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Christopher D. Palmieri, Chairman | Margaret A. Murray, Chief Executive Officer

February 20, 2024

Lisa M. Gomez, Assistant Secretary
Employee Benefits Security Administration
Department of Labor

Submitted electronically via: www.regulations.gov

RE: RIN 1210–AC16, Definition of "Employer" —Association Health Plans

Dear Assistant Secretary Gomez:

The Association for Community Affiliated Plans (ACAP) respectfully submits comments in response to the notice of proposed rulemaking, *Definition of "Employer" —Association Health Plans.*

ACAP is an association of 80 not-for-profit, community-based Safety Net Health Plans (SNHPs). Our member plans provide coverage to more than 25 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP), Medicare Special Needs Plans for dually-eligible individuals, the Basic Health Program, and the ACA Marketplaces. Nationally, Safety Net Health Plans serve almost half of all Medicaid managed care enrollees. Of ACAP's Safety Net Health Plan Members and Partner Plans, 27 offer qualified health plans (QHPs) serving approximately 950,000 enrollees in the Marketplaces.

ACAP has chosen to respond to a subset of proposals in this rule that are particularly relevant to SNHPs. ACAP appreciates the Administration's desire to strengthen the integrity of the Marketplaces; our comments are designed to ensure market stability for SNHPs and the consumers they serve. ACAP member plan enrollees generally have low-incomes, and we emphasize that the comments herein support SNHPs in their efforts to serve these vulnerable communities.

Summary of ACAP's Comments

In particular, we wish to draw attention to the following sections of our comments:

- **Proposal to Rescind 2018 AHP Rule:** ACAP strongly supports the proposal to rescind the 2018 Association Health Plan (AHP) rule in its entirety. We ask the Department of Labor (DOL) to finalize the rule this year to provide finality and certainty about the consequences

of the U.S. district court's decision that the rule was improper and exceeded the DOL's statutory authority.

- **Alternatives to Complete Rescission:** Ultimately, we suggest regulations are the best approach to provide stability and clarity to states, employers, and other stakeholders regarding what is a permissible AHP qualifying for single plan status under ERISA. However, simply codifying pre-rule guidance is a missed opportunity to the important work of reconciling this coverage option with the significant developments in the health insurance market more broadly that have taken place since much of the pre-rule guidance has been developed (e.g., ACA market reforms, health insurance Exchanges now insuring over 21 million Americans, ARPA and IRA-authorized enhanced premium tax credits, Medicaid unwinding, and individual coverage HRAs). A comprehensive evaluation of the definition of "employer" alongside the market dynamics and other coverage options for individuals is in order prior to rulemaking.

Expanded Comments

ACAP's comments are expanded below, with additional background.

TOPIC

The DOL proposes to formally withdraw a 2018 final regulation (the "2018 AHP Rule") which had expanded the availability of association health plans. The 2018 AHP Rule had significantly changed the DOL's previous policy, expressed in advisory opinions (albeit not technically precedential) indicating that the formation of this type of multiple employer welfare arrangement ("MEWA") that enjoys single plan status under ERISA can only be accomplished through a careful facts and circumstances inquiry into factors such as: (1) whether the association serves a business purpose other than the provision of benefits; (2) whether the plan and the individuals benefiting from the plan are tied by a common economic or representation interest other than the provision of benefits; and (3) other evidence establishing an employer-employee nexus, given that the very purpose of ERISA is to apply to employee benefits *arising out of employment relationships.*[1] As DOL aptly states in the Proposed Rule, "routinely treating people as 'employers' when they have no employees risks converting ERISA from an employment-based statute, as Congress intended, to one that regulates the sale of insurance to individuals, without regard to an employment relationship."[2]

MEWAs, including those formed by associations, have long been victim to fraudsters and bad actors selling shoddy coverage and insolvent products that are unable to pay claims due, as the

[1] See 88 FR 87968 (December 20, 2023).
[2] See 88 FR 87977.

proposed rule highlights. We appreciate the Administration's recognition of this reality and believe it is especially important for states and the DOL to oversee MEWAs at this vulnerable time of "churn" precipitated by the Medicaid unwinding period. Millions of individuals, many of whom are employed, are losing Medicaid coverage yet could be eligible for an affordable Exchange plan or employer-sponsored plan. While health coverage "churn" among households with lower incomes is not a new phenomenon, the current unwinding period places in stark relief how critical it is that MEWAs, along with short-term limited duration insurance, fixed indemnity policies, health care sharing ministry coverage, and other non-ACA-compliant plans, do not proliferate to take advantage of consumers and employers experiencing these upheavals.

