



March 6, 2018

U.S. Department of Labor
Office of Regulations and Interpretations
Employee Benefits Security Administration
ATTN: RIN 1210-AB6
Annual Report and Disclosure
Room N-5655
200 Constitution Avenue, NW
Washington DC 20210

Re: Definition of “Employer” under Section 3(5) of ERISA- Association Health Plans – RIN 1210-AB85

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) Council to develop and operate the District’s on-line health insurance marketplace, DC Health Link (DCHealthLink.com). 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. Leveraging the Affordable Care Act (ACA) and DC Health Link, the District now has the lowest uninsured rate we’ve ever had. More than 96% of District residents now have health coverage.

We strongly oppose this proposal to promote proliferation of association health plans (AHPs), overturning decades of guidance governing AHPs. The rule would open the door to fraud and insolvencies. And, by exempting association health plans from key requirements under the ACA, the rule would destabilize and destroy private health insurance markets.

The U.S. Department of Labor (DOL) did not provide evidence to support the proposal and used unsupported assertions to justify it. Accordingly, we recommend the following:

- We ask DOL to make available the data it relied on and DOL’s decades worth of information on MEWAs so that the public can assess the actual impact of this proposal. To this end, we fully support the FOIA request submitted by Georgetown University, Center on Health Insurance Reforms, and the accompanying FOIA letter.
- And in addition to our comments, we are submitting old studies and research (Attachment A) and recommending that DOL conduct its own research to understand how the association market is currently regulated by states. Both the requested information through FOIA and information about the existing association market should be available to the public.
- The proposed rule should be withdrawn. Commenters should be afforded an opportunity to assess the impact of any proposed AHP rule based on evidence and data produced by DOL.
- Finally, we request that DOL hold a public hearing on this issue prior to issuing any final rules.



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There is historical precedent of DOL holding public hearings on particularly complex or controversial proposals, as recently seen with the Conflict of Interest Proposed Rule. We ask that DOL continue to honor that practice.

We organize our comments below in the following way. 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 nondiscrimination. Section VI discusses preemption. Section VII discusses why the NPRM is arbitrary and capricious, exceeds DOL's regulatory authority, and addresses several specific elements of the proposal.

I. Association Health Plans Fraud

The proposed rule opens the door to fraud and scams. The AHP market has a long history of attracting bad actors and being susceptible to fraud. The proposal does not include any standards or processes to minimize potential fraud. The proposal actually creates 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. (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.) DOL did not act. States tried but were challenged by promoters asserting ERISA as a shield and arguing preemption. (Id. at 6.) 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. (Id.)

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. ("Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entities 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.) Cycles of scams typically correspond to significant increases in premiums. (Kofman, BNA 2003.) 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." (Id. at 17.) 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 medical bills. (See 3 statements from victims.¹) 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. (Id.) 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 DOL proposal adds new ambiguity to ERISA that will be used by promoters to evade state oversight. For example, the proposal would permit an AHP to operate in a metropolitan area that crosses into multiple states (29 CFR 2510.3-5(c)). The proposal does not say that each state has jurisdiction. Promoters will use this new ambiguity to evade state oversight.

In addition to new ambiguity, the proposal includes specific changes that will make it easier for promoters to set up scams. Overturning decades worth of guidance, the proposal under 29 CFR sections 2510-3.5(a) and (b) would allow entities to form for the sole purpose of offering health coverage. Furthermore, there is no requirement that an entity be in existence for any period of time. These entities can spring up with ease and target unsuspecting small businesses and self-employed people. Unlike AHP legislative proposals that required AHPs to have a legitimate purpose other than selling health insurance and be in existence for three years, see “Small Business Health Fairness Act of 2017, H.R. 1101 (115th Cong.), DOL’s proposal has neither requirement and would have the unintended consequence of inviting fly-by-night operators. 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 proposal creates new preemption ambiguity, has no real standards, and has no regulatory framework to license or certify entities to keep bad actors out. This proposal would make it easy to create fly-by-night entities masquerading as legitimate AHPs and would lead to proliferation of scams.

