"). Risk selection *between* the two markets would go against the external markets as people who do hold out and wait until they need services would then face no barriers such as being outside the enrollment window if they go to the external individual market.

A second-best policy would be to have two "open season" enrollment periods in the external markets, one aligned with the Exchange period in the Fall and another, perhaps limited to one month, in the Spring.

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[32] Sarah Lueck, "The Insurance Exchanges: Open Enrollment and Switching Plans." Health Affairs Blog, July 15, 2011. http://healthaffairs.org/blog/2011/07/15/the-insurance-exchanges-open-enrollment-and-switching-plans/

[33] Massachusetts Division of Insurance, Consumer Alerts. 2010.

[34] Massachusetts Health Connector, "Limits on health plan enrollment." August 10, 2012. https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/FindInsurance/LimitedEnrollmentNotice/LimitedOEFactSheet.pdf

[35] Alan G. Raymond, "Massachusetts Health Reform: A Five-Year Progress Report." Blue Cross Blue Shield of Massachusetts Foundation, November 2011. https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Overview/BlueCrossFoundation5YearRpt.pdf

Plan Switching

In addition to the adverse selection that may occur if people can enter the insurance market at any time with no penalty, adverse risk selection could also occur if people can switch health plans at any time and with no limits. This allows people to take a plan with high cost sharing when they are healthy and immediately switch to one with lower cost sharing when they get sick.

A risk selection mitigation strategy is to place limits on the ability of people to start off in a benefit tier that features the highest cost sharing (bronze for those 30 years of age and older, catastrophic for people under 30), and then shift to a much higher tier with much lower cost sharing, such as platinum, in the next enrollment period. If some limits are not considered, large numbers of Exchange low-risk enrollees might select the least generous tier and wait until some major health condition develops, after which they would leap up to the highest tier.

One way to address this is to limit benefit tier switching to one or at most two levels, at least in the early years of the Exchange. An offsetting disadvantage of this option is that it constrains individual choice, and could place a financial burden on some people whose ability to meet cost sharing requirements of lower-tier metals deteriorates due to a change in financial circumstances.

New York may also want to consider limiting the ability of people to change plan designs *within* benefit tiers outside of a specified enrollment period. Some plans in the silver category, for example, might have more generous coverage for a particular set of illnesses while having less generous coverage for another set of illnesses. This could lead to plan switching during the year if, for example, a person is suddenly starting treatment for mental illness or another serious medical condition.

New York may want to establish an exception to these limitations for those that need to change their benefit plans due to a change in financial circumstances. States are allowed to use their own data, such as on earnings from their work force agencies, to update the IRS determination of household income. This might enable New York to help people whose income falls during the year to switch plans in order to obtain a larger federal subsidy in the Exchange.

New York should have the same plan switching rules inside and outside the Exchange, and should consider limiting plan switching to specified enrollment periods and placing some limits on the number of tiers that people can "jump" in any one enrollment period.

Plan offerings Inside and Outside the Exchange

Another possible source of adverse selection can occur if some plans are offered inside the Exchange but not outside the Exchange, or vice versa. [36]

The ACA requires that a qualified health plan in the Exchange is one that "agrees to charge the same premium rate for each qualified plan of the issuer without regard to whether the plan is offered through

[36]Wakely Consulting Group, "Benefit Standardization Study for the State of New York." June, 2012. http:// healthcarereform.ny.gov/health_insurance_exchange/docs/wakely_benefit_standardization_study.pdf

the Exchange or whether the plan is offered directly from the issuer or through an agent…"[37] But it does not require that plans sold outside the Exchange be offered in the Exchange, or vice versa.

Health insurers must offer gold- and silver-level coverage within the Exchange as a prerequisite to selling other levels of coverage.[38] But insurers are not required to participate in the Exchanges, and can remain outside the exchange marketing "bronze-level" high cost-sharing plans, or catastrophic plans, which can be sold to people under 30 years of age or persons who cannot find affordable coverage.[39] This opens up the possibility for healthy individuals or small employers to purchase minimum coverage outside the Exchanges, leading to significant adverse selection against Exchanges. Further, self-insured plans, discussed below, are subject to even less rigorous requirements under ACA, and might offer coverage that is less comprehensive than Exchange coverage.[40]

It is our understanding that New York plans to require QHPs to offer all the metal levels inside the Exchange. We think that is a sensible approach.

New York could obtain helpful guidance on such matters from California's Assembly Bill 1602, known as the California Patient Protection and Affordable Care Act. The following features of the law are relevant to avoiding adverse risk selection:

- Health plans participating in the Exchange have to offer all levels of health coverage in the Exchange. It is also important that all of the levels ("metals") of plans be offered in the external markets. If this is not done, then insurers might try to get the lower-risk people in their "outside business," perhaps by offering only bronze and silver plans in these markets. Offering just these plans with higher levels of cost sharing would likely cause healthier people to remain outside of the Exchange while encouraging sicker people, for whom higher levels of cost sharing are more of a barrier since they expect to use more health services, to join the Exchange.
- The specific language from the California statute says that qualified health plans participating in the California Exchange shall "Provide, in each region of the state, a choice of qualified health plans *at each of the five levels of coverage* contained in subdivisions (d) and (e) of Section 1302 of the federal act (emphasis added).[41]
- The law also stipulates that QHPs "require, as a condition of participation in the Exchange, carriers that sell any products outside the Exchange to….Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange….and Fairly and affirmatively offer, market, and sell all products

