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DEPARTMENT *of*
FINANCIAL SERVICES

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Governor

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March 1, 2018

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Dear Leaders of the New York State Legislature,

Re: Study on Impact of Stop-Loss Insurance to Health Coverage for Small Groups

Pursuant to Chapter 12 of the Laws of 2016 §17, the Department of Financial Services (DFS) was tasked to contract with an independent entity to conduct a review and draft a report assessing the impact of:

- (a) prohibiting the sale of stop loss coverage to the expanded small group market (groups sized 51 to 100); and (b) allowing the sale of the stop loss coverage to groups that have between 51 and 100 employees or members and are exempt from paragraph 1 of subsection (h) of section 3231 of the insurance law of paragraph 1 of subsection (e) of section 4317 of the insurance law.

DFS contracted with Milliman, Inc. to prepare the Report, which is attached.

In compiling this Report, Milliman relied upon data and information from various sources, including from DFS. Because DFS does not have legal authority over self-insured plans and federal reporting is not mandatory for small employers, Milliman had limited New York State-specific data for self-insured employers with 51-100 employees. As a result, the data in the Report do not capture the universe of all employers with 1-100 employees. Likewise, strong conclusions could not be drawn from the very limited NY State-specific data collected for self-insured employers with 51-100 employees. Moreover, Milliman has not audited or verified the data and information collected other than reviewing it for general reasonableness.

Background

As originally enacted, the Affordable Care Act (ACA) required small group size to increase from 1-50 to 1-100 for coverage issued or renewed on or after January 1, 2016. New York's conforming legislation required the same change in group size on the same date. New York law further prohibits the sale of stop-loss insurance to small groups (Insurance Law §§ 4317(e)(1) and 3231(h)). In October 2015, the ACA was amended to rescind the increase in small group size, though New York did not rescind its law, and small group size was increased to 100 in January 2016. Around the same time, New York passed a law that grandfathered the ability of groups 51-100 to keep existing stop loss coverage, but prohibits the sale of such coverage to new groups.

Stop-loss insurance protects self-insured employers by covering all or part of certain catastrophic claims exceeding pre-determined levels. A significant difference between stop-loss and conventional employee benefit insurance is that stop-loss insures only the employer. Stop-loss does not insure employees (health plan participants). Stop-loss comes in two forms: *specific and aggregate*. **Specific Stop-Loss** is the form of excess risk coverage that provides protection for the employer against a high claim on any one individual. This is protection against abnormal severity of a single claim rather than abnormal frequency of claims in total. Specific stop-loss is also known as individual stop-loss. **Aggregate Stop-Loss** provides a ceiling on the dollar amount of eligible expenses that an employer would pay, in total, during a contract period. The carrier reimburses the employer after the end of the contract period for aggregate claims. Generally, all but the largest employers who self-insure would seek to protect their plan with both specific and aggregate stop-loss coverage.

The increase in small group size from 1-50 to 1-100 seeks in part to lower health insurance premium rates for a majority of small businesses. Premium rates are determined significantly by the relative health of the members insured. Larger groups tend to be somewhat more healthy. By increasing group size and attracting more healthy lives, rates for the majority of the smaller group will tend to decrease. In addition to lowering rates, larger risk pools are typically more stable. This allows employers to plan better for businesses expenses.

Key Findings. With the data limitations set forth in the Report, the Report makes the following findings:

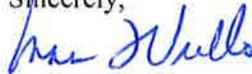
- **Grandfathering Puts Upward Pressure on Small Group Premiums.** Grandfathered stop loss coverage for employers with 51-100 employees causes upward pressure on small group comprehensive health insurance market premiums.
- **The Vast Majority of Employers Will See Rates Increase by Allowing Stop Loss.** Revising New York law to allow stop loss to non-grandfathered employers with 51-100 employees would increase premiums for the small group comprehensive health insurance market.
 - Specifically, allowing employers with 51-100 employees to purchase stop loss coverage and, hence, self-insure would increase premiums by up to 0.8% for 99.7% (146,520 small groups) of employers with 1-100 employees who remain in the small group comprehensive health insurance market.
- **A Tiny Minority of Employers Could Save Substantial Costs.** Some employers with 51-100 employees in the small group comprehensive health insurance could lower health insurance costs with self-insurance and stop loss coverage. But these lowered costs come at a substantial price to consumers, including: fewer required benefits, no required coverage of certain essential health benefits including contraception and mammography without cost sharing, and no network adequacy protections.

- Allowing employers with 51-100 employees to purchase stop loss coverage and, hence, self-insure would reduce healthcare costs by up to 30% for up to 0.3% (480 small groups) of employers.
- **Few Small Groups Will Self-Insure.** Based on Milliman's assumptions of take up given advantageous price points, a minority of employers with 51-100 employees, if allowed, would select self-insurance with stop loss. Up to 20% of employers with 51-100 employees may select self-insurance with stop loss. Of those, approximately half (10%) had grandfathered stop loss coverage in 2016.
- **Self-Insurance Provides Fewer Consumer Protections.** The insured employee or dependent of a self-insured program has substantially fewer consumer protections. Self-insured plans are federally regulated with standards set forth by the Employee Retirement Income Security Act of 1974 (ERISA), and thus not subject to DFS supervision. Fully insured plans are subject to the oversight of DFS.
- **Erosions to the Small Group Comprehensive Health Insurance Market Are Cumulative.** When added to other adverse impacts, allowing stop loss coverage for employers with 51-100 employees could have a significant cumulative adverse impact. This potential change, therefore, should be considered in conjunction with other recent and proposed changes. For example, the increasing number of professional employer organizations (PEOs) have pulled healthy employees out of the commercial small group insurance market, thereby increasing premiums. And continued federal proposals to undermine the ACA, including the recent proposed rule regarding association health plans, could further increase costs for most small businesses.

In sum, as the Report describes, allowing stop loss coverage for groups with 51-100 employees threatens to increase rates for the vast majority of small groups in the regulated commercial market and would contribute to the cumulative challenges to New York's small businesses, the engines of economic growth. The savings for a tiny minority of small groups is offset in part by the loss of valuable New York consumer protections to those groups that self-insure, including guaranteed benefits, network adequacy standards, and appeal rights. Larger risk pools are more stable and fair, with fewer rate winners and losers, and provide for a more stable commercial health insurance market with consumer protections that are not available in the self-insured market.

Accordingly, DFS recommends that stop loss coverage not be allowed in the small group market, including grandfathered plans.

Sincerely,



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Superintendent of Financial Services.



New York State Small Group Stop Loss Study

February 27, 2018

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New York State Department of Financial Services

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GLOSSARY

Term	Definition
ACA	Affordable Care Act
ASO	Administrative Services Only
AV	Actuarial Value
CCIO	Center for Consumer Information & Insurance Oversight
CDHP	Consumer Directed Health Plan
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPA	Certified Public Accountant
CPD	Claim Probability Distribution
CRR-NY	The State of New York Codes, Rules and Regulations
DFS	New York State Department of Financial Services
DoH	New York State Department of Health
DOL	U.S. Department of Labor
EBRI	Employee Benefit Research Institute
EHB	Essential Health Benefit
ERISA	Employee Retirement Income Security Act of 1974
FI	Fully Insured
Fully Insured	Describes an employer-sponsored health insurance plan where the employer pays premium to an insurer and the insurer assumes risk
FTE	Full Time Equivalent
GAAP	Generally Accepted Accounting Principles
GAAS	Generally Accepted Auditing Standards
GINA	Genetic Information Nondiscrimination Act
HCG	Health Cost Guidelines™
HHS	U.S. Department of Health and Human Services
HIOS	Health Insurance Oversight System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HRET	Health Research and Educational Trust
HAS	Health Savings Account
HRA	Health Reimbursement Account
IBNR	Incurred But Not Reported
IDR	Independent Dispute Resolution
Insurance company	A health insurance company or an HMO, also known as an “insurer”
Insurance plan	A specific plan offered by an insurance company
IQPA	Independent Qualified Public Accountant
LG	Large Group
Member	An insured person, including dependents of employees
MEPS	Medicare Expenditure Panel Survey

Term	Definition
MHPA	Mental Health Parity Act
MHPAEA	Mental Health Parity and Addiction Equity Act
MLR	Medical Loss Ratio
NAIC	National Association of Insurance Commissioners
NMHPA	Newborn Mothers Health Protection Act
OOP	Out-of-Pocket
PEPM	Per Employee Per Month
Plan	A description of the health insurance benefits and other contractual terms; insured plans are pre-approved by DFS; self-insured plans may be unique to the employer
PMPM	Per Member Per Month
Policy	A health insurance contract between an insurer and an employer
RFP	Request for Proposal
SAP	Statutory Accounting Principles
SG	Small Group
SHOP	Small Business Health Options Program
Small group comprehensive health insurance market	The New York State market for employer-sponsored fully insured health plans for employers with 1-100 employees
SI	Self-Insured
Self-insured	Describes an employer-sponsored health insurance plan whereby the employer, rather than an insurer, assumes risk
Subscriber	An insured individual with a primary relationship with the employer (typically an employee)
TPA	Third-Party Administrator
URRT	Uniform Rate Review Template
WHCRA	Women's Health and Cancer Rights Act

INTRODUCTION

Under a 2016 law, the New York State Department of Financial Services (DFS) is required to contract with an independent entity to conduct a review and draft a report assessing the impact on the New York commercial health insurance market of allowing employers with 51-100 employees to purchase stop loss coverage and self-insure their employee health care benefits. The DFS is required to consider the issue from the perspective of: (1) employers with 51-100 employees, (2) all employers with 1-100 employees participating in the small group comprehensive health insurance market, and (3) consumers (available consumer protections and wellness benefits under fully insured and self-insured health insurance options). [1]

Caveats and Limitations

This report relies upon data from NY State insurers, NY State rate filings and statutory annual and quarterly statement filings, reinsurer and employer surveys, and other sources. Because the DFS does not have authority over self-insured plans and federal reporting is not mandatory for small employers, we had very limited NY State-specific data for self-insured employers with 51-100 employees. As a result, these data do not capture the universe of all employers with 1-100 employees. In addition, strong conclusions could not be drawn from the very limited NY State-specific data collected for self-insured employers with 51-100 employees. Readers should review the entire report, including the Caveats and Limitations section below.

CHAPTER 1: BACKGROUND

INTRODUCTION

New York Insurance Law prohibits the sale of stop loss coverage to groups that are subject to community rating rules, which, prior to 2016, included small employers with 1-50 employees. [2] Effective with renewals beginning on January 1, 2016, New York expanded the definition of “small group” from employers with 1-50 employees to include employers with 51-100 employees (known as the small group market expansion). Once the small group market expanded, the prohibition of the sale of stop loss coverage extended to employers with 51-100 employees. [3] However, self-funded groups with 51-100 employees with existing stop loss could continue to renew their stop loss coverage (grandfathered stop loss), but could no longer purchase new stop loss coverage. [1]

Because stop loss coverage, in specific and/or aggregate form, is a near necessity for self-insured groups with 51-100 employees, employers who do not have grandfathered stop loss must purchase coverage on NY State’s small group comprehensive health insurance market, not offer insurance and potentially be subject to penalties,¹ or otherwise take the risk of self-insuring without stop loss coverage. Under the employer mandate provision of the Affordable Care Act (ACA), employers with 50 or more employees may be penalized² if they do not offer insured or self-insured employee health insurance coverage that meets minimum essential coverage³ with minimum value and affordability standards.⁴ [4], [5]

Under Chapter 12 of the Laws of 2016 § 7 the DFS was required to contract with an independent entity to conduct a review and draft a report assessing the impact of (a) prohibiting the sale of stop loss coverage for employers with 51-100 employees, and (b) allowing the sale of stop loss coverage to groups with 51-100 employees or members and that are exempt from paragraph 1 of subsection (h) of section 3231 of the New York Insurance Law or paragraph 1 of subsection (e) of section 4317 of the New York Insurance Law. [1]

Key components of the requested review include the following:

- Assess the impact of prohibiting or allowing the sale of stop loss on the ability of employers with 51-100 employees to provide health insurance coverage, including a comparison of the financial costs to employers between purchasing a fully insured product versus self-insuring with stop loss coverage.
- Assess the impact on premiums within the small group comprehensive health insurance market from allowing employers with 51-100 employees to self-insure with stop loss.
- Assess the impact on employers with 51-100 employees who have grandfathered stop loss of prohibiting or continuing to allow the sale of stop loss, including a comparison of the financial costs to employers between purchasing a fully insured product versus self-insuring

¹ A penalty may occur if at least one employee receives premium tax credits on the state Exchange.

² The penalties, or shared responsibility provisions, may not be applicable to all employers with 50+ employees if they do not meet the criteria of applicable large employers (ALEs) in a particular calendar year or if certain employers were subject to transitional relief policies when such relief was available. [103]

³ “Minimum essential coverage” refers to plans that cover comprehensive medical services and excludes plans that supplement health coverage, like vision or dental care, workers’ compensation, coverage for specific diseases only, or plans that only pay discounts on medical services.

⁴ Minimum value refers to the percentage of total costs paid for by the plan and must be above 60%; affordability refers to the amount an employee pays for health insurance as a percentage of the person’s income, and may not exceed 9.69%.

with stop loss coverage; separately assess the impact of these employers' absence from the fully insured market to the extent that stop loss coverage continues to be made available to this group.

- Survey and describe features, including wellness benefits, available to employers between the fully insured and self-insured markets.
- Compare consumer protections in the fully insured and self-insured markets.

To obtain data for the review and report, the DFS conducted a data call requesting information from health insurers and stop loss carriers. Self-insured information from other (non-health insurance company) third-party administrators (TPAs) was not collected, as these entities are not known and are not under the jurisdiction of the DFS. The data requested and received from insurers included high-level enrollment and claims data underlying the small group comprehensive health insurance market, which allowed for an analysis of the small group employer market in NY State, including the number of small employers offering health insurance, subscribers, and members, as well as demographic information and incurred claims experience.

OVERVIEW OF SELF-INSURANCE

Generally speaking, most employers can opt to self-insure or purchase from an insurer a fully insured policy to cover the medical costs of its employees. A self-insured employer may charge its employees a premium, pay some or all of the employees' medical costs themselves, and usually contract with a TPA for administrative services, including claims adjudication and payment. Most, particularly smaller employers, reduce their self-insurance risk by purchasing stop loss coverage. [6] Stop loss coverage reduces an entity's financial risk by insuring an employer's costs above a specified amount (e.g., for large or catastrophic claims). That is, once a member's paid claims reach a certain amount (which are covered by the employer), the stop loss insurer takes on the financial risk, instead of the employer, to pay for the remainder of the claims up to any coverage limits specified in the stop loss policy. Stop loss coverage may be specific (capping the employer-paid costs of each member individually) and/or aggregate (capping the employer-paid cost of all members in total). The cost of the self-insured plan is specific to the demographics and/or health status of the employees covered under the employer group; that is, if the employees are younger and/or generally healthier, the cost will be lower, if the employees are older and/or less healthy, the cost will be higher.

On the other hand, a fully insured policy is purchased from an insurer. Fully insured small group policies in New York are community-rated. Under New York and federal small group community rating laws, the cost of coverage is spread across all of the small groups covered by the insurer. Employers within that community-rated pool pay the same amount per employee as other employers covered by the insurer in the same geography, regardless of the age, gender, or health status of the employer's employees.

Self-insuring may be more or less expensive than purchasing a community-rated health insurance policy. For employer groups with employees that are disproportionately younger, male,⁵ and/or generally healthier, a self-insured employer health plan with stop loss may offer financial advantages

⁵ Men do not have maternity costs and men, separate from maternity, on average have lower costs than women when young. Younger people, on average, have lower costs than older people. The community rating of the small group pool, which prohibits age and gender rating, does not take these differences into account.

compared to fully insured, community-rated small group insurance where the employer pays the same amount per employee as other employers in the same geography, regardless of the age, gender, or health status of the employer's employees. On the other hand, other employers with an older and/or less healthy demographic of employees may find it more financially advantageous to purchase a fully insured community-rated policy.

Also, because a self-insured employer does not need to buy a predefined insurance plan and because self-insurance is regulated under the Employee Retirement Income Security Act of 1974 (ERISA) rather than state insurance law, self-insurance also provides employer groups more latitude for custom benefit and network design, including the design of wellness programs. [7], [8] However, consumer protections are more limited to employees in self-insured plans (as discussed in more detail below in Chapter 4: Consumer Protections in Fully Insured and Self-Insured Markets).

