



**Elizabeth G. Taylor**  
Executive Director

**Board of Directors**

**Robert N. Weiner**  
Chair  
Arnold & Porter, LLP

**Ann Kappler**  
Vice Chair  
Prudential Financial, Inc.

**Miriam Harmatz**  
Secretary  
Florida Health Justice Project

**Nick Smirensky, CFA**  
Treasurer  
New York State Health  
Foundation

**Ian Heath Gershengorn**  
Jenner & Block

**Robert B. Greifinger, MD**  
John Jay College of  
Criminal Justice

**John R. Hellow**  
Hooper, Lundy & Bookman, PC

**Rod J. Howard**  
CapKey Advisors

**Michele Johnson**  
Tennessee Justice Center

**Lourdes A. Rivera**  
Center for Reproductive Rights

**William B. Schultz**  
Zuckerman Spaeder

**Donald B. Verrilli, Jr.**  
Munger, Tolles & Olson

**Ronald L. Wisor, Jr.**  
Hogan Lovells

**Senior Advisor to the Board**  
**Rep. Henry A. Waxman**  
Waxman Strategies

**General Counsel**  
**Marc Fleischaker**  
Arent Fox, LLP

March 6, 2018

The Honorable R. Alexander Acosta  
Secretary, U.S. Department of Labor  
200 Constitution Avenue, NW  
Washington, DC 20210

Mr. Preston Rutledge  
Assistant Secretary, Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue, NW  
Washington, DC 20210

**RE: RIN 1210-AB85 – Definition of “Employer” under Section 3(5) of ERISA – Association Health Plans**

Dear Secretary Acosta and Assistant Secretary Rutledge,

Thank you for the opportunity to comment on the Department’s proposed rule, *Definition of “Employer” under Section 3(5) of ERISA – Association Health Plans*. The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals, by advocating, educating and litigating at the federal and state level.

We write with strong objection to the proposed rule on Association Health Plans (AHPs). The proposed rule allows the creation of AHPs that skirt numerous critical insurance market consumer protections, such as Essential Health Benefits and rating standards. The proposed rule will also encourage adverse selection and weaken the individual and small group markets that are critical sources of coverage for millions of people, including people with pre-existing health conditions including people with disabilities. Given the scope of the changes proposed, we request that the Department hold a public hearing on this proposed rule.

**I. AHPs should not be allowed to sell junk insurance and weaken the insurance market.**

The proposal to change current rules by exempting AHPs from many of the federal standards and protections that apply to individual and small group plans, and to instead allow AHPs to offer coverage as large employer plans, would jeopardize important consumer protections. This proposal would allow AHPs to bypass important ACA protections for small group and individual insurance, such as Essential Health Benefits, that will hurt millions of health care consumers, in particular those with pre-existing conditions. The proposed rule would allow AHPs to be regulated as large group plans even if they market to small businesses and self-employed individuals. This would harm people with disabilities, and people with other chronic conditions who have gained access to affordable coverage because of the ACA's important reforms.

Currently, AHPs are regulated by the “look-through” doctrine set forth in 2011 guidance from the Centers for Medicare and Medicaid Services (CMS).<sup>1</sup> This guidance has the effect of looking through the association to understand who is purchasing coverage through an AHP, and then to determine the applicable regulatory standard that should apply. Currently, AHP products sold to individuals are considered to be individual market insurance and AHP products sold to small employers are considered to be small group market insurance. The insurance products are then subject to the same requirements and consumer protections that exist in those markets under the ACA.

The proposed regulation would not apply the “look-through” doctrine to AHPs that fit the new definitions of associations in the rule. As a result, an AHP would be treated as a single plan providing large employer coverage, and therefore exempted from the individual and small group market protections.

As described in detail above, as result of this proposed rule, AHPs could substantially scale back their benefits, dropping benefits entirely or dramatically limiting them. Limiting plan benefits was a predatory practice that existed before the ACA as a way to discourage anyone with a pre-existing health condition or high expected health care utilization from enrolling in coverage.

The proposed rule puts the economic stability and health of consumers at risk by allowing employers to offer limited coverage that fails to meet the needs of individuals and families.

---

<sup>1</sup> Memorandum from Gary Cohen, Acting Director, Office of Oversight, Ctrs. Medicare & Medicaid Servs. (Sep. 1, 2011), [https://www.cms.gov/CCIIO/Resources/Files/Downloads/dwnlds/association\\_coverage\\_9\\_1\\_2011.pdf](https://www.cms.gov/CCIIO/Resources/Files/Downloads/dwnlds/association_coverage_9_1_2011.pdf).

A small employer, for example, with a relatively healthy workforce might offer an AHP with low premiums that only provides limited benefits. If an employee later develops a health condition such as cancer or HIV, or requires hospitalization, he could suddenly find that necessary care or treatment is not covered.<sup>2</sup>

While the proposed rule prevents health status rating of individual small businesses, the rule appears to allow groups or associations to base premium rates on any other factor, including gender, age, industry and other factors actuaries create to estimate health care utilization. Plans would be exempt from the rating protections that apply to individual and small group markets. Small businesses with a workforce that is older, disproportionately comprise of women, or in industries that are believed to attract high health care utilizers would suffer the most.

