

March 6, 2018

RIN 1210-AB85

Comments on the proposed definition of “employer” under Section 3-5 of ERISA-Association Health Plans

Submitted online at <http://www.regulations.gov>

Families USA appreciates the opportunity to comment on the proposed definition of “employer” for purposes of association health plans. Families USA is a nonprofit organization dedicated to the achievement of high-quality, affordable health care and improved health for all.

Over the years, we have seen various insurance scams defraud consumers of millions of dollars. For instance, we received numerous faxes offering cheap (but fraudulent) plans in 2002-2004 and heard from patient advocates about defrauded consumers. That 2002 scam was documented in a GAO report.<sup>1</sup> We watched with dismay as the unlicensed American Trade Association, Smart Data Solutions, and Serve America Assurance companies spread through 21 states in 2008- 2010, selling policies over the internet even after insurance commissioners and attorney generals were alerted to their abusive practices, collecting \$100 million in premiums, and leaving consumers with unpaid claims.<sup>2</sup> We were aware that at least one of the operators in these fraudulent sales had previously been involved in other insurance scams.<sup>3</sup>

**We are concerned that the sale of association health plans to self-employed individuals under this proposed rule, and the sale of association health plans (AHPs) to small businesses that have minimal linkages and limited administrative capacity, will again pave the way for the type of widespread scams we outline above. Such sales will be difficult to oversee and will undercut protections in the individual and small group insurance markets.** In the preamble of this proposed rule, DOL acknowledges that it would need more resources for oversight if the rule was finalized. It appears that despite its authority to oversee MEWAs, the last time DOL did a comprehensive review of MEWA filings was 2014. We are very concerned that if the final rule undercuts state authority and significantly increases the number and type of MEWAs, consumers will again be victims of unchecked fraud.

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<sup>1</sup> US General Accounting Office, *Private Health Insurance: Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage*, GAO-04-312, February 2004, available on <https://www.gao.gov/new.items/d04312.pdf>.

<sup>2</sup> Families USA, *Buyer Beware: Unlicensed Insurance Plans Prey on Health Care Consumers*, October 2010 available on [http://familiesusa.org/sites/default/files/product\\_documents/Scam-Insurance-Plans.pdf](http://familiesusa.org/sites/default/files/product_documents/Scam-Insurance-Plans.pdf).

<sup>3</sup> William Worthy is mentioned in this DOL fact sheet as a repeat fraudster: <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mewa-enforcement.pdf>

As we have stated elsewhere, the Department has not done the necessary analysis of its own data considering association-sponsored MEWAs in order to determine the likely impact of these proposed regulations. The regulations should be withdrawn until such an analysis can be produced as part of the proposed regulation.<sup>4</sup>

In the individual market, and in the small group market, plans currently must offer the same set of essential benefits and must participate in a single risk pool within their state (45 CFR 156.80 and Patient Protection and Affordable Care Act, Section 1343). However, if some individuals or small businesses join AHPs that are considered large groups or that self-insure, they will no longer participate in those risk pools. AHPs are likely to establish benefit packages that help them avoid costly treatments (and costly enrollees); since they are not contributing to the state's risk pools, more comprehensive insurance, and plans that serve people who are less healthy, will become ever costlier. We have already seen this problem in states with significant numbers of people in non-compliant and grandfathered plans, and we expect this problem to worsen under the proposed rule.

As Children's Dental Health Project has pointed out in its comments, oral health care is one of many examples for which coverage of essential health benefits (EHB) makes a difference – and it is a benefit that, under the proposed rule, individuals and small groups enrolled in AHPs are likely to lack. Because of EHB standards, children now get both preventive dental care and needed fillings and restorative care. This helps them maintain health, avoid pain, and impacts their school performance. But without EHB delineation, the Congressional Budget Office has noted that pediatric dental benefits would be one of the top targets for cuts. Maternity care, mental health and substance abuse benefits, and rehabilitative and habilitative care are others.<sup>5</sup>

The preamble says that possible administrative efficiencies are a reason that AHPs might be cheaper than current small group market plans. We find this difficult to believe. Fully insured small group market plans must already limit their expenses to achieve required medical loss ratios, and filings showed that a number of carriers had exceeded required loss ratios. Since AHPs will be regulated as large group carriers and exempted from loss ratio requirements, their administrative expenses are likely to be a higher percentage of premiums.

**For the above reasons, we strongly oppose this rule.**

If the Department of Labor persists with the rule despite our opposition, following are comments about ways to strengthen oversight and *perhaps* avoid some fraud and abuse.

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<sup>4</sup> March 1, 2018 FOIA request from Kevin Lucia et al. to Tim Hauser, Deputy Assistance Secretary for Program Operations, DOL.