The often cited financial advantages of self-insurance include: [8]

- Exemption from state premium tax and other insurance taxes (though the cost of stop loss coverage reduces or eliminates the impact of state premium tax and other insurance fees).
- No subsidy of groups with less favorable risk profiles, given that claims costs are pooled across the small group comprehensive health insurance market while self-insured plans are only at risk for the costs incurred by their own employees.
- Exemption from covering or providing state-mandated benefits in the health insurance policy, which may be costly.
- Choice to offer different benefits than required in the fully insured market (e.g., removing or varying from certain ACA Essential Health Benefits).
- Potential for lower administrative costs because self-insured employers can avoid incurring costs like marketing or commission expenses, which are typically incurred by insurers.
- No need to pay risk and profit charges to an insurance company (TPAs and stop loss carriers, however, build risk and profit into their charges for self-insurance).

Furthermore, level-funding⁶ arrangements offered by stop loss carriers can deploy a combination of specific and aggregate stop loss coverage to create cost predictability similar to full insurance with the possibility of receiving a refund from the surplus in the employer's claims fund. [9] The financial advantages of self-insurance for a given year, however, come with increased risk, even when accompanied with stop loss and a level-funding arrangement as the employer, rather than an insurance company, has the ultimate financial responsibility for the self-insured plan's costs. [10]

While stop loss and level-funding can protect a self-insured employer from higher than anticipated costs in a given year, they do not protect the employer from (sometimes dramatic) year-to-year cost increases and contract disruptions that may negate the financial advantage that self-insurance offered the employer the previous year. For small groups, stop loss and the potential lack thereof, is often the most volatile component of the self-funded employer's costs. Stop loss carriers can underwrite and experience rate, as permitted by law, to minimize the risk of writing new or renewal

⁶ Under level-funding arrangements, employers pay a set monthly amount for employees' healthcare benefits, comprising expected claims, administrative fees, and stop loss fees. These "premiums" remain level for the entire year, which provides employers with similar predictive monthly costs as those available through a fully insured plan.

contracts that will result in a loss. In today's healthcare world, where even "ordinary" treatment of some chronic diseases can cost \$50,000 or more a year, a younger, male, and generally healthy small group is often the emergence of one chronic disease away from being an unhealthy group.

Small employers are particularly vulnerable to the financial impact of employees and dependents with high-cost conditions as they lack a large number of employees over which to "spread" the costs. For example: for an employer group with 50 employees, a \$500,000 claim (the potential cost of a premature baby) costs \$10,000 per employee ($\$500,000/50$) while for an employer group with 5,000 employees, the cost is only \$100 per employee ($\$500,000/5,000$). Young healthy employees, male and female, have accidents, develop costly chronic conditions, and have children who are born prematurely or otherwise have costly needs, and marry spouses with costly needs. While wellness programs may reduce the risk of an emergent high-cost case, neither youth nor wellness programs can eliminate the risk.

There is a risk that employers with disproportionately younger, male, and/or generally healthier employees will self-insure as long as "their luck holds," move to a fully insured pool when facing multiyear high costs, and move back to self-insurance when the high costs end.⁷ The likelihood of such cycling, however, is diminished by the administrative burden and accompanying costs of setting up a self-insured plan. On the other hand, there is also a risk that an employer with disproportionately younger, male, and/or generally healthier employees that has to "pay extra" to offer its employees a health insurance plan (either fully insured or self-insured) will decide to potentially pay ACA penalties instead, and the employer's employees and dependents will not have access to employer-sponsored insurance under either scenario.

If employers with disproportionately younger, male, and/or generally healthier employees either self-insure with stop loss or choose not to provide access to employer-sponsored insurance, it may lead to an increase in premiums on the small group fully insured market, where employers with an older and/or less healthy demographic of employees remain.

OVERVIEW OF NEW YORK'S SMALL GROUP COMPREHENSIVE HEALTH INSURANCE MARKET

Prior to the enactment of the ACA, the small group comprehensive health insurance market in New York State (NY State) was defined by New York Insurance Law as groups covering classes of employees with between 1 and 50 employees. New York Insurance Law prohibited issuers from setting small group premium rates based on the employees' health status, age, gender, tobacco use, or industry. [11] As such, small groups in NY State were purely community-rated as well as being subject to several state-mandated and make-available benefit requirements. Post-ACA, NY State continued with community rating for small groups and various new insurance market reforms were introduced in the New York small group comprehensive health insurance market, including establishing the Small Business Health Options Program (SHOP), requiring minimum essential health benefits and coverage, medical loss ratio requirements, and premium rating restrictions along with

⁷ While high costs may persist for several years, they are seldom permanent. Employees and dependents enter and leave the group, and people recover from some high-cost conditions.

several risk mitigation programs intended to stabilize premiums and protect against the effects of adverse selection in the small group comprehensive health insurance market, among other changes.

While NY State has had ACA-related challenges similar to other state health insurance markets, it has had a vibrant and competitive small group comprehensive health insurance market, with several new issuers that have entered the market, providing health insurance benefits to about 1.2 million members based on data collected from insurer annual and quarterly statutory statement filings. Table 1 summarizes average monthly members by year in the small group comprehensive health insurance market.

Table 1: Average Monthly Members in NY State's Small Group Comprehensive Health Insurance Market, by Year

Health Insurance Company	2014	2015	2016
Aetna Health Inc.	14,425	4,755	11
Aetna Life Insurance Company	93,178	115,848	108,243
Capital District Physicians' Health Plan	10,433	6,967	2,968
CareConnect Insurance Company, Inc.	1,018	9,574	61,599
CDPHP Universal Benefits Inc.	82,318	73,412	53,602
Crystal Run Health Insurance Company, Inc.	0	267	1,828
Crystal Run Health Plan, LLC	0	0	1,225
Empire HealthChoice Assurance, Inc.	3,823	1,756	14,795
Empire HealthChoice HMO, Inc.	15,455	5,856	5,229
Excellus Health Plan, Inc	196,961	181,051	195,457
Health Insurance Plan of Greater New York	19,508	16,437	16,294
Health Republic Insurance of New York	43,012	95,037	0
Healthfirst Health Plan, Inc.	35	17	18
HealthNow New York Incorporated	49,037	50,763	75,610
Independent Health Association	1,556	893	1,184
Independent Health Benefits Corporation	43,754	34,702	40,339
MetroPlus Health Plan, Inc.	0	0	0
MVP Health Plan, Inc.	4,544	3,230	3,168
MVP Health Services Corp.	22,326	38,492	57,091
Oxford Health Insurance, Inc.	395,589	339,706	460,757
Oxford Health Plans (NY), Inc.	159,643	100,732	79,389
UnitedHealthcare Insurance Company of New York, Inc.	2,337	2,610	6,951
Total*	1,158,952	1,082,104	1,185,757

Source: Pg. 32 of annual statutory statement filing, except for Health Republic in 2015, which was estimated from its second quarter 2015 quarterly statutory statement filing and news articles.

* Average members from annual and quarterly statutory statement filings differ somewhat from average members estimated from data collected from insurers in this study.

In April 2015, New York Insurance Law was amended in response to the ACA and changed the definition of small employer from an employer with 1-50 employees to one with 1-100 employees for all groups issued or renewed on or after January 1, 2016. [3] Small group enrollment grew during 2016, consistent with the small group expansion. Because employers with 51-100 employees entered the small group comprehensive health insurance market over the course of 2016 (as groups renewed from their large group coverage), one can presume that they contributed to the growth of the small group comprehensive health insurance market over the course of the year and that 2016 ended with more than the 1.2 million average members that it had during the year. During 2016, insurance companies within the small group comprehensive health insurance market absorbed both enrollment for employers with 51-100 employees and the transfer of members from Health Republic, a health insurance company that ceased doing business in New York at the end of 2015.

Table 2 summarizes the number of available plan configurations on the NY State small group comprehensive health insurance market as well as premium rate increases over the last several years.

Table 2: Plans, Projected Members, and Rate Increases in NY State Small Group Comprehensive Health Insurance Market, by Year

Rate Filing Year	2013	2014	2015	2016	2017
Plan Year	2014	2015	2016	2017	2018
Number of Plan Configurations	1,891	2,618	3,751	4,029	5,314
Projected Average Monthly Members	903,094	1,052,720	1,259,968	1,158,010	1,139,571
Premium Per Subscriber Increase*	-	6.9%	9.8%	8.3%	9.3%

Source: Milliman summary of Uniform Rate Review Template (URRT) Public Use File Data, 2013-2017.

* Based on final and approved small group premium rate increases by DFS, accessed from DFS press releases.

The number of plan configurations have increased, and the average rate increases have remained relatively stable in the small group comprehensive health insurance market, ranging from 7% to 10% annually.

Based on 2017 small group comprehensive health insurance market rate filings for the 2018 plan year, 20 insurance companies plan to offer more than 5,000 small group plan configurations and enroll about 1.15 million members. Health insurance companies are clearly engaged in the NY State small group comprehensive health insurance market.

CHAPTER 2: IMPACT OF ALLOWING THE SALE OF STOP LOSS ON EMPLOYERS WITH 51-100 EMPLOYEES

Conclusions

- **A small number of employers with 51-100 employees in the small group comprehensive health insurance could lower health insurance costs with self-insurance and stop loss coverage.** A relatively diminutive number (approximately 0.3%) of employers with 51-100 employees—who are disproportionately younger, more male, and/or healthier—could have up to 30% in lower healthcare costs if they self-insure with stop loss coverage.
- **A minority of employers with 51-100 employees, if allowed, will select self-insurance with stop loss.** Up to 20% of employers with 51-100 employees may select self-insurance with stop loss. Of those, approximately half (10%) had grandfathered stop loss coverage in 2016.
- **The lower cost to these few employers will come at the expense of higher costs for the vast majority of small employers.** A large number (approximately 97.7%) of small employers will see their rates increase by up to 0.8% if stop loss is allowed for employers with 51-100 employees, as discussed in more detail below in Chapter 3: Impact of Allowing the Sale of Stop Loss on Employers participating in the Small Group Comprehensive Health Insurance Market.

Self-insurance with stop loss may or may not be financially advantageous to certain employers with 51-100 employees when compared to full insurance depending on the demographics and/or health status of the employer's employees and other factors. The self-insured employer has the ability to structure a unique benefit and network design and does not need to limit itself to designs complying with NY State insurance requirements in the small group comprehensive health insurance market. Self-insurance with stop loss, however, requires the employer to assume additional responsibilities and risks.

The remainder of this chapter will discuss the impact of prohibiting or allowing the sale of stop loss on the ability of employers sized 51-100 to provide health insurance coverage, including a comparison of the financial costs to employers between purchasing a fully insured product versus self-insuring with stop loss coverage.

TOTAL COST OF INSURANCE

We compared the costs of self-insurance and full insurance using healthcare claims and enrollment data collected from NY State health insurance companies (see Methodology in Appendix C) by DFS, for fully insured and self-insured groups (wherever the self-insured employer's TPA was also a NY State health insurance company) with contracts filed and/or delivered in NY State, and who had 1-100 employees for calendar years 2015 and 2016. We did not collect any self-insured data from other

(non-health insurance company) TPAs as these entities are neither known nor under the jurisdiction of the DFS. The self-insured data collected from insurance companies was very limited in scope (fewer than 10 employers for each year, from which strong conclusions could not be drawn), either by virtue of the fact that very few employers of this size self-insure or because the data points were unavailable to us. As such, these data do not capture the universe of all employers with 1-100 employees due to limitations in data collection or due to some employers of this size choosing not to offer health coverage to their employees.

The 2016 calendar year fully insured data was used to estimate the expected costs (in the form of “premium equivalent rates”) to employers sized 51-100 that choose to self-insure if they are allowed to purchase stop loss coverage, as well as any potential savings relative to staying fully insured. The costs, as defined for purposes of this analysis, consider only medical and pharmacy claims costs as well as accompanying administrative costs (e.g., TPA fees and cost of stop loss insurance), but exclude the costs associated with managing a self-insured plan (e.g., hiring FTEs to manage the plan). These management costs likely vary substantially from one employer to another, depending on how functions are delegated among existing staff, the need to hire additional professionals, and the use of consultants for employers who either fully insure or self-insure and are difficult to quantify for any employer, given the limitations in obtaining data for such costs. As such, these management costs were excluded from our financial savings estimates in this report.

The 2016 calendar year claims experience is used as a proxy to estimate the impact to small employers in future years, though we recognize that the actual impact to small employers will vary from these estimates.

As previously discussed, NY State expanded the small group comprehensive health insurance market as of January 1, 2016. That is, employers with 51-100 employees previously defined as large group under New York Insurance Law were defined as small group beginning with 2016 renewals, to the extent that these employers renewed into the fully insured market in 2016.

Table 3 provides a summary of groups who were fully insured in calendar year 2016 based on the data collected for the study. Given that some groups may have had renewals later in the year, they may still have technically been defined as large group under New York Insurance Law. For purposes of this analysis, we assume that these fully insured large groups were eligible to be enrolled in the small group comprehensive health insurance market and would do so upon renewal, though we recognize that it is possible that such groups may have dropped coverage altogether or transitioned into the large group market, to the extent that the new FTE counting definition as of 2016 qualified them for a large group 101+ employee plan (see Appendix B for more information related to the small group expansion).

Table 3: 2016 NY State Small Group Comprehensive Health Insurance Market, per Data Collected from Insurance Companies*

Number of Employees	1-50	51-100	Total 1-100
Number of Groups	144,659	2,430	147,089
Average Monthly Members**	1,169,000	234,000	1,402,000
Average Subscriber Age	46.6	43.9	46.2

Source: Data requested by DFS.

* Certain data exclusions were made (see Methodology in Appendix C).

** Average monthly members for employers with 51-100 employees vary from the average members reported for this employer segment in Table 5 below, given that those amounts are reported for a specific point in time (i.e., December 2016) while Table 3 reports average monthly members over the course of calendar year 2016.

The 2016 summary indicates that the majority of employer groups with 1-100 employees (98.3%) are classified as having 1-50 employees, with only a very small minority (1.7%) of this market representing employer groups with 51-100 employees.

In order to model the costs to employers with 51-100 employees of self-insuring with stop loss coverage, we stratified the 51-100 employer market into percentiles according to employee demographics (i.e., age and gender), because this information is most visible to the employer as a cost determinant⁸ (e.g., employers generally do not have visibility to, or the ability to accurately predict, the medical claims costs of their employees but do have a good sense of the age and gender of their employees). We ranked the groups with 51-100 employees into percentiles using Milliman Health Cost Guidelines™ (HCG) age/gender factors, based on subscriber “census” data only (see Methodology in Appendix C).

As discussed above in Chapter 1: Background: Overview of Self-Insurance, employer groups that are younger or predominantly male likely exhibit lower claims costs and may find it financially advantageous to self-insure. Of course, employers of this size may use considerations other than economic to determine whether self-insurance is the best option for them. Such considerations are discussed later in this chapter and elsewhere in the report (e.g., additional employer responsibilities and risks and available consumer protections), but are not modeled as decision points for purposes of this analysis.

Table 3 above indicates that the average subscriber age in the 1-50 employee market is approximately 47 and the average subscriber age in the 51-100 employee market is 44. However, there is substantial variation in the average subscriber age of groups within the 51-100 employer market, where it ranged anywhere from 34 to 54 in 2016. As such, it is reasonable to assume that certain employer groups in the 51-100 employer market may find it more financially advantageous to self-insure while others will find it more financially advantageous to fully insure.

In order to estimate the average savings to certain employer groups with 51-100 employees that have more “favorable” demographics for self-insuring with stop loss, we compared the medical and pharmacy costs and accompanying estimated premium rates for these groups to the estimated average premium rates that can be obtained in the small group comprehensive health insurance market, where the experience for all groups in the small group comprehensive health insurance market is pooled. As discussed above in Chapter 1: Background: Overview of Self-Insurance, self-insured plans are not subject to state-mandated benefits, pooling of risk, or state premium tax and other insurance fees; conversely, fully insured plans are subject to these elements. Stop loss fees associated with specific stop loss coverage as well as TPA fees were incorporated into the development of the self-insured premium equivalent rates and the estimated savings provided below.

⁸ Given the known correlation between age/gender and healthcare costs.

The estimated average premiums were developed with these adjustments in mind for employers in self-insured and fully insured plans, respectively.

We made several adjustments to the data in order to normalize and compare the resulting average premiums on a consistent basis (see Methodology) across NY State rating regions, benefits, and coverage levels. Given that ACA's risk adjustment program is zero-sum across the entire NY State small group comprehensive health insurance market, we did not model risk transfers across insurance companies.

Table 4 summarizes the estimated average savings of certain percentiles of employers with 51-100 employees in self-insuring at two common stop loss attachment points typically selected by groups of this size.⁹ These results assume that the remaining groups not self-insuring move to the small group comprehensive health insurance market.

Table 4: 2016 Estimated Average Premium Savings Percentages for Self-Insured Employers with 51-100 Employees Relative to New York's Small Group Comprehensive Health Insurance Market

Percentage Transitioning to Self-Insured Plan*	Stop Loss Attachment Points	
	\$25,000	\$40,000
0% - 10%	-29%	-31%
10% - 20%	-23%	-25%
20% - 30%	-14%	-16%
30% - 40%	-13%	-16%
40% - 50%	+7%	+4%

Source: Milliman analysis.

