

# PUBLIC SUBMISSION

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Definition of Employer Under Section 3(5) of ERISA-Association Health Plans

**Comment On:** EBSA-2018-0001-0001

Definition of Employer Under Section 3(5) of ERISA-Association Health Plans

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## Submitter Information

**Name:** Barry Furrow

**Address:** Kline School of Law @ Drexel University

3320 Market Street

Philadelphia, PA, 19104

**Email:** barry\_furrow@hotmail.com

**Phone:** 2155714706

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## General Comment

See attached file(s)

## **CRITIQUE OF DEPARTMENT OF LABOR AHP PROPOSAL**

The Department of Labor proposal<sup>1</sup> aims to broaden the criteria under ERISA section 3(5) for determining when employers may join together in an employer group or association that is treated as the “employer” sponsor of a single multiple-employer “employee welfare benefit plan” and “group health plan” as those terms are defined in Title I of ERISA. It justifies an association health plan [(“AHP”)] as a way “. . . for a group of small businesses to pool together to buy insurance, giving them more purchasing power and access to cheaper premiums.”<sup>2</sup> This approach has a superficial appeal, but is deeply flawed. It raises a number of serious concerns about the range of harms that may result from its implementation.

Before Obamacare, national associations could cherry pick particular states’ insurance rules and particular services that the health care policy would cover. This resulted in an insurance policy that mostly catered the needs of healthy and young members. The Affordable Care Act however treated association health plans as small-group or individual plans, and imposed upon them the requirement to meet certain essential benefits.<sup>3</sup> The AHP Proposal (hereafter “Proposal”) threatens to return small group health insurance to a earlier market environment that selects against the sicker and more vulnerable members of the U.S. population who lack employment-based insurance or are not eligible for Medicare or Medicaid.

### **A. Disruption of the Small Group Market by Adverse Selection.**

The Proposal claims to allow small businesses to join together and provide health insurance to its member employers and the respective employees. Small businesses accessing health insurance in the small group market are currently disadvantaged due to both lack of negotiating power and also the lack of large risk pools.<sup>45</sup> The Proposal seeks to make it easier for small business to purchase affordable health insurance by relaxing some existing requirements for AHPs: (i) the requirement that AHPs should exist for the reason other than providing health insurance; (ii) the requirement for common interest as long as the members are in a common geographic area; (iii) allowing members operating in the same industry to sponsor AHPs, regardless of geographic distribution; and (iv) providing that working owners and their dependents can participate in the AHP.<sup>6</sup>

The benefits are speculative, given the history of business association plans. The reality is that the Proposal will most likely have a “devastating effect on small-group insurance market, raising premiums for small businesses with older or sicker workers and reducing coverage and consumer protections for people in AHPs.”<sup>7</sup> The Proposal, by offering AHPs weaker standards than the Affordable Care Act (hereafter “ACA”), would allow these AHPs to structure their plans to cater to young and healthy individuals, thereby leaving older, sicker individuals without coverage.<sup>8</sup> Moreover, because self-employed people would also be able to pull out of the individual market and form an association to get health insurance, this would undermine the risk pool and raise premiums in the individual markets.<sup>9</sup> People who enroll in AHPs while in good health would be

at significant risk if they later develop costly health needs that makes them less attractive for renewal of coverage.<sup>10</sup> The current proposal would further exempt AHPs from any state patient protections, such as “direct access to an OB/GYN, access to emergency care, access to specialists, mandatory grievance procedures, and required internal and external appeals timelines and rights.”<sup>11</sup>

Data is lacking generally to support the promises of the Proposal. The Department should be wary of the threats this proposal poses to the stability of small-group markets, and the problems experienced due to AHPs in the past.

First, the liberal definitions allowed for “commonality” or geography of the AHPs would inevitably lead to adverse selection. By doing so, any benefits of competition among plans would be reduced. The rule allows businesses in the same industry but different states to band together as an association and buy coverage. Companies in the same geographic area, even if not in the same line of work, could form associations, if “commonality” is liberally defined. Associations using the geographical category could certainly “redline” their geographic definitions to exclude certain high-cost areas or employees, perhaps by defining their region to cover only a lower-cost urban area while excluding a higher-cost rural area. Such creative efforts to exclude high-cost employees and high-cost areas are a predictable method for reduce that AHP’s premiums by excluding higher cost subscribers. The same is true of AHPs using the flexible “commonality” test to insure that only occupations or other categories with younger healthier employees are included.