This concern is compounded by DOL’s Request for Information, which suggests that DOL is considering creating broad exemptions from state regulation, which if implemented would leave AHPs unregulated and promoters of scams with free rein, and ultimately consumers without anywhere to turn when they are

¹ 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.” Page 6 AHPs Loss of State Oversight Report

scammed out of premiums and left with hundreds of millions of dollars in medical bills. In the preamble, DOL acknowledges the fraud that has been present in the AHP market for years, but DOL has not proposed any solutions to minimize the risk to consumers. The DOL proposal would promote the proliferation of AHPs and create 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. DOL should not proceed with this proposal until it has given due consideration to the harm that consumers would be exposed to if phony AHPs were allowed to proliferate, and it has implemented adequate protections for consumers. DOL appears to be simply wishing the fraud problem away, but it has not taken any steps to practically address this known problem.

DOL needs to ensure that state authority to continue to regulate AHPs is clear and unimpeded. State regulation in this area is essential to combat the fraudulent actors that will flood the AHP market if this proposal is finalized.

II. Association Health Plans Insolvencies

The Regulatory Impact Analysis Operational Risks Section (RIA) begins by admitting that “Historically, a number of MEWAs have suffered from financial mismanagement or abuse, often leaving participants and providers with unpaid benefits and bills.” (83 Fed. Reg. 614, 631 (January 5, 2018)). The preamble continues by describing how both state insurance regulators and DOL have devoted substantial resources to detecting, correcting and prosecuting wrongdoers. DOL then cites (Id. at 631, Footnote 51.) a Government Accountability Office study, GAO-92-40, for a history of the abuses these types of entities have inflicted on individuals and families. DOL also cites in the same footnote two articles articulating the regulatory difficulties and the financial and medical harm that these entities cause when they fail. The analysis, however, fails to discuss these studies or make any attempt to quantify the likely costs of easing the ability to form AHPs. A discussion of such costs should include the losses likely to be incurred by employers, employees, self-employed people, and health care providers. In addition, any useful cost-benefit analysis should take into account the cost of additional resources likely to be needed by state and federal governments for monitoring AHPs and enforcing state and federal standards. DOL should also explain how it plans to conduct oversight to identify and prevent fraud and 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 DOL proposal to allow 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. (“Insurance Markets: Group Purchasing Arrangements: Implications of MEWAs,” California Healthcare Foundation, July 2003.) 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. (M. Kofman, E. Bangit, and K. Lucia, “MEWAs: The Threat of Plan Insolvency and Other Challenges,” The Commonwealth Fund, March 2004.)

Approximately 20 states have licensing standards specifically for self-insured AHPs. (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.)

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.² 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. (“Group Purchasing Arrangements: Implications of MEWAs,” California Health Care Foundation, July 2003, 5.) For example, an AHP in Michigan became insolvent due to unexpected claims from two premature babies. (Kofman, Commonwealth Fund, 2004.) 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 allow insurance departments to take over financially failing insurance companies, sometimes 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. (California Healthcare Foundation, July 2003.) 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 FTE 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. (Kofman, Commonwealth Fund, 2004; Kofman, *Journal of Insurance Regulation*, 2005.)

The DOL proposal’s stated purpose is to encourage the growth of AHPs, and more AHPs means more insolvencies. Under proposed 29 CFR 2510-3.5(a), 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. This proposal contradicts 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.

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).

² Note the study is from 2005. In order to understand the impact of the regulation, DOL should conduct a study that closely examines how states regulate such entities now.

DOL proposes 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 proposal, however, includes 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 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 proposed limited standards will not ensure that AHPs are financially stable. There are no solvency standards under ERISA that AHPs would have to meet. The proposed standards do not address the financial soundness of these entities. Moreover, by suggesting that AHPs would be able to operate across state lines (83 FR 619), the proposal creates confusion regarding states' ability to continue to regulate. Furthermore, while DOL claims that states will continue to have oversight, the RFI included in the preamble to the NPRM indicates that DOL is contemplating class and individual exemptions for self-insured AHPs from some aspects of state oversight.

DOL's proposal to encourage AHPs to proliferate does not provide any indication that it 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. (M. Kofman, E. Bangit, and K. Lucia, "Multiple Employer Arrangements: Another Piece of a Puzzle, Analysis of M-1 Filings," *Journal of Insurance Regulation*, Vol. 23, No.1, Fall 2004.) There is a fine of \$1,000 per day if AHPs do not file or filed information is not complete. There is no evidence that DOL has ever used 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 proposed weak AHP standards will no doubt lead to the establishment of many new AHPs. The lack of protections to ensure solvency, and DOL's checkered record of oversight of the simple AHP M-1 registration/reporting requirement, will 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. Until DOL is able to address these concerns, DOL must put these regulations on hold.

