

# JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

March 6, 2018

Submitted electronically to <https://www.regulations.gov>

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## **RE: Definition of “Employer” under Section 3(5) of ERISA – Association Health Plans (RIN 1210-AB85)**

Justice in Aging appreciates the opportunity to comment on the proposed rule, Definition of “Employer” under Section 3(5) of ERISA – Association Health Plans. Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources.

Justice in Aging strongly objects 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 older adults and others with pre-existing health conditions. While the rule may lower costs and create more choices for some small employers, it would increase cost and limit choice for all other employers, older adults and individuals in less-than-perfect health. Moreover, the history of AHPs is one of fraud and insolvency – leaving consumers with unpaid medical bills and no health coverage. By removing limits on age rating and given that nearly 85 percent of adults ages 55 to 64 have at least one pre-existing condition,<sup>1</sup> the changes proposed in this rule would be especially harmful to older adults.

We request that the Department of Labor (“the Department”) hold a public hearing on this proposed rule to allow consumers and other stakeholders to voice their concerns. Then, if the Department does decide to move forward with finalizing this rule, we strongly urge you to maintain the nondiscrimination provisions. We also strongly oppose any effort to limit states’ full authority to regulate AHPs. Both are critical to mitigating harm to consumers.

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<sup>1</sup>HHS Assistant Secretary for Evaluation and Planning, Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act (January 5, 2017), <https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf>.

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I. AHPs have a history of fraud and insolvency.

For the 30 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).<sup>2</sup> 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 patients without health insurance coverage.<sup>3</sup> 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.<sup>4</sup>

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).<sup>5</sup> Because of this broad authority, many states limited the potential risks, including fraud, insolvency, and market segmentation, associated with the expanded AHP market.<sup>6</sup> Even with increased oversight, fraudulent insurance sold through associations remained a problem. Researchers found that between 2000 and 2002, 144 operations left over 200,000 policyholders with over \$252 million in medical bills.<sup>7</sup> Four of the largest operations left 85,000 people with over \$100 million in medical bills.<sup>8</sup> 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>9</sup>

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 would allow AHPs to cover millions more individuals and small employers.

We are extremely concerned that the proposed regulation will once again leave consumers, 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. Not only would these consequences be particularly harmful to the health and economic wellbeing of older adults nearing retirement, they would also unnecessarily increase the burden on Medicare and Medicaid as these older adults would be in poorer health and with fewer resources to pay for the care they need.

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<sup>2</sup>Kofman, M., Georgetown University Health Policy Institute, Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud. (2005), available at <https://hpi.georgetown.edu/ahp.html>.

<sup>3</sup>*Id.*

<sup>4</sup>Lucia, K. & Corlette, S., The Commonwealth Fund, Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability (Jan. 24, 2018), available at [www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority](http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority).

<sup>5</sup>Association Health Plans are a type of multiple employer welfare arrangements (MEWAs).

<sup>6</sup>Lucia, K. & Corlette, S., The Commonwealth Fund, Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability (Jan. 24, 2018), available at [www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority](http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority).

<sup>7</sup>Kofman, M., Georgetown University Health Policy Institute, Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud. (2005), available at <https://hpi.georgetown.edu/ahp.html>.

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

<sup>9</sup>*Id.*

II. AHPs will weaken the individual and small group markets.

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 syphons healthier individuals and small groups from other markets. The result will be particularly harmful for older adults, who are more likely to have chronic conditions and require more comprehensive medical benefits.

As part of the implementation of the ACA, the Centers for Medicare and Medicaid Services (CMS) issued 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.<sup>10</sup> 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 undo this progress of ensuring AHPs provide a minimum standard of coverage and create an uneven playing field between AHPs and the individual and small-group 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 and sicker individuals behind, creating more costly risk pools. If healthier individuals and small groups are syphoned from the individual and small group markets, costs will increase and plan choices will decrease for employers and individuals remaining in those markets. Older adults and other consumers who need comprehensive coverage, including those with pre-existing conditions, would face rising premiums and potentially fewer plan choices.