Second, the asymmetry of rules applied to AHPs and the traditional small group market would predictably tend to segment small employers based on risk, steering more expensive groups to the traditional market and driving up community rated premiums. This would force employees in the higher cost areas (or areas of work) to get insurance from the ACA exchanges, driving up the ACA premiums. The AHPs would thus “skim the cream” off the relevant employment area or profession or geographic area, forcing other insurers to cover those excluded only at higher cost under ACA rules for the exchanges. And if the ACA exchanges begin to fail, the number of insured will grow rapidly.

Third, this would disrupt the small group market. Premiums in the traditional small group market would end up much higher for employers who need to seek coverage there. This could eventually force insurers to stop offering traditional small group coverage because they could not predict the risk of potential enrollees. Small employers could seek lower rates or less comprehensive coverage in an AHP when their employees are healthy, but theoretically move back to regular small group market plans if an employee becomes ill or if the group wants more comprehensive benefits. This could result in significant premium increases and instability in the small group market.

## **B. The Likelihood of Fraud in the Creation, Marketing, and Managing Benefits under AHPs.**

Proponents argue that AHPs would encourage competition, enlarge the insurance risk pool, and move the market to a more consumer-oriented system. Past regulations required an AHP to have a pre-existing bona-fide purpose; however, the current executive order does away with that requirement, leaving the doors open to abuse and fraud by AHPs.<sup>12</sup> The need to police fraud in such AHPs is predictable given the history of AHPs and their propensity to fraudulent coverages.<sup>13</sup> It is relatively easy to create an AHP and then market to the relevant group, promising low premiums and good coverage. As employees fall ill, policies will turn out not to cover them because of the coverage language, or the AHPs will turn out to have insufficient reserves to cover claims, as happened with many fraudulently run AHPs in earlier decades.

Consumers struggle with basic insurance concepts, have trouble shopping among plans, and often choose inference plans because of inertia. Consumers have virtually no ability to detect limits in policies, or to detect tricky language or lying salespeople.<sup>14</sup> State insurance regulators have normally policed such risks by notifications to consumers, fraud alerts, requiring company registration and proof of reserves, nondiscriminatory underwriting, benefit packages, and so on. And their enforcement has been relatively vigorous.

By contrast, the Department of Labor's past record of enforcement suggests that AHP creators will have little to worry about in terms of effective and quick enforcement. The DOL notes this: "Nevertheless, the flexibility afforded AHPs under this proposal could introduce more opportunities for mismanagement or abuse, increasing potential oversight demands on the Department and State regulators."<sup>15</sup>

The Department there acknowledges that its supervisory powers may have to be expanded at substantial expense. Proper policing will require a substantial strengthening of the capacities of the Department of Labor; even if this occurs, state insurance commissioners must be allowed to exercise their enforcement power of insurance commissioners in the fifty states in the federal system.

The proposal regulation needs far more clarity about the role of state regulators in imposing safeguards to protect subscribers to AHPs. To curb the devastating effect on small-group insurance markets and Exchanges, the States should be allowed to regulate AHPs to ensure that these plans meet the statutory minimums for patient protection set by the ACA.<sup>16</sup>

### **C. The Limits of Competition in the AHP Marketplace.**

Competition through shopping for choices in a health insurance market is not likely in an AHP marketplace. The member of an AHP, whether as part of an affinity group or by dint of geography, has only limited choices, driven either by the commonality test or geographic test. The AHP might have some ability to shop for better deals -- but that will be dependent on the local provider/insurer area and the size of the AHP. The Department comments offer hope for competition, without any evidence that most AHPs will have the size or bargaining power in their local markets to bargain. It is unlikely that AHPs will possess significant market power vis-à-vis hospitals, physicians, and insurers. The AHP subscriber will lack the choices that successful ACA exchanges like California's present to its subscribers.

It should be noted that in response to past federal proposals to create new small group insurance arrangements not subject to all state small group market regulation, the National Association of Insurance Commissioners, the American Academy of Actuaries, and others raised concerns that market fragmentation and harm to small businesses and consumers could result.

**D. The Department of Labor Lacks Clear Regulatory Authority.** AHPs must be fully insured group health plans, suggesting that states would continue to have regulatory authority over the insurance product itself, for example, to apply and enforce state standards related to risk based capital and solvency. The Proposal explicitly assumes oversight by both the Department of Labor and state insurance commissioners. On the other hand, the preemption language in the comments appears to be broad. "The regulation notably does not appear to preempt state regulations," making it easier for states to try to mitigate any adverse effects on the insurance market.<sup>17</sup> The proposal fails to specify which state laws can still be enforced, including for example, laws relating to qualifications of AHP sponsoring entities, or the covered benefits or rating practices under such plans. Without such clarification, the regulatory proposal is unclear, and currently legal challenges will arise if state insurance regulatory authority is not clarified with require to AHPs permitted under the Proposal.

