



March 5, 2018

Secretary R. Alexander Acosta  
U.S. Department of Labor  
Attn: Office of Regulations and Interpretations  
Employee Benefits Security Administration  
200 Constitution Avenue NW - Room N-5655  
Washington, D.C. 20210

RE: RIN-1210-AB85 – Definition of Employer-Small Business Health Plans

Submitted electronically to:

<https://www.regulations.gov/comment?D=EBSA-2018-0001-0001>

Dear Secretary Acosta,

For the record, I am Ted Doolittle, Healthcare Advocate for the State of Connecticut. The Connecticut Office of the Healthcare Advocate (“OHA”) is an independent state agency with a three-fold mission: assuring consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health plans; and informing legislators and regulators regarding problems that consumers are facing in accessing care and proposing solutions to those problems. I appreciate the opportunity to submit the enclosed comments regarding the Proposed Rule EBSA-2018-0001-0001, as published in 83 Fed. Reg. 614.

The Proposed Rule would broaden the scope of the definition of “employer” under of Title I of the Employee Retirement Security Act, Section 3(5); 29 U.S.C § 1002(5); by adding a new section, § 2510.3-5, to Title 29 of the Code of Federal Regulations. Under current law, an “employer” includes “any person acting directly

as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.”

Current law requires groups or associations of employers to share a “commonality of interest” in order to qualify as an employer within the meaning of § 1002(5). Presently, in order to demonstrate a “commonality of interest,” a bona fide group or association of employers must: (1) exist as an organization with organizational purposes and functions unrelated to the provision of benefits; (2) employ employees who share some commonality and genuine organizational relationship unrelated to the provision of benefits; and (3) exert control over the benefit program, in both form and substance. These current provisions present a fairly sizeable obstacle to employers, especially smaller employers, who might otherwise seek to form an association.

The new Section § 2510.3-5 would loosen this framework by allowing an association to exist solely for the purpose of sponsoring a group health plan. The plan would still be required to have a formal organizational structure that is controlled by member employers. In addition, membership in the group health plan would be restricted to employers of at least one direct employee participant.

The “commonality of interest” test would also be revised to recognize a commonality of interest among: (1) employers engaged in the same trade, industry, line of business or profession; or (2) employers having a principal place of business within a region that does not traverse state boundaries; or (3) employers having a principal place of business within the same metropolitan area, even if the metropolitan area crosses state boundaries.

The proposed rule would also incorporate important consumer protections adopted under the ACA, which prohibit group health plans, including association health plans (“AHPs”), from excluding an employer member on the basis of a health factor of an employee. In addition, the AHP would be prohibited from identifying

individual employers as distinct groups of similarly-situated individuals, for purposes of differentiating eligibility provisions or premium payments, for example, while retaining the ability to discriminate on other non-health related factors such as full-time or part-time employment status or geographical boundaries.

The Department's stated intent for proposing this new rule is multifaceted, but ultimately seeks to put downward pressure on the rapidly rising costs of healthcare in the United States, by incentivizing individuals and businesses to participate in larger risk pools. OHA agrees in principle with the Department's premise that larger risk pools will have a tendency to: have more bargaining power vis-à-vis healthcare providers and provider networks; create efficiencies in the administration of health plans; generate economies of scale that can pass cost savings on to consumers. OHA further acknowledges, in general, that the ACA's incentives for generating larger risk pools, such as the now-repealed individual mandate, did not achieve their full intended effect due to politically-motivated efforts to undermine their effectiveness.

OHA applauds the Department's efforts to seek ways of addressing cost barriers in the current healthcare insurance market that are limiting access to consumer care and coverage. Over the past few years, OHA has observed, both within Connecticut's market and nationally, the economic burdens that have been borne by consumers who are faced with escalating premiums and cost-sharing obligations. These burdens appear to strike particularly hard at a subset of consumers that includes self-employed individuals and employees of small businesses, who often find themselves eligible for coverage within smaller risk pools or risk pools with high rates of utilization of high-cost services. Very often these individuals elect to go uninsured or underinsured due to the prohibitive costs of greater coverage.

OHA understands that expanding access to association health plans ("AHPs") is intended to generate additional options for such uninsured and underinsured

employees to access potentially more affordable coverage by taking advantage of the benefits of pooling member employers into larger, healthier, less volatile risk groups. However, OHA is concerned that expansion of AHPs will result in further cost increases and erosion of the ACA marketplaces, thereby exposing another vulnerable demographic to additional economic hardship.