Currently, because of the ACA protections, plans are prohibited from basing premiums on anything other than age (within a 3:1 ratio for adults), tobacco use, family size, and geography. As one example of problematic rating practices before the ACA took effect, 92 percent of best-selling plans on the individual market practiced gender rating, costing women approximately \$1 billion a year.<sup>3</sup> While the proposed rule would protect *individuals* from being charged more because of their gender, it appears that employers with higher rates of female employees could be charged higher premiums, which would ultimately be passed down to their employees.

Similarly, the age and industry of employers could lead to higher premiums for employers with older employees or in certain industries because these factors can be used as a proxy for higher health care utilization and/or employees with less-than-perfect health.

We strongly recommend that the Department continue to apply the “look-through” doctrine, rather than treat AHPs as large group plans; if an AHP is offering coverage to individuals, including working owners, or small employers, the plans should be required to meet standards and protections set forth in the ACA.

---

<sup>2</sup> SARAH LUECK, CTR. BUDGET & POLICY PRIORITIES, TRUMP RULE ON ASSOCIATION HEALTH PLANS COULD DEVASTATE SMALL-GROUP MARKETS (2018), from <https://www.cbpp.org/blog/trump-rule-on-association-health-plans-could-devastate-small-group-markets>.

<sup>3</sup> NAT'L WOMEN'S LAW CTR., TURNING TO FAIRNESS: INSURANCE DISCRIMINATION AGAINST WOMEN TODAY AND THE AFFORDABLE CARE ACT (2012), [http://www.nwlc.org/sites/default/files/pdfs/nwlc\\_2012\\_turningtofairness\\_report.pdf](http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf).

**a. AHPs will not offer the essential health care benefits, exacerbating health disparities.**

We are particularly concerned that AHPs will not be required to cover all ten essential health benefits (EHBs) that ACA-compliant plans must cover. The EHB requirement has helped ensure people have access to **basic** health care services and has closed health care coverage gaps that for decades had left individuals underinsured. Before the ACA, consumers often did not have health coverage for services that are now covered as EHBs. For example, prior to the ACA, one in five people enrolled in the individual market lacked coverage of prescription drugs and mental health coverage was often excluded from health plans.<sup>4</sup> Also, 75% of non-group market plans did not cover maternity care (delivery/inpatient care), and 45% did not cover inpatient/outpatient substance use disorder services.<sup>5</sup> These services can be a small percentage of the relative benefit costs in commercial market plans, yet scaling back their coverage would significantly raise out-of-pocket costs for individuals who need them.<sup>6</sup> Allowing plans to forego these benefits also leads to discrimination by benefit design: plans can cherry-pick healthy individuals that do not seek services like maternity care or mental health benefits.

Allowing AHPs not to cover all EHBs would jeopardize adequate coverage of important health care benefits. While the Department's proposal purports to emphasize reducing coverage and lowering premiums, it will in fact will result in inadequate coverage of benefits and higher out-of-pocket costs for consumers. If they enroll in AHPs, consumers with specific health care needs may be offered less comprehensive plans that no longer cover vital services, forcing people who rely on those services to pay out-of-pocket for them or forgo the care they need. This will increase health care costs for many, including people with disabilities, chronic conditions, and other pre-existing conditions.<sup>7</sup> It will also drive up

---

<sup>4</sup> DANIA PALANKER *ET AL.*, THE COMMONWEALTH FUND, ELIMINATING HEALTH BENEFITS WILL SHIFT FINANCIAL RISK BACK TO CONSUMERS (2017), <http://www.commonwealthfund.org/publications/blog/2017/mar/eliminating-essential-health-benefits-financial-risk-consumers>.

<sup>5</sup> GARY CLAXTON *ET AL.*, KAISER FAMILY FOUNDATION, WOULD STATES ELIMINATE KEY BENEFITS IF AHCA WAIVERS ARE ENACTED? (2017), <https://www.kff.org/health-reform/issue-brief/would-states-eliminate-key-benefits-if-ahca-waivers-are-enacted/>.

<sup>6</sup> REBEKAH BAYRAM & BARBARA DEWEY, MILLIMAN, ARE ESSENTIAL HEALTH BENEFITS HERE TO STAY? (2017), <http://us.milliman.com/uploadedFiles/insight/2017/essential-health-benefits.pdf>.

