

RIN 1210-AB85

Comment and Request for Public Hearing on the United States Department of Labor NPRM on Association Health Plans

My name is Marc I. Machiz. I am an attorney admitted to practice in Pennsylvania, but I am currently retired and represent no one with an interest in this regulatory matter. I submit my comments as a concerned member of the public with a long history as a career Department of Labor employee who has been engaged in the fight against fraudulent and poorly funded MEWAs, including purported Association Health Plans (“AHPs”) over the course of many decades. I first joined the United States Department of Labor in 1978 as a trial attorney in the Plan Benefits Security Division of the Office of the Solicitor of Labor. With a brief, two year hiatus in 1984 and 1985, I served in the division until 2000, leading it as Associate Solicitor of Labor from 1988-2000. Until 2012, I represented participants and independent fiduciaries in ERISA fiduciary litigation and related matters as a partner in the firm of Cohen Milstein Sellers and Toll, PLLC and the head of the firm’s employee benefits practice group. In 2012, I returned to the Department to advise the Deputy Assistant Secretary for Program Operations for EBSA on enforcement matters, and became the Regional Director for EBSA in the Philadelphia Region from July of 2012 until January of 2016. Throughout 2016, I served as a Senior Advisor in the Office of Enforcement, reporting to the Director of the Office of Enforcement. I retired from federal service at the end of 2016.

The history of AHPs has been a history of fraud, failure, broken promises and lives destroyed on the altar of crushing medical bills that AHPs promised to cover often knowing full well that the promises were so much hot air. Promoters of AHPs have preyed on the desire of small businesses to provide affordable coverage to their employees and owners. Their modus operandi has followed the devastating model of the Ponzi scheme, facilitated by networks of dishonest insurance agents eager to earn a commission on a product they could not in good faith vouch for. Almost invariably, the story goes like this.

An aspiring criminal, often with a history of dubious financial dealings, if not crimes, learns of a new world to conquer, fat with easy marks. Often mentored by an individual who has walked this disreputable road before, who needs a front man to avoid scrutiny by authorities already familiar with him, our fraudster meets with a group of insurance agents who have experience selling associate health coverage. A few of them agree to be the original members of the Association who as charter members, elect the initial Board of Directors of the Association (friends of the fraudster, every one). The Board hires the fraudster or a close associate to serve as President of the Association and Trustee of a Trust established by the Association to receive employer contributions and pay health claims. The fraudster hires a business run by family members, perhaps his daughter and son in law, to administer the Trust and promote the coverage that the Association offers to its members. This the Association does by agreeing to pay commissions to a network of insurance agents who sign up new members of the Association who will pay dues in order to get access to attractively priced health coverage offered by the Trust.

The key to the scheme’s “success” is that the network of crooked agents will explain to the prospective Association members that the Association can offer favorable rates because the AHP will not be subject to burdensome state insurance regulation (and now we can add, if DOL is correct, that it will not be subject to the allegedly burdensome protections that the ACA imposes on insurance sold through the small group and individual insurance markets). To facilitate the sales pitch and promote rapid growth, the Trust offers coverage that is significantly cheaper than commercial insurance and pays the agents unusually generous commissions to drop any scruples they might otherwise possess. Between the administrative fees to the family business, the dues to the Association (which compensate the fraudster as

President of the Association), Trustee fees and commissions for the agents, about half of the money paid by the newly recruited association members as dues and contributions is used for something other than paying claims. With expenses so high, promised claims cannot possibly be paid in the long run, but the day of reckoning can be delayed, as in all Ponzi schemes by rapid, exponential growth in Association membership; importantly, there is a lag of several months between the first employer or employee contribution and the expectation that the first submitted claims will be paid. This lag, which can be extended by tactics used to slow walk claims, provides time for the Ponzi scheme to grow. Earlier incurred claims are paid with later employer (and employee) contributions, thereby creating the illusion of financial sufficiency during the Ponzi scheme's growth phase.