<sup>5</sup> Congressional Budget Office analysis of HR 1629, May 24, 2017, <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf>.

**1) Employers and employees need a way to verify that an AHP is authorized and financially sound**

Currently, MEWAs must file M-1 forms with the Department of Labor, and depending on state law, may be required to file with one or more states where they are doing business. However, there appears to be no easy way for a consumer to search the DOL website nor anyplace else to determine that a MEWA he or she is offered is registered and legitimate. If plans are offered to very small businesses including sole proprietors, these small entities will have a very difficult time determining what AHPs are authorized. Most such businesses have their hands full managing their day to day operations and do not have the training or capacity to determine if someone offering them a health insurance plan in fact has assets to pay claims and is offering them a legitimate product.

In searching the DOL website, the most recent compilation we found of enforcement actions against fraudulent MEWA operators was from 2013: <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mewa-enforcement.pdf> This is not enough. People buying these plans should be able to readily determine: a) if the plan has filed its M-1; and b) if the operators ever had enforcement action taken against them. The plan should be reporting its financial soundness to state and federal regulators. It is unclear whether the proposed rule even allows states to require reporting on financial soundness, and unclear how states could obtain necessary data for plans operating across state lines. The rule should explain what financial documentation must be provided and how consumers can verify compliance.

To that end, all AHPs should be required to provide notice to employer and worker members and applicants stating which ACA protections do and do not apply, what state rules apply, how to contact the state insurance department, and how to contact the Department of Labor. Penalties for not registering as MEWAs should be significant to encourage registration.

**2) Do not allow AHPs to choose a geographic area of operation that effectively discriminates based on health status**

On p. 619, DOL seeks comment on concerns associations could manipulate geographic areas to avoid costly claims and thereby discriminate. We believe discrimination is likely to occur if AHPs are permitted to sell based on geographic commonality in an area smaller than a metropolitan area – AHPs should not be permitted to redline certain neighborhoods, for example, refusing to sell in areas with prevalent health disparities or in neighborhoods with older workers. Therefore, if a metropolitan area becomes a basis for commonality, the area should be based on Census boundaries for metropolitan areas, except that state laws concerning AHPs should not be preempted; therefore, an AHP that wishes to operate in a metropolitan area that spans several states can still be excluded by a state from operating within its borders if it does not comply with the state's insurance laws.

The proposed rule would allow AHPs where employers had a principal place of business that “does not exceed” the boundaries of a state or metropolitan area. Please clarify that states are permitted to limit AHPs that are based on geography to operate within a single state rating area. Such a restriction may better help states preserve their risk pools and prepare for the likely effect of an AHP on the remaining pools’ claims.

We do support the proposal that HIPAA nondiscrimination rules that apply to group health plans will also prohibit AHPs from discriminating based on health factors against employer members or employers’ employees or dependents. We encourage DOL to retain this requirement in the final rule.

**3) Clarify responsibility within an AHP**

2510.3-5 (b) explains that a bona fide association has bylaws or a formal organizational structure, officers, and the “capability” of establishing a health plan; and that the employers or their directors, officers, or representatives control the plan. This is too vague. There must be some clear line of responsibility for the plan, and particularly if it is a self-insured plan, someone must have the expertise to ensure that it is operating on sound financial footing and meeting legal requirements. If an AHP is operating outside of the law, who is responsible and how will the employers understand their own responsibilities? Moreover, the rule should specify the right to sue and explain who is the responsible party.

**4) Do not allow working owners to be members of AHPs. If, contrary to our recommendation, you allow working owners to be members of AHPs, do not allow AHPs to be comprised *solely* of working owners.**

AHPs comprised solely of working owners seem particularly vulnerable to fraud. Working owners are not likely to have the time or expertise to determine if a contracted AHP is acting in good faith. It would be quite easy for a fraudster to sell phony AHP plans over the internet to working owners.

**5) If, contrary to our recommendation, working owners are allowed to form AHPs, significantly increase the requirements under subpart (iv).**

Currently, (iv) B would allow an owner to participate whose earned income was only equal to the cost of his or her own coverage, or the owner’s family coverage. This is a very low bar. For instance, a young person can currently buy individual market coverage for about \$270/month. Thus, under the proposed rule, someone who worked for themselves very few hours a month, and who was mostly employed elsewhere, could buy an AHP – potentially undermining risk pools for employer-based coverage as well as for the individual marketplace. With such a low business investment, such a worker-owner would have little incentive to attend to the AHP and its affairs. Since people with income below 400 percent of poverty can qualify for subsidized coverage in the marketplace, interest in a different coverage mechanism is more likely for people with income over 400 percent of poverty (roughly \$4000 per month). We recommend this as the dollar threshold for individuals under B.

