DC Health Benefit Exchange Authority

February 20, 2024

Submitted via www.regulations.gov

U.S. Department of Labor
Office of Regulations and Interpretations
Employee Benefits Security Administration
Attention: RIN 1210-AC16
Room N-5655
200 Constitution Avenue, NW
Washington, DC 20210

Re: Definition of "Employer" – Association Health Plans – RIN 1210-AC16

To Whom It May Concern:

The District of Columbia Health Benefit Exchange Authority (HBX) appreciates your consideration of our comments.

By way of background, HBX is a private-public partnership established by the District of Columbia (District) to develop and operate the District's on-line health insurance marketplace, DC Health Link (DCHealthLink.com). We cover approximately 100,000 people -- District residents and people who work for District small businesses. DC Health Link fosters competition and transparency in the private health insurance market, enabling individuals and small businesses to compare health insurance prices and benefits and to purchase affordable, quality health insurance. Since we opened for business, we have cut the uninsured rate by 50% and now approximately 97% of District residents have health coverage.

We opposed the Department of Labor's (DOL's) 2018 Rule that would have expanded the definition of "employer" under Section 3(5) of ERISA. That Rule promoted the proliferation of association health plans (AHPs) by overturning decades of DOL guidance and would have opened the door to fraud and insolvencies. We also expressed concern that by exempting AHPs from key requirements under the Affordable Care Act (ACA), the 2018 Rule would destabilize and destroy private health insurance markets.

We strongly support DOL's current proposal to rescind the 2018 Rule in its entirety. Section I discusses AHP fraud. Section II discusses AHP insolvencies. Section III discusses enforcement and oversight of AHPs. Section IV discusses risk segmentation. Section V discusses preemption. Section VI discusses the working owner issue. Section VII discusses why the proposed full rescission is necessary to correct the 2018 Rule's improper use of agency authority. Section VIII proposes that, in future rulemaking, the look through principle be codified in regulation along with strengthened standards to prevent insolvency and fraud.

The recommendations in these comments are informed by my experience as Superintendent of Insurance in Maine (2008-2011) and my expertise as former research faculty member at Georgetown University studying AHPs, AHP scams, AHP insolvencies, and regulation of AHPs. Your proposal cites my one of my research papers.

I. Association Health Plans and History of Fraud

We support the proposal to rescind the 2018 AHP rule. The 2018 Rule opened the door to fraud and scams. The AHP market has a long history of attracting bad actors and being susceptible to fraud. The 2018 AHP rule did not include any standards or processes to minimize potential fraud and created opportunities for fly-by-night promoters to set up scams.

There is a long, well documented history of health insurance scams promoted through AHPs. Promoters use ERISA as a shield to evade state oversight and enforcement. In the 1970s after ERISA was enacted, promoters claimed that ERISA preempted states from regulating multiple employer entities like associations. At that time DOL believed that it only had authority over ERISA plans and that multiple employer entities were not ERISA plans.[1] DOL did not act. States tried but were challenged by promoters asserting ERISA as a shield and arguing preemption.[2] In 1982 a Republican-led effort clarified ERISA to say that both states and DOL have authority over AHPs. The 1982 amendment was intended to remove ambiguity over preemption. It gave states full authority over multiple employer entities like associations but exempted collectively bargained arrangements (union plans) from state authority. Promoters continued to look for ways to evade state oversight, and some promoters set up fake unions and argued ERISA preemption. For example, an entity called International Workers' Guild (IWG) left thousands of people in 32 states with $25 million in unpaid medical bills. Generally, the 1982 amendments worked well and enabled states to effectively go after scams, but promoters of scams continue falsely to claim ERISA preemption.[3]

There have been several documented cycles of large-scale scams. According to the GAO, between 1988 and 1991, operators of multiple employer entities left 400,000 people with medical bills exceeding $123 million. The most recent cycle of scams was between 2000 and 2002. One hundred forty-four entities left 200,000 policyholders with $252 million in unpaid medical bills.[4] Cycles of scams typically correspond to significant increases in premiums.[5] Promoters market to small businesses and individuals, offering premiums at prices below what is generally available. According to a federal judge, one such entity established rates by "averaging sample rates posted on the internet and then reducing them…to compete with other providers."[6] Before the ACA, promoters also targeted self-employed people who couldn't pass medical underwriting or were charged higher rates based on their health. One self-employed person was left with $110,000 in

[1] M. Kofman, K. Lucia, and E. Bangit, "Proliferation of Phony Health Insurance: States and the Federal Government Respond," Bureau of National Affairs, Inc., Fall 2003, 13.
[2] *Id.* at 6.
[3] *Id.*
[4] "Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entitles Selling Coverage," GAO- 04-312, United State General Accounting Office, February 2004; "Employee Benefits: States Need Labor's Health Regulating Multiple Employer Welfare Arrangements," GAO/HRD-92-40, United States General Accounting Office, March 1992.
[5] M. Kofman, K. Lucia, and E. Bangit, "Proliferation of Phony Health Insurance: States and the Federal Government Respond," Bureau of National Affairs, Inc., Fall 2003.
[6] *Id.* at 17.

medical bills.[7] Her professional association, the National Writers Union, was duped into buying phony coverage from a nation-wide scam called Employers Mutual LLC that had 30,000 victims and according to some estimates had owed as much as $54 million in medical claims. Promoters of scams set up fake associations and also sell through well-established professional and trade associations.

Since the ACA was enacted, there has been less fraud because affordable coverage became available, for small businesses prices became more affordable, and underwriting became illegal. When the demand is low, the supply of phony insurance is low. Nonetheless, there are always promoters looking to scam small businesses and individuals.