Typically, these Ponzi schemes collapse of their own weight in 18 to 36 months. Most often, DOL investigators learn of these schemes when participants begin complaining that they cannot get a large claim paid, often after multiple promises that "the check is in the mail." Generally, this is much too late to avoid havoc. At best the DOL (or state regulators) will stop the marketing, and obtain a new Trustee to equitably distribute the Trust otherwise burdened with obligations far exceeding its income and assets). In the most successful enforcement actions, a court appointed Trustee will martial fiduciary liability coverage if there is any, and negotiate with medical providers to forbear from taking collection efforts against participants in exchange for pennies on the dollar in claims. "Enforcement success" means little more than transferring the financial pain of the fraud from participants to medical providers with some capacity to cost shift to their broader patient population.

Through the expenditure of enormous resources, relative to the sum of all resources available to enforce ERISA, the DOL has had limited "success" of the sort described above in resolving failed AHPs, but very little success in stopping their spread. Though courts will enjoin breaching fiduciaries from further service, the next scam requires only changing the name on the Association's governing documents, the Association President and the AHP trustee. Preexisting networks of unethical agents stand ready to sell the next shoddy or fraudulent product. The truth is that state insurance regulators have had more success in shutting down individual fraudulent AHPs than DOL, perhaps because they rely on tips from more scrupulous insurance agents, but state insurance regulation and enforcement is uneven. Certain states, Florida, Texas, Oklahoma, Arizona and Georgia, for example, have been historically more plagued by this species of fraud than other parts of the country.

Are there some "good" AHPs? Yes. And these AHPs are uniformly sponsored by entities that meet the DOL's current criteria for a bona fide association as set forth in advisory opinion letters and accepted by the courts. These associations are controlled by their membership in substance, not just in form and they have real representational missions apart from merely offering health coverage. They have members who pay dues that do not take advantage of the offered health coverage; they pay dues for the other benefits that Association membership confers on its members.

Why are these hallmarks of bona fide association status so important in distinguishing between legitimate AHPs and outright frauds? Because these indicia of a bona fide association status provide assurance that the association that does choose to offer health coverage to its employer members will represent the interests of those employer members, not the interests of whoever happens to be promoting the health care arrangement. A bona fide association, beholden to its membership in substance, will not tolerate a health care arrangement that is not only legitimate but which has a real likelihood of paying claims as they come due. To do otherwise, would destroy the bonds of trust between employer members and their employees and the employer members and their association. Moreover, a bona fide association, will not have any interest in offering a product that is appealing only to a portion of the membership, for example, those with a young workforce. A bona fide association will serve the interests of all its members in

establishing and maintaining a solvent plan that is valuable to its entire membership. Naturally, the frauds of the world do not get a friendly audience from the leadership of bona fide associations, as the DOL has traditionally defined them. They create their own associations, historically for the purpose of claiming an exemption from state insurance regulation (whether lawfully or not—depending on the inclination of each state and how confused the state is about the reach of ERISA preemption).

The DOL was never able to declare victory over fraudulent AHPs (or other fraudulent MEWAs). But it last published a list of cases in 2013, which can be found on EBSA's website. During my tenure as Regional Director of EBSA's Philadelphia Region, the number of fraudulent AHPs and other fraudulent MEWAs coming to the Department of Labor's attention dramatically decreased; my own case inventory consisted of older cases that were still open. While AHP fraud has not disappeared entirely (and the DOL should disclose the existence of pending investigations during the pendency of this regulation), the incidence of AHP fraud has abruptly dropped in the past few years. Why is that?

The implementation of the ACA dramatically reduced the incidence of fraudulent AHPs and other fraudulent MEWAs, but not because of provisions in the ACA designed to give greater enforcement and regulatory authority to the Department of Labor. Those new authorities have gone almost entirely unused. Rather, the ACA deprived fraudulent MEWAs of the air that they breathe, by offering affordable, subsidized insurance through the exchanges to small businesses and individuals employed by small businesses. Before the ACA small business owners were desperate for health coverage for themselves and their employees and they were easy prey for fraudulent AHP promoters who claimed to offer just what they needed, affordable coverage. After the ACA small business owners and the self-employed had no need to resort to suspect AHPs. Accordingly, during my tenure as an EBSA Regional director, enforcement resources devoted to health plans shifted away from fraudulent AHPs and toward assuring that provisions of the ACA requiring minimum benefits, especially in the small group market, were actually complied with.