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 lackluster 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. (Kofman, *Journal of Insurance Regulation*, Spring 2005.) 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. (Kofman, *Commonwealth Fund*, March 2004.)

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. (Kofman, *Journal of Insurance Regulation*, Fall 2004.) 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 (M-1 filings DOL database). 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. (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.) 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 20 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. ("Reporting by Multiple Employer Welfare Arrangements," *Fed. Reg.* 68, No. 68 (April 9, 2003): 17495, 17498.)

While in the proposed regulation DOL has not provided any current data on its review of its M-1 filings, we looked at the most recent M-1 filings available on the DOL website. Based on a cursory review of the M-1 filings, there are currently 12 MEWAs based in the District of Columbia, with another approximately 60 MEWAs offering coverage in the District. Of these filings, several appear to be incomplete, including one filing submitted without a signature. We could not find any evidence that DOL took any action to address the incomplete filings. There is no evidence that DOL took action to help filers comply.

Furthermore, while there is a fine of \$1,000 per day if AHPs do not file or file incomplete information,

there is no evidence that DOL has ever used its authority to fine delinquent AHPs. Given the troubling history of AHPs, DOL should conduct an internal review of M-1 filings, take appropriate enforcement actions, and implement appropriate oversight procedures before finalizing a rule that will guarantee proliferation of AHPs and put employers and workers at risk.

Congress gave DOL additional tools to address fraud and abuse related to AHPs by adding new section 520 to Title I of ERISA (Section 6604 of the ACA). Section 520 gives DOL a much needed oversight and enforcement tool. DOL has been authorized to act under this provision since 2010, but to date it has not issued regulations to implement this provision. A DOL Office of Inspector General Report from September 30, 2011 noted EBSA's failure to implement this provision which "authorizes the Department to determine standards, or issue orders, regarding when persons providing insurance through MEWAs are subject to State law as a means to prevent fraud and abuse." ("Further Action by EBSA Could Help Ensure PPAC Implementation and Compliance," Department of Labor, Office of Inspector General - Office of Audit, September 30, 2011, 4.) EBSA noted in its response that it would move forward with issuing regulation and implementing this provision. We strongly encourage DOL to begin the rulemaking process and to implement this critical authority under section 520 prior to moving forward with any proposal that would result in the proliferation of AHPs.

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. (See Kofman, BNA Fall 2003.)

Historically, DOL has been slow to take action against insolvent or fraudulent AHPs, in part because it did not have cease-and-desist authority, and it relied on states to shut down bad actors. (GAO 2004.) According to the GAO, during the 2000 scam cycle, states issued cease and desist orders against 41 entities, while DOL shut down three entities. (Id.) DOL was granted cease-and-desist authority in 2010, under the ACA, but has only used its new authority once, in 2017. During this same period, one state, Florida, has taken three enforcement actions against AHPs. (See Florida Office of Insurance Regulation, Actions Against Unlicensed Entities. Available at https://www.floir.com/Sections/MarketInvestigations/ue_regulatory_entities.aspx.) See detailed discussion of state oversight relating to scams in the section titled "AHP Fraud."

Given the history of fraud and insolvencies of AHPs, it is critical for DOL to address questions of oversight and enforcement. In 2007, the GAO found that DOL had a ratio of one employee conducting oversight or enforcement activities for every 8000 plans. (Enforcement Improvements Made but Additional Actions Could Further Enhance Pension Plan Oversight, GAO, January 2007³.) A decade earlier when Congress considered legislating standards for AHPs, DOL testified that it can review plans under its jurisdiction once every 300 years. (Testimony of Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration, Senate Labor and Human Resources Committee, October 1, 1997.) 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

³ This report noted that because of limited data their estimate of the number of plans actually underestimated the number of plans under EBSA jurisdiction.

to properly oversee an expansion of AHPs. (“H.R. 525: Small Business Health Fairness Act of 2005,” Congressional Budget Office, April 8, 2005, 6.) Importantly, since DOL’s proposal goes further to expand the proliferation of AHPs than the 2005 AHP bill, DOL would need even more staff to regulate effectively.

