

**America's Health
Insurance Plans**

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org



March 5, 2018

The Honorable Preston Rutledge
Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
Room N-5655
200 Constitution Avenue NW
Washington, D.C. 20210

Submitted electronically via regulations.gov

**RE: Definition of “Employer” Under Section 3(5) of ERISA – Association Health Plans
(RIN 1210-AB85) – AHIP Comments**

Dear Assistant Secretary Rutledge:

We are writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to the Department of Labor (DOL) Notice of Proposed Rulemaking (NPRM) titled Definition of “Employer” Under Section 3(5) of ERISA-Association Health Plans (83 FR 614).

AHIP is the national association whose members provide coverage for health care and related services. Our members offer health and wellness products in every insurance market, in every state, to individuals, families, small and large businesses as well as Medicaid and Medicare beneficiaries. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

Many of our members offer coverage through existing associations with products that promote financial stability and access to quality healthcare. If administered properly by licensed insurers in a regulated marketplace, these plans can be a viable option for consumers. However, we have serious concerns about many aspects of the NPRM and the effect a similarly-constructed final rule would have on the stability of health insurance markets nationwide and, above all, consumers. We support the goal of expanding access and increasing competition and choice in health insurance, as well as working towards lower cost options for all Americans. However, we believe that Association Health Plans (AHPs) as envisioned by the NPRM are the wrong way to achieve these goals due to the risks of fraud and insolvency they pose to consumers. We further believe that creating a different set of rules for different market actors will disturb insurance markets in a way that runs counter to DOL's stated objectives.

We urge DOL to retain existing regulations and sub-regulatory guidance that protect consumers who depend on coverage from a variety of health insurance markets (individual, small group, etc.). We also urge DOL to issue a final rule that protects the role of state governments in regulating insurance, provides clear oversight and enforcement mechanisms, respects the statutory definition of employer, and establishes guardrails to protect consumers who may purchase these products. Additionally, DOL should strongly weigh the impact on existing market stability for existing commercial and employer insurance markets and ensure that the final rule does not create inconsistent treatment or regulation for the sale and operation of insurance contracts, and employee protections in group coverage.

Summary of AHIP Recommendations

Below we summarize AHIP's major comments and recommendations:

- **Definition of Employer:** The statutory definition of “employer” should not be altered to include “working owners” who lack any employees. This would exceed the regulatory authority of DOL by creating a new definition of employer that would lead to significant confusion and harm existing insurance markets. Alternatively, DOL should make every effort to mitigate potential harms by establishing stricter criteria for establishing status as a working owner and requiring annual reporting verification from the association on the working owner's business. Among the criteria should be that working owners must demonstrate evidence of at least five (5) years of engagement in that business.
- **Eligible Participants:** Eligible participants in an Association Health Plan should not include former employees or extended family. Eligible participants should also include current employees with a direct and bona fide and direct connection to the association—not those with past relationships or that are not direct dependents.
- **Commonality of Interest Test:** The “commonality of interest” test is too broad and should be substantially limited to closely related industries and businesses that have an actual employment relationship to one another. The use of a common metropolitan area to establish commonality of interest should be removed with geographic commonality limited to single states. The most effective route would be to maintain the existing “bona fide association” requirements.
- **Bona Fide Association Standard:** The “bona fide association” standard should be maintained, and associations should not be eligible to establish health plans if they are formed solely for the purpose of offering health coverage. Groups or associations should have a common employment interest separate from health benefits and be required to have been in existence for at least five (5) years prior to forming an Association Health Plan. Alternatively, there are several restrictions on associations, including background checks, state registration, and limits on fiduciary compensation, that can help reduce the risk of bad actors.
- **State Oversight Authority of AHPs:** The authority of states to oversee AHPs or Multiple Employer Welfare Arrangements should not be limited by this rule. The final

rule should be explicit that nothing in the rule is intended to preempt state insurance laws or authority. State regulation and oversight authority is essential to protecting consumers against serious financial harm resulting from fraud and insolvency of Association Health Plans.

- **Level Competitive Playing Field: All health plans competing in a state market for consumers should be subject to the same rules.** Enrollment periods should be limited, and association members would be required to commit to a common coverage period of 12 months. Associations should be permitted to establish “lock-in” periods in which members must continue coverage arrangements through the association. The final rule should aim to protect market stability, reduce enrollee churn, and foster predictability in the risks and cost of insurance or employer plans.
- **Non-Discrimination Protections: Additional non-discrimination protections need to be delineated in the final rule.** These protections are necessary both to reduce uncertainty as to which rules apply and to guard against pretextual discrimination on the basis of health status. These rules should apply at both the association and the member-employer level.
- **Role of Licensed Issuers: The final rule should affirm that licensed issuers of insurance may act as a third-party administrator of a member-owned Association Health Plan.** Licensed insurers are uniquely capable of guarding against fraud and insolvency while increasing cost efficiencies and facilitating provider networks.
- **Rule Preemption: Any guidance – including final rules, sub-regulatory guidance, and advisory opinions – that DOL intends the final rule to supersede should be explicitly listed in a final rule.** This will ensure that entities know which rules continue to be applicable and how those interact with existing consumer and employee protections.
- **Effective Date and Relationship to HIPAA-Excepted Benefits: The effective date of the final rule should allow for sufficient time to adapt to the new rules and for states to ensure that laws and systems are in place for additional AHP enrollees.** This effective date should be no sooner than January 1, 2020, or no sooner than eighteen (18) months after the date of issue. And finally, the rule should not affect or alter the status of HIPAA excepted benefits offered as part of an Association Health Plan.

