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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

Attention: Definition of Employer—Small Business Health Plans, RIN 1210-AB85

RE: Definition of “Employer” Under Section 3(5) of ERISA—Association Health Plans, Proposed Rule

Dear Secretary Acosta and Assistant Secretary Rutledge,

The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes.

We are deeply concerned about the impact that the proposed rule changes for Association Health Plans (AHPs) would have on consumers across the country, as well as on states’ ability to protect their residents and their insurance markets from harm. The proposed rules lower the bar for forming an AHP, thus expanding the opportunity for bad-actor or financially irresponsible AHPs to replay a history of fraud, abuse and financial mismanagement and leaving individuals and health care providers with unpaid claims. We fear that neither the federal government nor the states are fully equipped to deal with a resurgence of these problems and keep consumers out of harm’s way.

At the same time, the proposed rules would exempt AHPs from many standards and consumer protections that would apply if the coverage were offered in traditional insurance markets that serve individuals and small groups. While the proposed rules attempt to protect people from discrimination based on health status, AHPs would still have ample room to structure eligibility rules, benefit designs, rating rules, and marketing practices in ways that encourage enrollment by healthier individuals and groups while discouraging less healthy people and groups from participating.

This would mark a return to practices that pre-date the Affordable Care Act (ACA), and the problems that resulted from those practices. Individuals and small groups seeking health coverage could find themselves once again at a disadvantage if they have chronic health conditions, are female, are older, or work in jobs or live in neighborhoods deemed high-risk. Individuals and small businesses that want comprehensive coverage in the individual and small-group insurance markets, along with the full complement of consumer protections that applies there, are likely to find they have fewer affordable options as AHPs proliferate and pull healthier people and small groups out of states' traditional insurance market risk pools. Meanwhile, people who enroll in AHPs and then get sick could find they don't have coverage of benefits they need or that they must pay large amounts out of pocket for their medical care.

We urge the Department not to finalize this proposed rule because of the harm it would cause to states' insurance markets and, as a result, to many individuals and small businesses. We recommend that the Department hold a public hearing to fully and transparently vet the impacts of the proposed rule. If the Department ultimately decides to finalize this proposal or some version of it, we recommend that the effective date be set at least three years from the date the final rules are issued, to give states time to determine impacts of the AHP changes in their markets, and to act (with legislation or regulations) to address any gaps in their regulatory frameworks, set standards for AHPs, and/or update and improve the information available to consumers about AHPs. Our detailed comments appear below.

Sincerely,

Sarah Lueck
Senior Policy Analyst

Tara Straw
Senior Policy Analyst

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Employers Could Band Together for the Single Purpose of Obtaining Health Coverage

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 regulation (at § 2510.3-5(c)) significantly weakens the commonality of interest test, allowing employers to more easily circumvent these protections.

The proposed commonality of interest test eliminates the requirement that associations be established for a purpose other than offering insurance and would instead allow an 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. This raises both policy and legal concerns because it would make these entities indistinguishable from "commercial-insurance-type arrangements that lack the requisite connection to the employment relationship" (at 83 Fed. Reg. 619 (Jan. 5, 2018)). Contrary to the preamble's contention, other aspects of the proposed regulation – namely, the requirement in § 2510.3-5(b)(6) that a group or association make health coverage available only to employees, former employees and

family members – do not distinguish these association arrangements from commercial insurance. In fact, selling policies to individuals and small businesses of different industries (or no industry, to the extent that the self-attestation requirement in § 2510.3-5(e) is toothless) for an insurance arrangement in a limited geographic area is very much like commercial insurance, distinguished mostly by the lack of protective individual and group market rules commercial insurance would provide.

Another unfortunate result of allowing associations to form based on geography alone could be redlining – the practice of rejecting individuals or groups based on their geographic location. Often this results in economic or racial discrimination, which seems perfectly permissible under this rule given the latitude associations would be given to set their geographic area. This could result in certain counties, zip codes or sections of cities being excluded from an association’s boundaries for only discriminatory reasons.