The 2018 Rule created new ambiguity to ERISA that promoters could use to evade state oversight. For example, the 2018 Rule would permit an AHP to operate in a metropolitan area that crosses into multiple states (29 CFR 2510.3-5(c)). The 2018 Rule does not say that each state has jurisdiction. Promoters will use this new ambiguity to evade state oversight. In addition to new ambiguity, the 2018 Rule included specific changes making it easier for promoters to set up scams. Overturning decades worth of guidance, the 29 CFR sections 2510-3.5(a) and (b) would allow entities to form for the sole purpose of offering health coverage. Furthermore, there was no requirement that an entity be in existence for any period of time.[8] These entities can spring up with ease and target unsuspecting small businesses and self-employed people. Furthermore, unlike states that license and certify entities to help keep convicted felons and fly-by-night promoters out of the insurance business, DOL does not certify or license ERISA plans.

The 2018 Rule created new preemption ambiguity, has no real standards, and has no regulatory framework to license or certify entities to keep bad actors out. The 2018 Rule would have made it easy to create fly-by-night entities masquerading as legitimate AHPs and would have led to the proliferation of scams.

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[7] Examples of victims of association health plan scams:

Joan, "a small business owner bought health insurance from Employers Mutual LLC through an association for herself, her family, and her employees. She was left with more than $500,000 in unpaid medical bills for her husband's treatment during the time she was covered by Employers Mutual LLC. On top of that, her husband needed a liver transplant to live. In her own words, "[W]e were informed that since we lacked insurance coverage, we would have to pay a deposit of $150,000 before my husband could enter the hospital's Liver Transplant Inpatient program. We simply did not have $150,000 to cover the deposit. Consequently, my husband was removed from the recipient list. Like the preceding months, the next two weeks were an emotionally tumultuous time for us. We feared, among other things, that my husband might die while we were attempting to deal with the predicament of being uninsured despite having paid premiums to what appeared to be a legitimate health insurer."

Judy "thought that she had insurance through the National Writers Union (NWU), a professional association for journalists. NWU contracted with Employers Mutual to sell coverage to its members. Judy only lost $12,000 (some in premiums, the rest she borrowed to have eye surgery). Unfortunately, Judy now has permanently impaired vision in one eye because she could not get her surgery in time to save her vision. So unlike other victims, she is lucky that she does not owe hundreds of thousands of dollars to her physicians. Unlike other victims, however, she will never recover her vision." "Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud," M. Kofman, Georgetown University Health Policy Institute, Summer 2005, at 6.

[8] A requirement to exist for a period of time coupled with regulatory oversight to ensure actual existence is one element that would make it harder to operate as a "fly-by-night" operation. Absent actual verification, promoters can "buy" an existing association – one that exists on paper but doesn't actually operate. Oversight coupled with other requirements will make it harder for promoters to set up scams.

The 2018 Rule would have promoted the proliferation of AHPs and created uncertainty about who has authority to regulate, the combination of which would increase the risk to consumers and reduce the likelihood that a state regulator would be able to intervene to protect consumers. Fortunately, a federal District Court found parts of the 2018 Rule to be an unlawful and unenforceable interpretation of the ERISA statute, preventing the Rule from being implemented, which in large part helped avert creating new opportunities for scams.

We support DOL's proposed rescission of the 2018 Rule. It recognizes the long and well documented history of fraud related to AHPs and is necessary to protect associations, employers, and workers against health insurance scams promoted through real and phony associations.

II. AHP Insolvencies

AHPs have a long history of insolvencies. Self-insured AHPs are inherently less stable than state regulated insurance companies because solvency requirements are lower and AHP operations are higher risk operations compared to traditional insurers. The 2018 Rule would have allowed for the proliferation of AHPs, including AHPs that choose to assume insurance risk, would expose members of AHPs to the risk of AHP insolvency and potentially millions of dollars in unpaid medical bills.

There are numerous examples of professional and trade AHPs becoming insolvent. For example, Sunkist Growers, Inc., a licensed MEWA in California, covering 23,000 people became insolvent in 2001 after collecting over $30 million in premiums. At the time of its bankruptcy the plan owed around $11 million for unpaid medical claims.[9] An insolvency of the New Jersey Coalition of Automotive Dealers left 20,000 people with $15 million in unpaid medical bills. The Indiana Construction Industry Trust, which had been in existence for over 40 years, became insolvent in 2002, leaving over 22,000 people with more than $20 million in unpaid medical bills.[10]

Approximately 20 states have licensing standards specifically for self-insured AHPs.[11] All other states reported that they require self-insured AHPs to be licensed as insurance companies. Compared to traditional insurers, self-insured AHPs are at greater risk of becoming insolvent when claims exceed their reserves. States with special licensing schemes for AHPs apply lower solvency standards, such as reserve requirements, to AHPs than to traditional insurers. Low reserves make it harder for AHPs to avoid insolvency resulting from mismanagement or even just large, unexpected claims.[12] For example, an AHP in Michigan became insolvent due to unexpected claims from two premature babies.[13] Furthermore, generally AHPs cannot participate in guaranty funds and the application of receivership laws can be unclear. Different from an insurer, when an AHP becomes insolvent, covered people are stuck with unpaid medical bills. When there is joint and several liability, then participating employers are assessed and are responsible for any unpaid medical bills. This exposes participating employers to significant financial risk. State receivership laws, which

[9] Insurance Markets: Group Purchasing Arrangements: Implications of MEWAs," California Healthcare Foundation, July 2003.
[10] M. Kofman, E. Bangit, and K. Lucia, "MEWAs: The Threat of Plan Insolvency and Other Challenges," The Commonwealth Fund, March 2004.
[11] M. Kofman and J. Libster, "Turbulent Past, Uncertain Future: Is it time to Re-evaluate Regulation of Self-insured Multiple Employer Arrangements?" Journal of Insurance Regulation, Vol. 23, No. 3, Spring 2005.
[12] Group Purchasing Arrangements: Implications of MEWAs," California Health Care Foundation, July 2003, 5.
[13] "MEWAs: The Threat of Plan Insolvency and Other Challenges," M. Kofman, E., Bangit, and K. Lucia, Issue Brief, The Commonwealth Fund, March 2004.

allow insurance departments to take over financially failing insurance companies, either exclude AHPs or are unclear. Without a receivership, an AHP ends up in bankruptcy court, where consumers line up with other creditors. Different from receiverships, outstanding medical claims do not receive priority status in bankruptcy court.[14] When self-funded AHPs become insolvent, their members' medical bills go unpaid, leaving consumers with huge debts for medical care and harming medical providers when those debts are not paid.