Our detailed comments are included in the attachment. Thank you for the opportunity to comment on this proposed rule.

Sincerely,



Matthew D. Eyles

Senior Executive Vice President and Chief Operating Officer
America's Health Insurance Plans

AHIP Detailed Comments and Recommendations

I. Expanded Definition of “Employer” to include Working Owners (29 CFR 2510.3-5(a); 29 CFR 2510.3-5(e))

A. Legal Authority

The expanded definition of “employer” to include working owners exceeds DOL’s authority under the Employee Retirement Security Act of 1974 (ERISA). ERISA has consistently applied to working owners only when they have employees and can be considered both an owner of a business and employee of the same. Absent any employees, a working owner is not an employer. Including such working owners in the definition of “employer” (for AHP purposes only) countermands the statute, departs from binding regulations, is an abrupt change from long-standing interpretations that have engendered serious reliance interests, and creates troubling inconsistencies between ERISA and other federal statutes governing group health plans (not to mention state law).

As to the statute and binding regulations, the term “employer” is defined in statute, by section 3(5) of ERISA as “...any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.”

Several references within the statute confirm that a working owner without employees is not an “employer.” First, the definition of both “employer” and “employee” clearly distinguish between an “employer” and an “employee” as separate persons; section 3(6) of ERISA defines “employee” to mean “any individual employed by an employer.” That is consistent with the common-law definition of employee, applied by the Supreme Court in interpreting the definition of “employee” in section 3(6) in *Nationwide Mutual Insurance Co. v. Darden*, 503 U.S. 318 (1992), which requires two parties – the hiring party and the hired party. See *Darden* at 322-323 (evaluating employee status by reference to the control exercised by the “hiring party” and the “hired party”).

Second, implementing regulations have long confirmed that one cannot be an employer unless one has employees other than oneself. Regulations found at 29 CFR 2510.3-3(c) clarify that “(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...” Although the Department proposes to amend 29 CFR 2510.3-3(c) to carve out an exception to the generally applicable definition solely for working owners without employees participating in AHPs, ERISA’s statutory text provides no warrant for the Department to define “employee” differently depending on the type of benefit and multi-employer arrangement at issue.

Third, the Department’s proposed carve-out to 29 CFR 2510.3-3(c) does not resolve the conflict between the proposed rule, on the one hand, and statutory text and binding regulations, on the other hand. As the Supreme Court recognized in *Yates v. Hendon*, 541 U.S. 1 (2004), the entirety of 29 CFR 2510.3-3 (not just the “employee” definition that the Department proposes to amend),

confirms that “[p]lans that cover only sole owners or partners and their spouses . . . fall outside Title I’s domain.” See *Yates* at 21. That, in turn, means that working owners without employees cannot be employers. The statutory definition in section 3(5) is limited to employers acting, directly or indirectly, “in relation to an employee benefit plan.” A working owner without employees plainly cannot act directly “in relation to an employee benefit plan,” because there can be no plan without employees. And, the statute does not permit him to do “indirectly” (i.e., through an association plan) what he cannot do directly. In other words, if a working owner cannot offer an employee benefit plan standing alone (and neither the statute nor regulations the Department proposes to leave untouched would allow him to do so), he cannot do so by joining with other working owners who are likewise prohibited from offering employee benefit plans.

For these reasons, the Department’s reliance on *Yates* is misplaced. While we agree that the Court in *Yates* recognized the dual status of working owners with employees in ERISA plans, the Court likewise recognized that a plan covering only working owners is not covered by Title I of ERISA. In footnote 6 of the *Yates* decision, the Court stated:

Courts agree that if a benefit plan covers only working owners, it is not covered by Title I. See, e.g., *Slamen v. Paul Revere Life Ins. Co.*, 166 F.3d 1102, 1105 (CA11 1999) (sole shareholder is not a participant where disability plan covered only him); *In re Watson*, 161 F.3d 593, 597 (CA9 1998) (sole shareholder is not a participant where retirement plan covered only him); *SEC v. Johnston*, 143 F.3d 260, 262-263 (CA6 1998) (owner is not a participant where pension plan covered only owner and “perhaps” his wife); *Schwartz v. Gordon*, 761 F.2d 864, 867 (CA2 1985) (self-employed individual is not a participant where he is the only contributor to a Keogh plan). Such a plan, however, could qualify for favorable tax treatment. *Id.* at 21 n.6.

A more accurate reading of *Yates* would conclude that that the long-standing position of DOL, expressed in regulations and guidance throughout decades, and the Court’s interpretation of ERISA are consistent that a working owner can participate in a Title I benefit plan only if there are other employees alongside the working owner.

Beyond the issue of how statutes define employer, we recognize that health plans are governed by different statutes and must comply with their standards, including who is eligible for participation in an association health plan and who may qualify as an employer. Section 2791(d)(6) of the PHSA establishes a definition of “employer” that, while similar to that of ERISA, is distinct: “[t]he term “employer” has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974, except that such term shall include only employers of two or more employees.” Both statutes are clear that an employer cannot exist without at least one employee.

