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: Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans (RIN 1210-AB85)

Dear Secretary Acosta and Assistant Secretary Rutledge:

On behalf of the more than 30 million Americans living with diabetes and the 84 million more with prediabetes, the American Diabetes Association (ADA) provides the following comments and recommendations regarding the Association Health Plan (AHP) Proposed Rule (RIN 1210-AB85).

The Affordable Care Act's (ACA) guarantee of coverage offering access to a comprehensive set of benefits, regardless of health status, provides critical protection that ensures people with diabetes and others with pre-existing conditions will have access to the services and treatments they need manage their disease.

While we believe the proposed rule is missing critical data and statistics detailing the history of financial abuses associated with AHPs and the agency's experience with financially failing multiple employer welfare arrangements needed to fully understand the potential negative impact of the proposed regulation, based on the information available we have deep concerns that the proposed rule will weaken the individual and small group markets that provide that guarantee of comprehensive coverage. Small business employees and individuals able to enroll in AHPs that can operate under the proposed rule may not have access to the benefits and services they need and may face significant out-of-pocket costs, while those who remain in coverage that meets the ACA's consumer protections will encounter higher premiums and reduced plan choice. At the same time, consumers will be put at far greater risk of fraudulent and insolvent plans that leave them with unpaid medical bills.

Below we provide comment on the potential impact of the proposed expansion of AHPs, followed by comment on specific provisions of the proposed rule.

Impact of the proposed rule on risk pools in the individual and small group markets

The Department of Labor (DOL) 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 has fewer protections against fraud and insolvency, covers fewer benefits, or syphons healthier individuals and small groups from other markets.

As part of the implementation of the ACA, the Centers for Medicare and Medicaid Services (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 be regulated under the same standards that apply to the individual market or the small-group market.[1] 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.

The proposed rule would make it far easier to establish an AHP that qualifies as large-group, single employer coverage that doesn't have to comply with many of the ACA's consumer protections, including essential health benefits and rating rules. Because the proposal would subject AHPs to substantially weaker standards than ACA-compliant plans, the plans could be structured and marketed 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. Consumers who need comprehensive coverage, including those with diabetes, and consumers with incomes too high to qualify for subsidies, would face rising premiums and potentially fewer plan choices.

The American Academy of Actuaries has said that allowing AHPs to operate under a different set of rules will undermine the ACA-compliant small group and individual markets and drive up premiums.[2] Likewise, a 2003 study of Congressional proposals to expand AHPs estimated that between 19% and 52% of small businesses would move to AHPs and prices for small businesses left in regulated markets would increase as much as 23%.[3] The impact of the proposed rule is likely to be much more severe because the study was done when individual and small group markets were not subject to many of the ACA protections that are critical to people with pre-existing conditions.

Wider use of AHPs previously caused substantial harm to regulated markets in several states, prior to tightening standards for bona fide status. A leading example is the market collapse that occurred in Kentucky in the 1990s. Kentucky implemented market reforms but exempted AHPs from these reforms, including rating reforms. Relatively healthy individuals obtained coverage through associations, while

higher cost individuals obtained coverage in the regulated markets to which the reforms applied. Carriers cancelled health insurance policies and over 20 carriers left the market, leaving a decimated market with just two carriers, one of which had experienced $30 million in losses over the prior 20 months.[4]

Impact of the proposed rule on risk of AHP fraud and insolvency

In lowering the barrier for associations to be treated as a large employer plan, the proposed rule opens the door to fraud and scams. This proposal not only does not include any standards or processes to minimize potential fraud, but it creates opportunities for fly-by-night promoters to set up scams. There is a long, well documented history of scams and fraud promoted through AHPs. Following enactment of ERISA in 1974, promoters claimed the federal law preempted states from regulating multiple employer entities like associations. In response to widespread fraud, Congress enacted an amendment to ERISA in 1983 to clarify that both states and DOL have authority over AHPs. Generally, the amendment worked well and enabled states to effectively go after fraudulent plans, but promoters of scams continue to falsely claim ERISA preemption.[5]

The proposed rule adds new ambiguity to ERISA that will be used by promoters to evade state oversight. For example, the proposal would permit an AHP to operate in a metropolitan area that crosses into multiple states, but fails to say that each state has jurisdiction. Promoters will use this new ambiguity to evade state oversight.