<sup>7</sup> SARAH LUECK, CTR. BUDGET & POLICY PRIORITIES, ADMINISTRATION'S PROPOSED CHANGES TO ESSENTIAL HEALTH BENEFITS SERIOUSLY THREATEN COMPREHENSIVE COVERAGE 7 (2017), <https://www.cbpp.org/research/health/administrations-proposed-changes-to-essential-health-benefits-seriously-threaten>.

medical debt and health-related bankruptcies, which have ameliorated since the ACA was enacted.<sup>8</sup>

An increase in out-of-pocket costs is not what consumers want. Two-thirds of consumers—67%—believe that the top health care priority should be to lower, not increase, their out-of-pocket costs.<sup>9</sup> Consumers value comprehensive benefits and the ACA’s consumer protections. At least two-thirds of marketplace enrollees—65% or more—reported satisfaction with their qualified health plan in 2014 through 2016 in three separate national surveys.<sup>10</sup> To improve their coverage, most consumers want policymakers to lower the cost of prescription drugs, to ensure that benefits are comprehensive, and to improve network adequacy.<sup>11</sup> That is not what this proposed rule does.

***b. The Rule Would Make Comprehensive ACA-Compliant Coverage More Expensive.***

If the proposed rule were finalized in its current form, AHPs could bypass important ACA protections and structure eligibility rules, benefit designs, and marketing practices in ways that encourage enrollment by healthier individuals and groups while discouraging less healthy individuals and groups. AHPs would be competing in the same market as individual and small-group plans, but would be subject to different rules. Although the rule prohibits AHPs from setting premiums based on an individual employer’s claims history, the AHP would still be allowed to base premiums on its overall enrollee risk pool. An AHP that structures its eligibility rules and benefit designs to attract a healthier risk pool would therefore be able to charge lower-than-average premiums. This would create an uneven playing field and lead to adverse selection because AHPs could siphon healthy individuals from the ACA-compliant plans in the individual and small group markets.

The impact of this exodus by healthy self-employed individuals from the individual market would be substantial; the U.S. Department of the Treasury found that, in 2014, one in five

---

<sup>8</sup> ALLEN ST. JOHN, CONSUMER REPORTS, HOW THE AFFORDABLE CARE ACT DROVE DOWN PERSONAL BANKRUPTCY (2017), <https://www.consumerreports.org/personal-bankruptcy/how-the-aca-drove-down-personal-bankruptcy/>.

<sup>9</sup> ASHLEY KIRZINGER, ET AL., KAISER HEALTH TRACKING POLL: HEALTH CARE PRIORITIES FOR 2017 (2017), <https://tinyurl.com/ychedlcaz>.

<sup>10</sup> U.S. Government Accountability Office, *Most Enrollees Reported Satisfaction with their Health Plans, Although Some Concerns Exist*, GAO-16-761, Sept. 2016, <https://www.gao.gov/assets/680/679673.pdf>.

<sup>11</sup> Drew Altman, “The Health Care Plan Trump Voters Really Want,” *New York Times* (Jan. 5, 2017), <https://www.nytimes.com/2017/01/05/opinion/the-health-care-plan-trump-voters-really-want.html>; KIRZINGER ET AL., *supra*, note 9; Jennifer Tolbert & Larisa Antonisse, *Listening to Trump Voters with ACA Coverage: What They Want in a Health Care Plan*, Kaiser Family Foundation, Feb. 2017, <http://files.kff.org/attachment/Issue-Brief-Listening-to-Trump-Voters-with-ACA-Coverage-What-They-Want-in-a-Health-Care-Plan>.

Marketplace consumers was a small business owner or self-employed.<sup>12</sup> People and small businesses that want comprehensive coverage in the individual and small-group insurance markets could find their options dwindling or that the premiums are unaffordable.

The ACA's single risk pool requirement requires issuers to determine rates based on the combined experience of all members within each market, and the risk adjustment program transfers funds from plans with lower-risk enrollees to plans with higher-risk enrollees. Together, these requirements create statewide rating pools for the individual and small group markets. AHPs would not be subject to these requirements, and the ability of AHPs to siphon healthier individuals from the ACA-compliant plans would therefore bifurcate the individual and small group markets and could create a rate spiral.<sup>13</sup> This would make it difficult or impossible for individuals with disabilities and chronic conditions to purchase affordable individual or small group coverage that meets their needs.

***c. AHPs will weaken the individual and small group markets.***

The Department states that the proposed rule will provide additional opportunities for employer groups or associations to offer coverage alternatives to small businesses that are more affordable than insurance currently available on the individual and small group market. The only way, however, that the coverage will be more affordable is if it covers fewer benefits, has fewer protections against fraud and insolvency, or syphons healthier individuals and small groups from other markets.

As part of the implementation of the ACA, CMS provided guidance to bring AHPs in line with the standards and consumer protections in the ACA. CMS required that health insurance policies sold through an association to individuals and small employers must be regulated under the same standards that apply to the individual market or the small-group market.<sup>14</sup> Because of this guidance, known as the "look through" doctrine, the coverage was required to comply with the ACA's protections for people with preexisting conditions and other standards such as the essential health benefits.