Fully-insured health plans, in order to comply with the PHSA, must follow the plain text of that statute. The Department of Labor lacks the authority, through a regulation, to alter the meaning or intent of a statute, and DOL is not the agency tasked with interpreting the PHSA. Even if a final rule were to adopt a definition of “employer” that exceeds the scope of DOL’s authority, fully-insured plans governed by the PHSA would need to continue to comply with the PHSA

statutory definition that does not allow for working owners. This sort of differing definition of the same term should be avoided.

In addition to being inconsistent with the statute and regulations, the Department has not justified its deviation from its long-standing interpretation. The preamble of the proposed rule asserts the authority to depart from non-binding sub-regulatory guidance and to supersede court interpretations of ERISA in order “to address marketplace developments and new policy and regulatory issues.” 83 Fed. Reg. at 622. This short statement fails to recognize that the Department’s prior policy has resulted in widespread reliance on its longstanding interpretation. For example, insurance providers have developed products and pricing, and made choices about whether to enter certain markets, based on the understanding that the same rules would govern all players in the individual and group marketplaces. The Department’s new rule would upend that understanding. An invocation of “marketplace developments” does not justify such a radical change.

The proposed rule would create insurmountable inconsistencies between the different federal statutes governing group health plans. No statutory interpretation exists in a vacuum, and this is particularly true for group health plans that are governed by multiple federal statutes. For example, section 1304(b) of the Patient Protection and Affordable Care Act (PPACA) defines “employers” in the large group and small group markets. Both definitions refer to an employer as one “who employs at least 1 employee...” The PHSAs definition of “employer” – applicable to fully insured plans – is distinct and expressly requires at least two employees.

Congressional intent is clear that, with narrow exceptions, group health plans should be subject to the same rules regardless of which statute applies—so much so that Congress has consistently imported PHSAs standards wholesale into ERISA as a “technical amendment.” See, e.g., PPACA § 1563(e) (amending ERISA to specify that part of the PHSAs, as amended by the PPACA, “shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart [of ERISA],” and that the PHSAs controls in case of any conflict with the part of ERISA governing group health plans, with only two exceptions). The proposed interpretation of “employer” under ERISA would disrupt that lock-step approach to health plan regulation with different rules applicable to working owners without employees under PPACA and the PHSAs (where the individual-market rules would apply) than under ERISA (where the group rules would apply).¹ The unintended consequences of redefining the meaning of “employer” for a narrow section of ERISA will inevitably include confusion and a lack of compliance with administration and reporting requirements of these other statutes and their implementing regulations.

The differing statutory and regulatory definitions of “employer” are not limited to federal law. Rather, they present a clear conflict of federal laws with many state laws governing who is considered an employer. The associated implications are numerous, including uncertainty for licensed insurers operating in a state as to who is considered an “employer” when DOL’s interpretation is in direct conflict with state law. Today, states have laws that not only dictate

¹ In addition, the ERISA definition of “employer,” even if limited to applications related to health plans, is relevant to who may be considered an employer under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Internal Revenue Code (IRC).

who is an employer, including for purposes of establishing an employee benefit plan, but they also establish who is eligible to form an association to be incorporated in that state.

In sum, including working owners without employees in a definition of “employer” is outside the scope of DOL’s authority under the law. It also has practical implications that result from unintended consequences of changing a definition that is critical to the nation’s economy. For our members, this change would have serious negative consequences on existing insurance markets that serve individuals, families, and small businesses. We address the impact of including working owners in Section VI.

Recommendations:

- The final rule should maintain the existing definition of employer so that only organizations representing at least an owner or owners with common law employees may participate in an association eligible to enroll in a group health plan.
- “Working Owners” without employees should be ineligible for participation in an Association Health Plan.

B. Alternative Recommendations

If DOL pursues the approach detailed in the proposed rule, certain clarifications to protect against the most harmful of consequences for different insurance markets should be incorporated in any final rule.

The criteria for working owners (who, per the discussion above, should be ineligible to join an association as they are not “employers” based on the statutory definition) establishes a standard that is ripe for abuse and should be narrowed. An individual may qualify as a working owner of an organization if s/he has earned income from the trade or business that equals at least the cost of coverage under the health plan. This standard is both vague and lacks a relationship to determining whether an individual is a legitimate employer. The cost of coverage criteria must be more fully defined so as to distinguish the type of coverage the Department will consider for eligibility. A working owner may seek to enroll in family coverage, but an association could allow the owner’s participation based on the cost of self-only coverage.

The income standard proposed is nominal. Monthly coverage in an AHP could cost, for example, \$150. Any individual who is engaged in a trade or business and earns \$150 per month from the same could therefore incorporate and claim working owner status to participate in the association. Again, this not only runs counter to ERISA, but is ripe for abuse. Essentially, *any* individual who establishes a corporation may claim status as a “working owner.” Thus, a group or association under the new rules may attract individuals who would otherwise have access to an individual market plan. The negative impact on the single risk pool in each state could be devastating to consumers, including those with pre-existing conditions, who rely on access to coverage through the individual market.