* Percentiles are in ascending order of employer groups with employees from the most to the least favorable demographics (e.g., 0%-10% represents employer groups with employees having the top 10% most favorable demographics in our data, 10%-20% represents the next rung of employer groups with employees reflecting favorable demographics, though not as favorable as the top 10% in our data, etc.).

The estimated average premium savings percentages from self-insuring with stop loss range from about 10% to 30% in our analysis, depending on the demographics of the employer self-insuring and the stop loss attachment point. These savings may be offset by expenses to the employer associated with managing the self-insured plan, which were not quantified in this report due to limitations in obtaining such data.

Higher savings are observed for employer groups with more favorable demographics (i.e., the "healthiest" 10% of employers) and those purchasing a stop loss policy with a higher attachment point, because the stop loss premium associated with a higher attachment point is lower (but, alternatively, the employer assumes more risk). These results are directionally consistent with what would be expected from groups with more favorable demographics though it is likely that the actual magnitude of savings will vary for each employer who chooses to self-insure, and in any given year. In addition, as previously discussed, even employers with favorable demographics may experience high administrative costs and, as such, the savings exhibited may be much lower or unavailable.

⁹ Common stop loss attachment points were identified via the survey of stop loss carriers in New York (see Appendix D for more information on survey results).

The estimated average premium savings percentages summarized above vary by percentile cohort transitioning (i.e., those employers with the most to least favorable demographics). That is, while the average savings estimate associated with moving the top 10% of employer groups with the most “favorable” demographics is approximately 30%, the savings estimate for groups stratified in the 30th and 40th percentiles are lower (these groups have less favorable demographics than the top 10%), approximately 13% to 16%, given that groups between the 30th and 40th percentile have a higher average subscriber age and higher claims cost experience in the data. Again, these savings would likely be offset by additional costs incurred by the employer to manage the self-insured plan and were not quantified in this report.

In our analysis, the “break-even” point where it is no longer financially advantageous for groups to self-insure is for groups with average demographics beyond the 40th percentile. That is, the demographics and subsequent claims costs associated with groups above the 40th percentile are more consistent with those in the small group comprehensive health insurance market. These employers (i.e., those above the 40th percentile) will find it financially advantageous to purchase a fully insured policy on the small group comprehensive health insurance market, rather than incurring higher costs by self-insuring, estimated to be approximately 4% to 7%.

However, it should be noted that employers do not typically have such explicit visibility into their existing or projected claims costs. Nor do employees’ costs consistently correlate with their demographics.¹⁰ The additional risks, responsibilities, and plan administrative costs associated with managing a self-insured plan may deter certain employers from self-insuring. As such, while the break-even point in our analysis is indicative of 40% of the youngest 51-100 employer groups finding self-insurance financially advantageous, in reality the proportion of employers who choose to self-insure will likely be much lower and will vary from our estimates.

Assuming NY State continues to have a robust small group comprehensive health insurance market, if it allows the sale of stop loss to employers with 51-100 employees, we anticipate that less than 20% (or 0.3% of the employer small group market¹¹) would elect self-insurance, even if there are apparent financial advantages to more than 20% of employers. This estimate is consistent with statistics obtained from publicly available information on the percentage of groups of this size that typically self-insure (discussed in more detail below in Chapter 3: Impact of Allowing the Sale of Stop Loss on Employers participating in the Small Group Comprehensive Health Insurance Market). We estimate that the employers electing self-insurance would save up to 30% compared to the premiums that they would pay for insurance on the small group comprehensive health insurance market.

We repeated this analysis using the 2015 calendar year data and arrived at similar results to those summarized above.

EMPLOYER OPTIONS

Given that employer-sponsored self-insured coverage is exempt from state law, employers are able to tailor their networks and benefits more relative to fully insured employers. The stop loss carriers

¹⁰ Young males may exhibit high costs as age and gender are not perfect determinants or predictors of claims costs.

¹¹ $0.3\% = 20\% \times 1.7\%$

that we surveyed most often selected “no essential health benefits requirement” as the most important reason that employers have chosen to continue with grandfathered self-insurance. Employers may also want to tailor benefits in order to lower total costs by other methods (such as narrower networks), meet specific employer or employee health needs, or comply with moral convictions.

EMPLOYER RESPONSIBILITIES AND RISKS FOR SELF-INSURANCE AND STOP LOSS

The self-insured employer group with stop loss coverage has more responsibilities and faces considerably more risk, within a single year and between years, than a fully insured employer group.

ERISA sets standards of conduct for those who manage an employee benefit plan and its assets—called fiduciaries. Self-insured employers retain considerably more ERISA fiduciary responsibilities than fully insured employers, including compliance with all applicable federal,¹² operational, and reporting requirements for the management of their health plans and the risks of not fulfilling the responsibilities. The retained fiduciary responsibilities are extensive and it is up to the employer to figure them out. [12] A breach of fiduciary duty can lead to personal liability. [13]

When employer groups are fully insured, they are released from many fiduciary duties and the risk of not performing those duties. In addition, much of the financial risk of an employee health plan is shifted to the insurance company and other employers within the small group comprehensive health insurance market.

An employer’s fully insured small group premium rates and rate increases are pooled across all small group health plans offered by an insurance company. While a given health plan may no longer be offered or a given insurance company may exit the small group pool, employers have guaranteed access to all health plans and insurance companies participating in the small group comprehensive health insurance market. In contrast, the NY State employer¹³ who self-insures with stop loss assumes considerably more financial risks than an employer offering a fully insured plan:

Risk of claims cost variation. Self-insured employers can use specific and aggregate stop loss insurance to reduce or even nearly eliminate the risk of claims cost variation within a year, but it comes with a price. Because the price for eliminating all claims cost variation risk may negate the savings from self-insurance, most employers retain some claims cost variation risk. Because risk offers the potential for savings, it is sometimes embraced by employers. According to our survey of stop loss carriers (see Appendix D), “employer wants to take risk” is one of the top reasons why employers choose to self-insure.

Risk of large stop loss premium increases. If an employee or dependent has a condition (or an injury) that will produce a stop loss claim in future years or that puts

¹² ERISA generally preempts state law and regulation. There are, however, occasionally state laws and regulations that indirectly impact ERISA plans. [94]

¹³ This section is specific to NY State employers. NY State classifies stop loss coverage as accident and health insurance and applies the laws and regulations applicable to accident and health insurance. [21] Classification and applicable laws and regulation for stop loss vary by state. [8] The U.S. Department of Labor is of the opinion that state laws and regulation for stop loss issuers are not preempted by ERISA. [102]

the employee or dependent at high risk of having stop loss claims in future years, the stop loss carrier will make an effort to cover the cost and risk via a premium increase.

Risk of changes to terms of stop loss contract. To the extent allowed by law, regulation, and their contracts with employers, stop loss carriers may change other (non-premium) contractual terms at renewal.

Risk of stop loss non-renewal. Though NY State regulates stop loss coverage as accident and health insurance [14], stop loss policies are not guaranteed renewable similar to other comprehensive health coverage in NY State. As such, employers are at risk of losing their stop loss coverage in any given year.

Risk of stop loss carrier exiting the market. A stop loss carrier may choose not to renew existing policies and exit the NY State market. In such a situation, there is no guarantee that the employer will be able to obtain alternative stop loss coverage or that there will not be coverage gaps between the old and new coverage.

Risk of stop loss limitations to certain employees. It is not clear whether stop loss carriers in New York can refuse to provide coverage to certain employees or dependents or apply higher thresholds to those individuals based on the individuals' medical conditions—an action known as “lasering.” New York Insurance Law and regulation does not prevent stop loss carriers from doing so, but carriers may have difficulty complying with HIPAA rules that prohibit discrimination by medical condition that apply because NY State classifies stop loss as health insurance. [15]

Risk of coverage gaps. Stop loss policies define the “run-out” (aka terminal liability) and “run-in” periods for healthcare claims that they will cover, where “run” refers to the time period from the healthcare service to the time the claim is submitted for payment or paid. The employer is fully responsible for claims outside the run-in and run-out periods. This is of particular concern when an employer changes stop loss carriers as the run-out terms of the prior carrier may not align with the run-in terms of the new carrier. [10] Options to mitigate this risk are generally available to the employer, although the employer must be aware of the risk to consider those options.

Risk of stop loss rescission. Stop loss carriers underwrite stop loss coverage. The employer applies for coverage, submits information related to the group's risk, and the stop loss carrier decides whether to issue coverage and what the premiums will be. If the employer omits or misrepresents adverse risk information, the stop loss carrier may be able to retroactively rescind coverage for the group or specific individuals after the issue date of the stop loss coverage. The employer will then be financially responsible for costs the employer thought the stop loss carrier would pay. The adverse information may also prevent the employer from obtaining replacement stop loss coverage from another stop loss carrier.

IMPACT ON DECISION TO OFFER ANY INSURANCE

Nationwide there is no evidence that implementation of the ACA has had a negative impact on the percentage of employers with 51-100 employees offering health insurance. Reversing a long trend, the 2017 Employee Benefit Research Institute (EBRI) headline reads “Some Small Employers Added Health Coverage in 2016.” [16] Likewise, the Kaiser Family Foundation (KFF) and Health Research and Educational Trust (HRET) find that the percentage of firms with 50-99 employees offering insurance (including self-insurance) was stable in the 52%-55% range from 2013 to 2016. [6] Both studies rely upon survey data to reach their conclusions as there currently is no mandatory reporting of small employer health insurance analogous to the Form 5500 that employers with more than 100 employees must file with the Department of Labor. [17]

The question for this report, however, is specifically whether prohibiting sale of stop loss coverage for employers with 51-100 employees negatively impacts the percentage of employers with 51-100 employees offering health insurance. Most states did not expand the small group market [18] and while several have various restrictions related to stop loss coverage, only New York prohibits the sale of (new) stop loss coverage. [19] Therefore we must use NY State-specific data. While we did not find strong evidence that the move from large group to the small group comprehensive health insurance market, after expansion, caused employers with 51-100 employees to discontinue offering insurance, we did find that a sizeable minority of employers with 51-100 employees chose to continue with self-insurance and grandfathered stop loss (see Chapter 3: Impact of Allowing the Sale of Stop Loss on Employers participating in the Small Group Comprehensive Health Insurance Market below). It is possible that a portion of this minority, if not allowed to continue stop loss coverage, may instead decide to discontinue offering insurance. If half of NY State employers with stop loss discontinue offering insurance rather than move to full insurance, approximately 0.06% (1 in 1,600)¹⁴ of currently insured New Yorkers will no longer have access to employer-sponsored health insurance.

Keeping such employers insured, via self-insurance, however, may contribute to higher premiums within the small group comprehensive health insurance market, which may cause certain small employers to drop coverage altogether. We do not have data to estimate how many employers did or may drop health insurance coverage due to the availability of stop loss.

¹⁴ About 1.2% of the New York population (approximately 250,000 of 20,000,000) obtain their insurance via NY State employers with 51-100 employees. If approximately 10% of them are self-insured and half of the self-insured discontinue offering insurance, then 0.06% of currently insured New Yorkers will no longer have access to employer-sponsored health insurance.,

CHAPTER 3: IMPACT OF ALLOWING THE SALE OF STOP LOSS ON EMPLOYERS PARTICIPATING IN THE SMALL GROUP COMPREHENSIVE HEALTH INSURANCE MARKET

Conclusions

- **Grandfathered stop loss coverage for employers with 51-100 employees causes upward pressure on small group comprehensive health insurance market premiums.** In 2016 about 10% of employers with 51-100 employees had self-insured plans with grandfathered stop loss coverage. If these employers have employees who are disproportionately younger, more male, and/or healthier, they may save in healthcare costs, relative to the premiums available in the small group comprehensive health insurance market, based on proxy estimates in this report. Their absence from the small group comprehensive health insurance market contributes to an increase in premiums of up to 0.4%, based on proxy estimates in this report.
- **Revising New York Insurance Law to allow stop loss to non-grandfathered employers with 51-100 employees could increase premiums for the small group comprehensive health insurance market.** If additional employers with 51-100 employees are allowed to self-insure with stop loss (e.g., those with disproportionately younger, more male, and healthier employees and dependents), 90% or more of employers with 51-100 employees who remain in the small group comprehensive health insurance market and employers with 1-50 employees will experience a small increase in premiums (approximately 0.4%). Likewise, the employers in the small group comprehensive health insurance market will benefit if the grandfathered employers that are currently self-insured with stop loss are prohibited from continuing to purchase stop loss and, as a result, join the small group comprehensive health insurance market.
- **Erosions to the small group comprehensive health insurance market are cumulative.** While allowing stop loss coverage for employers with 51-100 employees would have a modest adverse impact on the market, several other seemingly modest changes could have a significant cumulative adverse impact. This potential change, therefore, should be considered in conjunction with other recent and proposed changes.

MARKET SHIFT: 2015 TO 2016

There is no evidence that a large number of employers with 51-100 employees, who were insured in the large group market in 2015, dropped insurance coverage in 2016 rather than join the small group comprehensive health insurance market after its expansion.

We collected claims and enrollment data from NY State health insurance companies (see Methodology in Appendix C), for fully insured and self-insured groups with 51-100 employees for

2015 and 2016. Based on the data, there is no evidence of a large number of groups with 51-100 employees exiting the health insurance market before or at their 2016 renewals, when they were required to enter the small group comprehensive health insurance market after its expansion. There is, however, a small decline in the number of groups with 51-100 employees. There is also a decline in the average subscribers (employees with insurance) per group, indicating that some groups, particularly the larger groups, did not enter the small group comprehensive health insurance market after its expansion.

This does not necessarily imply that these employers chose to forgo health insurance. Prior to 2016, group size was based on the number of employees eligible to participate in the health insurance plan. The post-2016 definition is the total number of full-time equivalent employees. [20] It is possible that, due to changing definitions of group size, groups with approximately 100 employees that had been classified as 51-100 lives in 2015 were reclassified as 101+ in 2016, and remained in the large group health insurance market. It is not possible, however, to confirm a reclassification from the data that was collected.

Table 5: New York Employers with 51-100 Employees, per Data Collected from NY State Insurance Companies

Insurance Status	December 2015	December 2016
Fully Insured		
Number of Groups	2,572	2,428
Number of Subscribers	134,115	122,449
Number of Members	249,000	227,082
Average Number Subscribers/Grp	52	50
Self-Insured*		
Number of Employers	7	7
Number of Subscribers	578	629
Number of Members	1,295	1,319
Average Number Subscribers/Grp	83	90

Source: Data collected from NY State health insurance companies.

* When the NY State health insurance company is the administrator for the self-insured plan.

GRANDFATHERED STOP LOSS: 2016 AND 2017

Employers with 51-100 employees who were self-insured with stop loss coverage in 2015 were allowed to continue their stop loss coverage into 2016 and 2017. As shown above we obtained data for fewer than 10 self-insured plans being administered by NY State health insurance companies for 2015 and 2016, from which strong conclusions could not be drawn. Self-insured plans, however, can be administered by noninsurance companies, over which DFS has no knowledge or authority. As such, we are unaware of how many such groups use noninsurance companies as their TPAs.

DFS does, however, have knowledge and authority for stop loss carriers. [21] Milliman surveyed NY State licensed stop loss carriers and asked them how many grandfathered stop loss policies they had in force in mid-2017 for employers with 51-100 employees. About half of these carriers reported no

such policies. Eighteen carriers reported a total of 285 groups—10.5% of the December 2016 total fully insured and self-insured groups.¹⁵

The 10.5% figure is somewhat lower than national estimates of the prevalence of self-insured plans for groups of this size, which is expected given that only grandfathered policies remain in force in NY State. The KFF and HRET 2016 survey found that 13% of covered employees working at firms with 3-199 employees were self-insured. [6] EBRI, using Medicare Expenditure Panel Survey (MEPS) data, found that in 2013 13% of firms with 25-99 employees offering health plans were self-insured. [22]

Our report estimates that these employers, who are self-insured with grandfathered stop loss coverage, may be saving up to 30% in healthcare costs based on proxy estimates in this report, to the extent that they represent employers who have employees with the most favorable demographics, relative to the small group comprehensive health insurance market. Actual savings likely vary by employer and are offset by expenses associated with managing a self-insured plan. Such expenses could not be quantified in this study.

FINANCIAL IMPACT ON THE SMALL GROUP COMPREHENSIVE HEALTH INSURANCE MARKET

Chapter 2: Impact of Allowing the Sale of Stop Loss on Employers with 51-100 Employees above summarized the data requested by DFS and collected by Milliman, and indicated that, for calendar year 2016, only 1.7% of the 1-100 employer market represented employers with 51-100 employees; 14% on an average member month basis. However, only a small portion of these groups will likely move to self-insured coverage. As such, it is reasonable to assume the conclusions reached in our study. That is, allowing the sale of stop loss to employers with 51-100 employees will have a modest impact (less than 1% per our estimate) on the premiums in the small group comprehensive health insurance market, given the size of the 51-100 employer market and given that only a portion of employers with 51-100 employees will actually self-insure.