The NPRM seeks to undo the progress of the last several years, not only the progress against fraud, but the progress in offering broadly affordable insurance to small businesses and individuals. The NPRM dishonestly claims as its purpose the expansion of opportunities for affordable coverage by allowing small employers access to less regulated (and presumably less expensive) world of large group coverage. It is important that we call this effort by its right name, a torpedo aimed at the heart of the ACA. The NPRM's real effect is not to make less costly, less regulated insurance broadly available. Instead it will create winners and losers among small employers, benefitting somewhat larger groups of the young and the healthy, while unleashing a new wave of fraud on the vulnerable. It is a species of social darwinism that would embarrass the robber barons. It deserves not merely opposition, but moral revulsion and scorn. How will this sorting between winners and lambs led to the slaughterhouse occur?

We can assume that in the best case scenario, some new AHPs will come into being that are not complete frauds, in the sense that they intend to maintain adequate solvency and actually pay claims. They will be able to cherry pick the best risks from the small group market by, among other things a) unlimited age rating, making their product attractive only to younger, healthier groups; b) creating associations aimed at industries known to have healthier populations with better claims experience; c) limiting themselves to somewhat larger groups to avoid adverse selection; d) limiting their geographic reach to zip codes known to be healthier; and e) targeting marketing pitches to the young and the healthy. Nothing in the DOL's rule requiring health care non-discrimination will prevent these techniques for cherry picking risk, though we must acknowledge that the rule could be made even more sadistically savage still by simply allowing the halt, the lame and the chronically ill to be excluded from AHP coverage. Other comments will attempt to quantify the extent that risk selection by these non-fraudulent AHPs will disrupt the small

group and individual markets, making coverage more expensive or simply unavailable to those left in the dust. But the effect will be substantial and the DOL not only knows this, it hopes for it and plans for it, though it deviously makes no serious attempt of its own to quantify it. The very essence of the rule is to allow a new broader class of AHPs with no reason to exist other than to evade the ACA's protections for the small group and Individual market, the purpose of which is to assure that everyone in those markets gets high quality and affordable insurance, not just folks with attractive risk profiles. It is fair to project that the regulation will achieve its actual aim, to offer more affordable coverage for the privileged young and healthy, at the expense of the balance of the small group and individual markets.

But what will become of those left behind. First and foremost, the price of insurance for the laggards will rise. History teaches us (history hidden in DOL's own files), that when coverage is unaffordable in the small group and individual markets, the fraudsters will appear to prey on the most vulnerable. As a direct and inevitable result of the DOL's NPRM, we can anticipate a new wave of fraudulent AHPs. The key fact is that frauds don't care if their target population is high risk, old and chronically ill. Indeed, for a fraudster, a desperate customer is the best customer; the buyer with Stage 4 cancer won't think critically about the product on offer. Fraudsters don't care that the claims experience will be bad, because it will never have been their intention to pay all the claims; they will simply gather contribution income, and exorbitant fees and commissions and disappear to the Caribbean, where we can anticipate (based on past experience) that a number of them will fake their deaths. The "good" AHPs, by driving up the cost of coverage for the unattractive risks will create customers for the fraudsters, customers destined for medical bankruptcy and utterly destroyed credit when the fraudulent AHP fails, as it is designed to do.

Stunningly, the DOL was not content to disrupt the small group market and exposing it to rampant fraud. It chose to extend the reach of fraudulent AHPs to the individual market, promising to unleash fraud on a magnitude never before seen in the individual insurance market. How has the DOL done this?

Pursuant to the NPRM individuals may participate in AHP coverage based on no more than their self-certification that they meet some modest threshold of work or income for self-employed status. The details of this part of the rule need not detain us because they are irrelevant. What matters is self-certification. The AHP need not inquire whether an individual is truly self-employed (by whatever standard that might be determined), the AHP can cover anyone willing to check a box on a form that says they are self-employed. Ironically, the "legitimate" AHPs may have little interest in the individual market, accepting individuals without medical underwriting makes them vulnerable to adverse selection. But the fraudsters will happily accept self-certifications and contributions from individuals without worrying about how sick they are—it is not a fraudster's aim to pay claims—it is his aim to steal, pure and simple. If the NPRM becomes effective, we can assume that the individual market will have access almost exclusively to fraudulent AHPs.