In addition to new ambiguity, the proposal includes specific changes that will make it easier for promoters of scams to set up shop. Overturning decades' worth of guidance, the proposed rule would allow entities to form for the sole purpose of offering health coverage and fails to require an entity to be in existence for any period of time. Past AHP legislative proposals required AHPs to have a legitimate purpose other than selling health insurance and be in existence for three years. DOL's proposal has neither requirement and would have the unintended consequence of inviting fly-by-night scams.

In the preamble, DOL acknowledges the fraud that has been present in the AHP market for years, but fails to propose solutions to minimize the risk to consumers. Instead, the proposed rule would promote the proliferation of AHPs and create uncertainty about who has authority to regulate, the combination of which would increase the risk to consumers and reduce the likelihood that a state regulator would be able to intervene to protect consumers.

AHPs also have a long history of financial instability and insolvencies,[6] which the proposed rule recognizes. The Regulatory Impact Analysis, Operational Risks Section, begins by noting that "Historically, a number of MEWAs have suffered financial mismanagement or abuse, often leaving participants and providers with unpaid benefits and bills." However, there are no solvency standards under ERISA that AHPs would have to meet, and none included in this proposed rule. With the

proliferation of AHPs that will result from this proposed rule, potentially millions more employers and individuals will be at risk of illusory coverage under an AHP that has insufficient funds to pay claims. While states will continue to be able to set solvency standards, the proposed rule raises questions about state authority to establish other requirements needed to assess the financial health of AHPs.

The ADA urges the Department to ensure continued state authority to regulate AHPs is clear and unimpeded in the final rule. State oversight in this area is essential to combat the fraudulent actors and potentially poorly managed associations that will flood the AHP market if this proposal is finalized.

Expanding the test to determine whether an association is the plan sponsor of group coverage

Currently, only in rare cases is an association of small employers and individuals treated as a single employer plan subject to large group plan requirements. Under the proposed rule, associations will be able to sponsor plans even if the association exists solely for the purpose of offering health coverage to its members. Further, an association can more easily establish a "commonality of interest" and operate across multiple states with little more than an industry or geographic area in interest.

The ADA strongly urges the DOL to maintain the stronger requirements that currently apply to associations seeking large-group status under ERISA. That is, associations must continue to exist for a purpose other than providing health coverage and they must share some commonality and organizational relationship unrelated to the provision of health benefits.

The ADA also urges the DOL to omit "working owners" from eligibility for AHP coverage in the final rule. Expanding AHPs to include self-employed individuals goes against long-standing DOL guidance. ERISA's definition of an "employee welfare benefit plan" is premised on the existence of an employer/employee relationship. Furthermore, such a change will undermine the individual market if individuals can choose between buying in an ACA-regulated individual market or buying into an AHP that functions as a large group plan exempt from most ACA protections. In 2016, 31 percent of the individual or small group market was self-employed.[7] We are deeply concerned that as a result, AHPs will be able to design and market plans to cherry-pick healthy individuals from the ACA-complaint individual market, resulting in increased rates and decreased choice for the many left behind.

In addition, the proposal would authorize individual enrollment in an AHP based on the mere attestation that an individual is actually a "working owner," without a requirement that the AHP take steps to confirm this basic element of eligibility. This lax approach invites abuse that would likely exacerbate the negative effects of risk segmentation on the individual market.