Yet the proposed regulation would create an uneven playing field between AHPs and the individual and small-group markets. Because the rule would subject AHPs to substantially weaker standards than ACA-compliant plans, the plans could be structured and marketed

---

<sup>12</sup> U.S. DEP'T TREASURY, TREASURY NOTE: ONE IN FIVE 2014 MARKETPLACE CONSUMERS WAS A SMALL BUSINESS OWNER OR SELF-EMPLOYED (2017), <https://www.treasury.gov/connect/blog/Pages/One-in-Five-2014-Marketplace-Consumers-was-a-Small-Business-Owner-or-Self-Employed.aspx>.

<sup>13</sup> Letter from American Academy of Actuaries to the Employee Benefits Security Administration Office of Regulations and Interpretations (Feb. 9, 2018), [http://actuary.org/files/publications/AHP\\_modeling\\_considerations\\_02092018.pdf](http://actuary.org/files/publications/AHP_modeling_considerations_02092018.pdf).

<sup>14</sup> Memorandum from Gary Cohen, *supra*, note 1.



to attract younger and healthier people, thus pulling them out of the ACA-compliant small-group market and leaving older, sicker, and costlier risk pools behind. If healthier individuals and small groups are siphoned from the individual and small group markets, costs will increase and plan choices will decrease for employers and individuals remaining in those markets. Consumers who need comprehensive coverage, including those with pre-existing conditions, and consumers with incomes too high to qualify for subsidies, would face rising premiums and potentially fewer plan choices.

***d. “Working owners” should not be allowed to join AHPs.***

The proposed rule allows working owners to join AHPs providing ERISA plans. In 2016, 31 percent of the individual or small group market was self-employed.<sup>15</sup> This rule effectively allows those individuals to join AHPs that function as large group employer plans. We are deeply concerned that as a result, AHPs will be able to design and market plans to cherry-pick healthy individuals out of the ACA-complaint individual market, resulting in increased rates and decreased choice in the individual market.

In addition, the broad definition of AHPs means that they do not have to confirm that an individual is actually a “working owner”; this opens up the ability for any individuals, regardless of whether they are true “working owners”, to purchase coverage through an AHP. The Department should not allow associations to have working owners qualify as both an employer and as an employee as this will bring instability to the individual market.

**II. The Department should retain important consumer protections, given the history of AHPs committing fraud and becoming insolvent.**

For the 30 years prior to the Affordable Care Act (ACA), Association Health Plans (AHPs) were frequently used as a vehicle for selling fraudulent insurance coverage. Scams initially flourished after Congress exempted AHP arrangements from state oversight in 1974 through the Employee Retirement Income Security Act (ERISA).<sup>16</sup> The operators of these fraudulent AHPs targeted small businesses and self-employed people, and then collected premiums for non-existent health insurance, did not pay medical claims, and left businesses and individuals with millions of dollars in unpaid bills and patients without health insurance coverage.<sup>17</sup> AHPs would often set up headquarters in one state with limited regulatory oversight and market policies to businesses and consumers in other states with

---

<sup>15</sup> LIZ HAMEL *ET AL.*, KAISER FAMILY FOUND., SURVEY OF NON-GROUP HEALTH INSURANCE ENROLLEES, WAVE 3 (2016), <https://www.kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3>.

<sup>16</sup> MILA KOFMAN, GEORGETOWN U. HEALTH POLICY INST., ASSOCIATION HEALTH PLANS: LOSS OF STATE OVERSIGHT MEANS REGULATORY VACUUM AND MORE FRAUD (2005), <https://hpi.georgetown.edu/ahp.html>.

<sup>17</sup> *Id.*

more robust regulation, thereby bypassing those states' more protective rating and benefit standards.<sup>18</sup>

In 1982, Congress responded to widespread fraud by amending ERISA to clarify states' authority to regulate association health plans. Because of this broad authority, many states limited the potential risks, including fraud, insolvency, and market segmentation, associated with the expanded AHP market.<sup>19</sup> Even with increased oversight, fraudulent insurance sold through associations remained a problem. Researchers found that between 2000 and 2002, 144 operations left over 200,000 policyholders with over \$252 million in unpaid medical bills.<sup>20</sup> Four of the largest operations left 85,000 people with over \$100 million in medical bills.<sup>21</sup> For consumers and patients, the results were disastrous: some victims were forced into bankruptcy; others have lifelong physical conditions as a result of delayed or foregone medical care.<sup>22</sup>

AHPs also have a long history of financial instability and insolvency when medical claims exceed the association's ability to pay. There are no federal financial standards to guarantee that AHPs will remain financially stable, even as the proposed regulation could allow AHPs to cover millions more individuals and small employers.

We are extremely concerned that the proposed regulation will once again leave consumers and patients in AHP arrangements with insufficient coverage, unpaid medical bills, and lifelong health implications—just as AHPs did before the ACA provided more oversight and protection.