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

As described earlier, currently, AHPs are regulated by the “look-through” doctrine set forth in 2011 guidance from CMS,<sup>11</sup> which applies the consumer protections for individual and small group markets to AHP products sold to individuals and small employers.

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 consumer protections.

Older adults face particular harm from this exemption. By exempting an AHP from the look-through doctrine, the proposed rule would mean that plans would not be required to provide the essential health benefits. Individuals and small employers would not necessarily have coverage that includes

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<sup>10</sup>Centers for Medicare and Medicaid Services, “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.” (Sept. 1, 2011), available at [www.cms.gov/CCIIO/Resources/Files/Downloads/downloads/association\\_coverage\\_9\\_1\\_2011.pdf](http://www.cms.gov/CCIIO/Resources/Files/Downloads/downloads/association_coverage_9_1_2011.pdf).

<sup>11</sup>*Id.*

benefits such as prescription drugs, rehabilitative and habilitative services, and mental health and substance use services. We are extremely concerned that this will take consumers back to the days before the ACA, when plans frequently failed to meet the needs of older adults, people with disabilities and chronic conditions, and their 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 expected health care utilization, such as older adults, from enrolling in coverage. For example, before the ACA:

- One in five people enrolled in the individual market lacked coverage for prescription drugs.<sup>12</sup> Prescription drugs are vitally important to older adults and others with serious conditions such as hepatitis, cancer, multiple sclerosis (MS), HIV, and epilepsy. Rolling back coverage of prescription drugs means individuals and families would not be able to access the medicine they need to prevent or manage ongoing health conditions.
- Mental health coverage was often excluded from plans, or was very limited.<sup>13</sup> 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.<sup>14</sup> Since one in five people age 55 and older experiences some type of mental health concern, this is particularly relevant for older adults.<sup>15</sup>

The proposed rule puts the economic stability and health of consumers at risk by allowing employers to offer limited coverage that fails to meet their needs. For example, a small employer with a relatively healthy workforce might offer an AHP with low premiums but also very limited benefits. If an employee later develops a health condition such as cancer or requires hospitalization – they could suddenly find themselves in debt because the AHP does not cover necessary care.<sup>16</sup>

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 use to estimate health care utilization. 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.

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<sup>12</sup>Palanker, D., Volk, J., & Giovannelli, J., The Commonwealth Fund, Eliminating Essential Health Benefits Will Shift Financial Risk Back to Consumers (March 15, 2017), *available at* [www.commonwealthfund.org/publications/blog/2017/mar/eliminating-essential-health-benefits-financial-risk-consumers](http://www.commonwealthfund.org/publications/blog/2017/mar/eliminating-essential-health-benefits-financial-risk-consumers)

<sup>13</sup> *Id.*

<sup>14</sup>U.S. Department of Health & Human Services, Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans (Feb. 2013), *available at* [https://aspe.hhs.gov/sites/default/files/pdf/76591/rb\\_mental.pdf](https://aspe.hhs.gov/sites/default/files/pdf/76591/rb_mental.pdf).

<sup>15</sup> Centers for Disease Control and Prevention and National Association of Chronic Disease Directors, The State of Mental Health and Aging in America Issue Brief 1: What Do the Data Tell Us? Atlanta, GA: National Association of Chronic Disease Directors; 2008, *available at* [https://www.cdc.gov/aging/pdf/mental\\_health.pdf](https://www.cdc.gov/aging/pdf/mental_health.pdf).

<sup>16</sup>Lueck, S., Center on Budget and Policy Priorities, Trump Rule on Association Health Plans Could Devastate Small-Group Markets (Jan. 8, 2018), *available at* [www.cbpp.org/blog/trump-rule-on-association-health-plans-could-devastate-small-group-markets](http://www.cbpp.org/blog/trump-rule-on-association-health-plans-could-devastate-small-group-markets).