EBSA, DOL’s office charged with oversight of AHP plans, has recently experienced attrition, and DOL is also under a hiring freeze, making it even more challenging to meet the increased oversight and enforcement need created by this proposal. EBSA has an estimated 750 people responsible for health and pension plans. Only a small fraction are investigators. By comparison, state insurance departments have an estimated 11,209 employees and for FY 2018, a total of \$1,417,145,120 budget. (National Association of Insurance Commissioners, “2016 Insurance Department Resources Report,” Vol, One, June 2017, Table 7, 29.)

The President’s Budget for Fiscal Year 2019⁴ proposed \$189,500,000 for EBSA to cover all functions of the office, including oversight and enforcement for both health plans and pensions. The proposed budget has \$2 million for a mere “15 new FTEs for Small Business Health Plan, or Association Health Plan (AHP), assistance to provide interpretive guidance, enforcement, oversight activities, and compliance assistance initiatives ensuring Small Business Health Plans are adequately funded and that fiduciaries comply with their obligations of prudence and loyalty.” (“FY 2019 Department of Labor Budget in Brief,” 20, available at <https://www.dol.gov/sites/default/files/budget/2019/FY2019BIB.pdf>.)

Before proceeding to finalize the proposed rule, DOL should review each state’s approach to regulating AHPs to learn what types of oversight are necessary to prevent and mitigate AHP insolvencies and fraud. It also should provide realistic staffing estimates for EBSA for enforcement and oversight focused on AHPs. Prior to finalizing the proposal, federal enforcement resources should be in place. Adequate resources is one of many critical steps that DOL should take prior to finalizing the proposal.

States have historically been better positioned to conduct oversight and enforcement activities to protect consumers from fraud and mismanagement. It is essential for states to continue regulating. Unfortunately, the proposal establishes new obstacles and fails to consider the financial impact of the proposal on states. DOL should review how the proliferation of AHPs would impact state oversight and enforcement resources before finalizing regulations.

These oversight concerns are compounded when viewed in light of the preemption issues raised by DOL’s RFI. In the RFI, DOL requested information on use of its section 514 authority to issue individual or class exemptions for MEWAs that are otherwise subject to state regulation. It is well documented that DOL has neither the resources nor the expertise to serve as the sole regulator. DOL should not take action to prevent states from regulating.

DOL asserts that requirements in proposed 29 CFR 2510.3-5(b) for a formal AHP organizational structure and control by employer members, are intended to ensure that AHP sponsors are bona fide employment-based associations not prone to abuse. However, DOL admits that the flexibility afforded AHPs under this proposal could introduce more opportunities for mismanagement or abuse and thus increase the potential oversight demands on the Department and state regulators. (83 Fed. Reg. 632.) DOL cites new enforcement and reporting provisions added by the ACA to help reduce the rate of financial collapse in AHPs—but DOL offers no evidence that it is actually using these tools to protect consumers from AHP insolvencies.

It is also important to note that proposed 29 CFR 2910.3-5(e) raises significant oversight and enforcement

⁴ <https://www.whitehouse.gov/wp-content/uploads/2018/02/budget-fy2019.pdf>

concerns, by allowing individuals to simply self-certify compliance, without any review for compliance.

DOL has not supported this proposal with any data from its experience conducting oversight and enforcement against AHPs. DOL has not provided any data or analysis on the cost of fraudulent or financially unstable AHPs to their members. DOL has acknowledged that Congress has repeatedly intervened to address AHP fraud, but DOL has failed to provide any data on its experience identifying and intervening against fraudulent or insolvent AHPs. The failure to provide any data on its oversight and enforcement activities and the impact of fraud, insolvency, and noncompliance on AHP members is a significant failure of this proposal. DOL should provide data on its oversight and enforcement activities, as well as details on how it would address oversight and enforcement, before proceeding with this proposal.

IV. Risk Segmentation

We share the concern held by many that freer availability of AHPs will lead to destructive segmentation of healthier from sicker people (see Comment from Prof. Mark Hall for a more detailed discussion). The proposal if finalized will destabilize and eventually collapse private health insurance markets across the nation, will lead to higher premiums for small businesses and individuals, will leave people who need comprehensive coverage with no private options, and will force some people to become uninsured.

Risk segmentation is not a theoretical discussion for us. HBX commissioned Oliver Wyman to estimate the potential impact of DOL's proposal on the District's small group and individual health insurance markets. The analysis is based on characteristics of our market. Attached is the full analysis. Actuaries from Oliver Wyman estimate:

- 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.