Many states that license/certify self-insured AHPs invest significant resources to prevent problems and detect problems early. For example, to try to prevent problems like unqualified management, there are background checks on senior management prior to receiving authorization to operate a self-insured AHPs. Self-insured AHPs require greater state regulator resources for financial oversight than traditional insurers because solvency standards are lower for AHPs and because of the higher risk associated with AHP operations. Typically, AHPs are not diversified and membership may not withstand being assessed a shortfall of the AHP – employers can leave or may become bankrupt from an assessment. One state devoted one full time employee per AHP it licensed. This included monthly examinations of AHP financial condition – state regulators on-site reviewing AHP books. States also require prior approval of rates. This helps to ensure that rates are adequate and not artificially low. Inadequate rates can mean an insolvency when claims are higher than what is collected in premiums to pay the claims.[15]

The 2018 Rule's stated purpose was to encourage the growth of AHPs, and more AHPs means more insolvencies. Under the 2018 Rule, an AHP could be created for the sole purpose of offering health coverage. This is equivalent to setting up an insurance company without the type of standards that apply to insurance companies to ensure that promises are kept, bills are paid, and consumers are protected. The 2018 Rule contradicted Congressional intent articulated with the passage of the Erlenborn amendment:

> "It has come to our attention, through the good offices of the National Association of Insurance Commissioners, that certain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA covered plans. For instance, persons whose primary interest is in the profiting from the provision of administrative services are establishing insurance companies and related enterprises. . . . They are no more ERISA plans than any other insurance policy sold to an employee benefit plan."
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> House Committee on Education and Labor, Activity Report of Pension Task Force (94th Congress 2d Session, 1977) quoted in Cong. Rec. (daily ed. May 21, 1982) (statement of Rep. Erlenborn).

The 2018 Rule had some minimal standards for AHPs under 29 CFR 2510-3.5(b), such as: an AHP must have some formal organizational structure, and employers must have some level of control over the AHP (for example, by electing the board of directors). The 2018 Rule, however, included no standards similar to those found in state insurance regulatory frameworks, such as qualifications for people who set up and operate AHPs. The requirement that employers have some control is not a sufficient substitute for qualified professional management of entities that are essentially health

[14] "Insurance Markets: Group Purchasing Arrangements: Implications of MEWAs," California Healthcare Foundation, July 2003.

[15] "MEWAs: The Threat of Plan Insolvency and Other Challenges," M. Kofman, E., Bangit, and K. Lucia, Issue Brief, The Commonwealth Fund, March 2004; "Turbulent Past, Uncertain Future: Is it time to Re-evaluate Regulation of Self-insured Multiple Employer Arrangements?" M. Kofman, J. Libster, Journal Of Insurance Regulation, Vol. 23, No. 3, Spring 2005.

insurers. Small business owners and sole proprietors are generally not in the position to determine whether the persons setting up and running the AHP have the needed skills and experience or to provide adequate oversight of the AHP's operations.

Also, the 2018 Rule would not ensure that AHPs are financially stable. There are no solvency standards under ERISA that AHPs would have to meet. The standards in the 2018 Rule did not address the financial soundness of these entities. Moreover, by suggesting that AHPs would be able to operate across state lines, the 2018 Rule created confusion regarding states' ability to continue to regulate. Furthermore, while DOL claimed that states would continue to have oversight, the RFI included in the preamble to the 2018 NPRM indicated that DOL was contemplating class and individual exemptions for self-insured AHPs from some aspects of state oversight.

The 2018 Rule, which encouraged AHPs to proliferate, did not provide any indication that DOL would be able or willing to protect consumers from insolvencies. To the contrary, evidence shows that DOL is unable to perform appropriate oversight currently. In 1996, Congress empowered DOL to require AHPs to register with it and file information annually. A 2004 study found that 100 of 700 filings had missing information, conflicting information, and inaccurate information such as fake NAIC numbers. Some falsely claimed that they did not have to file. There was no evidence that DOL ever reviewed the filings. For example, the Indiana Construction Industry Trust reported doubling in size in one year. Such rapid growth is usually an indication of a solvency issue. This association became insolvent one year later, leaving 22,000 with $20 million in medical claims.[16] There is a fine of over $1,000 per day if AHPs do not file or filed information is not complete. There is no publicly available evidence that DOL uses this authority to fine delinquent AHPs.

A more recent example of the inadequacy of DOL enforcement efforts and resources is found in the 2016 M-1 filings. One entity reports on its 2016 Form M-1 that DOL has been investigating it since January 2011. It is unclear why an investigation would be ongoing for five years. This entity reports covering approximately 10,000 participants (total covered lives unknown) nationwide (M-1 filings DOL database). For a more detailed discussion on DOL's oversight, please see below.