DOL could impose additional requirements on working owners as part of a verification process that would help ensure that only legitimate business owners participate in an AHP as part of a good faith effort to obtain major medical coverage. As recommended below, these would include annual reporting standards and limits on when a working owner would qualify for enrollment in

Marketplace coverage. Increasing the minimum income requirements for verification would also ensure that only those who operate an actual business, rather than simply earning extra income, would qualify for enrollment in an AHP.

Recommendations:

- To minimize the potential for abuse, working owners should be required to establish proof of incorporation through records, such as federal income tax returns, for a period of not less than five (5) consecutive years prior to joining the group or association.
- DOL should clarify that voluntarily terminating or declining AHP coverage outside of the federal or state established open enrollment period for the individual market should not constitute a loss of Minimum Essential Coverage (MEC) that would entitle a working owner to qualify for a Special Enrollment Period.
- DOL should require annual reporting from an AHP to verify that the working owner is engaged in a legitimate trade or business through tax filings or evidence of state licensure.
- In any final rule, the Department should impose income and time requirements that are substantially higher than in the proposed rule to ensure that only bona fide working owners enroll in AHPs.

II. Definitions of Eligible Participants (29 CFR 2510.3-5(b)(6))

We are concerned that, as proposed, the definitions specifying who would be eligible to form and participate in a group or association are too vague, lack a reasonable relationship to employment or common interests, and are ripe for abuse.

The threshold definitions of eligible participants are too vague. The proposed rule uses the terms “former employee” and “family” without clarifying who would be included. The final rule should eliminate any reference to “former employees,” as this standard is ripe for abuse. Instead, the Department should use the definitions provided in the COBRA eligibility standards.

The definition of “family” should be clarified and limited to spouses and dependents. This definition should be uniform for all associations and determined by the Department rather than at the discretion of association members. We also note these definitions have likely conflicts with other aspects of federal and state law if not made uniform. For example, the IRC at 26 U.S.C. 152, defines “dependent” for purposes of federal taxation.² The definition of eligible dependents should be uniform and limited in order to conform with the IRC.

The proposed rule requires a “written representation” to verify that the requirements of a working owner have been satisfied. This standard is vague, unenforceable, and creates enough discretion on the part of the association to create a clear path for pretextual discrimination based on health status.

² The Code provides in relevant part, “...the term ‘dependent’ means: (1) a qualifying child, or (2) a qualifying relative” and goes on to provide further exceptions and clarifications to the same. 26 U.S.C. 152(a), *et seq.*

Even with a higher threshold to establish the requirements of a working owner, or indeed any eligible participant, we are concerned that insurers and third-party administrators could be subject to increased liability if a lawfully-ineligible participant enrolls in an AHP. The final rule should include a safe harbor for insurers and administrators that exercise reasonable diligence and act in good faith in enrolling participants purported by the association sponsor to be eligible and allow for the option to audit the association and members as part of this diligence.

Recommendations:

- Eligible participants should include employees, former employees using COBRA eligibility standards, spouses, and immediate dependents. The reference to family members should be deleted.
- For working owners with common law employees, the criteria for participation should be limited to the hours of service method. A method of verifiable proof beyond a written representation should be required.
- The final rule should include safe harbor protections for insurers and third-party administrators that enroll participants purported by the association to be eligible. Insurers that issue coverage to associations should be permitted the option to seek an audit of the association and member employers to ensure that eligibility requirements are being satisfied.

III. The Commonality of Interest Test (29 CFR 2510.3-5(c))

We are concerned that the “commonality of interest” test, as set forth in the proposed rule, is too broad and poorly defined and will lead to associations that lack any vested interest in the health outcomes of their members.

Present guidance from DOL requires an Association Health Plan or MEWA to be established by a *bona fide* group or association. “[I]n the absence of the involvement of an employee organization, a single ‘employee welfare benefit plan’ may nevertheless exist where a cognizable, bona fide group or association of employers acts in the interests of its employer members to establish a benefit program for the employees of member employers.³ The test for whether a group or association is *bona fide* in nature is well-established in existing sub-regulatory guidance:

A determination of whether there is a bona fide employer group or association must be made on the basis of all the facts and circumstances involved. Among the factors considered are the following: how members are solicited; who is entitled to participate and who actually participates in the association; the process by which the association was formed, the purposes for which it was formed, and what, if any, were the preexisting relationships of its members; the powers, rights, and privileges of employer members that exist by reason of their status as

³ Advisory Opinion 2003-13A (sub-group of employer members of trade association can be a bona fide group or association of employers acting as an “employer” within the meaning of section 3(5) of ERISA); Advisory Opinion 2005-20A (multi-state franchisee group can serve as a bona fide group or association of employers under ERISA section 3(5))

employers; and who actually controls and directs the activities and operations of the benefit program. The employers that participate in a benefit program must, either directly or indirectly, exercise control over the program, both in form and in substance, in order to act as a bona fide employer group or association with respect to the program.⁴

While the proposed rule in no way eliminates the aforementioned standard, it adds a new *commonality of interest* test that opens the door to groups or associations comprised of employers that lack any substantial relationship to one another. As employer-sponsored coverage is underpinned largely by the vested interest that an employer has in its employees, this broad threshold to claim association status raises serious concerns of spurious associations forming solely to offer health coverage. We believe the *bona fide* association test should remain the standard for determining whether a group or association would qualify as an employee welfare benefit plan under ERISA.