Application of non-discrimination rules

The proposed rule would apply to AHPs the HIPAA non-discrimination rules that apply to group health plans, thereby prohibiting AHPs from using health status in determining eligibility for benefits or in

setting premiums for employer members or their employees or dependents. **The ADA fully supports this protection as essential to reducing the power of AHPs to cherry pick healthy employers and individuals for enrollment. However, those protections, alone, are insufficient to prevent AHPs from designing benefits and varying rates to appeal to younger, healthier individuals.**

An AHP would be exempt from protections regarding essential health benefits (EHB), premium rating, and guaranteed issue, as well as the single-risk pool requirement. Consequently, an AHP can simply avoid covering people and businesses with costly medical needs. Using benefit design, an AHP can attract healthier groups. For example, an AHP could offer coverage without diabetes supplies, maternity care, mental health benefits, and expensive prescriptions in order to deter enrollees who need that care. Also, an AHP would be able to vary rates by gender, age (without limit), firm size and industry, among other factors. An AHP could also engage in marketing practices targeted at attracting healthier people by, for example, avoiding a geographic area where there is a high incidence of diabetes, cancer or heart disease.

To ensure that AHPs are not engaged in discriminatory practices and to prevent cherry-picking, the ADA recommends the final rule apply EHB, rate reforms, guaranteed issue and single-risk pool requirements to these plans. The single-risk pool requirement is an important way to ensure that AHPs, where they do exist, do not result in a segmented market. Failure to extend these protections to AHPs, in addition to protections against discrimination based on health status, will expose employers and their employees to discriminatory practices, including discriminatory rating and marketing practices.

State authority to regulate AHPs

We are deeply concerned that the proposal raises questions about preemption of state regulation. Any effort to preempt states through this rulemaking would be in conflict with clear Congressional intent. The 1983 amendment to ERISA 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 DOL'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 ADA recommends DOL 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. DOL appears to signal that it is considering using its section 514 authority to issue individual or class exemptions for multiple employer

welfare arrangements that are otherwise subject to state regulation. **The ADA strongly opposes any proposal that would exempt AHPs from state regulation.** States have long taken the lead in addressing AHP insolvencies and fraud and maintaining competitive markets, and any attempt to preempt state authority would harm consumers and markets. DOL's inability to serve as the sole regulator has been well documented. DOL neither has the resources nor the expertise to serve as the sole regulator, both of which weigh strongly against DOL 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.

Conclusion

The ADA appreciates the opportunity to provide feedback on the proposed rule. We are deeply concerned that the effect of the proposed changes will be to expose small businesses and individuals to fraud and unpaid medical bills and to destabilize the individual and small group markets where people with diabetes must obtain coverage that meets their needs. Should you have any questions on the comments or recommendations we have provided, please contact Krista Maier, Vice President, Public Policy & Strategic Alliances at KMaier@diabetes.org, or 703-253-4365.

Sincerely,

LaShawn McIver, MD, MPH
Senior Vice President, Government Affairs & Advocacy
American Diabetes Association

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[1] The Center for Medicare and Medicaid Services. (2011, September1.) "Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations." Retrieved 8 February 2018, from https://www.cms.gov/CCIIO/Resources/Files/Downloads/dwnlds/association_coverage_9_1_2011.pdf

[2] American Academy of Actuaries, *Issue Brief: Association Health Plans,* Feb. 2017. http://www.actuary.org/files/publications/AssociationHealthPlans_021317.pdf

[3] Mila Kofman & Karl Polzer, "What Would Association Health Plans Mean for California?" Calif. Health Care Foundation, Jan. 2004. https://www.chcf.org/wp-content/uploads/2017/12/PDF-AHPFullReport.pdf .

[4] Kentucky Department of Insurance, Health Insurance Reform in the 1990's: A Kentucky Historical Perspective (April 1997); Adele Kirk, Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts, Journal of Health Politics, Policy and Law 25:133 (2000).

[5] See, for example, Government Accountability Office, "Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage," (GAO-04-312) Feb. 2004. https://www.gao.gov/new.items/d04312.pdf

[6] M. Kofman, E. Bangit, K. Lucia, "MEWAs: The Threat of Plan Insolvencies and Other Challenges," The Commonwealth Fund, Mar. 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

[7] Kaiser Family Foundation. (2016, May 20.) *Survey of Non-Group Health Insurance Enrollees, Wave 3*. Retrieved 16 February 2018, from https://www.kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/