The Department should retain the existing commonality of interest test based on facts and circumstances. If some version of the proposed commonality of interest test is finalized, additional factors should be required beyond shared geographic location and the final rule should do more to prevent arbitrary definitions of shared geography that allow AHPs to carve out higher cost areas.

The Group or Association Must Have an Organizational Structure and Be Functionally Controlled by Its Employer Members

The existing requirement that a group or association must exist for a bona fide purpose other than offering health insurance coverage to be an employer under section 3(5) of ERISA also helps prevent groups and associations from freely circumventing protections that apply to the individual and small group markets. By abandoning the requirement and allowing the groups to form solely to form a health insurance arrangement, associations created under the proposed rule act more as commercial health insurance arrangements than employer associations; instead they should continue to be required to have a purpose other than arranging health insurance.

The Department would retain certain important and longstanding interpretations of the formality and characteristics of groups and associations (§ 2510.3-5(b)). First, the proposed regulation requires a “*bona fide* group or association of employers” (emphasis added). Second, the group or association must have a formal organizational structure with a (multi-person) governing body and bylaws. Third, the association must be “controlled” by its employer members. The Department should resist suggestions to further loosen these requirements; without them, employers would be even more exposed to fraudulent schemes. The requirements also help identify violations of the law. For example, a formal structure with clear bylaws that define who may participate in the association is necessary to identify discriminatory denials of entry.

Group or Association Plan Coverage Must Be Limited to Employees of Employer Members and Treatment of Working Owners

The proposed rule allows “working owners” without any employees to receive coverage through association health plans. These plans will presumably in most instances be considered large group plans as they will have more than 50 enrollees. Individual working owners who participate in them will, therefore, be deprived of the special protections Congress extended to individual market participants through the Affordable Care Act. They will also, of course, no longer be part of the

individual market single risk pool. To the extent that associations “cherry pick” healthier individuals to participate in their plans—as they have in the past—this will increase premiums for individuals who retain individual market coverage.

The Public Health Service Act (42 U.S.C. 300gg-91(d)(6)) defines employer to mean: “such term under section 3(5) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002 (5)], except that such term shall include only employers of two or more employees.” This strongly suggests that employer-owners without any employees should not qualify as employees.

ERISA regulation 29 C.F.R. 2510.3-3(c), adopted in 1975 and in force at the time the ACA was adopted, provides: “For purposes of this section: (1) An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and (2) A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership.”

In the preamble to the proposed rule, the Department relies on the Supreme Court’s decision in *Yates v. Hendon*, 541 U.S. 1 (2004), which held that self-employed working owners could be plan participants, to support its position that working owners can get small group coverage (or participate in large group coverage through an association) even if they have no other employees. *Yates*, in fact, asked a different question—assuming that an owner offers a plan that covers its employees, can the owner also be a participant? This is not the question raised by this proposed rule, which addresses the question of whether owners who have no employees can participate in group health plans. On that question, the Supreme Court acknowledged that “Courts [in three circuits] agree that if a benefit plan covers only working owners, it is not covered by Title I,” and that this position was taken by the Solicitor General’s brief submitted as *Amicus Curiae*

The cases cited by *Yates* recognize the long-standing position of the federal agencies that an ERISA plan had to have at least one employee participant other than the owner to be a group health plan. For example, 42 U.S.C. 300gg-21(d), which allowed partners in partnerships to be participants in group health plans, recognizes that self-employed individuals can only become plan participants if one or more employees are eligible to be participants in the plan as well as the partner.

Congress in adopting the ACA, with its special protections for individual market participants, was aware of this body of law and meant to retain it. The ACA includes definitions of the individual, small group, and large group market (42 U.S.C. 18024) that continue to recognize that owners of businesses who have no employees cannot qualify for group coverage (although it permitted small group coverage for groups that included only one employee other than the owner). The proposed rule, therefore, violates the ACA.