***a. Individuals and small businesses must be protected from discrimination.***

We are pleased that the proposed rule applies the HIPAA nondiscrimination provisions in 29 § 2590.702(a) and § 2590.702(b) to AHPs. The nondiscrimination provisions prevent AHPs from discriminating based on health status related factors against employer members or employers' employees or dependents. As proposed, this would prevent AHPs from using health factors to determine eligibility for benefits or in setting premiums. Health factors include: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. We support this

---

<sup>18</sup> Kevin Lucia & Sabrina Corlette, Commonwealth Fund, *Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability*, TO THE POINT BLOG (Jan. 24, 2018), <http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority>.

<sup>19</sup> *Id.*

<sup>20</sup> KOFMAN, *supra*, note 16.

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*



proposal, as it is essential to help protect both employers and their employees from discrimination based on health status. We strongly encourage the Department to retain this requirement in final rule. We support this provision applying to all AHPs, regardless of when in time they were established. AHPs currently in operation should be required to fully comply with nondiscrimination requirements, without exception and without delay.

While this is an important provision of the proposed regulation, it does not go far enough because, as described in detail above, an AHP can engage in other practices that result in discrimination. The proposal exempts AHPs from ACA consumer protections designed to protect people with preexisting conditions. An AHP would be exempt from EHB provisions, rate reforms, guaranteed issue and single-risk pool requirements. Consequently, an AHP can simply avoid covering people and businesses with medical needs. Using benefit design, an AHP can attract healthier groups. For example, an AHP could discriminate in rates, charging women higher rates than men, charging smaller businesses higher rates than larger businesses, charging businesses in certain industries higher rates, and charging older people higher rates without limit. Rating practices would result in healthier groups being covered through an AHP.

Furthermore, an AHP could engage in marketing practices targeted at attracting healthier people. An AHP could avoid a geographic area where there is a high incident of cancer rates, heart disease, and diabetes and thereby avoid covering sicker populations. Its geographic location can also be used to engage in redlining practices. An AHP could limit membership to a specific industry that has lower claims than other industries. All of these, and other discriminatory practices, would be allowed because AHPs would be exempt from the ACA's requirements regarding EHB, rate reforms, and guaranteed issue requirements.

The Department requests comment from stakeholders on its proposal to prohibit AHPs from treating different employer-members as different groups based on health factors of individual employees. Specifically, the Department requests comment on whether this structure would "create involuntary cross-subsidization across firms," and cites arguments in favor of health plan pricing where premiums match risk. We oppose any proposal that allows individuals or groups of individuals to buy insurance that matches their risk. This is functionally the same as allowing seemingly permissible "employment-based" criteria to serve as a pretext for discrimination on the basis of health factors. Health status is not static; individuals who are healthy today could be diagnosed with a disability or chronic illness at any time. Individuals with disabilities and chronic illness could still be employed in low-risk professions, but their offer of coverage through the AHP may not be adequate for their needs if the AHP were allowed to bypass ACA protections such as EHBs and rating restrictions. Additionally, if the offer of coverage through the AHP meets minimum value and affordability requirements, individuals with high health needs would become ineligible

for premium tax credits and therefore would not have the option of purchasing affordable coverage through the marketplace that meets their needs.

***b. Individuals and small businesses must be notified if AHPs are not meeting minimum value or providing all the essential health benefits.***

We appreciate the Department's request for information about required notices. Assuming that, against our recommendation, the Department allows AHPs to use coverage standards that are inferior to individual and small-group market standards, those AHPs should be required to provide notice to employer groups and potential beneficiaries detailing those differences. This will ensure that employer groups and employees know that the plans are less comprehensive than health plans available in the individual or small group markets. Further, in these circumstances, the employees and their dependents must be made aware of their right to receive coverage through the health insurance marketplaces, potentially with premium tax credits based on their income. Similarly, AHPs should be required to notify employer groups and potential beneficiaries of any essential health benefits not covered by their plans.

The Department should also clarify that all notice requirements that apply to group health plans apply to plans under this regulation, including notice of appeal rights, summary of benefits and coverage, and summary plan descriptions.

***c. The Department should retain existing law to prevent fraudulent entities from creating AHPs.***

Proposed regulation at § 2510.3-5 (b) allows a bona fide group or association of employers to exist for the sole purpose of offering health insurance, reversing decades of guidance that protect employers, beneficiaries, and insurance markets. Allowing a bona fide group or association to exist for the sole purpose of offering health insurance opens the door for fraud and financial insolvency. For example, an individual or entity could create an AHP that appears to meet all requirements of employer participation but places financial control in the hands of an individual who intends to defraud employer groups or leads to insolvency. By requiring only minimal qualifications for offering an AHP, the Department is opening the door to entities creating AHPs with the explicit purpose of defrauding small employers and individuals as AHPs could more easily establish and quickly expand across state lines. The Department should retain existing law that a group or association cannot exist solely for the purpose of sponsoring a group health plan.

***d. The Department should retain the commonality of interest test.***

The proposed regulation (at § 2510.3-5 (c)) significantly weakens the commonality of interest test, which is meant to show a commonality of interest related to the employers participating in the AHP. The existing commonality of interest test prevents groups and associations from circumventing protections that apply to the individual and small group markets by requiring that associations be established for a purpose other than offering insurance.