Georgetown University has filed a FOIA request for the DOL's files on MEWAS. We can anticipate that these files will substantiate the predictions here of widespread fraud. They will also show that DOL is well aware of the dangers of the present AHP proposal and the huge devotion of resources that might somewhat ameliorate the impact of the massive fraud that DOL invites with the NPRM. They will show that the characteristics of the AHPs that the DOL now encourages are indistinguishable from those of the AHPs that have been historically fraudulent. The public deserves to be fully full informed about this history of fraud and the agony at DOL over the possibility that AHPs could be expanded, without adequate plans to license and control them. This history will establish that there is no good faith explanation for DOL's issuance of the NPRM. This administration has set out to destroy the ACA, no matter what the consequences, no matter how many lives of the sick and most vulnerable are ruined as a result.

I join with those who have called upon DOL to release their files on MEWAs and withdraw the NPRM, reproposing the regulation only after doing a full economic analysis of the consequences of the regulation for the fraud that it now alludes to as an afterthought in its preamble, without any attempt to quantify the extent of that fraud based on data from its own files, instead alluding to the work of others as if DOL did not have the best information on MEWA fraud already in its own possession. At the very least, comment period should be extended to allow for more detailed comments based on a full review of the pertinent files that DOL must release pursuant to FOIA.

To this point, I have critiqued the regulation as cruel and malicious policy aimed at destroying the ACA by exposing the sick and defenseless to rampant fraud at their expense. That should be enough to give anyone but a monster pause. But the motivation behind the NPRM is patently monstrous, so I have to presume that merely calling it by its right name will not be sufficient to halt this abomination. My final appeal is to the law itself. As explained more fully below, the key provisions of the regulation are inconsistent with ERISA. The regulation cannot withstand review by the courts. For that reason alone, out of respect for the law, the NPRM should be withdrawn.

It is not consistent with ERISA to accept self-certification of employee status.

As the NPRM's preamble acknowledges, "the touchstone of ERISA is the provision of benefits through the employment relationship." 83 FR 621. "The rule is intended to cover genuine employment based relationships, not to provide cover for the marketing of individual insurance masquerading as employment based coverage." *Id.* At 622. The NPRM adopts a test for self-employed status based on minimal income earned from the self-employing enterprise (an amount equalling the cost of coverage) or hours worked in the enterprise (120 hours a month). This approach seems reasonable enough (though the income requirement seems especially low), but the Department asks for comments here and notes that many approaches might be reasonable, except that DOL's approach (and most any other) raises the difficult problem of how the plan can verify the claim of self-employed status. Here, the NPRM goes off the rails by effectively ignoring the "touchstone of ERISA," and actually facilitates the very "masquerade" the Department purports to denounce as incompatible with the law.

The regulation fails the Department's own test of assuring that the coverage is tied to an employment relationship (even if only self-employment) by "[including] an express provision that would allow the group or association sponsoring the AHP to rely, absent knowledge to the contrary, on written representations from the individual seeking to participate as a working owner as a basis for concluding that these conditions are satisfied." As a practical matter, those marketing this coverage and promoting memberships in the "associations" that purport to sponsor them, will have no knowledge to the contrary. Prospects will be given a pre-printed or online form to complete with check the box text representing that the signatory meets one of the tests for self-employment, along with acknowledgment of receipt of the association's governing documents and agreement to be bound thereby. In this way, the seller can market coverage unmoored from employment status to individuals with no legitimate claim to self-employment. There is no sanction for individuals falsely representing self-employed status, nor could an enforceable sanction be devised. This provision is so brazen that it calls into question the good faith of the NPRM's drafters. Moreover, it actually invites a particularly grotesque form of insurance fraud: after marketing to individuals willing to falsely self-certify self-employed status, nothing in the regulation prohibits the arrangement from auditing individuals who actually submit large claims for benefits, and denying them precisely because that same individual, when pressed, cannot document self-employed status. Without meaningful and enforceable provisions to assure that association sponsored coverage is only marketed to

individuals who can verifiably meet a legitimate test for self-employed status at the time of enrollment and on an ongoing basis, at reasonable intervals thereafter, the regulation utterly fails the Department's own correctly articulated test: to be offered by an ERISA covered plan, coverage must not merely "masquerade" as employment based coverage, it must actually be employment based coverage.

Without substantial modification which will meaningfully limit the marketing of this coverage to individuals, I believe the regulation is an abuse of the Department's discretion to allow for provision of association sponsored employment based coverage. Accordingly, a challenge to the regulation to the extent that it allows for self-certification of employment based status will be successful.