OHA therefore shares the Department's concern that expansion of AHPs will inevitably create a substantial risk that healthier individuals will exit the individual/small group market to join a lower-cost, lesser-coverage AHP. This would, in turn, destabilize the individual and small group marketplaces by increasing the ratio of high-cost, high utilization individuals remaining in those risk pools. Thus, expansion of AHPs has the potential of merely shifting the burdens of rising healthcare costs from one vulnerable sub-population to another. OHA would prefer that the Department takes steps to improve the conditions within the ACA marketplace rather than encouraging further fragmentation of the overall healthcare insurance market. Accordingly, OHA urges the Department to collect and analyze further data regarding these potential cost shifts before implementing its proposed rule, and consider implementing additional protections in the event that the data forecasts substantial negative counter-effects on consumers who are not anticipated to participate in an AHP.

OHA is also concerned that individuals who are solicited to join AHPs may not understand when an AHP will provide a narrower scope of coverage compared to other plans subject to all the provisions of the ACA. For example, as the Department acknowledges, AHPs that qualify as large group health plans under the proposed rule would not be required to offer all of the essential health benefits required of individual and small group health plans. In addition, AHPs would have more freedom to vary eligibility and premium costs on factors other than geography, age and tobacco use – although variations based on individual health factors would continue to be prohibited. AHPs also would not be subject to minimum loss ratios

("MLRs"), which could disincentivize plan managers from approving member claims.

In order to ensure that consumers are adequately educated about their options when considering whether to join an AHP plan, OHA recommends that the Department amend the proposed rule or issue further guidance that would require AHPs to provide conspicuous notice to consumers when the AHP does not offer benefits that meet ACA standards, such as limitations on essential health benefits. OHA further recommends that AHPs be required to notify consumers in a conspicuous manner about the rule's nondiscrimination provisions and clearly state the non-health factors used by the plan to vary participant eligibility and premium rate standards.

By way of example, notices regarding the limitations of AHP coverage should be issued to potential AHP members well in advance of enrollment. The notices must include various warnings in large, capitalized, boldface or other highly visible typeface. Further each warning must be included on a separate sheet of paper, each of which must be separately signed by the member acknowledging receipt and review of the warning. Such warnings must include, but are not necessarily limited to, applicable statements that: (1) the AHP coverage is not "major medical" or "comprehensive medical" insurance and that certain essential health benefits (as listed in the notice) are not covered; (2) broader coverage may be available for a lower cost on the state/federal exchange, particularly for individuals who qualify for financial assistance, which can be reached at a phone number or website specified in the notice; (3) the AHP imposes annual or lifetime dollar limits on benefits, as specified in the notice; (4) the AHP imposes potentially high levels of cost sharing (specifying deductibles, coinsurance, etc.) that the member will be required to pay before and after the plan begins to make payments, and that consumers at the 25<sup>th</sup>, 50<sup>th</sup>, 75<sup>th</sup> and 90<sup>th</sup> percentiles each are anticipated to spend "w," "x," "y" and "z" dollars toward their own care during a plan year; (5) the AHP is not required to spend any given portion of premiums it collects on health benefits; (6) the AHP may

rescind the member's coverage under specified conditions related to post-claims underwriting; and (7) the AHP is not required to guarantee issue or renewal of the coverage and the circumstances under which issue or renewal would be denied.

Lastly, OHA shares the Department's concerns regarding the history, albeit rare, of insolvency of some employee benefit plans. Accordingly, OHA further suggests that AHPs be required to adopt some level of reserves, based on actuarially sound principles, in order to insulate themselves from volatility in their respective risk pools, particularly with respect to newer, less established plans or plans that experience heightened risk of insolvency that would jeopardize payment of employee benefits.

Accordingly, for all of the foregoing reasons, I encourage the Department to revise its proposed rule to incorporate additional protections for consumers, as listed herein, before expanding access to the AHP market and potentially disrupting existing markets that are already struggling to provide consumers with affordable comprehensive coverage options.

Thank you for your time and consideration as you undertake this extremely important review of the Department's rules. If you have any questions concerning our position on this issue, please feel free to contact me at your convenience.

Regards,

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