The proposed commonality of interest test eliminates that requirement and would instead allow association to be based on member employers' line of business or trade, or on geography, regardless of industry. The proposed test is so broad that employers with no common interest will be allowed to join together as an AHP, opening the door to fraudulent entities to offer coverage.

The Department should retain the existing commonality of interest test based on facts and circumstances. If the commonality of interest test is changed, additional factors should be required beyond shared geographic location or industry in order to limit the ability of groups or associations to form without any true commonality of interest among employers. With regard to shared geography, the final rule must prevent arbitrary definitions of shared geography that allow AHPs to carve out higher cost areas.

**III. States are best situated to regulate AHPs.**

Strong oversight of AHPs is essential because of a long and well documented history of AHP insolvencies and fraud. Since ERISA was enacted, several times Congress has expanded the Department's oversight authority and has given the Department new enforcement tools. In 1982, Congress amended ERISA to clarify that both the Department and states have authority to regulate AHPs. In 1996, Congress granted the Department authority to require AHPs to register (MEWA registration or Form M-1 requirement). In 2010, Congress granted the Department new oversight authority including cease-and-desist authority to shut down insolvent or fraudulent AHPs administratively without first having to go to court. While all of these federal enforcement tools are important, none compare to the enforcement authority that states have and use. Further, while the Department has some enforcement tools, it lacks adequate staffing or funding to conduct meaningful oversight. And even if the Department gained resources, it is very unlikely that the Department could ever replace or replicate state regulation and oversight: federal oversight is reactive, while state oversight is proactive.

Compared to the Department's lackluster record, generally states have a strong record of effective oversight—in cases of both insolvencies and scams. For self-insured AHPs, states

either require licensure as an insurer or have AHP-specific laws with lower reserve and capital requirements than for other issuers.<sup>23</sup> Registration or licensing requirements, including background checks to keep convicted felons from operating self-insured AHPs, help mitigate risk of mismanagement. Depending on the financial strength of AHP in their states, state regulators use varied approaches.<sup>24</sup>

**a. Given the Department's capacity constraints, it should seek to complement, not supersede, State oversight and enforcement of AHPs.**

The Department generally investigates plans only after they establish a pattern of failing to pay claims. Thus, by the time the Department acts, consumers have already been harmed. States have numerous tools that allow them to conduct regular oversight and intervene before consumers are harmed. These tools include background checks for operators/management of AHPs, financial and market conduct examinations, form reviews, rate reviews, etc. The broker community also provides states with “eyes and ears” on the ground to quickly identify bad actors who promote fake insurance. States also have and use enforcement tools, including cease-and-desist authority and state receivership laws. States have vigorously pursued bad actors in the AHP market and have been able to act earlier and quicker than the Department, better protecting consumers from harm.

Historically, the Department has been slow to take action against insolvent or fraudulent AHPs, in part because it did not have cease-and-desist authority, and it relied on states to shut down bad actors.<sup>25</sup> During the 2000 scam cycle, states issued cease and desist orders against 41 entities, while the Department shut down only three entities.<sup>26</sup> The Department was granted cease and desist authority in 2010, under the ACA, but has only used its new authority once, in 2017.<sup>27</sup> During this same period, one state, Florida, has taken three enforcement actions against AHPs.<sup>28</sup>

---

<sup>23</sup> Mila Kofman & Jennifer Libster, *Turbulent Past, Uncertain Future: Is It Time to Re-evaluate Regulation of Self-Insured Multiple Employer Arrangements?*, 27 J. INS. REG. 17 (2005), <http://hcfo.org/publications/turbulent-past-uncertain-future-it-time-re-evaluate-regulation-self-insured-multiple-em.html>.

<sup>24</sup> See, e.g., MILA KOFMAN ET AL., COMMONWEALTH FUND, MEWAS: THE THREAT OF PLAN INSOLVENCY AND OTHER CHALLENGES 7 (2004), [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2004/mar/mewas--the-threat-of-plan-insolvency-and-other-challenges/kofman\\_mewas-pdf.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2004/mar/mewas--the-threat-of-plan-insolvency-and-other-challenges/kofman_mewas-pdf.pdf).

<sup>25</sup> U.S. GEN. ACCOUNTING OFF., EMPLOYERS AND INDIVIDUALS ARE VULNERABLE TO UNAUTHORIZED OR BOGUS ENTITIES SELLING COVERAGE 4-5 (2004), <https://www.gao.gov/new.items/d04312.pdf>.

<sup>26</sup> *Id.* at 4.

<sup>27</sup> See Press Release, U.S. Dep't Labor, U.S. Department of Labor Obtains a Temporary Restraining Order to Protect Participants and Beneficiaries of Failing MEWA (Nov. 8, 2017), <https://www.dol.gov/newsroom/releases/ebsa/ebsa20171108>.

