

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,

National Latina Institute for Reproductive Health (NLIRH) appreciates the opportunity to comment in response to the proposed rule, Definition of “Employer” under Section 3(5) of ERISA – Association Health Plans.

NLIRH is the only national reproductive justice organization dedicated to building Latina power to advance health, dignity, and justice for 28 million Latinas, their families, and communities in the United States through leadership development, community mobilization, policy advocacy, and strategic communications. NLIRH works to ensure that all Latinas are informed about all their options for safe, effective, and acceptable forms of contraception and family planning. NLIRH supports affordable, accessible, and quality contraception and counseling for all persons regardless of their age or gender identity.

NLIRH writes with strong objection to the proposed rule on Association Health Plans (AHPs). We have deep concerns that the proposed rule will weaken the individual and small group markets that are critical sources of coverage for individuals with pre-existing health conditions. While the proposed rule may lower costs and provide alternative choices for some small employers, the actual effect is that it would increase cost and limit choice for all other employers and individuals facing health. Moreover, as detailed below, the history of AHPs is one of fraud and insolvency – leaving consumers with unpaid medical bills and no health coverage.

If the Department of Labor (“the Department”) moves forward with finalizing this rule, NLIRH strongly urges you to maintain the nondiscrimination provisions. We also strongly oppose any effort to limit states’ full authority to regulate AHPs. Both are critical to stem the damage that the proposed rule will cause for insurance markets and marginalized communities who need access to comprehensive health care plans. In the event that the Department moves forward with this rule, we request that the Department hold a public hearing on the proposed AHP regulations.

I. The Latinx¹ community already faces barriers to care and AHPs have a history of fraud and insolvency.

Latinas have the highest rates of uninsurance when compared to other groups in the U.S.,² therefore seeing a provider and accessing affordable health care services is not an option for many. Additional barriers, such as cultural and linguistic differences, already exist for the Latinx community. When an individual experiences multiple identities, access to healthcare becomes even more complex; for example, in 2010, twenty-six percent of lesbian, gay, and bisexual Latinx adults did not have a regular source for basic healthcare.³ For these reasons, the Latinx community needs affordable and accessible health care plans, not increased access to plans perpetuating fraud and insolvency.

For the thirty 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).⁴ 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 individuals without health insurance coverage.⁵ AHPs would often set up headquarters in one state with limited regulatory oversight and market policies to businesses and consumers in other states with more robust regulation, thereby bypassing those states' more protective rating and benefit standards.⁶

In 1982, Congress responded to widespread fraud by amending ERISA to clarify states' authority to regulate association health plans and multiple employer welfare arrangements (MEWAs).⁷ Because of this broad authority, many states limited the potential risks, including fraud, insolvency, and market segmentation, associated with the expanded AHP market.⁸ Even with increased oversight, fraudulent insurance sold through associations remained a problem.

¹ NLIRH, conscious of the importance of gender equity in the production of educational materials utilizes gender-neutral terms throughout this document. "Latinx" is a term that challenges the gender binary in the Spanish language and embraces the diversity of genders that often are actively erased from spaces. Due to the limitations of data collection, we use "Latina(s)" or "women" where research only shows findings for cisgender women, including Latinas.

² Latinos for Planned Parenthood. "Health Equity Issues for the Latino Community." Available at: <https://www.plannedparenthoodaction.org/communities/latinos-planned-parenthood/health-equity-issues-for-the-latino-community>

³ *Health Disparities in LGBT Communities of Color: By the Numbers*, CENTER FOR AMERICAN PROGRESS (2010), <https://www.americanprogress.org/issues/lgbt/news/2010/01/15/7132/health-disparities-in-lgbt-communities-of-color>

⁴ Kofman, M. (2005). *Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*. Georgetown University Health Policy Institute. Retrieved 8 February 2017, from <https://hpi.georgetown.edu/ahp.html>

⁵ *Ibid.*

⁶ Lucia, K. & Corlette, S. (2018, January 24.) *Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability*. The Commonwealth Fund. Retrieved 8 February 2017, from <http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority>

⁷ Association Health Plans are a type of multiple employer welfare arrangements (MEWAs).

⁸ Lucia, K. & Corlette, S. (2018, January 24.) *Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability*. The Commonwealth Fund. Retrieved 8 February 2017, from <http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority>

Researchers found that between 2000 and 2002, 144 operations left over 200,000 policyholders with over \$252 million in medical bills.⁹ Four of the largest operations left 85,000 people with over \$100 million in medical bills.¹⁰ The results were disastrous: some victims were forced into bankruptcy; others have lifelong physical conditions as a result of delayed or foregone medical care.¹¹

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.

As the most uninsured community many in the Latinx already struggle to pay medical bills, NLRH is extremely concerned that the proposed regulation will once again leave individuals 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.

II. AHPs will weaken the individual and small group markets, exacerbating gaps in coverage for the Latinx community.

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 has fewer protections against fraud and insolvency, covers fewer benefits, or siphons 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 must be regulated under the same standards that apply to the individual market or the small-group market.¹² 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.