The proposed rule allows for a group or association to be considered an “employer” within the meaning of section 3(5) of ERISA if they are in the “same trade, industry, line of business, or profession.” The ability to form an association with others in the “same trade, industry, line of business, or profession” is too broad and would likely lead to fraudulent associations with no reasonable relationship to one another as employers. The proposed rule does not offer guidance on how the Department would define trade, industry, line of business, or profession. These terms are inherently broad and can encompass employers and organizations that have no genuine relationship to one another. For example, an advertising agency and a home cleaning agency could both be reasonably considered to be part of the “service industry” but otherwise lack any meaningful connection to one another. Similarly, even more closely-associated businesses, such as a collection of fast food restaurant franchises in the Midwest and a fine dining restaurant in New York City, are both in the restaurant business. However, few observers would assert they share a true commonality of interest.

The ability of a group of employers to form an association based on geographic location, including a single state or a metropolitan area that includes multiple states, is overly broad and diminishes the likelihood that businesses will bear a reasonable relationship to one another. As recommended below, the metropolitan area criteria should be eliminated. Further, this presents a regulatory burden for insurers and plan sponsors who must design a plan that complies with state laws that will likely vary significantly in their minimum requirements and compliance standards. Many associations would likely choose to operate under the laws of the least burdensome state and leave consumers not domiciled in that state without legal recourse—for example, of a clear external review process.

Additionally, we believe that the opportunity to rely upon either geography or common industry alone (rather than both criteria) presents an opportunity for some associations to select favorable health risk in a fashion that effectively discriminates against certain populations at higher risk for health claims. By claiming a commonality of interest due to a shared metropolitan area alone, an association is free to exclude certain industries or sub-sets of industries that may include a

⁴ Advisory Opinion 2017-02AC

disproportionate share of older workers, female workers, workers likely to incur physical injuries, those more frequently exposed to chemicals, or other means of predicting health claims based on non-explicit factors.

We believe that the language in the proposed rule that references geography would allow for geographic “redlining.” Under such redlining, targeted units (such as a zip code, neighborhood, or even a city block) could be excluded from participation in an association because that area is known to have a population that closely resembles higher risk individuals or those more likely to have chronic illness. The broad language of the proposed rule mentions nothing about a geographic region being contiguous. Simply, the metropolitan area criteria is ripe for pretextual discrimination and avoidance of state insurance department oversight. Limiting to a single state and requiring contiguous geographic connection would help reduce the risk of geographic redlining by associations.

Recommendations:

- The final rule should maintain the “bona fide association” test currently relied upon by the Department.
- Alternatively, if the Department decides to adopt the changes to the “bone fide association” test, the final rule should precisely and narrowly define “trade, industry, line of business, or profession.” The Standard Industrial Classification (SIC) provides a useful set of definitions and limits.
- The final rule should eliminate any reference to metropolitan areas and limit geographic commonality to a single state.
- The final rule should require that any geographic commonality be contiguous in nature.

IV. Associations Formed Solely to Offer Health Benefits (29 CFR 2510.3-5(b)(1))

A. Congressional Intent

The proposed rule allows for AHP-eligible groups or associations to form solely for the purpose of offering health benefits. This creates opportunities for fraud, further divides the playing field, and diminishes the distinctions between associations and insurers.

The test for eligible associations should be uniform across federal departments and respect the standards for associations written into statute. Namely, Section 2791(d)(3) of the PHSA requires an association to be “bona fide” and establishes that an association meets the requirements if it: (1) has been actively in existence for five years; (2) has been formed and maintained in good faith for purposes other than obtaining insurance; (3) does not condition membership in the association on health status-related factors; (4) makes coverage available to all members regardless of any health status-related factor; (5) does not make coverage available other than in connection with members; and (6) meets any additional requirements imposed under State law.

Congress showed clear intent in wanting to distinguish bona fide associations from opportunistic purveyors of benefits. This intent should be respected and, to mitigate compliance uncertainty, be consistent for associations established under ERISA.

We are concerned that groups or associations that newly form after this rule's effective date solely to offer health coverage will include a disproportionate number formed either in bad faith or as a means to sell a "quasi-insurance" product without being subject to the requirements that must be met by licensed insurers. This creates an unlevel competitive playing field for those licensed insurers that are heavily regulated not only by the states in which they operate, but also by the federal government. The *bona fide* association requirement helps protect against this. Through our membership, we see successful health plans through associations that have existed for decades for purposes primarily other than offering health coverage. These associations have a vested interest in their members and are stable, allowing for the type of success we see with most large group or large self-funded plans.

Historically, a lack of sufficient regulation of health benefit arrangements has led to consumer fraud, insolvency, and myriad unpaid medical claims. Further, it presents another opportunity for consumer fraud, as consumers have no means of assessing the solvency or historical practices of the entity from which they would be purchasing coverage.

Below we discuss the important role that state laws play in regulating Multiple Employer Welfare Arrangements (MEWAs). It is worth noting that the question of what constitutes the "business of insurance" has historically been a question for the states, as codified by the McCarran-Ferguson Act (15 U.S.C. §§ 1011-1015). Associations that exist solely to offer health coverage will likely find themselves being determined by states to conduct the business of insurance and therefore be subject to licensure requirements. As recommended below, this change to the existing guidance, allowing associations to exist solely to offer health coverage, is fraught with peril and should be removed in any final rule.