In addition to these legal considerations, there are strong policy reasons the Department should not allow associations to have working owners that qualify as both an employer and as an employee, as this will bring instability to the individual market. AHPs will likely 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 definition of “working owner” is too broad. While the preamble clarifies that, for example, someone selling a single scarf online is not a working owner, the required connection to

employment is minimal. And most troubling, the regulation does not require associations to verify a member's attestation that they meet the rules to be a working owner at the time of enrollment or that the member remains actively engaged in work for the duration of the plan year or at the time of re-enrollment. Associations aren't required to keep any evidence more than the attestation, further reducing the possibility of effective oversight. Absent such oversight, associations have little incentive to apply rules consistently versus to enroll any healthy individual who applies.

Taken together, the rules allowing working owners to participate in an association health plan allow virtually any individual to enroll and make the plan indistinguishable from commercial insurance but without the state and federal protections that would normally apply to this population in the individual and small group markets, to the detriment of those not in associations and potentially to the detriment of those in associations as well, if they get sick and their association coverage lacks benefits they need.

Health Nondiscrimination Protections

We support that the proposal applies the HIPAA nondiscrimination provisions to AHPs, thus preventing AHPs from discriminating based on health status-related factors to determine eligibility for benefits or to set premiums. This will help to mitigate, but will not avoid, discrimination against employer members, employees, or dependents participating in AHPs related to health factors such as health status, medical conditions, claims experience, and disability. If the Department moves forward with finalizing the rule, we strongly encourage it to retain this requirement, and to ensure that it applies to all AHPs without exceptions or delay.

Even with the proposed nondiscrimination protections included, the proposed rule would still leave significant leeway for AHPs to engage in other practices that result in discrimination against people with medical needs and pre-existing conditions. For example, an AHP would be exempt from a number of consumer protections that would otherwise apply if individuals were enrolling in regular health insurance in the individual market, including the ACA's essential health benefits and rating standards. An AHP could use benefit design to attract healthier groups. For example, AHPs could leave out coverage of mental health treatment and prescription medications for costly conditions, and people who need those benefits would not sign up. In addition, an AHP could structure its membership rules and marketing tactics in ways more likely to attract healthier people and groups. An AHP with a healthier-than-average membership would then have premiums lower than the market average, while also – because ACA rating standards don't apply – charging far more to small groups (as well as to individual “working owners”) that are made up of women, older people, that are very small, that work in professions deemed high-risk, and that live in areas classified as higher cost.

In order to more meaningfully protect against discrimination, the Department should ensure that AHPs that enroll individuals and small groups continue to abide by the standards and protections that otherwise apply to individuals and small groups. This would, for example, prevent associations from varying premium rates to different small employers based on gender, industry, or firm size, or to charge unlimited premiums due to age – all of which can result in premium rates that vary based on expected health care utilization. The final rule should also apply EHB, guaranteed issue and single-risk pool requirements to AHPs that cover small groups and individuals, just as these requirements would apply in the regular individual and small-group markets. Failure to extend these

protections would expose employers and their employees to discriminatory practices. Failure to extend these protections will also place the regulated health insurance markets in jeopardy, as AHPs would be free to attract healthy consumers out of the regulated markets, leading to instability and premium increases in those markets.

Request for Public Comment

Notices

The Department requests comment on required notices about AHPs. We urge you to require AHPs to provide notice to employer groups and individuals considering enrolling in an AHP about the availability of coverage through the health insurance marketplace that may potentially be more affordable. The Department should also require AHPs to provide notices about whether the plans do or do not meet federal minimum value standards and which essential health benefits are excluded from or subject to dollar limits. This would help ensure that employer groups and employees are aware when an AHP may be less comprehensive than plans that meet ACA standards in the individual and small-group markets. In addition, if the AHP does not meet the minimum value standard, then the AHP should be required to provide a notice to ensure that employees and their dependents are aware that they may be eligible for more affordable and comprehensive coverage through the ACA marketplace. The Department should also clarify that all notice requirements that apply to group health plans apply to plans under this regulation, including notices of appeals rights, summaries of benefits and coverage, and summary plan descriptions.