For a playing field that is already unequal for the Latinx community, the proposed regulation would additionally create an uneven playing field between AHPs and the individual and small-group

⁹ Kofman, M. (2005). *Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*. Georgetown University Health Policy Institute. Retrieved 8 February 2017, from <https://hpi.georgetown.edu/ahp.html>

¹⁰ Kofman, M. (2005). *Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*. Georgetown University Health Policy Institute. Retrieved 8 February 2017, from <https://hpi.georgetown.edu/ahp.html>

¹¹ Kofman, M. (2005). *Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*. Georgetown University Health Policy Institute. Retrieved 8 February 2017, from <https://hpi.georgetown.edu/ahp.html>

¹² The Center for Medicare and Medicaid Services. (2011, September 1.) “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/downloads/association_coverage_9_1_2011.pdf

markets. Because the rule 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. 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. The Latinx community is already under-insured needs comprehensive coverage, including those with pre-existing conditions, not rising premiums and potentially fewer plan choices.

III. The AHPs should not be allowed to sell junk insurance and charge higher premiums to businesses based on employees' age, gender, or industry.

Currently, AHPs are regulated by the “look-through” doctrine set forth in 2011 guidance from CMS.¹³ This guidance has the effect of looking through the association to understand who is purchasing coverage through an AHP, and then to determine regulation of the insurance products. 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.

By exempting an AHP from the look-through doctrine, plans offered to working owners and small employers would be exempt from the requirement to provide the essential health benefits, coverage that the Latinx community rely on for critical preventative services. Individuals and small employers would not necessarily have coverage that includes benefits such as maternity care, prescription drugs, and mental health and substance use services. We are extremely concerned that this will take our community back to the days before the Affordable Care Act, when plans frequently failed to meet the needs of individuals and families.

As a 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. For example, before the ACA:

- **Latinxs did not have a guarantee that their insurance would cover services such cervical cancer screenings.** Essential Health Benefits (EHBs) are critical for Latinxs to get the care that they need. Cervical cancer is a highly preventable disease and EHBs

¹³ The Center for Medicare and Medicaid Services. (2011, September 1.) “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/downloads/association_coverage_9_1_2011.pdf

include access to cervical cancer screenings. The incidence of cervical cancer for Latinx women in the United States is among the highest of all racial/ethnic groups, and almost twice as high as their white counterparts.¹⁴ Under the ACA, women’s preventive services are covered at no additional co-pay. This includes cervical cancer screenings (including the Pap and HPV DNA tests) and the vaccine against the Human Papilloma Virus (HPV) – one of the main causes of cervical cancer. In fact, cancer researchers have found that women under the age of 26 have been diagnosed at earlier stages of cervical cancer due to their ability to gain coverage under the ACA, giving these women a better chance to overcome cervical cancer. A lack of EHB requirements, would mean more Latinxs receiving insurance plans in fact do not cover the services they need for a highly preventable disease.

- **The vast majority of plans in the individual market did not cover maternity care.** In fact, only 12 percent of plans in the individual market covered this benefit.¹⁵ Latinas have a higher pregnancy rate than their white counterparts, as well experience higher rate of postpartum depression, making this a critical health care benefit. Even among plans that covered maternity services, the coverage was not always comprehensive or affordable. One study found that several plans charged a separate maternity deductible that was as high as \$10,000, and some plans had waiting periods of up to a year before maternity care would be covered.¹⁶
- **Mental health coverage was often excluded from plans, or was very limited.**¹⁷ It is estimated that over 32 million people gained access to coverage for mental health services, substance use disorder treatment or both benefits under the ACA.¹⁸ Latinas experience depression at more than twice the rate of Latino men and are more likely to suffer from depression than blacks and non-Hispanic whites, but among Latina women with a mental health disorder, only 1 in 5 contact their health care provider. Adolescent Latinas have the highest suicide attempts. 15 percent of Latina adolescents in the U.S. have attempted suicide, compared to 9.8 percent of white female adolescents and 10.2 percent of black

¹⁴ National Latina Institute for Reproductive Health. “Cervical Cancer & Latinxs*: The Fight For Prevention & Health Equity.” January 2018. http://www.latinainstitute.org/sites/default/files/NLIRH_CervicalCancer_FactSheet18_Eng_R1.pdf

¹⁵ National Women’s Law Center. (2012). Turning to Fairness: Insurance Discrimination against Women Today and the Affordable Care Act. Retrieved 14 December 2016, from http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf

¹⁶ National Women’s Law Center. (2012). Turning to Fairness: Insurance Discrimination against Women Today and the Affordable Care Act. Retrieved 14 December 2016, from http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf

¹⁷ Palanker, D., Volk, J., & Giovannelli, J. (2017, March 15). *Eliminating Essential Health Benefits Will Shift Financial Risk Back to Consumers*. The Commonwealth Fund. Retrieved 23 March 2017, from

<http://www.commonwealthfund.org/publications/blog/2017/mar/eliminating-essential-health-benefits-financial-risk-consumers>

¹⁸ U.S. Department of Health & Human Services. (2013, February). *Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans*. Retrieved 23 March 2017, from https://aspe.hhs.gov/sites/default/files/pdf/76591/rb_mental.pdf

female teens; nearly 26 percent of Latina teens considered suicide.¹⁹ Additionally, Latinas are 37 percent more likely than other groups to suffer from postpartum depression.²⁰

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. A small employer, for example, with a relatively healthy workforce might offer an AHP with low premiums but that also provides limited benefits. If an employee later develops a health condition such as cancer or HIV, or requires hospitalization, they could suddenly find that necessary care or treatment is not covered.²¹

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 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 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.²² 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.