Recommendations:

- The final rule should maintain the requirement that groups or associations exist for purposes other than offering group health coverage. In addition, the purpose should bear a reasonable relationship to the common employment interests of the member entities.
- The final rule should require a group or association to have been in existence, subject to verification by the State, for a period not less than five (5) years.
- The final rule should ensure that, if an entity engages in a practice that closely resembles the offering of insurance—particularly across state lines—then it must be subject to the same laws and regulations as licensed insurers.
- Any new MEWA with enrollees in a given state should be required to register with the Department of Insurance or equivalent agency in each state in which it conducts business or enrolls individuals or businesses. This should be required prior to commencing operations.

B. Alternative Recommendations

If the Department allows associations to form solely for the purpose of offering health benefits, despite the conflicts with existing law and Congressional intent, a final rule should include safeguards to protect against the most severe possible instances of fraud and abuse.

We are concerned that some fraudulent purveyors of coverage may seek to take advantage of regulatory ambiguity and sell coverage that appears to be major medical coverage but in fact is not such coverage. The DOL should prohibit individuals with a demonstrated history of civil or

criminal fraud from operating an AHP and would aid in keeping the most obvious purveyors of fraudulent coverage from selling to employers.

As discussed below, it is critical to maintain the involvement of state insurance departments in regulating associations and an AHP registration requirement would ensure states have the information needed to enforce their laws. Further, imposing limits on fiduciary compensation and establishing open-enrollment periods are important safeguards against providing an unfair competitive advantage to associations selling quasi-insurance products.

Recommendations:

- Respecting the PHSA’s statutory requirement of a *bona fide* association would be most prudent.
- However, we offer these alternative recommendations if DOL allows associations to form solely for the purpose of offering health coverage. In that case, it is critical to adopt certain protections in the final rule to protect consumers in the existing fully-insured market and all consumers against fraud and abuse.
- Some recommended safeguards would include:
 - Requiring association leaders to complete and pass a criminal background check, affirming the applicant lacks a history of criminality.
 - Registering all newly formed associations with the state Department of Insurance or other designated government agency.
 - Continuing state authority to regulate and enforce minimum solvency requirements.
 - Requiring that employers maintain a voting majority on the board of directors.
 - Limiting fiduciary and broker compensation.
 - Defining open-enrollment and lock-in periods.

V. Pre-Emption of State Laws

We are concerned that some states or associations may interpret the rule as effectively pre-empting state laws governing MEWAs or insurance providers. The proposed rule does not directly address the issue of state preemption but instead invites comments for information (83 Fed Reg 625).

We believe that states should continue to have the authority to regulate MEWAs and that Congress clearly intended this as part of the 1982 amendments to ERISA. We are concerned about the lack of oversight and enforcement discussion in the proposed rule and strongly believe that a clear statement reaffirming that regulatory authority over MEWAs continues to be vested in the States is critical to protecting consumers.

Our members have substantial history, dating back decades, both in administering MEWAs and seeing markets collapse because of fraudulent and unregulated MEWAs. Clearly articulated state authority to regulate MEWAs is essential with a federal backstop for states that do not closely regulate MEWAs.

We are concerned that a final rule that is ambiguous on state authority would risk creating an environment where mistakes of the past are repeated and potentially millions of consumers find themselves with unpaid medical bills and little recourse. States have proven to be best situated to regulate traditional insurance products and association plans within their jurisdiction and must continue to be allowed to do so.

Absent legislation or a rule that establishes a process for exemption from state regulation, nothing in the rule should preempt state law. Nonetheless, some may interpret a final rule as providing such an exemption. The final rule should explicitly clarify this is not the case.

The oversight role of the States with respect to MEWAs is part of statute. Section 514(a) of ERISA provides that any state law or regulation which relates to an employee benefit plan covered by ERISA is preempted. ERISA section 514(b)(2) saves from preemption any state's laws that regulate insurance. In the case of a "plan MEWA," ERISA 514(b)(6) was added as part of amendments in 1982 as part of a Congressional scheme "to protect employee benefit plan participants and beneficiaries by ensuring state regulation of MEWAs." (quoting DOL Adv. Op. 2011-01A [2011]). That section provides that a fully insured MEWA may be subject to any state insurance law governing reserve or contribution levels and any requirements necessary to ensure compliance with those mandates, or licensing and registration. If the MEWA is self-insured, a state may regulate the plan under state laws that are not inconsistent with Title I of ERISA.

The statutory basis for maintenance state oversight of AHPs is codified beyond ERISA section 514. Section 2724 of the Public Health Service Act states that "[this part] shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part."

Congress has, for good cause, amended ERISA to ensure state oversight of MEWA plans. The proposed rule does not clearly establish oversight jurisdiction of the States and ambiguity in this regard is potentially harmful to plan sponsors and consumers alike. In the background discussion in the proposed rule, specifically part (2), the Department discusses the role that Congress has established for States in response to MEWA fraud and abuse, but the text of the rule itself neither articulates the role of the States should the rule take effect nor establishes procedures for class exemption from state insurance laws, as would be required under section 514(b)(6)(B). The final rule should clarify that nothing in the rule is intended to preclude state law applicability so long as such is consistent with section 514(b) of ERISA.