[37] ACA Section 1301 42 U.S.C 18021. Qualified Health Plan Defined (A) (1) (C) (iii)
[38] ACA Section 1301 (a) (1) (C) (ii) and (iii).
[39] ACA Section 1302 (e).
[40] Timothy S. Jost, "Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues." The Commonwealth Fund, September 2010. p. 9.
[41] California Assembly Bill No. 1602, Chapter 655. Section 100503 (d).

made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange."[42]

- Health benefit packages will be standardized across the Exchange and external markets. Plans cannot offer their own product inside the Exchange and then an ACA-consistent (essential benefits package) product in the external markets, or vice versa.
- California requires that health plans that sell products outside the Exchange must sell them inside the Exchange at the same price.
- Plans not participating in the Exchange must still offer Exchange standard products outside the Exchange. The intent here is to avert a situation where plans operating only in the external markets could skim the healthiest people and leave the higher-risk people inside the Exchange.
- Catastrophic coverage can be sold only inside the Exchange through an ACA-consistent high-deductible plan for adults younger than 30 years of age.

Timothy Jost highlights the importance of avoiding more subtle and nuanced sources of adverse risk selection. Jost notes that while most of the requirements that ACA imposes on insurers apply both inside and outside of the Exchanges, Section 1311 of ACA lists a number of additional requirements that must be met by all QHPs certified to participate in Exchanges but not necessarily by non-participating plans. These include requirements that certified plans must:

- Comply with requirements that prohibit marketing practices and benefit designs that discourage high-risk enrollees;
- Include a sufficient number of in-network providers and supply information on the availability of providers in and out of network;
- Include essential community providers that serve low-income, medically underserved individuals;
- Be accredited by HEDIS and CAHPS;
- Implement a quality improvement strategy;
- Use a unified enrollment form;
- Use the standard benefit form for presenting health benefit options;
- Provide information to enrollees and prospective enrollees on quality measures of performance;
- Implement activities to reduce health and health care disparities;
- Report pediatric quality measures.

[42] California Assembly Bill No. 1602, Chapter 655. Section 100503 (f) A and B.

Jost concludes that "These requirements should also be applied generally to plans outside the exchange to ensure a level playing field and to discourage those plans from offering lower cost and lower quality.[43]

New York should consider adopting some or all of these strategies related to plan offerings to limit risk selection across the boundary between the Exchange and the external Markets.

2. Should the Exchange Constitute the Entire Market for Individuals and Small Groups?

One way to avoid adverse selection against the Exchange is by having all private individual and small group health insurance coverage sold through the Exchange. In effect, the Exchange would become the private market for health insurance for the non-group and small group markets.

We decided to limit the focus to the option of folding the non-group market into the Exchange. The reason is that there is really no vibrant, large-scale individual market in New York to disrupt. The non-group market in New York is small, shrinking, very high-cost, and mostly serving a very high-risk population—it does not now function as a market that spreads risk across a wide range of healthier and less healthy people.

As a result, trying to adjust this very limited and troubled market to meet ACA requirements, i.e. metal tiers, would be cumbersome and unwieldy. In contrast, the small-group market in New York is a diverse, competitive market. It has a wide variety of plan options and a broad mix of people with regard to age and health status. Condensing the broad range of coverage options now available in this small group market into a few or several might restrict consumer choice. While it is possible that bringing the small-group market into the Exchange might mitigate selection issues, this advantage would be offset by forcing too many plan designs into the Exchange, which could raise administrative costs and confuse consumers. Another unfortunate outcome could be the elimination of some of the varying plan designs that contribute to the current vibrancy of New York's current small group market.

Therefore, we recommend preserving the small-group market, and transitioning the non-group market into the Exchange.

This step presents some challenges that should be considered. One challenge is that some undocumented people now obtain coverage through the individual market. If that market is brought into the Exchange, they would not be able to obtain coverage, as undocumented individuals are not allowed to purchase insurance in the Exchanges. Another challenge is how to bring the individual market into the Exchange in a way that does not disrupt patterns of care delivery, or impose an undue financial hardship, on people with currently relatively low-cost coverage, like those obtaining state supported coverage through Healthy NY or federal supported coverage through New York's Bridge Plan (New York's Pre-existing Condition Insurance Plan) or those with very comprehensive coverage and complex medical needs such as the enrollees who are currently served by New York's standardized individual

[43] Timothy S. Jost, "Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues." Supra, pp. 11-12.

market. With regard to Healthy New York, other analysis indicates that individuals, sole proprietors, and lower-wage employees enrolled in Healthy New York will face reduced costs and more comprehensive coverage in the Exchange relative to Healthy New York, while moderate and higher-wage employees enrolled in Healthy New York may face comparable or higher costs through the Exchange relative to Healthy New York.[44]

The following steps could be considered:

- Use 2013 to educate plans participating in the individual market and enrollees in these plans that they will be transitioned into the Exchange in 2014, and educate them about what this means.
- With the possible exception of enrollees participating in currently subsidized products including certain moderate to higher-income small-firm employees in Healthy NY and the New York Bridge Plan, enrollees should be informed that they will have much lower premiums inside the Exchange than they currently have in the individual market. This is because there will be a much broader and more diverse risk profile in the Exchange than is currently the case in the individual market. In addition, a large number of people who will transition from the individual market to the Exchange will qualify for premium assistance tax credits inside the Exchange. This will lower their premium cost much further. This benefit to consumers previously in the individual market, however, will be partly offset by somewhat more exposure to cost sharing in the Exchange than applies to the current individual standardized HMO and POS products, even with ACA-stipulated limits on out-of-pocket spending that will help many Exchange enrollees.
- People making the transition might want to select the platinum or gold metal tiers to reduce the increase in their cost sharing, relative to the very low levels they receive now in the individual market. Since people with incomes below 200% of the FPL must select a silver plan in order to benefit from cost sharing assistance, they should be educated not to select gold or platinum plans, since such a choice could leave them with a lower level of coverage at a higher price.
- Take steps to assure that people who are under the care of one or more specialists or sub-specialists on a long-term basis can find at least one plan in the Exchange in which that provider participates. If this cannot be done, special permission to go “out-of-network” without undue financial hardship should be arranged. We think that in most cases, the insurers now offering in the individual market would offer comparable provider networks inside the Exchange. New York could consider requiring each carrier to extend a plan with an out-of-network option within the Exchange. This would assure the availability of continuity of providers, but of course, would affect cost as well.

[44] Deloitte Consulting, forthcoming, “New York State Health Benefit Exchange Study 5: Healthy New York and the Family Health Plus Employer Buy-In.”

- Explore the potential to work with groups providing financial assistance in hardship situations for out-of-pocket medical costs beneath the ACA cap. In addition to financial assistance, people making this transition, many of whom have complex medical needs, would benefit from active care management that may go beyond assistance they might get from ACA-related Navigators.

Continue to Prepare for Risk Adjustment and Reinsurance Mechanisms

The ACA contains three mechanisms to correct for the effects of adverse risk selection—risk adjustment, reinsurance, and risk corridors.[45] Under the ACA New York may choose between establishing its own risk-adjustment program or using one being constructed by the federal government. Risk adjustment is a permanent program created by the ACA that aims to eliminate, or at least substantially reduce, premium differences across plans based solely on favorable or unfavorable risk selection. All plans except those grandfathered are subject to risk adjustment, which moves premium dollars from those with a disproportionate share of low-risk members to those with a disproportionate share of high-risk members. [46]

New York operates several risk adjustment and reinsurance programs. Others have been suspended but are still relevant. Current programs include the Regulation 146 5th amendment and the Regulation 171 programs. The Regulation 146 4th amendment program is suspended but it was a risk adjustment program based upon specified medical conditions that applied to the commercial market and as a result, was most similar to the ACA requirements. In 2010 Regulation 171 payments were about $16 million and Regulation 146 payments were about $63 million. In comparison, ACA reinsurance payments in New York are expected to be about $600 million in 2014, and although there is uncertainty around this estimate, it does appear that substantially more money will be shifted across insurers under ACA than under previous state reinsurance programs.[47]

A report prepared by Wakely Consulting Group for New York State recommends that the state create its own reinsurance and risk adjustment programs. The authors state that: "Because of the state of New York's market size, rating rules, geographic and issuer variation, its experience working on risk mitigation programs in the commercial and Medicaid markets, available grant funding to create an all payer data base (APCD), and other issues to create a state-specific solution, we recommend that the state administer the Reinsurance and Risk Adjustment programs."[48]

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[45]Department of Health & Human Services, "Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Final Rule." March 16, 2012. http://www.healthcare.gov/news/factsheets/2012/03/risk-adjustment03162012a.html

[46]Ross Winkelman and Syed Mehmud, "Risk Adjustment and Reinsurance under the ACA: New York State Recommendations." Wakely Group, June 2012. http://www.healthcarereform.ny.gov/health_insurance_exchange/docs/wakely_risk_adjustment_and_reinsurance.pdf

[47] Winkelman and Mehmud, "Risk Adjustment and Reinsurance under the ACA: New York State Recommendations." Wakely Consulting Group, June 2012. P. 2.

[48] Winkelman and Mehmud, supra. P. 3.

Regulation 171, a reinsurance program for the individual market, provides state-funded assistance that picks up 90% of the cost per case in the corridor of $20,000 to $100,000.[49] A corresponding reinsurance program for Healthy New York provides 90% of the cost of claims per patient in the range of $5,000 to $75,000.[50] A Medicaid risk-adjustment program is based on clinical risk groups (CRG).[51] The Regulation 146 market stabilization mechanism for the small group and individual markets, as well as Medicare Supplemental Insurance, is most like the federal risk adjustment mechanism.[52]

The ACA also establishes a reinsurance program. Reinsurance payments are similar to commercial reinsurance premiums, and the reinsurance will cover a substantial portion of the costs per patient above an "attachment point" where the insurance kicks in, until a cap is met (this is how Healthy New York operates). Finally, the ACA establishes a risk corridor program creating a mechanism for risk sharing between the federal government and qualified health plan issuers. Both reinsurance and risk corridor programs cover only the period from 2014-2016.[53]

For each of these three initiatives, New York has a choice between building its own program and using a program scheduled to be developed by the federal government. In the Blueprint application New York submitted to HHS on October 26,2012, they indicate that they plan to use the federal government method in the near-term (e.g. 2014-2016). One reason is that health plans have experience with the HCC model that is the federal approach under Medicare. The plans' experience with this model should reduce data errors and improve efficiency. The state may switch to a state-based approach for later years.