Currently, 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 some premiums not increasing or even decreasing because of competition. If 90% of the small group market moves to AHP coverage, we will have less than 10,000 people left covered through small businesses. It is unlikely that insurers will 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.

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. (See T. Miller, "The Concentration and Persistence of Health Care Spending," 40(4) Regulation 28, Dec. 2017.) 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.

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. And 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%. (M. Kofman and K. Polzer, "What Would Association Health Plans. Mean for California?" California Healthcare Foundation, Jan. 2004.) The impact of the DOL proposal would be much more severe now because the older studies were done when individual and small group markets did not have 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 proposed 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 program (see 83 Fed. Reg. at 628) is to provide a less expensive alternative to plans that must meet minimum actuarial value requirements (56% under the latest regulations) 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. If AHPs are not intended to be a vehicle for skimpy coverage, then the proposed rule should be revised to prevent them from selling skimpy coverage.

AHPs will likely 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 needs of healthier workers/families but discourages enrollment by sicker people. This is similar to the widely-criticized practice of "lasing" that once prevailed in the unregulated small group market. (A. Monahan, *Saving Small-Employer Health Insurance*, Iowa Law Rev. 98:1935, 2013.) By allowing AHPs to reinstate these discredited practices, the proposed rule creates 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 proposed rule explicitly allows geographic (and thus socioeconomic) redlining, by allowing AHPs to form merely based on geographic units of whatever size and proximity they choose. Thus, the proposed rule allows 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. (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.)

The proposed rule also allows similar forms of cherry-picking through the design of covered benefits, including, for instance, whether to cover expensive drugs for chronic illnesses. The proposed rule reasons that, in fact, most large employers do not offer skimpy coverage, and it speculates that, therefore, AHPs also will be unlikely to 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 the large group market, in this regard. They 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, as proposed, 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 will produce in these and other ways would threaten the stability of individual and small group markets. This threat is not mere speculation or simply a question of 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. 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 over the prior 20 months. (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’y & L.* 25:133, 2000.)

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 thoughtful opinion letters and issue briefs written by the 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,” (“Association Health Plans,” American Academy of Actuaries, Feb. 2017) 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.” (“Consumer Alert: Association Health Plans are Bad for Consumers,” National Association of Insurance Commissioners.) More recently, 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.” (“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.”)

The proposal runs 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 will not only be left with higher cost populations after AHPs cherry-pick the healthiest enrollees, they will also be deprived of the full benefit of the risk adjustment mechanism that Congress intended.

The market segmentation effect of the proposed rule will also be more dramatic because it will allow self-employed "working owners" access to AHP coverage based on mere self-attestation that they are in fact "working owners." It is likely that there will be widespread attempts by healthy individuals to claim falsely that they meet "working owner" requirements. This will serve to dramatically further risk-segment the individual market.

The proposed rule provides no citations or documentation to the contrary, reflecting 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 proposed rule's speculation that AHPs will 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. ("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.) Experience shows that associations don't actually reduce administrative expenses, but add to them by replicating functions that insurers already perform, like marketing and enrollment. (E. Wicks and M. Hall, "Purchasing Cooperatives for Small Employers: Performance and Prospects," The Milbank Quarterly, Vol. 78, No. 4, 2000.) Contrary to DOL's claim, association coverage adds to administrative costs.

DOL fails to provide any evidence to support any of its assertions, and if the proposal is finalized, there is substantial evidence that AHPs will segment the market and lead markets to collapse. If DOL goes forward with the proposal, then it should apply to AHPs the guaranteed-issue, EHB, rate reforms, single risk pool requirements applicable to individual and small group markets, minimum actuarial value requirements, and risk adjustment. This is the only way to prevent market segmentation. Without these protections, AHPs would destroy state regulated private health insurance markets and leave small businesses and individuals without any affordable quality coverage options.

DOL has not provided evidence that it has adequately considered how its proposal would affect the regulated markets. DOL should provide the studies it has reviewed and data on the proposal's impact on regulated markets across the country. Prior to finalizing any proposal, DOL should issue new proposed regulations to give the public an opportunity to comment.