**Professor Barry R. Furrow**  
**Caitlin E. Duffy**  
**Brian Han**  
**Joseph E. Mattia**  
**Ruba Noor**  
**Stephen E. Purcell**

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*The Health Law Program*  
*Kline School of Law*  
*Drexel University*  
**3320 Market Street**  
**Philadelphia, Pa. 19104**  
**215 571 2406**  
**Contact: [barry\\_furrow@hotmail.com](mailto:barry_furrow@hotmail.com)**

## ENDNOTES

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<sup>1</sup> DEPARTMENT OF LABOR, Employee Benefits Security Administration, 29 CFR Part 2510, RIN 1210-AB85, Definition of “Employer” under Section 3(5) of ERISA -- Association Health Plans. ¶ 1.10.

<sup>2</sup> Dylan Scott, *Trump’s big new proposal to undercut the Affordable Care Act, explained*, VOX (Jan. 4, 2018), <https://www.vox.com/policy-and-politics/2018/1/4/16849136/trump-association-health-plans-explained>.

<sup>3</sup> *Id.* (providing that essential health benefits included everything from hospital care to prescription drugs to maternity care).

<sup>4</sup> Definition of “Employer” under Section 3(5) of ERISA – Association Health Plans, 83 Fed. Reg. 614, 626 (proposed Jan. 5, 2018) (to be codified at 29 C.F.R. 2510).

<sup>5</sup>  
<sup>6</sup> *Id.* at 627.

<sup>7</sup> Sarah Lueck, *Trump Rule on Association Health Plans Could Devastate Small-Group Markets*, *CTR. ON BUDGET AND POL’Y PRIORITIES* (Jan. 5, 2018), <https://www.cbpp.org/blog/trump-rule-on-association-health-plans-could-devastate-small-group-markets>.

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*; see also Scott, *supra* note 1 (discussing that allowing self-employed people to join AHPs could result in legal challenges as this goes to the heart of what ERISA is supposed to be – a Federal Act regulating group plans and not individuals).

<sup>10</sup> See Lueck, *supra* note 6.

<sup>11</sup> CONSUMER ALERT: ASSOCIATION HEALTH PLANS ARE BAD FOR CONSUMERS, NAIC, [http://www.naic.org/documents/consumer\\_alert\\_ahps.pdf](http://www.naic.org/documents/consumer_alert_ahps.pdf) (last visited Feb. 4, 2018).

<sup>12</sup> See Lueck, *supra* note 6.

<sup>13</sup> U.S. General Accounting Office, *Private Health Insurance: Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage*, GAO-04-312 (2004) “About 80 percent of the unauthorized entities identified by DOL and the states characterized themselves as associations, professional employer.

organizations, unions, single-employer ERISA plans, or some combination of these arrangements.”(P.11)

<sup>14</sup> George Loewenstein et al., *Consumers’ Misunderstanding of Health Insurance*, 32 J. Health Econ. 850 (2013); Florian Heiss et al., *Plan Selection in Medicare Part D: Evidence from Administrative Data*, 32 J. Health Econ. 1325 (2013); Christopher C. Afendulis et al., *Dominated Choices and Medicare Advantage Enrollment*, 119 J. Econ. Behav. Organ. 72 (2015) 2015

<sup>15</sup> DEPARTMENT OF LABOR, Employee Benefits Security Administration, 29 CFR Part 2510, RIN 1210-AB85, Definition of “Employer” under Section 3(5) of ERISA -- Association Health Plans. ¶ 1.10.

<sup>16</sup> One suggestion has been to create a probation period for new AHPs, to be policed by each state’s insurance department Commissioner. The purpose of the probation period would be to require a new entrant into the health insurance provider marketplace pass several tests and meet multiple goals/checkpoints before being removed from the probation list. AHPs on the probation list will be followed more closely by a state’s insurance commission to make sure they comply with state and federal regulations and pay out necessary claims. Another potential issue would be the difficulty of effectively policing AHPs that cross state lines. One suggestion would require AHPs to only accept health insurance customers from the same state, at least until the AHP passes the probation period proposed above. Once an AHP passes the probationary period, the AHP can accept consumers from other states and officially be under the purview of the Department of Labor.

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