We support this approach and see the value of a two-step approach, with the familiar federal model that is well developed permitting a fast start, while permitting the state ample time to refine and test its own approach for possible later use.

The ACA's risk adjustment requirements would shift more money across insurance plans than is now the case under the state's own programs. New York should consult with both in-house actuaries and obtain outside actuarial advice on how to make this transition.

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[49] The state-funded assistance has been reduced on a pro-rata basis in recent years due to insufficient funding from the Legislature.

[50] The state-funded assistance has been reduced on a pro-rata basis in recent years due to insufficient funding from the Legislature.

[51] Clinical Risk Groups is a classification system for risk-adjustment that assigns each individual to a single, mutually exclusive risk group based on historical clinical and demographic characteristics in order to predict the future use of health services. See Hughes, JS, Averill, RF, et al. "Clinical risk groups (CRGs): a classification system for risk adjustment of capitation payments and health care management." *Med Care* January 2004; 42 (1):81-90.

[52] http://www.dfs.ny.gov/insurance/hregindx.htm

[53] Department of Health & Human Services, "Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Final Rule." March 16, 2012. http://www.healthcare.gov/news/factsheets/2012/03/risk-adjustment03162012a.html

3. What should be done with Association Health Plans (AHPs) and Professional Employer Organizations (PEOs)?

Various purchasing entities have formed over the years to enable small firms to obtain some of the advantages in purchasing health insurance normally enjoyed by larger firms. The idea is to enable these smaller employers to band together under one larger umbrella and obtain lower insurance premiums. But these entities can also be a mechanism to foil attempts to regulate insurance markets and a subterfuge with no real purpose other than to skirt the requirements of health reform legislation.[54]

The overall term for these arrangements is Association Health Plans (AHPs). Under AHPs, an insurance policy is held by the organization to cover all of its members. This association issues certificates of insurance coverage to its members. These associations can be either a legitimate professional or trade association, which incidentally offers health insurance to its members, or a "captive" of an insurance company, established specifically to market the insurer's products.[55] AHPs include multiple employer welfare associations, or MEWAs, which are active in the small-group market.[56]

Professional Employer Associations (PEOs) are also active in the small group market. PEOs are established to offer a wide range of products to employers, particularly small firms, including health insurance, Workers' Compensation, and disability insurance. They provide a kind of "one-stop shopping" for small companies and a way to "outsource" the human relations function for companies that do not have staff dedicated to this purpose.

Many AHPs provide helpful services to their members, including making health insurance more affordable for small firms and individuals. They can offer economies of scale and enhanced bargaining power by pooling individuals and small companies. But AHPs have a history of marketplace disruption.[57] In addition, an analysis by Mark Hall at Wake Forest University Law School concludes that AHPs can foster adverse risk selection by marketing their products to low-risk individuals and groups, while leaving the sicker people with higher risks in more traditional markets.[58]

Loopholes Must Be Closed

Timothy Jost of the Washington and Lee School of Law has conducted a very thorough and careful analysis of the potential threats to the achievement of the intent of the ACA's insurance market regulations. He concludes that:

> "the ACA is a leaky vessel, and if its many perforations are not attended to, they may sink it. Some of these are intentional and likely to cause little damage, like the religious sharing ministry exception to the minimum coverage requirement or the short-term limited duration policy exception….But some potential loopholes, like association health

[54] Timothy Jost, "Implementing Health Reform: Association Health Plans." Health Affairs, September 1, 2011. http://healthaffairs.org/blog/2011/09/01/implementing-health-reform-association-health-plans/
[55] Mila Kofman et al, "Association Health Insurance: Is it Time to Regulate this Product?" *J. Ins. Reg.* Fall 2005; Mila Kofman et al, "Association Health Plans: What's All the Fuss About?" *Health Affairs* Vol. 25: 1591-92; (2006).
[56] http://slu.edu/Documents/law/SLUJHP/JHLP5-1_Jost_Article.pdf
[57] Kofman, "What's All the Fuss About?" Supra.
[58] Mark A. Hall, "The Geography of Health Insurance Regulation." *Health Affairs,* March/April 2000. PP. 173-182.

> plans and faux self-insured plans, are serious and have the potential to sink the ACA. Federal and state regulators must be fully aware of the loopholes in the ACA, and must take action where necessary to protect its integrity."[59]

A particular concern with AHPs and PEOs for New York is that there is a potential incentive for plans covering both individuals and small groups to achieve large-group and/or self-insured status and thereby avoid a number of key ACA requirements. Both inside and outside of the Exchange, small groups under ACA must offer the essential benefits package, include their members in a single risk pool, participate in the risk-adjustment program, offer non-discriminatory premiums, and offer the metal tiers. Since large groups and/or self-insured plans are not subject to these requirements, AHPs and MEWAs could siphon off the best risks into an aggregated larger group that is free from ACA rules. This would raise costs both inside the Exchange and among those left in the individual and small-group markets.[60]

The main concern is with what some have called "air breather" AHPs existing only to market health insurance—these entities will sell insurance to anyone who meets underwriting requirements (who breathes the air) without requiring that members belong to the association for any other reason.[61] The main challenge for New York is to assure that the state complies with ACA and that the law is enforced against those who might try to game it.