Under the Affordable Care Act, people who qualify for hardship exemptions are allowed to buy catastrophic coverage, originally envisioned as a less expensive alternative that would limit their debt in a catastrophic circumstance. We appreciate that catastrophic coverage has not been priced low enough to be a realistic alternative. The framework, however, of allowing people to buy a different plan if their premium expenses would otherwise create a hardship is a useful one and perhaps could be applied to AHPs. If AHP sales to working owners are allowed at all, participation by workers who would otherwise be in the individual market could be limited to those who qualify for hardship exemptions. Based on premium prices by age, the Administration could annually issue guidance providing the income points where people would likely qualify for hardship exemptions and so could be permitted to instead enroll in an AHP with lesser benefits.

**6) Retain and strengthen non-discrimination requirements**

We strongly support the nondiscrimination requirements of this proposal, and the included examples of nondiscrimination based on health. However, it may be unnecessarily hard to prove that an AHP had knowledge of a member's health status when raising premiums. In example 6, for instance, in addition to not raising prices in a city when a member has cancer, an AHP should never set premiums higher in a given city where it does business unless it can show that the prices charged by providers are higher in that city, and that the premium structure will not have the effect of discriminating based on health status nor result in other improper discriminatory practices.

**7) Retain joint regulation of AHPs as MEWAs by states and by ERISA.**

We strongly support continuation of the rule that self-insured MEWAs are subject to state as well as federal law and oversight. We oppose preemption of state laws and would consider any attempt by DOL to preempt states through this rulemaking as a usurpation of Congress' lawmaking authority. Any effort to preempt states through this rulemaking would be in conflict with clear Congressional intent. The Erlenborn-Burton amendment, enacted in 1983, gave states broad authority over entities that cover two or more employers. Further, any state insurance law that is not inconsistent with ERISA may apply to MEWAs. The preemption standards applicable to group health plans, as added by Congress to ERISA through HIPAA and reaffirmed by the ACA, all support the authority of states to regulate in this area.

DOL's Request for Information suggests that DOL is considering broad exemptions from state regulation which would leave AHPs unregulated and consumers without any place to turn when they are scammed out of premiums and left with millions of dollars of unpaid medical bills. States that license and certify entities help keep convicted felons and fly-by-night promoters out of the insurance business, but DOL does not certify or license ERISA plans. It is therefore imperative that states continue to have authority to regulate AHPs.

Self-insured AHPs should be subject to state insurance laws for reserves and contributions.<sup>6</sup> Moreover, states should be able to determine whether both self-insured and fully insured AHPs should have to follow other state laws that preserve the integrity of their individual and small group markets and protect state residents.

**8) AHPs that operate across state lines should be registered in each state where they operate, and should follow laws of each state as well as federal law.**

Reporting to the Department of Labor should include the information about each AHP's state registrations, the names and positions of principals operating the AHP, the reason for the AHP, the geographic boundaries, trades involved, and the number and names of its members. AHPs operating across state lines should be subject to all state laws, including anti-fraud and consumer protection laws and regulations, in all of the states where they operate.

**9) AHPs comprised of individual or small group members should have to follow individual or small group rules.**

If, despite our strong recommendation, the rule allows them to be treated as part of a large group instead, the members cannot then claim to be a small employer for the sake of other laws, such as the pregnancy act.

**10) The rule should specify that AHPs are subject to administrative requirements of Title I, including claims and appeals, Summary Plan Descriptions, and other notices.**

These are important consumer protections, and there is no logical reason to exempt AHPs from any of the Title I administrative requirements.

**11) If you proceed at all, you should first seek authority to conduct a time-limited demonstration project in one geographic area. Such a project should be designed to determine the effects of the rule's proposed approach before implementing it permanently or nation-wide.**

During such a one- or two-year demonstration, the federal government should collect and make public data about: benefits provided, claims costs, premiums by age, administrative costs, solvency, in what way members exerted meaningful control; types and sizes of employers enrolled and their prior insurance status; whether the AHP negotiated any particular pricing discounts with providers that were beyond the discounts negotiated by small group and individual insurance carriers in the area; effect on premiums and risk pool in the individual and small group market in the area; what state rules and oversight applied. The demonstration should cease after the allotted time and the federal government

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<sup>6</sup> For an overview of how states have overseen MEWAs, see Koffman, et al, "MEWAs: The Threat of Plan Insolvency and Other Challenges", Commonwealth Fund, 2004 available at [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).



should publish findings about oversight, solvency, price, benefits, administrative costs, and effects on the rest of the market before proposing next steps for public comment.

Thank you for considering these comments. Please feel free to reach out with any questions at 202-628-3030 or at the email address below.

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