The 2018 Rule's weak AHP standards would have led to the establishment of many new AHPs. The lack of protections to ensure solvency would allow individuals with limited or no expertise in health plan operations to operate AHPs. This puts small businesses and self-employed individuals at risk of having millions of dollars in unpaid medical bills when an AHP becomes insolvent. Fortunately, a federal District Court stepped in, which in large part helped avert proliferation of self-insured AHPs.

We support DOL's proposed rescission of the 2018 Rule. It recognizes the long and well documented history of insolvencies of AHPs and is necessary to protect associations, employers, and workers.

III. Oversight and Enforcement

Strong oversight of AHPs is essential because of a long and well-documented history of AHP fraud and insolvencies. Since ERISA was enacted, several times Congress has expanded DOL's oversight authority and has given DOL new enforcement tools. In 1982 Congress amended ERISA to clarify that both DOL and states have authority to regulate AHPs. In 1996 Congress granted DOL

authority to require AHPs to register (MEWA registration, also called Form M-1 requirement). In 2010, Congress granted DOL new oversight authority including cease-and-desist authority to shut down insolvent or fraudulent AHPs administratively without first having to go to court. Congress also added new Section 520 authority giving additional tools to DOL for fraud and abuse. While all of these federal enforcement tools are important, none compare to the enforcement authority that states have–and use. Further, while DOL has some enforcement tools, it lacks adequate staffing or funding to conduct meaningful oversight. And even if DOL gained resources, DOL could never replace or replicate state regulation and oversight: Federal oversight is reactive, while state oversight is proactive.

Compared to DOL's record, generally states have a strong record of effective oversight – in cases of both scams and insolvencies. For self-insured AHPs, states either require licensure as an insurer or have AHP-specific laws with lower reserve and capital requirements than for other issuers.[17] Registration or licensing requirements, including background checks to keep convicted felons from operating self-insured AHPs, help mitigate risk of mismanagement. Depending on the financial strength of AHP in their states, state regulators use varied approaches. For example, in the 1990's one state conducted monthly financial exams to monitor AHP stability and act quickly when financial condition erodes. That state's insurance department assigned the equivalent of one full-time employee to each self-insured MEWA in the state.[18]

In contrast with states' strong oversight record, there is no evidence that DOL is performing oversight. Although AHPs must register with DOL, there is no evidence that DOL conducts regular reviews or takes actions based on filings. For example, the Indiana Construction Industry Trust reported doubling in size in one year--explosive growth that usually points to a solvency issue. DOL did nothing. Just one year later, the association became insolvent leaving 22,000 members with $20 million in medical claims.[19] In 2016 an entity reported in its M-1 filing with DOL that the entity had been under investigation for five years, since 2011. It is concerning that the organization was investigated for five years with no apparent corrective action by DOL. This entity reports covering approximately 10,000 participants (total covered lives unknown) nationwide.[20] Based on a quick review of some 2016 M-1 filings, it appears that some filings contain incorrect or incomplete information. These problems are consistent with the DOL 2014 report on M-1 Filings.[21]

DOL has had since 1996, when Congress gave DOL authority to require AHPs to register, to establish an effective oversight program to protect businesses and individuals covered through AHPs. Yet after more than 27 years there is not a single action or evidence that anyone at DOL even reviews the filings on a regular basis, much less takes action based on the self-reported information from AHPs. DOL has itself admitted that there is a high M-1 noncompliance rate and estimated that in 2003 fewer than half of existing MEWAs registered with DOL.[22]

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[17] "Turbulent Past, Uncertain Future: Is it time to Re-evaluate Regulation of Self-insured Multiple Employer Arrangements?" M. Kofman, J. Libster, Journal Of Insurance Regulation, Vol. 23, No. 3, Spring 2005.
[18] "MEWAs: The Threat of Plan Insolvency and Other Challenges," M. Kofman, E., Bangit, and K. Lucia, Issue Brief, The Commonwealth Fund, March 2004.
[19] "Multiple Employer Arrangements: Another Piece of a Puzzle, Analysis of M-1 Filings," M. Kofman, E. Bangit, and K. Lucia, Journal of Insurance Regulation, Vol. 23, No.1, Fall 2004.
[20] M-1 filings DOL database
[21] U.S. Department of Labor (DOL): Employee Benefits Security Administration (EBSA); Office of Policy and Research (OPR) Contract 2 Deliverable 5.2: Analysis of Form M-1 Data for Filing Years 2010-2013.
[22] "Reporting by Multiple Employer Welfare Arrangements," Fed. Reg. 68, No. 68 (April 9, 2003): 17495, 17498.

Additionally, states have oversight and enforcement resources that DOL simply does not have. DOL generally investigates plans only after they establish a pattern of failing to pay claims. Thus, by the time DOL acts, consumers have already been harmed. States have numerous tools that allow them to conduct regular oversight and intervene before consumers are harmed. These tools include background checks for operators/management of AHPs, financial and market conduct examinations, form reviews, rate reviews, etc. Thanks to the broker community, states also have "eyes and ears" on the ground to quickly identify bad actors who promote fake insurance. States also have and use enforcement tools, including cease-and-desist authority and state receivership laws. States have vigorously pursued bad actors in the AHP market and have been able to act earlier and quicker than DOL, better protecting consumers from harm.[23] According to the GAO, during the 2000 scam cycle, states issued cease and desist orders against 41 entities, while DOL shut down three entities.[24]

In 2007, the GAO found that DOL had a ratio of one employee conducting oversight or enforcement activities for every 8000 plans.[25] A decade earlier when Congress considered legislating standards for AHPs, DOL testified that it can review plans under its jurisdiction once every 300 years.[26] In 2005 when Congress considered a similar AHP, CBO estimated that the legislation would have required DOL to hire 150 additional employees and spend an additional $136 million over 10 years to properly oversee an expansion of AHPs.[27] Importantly, since the 2018 Rule went further to expand the proliferation of AHPs than the 2005 AHP bill, DOL would have needed even more staff to regulate effectively.