In addition, as we expressed previously in our comments to the proposed rule that led to the 2018 AHP Rule, there are several important tradeoffs to expanding the availability of association health plans that have the potential to create significant risk segmentation and increase premiums in the individual market. While the 2018 AHP Rule largely mirrored existing HIPAA rules with respect to discrimination by prohibiting an AHP from discriminating in eligibility, benefits, or premiums against an individual based on a health factor, it gave associations broad latitude to permit health discrimination across different groups of similarly situated individuals. Such "bona fide" classifications may not be overtly discriminatory but are still effectively so—as part- (versus full-time) workers may well have significantly different health statuses and needs in certain industries. Similarly, workers in differing locations may have different health statuses and needs based on their specific geography.

Without nondiscrimination protections akin to those applicable to qualified health plans (QHPs), associations formed under the 2018 AHP Rule were able to offer "skinny" benefit packages with limited financial protections and/or those that are discriminatory in nature. Without requirements to cover particular categories of services or benefits, AHPs could design their product offerings and drug formularies to exclude high-cost conditions such as cancer, HIV, hepatitis, and more. A proliferation of AHPs participating in such practices could have led to only the healthiest employees participating in the AHP, leaving high-utilizers with chronic or high-cost conditions remaining in the individual market—creating significant risk segmentation and increasing premiums in the individual and small group insurance market. Indeed, the 2018 AHP Rule estimated a material premium increase to individual and small group insurance market premiums of between 0.5 to 3.5 percent. We are pleased that the decision in *New York v. United States Department of Labor* prevented this undesirable outcome and that the Administration also determined it would undertake notice and comment rulemaking on a proposal to rescind the 2018 AHP Rule rather than continue its appeal.

ACAP member plans strongly support the rescission of the 2018 AHP Rule and urge DOL to finalize this rule expeditiously.

Alternatives to Complete Rescission and Future Rulemaking

The proposed rule solicits feedback on potential future rulemaking or other steps appropriate to take after the substantially illegal 2018 AHP Rule is rescinded. DOL is weighing two alternative approaches: (a) codifying in regulations the pre-2018 AHP Rule guidance, or (b) creating alternative criteria as part of conducting a comprehensive evaluation of the definition of "employer" in the AHP context. ACAP appreciates that in the absence of federal regulations clarifying the definition of "employer" in the AHP context, a complex body of advisory opinions, case law, subregulatory federal guidance, and applicable state law surround the formation of an association qualifying for single plan status under ERISA and the type of consumer protections that attach to that plan.

Much of the body of guidance used to determine whether an association is bona fide and how the underlying coverage is regulated was developed prior to major changes in the individual and small group insurance markets. For example, in 2011, CMS set forth guidance addressing the consequence of an association formed by employers that does not constitute a single group health plan.[3] Such association would operate a MEWA whereby each participating employer is deemed to sponsor its own ERISA plan. Furthermore, the coverage rules for each of the constituent ERISA plans would be evaluated based on the employer's size, such that the coverage might be a small group or large group plan, depending on the size of the employer. In another specific circumstance, the association might offer coverage to a group of individual consumers as members of the association, rather than through a group of employers. In this circumstance, CMS's guidance considers the coverage to be individual market coverage, *regardless* of whether the coverage would be considered group coverage under State law. We appreciate the DOL's efforts in this proposed rule to clarify and remind issuers that coverage provided to or through associations —other than bona fide employment associations—is not defined as group coverage

However, as the tri-Departments recently noted in its proposed rule amending the definition of "short-term, limited-duration insurance," most sales of short-term, limited-duration insurance (STLDI) occur through group trusts or associations that are not related to employment, in which out-of-state issuers file for product approval in one state and then sell the same policies in other states through an association—effectively bypassing state regulation in the state they are being sold and where the consumer resides. Not only may consumers not realize that such products may not include their state's consumer protections, but regulators in their state are unable to track their sales and data collection efforts are stymied.