Impact on Risk Pools

We are concerned that this proposal would harm small-group insurance markets and also that it would harm individual insurance markets because of its extension to “working owners,” thus endangering people’s access to affordable coverage in these markets. By effectively exempting AHPs with small business and individual members from many standards and consumer protections that would otherwise apply to small groups and individuals, this proposal would effectively segment insurance markets into healthier and sicker groups. For example, AHPs would be able to widely vary premiums for groups and individuals based on age, industry, geographic area, and gender — factors that ACA plans are prohibited or limited in being able to consider when setting premiums. AHPs could also avoid covering or sharply limit coverage of the ACA’s essential health benefits. As the American Academy of Actuaries noted in its February 9 comments on the proposed rule, this means, “AHPs could benefit from positive selection — that is, they would attract a lower-cost enrollee population. In contrast, ACA plans would be subject to adverse selection — they would attract a higher-cost enrollee population, which would lead to higher ACA premiums.” This “bifurcated” market could worsen over time, the actuaries wrote, especially because AHPs are outside of the “single risk pool” and risk adjustment requirements that apply to ACA-compliant plans. This “could lead to potential rate spirals in the ACA markets as healthier groups move to the AHP market...”¹

¹ American Academy of Actuaries, “Considerations Related to Modeling the Potential Impact of Association Health Plans,” letter to EBSA, February 9, 2018. http://actuary.org/files/publications/Idaho_030218.pdf

The expectation that AHPs would segment insurance markets and raise premiums for sicker groups and individuals has been a major reason that a wide variety of stakeholders and experts, from state insurance regulators and governors to insurers and consumer advocates, have long criticized proposals to expand AHPs.² Yet the proposed rule downplays these concerns and even speculates that less healthy people will have just as much reason as healthy people to sign up for AHPs. That is most certainly not the case. Because medical spending is heavily concentrated in a small percentage of the population, any given AHP stands to gain from using available tools (including benefit design and rating) to avoid very high-cost enrollees and attract people who cost less to cover. This would leave the regular individual and small-group markets to absorb a greater share of the costs for higher-cost people.

Prior experience with associations supports the idea that a disparity in rules undermines the more strongly regulated market. For example, in the mid-1990s, Kentucky passed a set of health insurance reforms that were very similar to the ACA's market reforms, including a requirement for insurers to accept all applicants regardless of their health status, benefit standards, and limitations on premium variation for age, family size, and geographic factors. Later, Kentucky's legislature passed a law exempting associations of employers or individuals from the premium-rating and benefits requirements, a loophole that allowed associations to sell coverage under a much weaker regulatory scheme. In part because healthy individuals could buy association plans, the risk of adverse selection against the reformed individual market increased. Nearly all insurers left Kentucky's individual market or declined to sell new policies that were subject to the stronger rating and benefits standards. In 1998, the Kentucky legislature passed a bill that repealed many of the state's remaining health insurance reforms.³

To truly protect the individual and small-group markets from premium increases, adverse selection, and instability, and to ensure that consumers can access affordable, comprehensive coverage, the Department should ensure that AHPs serving individuals and small businesses play by the same rules that apply to ACA-compliant plans that cover individuals and small businesses. Allowing AHPs to abide by a weaker set of standards than their competitors (regarding benefits, cost-sharing, rating, and other market rules) would only serve to promote market segmentation and raise premiums for many small groups and individuals.