Through section 520 of ERISA, Congress has empowered DOL with additional tools to address fraud and abuse, including oversight and enforcement powers. DOL has been authorized to act under this provision since 2010, but to date it has not issued regulations to implement this provision. If DOL is considering proposed rulemaking under section 514(b)(6)(B), we recommend the Department first take steps to fully implement section 520 of ERISA.

Additionally, there are important practical reasons for ensuring that state authority remains clear and unfettered. State laws governing MEWAs and the unauthorized sale of insurance exist to

protect residents and consumers in that state from fraud, insolvent offerors of coverage, noncompliance with nondiscrimination protections, and to protect the unified insurance risk pools in which individuals and small businesses participate for coverage.

Most States are equipped with oversight mechanisms as a result of reporting requirement that act as early-warning systems. When a fraudulent operator is found to be enrolling consumers in an AHP, the States are best suited to quickly shut down the operation. State regulators are most familiar with their local markets and are more accessible to receive complaints or warnings. Part of the efficiency comes from the difference in the statutory authority most States have to take action compared with the recourse available to DOL – the judicial system. Most States can issue emergency cease-and-desist orders within days, whereas DOL must obtain a temporary restraining order from a federal district court by showing a likelihood of prevailing at trial.

As DOL readily acknowledges in the proposed rule, the history of MEWAs is one of fraud and insolvency. Most notably, the abuses of the late 1970s and early 1980s led to the 1982 ERISA Amendments, but MEWA abuses are far from a thing of the past. Indeed, they are taking place today. For example, in 2017, DOL filed suit against a Washington State AHP whose officers had issued fraudulent charges totaling \$3 million for an association consisting of 300 employers. And a New Jersey association that targeted small businesses went defunct with more than \$7 million in unpaid medical claims.⁵ Our concern is that the proposed rule, if finalized, would not limit these bad actors, but rather increase them in both number and scope of impact.

The significant potential for fraud and insolvency in the aftermath of this rule is a very real concern. The long history is more than just a few instances noted by the news media but rather a consistent theme of how AHPs have operated.⁶ Neither current federal standards nor anything in the proposed rule guarantees the financial stability of AHPs.

Given that the proposed rule is intended to cover “millions and millions of people,”⁷ the lack of discussion in the proposed regulation of how oversight of these new plans – including their solvency – will be conducted is disconcerting. It is not just that number of additional people covered by AHPs, the bar to formation would be so low that scams will inevitably flourish in the space created by confusion over state authority. It has been noted that “[i]n the past, promoters of fraudulent health plans have used this type of regulatory ambiguity to avoid state oversight and enforcement activities that could have otherwise quickly shut down scam operations.”⁸ Current law allows state insurance departments to exercise broad authority over AHPs, including registration requirements, solvency standards, mandated benefits, marketing standards, required

⁵ R. Pear. “Cheaper Health Plans Promoted by Trump Have a History of Fraud” *New York Times*, October 21, 2017.

⁶ M. Kofman, E. Bangit & K. Lucia. “MEWAs: The Threat of Plan Insolvency and Other Challenges.” Issue Brief: The Commonwealth Fund. March 2004; M. Kofman, E. Bangit & K. Lucia. “Health Insurance Scams: How Government Is Responding and What Further Steps Are Needed.” Issue Brief: The Commonwealth Fund. August 2003.

⁷ R. Pear, M. Haberman & R. Abelson, “Trump to Scrap Critical Health Care Subsidies, Hitting Obamacare Again.” *New York Times*, October 12, 2017.

⁸ K. Lucia & S. Corlette, “Association Health Plan’s: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability.” The Commonwealth Fund. Archived at <http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority>

contributions to guaranty funds, and other insurance market rules and oversight authorities. Such state authorities should absolutely be preserved with any ambiguity eliminated.

Recommendations:

- The final rule should explicitly clarify that nothing in the rule is intended to preempt any state law or regulation affecting a MEWA or insurance contract in that state.
- The final rule should address whether the federal government or States have responsibility for ensuring that plans maintain enough capital reserves to remain solvent. We recommend that this authority be primarily vested in States with DOL establishing a mechanism to intervene if a state fails to adequately govern solvency requirements.
- The Department should issue an NPRM implementing its authority to oversee allegations of fraud and abuse by MEWAs, as established by section 520 of ERISA. This should take place prior to any rulemaking addressing state preemption under section 514(b)(6)(B).
- If MEWAs are permitted to operate in multiple States, the final rule should clarify that all States in which the MEWA operates or enrolls participants – not just the place of incorporation – have the right to exercise regulatory authority over the plan.