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[3] Centers for Medicare & 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, Insurance Standards Bulletin Series—INFORMATION (Sept. 1, 2011), available at https://www.cms.gov/cciio/resources/files/downloads/association_coverage_9_1_2011.pdf.

This is why it is critical for the tri-Departments to finalize its pending STLDI proposed rule and this proposed rule to clearly reinforce an important intersection of the two regulations: coverage provided to or through associations—other than bona fide employment associations—is not defined as group coverage and therefore is considered coverage under the individual market and therefore must meet all of the new STLDI requirements as set forth under the (pending) STLDI final rule or else be individual health insurance coverage that is subject to all Federal individual market consumer protections and requirements for comprehensive coverage. The Departments also noted in the STLDI proposed rule that there is no provision excluding STLDI from the Federal definition of group health insurance coverage and therefore any health insurance sold through a group trust or association in connection with a group health plan that purports to be STLDI would in fact be group health insurance that must comply with the Federal consumer protections and requirements for comprehensive coverage in the group market. We strongly support these clarifications and urge the Administration to finalize this important clarification in the final rules for both the STLDI rule and this proposed rule. As discussed in previous comments in connection with the STLDI proposed rule, we also urge the tri-Departments to consider enforcement mechanisms to ensure that STLDI issuers are not selling STLDI products in states in which they are not approved, as well as to require additional data reporting on all STLDI products sold through an association.

Future rulemaking in the AHP space should account for changed market conditions in the individual market that have increased the availability of affordable, quality coverage, thereby shifting the cost-benefit analysis of new public policies that would potentially expand the growth of "MEWAs, especially self-funded MEWAs, that have disproportionately suffered from financial mismanagement or abuse, leaving participants and providers with unpaid benefits and bills and putting small businesses at financial risk, " as noted in the proposed rule.[4] Namely, (1) the enhanced premium tax credits available to nine out of every 10 Exchange consumers, with four out of every five such HealthCare.gov consumers eligible for a $10 or less per month premium;[5] (2) starting 2023, a regulatory fix to the "family glitch" that had blocked up to 5 million consumers from accessing affordable QHPs;[6] (3) the growing employer uptake of level-funded individual coverage health reimbursement arrangements (HRAs);[7] and (4) the increased plan competition and choices to individual market consumers relative to those provided with

[4] 88 FR 87973.

[5] https://www.cms.gov/newsroom/fact-sheets/marketplace-plan-year-2024-open-enrollment-fact-sheet

[6] https://www.whitehouse.gov/briefing-room/statements-releases/2022/04/05/fact-sheet-biden-harris-administration-proposes-rule-to-fix-family-glitch-and-lower-health-care-costs/

[7] See "Employer adoption of ICHRAs increases significantly, study finds," available at https://www.benefitspro.com/2023/09/21/employer-adoption-of-ichras-increases-significantly-study-finds/?slreturn=20240109124900

typical employer-sponsored coverage offerings,[8] are just some of the significant changes that DOL's pre-2018 AHP guidance does not account for.

For the reasons stated above, we believe it would be preferable for the DOL to first conduct a comprehensive evaluation of the definition of "employer" in the AHP context and develop new criteria, as opposed to codifying the pre-2018 AHP Rule guidance. This comprehensive evaluation will provide DOL with helpful input that could inform the issuance of new regulations in a manner that provides a reasonable transition period to AHPs in existence today pursuant to the pre-rule guidance.

Conclusion

ACAP thanks DOL for its willingness to consider the aforementioned issues. If you have any additional questions or comments, please do not hesitate to contact Heather Foster (202-204-7508 or hfoster@communityplans.net).

Sincerely,

/s/

Margaret A. Murray
Chief Executive Officer

[8] More than 90% of HealthCare.gov enrollees in the 2024 open enrollment period were able to choose among three or more plans. https://www.cms.gov/newsroom/press-releases/more-7-million-selected-affordable-health-coverage-aca-marketplace-start-open-enrollment-period