It is inconsistent with ERISA to deem any employer association bona fide solely on the basis that it allows its employer members to control it through the election of a Board of Directors with broad authority to control the association and the coverage that it offers to its members, their employees and beneficiaries.

Pursuant to ERISA, an "association" can arguably establish or maintain a plan providing benefits to the employees of association members, so long as the association acts "indirectly in the interest of an employer, in relation to an employee benefit plan." ERISA section 3(5).

Minimally, "[c]ourts have ...held that there must be some cohesive relationship between the provider of benefits and the recipient of benefits under the plan so that the entity that maintains the plan and the individuals who benefit from the plan are tied by a common economic or representational interest. [citations omitted] Id. at 616.

As the DOL acknowledges, its current interpretation, upheld by the courts, determines whether an association is bona fide by focusing on:

- (1) Whether the group or association is a bona fide organization with business/organizational purposes and functions unrelated to the provision of benefits;
- (2) whether the employers share some commonality and genuine organizational relationship unrelated to the provision of benefits; and
- (3) whether the employers that participate in a benefit program, either directly or indirectly, exercise control over the program, both in form and substance.

Id. At 617.

DOL may be correct that its precise current position is not legally compelled. In particular, the text of the employer definition which suggests that the association need only act in its members' interests "in relation to an employee benefit plan" seems to support the DOL's conclusion that the association need not act for its employer members (let alone act in their interests) in any matter unrelated to an employee benefit plan.

Nevertheless, the DOL has acknowledged that it must distinguish associations from "mere commercial insurance-type arrangements" unconnected to the employment relationship. Id. At 617.

In replacing the longstanding requirements found well supported by the courts, the DOL offers thin gruel indeed. Under the NPRM an association must limit itself to employers in the same trade or business or a single geographic area. Requiring that an association market to only employers in a single trade or

business does nothing to assure that the association purporting to represent the interests of the employers in the designated trade or business will actually represent those interests. This requirement is not even a fig leaf. The alternate requirement, that the association be limited to a state or metropolitan area bears no nexus to the employer relationship at all, and does nothing to distinguish the association from a commercial insurance-type arrangement. If it accomplishes anything, it is only to assure that no one geography based association grows so large as to preclude competition from a trade or business based association. It hardly assures that the association will represent the interests of employers as opposed to the insurance agents who will market the coverage and the service providers who will be compensated for administering the coverage.

At barest minimum, what must distinguish a bona fide association from a commercial insurance type arrangement is that the association can be counted on to protect the participating employers from the commercial interests of the arrangements promoters, salespeople and service providers who are necessary to actually run an association sponsored plan. Most poignantly, it is the association that stands as the critical bulwark against the fraudsters that have historically created MEWAs that serve their own interests. These fraudsters have occasionally sought to capture control of pre-existing legitimate associations to run Ponzi schemes that deliberately sell cut rate uninsured coverage with the intention of gathering contributions, distributing them as commissions and compensation to service providers and then blowing up. But most often, the fraudsters have created fake associations (or unions) in to serve their interests rather than the interests of the employers (or in the case of fake unions, employees). These tragic enterprises leave tens of millions of dollars in unpaid claims, participants in bankruptcy and/or with their credit destroyed, and medical providers holding worthless claims for payment and forced to threaten their patients with ruin if they seek to get paid for necessary, even life-saving care. An Association that cannot be counted on to act to police the plan's service providers and sales force, is one that does not act in the interest of its constituent employers in relation to an employee benefit plan. An Association that is, as a practical matter, the captive creature of an arrangement's fraudulent promoters, certainly fails the statutory test.

To assure that associations actually represent the interests of employers, the NPRM offers us only:

- 3) The group or association has a formal organizational structure with a governing body and has by-laws or other similar indications of formality;
- 4) The functions and activities of a group or association, including the establishment and maintenance of the group health plan, are controlled by its employer members, either directly or indirectly through the regular nomination and election of directors, officers, or other similar representatives that control the group or Association and the establishment and maintenance of the plan...