ACA is very clear about the status of AHPs that market to individuals—they do not enjoy any special status and are clearly regulated as individual insurance. No provisions of the ACA suggest that a plan that markets coverage to individuals outside of an employee group is anything other than an individual health plan. Section 1304 of the ACA defines the group market only in terms of employer groups and defines the individual market to include all health insurance coverage marketed to individuals other than through employer groups.[62] If AHPs gather up younger and healthier individuals and place them into a kind of "phantom" large group, thereby insulating this aggregation from state and ACA regulation, New York will need to enforce clear legal requirements indicating that these people are still individuals and should be treated as such, because they do not belong to an employer group, large or small.

The situation with group health plans is more complex. Jost argues that whether group association health plans are considered as self-insured group plans or insured group plans makes a difference under ACA, as does whether they are classified as small group or large group plans. The reason is that ACA provisions such as limitations on annual or lifetime benefits, and guaranteed access to internal and external appeals, apply to self-insured plans but other provisions do not. It will be critical to determine whether association health plans are always considered to be insured plans or whether they might be considered self-insured in certain cases. Moreover, some of the protections afforded to enrollees of small-group plans are not assured to those in large-group plans so that it also becomes important to

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[59] Timothy S. Jost, "Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them." *Saint Louis University Journal of Health Law and Policy,* August 15, 2011. P. 82.
[60] Timothy S. Jost, "Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them." *Saint Louis University Journal of Health Law and Policy*, August 15, 2011.
[61] Hall, "The Geography of Health Insurance Regulation." Supra.
[62] Jost, "Loopholes in the Affordable Care Act…" Supra, p. 62.

determine if MEWAs that aggregate small groups are considered to be large groups for purposes of state regulation. This will require further interpretation as the ACA never mentions association health plans. [63]

Another source of concern about AHPs and ACA was that AHPs would aggregate individuals and small groups in order to avoid rate review by states and the federal government, as called for under ACA. To address this concern, HHS clarified the status of AHPs. The rule released in September 2011 states that regardless of state law, association plans that market plans to individuals must be regulated as individual plans, and association plans that market to small groups must be regulated as small groups for purposes of rate review. But the preamble to this rule makes it clear that it will apply to all regulatory provisions of the ACA. [64]

The HHS rule regarding AHPs is critically important to New York and should be taken as important federal decision-making that can help the state reduce market skimming that would pull people out from under the intended protections afforded by ACA market reforms.

A full understanding of the potential loopholes in ACA requires an understanding of ERISA. Under ERISA, most association plans that cover employment-related groups are classified as MEWAs, and such a classification also requires that the association include two or more employee groups. If a MEWA can be classified as an "employee welfare benefit plan," then it qualifies for an ERISA exemption from state regulation. But such a classification requires that the MEWA be determined to be an "employer," and MEWAs are not an employer. Only a bona fide employer group or association can be categorized as an employer and be allowed designation as an employee welfare benefit plan. Further, to be an employer, the MEWA must include "only those associations that have a genuine organizational relationship among the members" and cannot include individuals along with groups. An association that forms solely to market insurance would certainly not be considered an employer.[65]

MEWAs that are deemed to be employee welfare plans are subject to federal regulation under ERISA, and are also subject to state regulation.[66] Since MEWAs that are fully insured are clearly subject to state regulation, the state's ability to regulate these entities under virtually any configuration is established, but it must be enforced.

A key distinction is that an entity can only be considered an employer under federal law if it actually directs and controls the work flow and assignments of the employees. Clearly, organizations such as MEWAs do not do that.

In making these determinations, the US Department of Labor would consider such factors as how members are solicited; who is entitled to participate; how the association was formed and the purpose

[63] Jost, "Loopholes in the Affordable Care Act..." Supra, p. 63
[64] Rate Increase Disclosure and Review: Definitions of "Individual Market" and "Small Group Market." 76 Fed. Reg. 54,969 (September 6, 2011) (to be codified at 45 C.F.R. pt. 154).
[65] Jost, "Loopholes in the Affordable Care Act…" Supra, pp. 65- 66.
[66] 29 U.S.S. Section 1144(b)(6)(A)(ii); Jost, supra, p. 67.

for which it was formed; the pre-existing relationships of its members, if any; the rights of employer members; and who actually controls the activities and operations of the benefit program.[67]

New York should maintain a vigilant and active position in monitoring how the activities of AHPs and MEWAs might lead to adverse selection against the Exchange. A range of federal and state laws set strict limits on the ability of these organizations to aggregate smaller groups into larger groups in ways that would allow them to escape insurance regulations and engage in risk selection. If these laws are effectively enforced, this risk selection should be minimal. If they are not, there is a potential for AHPs to siphon off the youngest and healthiest individuals and small groups into phony large groups, and leave an older and sicker population in the Exchange and the existing individual and small-group markets.

Professional Employer Organizations (PEOs)

A substantial number of small firms in New York contract out a full range of employee benefits to Professional Employer Organizations (PEOs). These firms offer the small companies a "one check takes care of everything" opportunity that encompasses health benefits, 401ks, disability benefits, risk management, training, and Workers Compensation. This outsourcing of the human resources function is popular among small firms.

PEOs claim to "co-employ" the workers of a firm that contracts with them. But the US Department of Labor has determined that PEOs do not qualify as ERISA plans. DOL determines if PEOs actually employ the workers of the member groups, applying a test related to whether the PEO actually controls and directs the work activities of the members. But PEOs cannot possibly meet this test of controlling workers' assignments and activities, so that if the law is properly applied, they cannot be considered as employee welfare benefit plans, and therefore cannot be ERISA companies exempt from state insurance regulation.