DOL itself acknowledges that it lacks adequate staffing or funding to conduct meaningful oversight of the AHP market. In a report dated October 24, 2023 from the GAO about the Employee Benefits Security Administration (EBSA) division of DOL, the GAO noted that EBSA itself has "acknowledged the impact of declining resources" especially related to "investigative resources and other employee benefits projects."[28] Indeed, the same report notes that EBSA officials have acknowledged that enforcement efforts of MEWAs, which include AHPs, "have been a chronic problem for the agency" because, among other reasons, the funding for such enforcement has not been sufficient for the scope of the task.[29]

Despite the history of fraud and insolvencies of AHPs, DOL finalized the 2018 Rule to create more AHPs without actually addressing its lack of resources and authority to protect employers and workers.

The proposed Rule to rescind the 2018 Rule is grounded in a recognition that DOL lacks resources for effective oversight and investigations of AHPs. DOL should finalize the proposed Rule to

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[23] M. Kofman, K. Lucia, and E. Bangit, "Proliferation of Phony Health Insurance: States and the Federal Government Respond," Bureau of National Affairs, Inc., Fall 2003.
[24] "Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entitles Selling Coverage," GAO-04-312, United State General Accounting Office, February 2004.
[25] Enforcement Improvements Made but Additional Actions Could Further Enhance Pension Plan Oversight, GAO, January 20073.
[26] Testimony of Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration, Senate Labor and Human Resources Committee, October 1, 1997.
[27] "H.R. 525: Small Business Health Fairness Act of 2005," Congressional Budget Office, April 8, 2005, 6.
[28] Government Accountability Office, Employee Benefits Security Administration: Systematic Process Needed to Better Manage Priorities and Increased Responsibilities, October 24, 2023 at 8, available at https://www.gao.gov/products/gao-24-105667.
[29] *Id.* at 6-7, n.26.

rescind the 2018 Rule in its entirety.

IV. Risk Segmentation

We support DOL's proposed rescission of the 2018 Rule, which will prevent a segmented risk pool. Had the federal district court allowed the 2018 Rule to take full effect, the 2018 Rule would have jeopardized availability and affordability of health insurance that small businesses, their workers, sole proprietors and individuals rely on.

The proliferation of AHPs that the 2018 Rule would have permitted would have led to segmentation of healthier from sicker people, destabilizing the individual and small group markets under the Affordable Care Act including exchange marketplaces like what HBX operates in DC. The 2018 Rule would eventually cause collapse of private health insurance markets across the nation, leading to higher premiums for small businesses and individuals, leave people who need comprehensive coverage with no private options, and force some people to become uninsured.

Risk segmentation is not a theoretical discussion. Wider use of AHPs previously caused actual substantial harm to regulated markets in several states. A leading example is the market collapse that occurred in Kentucky in the 1990s. Kentucky implemented market reforms but exempted AHPs from these reforms, including rating reforms. This resulted in healthy people seeking coverage through associations, which were not community rated. This left unhealthy people to seek coverage in the regulated markets. Carriers began canceling health insurance policies and fleeing the state, leaving a decimated market. Over 20 carriers left the market, leaving two carriers, one of which had experienced $30 million in losses.[30]

In the District of Columbia, the 2018 Rule would have increased premiums for employers and self-employed people and would have left many uninsured. In 2018 HBX commissioned Oliver Wyman to estimate the potential impact of DOL's proposed 2018 Rule on the District's small group and individual health insurance markets. The 2018 analysis is based on characteristics of DC's private health insurance market. Actuaries from Oliver Wyman estimated:

- AHPs would enroll as much as 90% of people in the small group market now and as much as 25% of people in the individual market now.

- As many as 2.4% of people with small group coverage and 2.94% of people with individual coverage currently would become uninsured in the District as a result of this proposal.

- People who stay in state regulated markets will see premiums increase: small group claims costs would increase by as much as 25.8% and individual market claims costs would increase by as much as 10.9%. These estimates exclude other factors that impact premiums, such as trend.

Small businesses in the District have robust coverage options. We have three United Health companies, two Aetna companies, Kaiser, and CareFirst Blue Cross Blue Shield in the small group market offering more than 150 qualified health plan options. Price points are competitive with

[30] Kentucky Department of Insurance," Health Insurance Reform in the 1990's: A Kentucky Historical Perspective," April 1997; A. Kirk, "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts," *J. Health Pol. Pol'y & L.* 25:133, 2000.

some premiums not increasing or even decreasing because of competition. If 90% of the small group market moved to AHP coverage, there would be less than 10,000 people left covered through small businesses. It is unlikely that insurers would stay. No insurer wants to insure only sicker and older small businesses and the remaining pool would simply be too small for any insurer to want to make an investment to compete.

The results of this analysis were unsurprising, as AHPs have a history of harming regulated markets through risk segmentation, and risk segmentation is virtually inevitable, for the following reasons.

Due to the well-documented concentration of medical expenses in a small percentage of the population, avoiding even just the top 1 percent of medical spenders can save almost 25 percent of total costs, in any given health risk pool.[31] Thus, like any risk pooling mechanism, AHPs have a great deal more to gain by avoiding a few very high-cost subscribers than by including features that are attractive to a broader swath of the population.[32]

This iron law of health care expenditures means that it is highly likely that AHPs will take every opportunity to tailor their coverage and their membership criteria to attract better risks and avoid worse risks. Doing that will leave the regular individual and small group markets to absorb a greater share of the much-higher-cost patients, threatening the markets' basic stability. In fact, older studies analyzing congressional AHP proposals show that between 19% and 52% of small businesses would move to AHPs, and prices for small businesses left in regulated markets would increase as much as 23%.[33] If the 2018 Rule is not rescinded, the market segmentation risk would be much more severe now because the older studies were done when individual and small group markets did not have ACA guaranteed issue, adjusted community rating, single risk pool and EHB standards.