<sup>28</sup> See Fla. Off. Ins. Reg., Actions Against Unlicensed Entities, [https://www.floir.com/Sections/MarketInvestigations/ue\\_regulatory\\_entities.aspx](https://www.floir.com/Sections/MarketInvestigations/ue_regulatory_entities.aspx) (last visited Feb. 28, 2018).

Given the history of fraud and insolvencies of AHPs, it is critical for the Department to address questions of oversight and enforcement. In 2007, the Government Accountability Office (GAO) found that the Department had a ratio of one employee conducting oversight or enforcement activities for every 8,000 plans.<sup>29</sup> When Congress considered legislating standards for AHPs, the Department testified that it can review plans under its jurisdiction once every 300 years.<sup>30</sup> Before proceeding to finalize the proposed rule, the Department should review each state's approach to regulating AHPs to learn what types of oversight are necessary to prevent and mitigate AHP insolvencies and fraud. When Congress considered an AHP bill in 2005, the Congressional Budget Office (CBO) estimated that the legislation would have required the Department to hire 150 additional employees and spend an additional \$136 million over 10 years to properly oversee an expansion of AHPs.<sup>31</sup> Importantly, since the Department's proposal goes further to expand the proliferation of AHPs than the 2005 AHP bill, the Department would need even more staff to regulate effectively. EBSA, the Department's office charged with oversight of AHP plans, has recently experienced attrition, and the Department is also under a hiring freeze, making it even more challenging to meet the increased oversight and enforcement need created by this proposal. EBSA has an estimated 750 people responsible for health and pension plans. Only a small fraction are investigators. By comparison, state insurance departments have an estimated 11,209 employees and for FY 2018, a total of \$1,417,145,120 budget.<sup>32</sup>

States have historically been better positioned to conduct oversight and enforcement activities to protect consumers from fraud and mismanagement. It is essential for states to continue regulating. Unfortunately, the proposal establishes new obstacles and fails to consider the financial impact of the proposal on states. The Department should review how the proliferation of AHPs would impact state oversight and enforcement resources before finalizing regulations.

The Department asserts that requirements in proposed 29 C.F.R. § 2510.3-5(b) for a formal AHP organizational structure and control by employer members, are intended to ensure that AHP sponsors are bona fide employment-based associations not prone to abuse. However, the Department admits that the flexibility afforded AHPs under this proposal

---

<sup>29</sup> U.S. GOV'T ACCOUNTABILITY OFF., ENFORCEMENT IMPROVEMENTS MADE BUT ADDITIONAL ACTIONS COULD FURTHER ENHANCE PENSION PLAN OVERSIGHT 10 (2007), <https://www.gao.gov/assets/260/255488.pdf>.

<sup>30</sup> 105 CONG. REC. D1044 (daily ed. Oct. 1, 1997) (Testimony of Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration, Senate Labor and Human Resources Committee).

<sup>31</sup> CONG. BUDGET OFF., COST ESTIMATE: H.R. 525: SMALL BUSINESS HEALTH FAIRNESS ACT OF 2005 at 6 (2005), <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/62xx/doc6265/hr525.pdf>.

<sup>32</sup> NAT'L ASSN. INS. COMM'NRS, 2016 INSURANCE DEPARTMENT RESOURCES REPORT, VOL. ONE 29 tbl. 7 (2017), [http://www.naic.org/prod\\_serv/STA-BB-16-01.pdf](http://www.naic.org/prod_serv/STA-BB-16-01.pdf).

could introduce more opportunities for mismanagement or abuse and thus increase the potential oversight demands on the Department and state regulators. The Department cites new enforcement and reporting provisions added by the ACA to help reduce the rate of financial collapse in AHPs—but the Department offers no evidence that it is actually using these tools to protect consumers from AHP insolvencies.

It is also important to note that proposed 29 C.F.R. § 2910.3-5(e) raises significant oversight and enforcement concerns, by allowing individuals to simply self-certify compliance, without any review for compliance.

The Department has not supported this with any data from its experience conducting oversight and enforcement against AHPs. The Department has not provided any data or analysis on the cost of fraudulent or financially unstable AHPs to their members. The Department has acknowledged that Congress has repeatedly intervened to address AHP fraud, but the Department has failed to provide any data on its experience identifying and intervening against fraudulent or insolvent AHPs. The failure to provide any data on its oversight and enforcement activities and the impact of fraud, insolvency, and noncompliance on AHP members is a significant failure of this proposal. The Department should provide data on its oversight and enforcement activities, as well as details on how it would address oversight and enforcement, before proceeding with this proposal.

While we support the Department's work to expand its oversight and enforcement capacity, it must be sure that its efforts complement and do not supplant state efforts. We also encourage the Department to evaluate states' capacity for oversight and enforcement, and focus its efforts in states that have less robust schemes for monitoring and enforcement.

***b. The Department must avoid preempting state laws.***

The proposed rule raises questions about preemption of state law. We oppose preemption of state laws and would consider any attempt by the Department to preempt states through this rulemaking as a usurpation of Congress' lawmaking authority. Any effort to preempt states through this rulemaking would be in conflict with clear Congressional intent. The 1982 Erlenborn amendment gave states broad authority over entities that cover two or more employers and the preemption standards applicable to group health plans, as added by Congress to ERISA through HIPAA and reaffirmed by the ACA, all support the authority of states to regulate in this area.

