

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,

The Board of Directors of the Health District of Northern Larimer County appreciates the opportunity to comment in response to the proposed rule, Definition of “Employer” under Section 3(5) of ERISA – Association Health Plans. The Health District is a special tax district — like a school, fire or water district — that was created by voters in 1960 to serve the health needs of our community. It is local government, operating under special district laws of the State of Colorado.

The Health District is very concerned about the impact that the proposed federal rules on Association Health Plans (AHPs)<sup>1</sup> could have on consumers as well as state regulators’ ability to control how these plans operate and to protect consumers. Consumer protections are critical to the health insurance market.

- **We oppose limiting states’ full authority to regulate AHPs**, which can provide financial oversight to limit the possibility of fraud and insolvency.
- **We oppose exempting multi-state AHPs from state insurance regulation**, an exemption that could open the door to undermining the state insurance market and state-mandated consumer protections.
- **We strongly recommend that the Department of Labor clarify that AHPs must comply with all state laws in states where they operate and continue to be subject to state oversight and regulation.**
- **We oppose allowing for a group to exist with the sole intent of providing health insurance**, as this opens the door to fraudulent entities.
- **We oppose allowing AHPs to operate as large-group insurance**, which will allow them to waive consumer protections mandated by the Affordable Care Act (ACA).
- **We oppose allowing AHPs to waiver any of the consumer protection provisions that are in the ACA. We urge the final rule to include requirements for AHPs to provide notice to employer groups and potential beneficiaries if plans do not meet standards for minimum value or do not cover essential health benefits.**
- **We oppose weakening the commonality of interest test**, as it opens the door to fraudulent entities and AHPs carving out higher cost areas.

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<sup>1</sup> “Definition of ‘Employer’ Under Section 3(5) of ERISA—Association Health Plans,” Department of Labor, Federal Register, Vol. 83, No. 4, January 5, 2018.

If the Department of Labor moves forward with finalizing this rule:

- **We support the maintenance of the nondiscrimination provisions.** This is critical to stem the damage that the proposed rule will cause for consumers.
- **We strongly urge you to strengthen these nondiscrimination provisions by prohibiting associations from varying premium rates for different employer members based on factors that may be used to determine rates based on expected health care utilization.**

## Discussion

**AHPs have a history of fraud and insolvency.** Those who have committed health insurance scams in the past have used AHPs to sell fraudulent plans to consumers.<sup>2</sup> The proposed rule makes it easier to form AHPs, which could enable the emergence of fraudulent associations across state lines. Since the proposed rule creates uncertainty of the role for states in regulation and enforcement of AHPs, this could further encourage health care scammers to proliferate. The history of AHPs has included the instability and insolvency of plans when claims were larger than their ability to pay.<sup>3</sup> Consumers have been left with large unpaid claims or lack of health insurance coverage when the AHP dissolves. Researchers found that between 2000 and 2002, 144 operations left over 200,000 policyholders with over \$252 million in medical bills. Four of the largest operations left 85,000 people with over \$100 million in medical bills. 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>4</sup> Financial stability of AHPs is not guaranteed as there are no federal financial standards or oversight, even as the proposed regulation could allow AHPs to cover millions more individuals and small employers.

We are 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 Affordable Care Act (ACA) provided more oversight and protection.

**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. 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. **We urge the Department to retain existing law that a group or association cannot exist solely for the purpose of sponsoring a group health plan.**

**The individual and small-group market will be weakened by AHPs.** The proposed rule states that it 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 proposed regulation would create an uneven playing field between AHPs and the individual and small-group markets. The proposed rule allows for AHPs to operate like large groups, which excuses them from covering the ten classes of essential health benefits. These plans can elect what benefits to cover and

<sup>2</sup> Kofman, M. & Bangit, E. (Aug. 2003). *Health Insurance Scams: How Government is Responding and What Further Steps Are Needed*. Retrieved from [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2003/aug/health-insurance-scams-how-government-is-responding-and-what-further-steps-are-needed/kofman\\_insurancescams\\_ib\\_665-pdf.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2003/aug/health-insurance-scams-how-government-is-responding-and-what-further-steps-are-needed/kofman_insurancescams_ib_665-pdf.pdf)