Despite the obvious potential of AHPs to segment better from much worse risks, the 2018 Rule speculates, in several places, that this will not happen because unhealthy people have just as much reason to seek the advantages of AHPs as do healthy people. This claim is a *non sequitur,* even if it were true. The issue of risk segmentation arises because healthy people are seeking the additional advantages of the costs they can save if they can get into an AHP that has very few unhealthy people. Unhealthy people might, hypothetically, have some interest in joining a particular AHP, but they won't, if they're smart shoppers, have any interest in signing up for an AHP with a low actuarial value, or one that fails to cover the particular costly drugs and treatments that their condition requires. This makes that particular AHP even more attractive to healthy people than it already was.

The notion that we can depend on AHPs not to offer skimpy coverage is disingenuous, since one of the stated goals of the 2018 Rule[34] was to provide a less expensive alternative to plans that must meet minimum actuarial value requirements and provide all benefits that have been determined to be "essential." It is certain that healthy people will leave regulated "more expensive" coverage. And that's what risk segmentation is all about.

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[31] *See* T. Miller, "The Concentration and Persistence of Health Care Spending," 40(4) Regulation 28, Dec. 2017.
[32] See Comment from Professor Mark Hall submitted in response to the proposed rulemaking that preceded the 2018 Rule.
[33] M. Kofman and K. Polzer, "What Would Association Health Plans. Mean for California?" California Healthcare Foundation, Jan. 2004.
[34] *See* 83 Fed. Reg. at 628.

AHPs segment the market both by appealing differentially to healthier groups, and also to healthier individuals *within* groups. As long as an AHP avoids offering what the ACA defines as "minimum value" or bronze level coverage, then individual employees are free to seek richer coverage through the subsidized individual market. This below-minimum value coverage can easily be structured in a way (coupled with a health savings or reimbursement account) that meets the needs of healthier workers/families but discourages enrollment by sicker people. This is similar to the widely-criticized practice of "lasering" that once prevailed in the unregulated small group market.[35] By allowing AHPs to reinstate these discredited practices, the 2018 Rule would have created a vehicle for employers to more easily "dump" their sicker workers or families onto the publicly subsidized individual market, without having to make the employer responsibility payment that the ACA otherwise would assess on large groups that might deploy this tactic.

Additionally, there are many other ways an AHP can segment insurance markets. One obvious way is through "redlining," another long-discredited practice. Redlining is the pejorative term applied to techniques by which insurers (of various types, including life, property, etc.) illegally refuse to sell, or selectively market, in certain locations based on the economic or racial profile of the population. The 2018 Rule would have explicitly allowed geographic (and thus socioeconomic) redlining, by allowing AHPs to form merely based on geographic units of whatever size and proximity they choose. Thus, the 2018 Rule would have allowed an AHP to form based on a particular zip code or census tract, or to "cherry-pick" the particular micro-areas that have the population features considered most desirable, without even needing, necessarily, for the covered areas to be contiguous. In addition, AHPs can use rating practices as well as marketing to attract desirable populations and to avoid groups and individuals expected to have higher claims.[36]

The 2018 Rule also allowed similar forms of cherry-picking through the design of covered benefits, including, for instance, whether to cover expensive drugs for chronic illnesses. The 2018 Rule claimed that, in fact, most large employers do not offer skimpy coverage, and asserted that, therefore, AHPs also would not skimp in order to segment risks. However, there is a major structural difference between AHPs and actual large employers that causes them to behave differently. AHPs are an open invitation for self-employed people and small businesses to pick their insurance group based on the particular coverage they want. In contrast, people covered by large employer plans simply accept the insurance their employer chooses. Large employers cover the full range of services that many or most people want, so that, when they hire, the benefits are comprehensive enough to satisfy most everyone. Thus, large group insurance is not tailored to particular health needs, whereas unregulated individual and small group insurance is.

AHPs can be expected to behave much more like the unregulated individual and small group markets, prior to market reforms, than like large employers. AHPs have every reason to form more limited coverage packages that appeal distinctively to particular demographics or health profiles – thus undercutting critical public health goals embodied in existing market regulations. Unlike regulated markets, AHPs are not subject to any minimum benefits requirement, nor is there a risk adjustment mechanism to discourage AHPs from avoiding higher risks.

The risk segmentation that AHPs produce in these and other ways threaten the stability of individual and small group markets. This threat is not mere speculation or simply a question of

[35] A. Monahan, Saving Small-Employer Health Insurance, Iowa Law Rev. 98:1935, 2013.
[36] *See* M. Hall, E. Wicks and J. Lawlor, HIPCs, MEWAs, and Association Health Plans: A Guide for the Perplexed, *Health Aff*. 21(1):142, Jan. 2001.

differing opinions. Wider use of AHPs previously caused actual substantial harm to regulated markets in several states, prior to the tightening of standards for bona fide status. A leading example is the market collapse that occurred in Kentucky in the 1990s (discussed above) -- associations cherry picked healthy people to cover leaving unhealthy people in the regulated markets.[37]

In addition to the results of the modeling by Oliver Wyman for DC discussed above, the seriousness of this threat to regulated markets is also documented by leading expert authorities in the country. The American Academy of Actuaries, for instance, has warned that AHPs "would result in market fragmentation and threaten the viability of the insured market,"[38] and the National Association of Insurance Commissioners (NAIC) has issued a "Consumer Alert" warning that "Association Health Plans are Bad for Consumers" because they "threaten the stability of the small group market." Similarly, the NAIC has advised Congress that AHPs "would actually harm consumers by further segmenting the small group market"; proposals that would interfere with state regulation "would encourage AHPs to 'cherry-pick' healthy groups by designing benefit packages and setting rates so that unhealthy groups are disadvantaged. This, in turn, would make existing state risk pools even riskier and more expensive for insurance carriers, thus making it even harder for sick groups to afford insurance."[39]

The 2018 Rule ran counter to the Congressional intent to prevent market segmentation through the ACA's risk adjustment program, which currently moves resources from insurers that attract low-cost enrollees to insurers that cover enrollees with higher medical costs. Insurers that continue to cover individuals and small groups through the ACA-compliant individual and small group market would have not only been left with higher cost populations after AHPs cherry-pick the healthiest enrollees, they would have also been deprived of the full benefit of the risk adjustment mechanism that Congress intended.