Furthermore, we are concerned that the Department's proposal to change more than 40 years of ERISA interpretation creates new ambiguity. Historically, entities seeking to evade state oversight and state standards used ERISA as a shield and exploited exceptions and ambiguity to challenge state actions. To head-off such ERISA abuses, the Department



should clearly state that ERISA single employer AHPs, including the ones covering people in more than one state, would have to comply with all state laws in states in which they operate and continue to be subject to state oversight and regulation.

Finally, we are concerned about the questions raised in the RFI. The Department appears to signal that it is considering using its section 514 authority to issue individual or class exemptions for plans that are otherwise subject to state regulation. We strongly oppose any proposal that would exempt AHPs from state regulation. As discussed above, states have long taken the lead in addressing AHP insolvencies and fraud, and any attempt to preempt state authority would harm consumers. The Department's inability to serve as the sole regulator has been well documented. The Department neither has the resources nor the expertise to serve as the sole regulator, both of which weigh strongly against the Department taking action to prevent states from regulating. Any attempts to issue class or individual exemptions would be an attack on the states and would only serve to fuel fraud and insolvency. Any attempt to exempt all AHPs from state regulation would exceed the Department's statutory authority.

#### **IV. The Affordable Care Act has already addressed many of the problems AHPs were designed to solve.**

AHPs were originally offered in the 1990s and early 2000s as a possible policy solution to the lack of affordable health coverage options for small businesses and self-employed individuals.<sup>33</sup> Moreover, because plans could charge higher premiums—or even refuse coverage—based on a variety of factors including pre-existing conditions, age, and gender, etc., proponents of AHPs suggested that allowing small businesses and individuals to purchase coverage as a larger group would help spread out risk factors allowing the group to obtain a more favorable rate.<sup>34</sup> Proposals to encourage AHPs at that time also contended that by allowing small employers to come together and purchase health coverage as a group, those small employers would be able to negotiate more favorable rates and offer more comprehensive coverage.<sup>35</sup> In practice, as described in more detail below, these promises never bore fruit since many AHPs during this time period were under-regulated and struggled to pay claims and maintain solvency.

---

<sup>33</sup> See, e.g., Mark A. Hall *et al.*, *HealthMarts, HIPCs, MEWAs, And AHPs: A Guide For The Perplexed*, 20 Health Aff. 142, 142-43 (2001), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.20.1.142>; CONG. BUDGET OFFICE, INCREASING SMALL-FIRM HEALTH INSURANCE COVERAGE THROUGH ASSOCIATION HEALTH PLANS AND HEALTH MARTS 1-2 (2000), <https://www.cbo.gov/sites/default/files/106th-congress-1999-2000/reports/healthins.pdf>.

<sup>34</sup> See Hall *et al.*, *supra*, note 33, at 142, 147; see also, e.g., MILA KOFMAN & KARL POLZER, WHAT WOULD ASSOCIATION HEALTH PLANS MEAN FOR CALIFORNIA? 4 (2004), <https://www.chcf.org/wp-content/uploads/2017/12/PDF-AHPFullReport.pdf>.

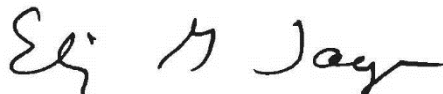
<sup>35</sup> See Hall *et al.*, *supra*, note 33, at 143, 145.

In the meantime, the Affordable Care Act created different policy solutions to the lack of affordable coverage options for individuals (including self-employed individuals) and small businesses. These include health insurance exchanges for both individuals and small groups, prohibitions on pre-existing condition exclusions or limitations, premium subsidies and cost-sharing reductions for lower-income individuals, community rating, and limits on premium rating. As a result of these reforms, small businesses and self-employed individuals already have several options to obtain affordable, comprehensive coverage. Thus, the U.S. Department of the Treasury found that, in 2014, one in five Marketplace consumers was a small business owner or self-employed.<sup>36</sup> As described in more detail below, rather than providing another option for small businesses and self-employed individuals to purchase affordable and comprehensive coverage, allowing more AHPs to operate as large group plans will have the effect of driving up costs and reducing coverage, while destabilizing the overall health insurance market.

## Conclusion

In sum, the proposed rule will weaken insurance markets and increase costs while reducing benefits for small businesses and their employees. It will increase health disparities and disproportionately impact people with disabilities and chronic conditions. Thank you for your attention to our comments. If you have any questions or need any further information, please contact Abbi Coursolle, Senior Attorney ([coursolle@healthlaw.org](mailto:coursolle@healthlaw.org); (310) 736-1652)).

Sincerely,



Elizabeth G. Taylor

---

<sup>36</sup> U.S. DEP'T TREASURY, *supra*, note 12.