We followed the same exercise as described in Chapter 2: Impact of Allowing the Sale of Stop Loss on Employers with 51-100 Employees above that was used to estimate the impact of allowing certain small groups to self-insure. Instead of modeling the impact to self-insured employers, we instead modeled the impact that the self-insured plans leaving would have on the premiums in the small group comprehensive health insurance market in New York (i.e., impact of adverse selection). Table 6 summarizes our findings:

¹⁵ 10.5% = 285 / (285 + 2,428).

Table 6: 2016 Estimated Average Premium Impact Percentage to New York’s Small Group Comprehensive Health Insurance Market

Percentage Transitioning to Self-Insured Plan^	Impact to Small Group Comprehensive Health Insurance Premiums	51-100 Employers Transitioning to Self-Insured Plan as % of Small Group Fully Insured Market (using member months)
10%	0.4%	1.5%
20%	0.8%	3.0%
30%	1.0%	4.6%
40%	1.2%	6.2%
50%	1.2%	8.0%
60%	1.1%	9.8%

Source: Milliman Analysis.

* Percentiles are in ascending order of employer groups with employees with the most to least favorable demographics (e.g., 0%-10% represents employer groups with employees having the top 10% most favorable demographics in our data, 10%-20% represents the next rung of employer groups with employees reflecting favorable demographics, though not as favorable as the top 10% in our data, etc.).

If 20% of the most favorable employer groups with 51-100 employees transition to a self-insured plan, the small group comprehensive health insurance market will be modestly impacted by the change (less than 1% impact on premiums). Approximately half of this impact is already reflected in the premiums in the small group comprehensive health insurance market due to grandfathering of stop loss coverage. That is, employers with 51-100 employees who are currently self-insured with grandfathered stop loss coverage and represent 10% of the 51-100 employer market contribute to at most a 0.5% increase in premiums in the small group comprehensive health insurance market, based on proxy estimates in this report.

It should be noted that, given the variation in demographics of employers with 51-100 employees, not all employers with 51-100 employees have “favorable” demographics and would find self-insurance financially advantageous. As previously discussed, certain groups in this cohort may actually find it financially advantageous to fully insure (i.e., their costs under a self-insured plan exceed those in a fully insured plan), as evidenced by the reduction in impact to the small group comprehensive health insurance market premiums in Table 6 above, between the 50th and 60th percentile transition points.

We repeated this analysis using the 2015 calendar year data and arrived at similar results to those summarized above.

SELF-INSURANCE UPTAKE

Employers opting for self-insurance assume considerable financial, regulatory, and administrative responsibilities and risks. The responsibilities and risks can be overwhelming for small employers who have neither the staff with appropriate experience, nor the budget for an outside consultant. As a result, a minority of small employers choose self-insurance.

An analysis of Form 5500 Annual Return/Report of Employee Benefit Plans filed with the Department of Labor found that, in 2014, 29% of U.S. health insurance plans with 100-199 participants were

mixed-funded¹⁶ or self-insured, compared with 90% of plans with 5,000+ participants. [23] Because not all employees participate in employer health insurance plans, 100 participants typically corresponds to a group with considerably more than 100 total employees. The same report notes a trend toward full insurance among relatively small plans and toward mixed funding or self-insurance among relatively large plans.

MEPS estimates that in 2016 19.8% of NY State establishments with fewer than 100 employees offered at least one self-insured plan, compared with 68% of establishments with 500 or more employees. MEPS counts employees by location (establishment). An establishment with fewer than 100 employees is often part of a much larger employer. We therefore assume that employers with fewer than 100 employees across all locations have self-insurance rates substantially less than 19%. [24]

Nationally, the KFF/HRET survey of employer-sponsored health benefits finds that in 2016 13% of firms with 3-199 employees were self-insured. This is down from 17% in 2015, which may represent a trend or simply the instability inherent in surveys, as evidenced by a dip in 2011 that did not persist. In 2016 the KFF/HRET survey (for the first time) asked fully insured firms with 3-199 employees if they planned to self-insure because of any provisions of ACA. Only 1% said yes, 94% said no, and 6% did not know.

Table 7: Percentage of U.S. Covered Workers in Self-Insured Plans, by Year

Year	Firms With 3-199 Workers	
	Firms Surveyed	Percentage of Workers
2009	no data	15%
2010	no data	16%
2011	no data	13%
2012	724	15%
2013	782	16%
2014	778	15%
2015	746	17%
2016	725	13%

Source: KFF/HRET surveys 2012-2016.

Self-insured groups with fewer than 100 participants are not regulated by states and are not required to file Form 5500 with the Department of Labor. [23] There is, therefore, no direct way of knowing exactly how many self-insured groups with fewer than 100 employees there are in New York or nationally. The above surveys indicate, however, that nationally a minority of employers with fewer than 100 employees self-insure and that there has not been the post-ACA “surge” in self-insurance or desire to self-insure that was predicted by some.¹⁷ [7]

¹⁶ In mixed-funding plans a portion of the health insurance coverage is self-insured.

¹⁷ Not everyone predicted a surge in self-insurance. A RAND paper, for example, did not. [90]

IMPACT SUMMARY

While self-insurance has financial advantages for some employers with 51-100 employees, there are substantial reasons why self-insurance, even when it costs less than full insurance, is not an appealing option for many employers. First, establishing and managing a self-insurance plan requires expertise from in-house professionals or outside consultants [11] and is typically an expensive proposition. Second, even the experts cannot fully mitigate the additional financial risk that accompanies self-insurance—and most small employers are ill-equipped to absorb the risk. In contrast, full insurance is easy and transfers risk to an insurance company.

Furthermore, some features of the small group comprehensive health insurance market are not new to employers with 51-100 employees, particularly those who were previously fully insured. These employers were historically on the “small end” of the large group market and, as such, health plans typically offered them limited benefit design options and partially pooled their costs via pooled rates and credibility factors within the rating formula. Lastly, NY State has long had premium taxes and rich mandated benefits.

Assuming NY State continues to have a robust small group comprehensive health insurance market, if NY State allows stop loss for employers with 51-100 employees, we anticipate that less than 20% would elect self-insurance (or 0.3% of the employer small group market), even if there are apparent financial advantages to more than 20% of employers. Our estimate is consistent with statistics obtained from publicly available information on the percentage of groups of this size that typically self-insure. If 20% of employers with 51-100 employees that have the most favorable demographics (e.g., disproportionately younger, more male, and healthier) leave the small group comprehensive health insurance market to self-insure with stop loss coverage, it will result in an increase in average premiums for 99.7% of employers in the small group comprehensive health insurance market of about 0.8%, approximately half of which is already reflected in the premiums in the small group comprehensive health insurance market due to grandfathering of stop loss coverage, based on proxy estimates in this report.

The adverse impact on the small group comprehensive market of allowing stop loss coverage should be considered in conjunction with other recent and proposed changes impacting the small group market, a review of which is beyond the scope of this paper.

CHAPTER 4: CONSUMER PROTECTIONS IN FULLY INSURED AND SELF-INSURED MARKETS

Conclusions:

- **Self-insurance provides fewer consumer protections.** Insured employees or dependents in a self-insured program have substantially fewer consumer protections than those insured via the small group comprehensive health insurance market. Self-insured plans are federally regulated with standards set forth by ERISA. Fully insured plans are subject to the oversight of the DFS.

While self-insuring with stop loss offers some advantages (e.g., financial), the advantages are accompanied by fewer consumer protections.

We have thus far discussed the advantages and disadvantages of full insurance and self-insurance from the perspective of employers. This section is from the perspective of the insured employee or dependent—the healthcare consumer.

CONSUMER PROTECTIONS OVERVIEW

Employer-sponsored health insurance, with a few exceptions (e.g., government or church plans), is regulated by federal law (primarily but not exclusively the U.S. Department of Labor [DOL]), with standards set forth by ERISA, regardless of whether the healthcare benefits funding mechanism is insurance or self-insurance. [25] ERISA dictates standards for how the plan is established and administered for purposes of reporting and disclosure, and defines fiduciary duties in order to protect health plan participants' rights in employer-sponsored plans. [26]

ERISA includes a preemption provision from state laws so that employers are not subject to multiple and/or conflicting laws in each state, among other potential reasons, given that employers may cover employees across multiple states, and to ensure consistency in how employer-sponsored plans are administered. However, because the regulation of insurance is left to the states, the preemption provision includes a "savings" clause that allows states to indirectly regulate ERISA plans provided through insurance companies. [27] Furthermore, the "deemer" clause under ERISA cannot deem an employer that provides an employer-sponsored health plan to be an insurance company. [28] As such, employer-sponsored plans that are self-insured are not subject to state insurance regulation, while employer-sponsored plans that are fully insured are subject to state laws. Employer-sponsored plans that are fully insured, while regulated by states, are also subject to certain federal laws and regulations. The passage of the ACA, which amended ERISA, has strengthened certain consumer protections in the self-insured market. [29]

The importance of these distinctions leads into the discussion of consumer protections provided under the small group comprehensive health insurance products and consumer protections provided under self-insured benefit plans in New York, and the differences thereof.

Consumer protections that are either embedded in health insurance contracts or otherwise required by law or regulation are important features in insurance plans. Health insurance consumer protections include disclosure of information with respect to the health plan benefits, network, and care management practices, choice of healthcare providers, marketing practices, nondiscrimination practices, fairness in rate setting, processes for complaints and appeals, incorporation of mandated and essential health benefits, and assurance of the financial soundness of the health plan. Governing bodies play an important role in instituting, regulating, and enforcing the laws and regulations that provide these protections. However, consumer protections vary widely depending on how the employer-sponsored plan is funded and, subsequently, regulated (i.e., fully insured vs. self-insured).

A number of federal laws have amended ERISA over the years and established certain standards related to consumer protections for employer-sponsored health plans, including the following:[30]

- Affordable Care Act (ACA)
- Mental Health Parity Act (MHPA) and Mental Health Parity and Addiction Equity Act (MHPAEA)
- Health Insurance Portability and Accountability Act (HIPAA)
- Consolidated Omnibus Budget Reconciliation Act (COBRA)
- Newborns and Mothers Health Protection Act (NMHPA)
- Women's Health and Cancer Rights Act (WHCRA)

The ACA is federal legislation, with general applicability to both fully insured and self-insured plans. Some specific provisions of the ACA, however, do not apply to the self-insured plans.[28]

The next subsections of this report compare consumer protections between self-insured and fully insured small group plans in New York as they relate to access to insurance, required benefits, limits on cost sharing, network adequacy, patient appeal rights, consumer review or rates, examinations, audits, oversight, and solvency.

ACCESS TO INSURANCE

All health plans that offer dependent coverage, including grandfathered plans, must offer coverage to dependent children until age 26. [31] New York Insurance Law also requires that insurers make available a rider or extend coverage to dependent or young adult children until age 29. [32]

HIPAA, applicable to all health plans, provides additional protections to consumers in the way of access: portability options to consumers upon loss of insurance coverage, prohibitions on discrimination based on health factors and medical history, restricting preexisting condition limitations, and guaranteeing renewability. [33] HIPAA applies to coverage offered in both the fully insured and self-insured markets. When it was enacted, HIPAA defined a list of certain benefits that are deemed excepted under the law (i.e., do not have to comply with requirements of HIPAA). These benefits include those that are not health-related, limited-scope benefits like dental and vision, or specific disease or illness products. [34] The excepted benefits definition was also extended to the ACA and, as a result, these excepted benefits are generally exempt from the ACA's insurance market reforms, including limitations on cost sharing, such as out-of-pocket limitations.

Another federal law that impacts all group health plans, including self-insured plans, is COBRA, which requires that temporary continuation of health coverage be provided when the coverage is lost in certain circumstances and that it must be identical in scope to coverage offered to “similarly situated beneficiaries.” [35]

REQUIRED BENEFITS

As self-insured plans are exempt from state law, they are also exempt from state-mandated benefits. However, state-mandated benefits must be offered by insurance companies in New York’s small group comprehensive health insurance products. Appendix A summarizes the state-mandated benefits in New York, which all fully insured plans are subject to, including small groups.

Self-insured plans are also exempt from the Essential Health Benefit (EHB) requirements that the ACA imposes upon fully insured plans. Fully insured plans must offer the 10 EHBs, including hospitalization, ambulatory, maternity and newborn, emergency, mental health and substance abuse, prescription drug, rehabilitative and habilitative, laboratory, preventive and wellness, and pediatric (dental and vision) services.

NMHPA sets minimum standards for the length of time a mother and newborn are covered in the hospital after childbirth. [36] This federal law states that the minimum covered hospital stay may not be under 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. This law applies to all group health plans, including fully insured and self-insured. However, it does not mandate coverage for maternity services by all group health plans, only that minimum length of time be covered in the hospital in connection with childbirth. As such, self-insured plans in New York may exclude coverage for maternity care while small group comprehensive health insurance products are required to offer this benefit due to state mandates.

WHCRA provides certain protections for individuals who choose to have breast reconstruction after a mastectomy. [37] This federal law provides for coverage of breast reconstruction surgery, prostheses, and treatment of any physical complications resulting from mastectomy. This law applies to all group health plans, including fully insured and self-insured. However, it does not mandate coverage for mastectomy by all group health plans, only that certain benefits be provided under the federal law in connection with a mastectomy. As such, self-insured plans in New York may exclude coverage for mastectomies while small group comprehensive health insurance products are required to offer this benefit due to state mandates.

The Mental Health Parity and Addiction Equity Act (MHPAEA), which applies to group health plans, including self-insured plans, requires employer-sponsored plans that offer mental health and substance abuse benefits to provide cost sharing that is no more restrictive than that applied to medical and surgical benefits. [38] However, it does not mandate coverage for mental health or substance abuse services by all group health plans, only that the cost sharing be no more restrictive than that applied to medical and surgical benefits for these services. As such, self-insured plans in New York may exclude coverage for mental health and substance abuse services while small group comprehensive health insurance products are required to offer this benefit due to state mandates.

While self-insured plans in New York do not have to cover state-mandated benefits and EHBs, most employers providing health insurance coverage to their employees typically offer comprehensive

benefit packages due to business reasons including retention, fewer sick days or paid leave, and employee productivity. [39] Based on available research of employer-sponsored plans, most self-insured plans still cover largely the same categories of benefits with similar actuarial values as fully insured plans [39] [40], but will be more inclined to exclude coverage for benefit mandates employers have a moral objection to or otherwise choose not to cover, such as bariatric surgery, infertility treatment, or autism. [41]

LIMITS ON COST SHARING

The ACA limits cost sharing for group health plans, including self-insured plans. [42] The following provisions relate to cost-sharing limitations for non-grandfathered¹⁸ group health plans:

- Prohibition on annual and lifetime limits
- No cost sharing for preventive services
- Limits on out-of-pocket (OOP) spending for EHBs
- Limits on cost sharing for out-of-network emergency services (i.e., may not exceed cost-sharing requirements for in-network emergency services, excluding balance billing)

NETWORK ADEQUACY

Network adequacy refers to the ability of a health plan to provide its members with appropriate and timely care, and access to a sufficient number of geographically accessible in-network providers to deliver the benefits covered under the policy. [43] In the absence of an adequate network, consumers may need to obtain care from less qualified providers (such as a primary care physician when a specialist is required), seek care at other sites of service in their networks (such as a hospital's emergency department when urgent care is not available), wait for care, seek out-of-network care, or forgo care entirely. Out-of-network care is generally subject to higher cost sharing and sometimes is not covered.

The ACA established minimum standards for qualified health plans (QHPs) offering coverage on the marketplaces to ensure that issuers have a provider network that is "sufficient in number and types of providers," that "services are accessible without unreasonable delay," that access to provider directories are provided, and that the network includes essential community providers. [44]

While New York had network adequacy standards that predated the ACA requirements for health maintenance organizations (HMOs), it strengthened those requirements after the enactment of the ACA for all commercial insurance products, including small group comprehensive health insurance products. Network adequacy standards are currently regulated by two state agencies in New York: the DFS and the Department of Health (DoH). These agencies have outlined network adequacy standards that have certain requirements related to service area definitions, network compositions (e.g., primary care and specialists, facilities, home health, durable medical equipment), time and distance requirements, and requirements for behavioral health providers, among others. [45]

¹⁸ Grandfathered health plans, both fully insured and self-insured, are plans that have existed without major changes to their provisions since March 2010. They are not subject to some provisions of the ACA. [100]

While these network adequacy standards apply to insurance companies offering products in the state of New York, including small group comprehensive health insurance products, these same standards do not apply to self-insured employers, given ERISA exemptions from state insurance law.