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. Prior to the ACA, many older adults were priced out of insurance markets because of limitless age rating. Insurance companies charged small employers as much as ten times more for older workers than younger workers, which made coverage inaccessible to employers with older workforces and left the older workers without affordable options. This could be the case again for older employees as AHPs would be exempt from the ACA's 3:1 age rating limit and allowed to use other factors like the industry of employers as a proxy for higher health care utilization and/or employees with less-than-perfect health.

The proposed rule would be especially harmful to older women. 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.<sup>17</sup> 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.

We strongly recommend 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.

#### IV. States must retain authority to regulate multiple employer welfare arrangements (MEWAs).

The proposed rule raises questions about preemption of state law. We oppose preemption of state laws and would consider any attempt by the Department to preempt states through this rulemaking as usurping 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.<sup>18</sup>

We urge 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, we strongly oppose 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. Furthermore, the Department neither has

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<sup>17</sup>National Women's Law Center, *Turning to Fairness: Insurance Discrimination against Women Today and the Affordable Care Act (2012)*, available at [www.nwlc.org/sites/default/files/pdfs/nwlc\\_2012\\_turningtofairness\\_report.pdf](http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf).

<sup>18</sup>Lucia, K. & Corlette, S., *The Commonwealth Fund, Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability (Jan. 24, 2018)*, available at [www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority](http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority).

the resources nor the expertise to serve as the sole regulator and should therefore take care not to undermine states' regulatory authority of AHPs in this rule.

- V. 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 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. AHPs Should Not Be Allowed to Exist Solely to Provide Insurance and Should Maintain Commonality of Interest Among Members

The proposed regulation at §2510.3-5 (b) would allow a bona fide group or association of employers to exist for the sole purpose of offering health insurance, reversing decades of authority 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. 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 the existing rule that a group or association cannot exist solely for the purpose of sponsoring a group health plan.

We are also concerned that the proposed regulation at §2510.3-5 (c) would significantly weaken 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.

The Department should retain the existing commonality of interest test based on facts and circumstances. If the commonality of interest test is changed, additional factors should be required beyond shared geographic location or industry in order to limit the ability of groups or associations to form without any true commonality of interest among employers. With regard to shared geography, the final rule should prevent arbitrary definitions of shared geography that would allow AHPs to carve out higher cost areas.

VII. Individuals and small businesses must be protected from discrimination.

We are pleased that the proposed rule would apply the HIPAA nondiscrimination provisions in §2590.702(a) and § 2590.702(b) to AHPs. These provisions prevent AHPs from discriminating based on health status related factors against employer members or employers' employees or dependents. Thus, AHPs could not use 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 this requirement in final rule and to apply it to all AHPs, regardless of when 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 could 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 could avoid covering people and businesses with medical needs. Using benefit design, an AHP could 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 adults higher rates without limit. Rating practices would result in healthier and younger groups being covered through an AHP, raising premiums and costs for older adults and others with higher health care needs in markets that offer comprehensive coverage.

Furthermore, an AHP could engage in marketing practices targeted at attracting healthier people. An AHP could avoid offering coverage in a geographic area where there is a high incident of conditions such as cancer, heart disease, and diabetes. Its geographic location can also be used to engage in redlining practices. That is, 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 the ACA's 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 set 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 rating and marketing practices. Failure to extend these protections will also jeopardize the regulated health insurance markets as AHPs would be free to cherry pick healthier consumers out of the regulated markets, leaving those markets with worsening risk pools and skyrocketing premiums.

VIII. Conclusion

Thank you for this opportunity to comment in response to this proposed rule on Association Health Plans. If you have any questions or concerns about our recommendations, please contact me at [jgoldberg@justiceinaging.org](mailto:jgoldberg@justiceinaging.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Jennifer Goldberg". The signature is written in a cursive, flowing style.

Jennifer Goldberg  
Directing Attorney