Oversight and Enforcement

AHPs have frequently served as a vehicle for selling fraudulent insurance coverage, and they have a history of insolvencies and financial mismanagement. In light of these problems, strong oversight is essential. However, we are concerned that the Department lacks sufficient capacity to protect consumers from harm, even as this proposal would result in an expansion of AHPs and expose more people to potential problems. At the same time, the proposal raises new obstacles for states that want to conduct their own oversight and enforcement activities to protect their residents. We

² See, for example, "Consumer Alert: Association Health Plans are Bad for Consumers," National Association of Insurance Commissioners, http://www.naic.org/documents/consumer_alert_ahps.pdf and "NGA Opposes Association Health Plans, Governors maintain opposition to proposed federal legislation that they say would raise premiums," March 31, 2004. https://www.nga.org/cms/home/news-room/news-releases/page_2004/col2-content/main-content-list/nga-opposes-association-health-p.html

³ Adele M. Kirk, "Riding the Bull," *Journal of Health Politics, Policy and the Law*, vol. 25, No. 1, February 2000, pp.133-173.

are concerned that this proposal ultimately puts consumers at significant financial risk, as they may face large unpaid claims for their health care or evaporating insurance coverage when their AHP fails.⁴

If this rule (or some version of it) is finalized, then states will need time prior to the resurgence of AHPs to review current state laws that might apply to AHPs, consider how AHPs might affect their insurance markets, identify any gaps in the regulatory framework or oversight process, and prepare to monitor and oversee the AHP market within their borders. Some states may decide they want to pass legislation, issue regulations to establish new standards for AHPs (regarding benefits, rating, marketing practices, and/or financial reserves), issue guidance to their regulated entities and undertake robust consumer education efforts. Therefore, we urge you to set the effective date of any final AHP rule at least three years from the time they are issued. If the Department's intention is to ensure that states can truly retain authority over AHPs, then states will need this lead time.

Request for Information

The proposed rules raise questions about pre-emption. We oppose 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. Any effort to preempt states through this rulemaking would be in conflict with clear Congressional intent. The 1982 Erlenborn amendment gave states broad authority over entities that cover two or more employers and 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.

Furthermore, we are concerned that the Department's proposal to change more than 40 years of ERISA interpretation creates new risks. Historically, entities seeking to evade state oversight and state standards used ERISA as a shield and exploited exceptions and ambiguity to challenge state actions. The proposed rule would allow this to happen again. To head-off such ERISA abuses, the Department should clearly state that ERISA single employer AHPs, including the ones covering people in more than one state, would have to comply with all state laws in states in which they operate and would continue to be subject to state oversight and regulation.

Finally, we are concerned about the questions raised in the request for information. The Department appears to signal that it is considering using its section 514 authority to issue individual or class exemptions for MEWAs that are otherwise subject to state regulation. 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 any attempt to preempt state authority would harm consumers and have a better track record than the federal government, which currently lacks the resources and the expertise to serve as the sole regulator. This should weigh strongly against the Department taking action to prevent states from regulating. Any attempts to issue class or individual exemptions would be an attack on the states and would only serve to fuel fraud and insolvency. Any attempt to exempt all AHPs from state regulation would exceed the Department's statutory authority.

⁴ Kevin Lucia and Sabrina Corlette, "Association Health Plans: Maintaining State Authority is Critical to Avoid Fraud, Insolvency, and Market Instability," Commonwealth Fund, January 24, 2018.
<http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority>

The Department raises the possibility of taking action under Section 514(b)(6)(B) in this request for information, which could be used to exempt a class or an individual AHP that is an employee welfare benefit plan from state insurance regulation. As noted, we strongly oppose any proposal that would limit state's ability to regulate AHPs. If the Department is considering proposed rulemaking under section 514(b)(6)(B), it should first fully implement Section 520 of ERISA. If the Department is going to exempt AHPs from state oversight, it is essential that it revoke the exemption for fraud and abuse — a remedy Congress expressly provided. Congress amended ERISA in 2010 specifically providing DOL with new tools to address fraud and abuse related to AHPs. The Department should promulgate a proposed rule for section 520 for public comment and ensure that section 520 is fully implemented prior to exercising its authority under section 514(b)(6)(B) to exempt as a class or individually AHPs from state oversight.