One exception, however, is related to the MHPAEA. This is a federal law that applies to both fully insured and self-insured plans and requires that if mental health and substance abuse benefits are offered, the plan may not impose restrictions related to the facility type, provider, or geographic location that are more restrictive than those available for medical or surgical benefits. [45] An additional exception is for self-insured plans that offer plan designs using reference-based pricing, where providers are paid a fixed amount for certain procedures as “paid in full.” A CMS FAQ issued in October 2014 indicated that a plan offering this type of design would not fail to comply with maximum OOP restrictions as long as the plan “uses a reasonable method to ensure that it offers adequate access to quality providers.” [46] However, as previously noted, self-insured plans are exempt from the ACA’s specific network adequacy requirements and this is the first and only instance indicating that self-insured plans need to offer “adequate networks.”

Because out-of-network fees are not negotiated in advance with a payer, they are often high. In March 2015 New York passed the Out-of-Network Emergency Services and Surprise Bills law, which protects certain consumers from services performed by nonparticipating providers at in-network facilities or when participating providers refer a patient to a nonparticipating provider without the patient’s knowledge as to their potential liability, as well as for emergency services (i.e., patients are “held harmless” from additional nonparticipating provider charges that exceed in-network cost-sharing requirements for these services). This law applies predominantly to members enrolled in commercially insured products (including small group comprehensive health insurance plans) and, as such, would not apply to employees covered under self-insured plans. However, employees in self-insured plans are eligible for independent dispute resolution (IDR) under the new law if they believe that the bills received by the nonparticipating provider for these services are excessive. [47]

While we were unable to find definitive research on actual network adequacy in self-insured plans, employees enrolled in self-insured employer-sponsored plans do have far fewer consumer protections related to network adequacy that are formalized into law or regulation. As such, these consumers may be more vulnerable than those enrolled in fully insured plans as it relates to network adequacy, particularly if self-insured plans are free to implement cost-containment measures using more limited networks.

PATIENT APPEAL RIGHTS

Patient appeal rights are critical consumer protections giving consumers the ability to appeal certain health insurance decisions (e.g., disapproving care, denying claims, or ending coverage). Similar to network adequacy standards, NY State has required insurance companies to comply with patient appeal regulations prior to the enactment of ACA (in the form of grievance and utilization review procedures [48]), with standards regulated by two agencies, DFS and DoH. Post-ACA, certain requirements related to patient appeal rights were strengthened under New York law. [49] More notably, however, the ACA strengthened patient appeal rights for employees enrolled in self-insured plans, who previously had fewer recourse options under their employer-sponsored plans.

In general, patient appeal rights under the ACA include one or two levels of internal appeals (to the plan) and external appeals (to an independent objective external party) for adverse benefit determinations, including denial of coverage, service, or termination of benefits. [29]

While the patient appeal rights available to consumers in self-insured and fully insured plans have converged post-ACA, with both offering internal and external appeals, there are remaining differences: [50]

- Permitted grievances. Grievances (relating to insurance issues other than adverse benefit determinations) are available in the New York fully insured market, but not in the self-insured market.
- External appeal adjudicating organization. External appeals in the fully insured market are heard through independent review organizations (IROs) that are contracted through the DFS. IROs in self-insured plans contract directly with the health plan, which may offer less independence to self-insured employees.
- Permitted external appeals. External appeals for fully insured plans in New York are permitted for certain plan decisions (denials due to absence of medical necessity, experimental treatments, or OON services for HMO patients) while external appeals for self-insured plans are permitted for plan decisions that involve medical judgement or rescissions.
- Timing. Fully insured plans in New York have a more limited time window to file for external appeal, with the four-month window beginning after the decision from the first internal appeal. Self-insured plans allow the same four-month window for external appeals after exhausting all internal appeal options. As such, employees in fully insured plans are more likely to miss the window for filing external appeals.

CONSUMER REVIEW OF RATES DURING THE PRIOR APPROVAL PROCESS

NY State enacted prior approval laws in 2010 (Chapter 107 of the Laws of 2010) that require the DFS to review insurance companies' proposed rate increases, including its historical claims experience, projected trends, financial condition, and other items, to approve, adjust, or deny its filed premium rates prior to their becoming effective, if the superintendent finds the rates to be unreasonable, excessive, inadequate, or unfairly discriminatory. [51] This law applies to fully insured products, including individual, small group, community-rated large group, and Medicare Supplement. The law also requires insurance companies to notify policyholders of impending premium adjustments and allows for an opportunity to submit comments. [52] This prior approval process assures that the rates charged are based upon reasonable assumptions, while preserving the financial solvency of the insurance company.

Because New York is considered to have an effective rate review program for purposes of the Center for Consumer Information and Insurance Oversight (CCIIO), [53] NY State has authority to review all rate adjustments for ACA products (both individual and small group).

Rate review is not available or required for consumers enrolled in self-insured employer-sponsored plans through any federal laws, as ERISA does not set forth standards to ensure the adequacy of an employer's funding commitment. [26] In general, employees in self-insured plans rely on plan fiduciaries or trustees to manage a plan and its assets prudently. [54] A fiduciary is defined as any

individual or entity who exercises discretion or control over the plan. There are, however, no substantive qualifications required of fiduciaries. [26] Fiduciaries have standards of conduct that must be met and their responsibilities include to: [55]

- Act solely in the interest of plan participants and their beneficiaries and with the exclusive purpose of providing benefits to them
- Carry out their duties prudently
- Follow plan documents, unless inconsistent with ERISA
- Hold plan assets in a trust
- Pay only reasonable plan expenses

If fiduciaries violate these standards of conduct, they may be personally liable to restore losses or profits of the plan. [56] However, the personal liability may be limited in scope and may not include punitive damages to participants. [26]

Given these responsibilities, it is likely that fiduciaries review premium rates and expected budgets in self-insured plans, as well as performing a review of the employee contribution rates, and other fees that go into the rate-setting process. However there are no specific standards set forth in how those reviews must or should be conducted, other than the general responsibilities associated with acting as a fiduciary.

EXAMINATIONS

DFS is required, by New York's Consolidated Insurance Laws Sections 309-312, and Section 4409 of the New York Public Health Law, to conduct examinations into the affairs of all domestic insurance companies and HMOs authorized to conduct business in the state of New York at least once every three to five years. [57] New York examines insurers' financial conditions and market conduct practices.

In general, market conduct examinations are focused on ensuring compliance with "fair treatment of policyholders" in areas of marketing, complaints, operations, utilization review, prompt pay, providing ACA benefits, rate and form filings, and policyholder services. Financial examinations monitor and review an entity's financial condition and future solvency risks, evaluate its risk and management activities in several categories, including pricing/underwriting, reserving, operational, strategic, legal, reputational, and other categories. [59], [60]

Such insurance company examinations may identify deficiencies where the entity is out of compliance with certain laws, rules, or regulations and the Superintendent of Financial Services may make recommendations or requests that the entity take certain actions to address and rectify the deficiencies. As self-insured employer plans are exempt from state insurance laws, they are not subject to the same periodic examination requirements as insurance companies offering small group comprehensive health insurance products in New York.

While self-insured plans are not subject to state examinations, the DOL, under ERISA, requires employee benefit plans to file annual audited reports (Form 5500 Annual Return/Report and accompanying schedules) concerning the financial condition and operations of the plan to ensure compliance with ERISA and the Internal Revenue Code. [61] However, small self-insured welfare

benefit plans with fewer than 100 participants or employees are not required to file Form 5500 if the plan pays for benefits out of its general assets (i.e., assets are not held in a trust). [62] Furthermore, small (i.e., those with fewer than 100 participants) self-insured plans that are not exempt from filing Form 5500 may be eligible to file Form 5500-SF (short form), which is more simplified. [63] Lastly, the requested information in various accompanying schedules to the Form 5500 annual report, including insurance information, service provider information, financial schedules, and actuarial information, are not required to be filed by small welfare benefit plans that have fewer than 100 employees. [64] Therefore, to the extent that the Annual Return/Report provides consumer protection, employees in employer plans with 51-100 employees in NY State do not necessarily have this protection.

Self-insured and fully insured plans may also be subject to DOL health plan investigations to ensure compliance with all applicable ERISA provisions, including compliance with applicable federal health laws (e.g., COBRA and HIPAA). However, such investigations are not annually performed or required of all plans and are either typically chosen at random, stem from reviews of annually filed Form 5500s, or arise from participant complaints against the group health plan. [65]

An exemption from a reporting requirement or annual/periodic examination, however, is not an exemption from fiduciary responsibilities. As such, it is reasonable to assume that fiduciaries assume the role of ensuring that the employer-sponsored plan is complying with ERISA and all applicable federal laws even when Annual Return/Report filings are not required.

AUDITS

The State of New York Codes, Rules, and Regulations has issued certain laws and regulations with respect to reporting and auditing standards for licensed insurance companies and HMOs (New York Insurance Law Section 307 for insurers, 10 NYCRR 98-1.16 for HMOs, and Insurance Regulation 118 [11 NYCRR 89]) that are substantially similar to those in the Model Audit Rule of the National Association for Insurance Commissioners (NAIC). [66] The purpose of these financial reporting standards is to monitor and ensure the solvency of the insurance company. These regulations require insurance companies to annually file audited financial reports according to statutory accounting practices, signed by an independent Certified Public Accountant (CPA), on the financial position of the company and its operations, including reports of cash flows and changes in capital and surplus. [67] The regulations also set forth requirements for the scope of the audit (according to Generally Accepted Auditing Standards [GAAS]), contents of the audited financial report, notifying the superintendent of any misstatements of financial information, maintaining work papers related to the audit, and the timing for filing these audited financial statements.

Under ERISA, Sections 103 and 104, and DOL regulations, employer-sponsored plans must also annually file an audited financial report (Form 5500 and accompanying schedules) signed by an independent qualified public accountant (IQPA) to ensure that the financial statements “accurately set forth the financial condition of the plan” and, as part of an auditing process, “review internal controls to determine whether they provide adequate safeguards for plan participants.” [68] The IQPA is required to audit the financial statements and form an opinion as to whether the financial statements conform to Generally Accepted Accounting Principles (GAAP) and to conduct the audit in accordance with GAAS. [69], [70]

However, self-insured employer-sponsored health insurance plans with fewer than 100 employees are generally exempt from Form 5500 and hence the auditing requirements.

OVERSIGHT

Oversight of insurance companies in the United States rests with the states. As such, New York's Department of Financial Services has responsibility for overseeing and regulating health insurance companies in the state of New York. DFS is responsible for overseeing licensing, insurance company examinations, prior approval of health insurance premium rates, solvency, enforcing statutes and regulations, and ensuring compliance with New York Insurance Law, among other responsibilities, in order to protect consumers purchasing health insurance plans from insurance companies in New York. This oversight is part of DFS's policy to, among other things, ensure solvency and prudent conduct of insurance companies and the fair and equitable fulfillment of financial obligations, protect consumers from financially impaired or insolvent insurance companies, and eliminate fraud and abuse in the insurance industry. [71] Because federal laws directly regulate employer-sponsored plans, for whom insurance companies provide services, certain federal laws impact insurance companies as well, providing added layers of protections for consumers (e.g., ERISA, HIPAA, COBRA, MHPAEA, etc.).

As previously discussed, state authority is preempted by ERISA for employer-sponsored plans that choose to self-insure. As such, self-insured plans are not subject to the same state oversight and regulation as fully insured plans administered by insurance companies, discussed above. The Employee Benefits Security Administration (EBSA), an agency under the DOL, is responsible for administering, regulating, and enforcing Title 1 of ERISA. Title 1 of ERISA is concerned with protecting the interests and rights of the participants and beneficiaries enrolled in employer-sponsored plans. To that end, EBSA requires plans to report on and disclose adequate information about the plan, including certain reporting requirements to the government (e.g., Form 5500 and accompanying schedules), sets forth standards of conduct and responsibilities for fiduciaries, and includes enforcement provisions to ensure that beneficiaries who qualify receive their benefits, lays out criminal and civil penalties, and includes other federal laws with which health plan sponsors must comply (e.g., HIPAA, COBRA, MHPA/MHPAEA). [72]

While general oversight of employer-sponsored welfare benefit plans and associated laws and regulations generally rests with the DOL, plan-specific oversight rests with plan fiduciaries. As previously discussed, fiduciaries have authority to control and manage the operation and administration of the employer-sponsored plan [73] and, as part of their responsibilities, must act prudently and solely in the interest of the plan and its participants.

SOLVENCY REQUIREMENTS

The solvency of an insured or employer-sponsored plan is critical to ensuring that sufficient funds will be available to meet the benefit obligations under a health insurance policy. The state of New York has reserve and risk-based capital (RBC) requirements, according to New York Insurance Law Sections 1322 and 1324, for insurance companies (including certain HMOs) that require the companies to hold funds for incurred but unpaid healthcare and administrative costs and capital funds in the form of reserves, paid-in capital, and surplus. [74]

An insurance company's financial statements in New York are independently audited and reviewed annually to ensure, among other things, that it maintains the minimum amount of capital. Insurance companies that are in danger of becoming insolvent may be ordered under the control of DFS under New York Insurance Law Article 74. [75]

Self-insured employer-sponsored plans, on the other hand, are not subject to New York state laws and the accompanying capital requirements and standards. In general, self-insured employers pay for health claims either out of general assets or through a trust. Establishing a trust affords more protection if a firm declares bankruptcy, to the extent that the trust is managed properly. However, trusts are not required to be established by firms and typically employers have less access to assets if they are held in a trust. Research has shown that most small firms offering health insurance benefits to their employees pay for claims out of their general assets rather than setting up trusts. [39] Fiduciaries who manage self-insured plans and oversee that the plan's assets are managed prudently and in the interest of plan participants must be bonded (i.e., insured) to protect against loss due to fraud that results in misuse of assets by a fiduciary. [55] Aside from general fiduciary responsibilities, there are no specific solvency standards for self-insured plans. [40] When an employer declares bankruptcy, the consumer may have little recourse other than to file proof of claim with bankruptcy court. [77] Given these various considerations, employees in self-insured plans have far fewer protections than consumers in fully insured plans in New York.

OTHER CONSUMER PROTECTIONS

There are a number of additional ACA insurance reforms that were implemented that do not directly apply to the consumer protections discussed above but are included here for purposes of completeness, as they highlight differences in various other protections between the fully insured and self-insured markets. These protections are usually applicable to the employer, though their impact could filter down to the employee and consumer. They include the protections shown in Table 8. [28]

Table 8: Other Consumer Protection Differences between Fully Insured and Self-Insured Markets

Additional ACA Insurance Reforms	Fully Insured Market	Self-Insured Market
Restricts rescissions	Required	Required
Requires uniform explanation of benefits	Required	Required
Requires quality of care reporting	Required	Required
Requires Medical Loss Ratio (MLR) reporting/rebating	Required	Not Required
Prohibits coverage exclusions for preexisting conditions	Required	Required
Imposes adjusted community rating rules	Required	Not Required
Requires guaranteed issue/renewability	Required	Not Required
Prohibits waiting periods in excess of 90 days	Required	Required
Requires coverage for clinical trials for qualified individuals	Required	Required

As noted above, several employer protections are not available in the self-insured market, including:

- Compliance with MLR standards, which requires issuers to refund rebates to consumers when the MLR threshold (80% in the small group comprehensive health insurance market) is not met.
- Compliance with adjusted community rating rules, which requires pooling of risk across the small group comprehensive health insurance market and only permits variation in premium

rates based on family composition, geographic area, age, and tobacco use, and which is mitigated by the ACA's risk adjustment program:

- In New York, there are further rate restrictions: premiums for a group cannot vary based on either age or tobacco use.
- Compliance with guaranteed issue and renewability. Insurance companies cannot deny coverage or renewal to small employers based on health status.

CONSUMER PROTECTION SUMMARY

While several consumer protections in the self-insured market have been strengthened by the passage of the ACA, including limits on cost sharing and patient appeal rights, consumer protections with respect to network adequacy, examinations and reporting (particularly for smaller employers sized 51-100 employees), and solvency requirements are still lagging behind those available in the NY State fully insured market.

CHAPTER 5: OTHER CONSUMER CONSIDERATIONS

CONSUMER ADVANTAGES

From the consumer perspective, self-insurance offers a few advantages. Because employees often pay a percentage of employer health insurance cost via premium contributions, cost matters to employees. In addition, a self-insured plan may have benefits that align with an employee's needs and/or moral convictions (assuming the employee's moral convictions are aligned with the employer's).