V. Nondiscrimination

DOL is proposing to apply the nondiscrimination rules that apply to group health plans under 29 CFR 2590.702 (1996 HIPAA non-discrimination standards for ERISA covered group health plans in Part 7 of Title 1 of ERISA) to prohibit AHPs from discriminating based on health status related factors (health factors) against employer members or employers' employees or dependents. As proposed, this would prevent AHPs from using health factors to determine eligibility for benefits or in setting premiums. Health factors include: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. We applaud this proposal, as it is

essential to help protect both employers and their employees from discrimination based on health status. We strongly encourage DOL to retain this requirement in final rule. We support this provision applying to all AHPs, regardless of when in time they were established. AHPs currently in operation should be required to fully comply with nondiscrimination requirements, without exception and without delay.

However, the 1996 nondiscrimination standards are insufficient because an AHP can engage in other practices that result in discrimination against people with medical needs. The proposal exempts AHPs from ACA consumer protections designed in part to protect people with preexisting conditions. An AHP would be exempt from essential health benefits (EHB), rate reforms, guaranteed issue and single-risk-pool requirements. Consequently, an AHP can simply avoid covering people and businesses with medical needs. Using benefit design, an AHP can attract healthier groups. For example, an AHP could offer coverage without maternity, mental health benefits, and expensive prescriptions. People who need such coverage would not enroll in AHP coverage. Also, an AHP could discriminate in rates, charging women higher rates than men, charging smaller businesses higher rates than larger businesses, charging businesses in certain industries higher rates, and charging older people higher rates without limit. Rating practices would result in healthier groups being covered through an AHP. Furthermore, an AHP could engage in marketing practices targeted at attracting healthier people. An AHP could avoid a geographic area where there is a high incidence of cancer, heart disease, and diabetes and thereby avoid covering sicker populations. Its geographic location can also be used to engage in redlining practices. An AHP could limit membership to a specific industry that has lower claims than other industries. All of these and other discriminatory practices would be allowed because AHPs would be exempt from EHB, rate reforms, single risk pool, and guaranteed issue requirements.

To ensure that AHPs are not engaged in discriminatory practices and to prevent cherry-picking, in addition to the proposed non-discrimination standard, the final rule should apply EHB, rate reforms, guaranteed issue and single-risk pool requirements. The single-risk pool requirement is an important way to ensure that AHPs where they exist do not result in a segmented market.

Failure to extend these protections to AHPs, in addition to protections against discrimination based on health status, will expose employers and their employees to discriminatory practices, including discriminatory rating and marketing practices. Failure to extend these protections will also place the regulated health insurance markets in jeopardy, as AHPs would be free to cherry pick healthy consumers out of the regulated markets, leaving those markets to fail as the risk pool worsens and premiums spiral out of control. See section on market segmentation for a detailed discussion.

VI. Preemption

The proposal raises questions about preemption. We oppose preemption of state laws and would consider any attempt by DOL to preempt states through this rulemaking as a usurpation of Congress' lawmaking authority. Any effort to preempt states through this rulemaking would be in conflict with clear Congressional intent. The 1982 Erlenborn amendment gave states broad authority over entities that cover two or more employers, and the preemption standards applicable to group health plans, as added by Congress to ERISA through HIPAA and reaffirmed by the ACA, all support the authority of states to regulate in this area.

Furthermore, we are concerned that DOL's proposal to change more than 40 years of ERISA interpretation creates 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. To head off such ERISA abuses, DOL should clearly state that ERISA single-employer AHPs, including the ones covering people in more than one state, would have to comply with all state laws in states where

they operate and continue to be subject to state oversight and regulation.

Finally, we are concerned about the questions raised in the RFI. DOL appears to signal that it is considering to use its section 514 authority to issue individual or class exemptions for MEWAs that are otherwise subject to state regulation. We strongly oppose any proposal that would exempt AHPs from state regulation. States have long taken the lead in addressing AHP insolvencies and fraud and maintaining competitive markets, and any attempt to preempt state authority would harm consumers and markets. DOL's inability to serve as the sole regulator has been well documented. DOL has neither the resources nor the expertise to serve as the sole regulator, both of which weigh strongly against DOL taking action to prevent states from regulating. Any attempts to issue class or individual exemptions would be an attack on the states and would only serve to fuel fraud and insolvency.