NLIRH strongly recommends 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.

¹⁹ “Latina teens have highest rate of suicide attempts in the U.S.” Univision. June 24, 2016 <https://www.univision.com/univision-news/health/latina-teens-have-highest-rate-of-suicide-attempts-in-the-us>

²⁰ Latino Voices: Huffington Post. “Latinas At Higher Risk Of Postpartum Depression Due To Cultural Stigmas.” December 17, 2012 https://www.huffingtonpost.com/2012/12/17/latinatas-at-higher-risk-of-postpartum-depression_n_2315969.html

²¹ Lueck, S. (2018, January 8.) *Trump Rule on Association Health Plans Could Devastate Small-Group Markets*. Retrieved 8 February 2018, from <https://www.cbpp.org/blog/trump-rule-on-association-health-plans-could-devastate-small-group-markets>

²² National Women’s Law Center. (2012). *Turning to Fairness: Insurance Discrimination against Women Today and the Affordable Care Act*. Retrieved 14 December 2016, from http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf

IV. To protect coverage for the Latinx community, States must retain authority to regulate multiple employer welfare arrangements (MEWAs).

The proposed rule raises questions about preemption of state law. NLIRH opposes 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.

While the Department states that the proposed rules do not alter existing ERISA statutory provisions governing MEWAs, we are concerned that the proposed rules will have the result of preempting existing and future efforts by states to regulate MEWAs. The proposed rules' new framework allowing many more AHPs to be treated as large, single employer plans invites new insurance scams by creating confusion about states' enforcement authority over AHPs. In the past, promoters of fraudulent health plans have used this type of regulatory ambiguity to avoid state oversight and enforcement activities that could have otherwise quickly shut down scam operations.²³

NLIRH urges the Department to clarify that ERISA single employer 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. This will maintain states' ability to protect consumers from the potential ramifications of fraudulent or insolvent AHPs, and to manage their insurance markets.

Finally, NLIRH 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. 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 for AHPs would be an attack on the states and would only serve to fuel fraud and insolvency.

V. To eradicate barriers to care, individuals and small businesses must be notified if AHPs are not meeting minimum value or providing all the essential health benefits.

NLIRH appreciates 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

²³ Lucia, K. & Corlette, S. (2018, January 24.) *Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability*. The Commonwealth Fund. Retrieved 8 February 2017, from <http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority>

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.

VI. Retain existing law to prevent fraudulent entities from creating AHPs.

The Latinx community deserves health care coverage that is free from fraud, this can be accomplished by retaining the existing law that prevents 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 that 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.

VII. 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 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. NLRIH applauds this 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 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. 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, individuals and small employers would not necessarily have access to coverage that includes maternity, mental health benefits, and expensive prescriptions. People who need such coverage would not enroll in AHP coverage. 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. 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. Due to structural barriers to health care, the Latinx community is at greater risk for heart disease, cancer, stroke, and diabetes. Its geographic location can also be used to engage in redlining practices.²⁴ Additionally, fourteen percent of Hispanics have been diagnosed with diabetes compared with 8 percent of whites.²⁵ 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 EHB, rate reforms, and guaranteed issue requirements.

In order to more meaningfully prevent discrimination, the Department should also 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 final rule should also apply EHB, guaranteed issue and single-risk pool requirements. The single-risk pool requirement is an important way to ensure that AHPs, where they exist, do not result in a segmented market.

Failure to extend these protections, in addition to protections against discrimination based on health status, to AHPs will expose employers and their employees to discriminatory practices, including discriminatory rating and marketing practices. Failure to extend these protections will also place the regulated health insurance markets in jeopardy, as AHPs would be free to cherry pick healthy consumers out of the regulated markets, leaving those markets to fail as the risk pool worsens and premiums spiral out of control.

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

²⁴ “Hispanic/Latino Americans.” *Office of Minority Health Resource Center*. Accessed: March 5, 2018. <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=64>

²⁵ “Health Disparities by Race and Ethnicity.” *Center for American Progress*. December 16, 2010. <https://www.americanprogress.org/issues/healthcare/news/2010/12/16/8762/fact-sheet-health-disparities-by-race-and-ethnicity/>

The proposed rule allows working owners to join AHPs providing ERISA plans. These additional changes would be detrimental to the Latinx community that is already struggling with the highest uninsured rate in country, and these changes would exacerbate this disparity. In 2016, 31 percent of the individual or small group market was self-employed.²⁶ 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.

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 Nina Esperanza Serriane at nina@latinainstitute.org.

Sincerely,

National Latina Institute for Reproductive Health

²⁶ 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/>