WELLNESS PROGRAMS

HealthCare.gov defines a wellness program as *"A program intended to improve and promote health and fitness that's usually offered through the work place, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs, and preventative health screenings."* [78]

As noted in the description, wellness programs may be embedded in an insurance plan or offered by the employer. [79] An employer offering a wellness program is not necessarily self-insured, as wellness programs can sit alongside insured plans. For example, being fully insured does not prohibit an employer from sponsoring a smoking cessation program that is not linked to the insurance plan. And a wellness program does not necessarily need to drive medical cost savings to provide financial return. An employer may, instead, earn a return from a wellness program by way of higher employee productivity, less absenteeism, less disability, higher morale, lower turnover, and more effective recruiting. [80]

Smaller groups favor simple wellness programs [79], [81], [6], which is likely due to the complexity of creating a comprehensive wellness program, including the regulatory hurdles, the significant cost of buying a complex program from a third party, and uncertain program returns. While many employers believe in the value of wellness programs, hard data regarding program returns is generally lacking. [82], [83] Smaller employers also don't have the number of employees necessary to spread fixed program costs and to support disease-specific wellness efforts. For example, diabetes is a relatively common disease, impacting about 10% of the working age population.¹⁹ Many employers with 50 to 100 employees will have 10 or fewer diabetics and, if 20% of the diabetics participate,²⁰ then only a couple of employees are impacted.

NY State small group health insurance companies offer wellness programs, both integrated with fully insured plans and as for-purchase add-ons that an employer can offer alongside a health plan. TPAs also offer wellness programs, typically for an extra fee (in addition to the standard TPA fee). Some insurance-integrated wellness programs automatically reduce employer premiums when employees participate in the program—resulting in an immediate healthcare savings for the employer. [83] In contrast, a self-insured employer or an employer offering a wellness program that is not embedded

¹⁹ Diabetes prevalence for the working age population is about 10%. [104]

²⁰ The majority of disease management plans have less than 20% participation. [79]

in an insurance plan may or may not see a financial return and the financial return may require an up-front investment.

CONSUMER DIRECTED HEALTH PLANS

Consumer directed health plans (CDHPs) refer to the combination of a high deductible health plan (HDHP) and a health savings account (HSA) or health reimbursement arrangement (HRA). CDHPs provide consumers tax advantages. [84]

CDHPs are most commonly offered by large employers as one of multiple health plan options. Smaller employers are less likely to offer CDHPs than large employers. [85], [86] However, when a small employer offers a CDHP, it is more likely to be the only plan the employer offers. Therefore, nationally, the percentage of employees covered under a CDHP as a percentage of the total employees covered under any health plan is nearly the same for firms with fewer than 200 employees as for firms with 200 and more employees (26% vs. 30%, respectively). [6]

HDHPs, suitable for pairing with an HSA or HRA, can be sponsored by a self-insured employer and are widely available on the NY State small group comprehensive health insurance market.²¹

²¹ NY State standard plans offered on and off the Exchange include several HDHP options; In addition, the HHS actuarial value calculator makes it difficult to design a bronze or silver AV-compliant plan that is not a HDHP.

CONCLUSIONS

We estimate that allowing employers with 51-100 employees to purchase stop loss coverage and, hence, self-insure will reduce healthcare costs by up to 30% for up to 0.3% of employers and increase premiums by up to 0.8% for 99.7% of employers with 1-100 employees who remain in the small group comprehensive health insurance market. The employees and covered dependents of employers who select self-insurance with stop loss will have fewer guaranteed benefits and consumer protections, and will not benefit from the DFS's oversight. Alternatively, the self-insured plan will provide employers somewhat more ability to tailor their health benefits and networks.

The adverse impact on the small group comprehensive market of allowing stop loss coverage should be considered in conjunction with other recent and proposed changes impacting the small group market, a review of which is beyond the scope of this paper.

Specifically:

- **Grandfathered stop loss coverage for employers with 51-100 employees causes upward pressure on small group comprehensive health insurance market premiums.** In 2016 about 10% of employers with 51-100 employees had self-insured plans with grandfathered stop loss coverage. If these employers have employees who are disproportionately younger, more male, and/or healthier, they may save in healthcare costs, relative to the premiums available in the small group comprehensive health insurance market, based on proxy estimates in this report. Their absence from the small group comprehensive health insurance market contributes to an increase in premiums of up to 0.4% based on proxy estimates in this report.
- **Revising New York Insurance Law to allow stop loss to non-grandfathered employers with 51-100 employees could increase premiums for the small group comprehensive health insurance market.** If additional employers with 51-100 employees are allowed to self-insure with stop loss (e.g., those with disproportionately younger, more male, and healthier employees and dependents), 90% or more of employers with 51-100 employees who remain in the small group comprehensive health insurance market and employers with 1-50 employees will experience a small increase in premiums (approximately 0.4%). Likewise, the employers in the small group comprehensive health insurance market will benefit if the grandfathered employers that are currently self-insured with stop loss are prohibited from continuing to purchase stop loss and, as a result, join the small group comprehensive health insurance market.
- **A small number of employers with 51-100 employees in the small group comprehensive health insurance could lower health insurance costs with self-insurance and stop loss coverage.** A relatively diminutive number (approximately 0.3%) of employers with 51-100 employees—who are disproportionately younger, more male, and/or healthier—could have up to 30% in lower healthcare costs if they self-insure with stop loss coverage.

- **The lower cost to these few employers will come at the expense of higher costs for the vast majority of small employers.** A large number (approximately 97.7%) of small employers will see their rates increase by up to 0.8% if stop loss is allowed for employers with 51-100 employees.
- **A minority of employers with 51-100 employees, if allowed, will select self-insurance with stop loss.** Up to 20% of employers with 51-100 employees may select self-insurance with stop loss. Of those, approximately half (10%) had grandfathered stop loss coverage in 2016.
- **Self-insurance provides fewer consumer protections.** Insured employees or dependents in a self-insured program have substantially fewer consumer protections than those insured via the small group comprehensive health insurance market. Self-insured plans are federally regulated with standards set forth by ERISA. Fully insured plans are subject to the oversight of the DFS.
- **Erosions to the small group comprehensive health insurance market are cumulative.** While allowing stop loss coverage for employers with 51-100 employees would have a modest adverse impact on the market, several other seemingly modest changes could have a significant cumulative adverse impact. This potential change, therefore, should be considered in conjunction with other recent and proposed changes.

CAVEATS AND LIMITATIONS

The information contained in this report has been prepared for the Superintendent and the New York State Department of Financial Services (collectively referred to as the “Department”) in accordance with the requirements of Chapter 12 of the Laws of 2016 § 7. The information contained within the report may not be appropriate for other purposes. The conclusions of this report are appropriate to today’s healthcare regulatory environment. To the extent that future federal or state legislation or regulation modifies the current regulatory environment, the statements and conclusions reached in this report may require modifications.

In compiling this report we relied upon data and information from various sources, as documented within the report. Because the DFS does not have authority over self-insured plans and federal reporting is not mandatory for small employers, we had very limited NY State-specific data for self-insured employers with 51-100 employees. As a result, these data do not capture the universe of all employers with 1-100 employees. In addition, strong conclusions could not be drawn from the very limited NY State-specific data collected for self-insured employers with 51-100 employees. We have not audited or verified the data and information collected other than reviewing it for general reasonableness. Whenever the underlying data or information is inaccurate, incomplete, or misleading, the results of our analysis may likewise be inaccurate or incomplete. The results of the financial analysis are estimates based upon chosen assumptions. Actual experience will differ from these estimates.

It is our understanding that the information contained in this report will be released publicly. Any distribution of the information should be in its entirety. Summaries of this report, such as a standalone executive summary or chapter, must still cite the full report. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for the Department by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

APPENDICES

APPENDIX A: NY STATE SMALL GROUP COMPREHENSIVE HEALTH INSURANCE MARKET MANDATED BENEFITS

New York State Department of Financial Services* State-Mandated Benefits as of September 1, 2015
Home healthcare
Preadmission testing
Second surgical opinion
Emergency services
Maternity care
Medical conditions leading to infertility
Infertility treatment
Diabetic equipment, supplies, and self-management education
Mastectomy care
Second medical opinion for cancer diagnosis
Post-mastectomy reconstruction
Enteral formulas
Chiropractic care
Bone mineral density measurements or tests, drugs, and devices
Out-of-network dialysis
Eye drop refills
Inpatient mental healthcare services
Outpatient mental healthcare services
Inpatient substance use services
Outpatient substance use services
Preventive and primary health services
Mammography screening
Prostate cancer screening
Off label cancer drugs
Orally administered anticancer medications
Cervical cytology screening
Pre-hospital emergency medical services
Contraceptive drugs and devices
Autism spectrum disorder treatment
Essential health benefits

* Source: DFS. [87]

APPENDIX B: SMALL GROUP EXPANSION AND DEFINITIONS

Effective January 1, 2016 the definition of a small group under the Affordable Care Act was expanded to include employers with up to 100 employees upon their effective or renewal dates. Originally, the ACA called for a mandatory expansion of the small group comprehensive health insurance market but that was later amended to allow states the flexibility to adopt the new definition or maintain the 1-50 employee definition of a small group.

New York is one of several states that chose to expand the small group comprehensive health insurance market to include employers with 1-100 employees. The change applied to all groups issued or renewed on or after January 1, 2016.

The group size determines whether an employer is defined as small or large under New York Insurance Law. Counting method refers to the way employees are counted in order to calculate group size. In addition to expanding the small group definition, NY State also changed the employee counting methodology for 2016, from number of eligible employees to a full-time equivalent (FTE) methodology. This change may have impacted which market segment (small or large group) employers fall into under New York Insurance Law as of 2016.

Under the new counting methodology, all "common law" employees, defined as anyone who performs services for an employer, if the employer controls what "*will be done and how it will be done,*" are considered eligible for coverage. Hours worked by both full-time and part-time common law employees must be calculated and converted into FTEs. Full-time is defined as employees who work on average 30 hours a week for any given month. Hours worked by part-time employees during a given month are added together and divided by 120 to convert them to a full-time equivalent basis.

The regulations provide additional guidance regarding the treatment of independent contractors and seasonal workers.

APPENDIX C: MILLIMAN METHODOLOGY

Survey Methodology

We worked with DFS to design a stop loss carrier survey. DFS distributed the survey and followed up with nonresponders. Results to the survey are summarized in Appendix D.

Insurance Company Data Methodology

As part of the NY State small group stop loss study, DFS requested claims and enrollment data from 23 NY State-licensed health insurance companies (several companies had multiple insurance licenses). Data was not requested from two insurance companies that were going into liquidation. The data was requested for both fully insured and self-insured group plans (wherever the self-insured employer's TPA was also a NY State health insurance company) with contracts filed and/or delivered in New York, and who had 1-100 employees for calendar years 2015 and 2016. We did not collect any self-insured data from other (non-health insurance company) TPAs, as these entities are neither known nor under the jurisdiction of the DFS.

Data was provided at a member level, including enrollment months, allowed and paid medical and pharmacy claims, demographic information (area and age), plan information (such as actuarial value [AV] and metallic level, where applicable or available), group size, and market segment (i.e., small group or large group, given that NY State expanded the definition of small group to include up to 100 FTEs in 2016). The data collected included six months of run-out, and assumed to be 99% complete. As such, no additional adjustments for incurred but not reported (IBNR) claims were made.

Financial Analyses Methodology and Assumptions

Key components of the requested analysis include the following:

- Assess the impact of prohibiting or allowing the sale of stop loss on the financial costs to employers with 51-100 employees between purchasing a fully insured product versus self-insuring with stop loss coverage.
- Assess the impact on premiums within the small group comprehensive health insurance market from allowing employers with 51-100 employees to self-insure with stop loss.

In order to develop the impact of prohibiting or allowing the sale of stop loss on both the small group comprehensive health insurance market and employers with 51-100 employees who choose to self-insure with stop loss coverage, the financial costs (i.e., premiums) for both of these cohorts were estimated and compared for calendar years 2015 and 2016. The estimated premiums include:

- Medical and pharmacy paid claims
- Administrative expenses (TPA fees for self-insured employers only)
- Insurance company taxes and fees (applicable to fully insured market only)
- Risk/profit charges (applicable to fully insured market only)
- Net cost or stop loss insurance (applicable to self-insured employers only)

The remainder of this section describes the methodology and assumptions for calculating these premium rates.

Group Size Determination

NY State expanded the small group comprehensive health insurance market as of January 1, 2016. That is, any employer with 51-100 employees previously defined as large group under New York Insurance Law would be defined as small group beginning with their 2016 renewals, to the extent that these employers renewed into the fully insured market in 2016.

Given that some groups may have had renewals later in the year, they may still have technically been defined as large group under New York Insurance Law. For purposes of this analysis, we segmented employer groups into either the 1-50 employer or the 51-100 employer small group market in order to bifurcate the data and identify the 51-100 employer groups that are eligible, and may opt to self-insure with stop loss coverage if they are permitted to do so.

We also made the assumption that some groups that are technically defined as fully insured large group in a given calendar year are eligible to be enrolled in the small group comprehensive health insurance market and would do so upon renewal. We recognize that it is possible that such groups may have dropped coverage altogether or transitioned into the large group market, to the extent that the new FTE counting definition as of 2016 qualified them for a large group 101+ employee plan, but such modeling was not handled in this study.

We assigned the employer group size in each calendar year based on the number of eligible employees reported by each carrier as of the latest renewal date within the 2015 or 2016 calendar years for the group. If there were multiple group sizes reported at the member level as of the latest renewal date, the most frequent group size was assigned to the whole group.

Determination of Employers with 51-100 Employees Choosing Self-Insurance

The employer groups with 51-100 employees were stratified into percentiles according to subscriber demographics (i.e., age and gender). We ranked the groups with 51-100 employees into percentiles using Milliman's 2017 Health Cost Guidelines (HCG)²² age/gender factors. These rankings were used to determine which groups may choose to self-insure from the groups with 51-100 employees versus those who may remain fully insured (e.g., groups with lower average age/gender factors would be expected to self-insure while groups with higher average age/gender factors would be expected to remain fully insured).

As such, the 51-100 employer groups were further bifurcated into the employers with 51-100 employees expected to self-insure versus those expected to remain fully insured, using these percentile rankings, as shown in Table 9.

²² The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research, and judgement. An extensive amount of data is used in developing the HCGs and that data is updated annually.

Table 9: Small Group Market Segmentation

Group Size	1-50	51-100	51-100
Group Size Segment	1-50 Small Group - Fully Insured	51-100 Expanded Small Group - Fully Insured/FI	51-100 Expanded Small Group - Self-Insured/SI
Definition	Small Group Comprehensive Health Insurance Market	Small Groups Remaining Fully Insured	Small Groups Transitioning to Self-Insurance

The modeling did not use a static bifurcation approach but rather a dynamic method that assumed certain percentages of employers transition to the self-insured market (e.g., 10%, 20%, etc.), with the remainder transitioning to the fully insured market.

Milliman’s HCG age/gender factors were also assigned to all members in the group, as these metrics were needed elsewhere in the analysis.

Normalization Factors

In order to compare costs of employers between staying fully insured versus moving to the self-insured market and also to estimate the impact to the small group comprehensive health insurance market, we normalized the paid claim per member per month (PMPM) amounts from the experience for each group size segment—1-50 and 51-100 fully insured (FI)/self-insured (SI)—and for each calendar year to get them on the same basis. The paid claims were normalized for the following factors:

- Area/rating region, given that member costs vary depending on the NY State region in which they reside
- Benefit coverage level (i.e., actuarial value and induced demand), given that members are enrolled in a variety of benefit plans with different coverage levels

We assumed that all employers in the data collected cover roughly the same major categories of benefits, including hospitalization, ambulatory, maternity and newborn, emergency, mental health and substance abuse, rehabilitative, laboratory, preventive, and wellness services, given the benefit mandate requirements for fully insured plans in the state of New York, as well as the employer’s propensity to cover such services for purposes or retention, recruitment, productivity, etc.

Area Adjustment

The paid claims were normalized for area using area factors from Milliman’s 2017 HCGs. The area factors were assigned based on the rating region reported by the carriers for each member.

Benefit Coverage Level

We adjusted paid claims for each group size segment (1-50 and 51-100 FI/SI) using calculated actuarial values from the data. Actuarial value is defined as the ratio of total paid claims to total allowed claims. It is a proxy measurement for the coverage level of a plan. Given that the U.S. Department of Health and Human Services (HHS) actuarial values were only reported for groups enrolled in ACA-compliant plans, but not for some groups with 51-100 employees, we used an alternative approach to estimate the coverage levels (i.e., actuarial values) at the group size segment level on a consistent basis for all employer groups in the data. We calculated the actuarial values as the paid claims divided by the allowed claims for each group size segment and calendar year. The

paid and allowed amounts for each group were normalized for age/gender mix and area at the member level before combining these amounts at the group size segment level to calculate the actuarial value. Once the actuarial value was calculated for each group size segment, we adjusted the paid claims to 80% (i.e., an approximately gold-level plan) because this is the typical coverage level observed in the small group comprehensive health insurance market.²³ Metallic actuarial values (using the HHS AV calculator) for ACA-compliant plans, where available, were reviewed relative to the estimated actuarial values using this alternative approach and were found to be consistent between the two methods.