<sup>3</sup> Kofman, M., Bangit, E., & Lucia, K. (March 2004). *MEWAs: The Threat of Plan Insolvency and Other Challenges*. Retrieved from [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>4</sup> Kofman, M. (2005). *Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*. Georgetown University Health Policy Institute. Retrieved from <https://hpi.georgetown.edu/ahp.html>

which to forgo. These exemptions would eliminate consumer and patient protections that have been made available under the ACA. AHPs are structured to attract employers that have healthier than average employees. Over time the plans may draw healthy people out of the marketplace and into AHPs, leading to adverse selection, which could have a deleterious effect on premiums for those remaining in the marketplace. The American Academy of Actuaries noted, “The viability of many state-based markets would be challenged as a result” of adverse selection.<sup>5</sup> Therefore, 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.

**AHPs should not be able to sell ‘junk’ insurance.** 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 must be regulated under the same standards that apply to the individual market or the small-group market. 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 regulation would not apply the “look through” doctrine to AHPs that fit the new definitions of associations in the rule. As a result, AHPs would be exempt from the standards that apply to the individual and small-group market.

By exempting an AHP from the “look through” doctrine, the plans offered would be exempt from the requirement to provide the essential health benefits. Individuals and small employers would not necessarily have coverage that includes benefits such as maternity care, prescription drugs, and mental health and substance use disorder services. We are extremely concerned that this will take consumers and patients back to the days before the ACA, when plans frequently failed to meet the needs of individuals and families. **We strongly recommend that the Department to continue to apply the “look-through” doctrine, rather than treat AHPs as large group plans.**

**AHPs should not charge higher premiums to businesses based on employees’ age, gender or industry.** While the proposed rule prevents health status rating of separate employers, the rule appears to allow groups or associations to base premium rates on any other factor, including gender, age, industry and other factors that 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 women, or in industries that are believed to attract high health care utilizers would suffer the most. 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 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.**

**Individuals and small businesses must be protected from discrimination.** We are pleased that the proposed rule applies the HIPAA nondiscrimination provisions in § 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

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<sup>5</sup> American Academy of Actuaries. (Feb 2017). *Issue Brief: Association Health Plans*, Retrieved from <http://www.actuary.org/content/association-health-plans-0>

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 strongly encourage the Department to retain the nondiscrimination requirement in final rule. We support this provision applying to all AHPs, regardless of when in time they were established.**

While this is an important provision of the proposed regulation, it does not go far enough because an AHP can engage in other practices that result in discrimination against people with medical needs. The proposal exempts AHPs from ACA consumer protections designed to protect people with preexisting conditions. Using benefit design, an AHP can attract healthier groups. Also, 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. **In order to more meaningfully prevent discrimination, we encourage the Department to strengthen the protections in this provision by preventing groups or associations from varying premium rates to different employer members based on gender, age, zip code or other geographic identifier, industry, or other factor that may be used to vary rates based on expected health care utilization.**

**The proposed rule creates confusion regarding states' roles in regulating health insurance.** The proposed rule raises questions about preemption of state law. It suggests states would continue to have authority to impose financial requirements on AHPs. 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. **We urge the Department to clarify that the states would have authority to regulate the financial aspects of AHPs.**

In the proposed regulation, the Department of Labor points to its authority to exempt AHPs, individually or by class, from state insurance regulation. The proposed rules note that "some stakeholders" want the Department to use this exemption authority, and requests comment on the issue. An exemption by the Department would preempt the states and cause even further confusion regarding the regulation of AHPs. In the final rule, the Department should not allow for an exemption for AHPs from state regulatory authority. Additionally, if the intent is to ensure state authority over AHPs, then the federal government should allow time for states to review current laws and regulations before implementation of the final rule. **We urge the Department to clarify that AHPs, including those that cover 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.**

**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. AHPs should be required to provide notice to employer groups and potential beneficiaries if plans do not meet standards for minimum value. 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, if the AHP does not meet minimum value, 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 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. With regard to shared geography, the final rule must prevent arbitrary definitions of shared geography that allow AHPs to carve out higher cost areas. **We encourage the Department to retain the existing commonality of interest test based on facts and circumstances.**

Thank you for this opportunity to comment in response to the proposed rule, Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans. If you have any questions or concerns about our recommendations, please contact Alyson Williams at [awilliams@healthdistrict.org](mailto:awilliams@healthdistrict.org) or (970)224-5209.

Sincerely,

The Board of Directors of the Health District of Northern Larimer County