Thus, we believe that PEOs will not succeed in being treated as large employers, particularly if effective oversight is carried out. But it is worth noting that if they were, they would be subject to the requirements facing firms with 50 or more workers to offer health coverage or pay a penalty if at least one worker goes to the Exchange and receives a federal subsidy.

Some of these PEOs offer health coverage—for example, "mini-med plans"—that will not be considered qualified health plans in 2014. Such plans offer front-end insurance that includes good coverage for routine health services such as office visits, screening tests, and lab work, but incorporates a cap on benefits at levels such as $15,000 or $20,000 per year. In a sense, these mini-med policies are the mirror opposite of catastrophic coverage. Since such plans will not meet the requirements for employers to offer and employees to obtain coverage that includes all essential health services as defined under the ACA, these mini-med plans should disappear. But this depends on adequate ACA enforcement.

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[67] US Department of Labor, "Multiple Employer Welfare Arrangements Under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation." (2004) http://www.dol.gov/ebsa/Publications/mewas.html

An important issue is whether the companies that use these PEOs would be allowed to go into the New York Exchange. Since PEOs provide a service that many small firms value, there seems to be no reason why they should not be permitted to make their insurance coverage ACA-compliant and consistent with the rules for Exchange-based coverage. Some issues would need to be worked out, however, regarding who is billed for the Exchange coverage and who makes the payment.

Some PEOs may re-work their health coverage offerings to be qualified plans under the ACA, but others may just continue on as is, and see what happens.

New York should prepare a vigilant and active stance to assure that PEOs do not lead to adverse risk selection against the Exchange. PEOs cannot meet federal government tests of being employers or "co-employers." New York may want to take regulatory action that reinforces federal policy to help assure that PEOs are not allowed to carry small firms into some type of "phantom" large firm that avoids the protections extended to small employers under the ACA and state law.

4. "Employee Choice" Model for Small Firms in the Exchange

Under the ACA, states have a choice as to whether to follow the "employee choice" model for small groups entering the Exchange—so that individual employees can choose any plan offered through the Exchange—or to follow the alternative model under which the small employer chooses one or more plans for its employees.

A compelling case can be made for the employee-choice model. A strong rationale for Exchanges is to create a more consumer-centric experience and to thereby enhance competition among health plans. Exchanges are meant to be competitive marketplaces with full transparency where individuals and small firms can find information that is useful in comparing health plans and easily enroll in a plan that meets their needs, regardless of whether this plan is preferred by their employers.[68] Having a broad and meaningful choice of plans is essential for this vision, supported by a toll-free call center, a website with comparison tools, and a personalized calculator showing enrollees the cost of coverage after government provided financial assistance. When employees can change plans at every open-season enrollment period and they have the information to make valid comparisons of the relative value of plans, health plans are under strong pressure to compete on the basis of cost and quality. Moreover, individual employees are certainly in a better position than their employer to decide which plan best meets their needs and satisfies their preferences. In addition, individual employee choice makes it possible for employees to avoid having to change health plans and likely disrupt provider relationships when they change jobs.

Some might suggest starting with allowing firms to bring their plan with them and only offering that plan to their employees in the first year, with the employee choice model brought in after that. But our concern is that once the employee choice model is put on the back burner, it may never be implemented, and a key feature of the Exchange involving consumer-centered and supported choice could be lost.

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[68]Center for Medicaid & Medicare Services, "Affordable Insurance Exchanges." State Exchange Grantee Meeting, September 19-20, 2011. http://cciio.cms.gov/resources/files/Files2/06_exchanges_nprm.pdf.pdf

We recommend that New York use the Employee Choice model for plan selection in the SHOP Exchange.

5. Minimum Participation Rule

Current law in New York requires that insurers, when signing up small groups in the private market, assure that at least 50% of the employees of the company actually enroll in the plan. In 11 NYCRR 360, Fourth Amendment to Regulation 145, it is stated that "Minimum participation requirements as set forth in section 4235 (c) (1) must continue to be utilized." This 50% minimum participation rate is well below what most US insurers require. In our experience, most insurers have minimum participation rates of 70% to 75%. Thus, this legal requirement, in actual practice, seems unlikely to have much impact on the market. In New York, HMOs are not permitted to apply minimum participation requirement, ensuring some level of access to coverage for all employers and employees.

Federal regulations give Exchanges the option of establishing a uniform minimum employee participation requirement for small firms participating in SHOP Exchanges. These regulations require that the minimum requirement be "uniform" across employers who participate in the SHOP but do not define a certain minimum percentage. The minimum must be based on participation in the SHOP, not on the number of individuals enrolled in any particular plan or insurer. While the rule does not address whether or not an Exchange may vary participation requirements based on the type of health plan issuer (i.e., HMO products vs. non-HMO products), it also does not explicitly prohibit such a requirement. The preamble of the final rule does not provide any additional information on participation requirements.

The purpose of the minimum participation requirement is to reduce the degree of adverse risk selection. For example, if a firm with ten workers was ready to sign up with an insurer, and two of the workers have serious health conditions while the other eight are generally healthy, if only these two enroll, the premium would normally be very high, but under New York's full community rating, the insurer would have to charge the community rated premium rate that was far below the actuarial cost of insuring just those two people. If the insurer got those two plus several of the other eight, there would not be nearly as big a gap between the risk profile of this group and full community rating.