We also reflected the changes in the average utilization of services (i.e., induced demand) associated with differences in average actuarial values at the group size segment level in order to get the paid claims on the same basis. We used the same induced demand factors as those used to estimate risk transfers in the HHS risk adjustment program, as shown in Table 10.

Table 10: HHS Risk Adjustment Induced Demand Factors

Metallic Tier	Actuarial Value Range	Induced Demand Factor
Bronze	60%	1.00
Silver	70%	1.03
Gold	80%	1.08
Platinum	90%	1.15

Source: 2014 Notice of Benefit and Payment Parameters.

Adjusted Paid Claims

Adjusted paid claims were estimated by group size segment by adjusting the calendar year paid claims for area and coverage level (i.e., actuarial value and induced demand), as described above.

We further adjusted the paid claim PMPM amounts for the groups expected to transition to self-insurance for the expected cost of New York’s state-mandated benefits. We reduced the paid claim PMPM amounts for the removal of the following NY State-mandated benefits based on publicly available research: [41]

- Infertility treatment: Estimated as 0.7% of claims. [88]
- Enteral formula: Estimated as 0.1% of claims. [88]
- Autism: Estimated as 0.5% based on prevalence rates and costs from Milliman’s HCGs.

Premium Development

The premium PMPM amounts were estimated from the adjusted paid claims described above for each group size segment separately (1-50 and 51-100 FI/SI).

²³ Based on a review of HHS metallic values in the filed URRTs.

A total retention equal to 15%²⁴ of premiums was added for the group size segments expected to be fully insured. This total retention amount is inclusive of all administrative expenses, risk/profit charges, and state and federal insurance company fees expected to be incurred by the insurer.

To calculate the premium equivalent rates for groups that are expected to move to self-insurance we added Administrative Services Only (ASO) fees of \$40²⁵ per employee per month (PEPM), as well as the net cost of stop loss, given that these groups will be purchasing stop loss. The methodology and assumptions used to estimate the net cost of stop loss is described in further detail below. We estimated the net cost of stop loss at two attachment points most commonly observed as being purchased by groups of this size (\$25,000 and \$40,000), based on the survey of NY State stop loss carriers, as summarized in Appendix D.

Given that the ACA's risk adjustment program is zero-sum across the entire NY State small group comprehensive health insurance market, premiums were not adjusted for risk transfers.

Premiums for each group size segment were composited using member months.

Net Cost of Stop Loss Development

A stop loss premium generally has two components: the net loss benefit and the transaction costs. The net loss benefit represents the recoveries an employer can expect over the term of the policy while the transaction costs reflect the stop loss carrier's administrative expenses and profit. Because the first component of the estimated stop loss premium offsets claims that an employer would otherwise be expected to pay, only the second component of the stop loss premium represents additional costs to employers. Thus, we reflect the cost of purchasing stop loss in our projections by adding the transaction cost of stop loss premium only and we leave the expected large claims unadjusted in the data.

The net cost of stop loss was developed for groups with 51-100 employees for two attachment points: \$25,000 and \$40,000. The expected cost above the two attachment points was simulated using calibrated actuarial cost models and claim probability distribution (CPD) tables from Milliman's 2017 HCGs.

Milliman's actuarial cost models consider utilization and average charge levels for 60 benefit categories. The models make provision, by type of service category, for benefit characteristics such as copays, deductibles, coinsurance, and out-of-pocket maximums. For each type of service category, utilization is adjusted to reflect the anticipated change in utilization due to the average expected cost sharing (copays, deductibles, and coinsurance). We calibrated the HCGs with a plan design roughly assumed to represent a gold plan with an actuarial value of 80%.

We also made adjustments for the expected demographics (i.e., age/gender) of the groups that are assumed to transition to the self-insured market. We area-adjusted our model to the NY State area and trended it back from the midpoint of the HCGs (July 1, 2017) to the midpoint of the analysis period

²⁴ Based on projected loss ratios as reported in 2018 URRTs.

²⁵ Based on responses from the stop loss survey.

(either July 1, 2015, or July 1, 2016). We used an annualized first dollar trend of about 8%, in line with industry averages.

We calibrated the HCGs for the average expected reimbursement levels in the New York commercial market based on internal Milliman research.

The HCGs provide utilization targets for Loosely Managed and Well Managed healthcare delivery systems. Loosely Managed equates to a Degree of Healthcare Management (DoHM) of 0% and represents relatively high utilization levels. The Loosely Managed utilization levels represent plans with some prospective, concurrent, and retrospective review requirements, but not programs and protocols directly related to disease management. Well Managed equates to a DoHM of 100% and represents utilization rates exhibited by the most efficient integrated delivery systems. The inpatient, outpatient, and, professional utilization levels in our actuarial cost models were derived from Milliman's HCGs, assuming a 30% DoHM for all categories of services, representing a moderately managed plan.

Lastly, we assumed a target administrative expense and risk charge of 30% for the stop loss premiums.

Data Limitations and Exclusions

We performed certain reasonability checks of the insurer data received (e.g., relative to publicly available data points, including MLR forms and URRTs) but did not audit the data. Where material deficiencies were observed in the data, clarifications and/or corrections were requested as needed on an insurer-by-insurer basis to ensure consistency of the data received.

We made the following exclusions from the collected data to ensure that it is reasonable and appropriate for the analysis we were performing:

- Incomplete records: Records were excluded due to major fields left blank such as company name, year, member or subscriber, subscriber indicator, group ID, product tier, year of birth, gender, group size, market segment, or contract date.
- Rating area: Records were excluded due to no rating area or county being provided or a county provided for a state other than New York.
- Groups size: Groups and the experience of their members with a reported group size above 100 were excluded from the analysis.
- Other: Groups with zero member months, or negative or zero reported allowed claims, were excluded from the analysis.

Table 11 summarizes the lives included and excluded from our study. Our results are based on analyzing the enrollment and claims of 14 million member months.

Table 11: Summary of Member Month Exclusions

Member Months Exclusions		
	2015	2016
Total Member Months Received	14,606,705	14,274,019
Exclusions	369,256	328,640
<i>[1] Data Quality</i>	50,849	169
<i>[2] Location</i>	62,265	53,598
<i>[3] Group Size</i>	229,313	248,194
<i>[4] Other</i>	26,829	26,679
Analyzed Member Months	14,237,449	13,945,379

Source: Data collected from NY State health insurance companies.

Data from Health Republic Insurance of New York, a health insurance company that failed at the end of 2015, was not requested. As such, the financial analysis discussed in Chapters 2 and 3 focused primarily on the data collected for calendar year 2016, given that it represented a more complete picture of the NY State small group comprehensive health insurance market.

Only one of the carriers contacted by DFS did not provide enrollment and claims information. However, based on other publicly available information, the small group enrollment for this carrier was deemed to be immaterial for purposes of this study.

APPENDIX D: DATA REQUEST RESPONSE SUMMARY**Survey Summary**

DFS sent surveys to 43 NY State-licensed stop loss carriers. Insurance companies that operate under more than one license generally consolidated their responses. We received 34 total responses. Eighteen of the respondents reported that they were a stop loss carrier or a TPA for NY State small group employers. Table 12 shows the surveys sent and the responses received.

Table 12: Stop Loss Carrier Surveys Sent and Received

	Stop Loss Carrier	Small Group Stop Loss Carrier (Yes=1)
1	American Alternative Insurance Corporation	0
2	AIG Group Benefits	1
3	Aetna Health Inc. (NY)	1
4	Amalgamated Life Insurance Company	1
5	BCS Insurance Company	1
6	Berkley Life and Health Insurance Company	1
7	Capital District Physicians Health Plan Inc.	0
8	CIGNA Health and Life Insurance Company	1
9	Emblem Health	0
10	Empire HealthChoice Assurance, Inc.	0
11	Everest Reinsurance Company	0
12	Excellus Health Plan, Inc.	0
13	Fidelity Security Life Insurance Company of New York	0
14	Gerber Life Insurance Company	1
15	Guardian Life Insurance Company of America	1
16	HCC Life Insurance Company	1
17	Healthfirst Health Plan, Inc.	0
18	Healthnow New York Inc.	0
19	Health Insurance Company of America, Inc.	1
20	HM Life Insurance Company of New York	1
21	Independent Health Association, Inc.	1
22	MVP Health Plan, Inc.	0
23	Nationwide Life Insurance Company	1
24	Niagara Life and Health Insurance Company	1
25	Oxford Health Insurance, Inc.	0
26	Oxford Health Plans (NY), Inc.	0
27	PartnerRe America Insurance Company	1
28	ReliaStar Life Insurance Company of New York	0
29	First Symetra National Life Insurance Company of New York	1
30	Transamerica Financial Life Insurance Company	0
31	UnitedHealthcare Insurance Company of New York	0
32	Union Labor Life Insurance Company	0
33	Westport Insurance Corporation	1
34	Zurich American Insurance Company	1
	Total	18

We asked 17 questions. Respondents who were not a stop loss carrier or a TPA only had to answer the first question.

Question 1. For self-insured small group health insurance is your organization a:

Type of Organization	# of Responses	% of Total
Stop Loss Carrier	15	44%
Third Party Administrator	0	0%
Stop Loss and a TPA	3	9%
Neither	16	47%

Question 2. Does your organization insure or administer fully insured (ACA compliant) small group health insurance?

Function	# of Responses	% of Applicable Organizations
Insure	4	22%
Administer	0	0%
Both	1	6%
Not Applicable	13	72%

Question 3. How many small group employers did your organization serve in 2016?

Organizations	Self-Insured	Fully Insured
Number of Responding > 0	8	5

Using # Employees to Define Group Size

Group Size	Total # of Groups		# of Responses	
	Self-Insured	Fully Insured	Self-Insured	Fully Insured
1-50	6	15,125	8	5
51-100	228	285	8	5

Using # Subscribers to Define Group Size

Group Size	Total # of Groups		# of Responses	
	Self-Insured	Fully Insured	Self-Insured	Fully Insured
1-50	3	0	7	3
51-100	40	0	7	3

Question 4. If you act as a TPA for self-insured plans, does your organization have a “standard” small group self-insured contract?

Response	# of Responses	% of Applicable Organizations
Yes	1	6%
No	4	22%
Not Applicable	13	72%

Rank-order the reasons, with #1 being the dominant variation.

Question 5. What are the most common variations from the standard small group self-insured contract?

Variation	Rank Order and Number of Times Rank Selected							All Other Ranks
	1	2	3	4	5	6		
Cost sharing variations	4	0	0	0	0	0	0	
Fewer drug tiers	0	0	0	0	0	0	0	
More drug tiers	0	0	1	1	0	0	0	
Eliminate or restrict health benefits	0	0	0	0	0	1	0	
Add wellness plan	0	2	0	0	1	0	0	
Customized care management provisions	0	1	0	0	1	0	0	
Add health benefits	0	1	1	0	0	0	0	
Add non-health benefits	0	0	1	1	0	0	0	
Enhanced patient grievance and appeal provisions	0	0	0	0	0	0	0	
Reduced patient grievance and appeal provisions	0	0	0	0	0	0	0	

Question 6. If you selected “eliminate health benefits” above, what benefits are most commonly eliminated or reduced from the benefits described in the standard small group self-insured contract?

Benefits	# of Responses	% of Respondents
Maternity	0	0%
Prescription Drugs	1	100%
Mental Health	1	100%
Substance Abuse	1	100%
Family Planning	1	100%
Child Vision	0	0%
Child Dental	0	0%
Habilitative Autism Services	0	0%
Gender Reassignment	1	100%
Other	0	0%

Question 7. Are the following consumer protections included in insurance products a consideration for employers in making the decision to fully or self-insure? Consumer protections include:

- Insurance department involvement in grievances and appeals
- Insurance department consumer review of rates during prior approval
- Insurance department market conduct examinations
- Insurance department financial audits
- Insurance department oversight
- Insurance department insurer solvency requirements

Consumer protections are:

Consumer Protections	# of Responses	% of Applicable Organizations
Seldom a consideration	7	39%
Routinely mentioned as a consideration, but ultimately cost and other considerations dominate	5	28%
A somewhat important or important consideration in favor of full insurance	0	0%
Not Applicable	6	33%

Question 8. Health insurance sold on the small group ACA (fully insured) market must comply with ACA network adequacy requirements for the number of providers by specialty and distance to those providers (see Network Adequacy on <http://www.dfs.ny.gov/insurance/ihealth.htm>). How do networks for your self-insured groups compare to ACA adequate networks?

Self-Insured Network Adequacy	# of Responses	% of Applicable Organizations
Generally well above the ACA minimum for adequacy	4	22%
Generally at or above the ACA minimum for adequacy but “narrow” compared to many plans offered on the small group market	2	11%
Often below the ACA minimum for adequacy	0	0%
Don't know	5	28%
Other	7	39%

Rank-order the reasons, with #1 being the dominant reason.

Question 9. Why do NYS small groups employers continue with self-insurance and stop loss rather than a fully insured product?

Reasons:	Most Common Rank	No Rank	1	2	3	4	5	6	7	8	9	10
Interia	6	7	0	1	0	0	1	3	1	2	3	0
Broker Recommendation	4	6	0	2	2	3	2	1	2	0	0	0
Lower Cost	1	7	10	1	0	0	0	0	0	0	0	0
Narrower Network	7	12	0	0	0	0	0	1	4	1	0	0
No essential health benefits requirement	7	11	0	1	1	0	1	1	2	0	1	0
Flexibility in plan design	2	5	1	5	4	3	0	0	0	0	0	0
Better data sharing	3	6	0	1	4	1	4	1	0	1	0	0
More opportunity for innovation	4	6	0	2	1	5	2	2	0	0	0	0
Employer wants to take risk	5	7	1	0	1	1	2	2	2	1	1	0
Other	1	17	1	0	0	0	0	0	0	0	0	0

Rank-order the ranges, with #1 being the dominant range

Question 10. If you listed cost as a reason why do NYS small group employers continue with self-insurance and stop loss rather than a fully insured product, what's a typical range of savings?

	Most Common Rank	No Rank	1	2	3	4	5
0-2.5%	1	17	1	0	0	0	0

	Most Common Rank	No Rank	1	2	3	4	5
2.5-5%	1	16	1	0	1	0	0
5-7.5%	1	16	1	0	1	0	0
7.5-10%	1	11	5	2	0	0	0
10%+	1	15	2	0	0	1	0

Provide %'s for the first two lines or check the last line

Question 11. If you are a TPA, what % of your self-insured small group health insurance is written on a "level premium basis" whereby the group pays a level premium each month into a fund to cover self-insured costs and stop loss costs, with a true-up at the end of the year that may result in a partial refund of a positive fund balance or a carry-forward of a negative fund balance?

Group Size	# of Responses	Average %	Min%	Max%
% of groups 1-50 employees	1	0%	0%	0%
% of groups 51-100 employees	3	98%	95%	100%
not applicable: my organization is not a TPA	16	n/a	n/a	n/a

Question 12. If you are a TPA, what is the typical per member per month administered services only (ASO) fee charged to small group employers?

TPA Fee	# of Responses	Average	Min	Max
\$ per subscriber	2	\$42	\$34	\$50
\$ per person	0			
% of claims	0			
not applicable: my organization is not a TPA	15			

Question 13. What are the most common specific (person-level) stop loss attachment points for self-insured small group health insurance?

Attachment Point: 1-50 employees	Most Common Rank	No Rank	1	2	3	4	5	6	7	8
<\$25,000	2	15	0	3	0	0	0	0	0	0
\$25,000	1	13	5	0	0	0	0	0	0	0
\$40,000	3	14	0	0	4	0	0	0	0	0
\$50,000	4	14	0	1	0	3	0	0	0	0
\$75,000	1	16	1	0	0	0	1	0	0	0
\$100,000	0	18	0	0	0	0	0	0	0	0
>\$100,000	1	17	1	0	0	0	0	0	0	0

Attachment Point: 51-100 employees	Most Common Rank	No Rank	1	2	3	4	5	6	7	8
<\$25,000	1	16	1	0	0	1	0	0	0	0
\$25,000	1	10	4	2	0	1	0	1	0	0
\$40,000	1	10	3	3	2	0	0	0	0	0
\$50,000	1	7	4	3	4	0	0	0	0	0
\$75,000	3	8	2	1	3	3	1	0	0	0
\$100,000	4	12	1	0	0	2	1	2	0	0
>\$100,000	1	15	2	0	0	0	1	0	0	0

Question 14. How is group-specific experience reflected in stop loss rates for self-insured small group health insurance?