Regulatory Impact Analysis

We do not agree with the rationale the Department offers in support of the proposed rule, which is primarily that the regulation is needed to “lower some barriers” in order for small businesses to access coverage on the same terms as large businesses. The barriers discussed in the proposed rule are, first, a need to provide small employers with “administrative efficiencies” and “negotiating power” similar to what larger employers can achieve and, second, to help more small businesses form “naturally cohesive large risk pools” akin to large employers.

No solid evidence exists to support the proposed rule's speculation that expanding AHPs would generate substantial efficiencies. In fact, experience shows that associations don't actually reduce administrative expenses but instead replicate functions such as marketing and enrollment that insurers already perform.⁵

The proposed rule says it “may be advantageous to allow more small businesses to combine into large groups for purposes of obtaining and providing insurance.” But the ACA already improved pooling for small businesses, via the single-risk pool requirement, which requires each insurer in a state's ACA-compliant small-group market to consider its full enrollee population when establishing premium rates, rather than setting premiums for each small business based on the expected costs of that small business. In addition, the ACA bars insurers from charging small businesses higher rates based on the number of employees they have or the number of workers that enroll in the plan, opening a path to coverage for so-called micro-firms that often didn't exist before. To the extent that AHPs provide some small businesses and individuals with access to lower premiums, it would be as a result of market segmentation. Some lower-cost groups and individuals would benefit from the looser rating rules and benefit standards that would apply to AHPs and would leave the regular insurance risk pools to obtain the lower premiums that would result from these advantages. Therefore, any improvements for some small businesses and individuals that might result from an AHP expansion are likely to occur only at the expense of other small businesses and individuals with characteristics that don't allow them to benefit from risk selection by AHPs.

⁵ Elliot K. Wicks and Mark A. Hall, “Purchasing Cooperatives for Small Employers: Performance and Prospects,” *The Milbank Quarterly*, Vol. 78, Issue 4, December 2000.

Medicaid

The Department notes that under the proposed rules, some Medicaid-eligible workers could become eligible to enroll in AHPs. We note that it would be problematic if low-income people accessing comprehensive Medicaid coverage were shifted into more limited AHP coverage with unaffordable premiums and cost-sharing charges. The Department should ensure that Medicaid beneficiaries are accurately and completely informed that Medicaid provides much better coverage and access to needed medical services.

Operational Risks

AHPs have a long history of insolvencies, fraud, and abuse. The Department briefly acknowledges this history and notes that these entities have “often” left plan participants and medical providers with unpaid benefits and bills. But the proposed rules fail to fully discuss this issue, to quantify the likely costs of allowing a proliferation of AHPs, to thoroughly analyze the impact of the proposed rule on regulators, consumers, and health care providers, or to propose methods to prevent fraud and abuse that could be required of all AHPs. We note that Georgetown University’s Center on Health Insurance Reforms has submitted a Freedom of Information Act (FOIA) request for various documents and data from the Department that would provide crucial details about the history of financial abuses associated with Multiple Employer Welfare Arrangements (MEWAs) and the Department’s experience with financially failing MEWAs. And a coalition of stakeholders has called on the Department to withdraw or delay the proposed rule until this request is fulfilled.⁶ We agree that the Department should make this information available to the public so that the potential negative impact of the proposed rule can be fully understood.

Federal Budget Impacts

We agree that the proposal is likely to increase the deficit on net, including as a result of additional tax subsidies for individuals enrolling in AHPs and the likely increase in resources allocated to support federal efforts to prevent and correct mismanagement and abuse.

⁶ “Coalition Demands Crucial Information About Association Health Plan Rulemaking,” Center on Health Insurance Reforms, March 2, 2018. <http://chirblog.org/coalition-demands-crucial-information-association-health-plan-rulemaking/>