The 2018 Rule provided no citations or documentation, other than wishful thinking, that AHPs will avoid market disruption by promoting risk pooling or minimizing risk segmentation. Virtually all logic, experience, and unbiased expert opinion contradicts the unsubstantiated assertion.

Furthermore, there is no solid basis for the 2018 Rule's speculation that AHPs would generate substantial efficiencies. In fact, the Congressional Budget Office assumed no administrative savings for either administrative efficiencies or "market clout" in analyzing the impact of Congressional proposals.[40] Experience shows that associations don't actually reduce administrative expenses, but add to them by replicating functions that insurers already perform, like marketing and

[37] Kentucky Department of Insurance," Health Insurance Reform in the 1990's: A Kentucky Historical Perspective," April 1997; A. Kirk, "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts," J. Health Pol Pol'y & L. 25:133, 2000.
[38] "Association Health Plans," American Academy of Actuaries, Feb. 2017.
[39] February 28, 2017 Letter from the National Association of Insurance Commissioners to the, Committee on Education and the Workforce Ranking members, United States House of Representatives.
[40] CBO Paper: Increasing Small-Firm Health Insurance Coverage through Association Health Plans and Healthmarts," Congressional Budget Office, January 2000.) "H.R. 660: Small Business Health Fairness Act of 2003 (as passed by the House on June 19, 2003), Congressional Budget Office, July 2003.

enrollment.[41] Contrary to DOL's claim in the preamble to the 2018 Rule, association coverage adds to administrative costs.

DOL's proposal to rescind the 2018 Rule is grounded in overwhelming evidence and history of risk segmentation by AHPs.

V. Preemption

We support the proposed rescission of the 2018 Rule because the 2018 Rule raised questions about preemption, was in conflict with clear Congressional intent and was an attempt to usurp Congress' lawmaking authority.

The 2018 Rule attempted to change more than 40 years of ERISA interpretation, which would have created new ambiguity. 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 2018 Rule failed to 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 where they operate and continue to be subject to state oversight and regulation.

The 2018 Rule was in conflict with clear Congressional intent expressed by Congress in 1982. 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 group purchasing arrangements including AHPs. The 2018 Rule contradicted Congressional intent and was an impermissible attempt to broaden preemption under ERISA.

VI. Working Owner

The 2018 Rule would have allowed individuals to claim employer status, even when they did not have employees, so they can be covered by AHPs.

The 2018 Rule undermined the fundamental premise that ERISA plans offer benefits based on an employment relationship. As DOL now acknowledges in the preamble to this proposed rescission, "ERISA applies when there is an employer-employee nexus . . . the standard is meant to reflect genuine employment relationships."[42] Yet, the 2018 Rule would have "treated persons as employers even though they had no employment relationship with anybody other than themselves."

This 2018 Rule was also problematic because it would have allowed individuals to opt out of the regulated markets—a step that exceeds DOL's authority. AHP plans would presumably be considered large group plans, as they would generally have more than 50 enrollees. Individual working owners who participated in them would have therefore lost the special protections Congress extended to individual market participants through the Affordable Care Act (ACA). Individuals joining AHPs would also, of course, no longer be part of the individual market single risk pool. If Congress intended for DOL to have authority to redefine individual market single risk pools, Congress would have given this authority explicitly to DOL. The Public Health Service Act

[41] E. Wicks and M. Hall, "Purchasing Cooperatives for Small Employers: Performance and Prospects," The Milbank Quarterly, Vol. 78, No. 4, 2000.
[42] 88 FR 87968, at 87977 (December 20, 2023).

(42 U.S.C. 300gg-91) defines "employer" to mean: "The term 'employer' has the meaning given 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 definition strongly suggests that employer-owners without any employees would not qualify as employers. ERISA regulation 29 C.F.R. 2510.3-3, adopted in 1975 and in force at the time the ACA was enacted, 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 preface to the 2018 Rule, DOL relied 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 considered a different question—if an owner offers a plan that covers its employees, can the owner also be a participant? This was not the question raised by the 2018 Rule. Instead, the 2018 Rule addressed the question of whether owners who have no employees can participate in group health plans. On that question, the Supreme Court noted that "[C]ourts [in three circuits] agree that if a benefit plan covers only working owners, it is not covered by Title I" and that the Solicitor General's *amicus curiae* brief took the same position.

The cases cited by the Court in *Yates* recognize the long-standing position of Congress and the federal agencies that an ERISA plan must 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 allows partners in partnerships to participate in group health plans, recognizes that self-employed individuals can only participate in a plan if one or more employees are eligible to participate in the plan as well as the partner.

In enacting the ACA, with its special protections for individual market participants, Congress was aware of this body of law and meant to retain it. The ACA defines the individual, small group, and large group markets (42 U.S.C. 18024) to recognize that owners of businesses who have no employees cannot qualify for group coverage (although the ACA permitted small group coverage for groups that included only one employee other than the owner). The 2018 Rule, therefore, violated the ACA. Therefore, it is necessary to rescind the 2018 Rule.