2310.3-5(b). The rest of the requirements for an association, that it exist to sponsor a health plan that it offers to its members, that the members are employers, that the members meet the trade or locality test, discussed above, that the plan in question is only available to association members, that the plan doesn't discriminate among covered participants based on health status, that the association is not an insurer or owned by an insurer are all irrelevant to assuring that the association will represent the interests of employer members against those who seek to profit at the expense of members, their employees and their covered family members. This bears repeating, to protect the interest of employers from those with an adverse commercial interest who history shows are often fraudfeasors, all the DOL offers is an association with a formal structure, and the opportunity to control the association through the member election of a board of directors or something like one. Gone is the requirement of an independent

existence unrelated to the commercial type insurance product being marketed and gone is the requirement of actual control judged by facts and circumstances. In response to decades of fraud, often out of control, the DOL offers us a Gilbert and Sullivan farce decorated with fancy documents and preening “directors” singing the tunes called by lightly regulated and often fraudulent promoters of commercial insurance type schemes.

The Courts will be rightly contemptuous of DOL’s “solution.”

DOL’s “protections” will fail in the face any promoter whose motives are venal. Experience teaches that those who would defraud employers (or even seek excessive compensation) will ordinarily start a new association to sponsor the weak or fraudulent product they seek to market. In this fashion they are able to assure their control, since preexisting associations will have preexisting leadership loyal to their members, unless they can be corrupted (a route not unheard of). On day one the charter members of the newly formed association will be enterprises (however inconsequential) run by friends, relatives, co-conspirators and insurance salesmen who intend to earn their living selling the very product that Association members would want to see policed and carefully supervised. These charter member/insiders/potential fraudfeasors will elect a board of directors for a term of a year or even longer if permitted by DOL regulations. From there things only go downhill.

Sales will begin, each sale carrying with it membership in the sponsoring association and notice of the Association’s governing document and incumbent board members, each an association member and each with interests adverse to the ordinary employer/purchaser of coverage. Thus, even a patent Ponzi scheme can be marketed for at least a year with no oversight from a Board elected by anyone not beholden to the fraudster.

But at the end of the year the situation is hardly improved. Because inexpensive coverage is easy to market through its first year (and much of its second), the Ponzi scheme grows exponentially and there are few if any unpaid claims. Come time for new elections to the Board, with no evidence that anything is awry, why would a small employer mount a campaign for director? He does not have enough at stake, seemingly or unless he is a large employer, actually, to begin to justify the liability and time demands of serving as an actual director of an entity he knows nothing about, in a business (essentially insurance) that he knows nothing about. Even if some member were foolish enough to stand for election, how would he communicate with the membership, and if he did, what qualifications for the Board could he point to? As a practical matter, the original board of scoundrels will win reelection the first time and likely the second. By the end of the second year, problems may have begun to surface, but now the liability of stepping into a fiduciary role for a troubled enterprise will deter even public spirited potential directors. Experience and common sense teaches that these potential centurions will not run for office; they will, instead, take their complaints to the DOL and state insurance regulators. However slowly, the process of assessing the carnage and shutting down the enterprise will begin. Lives will be ruined. The DOL’s regulatory farce will be followed by tragedy on the ground.

This design is more than terrible policy. It is legally impermissible. The DOL has a responsibility to adopt a rule that assures that the Association sponsoring a plan actually and ordinarily, if not invariably and inevitably, represents the interests of the employer members of the association against the adverse interests of those who would treat the Association plan as a commercial (or criminal) enterprise, the purpose of which is to make money for its promoter, service providers and salesforce. There is nothing in the regulation that can reasonably be expected to produce that result. If anything, the regulation’s encouragement of sales to sole proprietors worsens the problem, as these individuals will have even less at stake than employers running larger enterprises and seeking quality coverage for their employees. It is

inconceivable that these sole proprietors will be seeking a position on a Board of Directors for an association that they learned of as an incident to their purchase of health coverage.

The NPRM as drafted is inconsistent with ERISA. It should be withdrawn.

I hereby request a public hearing on the NPRM. A regulation that promises to unleash a wave of fraud on an unsuspecting public, that even seems purposely designed to do just that deserves a full hearing.

Moreover, the regulation should be withdrawn and repropose, if at all, only after the DOL releases and fully analyzes its files on MEWAs and Association Health Plans pursuant to the FOIA request submitted by Georgetown University. In its current condition, the NPRM fails to have adequately considered the long history of fraudulent Association Health Plans and similar arrangements that the regulation actively facilitates.