If DOL is considering proposed rulemaking under section 514(b)(6)(B), it should first fully implement Section 520 of ERISA. Congress amended ERISA in 2010, specifically providing DOL with new tools to address fraud and abuse related to AHPs. DOL should promulgate a proposed rule for section 520 for public comment and ensure that section 520 is fully implemented prior to exercising its authority under section 514(b)(6)(B) to exempt as a class or individually AHPs from state oversight.

VII. Discussion of Specific Changes Being Proposed

To be clear, we strongly oppose the DOL proposal. The NPRM is arbitrary and capricious because it will destabilize the small group and individual markets, and DOL has failed to address or even analyze this effect. The estimates from Oliver Wyman actuaries show the impact of AHPs in the District -- double digit premium increases, increase in the uninsured, and small group and individual markets shrinking. This would eventually lead to no choices of insurers and market collapse, in other words no comprehensive coverage and no protections for people with preexisting conditions. Oliver Wyman found that 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%. People would lose coverage and 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. And the small group market would shrink by 90% while the individual market would shrink by 25%.

In addition, this proposal is an unlawful use of regulatory authority for many reasons, two of which we discuss here. 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 proposal 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 estimate the small group market shrinking by as much as 90% and the individual market shrinking by as much as 25%. The DOL proposal guts 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 it is functionally doing by redefining AHPs.

Furthermore, by redefining the three markets, DOL's proposal contradicts 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 (Program Memorandum Insurance Commissioners and Insurance Issuers, Centers for Medicare and Medicaid Services, Transmittal No. 02-02 (August 2002); 02-03 (August 2002); 02-04 (September 2002); and 02-05 (September 2002)). Congress recognized the regulatory interpretation and did not change it but relied on it. Therefore DOL's proposed approach for AHPs is not permitted.

In addition, we offer the following specific feedback.

Under current law, an "association" can sponsor a plan that provides benefits to the employees of association members, if the association acts directly or indirectly "in the interests" of its association's employer members in relation to an employee benefit plan. While this language gives DOL considerable latitude to define when an association is bona fide, the courts have set a minimum requirement. "Courts 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]." (83 Fed. Reg. at 616.)

As DOL acknowledges in the proposal, its current interpretation, upheld by the courts, determines whether an association is bona fide based 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's traditional view has effectively distinguished associations from "mere commercial insurance-type arrangements" unconnected to the employment relationship. (Id. At 617.)

Under the proposal an association must limit itself to employers in the same trade or business or a single geographic area. It is unclear how marketing to only employers in a single trade or business assures that the association purporting to represent the interests of the employers in the designated trade or business will actually do so. 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. The geographic area proposal does not assure that the association will represent the interests of employers.

What distinguishes 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

promoters, salespeople, and service providers, who are necessary to actually run an association-sponsored plan. The association stands as the safeguard against the fraudsters that have historically created associations and labor organizations. These fraudsters have occasionally captured control of pre-existing legitimate associations to run Ponzi schemes that deliberately sell cut-rate coverage with the intention of gathering contributions, distributing them as commissions and compensation to service providers and then blowing up. And as discussed earlier, these fraudulent entities leave 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 police the plan's service providers and sales force does not act in the interest of its constituent employers in relation to an employee benefit plan. An association that is 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:

- The group or association has a formal organizational structure with a governing body and has by-laws or other similar indications of formality;
- 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....

29 C.F.R. 2310.3-5(b). The rest of the requirements for an association--that it exist to sponsor a health plan it offers to members, that members are employers, that members meet the trade or locality test (discussed above), that the plan is only available to association members, that the plan does not 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 families. In other words, to protect the interests of employers from those with an adverse commercial interest who history shows are often fraudulent actors, 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. DOL is proposing to remove the requirement that an association has an independent existence unrelated to the commercial type insurance product being marketed and the requirement of actual control judged by facts and circumstances. In response to decades of fraud, often out of control, DOL proposes to strip the current standards and leave AHPs to proliferate with abandon.

The proposal's encouragement of sales to sole proprietors worsens the problem, as these individuals will be in even less of a position to perform due diligence than employers running larger enterprises. Easy access to the individual market through sales to self-employed will make the association marketplace even more attractive to fraudsters.

In addition to being bad policy, DOL's proposal is legally impermissible. DOL has a responsibility to adopt a rule that assures that the association sponsoring a plan actually represents the interests of the employer members against the adverse interests of the promoter and others who would use the association plan to make money for themselves. There is nothing in the regulation that can reasonably be expected to fulfill this responsibility.