Establishing a minimum participation rate in the small employer (SHOP) portion of the Exchange that New York is designing could help reduce adverse selection. Adverse selection could occur if participation requirements are different between the small-group market and SHOP portion of the New York Exchange. If the Exchange minimum participation rates are lower than in the external small-group market, employers seeking coverage inside the Exchange might have employees who are sicker than those in the external market.

6. Changing the Small-Group Market Definition

The ACA stipulates that the states must define small employers as firms with 100 or fewer employees by 2016. But states have the option to expand the definition of small firms, from up to 50 workers to 100 or fewer workers, prior to 2016 and as early as 2014. Generally speaking, states define the small group market today as either firms with up to 50 employees or in some cases all firms with 50 or fewer employees, including "groups of one" that are typically sole-proprietors. New York can decide how long

to retain the current definition of the small group market, which includes up to 50 employees. At issue is when to make the change to firms with up to 100—in 2014 or in 2016, as permitted by the ACA.

A study by the Urban Institute found that changing the definition of small groups from 100 or fewer workers to 50 or fewer has relatively little impact on the proportion of people covered in New York State. The authors estimated that the lower employer-size limit would reduce the number of people purchasing employer-sponsored coverage through the Exchange, and at the same time, increase the number of people who would obtain coverage outside the Exchange. There is almost no change in other forms of coverage, and the number of people uninsured is unchanged. This is largely because firms with 51-100 employees can generally purchase coverage independently with lower administrative cost than the estimated administrative costs under the Exchange.[69]

An important issue is the extent to which mid-size firms in New York currently self-insure, and whether expanding the small group size to 100 would encourage lower-risk firms to opt for self-insurance. Under ERISA, self-insured groups are exempt from community rating requirements, risk- adjustment, risk-pooling and essential benefit requirements. Smaller groups normally are less likely than larger groups to self-insure due to the financial risks associated with such a decision. However, the 2010 Medical Expenditure Panel Survey (MEPS) data on self-insured groups provides some surprising information for New York. The MEPS data shows that New York is one of only two states that had a higher proportion of small groups that currently self-insure than medium-size groups of 100-999 employees.[70] (The only other state with similar findings is Connecticut, for which the survey notes the reported data does not meet the standard of reliability or precision.)

While the survey does not explain the anomaly in New York, this fact is particularly unexpected given that New York law prohibits insurers from selling stop-loss or reinsurance to groups that are subject to community rating, or small groups.[71] Because of the financial risk associated with self-insuring, many firms – and especially smaller firms – purchase stop loss to provide protection from payouts per case that exceed a certain dollar amount. Because small employers cannot obtain such coverage, the relatively high number of small firms who are self-insured suggests that at least some employers have determined that the risk of self-insuring is a better financial decision than purchasing fully insured coverage from a health plan. This may be especially true for lower-risk groups with relatively low health care expenses in a typical year. While the survey data does not report self-insurance rates for enrollees in groups of 51-100, if the state were to extend the small employer definition to include groups of 51-100 employees in 2014, it is reasonable to assume that healthier mid-size groups would "do the math" to determine if self-insuring is more advantageous. Those groups with healthier, younger members would have the most to gain from self-insurance as their rates for purchasing insurance under

[69] Fredric Blavin, Linda J. Blumberg et al, "How Choices in Exchange Design for States Could Affect Insurance Premiums and Levels of Coverage." *Health Affairs,* February 2012. Pp. 290-298.
[70] See Table II.B .2.b, Percent of private-sector enrollees that are enrolled in self-insured plans at establishments that offer health insurance by firm size and State: United States, 2010, available at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2010/tiib2b1.pdf
[71] New York Insurance Law §3231(h)(1)

community rating would likely increase. Groups with higher risks would have the most to gain by joining the Exchange in order to benefit from lower premiums.

Health plans – particularly those that do not participate in the Exchange – are likely to aggressively compete with Exchange plans for the business of lower-risk groups, and could encourage plans to make decisions that would further enhance the risk of adverse selection against the Exchange. (This assumes that some insurers would be allowed to sell outside the Exchange but not inside, something that we recommend against, as noted earlier). Since groups of more than 50 employees are not subject to the law prohibiting insurers from selling stop-loss coverage to small groups, medium-size firms with healthier work forces may be encouraged by some insurers to self-insure and combine this with the purchase of stop-loss coverage, or reinsurance. If at some point in the future the health status of the group makes self-insurance a more expensive proposition than purchasing full insurance, the employer can simply choose to purchase a fully insured plan through the Exchange, further enhancing the risk of adverse selection.

Ideally, federal rules would provide a solution to regulate self-insured groups in a way that prohibits their ability to game the system by initially choosing to self-insure while later opting to buy insured coverage when it becomes financially advantageous to do so. However, in the absence of federal action, we recommend that **New York should consider prohibiting insurers from selling stop-loss insurance to firms with fewer than 100 workers at the time when the state goes from 50 to 100 employees as the cutoff point for entry of small firms into the Exchange.** Per New York State law, this will be the case when New York expands the definition of small groups to include groups from 1 to 100.

This could help protect the Exchange from this source of adverse risk selection and provide a more level playing field for small and mid-size firms.