Stop loss experience rating	# of Responses	% of Total
Stop loss coverage is community-rated and therefore the group's experience has no impact	0	0%
Stop loss coverage is rated using credibility factors that are applied to simple projections of the group's previous costs	3	17%
Stop loss coverage is rated using credibility factors that are applied to projections of the group's previous costs, where the projections use underwriting judgement related to the specific cause and expected duration of the group's previous costs	13	72%
Stop loss coverage is fully experience-rated	0	0%
Not Applicable	2	11%

Question 15. If small group employers could freely move back and forth between self-insurance with stop loss and community-rated small group health insurance, do you think that small group employers with emergent high costs (for example, a child born with hemophilia or and employee requiring a transplant) move to community-rated small group health insurance at the next renewal and stay until the costs are reduced rather than pay increased stop loss premiums?

Potential for Churn	# of Responses	% of Total
Yes	11	61%
No	4	22%
Not Applicable	3	17%

Question 16. If stop loss was no longer available, how many self-insured small group employers do you think would:

Potential for Churn	# of Responses	Average %	Min %	Max %
% Move to small group fully insured health insurance	16	66%	30%	100%
% Self-insure without stop loss	16	3%	0%	20%

Potential for Churn	# of Responses	Average %	Min %	Max %
% No longer offer employer-sponsored insurance	16	22%	0%	50%
% Find some way to obtain large group insurance (such as by merging with another firm)?	16	9%	0%	30%

Question 17. For an insurer who offers small group fully insured products and TPA services with stop loss, which product is most financially advantageous to the insurer?

Most Financially Advantageous	# of Responses	% of Applicable Organizations
Fully Insured	2	11%
TPA services with stop loss	2	11%
Not Applicable	14	78%

Insurance Company Data Summary

DFS sent data requests to 23 NY State-licensed insurance carriers. The data request was not sent to two insurance carriers that were liquidated or going into liquidation.

Insurance carriers that operate under more than one license generally consolidated their responses. We received 11 total responses. Only one state-licensed insurance carrier did not submit its data. However, based on other publicly available information, the small group enrollment for this carrier was deemed to be immaterial for purposes of this study.

Table 10: Insurance Company Data Requests Sent and Received

NY State Licensed Insurance Carrier	
1	Aetna
2	Care Connect
3	CDPHP
4	Crystal Run Health
5	Empire
6	Excellus
7	Emblem
8	HealthNow
9	Independent Health
10	MVP
11	United

APPENDIX E: INSURANCE COMPANY DATA REQUEST LETTER

New York State Department of Financial Services Claims Data Request for the New York Small Group Stop Loss Study To Be Sent to NYS Health Insurers and Third Party Administrators

July 14, 2017

Dear Health Plan/Third Party Administrator Designee:

As you may know, New York expanded the definition of “small group” for the purpose of health insurance from 1-50 to 1-100. To help determine the impact of this change, Chapter 12 of the Laws of 2016 (attached) requires the Department of Financial Services (DFS) to contract with an independent entity to draft a report assessing the impact of the change in group size on employers with 51-100 employees. Specifically, the report must assess the impact of (1) discontinuing the sale of stop loss coverage to groups sized 51-100 employees or members and (2) continuing the sale of stop loss coverage to groups sized 51-100 employees or members that are grandfathered and do not have to comply with the new group size definition. (There are groups with 51-100 employees who were self-funding with stop-loss coverage prior to the small group market expansion (i.e., increase in small group size) which was effective for contracts issued or renewed on or after 1/1/16. Since these groups with 51-100 employees would now be considered “small groups” they could no longer be sold stop-loss coverage which makes it financially difficult to self-fund. The legislature “grandfathered” these groups for a year or two (depending on their situation) which means they are allowed to continue to purchase stop-loss coverage to give them time to figure out their options for fully-insured small group coverage.)

DFS has contracted with Milliman, an independent entity, to perform a study in accordance with the requirements of Chapter 12 of the Laws of 2016. Milliman will examine the impact of the prohibition on the sale of stop-loss coverage to employers with 51-100 employees, compare employer costs of providing health coverage through purchasing a small group health insurance policy with providing self-insured benefit plans with stop loss coverage, and calculate the impact on small group health insurance rates of allowing groups to obtain stop loss coverage.

This data request will provide Milliman, as the independent entity, the data to complete the analysis described herein.

Data Collection Process

Overview

Health plans and Third Party Administrators (TPA) should use the instructions below and the technical details provided under separate cover to guide their data submission.

We request that you provide contract and member-level data for:

- Employer-sponsored fully insured (including Healthy New York) and self-insured New York contracts (i.e., administrative contracts with TPAs)

- For employers with 1-100 full time equivalent (FTE) employees
- That were in-force in calendar years 2015 and 2016

Health plans and TPAs that had no employer-sponsored contracts that met the above criteria should inform us that the request is not applicable to their organization.

Pursuant to NYS law, the fully insured employer-sponsored contracts for groups with 51-100 employees were classified as “large group” prior to their 2016 renewal and “small group” from their 2016 renewal onward. We are requesting 2015 and 2016 data for groups with 1-100 FTE employees regardless of whether they were classified as large group or small group.

Details

- Refer to the enclosed Excel workbook for the technical details of specific data elements requested (i.e., data elements/definitions/formats).
 - Note that the fully insured and self-insured requests are somewhat different.
 - Health plans who have fully insured and self-insured contracts that meet the above criteria should submit two separate data sets, one for fully insured and the other for self-insured.
- New York contracts include fully insured contracts for policy forms filed and approved in New York and self-insured contracts delivered in New York. Data for contracts filed and approved outside the state of New York should be excluded (even if some members reside in New York).
- A subscriber is an employee covered under in the insurance contract (some employees do not participate). A member is either a subscriber or a covered dependent of a subscriber.
 - Subscribers and members are individuals covered under New York contracts, even if they live out of New York.
 - A subscriber or member may be covered under multiple New York contracts over the two year period. Subscribers and members should have a record under each contract.
- A member-level record is expected to be provided for each calendar year and if a group renews mid-year (other than January 1), please submit two member-level records for the pre- and post-renewal periods.
 - Each record should describe the group contract information for that contract year.
- The number of employees for the 1-100 and 51-100 demarcations is the employer's total number of employees, at the group's last renewal. If total number of employees is not available, substitute the total number of subscribers. For more information regarding counting the number of employees, please see Q-7 through Q-26 of “FAQs For Small Group Expansion to 1-100 Employees” at http://www.dfs.ny.gov/insurance/health/faqs_sm_grp_expansion_1to100.htm.
- Member data should be provided for all members, including partial year members and members without claims.

- The claims data should include all medical and pharmacy claims with dates of service in 2015 and 2016 as paid through June 30, 2017.
 - Please include those carved out or processed through a sub-contractor.
 - If the payment for certain benefits is capitated, include the fee-for-service equivalent amount.
 - Do not adjust the paid claims for any stop loss for high-cost claims or reinsurance programs currently in place.
- Health plans and TPAs should provide proxy group, subscriber, and member IDs and to take other steps to de-identify the data per HIPAA.
- Each submission should include the Company Name and NAIC Number of the specific health plan issuer and the Company Name for the TPA making the submission.
- Contact Milliman if you are unable to provide data consistent with these instructions and for approval of adjustments and/or exceptions.

Timing

Submit any questions you have regarding the data request by July 24th to Lidia Asparouhova and Steve Metz (contact information below). Milliman will compile all questions and distribute the answers to all participants no later than July 31st.

All data must be provided no later than August 11, 2017.

Data should be provided in flat text file format with tab delimiters used to separate data fields and sent on a CD/DVD via mail to the following individuals (**redacted**):

Alternatively, the files may be securely FTP'd to Milliman by the required deadline. Health plans and/or TPAs wishing to use this option to submit their data must provide appropriate contact information, including the email address of the individual who will be sending data to Milliman via the FTP, to both Lidia Asparouhova and Steve Metz so that we may set up this process. Such contact information should be provided no later than July 28, 2017 in order to allow sufficient time for the necessary FTP accounts to be established.

Final Notes

To ensure the process continues to move forward, DFS requests **acknowledgment of receipt of this letter within two business days**. Any questions or comments regarding the requested data should be directed to (**redacted**).

Sincerely,
Jon Thayer

DATA REQUEST FILE

PLAN INFO

Company Name	
NAIC Number	
Company Contact Name and Email	
Indicate with a Yes/No regarding whether data is being sent for:	
Data Submission - Fully Insured	
Data Submission - Self-Insured	
Other/Comments	

DATA DICTIONARY

Definitions:

- Fully Insured Group (FI)
- Self-Insured Groups (SI)
- Small Group (SG)
- Large Group (LG)

Required Data Elements and Definitions

Field	Definition	Required (FI/SI)
NAIC Number	National Association of Insurance Commissioners number (if available) of the organization submitting the data	FI/SI
Legal Company Name	The legal company name of the organization submitting the data	FI/SI
Calendar Year	Calendar year 2015: dates of service in calendar year 2015, with claims paid through June 30, 2017	FI/SI
	Calendar year 2016: dates of service in calendar year 2016, with claims paid through June 30, 2017	
Non patient identifiable unique member indicator	De-identified member Indicator that ties across membership files across market segments in table 1 (fully insured data), to the extent a group's market segment (small group vs large group) changes mid-year.	FI/SI
Subscriber Identifier	Indicator to allow for unique subscriber identification (all members within a subscriber should have the same identifier)	FI/SI
Subscriber Indicator	Indicates the subscriber / employee	FI/SI

Unique Group Identifier	Identify the specific small group each member is associated with. A numeric counter (e.g. 1, 2, 3, etc.) for each group within a health plan's and TPA's data set would be acceptable. If the group size changed from a large group to a small group definition or vice versa during the year or across years, the same group number should be maintained.	FI/SI
HIOS Plan ID Number	Plan identification number for rate review system - applicable to ACA compliant small group business only.	FI
Rating Region	Indicates the rating region associated with the group - applicable to ACA compliant small group business only.	FI
Group County	Indicates the New York county associated with the group - see Appendix A.	FI/SI
Product Tier	Indicate level of coverage (subscriber, subscriber + spouse, subscriber + child(ren), family, child-only)	FI/SI
Year of Birth	Member year of birth	FI/SI
Gender	Member male/female/unknown	FI/SI
Actuarial Value	Actuarial Value output from the AV calculator for the given plan - applicable to ACA compliant small group business only.	FI
Metal Level	Plan's assigned metal level based on AV - applicable to ACA compliant small group business only.	FI
Group Size Category	Indicates the group's size category at the time of renewal. If a group is enrolled in an ACA compliant plan, then the segment should be indicated as SG. If a group is enrolled in a fully insured plan prior to the expansion of the market to 51-100, then the segment should be indicated as LG. The LG segment should include only groups up to 100 employees. See Appendix B for examples.	FI
Group Size	The number of employees from 1-100 (see Data Collection Process Details for more information).	FI/SI
Pharmacy Coverage Indicator	Whether the member's plan covers pharmacy benefits	FI/SI
Member Months	Sum of member's member months for calendar year and contract.	FI/SI
Total Paid Amount Medical	Total paid medical amount for all claims for the member for calendar year and contract.	FI/SI
Total Paid Amount Pharmacy	Total paid pharmacy amount for all claims for the member for calendar year and contract.	FI/SI
Total Member Cost Sharing Medical	Total member cost sharing for medical claims for the member for calendar year and contract.	FI/SI
Total Member Cost Sharing Pharmacy	Total member cost sharing for pharmacy claims for the member for calendar year and contract.	FI/SI
Contract Date	Issuance date or most recent contract renewal date, whichever is later.	FI/SI

DATA FORMAT

The following table describes the format requested for the DFS Small Group Stop Loss Study, including the required field name and format type. This data table request is intended for fully insured data only.

Table 1 - Fully Insured Data Request (2015 and 2016 Benefit Years)			
Field Name	Format	Allowed Values	Example Values
Legal Company Name	Text		
NAIC Number	Text		
Calendar Year	Integer	2015, 2016	2015
Non patient identifiable unique member indicator	Text		
Subscriber Identifier	Text		
Subscriber Indicator	Integer	1 = subscriber, 0 = non-subscriber	1
Unique Group Identifier	Text		
HIOS Plan ID Number	Text	xxxxxxxxxxxxxx, 14 characters	
Rating Region	Integer	See allowed values in Appendix A	7
Group County	Text	See allowed values in Appendix A	Jefferson
Product Tier	Text	See allowed values in Appendix A	S
Year of Birth	Integer	YYYY	1980
Gender	Text	M,F,U	M
Actuarial Value	Decimal	##.## format, less than 100.0	70.8
Metal Level	Text	Platinum, Gold, Silver, Bronze	Silver
Group Size Category	Text	SG, LG	SG
Group Size	Integer	Between 1 to 100	75
Pharmacy Coverage Indicator	Text	Y, N	Y
Total Paid Amount Medical	Decimal	#####.## format	9999.99
Total Paid Amount Pharmacy	Decimal	#####.## format	9999.99
Total Member Cost Sharing Medical	Decimal	#####.## format	9999.99
Total Member Cost Sharing Pharmacy	Decimal	#####.## format	9999.99
Member Months	Integer	Between 1 and 12	3
Contract Date	Date	MM/DD/YYYY format	01/01/2014

Table 2 - Self-Insured Data Request (2015 and 2016 Benefit Years)			
Field Name	Format	Acceptable Values	Example Values
Legal Company Name	Text		
NAIC Number	Text		
Calendar Year	Integer	2015, 2016	2015
Non patient identifiable unique member indicator	Text		
Subscriber Identifier	Text		
Subscriber Indicator	Integer	1 = subscriber, 0 = non-subscriber	1
Unique Group Identifier	Text		
Group County	Text	See allowed values in Appendix A	Jefferson
Product Tier	Text	See allowed values in Appendix A	S
Year of Birth	Integer	YYYY	1980
Gender	Text	M,F,U	M
Group Size	Integer	Between 1 to 100	75
Pharmacy Coverage Indicator	Text	Y, N	Y
Total Paid Amount Medical	Decimal	#####.## format	9999.99
Total Paid Amount Pharmacy	Decimal	#####.## format	9999.99

Table 2 - Self-Insured Data Request (2015 and 2016 Benefit Years)			
Total Member Cost Sharing Medical	Decimal	#####.## format	9999.99
Total Member Cost Sharing Pharmacy	Decimal	#####.## format	9999.99
Member Months	Integer	Between 1 and 12	3
Contract Date	Date	MM/DD/YYYY format	01/01/2014

NOTE: If data is unavailable (or Null), please populate text fields with "N/A", integer and numeric fields with 0, and date fields with 12/31/9999.

COUNTY AND TIER VALUES

The following table lists all New York counties. Please use the values below to fill out the "Group County" field.

The following table lists Product Tiers. Please use the values below to fill out the "Product Tier" field.

The following table lists how New York counties map to the ACA rating regions. Please use the values below to fill out the "Rating Region" field.

Allowed Values
Albany
Allegany
Bronx
Broome
Cattaraugus
Cayuga
Chautauqua
Chemung
Chenango
Clinton
Columbia
Cortland
Delaware
Dutchess
Erie
Essex
Franklin
Fulton
Genesee
Greene
Hamilton

Product Tier	Allowed Value
Subscriber	S
Subscriber + Spouse	SS
Subscriber + Child(ren)	SC
Family	F

Counties	Rating Region - Allowed Value
Albany	1
Allegany	2
Bronx	4
Broome	6
Cattaraugus	2
Cayuga	6
Chautauqua	2
Chemung	6
Chenango	7
Clinton	7
Columbia	1
Cortland	6
Delaware	3
Dutchess	3
Erie	2
Essex	7
Franklin	7
Fulton	1
Genesee	2
Greene	1
Hamilton	7

Herkimer
Jefferson
Kings
Lewis
Livingston
Madison
Monroe
Montgomery
Nassau
New York
Niagara
Oneida
Onondaga
Ontario
Orange
Orleans
Oswego
Otsego
Putnam
Queens
Rensselaer
Richmond
Rockland
Saratoga
Schenectady
Schoharie
Schuyler
Seneca
St. Lawrence
Steuben
Suffolk
Sullivan
Tioga
Tompkins
Ulster
Warren
Washington
Wayne
Westchester
Wyoming
Yates

Herkimer	7
Jefferson	7
Kings	4
Lewis	7
Livingston	5
Madison	7
Monroe	5
Montgomery	1
Nassau	8
New York	4
Niagara	2
Oneida	7
Onondaga	6
Ontario	5
Orange	3
Orleans	2
Oswego	7
Otsego	7
Putnam	3
Queens	4
Rensselaer	1
Richmond	4
Rockland	4
Saratoga	1
Schenectady	1
Schoharie	1
Schuyler	6
Seneca	5
St. Lawrence	7
Steuben	6
Suffolk	8
Sullivan	3
Tioga	6
Tompkins	6
Ulster	3
Warren	1
Washington	1
Wayne	5
Westchester	4
Wyoming	2
Yates	5

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