"Working Owner"- Proposed 2510.3-5(e)

DOL proposes to allow individuals to claim employer status so they can be covered by AHPs. The proposal calls individuals "working owners." This proposal would allow both individuals who are not

self-employed and self-employed people to purchase group health coverage as an “employer” through an AHP. DOL has not created any oversight framework to ensure that people actually meet the loose standards proposed.

DOL’s proposal to allow individuals to self-certify “working-owner” status would undermine the fundamental premise that ERISA plans offer benefits based on an employment relationship. As the NPRM’s preamble acknowledges, “the touchstone of ERISA is the provision of benefits through the employment relationship.” (Id. at 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 proposal adopts a test for self-employed status based on minimal income earned from the self-employing enterprise (an amount equaling the cost of coverage) or hours worked in the enterprise (120 hours a month). DOL asks for comments and notes that many approaches might be reasonable. However, DOL’s approach (and most any other) raises the difficult problem of how the plan can verify the claim of self-employed status. The proposal effectively ignores the “touchstone of ERISA” and actually facilitates the very “masquerade” DOL purports to denounce.

The proposal fails DOL’s own test of assuring that 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.

Moreover, the proposal actually invites a particularly grotesque form of insurance fraud: After marketing to individuals who willingly or unwillingly falsely self-certify self-employed status, the sponsor could then—with no impediment in the regulation—audit individuals who actually submit large claims, and deny the claims precisely because the same individuals, when pressed, cannot document self-employed status. While the Public Health Services Act (PHSA) allows rescission only in the case of fraud or intentional misrepresentation of material fact, forms that purportedly self-employed individuals will have to fill out to obtain such coverage will solicit written misrepresentations of fact to establish the facial validity of self-certification and will then help document a case for rescission when a fraudulent AHP sponsor wants to invoke it. Because the misrepresentation must be intentional to justify rescission, we can expect a clever fraudster to get those misrepresentations in large font with bold print. Without meaningful and enforceable provisions to assure that association-sponsored coverage is marketed only to individuals who can verifiably meet a legitimate test for self-employed status at the time of enrollment and reasonable intervals thereafter, the proposal fails DOL’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. But even if there was a meaningful regulatory framework, it is highly questionable whether DOL’s new interpretation contradicting nearly five decades of benefits law, would withstand judicial scrutiny.

This proposal is also problematic because it would allow 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 participate in them would therefore lose 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 (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 proposed rule, DOL relies on the Supreme Court’s decision in *Yates v. Hendon*, 541 U.S. 1 (2004), which held that self-employed working owners could be plan participants, to support its position that working owners can get small group coverage (or participate in large group coverage through an association) even if they have no other employees. *Yates* in fact considered a different question—if an owner offers a plan that covers its employees, can the owner also be a participant? This is not the question raised by DOL’s AHP proposal. Instead, the proposal addresses 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 proposed rule, therefore, violates the ACA.

Conclusion

DOL has failed to provide evidence to support assertions and assumptions made in the proposal. We support the request that DOL withdraw the proposal until DOL provides an adequate and complete answer to the Georgetown FOIA request and also provides the information broadly to the public. After the public has an opportunity to review and consider this information, DOL should restart the regulatory process—but only if DOL can document that the proposal is consistent with federal law, including ERISA and the ACA, and that the proposal will not amount to a repeal of the ACA without Congress. We also request that DOL hold a public hearing on the proposal before issuing any final rules.

Thank you for considering our comments on issues that will directly impact District residents and our current competitive private health insurance market. The perspective in these comments is also 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 one of my research papers. If you have any questions, please contact Jenny Libster, Associate General Counsel, HBX, at (202) 715-7576. Ms. Libster is also a co-author of the article you cite in the proposed regulation.

Sincerely,

A handwritten signature in black ink, appearing to be 'Mila Kofman', with a long horizontal flourish extending to the right.

Mila Kofman
Executive Director
DC Health Benefit Exchange Authority

APPENDIX A - Reference Materials Included in Comment Submission⁵

- 1) "Association Health Plans," American Academy of Actuaries, February 2017.
<https://www.actuary.org/content/association-health-plans-0>
- 2) "Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud," M. Kofman, Georgetown University Health Policy Institute, Summer 2005.
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