In 2017, the ACA permits states to allow all companies of any size to bring their workers into the Exchange. This could greatly expand the reach of the Exchange. The critical issue is what size a firm has to be to safely self-insure. In most cases, the ability to self-insure requires at least 200 employees and perhaps as many as 300, though obviously some small firms in New York feel differently based on the data reported above. But in addition to size of the group, the risk profile is also important. The lower-risk medium-size firms are going to want to continue to self-insure under the current rules, but may change their position if they are unable to obtain stop-loss coverage. The higher-risk firms would likely opt for the Exchange. This might require a separate rating pool for the larger firms.

On balance, it seems that it would be a mistake to increase the pool of eligible Exchange enrollees by expanding the definition of small employers in 2014 before the state gets a chance to gain experience with the more limited base of individuals and smaller companies. The initial administrative and enrollment challenges will be significant during the first year, and anything the state can do to minimize the strain would be a wise business decision. The Exchange could be overwhelmed before it gets its feet on the ground. In 2016, the Exchange will have a better sense of how to avoid risk selection and manage employee choice and health plan performance in this new environment.

We recommend that New York postpone expanding the definition of the small group market from 50 or fewer employees to 100 or fewer employees until 2016. New York has made this decision, as indicated in the Blueprint.

7. Large Employer Groups and the Exchange

Beginning in 2017, the ACA allows states to expand Exchanges to include groups of more than 100 employees. In smaller states, this may be an appealing option since doing so will provide a larger number of participants, which may create a more stable risk pool and provides a wider base for sharing the administrative costs of operating the Exchanges. In a state the size of New York, the Exchange is expected to have a sufficiently large number of enrollees in the individual and small group market to provide a stable risk pool. However, depending on how the state decides to finance the Exchange, the ability to spread operational costs over a larger population may be appealing, and could lower premium costs for enrollees.

Inclusion of large employers, however, creates some challenges given the unique nature of their risk and the differences in how this market traditionally operates compared to that of small groups. First, large employers and self-insured groups (most of which are large employers) are not subject to certain ACA requirements. While all small group and individual plans must comply with essential benefit requirements, only large employer plans purchased through the Exchange must include the benefits. Large employer plans sold outside the Exchange also are not restricted to the precious metal tier requirements. In addition, although large groups generally do not engage in underwriting based on individual member characteristics and generally mimic the community rating required in New York's small group market, only plans purchased through the Exchange are subject to the ACA underwriting restrictions. Unless the state imposed rating restrictions on all large groups similar to those required of Exchange plans, fully-insured large employer plans offered outside the Exchange will have freedom to use whatever rating characteristics they want, which could create opportunities for health plans to use criteria that would steer healthier large groups outside the Exchange and less healthy, riskier groups to the Exchange.

Important differences also exist between the benefits and services small groups offer and those of large groups, many of which the Exchange may not intend to provide. Large groups usually offer multiple health plan choices, such as an HMO or a PPO, while most health plans limit small groups to a single benefit plan in order to avoid adverse selection between plans based on the specific health needs of enrollees. Large employers frequently also provide "add-on" or optional benefits to their employees, such as enhanced vision or dental coverage, life insurance, disability coverage and long term care benefits, often sharing the cost with employees who elect these additional benefits. They also may offer Section 125 options and flexible spending accounts, and often contract with their health plan to administer their COBRA compliance activities.

Employers and enrollees are unlikely to want to give up these options. To attract their business, the Exchange would have to create a process for coordinating the addition of these other benefits for large firms, or both large and small firms if the state decides to offer these options to small groups. While the Exchange would have several years to develop a process for accommodating these additional services

since large groups would not participate until at least 2017, the state would need to begin early to develop a plan for implementing these complex operational requirements,

The biggest concern with accepting large employer groups is the risk of adverse selection associated with the ability to enroll in the Exchange at any time. While this is true of individuals and small employers, the volume of enrollees that large employers could bring to the Exchange increases the ability to impact the health of the risk pool more significantly at any point in time. Large groups that can obtain less expensive premiums in plans outside the Exchange and groups that determine it is more financially beneficial to remain self-insured will do so. Groups most likely to enter the Exchange are those who cannot get favorable rates outside the Exchange and those who find the risk of their enrollees has increased to the point that self-insuring is not financially logical. Large employers are generally much more sophisticated purchasers than are small groups and will use their expertise to determine the most financially beneficial solution for their business, but not necessarily for the Exchange.

Allowing larger firms to participate in the Exchange has advantages and potential disadvantages. We suggest that the state delay a decision regarding the inclusion of large employers until after the Exchange has been operational and instead focus on the immediate issues related to getting the Exchange implemented by 2014. Given that the insurance market will experience dramatic changes in 2014 -2016, we recommend that New York conduct an actuarial impact study to evaluate the impact of extending coverage to large employers under the market conditions that exist at that time.

8. "Under 26" ACA Rule

New York has gone beyond the ACA provision that allows young adult children to remain on their parents' family health plans until they reach the age of 26. The New York law allows adult children between 26 and 29 years of age to use a "COBRA-like" arrangement to buy back into their parents' coverage.

The current dependent coverage law in New York protects young adults from having to go into the individual market, where rates are high for everyone because of full community rating and no mandate. Once the ACA goes into effect, assuming New York retains full community rating and with an individual mandate, rates in the individual market are expected to decline overall. As a result, the need for this provision for 26 to 29 year olds is greatly diminished. Should New York merge the individual and small group markets this provision is likely to become irrelevant.