VII. The Proposed Rescission is Needed to Correct the 2018 Rule's Impermissible Use of Agency Authority

Rescinding the 2018 Rule is necessary because the 2018 Rule was an unlawful use of regulatory authority. More than twenty years ago, in passing HIPAA, Congress clearly delineated three distinct health insurance markets and established distinct consumer protections and standards for each: the large group, small group, and individual market. The ACA preserved this framework, and added further consumer protections and market stabilization measures such as risk corridors, reinsurance, and risk adjustment, varying such measures depending on the market. The distinct laws specific to each market were based on the respective markets' estimated size and demographics as defined in the statute and CBO estimates. For example, for stability and risk spreading there are single risk pool requirements that apply to the small group market and the

individual market, but not to the large group market. Because traditionally the individual market has been a residual market which consumers avoided if possible, Congress included stringent consumer protections, high standards, and significant financial subsidies to ensure that the individual market would be large enough and have enough healthy risks to be sufficiently stable. The DOL 2018 Rule would restructure the large group, small group, and individual markets – shrinking the small group and individual markets and expanding the large group market.

Consequently, and as discussed above, in DC we estimated the small group market would have shrunk by as much as 90% and the individual market would have shrunk by as much as 25% if the 2018 Rule had gone into effect. The DOL 2018 Rule would have gutted the stability mechanisms for the small group and individual markets under the ACA. DOL does not have the authority to redefine the three markets, which the 2018 Rule would have functionally done by redefining AHPs.

Furthermore, by redefining the three markets, DOL's the 2018 Rule contradicted the Congressional intent to provide a level playing field for all coverage sold within each market, with the same consumer protections applying uniformly to all health plans sold to small businesses, and a different set of consumer protections applying uniformly to all health plans sold to individuals. Congress has not given authority to DOL to rewrite the ACA in this way. The manner in which coverage through associations fits within the three markets, and specifically the "look through" standard for AHPs, has been the law of the land since 1996 when Congress first established the structure for three markets under HIPAA. Federal interpretation of the three distinct markets and the look-through language of the Public Health Service Act is well documented in CMS Guidance issued in 2002 and reaffirmed as recently as a 2023 letter from CMS addressed to the state of Virginia.[43] Congress recognized the regulatory interpretation and did not change it but relied on it. Therefore DOL's 2018 Rule is not a permissible use of regulatory authority. DOL's current proposal to rescind the 2018 Rule corrects its earlier impermissible use of agency authority.

VIII. Future Rulemaking Should Codify the Time-Tested Look Through Principle and Strengthen Standards to Prevent Fraud and Insolvency

The proposal to rescind the 2018 Rule should be finalized as proposed and as expeditiously as possible. Additionally, in future rulemaking, the DOL should also codify the time-tested look through principle and strengthen pre-2018 Rule standards to help prevent fraud and insolvency. This is important given a long history of fraud and insolvency even under the pre-2018 regulatory framework.

The Look Through Principle

DOL should codify the look through principle (discussed above) in future rulemaking. In codifying the look through standard, DOL should make clear that the group health plan at the association level is never exempt from individual market standards when the group health plan covers individuals who do not have employees. In a rare case if DOL determines an AHP to be a single large employer with respect to its members, e.g. there is a significant common controlling ownership interest of at least 25%, prior to operating in any state, the association must have a determination from DOL that there is a single group health plan at the association level. DOL should also provide notice to every state the single employer association will have enrollees and

[43] CMS Letter to Virginia dated May 31, 2023, at 1-2, available at https://www.cms.gov/files/document/virginia-preliminary-determination-letter.pdf.

advise the state insurance regulators and ACA marketplaces which ACA market rules will continue to apply to that single employer association. This type of clarity will help the association comply with both federal and state law requirements. It will also help state regulators in applying the right set of state standards.

Association Fees

DOL should require AHPs to provide and publicize a plain English notice of any financial benefit the association gets from offering health insurance including commissions, marketing, administrative, or any other fees. Further, there should be a clear statement for each employer group signing up that details what their premium would be without the fees that the association gets. That notice should also include a comparison between what the employer would pay through the association and the cost of premiums from carriers or ACA marketplaces. Furthermore, the association should disclose whether any ad-on supplemental benefits, e.g. accident only, hospital indemnity, are required to be purchased with the health coverage. This should include price of coverage for just health coverage without the ad-ons.

Strengthening pre-2018 standards to help prevent fraud and insolvency

Even under pre-2018 standards, AHP fraud and insolvency were significant problems. In proposed future rulemaking, DOL should focus on ways to address fraud and insolvency. It should consider a state-federal working group that includes state-based ACA marketplaces and insurance regulators. In DC, we have talked to small businesses who were thinking of leaving ACA small group coverage for association coverage (associations that were operating illegally). We have also had customers who were induced into signing up for association coverage thinking they were enrolling in ACA coverage only to find out too late that they enrolled in bundled limited benefit plans through misleading and fraudulent marketing practices.

Conclusion

HBX strongly supports DOL's proposal to rescind the 2018 Rule in full and encourages DOL in future rulemaking to codify the look through principle, to adopt standards to better protect employers and individuals against AHP insolvency and fraud. HBX also supports the pre-2018 Rule facts and circumstances standard that DOL has used for decades that was consistent with the purpose of ERISA, recognized ERISA's framework of employer – employee relationship, was consistent with Congressional intent, and was within DOL's agency authority.

Thank you for considering our comments on issues that will directly impact District residents, employers, and the continued operations of our marketplace.

Sincerely,

Mila Kofman, J.D.
Executive Director
DC Health Benefit Exchange Authority