VI. Stability of Existing Risk Pools and Insurance Markets; Predictability Concerns

We support the goals of increased choice and competition in health insurance markets. However, based on our long experience, we believe that any insurance options must be offered in a system where the same rules apply to **all** actors competing in a market. The American Academy of Actuaries, in analyzing AHPs notes that “a key to sustainability of health insurance markets is that health plans competing to enroll the same participants must operate under the same rules. Although AHPs would be offered in competition with other small group and individual market plans, they could operate under different rules.”⁹

We are concerned that the proposed rule would create parallel markets where certain actors would not be subject to the same rules. As a result, there would inevitably be a shifting of more favorable risk away from the single risk pool established in each state for the individual and small group markets. This will also lead to additional instability in those markets, causing premiums to increase for individuals, the self-employed, and small businesses that purchase individual or small group insurance products. Individuals with serious or chronic health conditions will be most affected, as they will often find themselves excluded from the parallel AHP market, either by plan design, membership criteria, or price. Additionally, we are concerned that the lack of restrictions on the AHP market will result in individuals or small groups exiting and entering markets as health needs arise, further leading to instability and a lack of predictability. For any insurance market to succeed, predictability and stability are essential. The proposed rule sets up a structure that risks depriving regulated insurers of both.

The proposed rule is silent on critical restrictions on associations, including whether individuals may participate in more than one association or whether they may join and leave an association

⁹ American Academy of Actuaries: Issue Brief. February 2017. Archived at: http://www.actuary.org/files/publications/AssociationHealthPlans_021317.pdf

without restriction. Much additional clarity on any restrictions, either at the association or member level, are needed in a final rule to ensure that the rules for all actors competing for consumer enrollments are as even and as clear as possible. A required minimum participation period and defined Open Enrollment period for AHPs would help ensure greater predictability and reduce market churn.

We note the Department's statement that in light of a variety of "uncertainties" the NPRM "is a mostly qualitative assessment of this proposal's potential impacts, rather than a quantitative prediction." NPRM at 627. However, the Department is not relieved of its obligations to conduct such an analysis merely because any such "uncertainties" may render it difficult to do so. The proposed rule notes that "[s]ome stakeholders have expressed concern that AHPs, by offering less comprehensive benefits, could attract healthier individuals, leaving less healthy individuals in the individual and small group markets and thus driving up premiums in those markets and potentially destabilizing them." We agree and an actuarial analysis supports this contention.

The proposed rule claims that the regulations address "the risk of adverse effects on the individual and small group markets by including nondiscrimination provisions under which AHPs could not condition eligibility for membership or benefits or vary members' premiums based on their health status." While these nondiscrimination provisions are welcomed and an important part of this proposed rule, they neither go far enough to actually prevent discrimination based on health status nor do they protect against a mass exodus of favorable risk from the individual or small group markets. Moreover, such provisions do not limit the ability to enter and exit markets based on health needs.

An actuarial analysis of the proposed rule performed by Avalere Health found that "the proposed rule on AHPs would lead to a substantive shift, within the first four years, of enrollees in both the individual and small group markets into the new AHPs.¹⁰ Up to 4.3 million enrollees are projected to shift into AHPs by 2020. The analysis notes that the proposed rule is one of a series of actions that could lead less healthy individuals to remain in the individual market while others pursue less costly, unsubsidized and non-compliant coverage elsewhere.

"Changes that allow or incentivize healthier individuals to exit the individual and small group market to pursue other, sometimes non-complaint coverage offerings, could lead to higher costs for those sicker, less healthy individuals and groups who remain behind in the ACA regulated markets," according to the Avalere analysis. Due to the shift in risk from the individual and small group markets to AHPs, premiums in the individual market are expected to increase up to 4 percent, with small group increases up to 2 percent. At the same time, the direct effect of the proposed rule on the number of uninsured in the United States is estimated to be an increase of 130,000 to 140,000 uninsured individuals by 2022.

Insurance markets for individual and small group coverage have been experiencing both an unstable present and uncertain future with certain geographic regions faring better than others. The proposed rule, particularly the ability of AHPs to pretextually discriminate based on health

¹⁰ Association Health Plans: Projecting the Impact of the Proposed Rule. Available at: <http://avalere.com/expertise/managed-care/insights/association-health-plans-projected-to-enroll-3.2m-individuals> (February 28, 2018).

status and enroll individuals in coverage, will have a negative impact on the stability of individual and small group markets while simultaneously and certainly raising premiums.

Risk segmentation is also highly predictable based on the distribution of medical costs. If an AHP is able to avoid even just the highest one percent of a risk pool that incurs a disproportionate share of the costs, the plan could save almost 25 percent of costs.¹¹ Given that excluding such a small fraction of possible participants from the risk pool can have such an impact, AHPs will likely find every opportunity to tailor coverage and criteria to avoid the small portion of the population that incurs most health costs. The remaining population in the regulated individual and small group markets will be potentially devastated with even less stability.

In setting rates for insurance products available in the individual, small group, or large group markets, licensed insurers require as much predictability and market stability as possible. Therefore, measures that ensure that association coverage remains stable over a period of time would aid actuaries in determining rates for insurance coverage. A defined open-enrollment period would also help ensure that participants in association coverage do not enter or exit the less-regulated association market based on their health needs.

Recommendations:

- Any final rule should include a requirement that groups or associations commit to a two (2) year minimum participation period with an average number of lives enrolled for the duration of such period.
- Enrollment in AHPs should be limited to a state-prescribed Open Enrollment period once annually with limited special enrollment circumstances.

VII. Non-Discrimination Protections

We are encouraged to see the inclusion of non-discrimination protections in the proposed rule. We believe that the final rule should include stronger protections that are explicitly prescribed by DOL that mirror the protections individual employer members would otherwise enjoy in the small group or large group markets.

Insurers and plan sponsors would also strongly benefit from knowing precisely which rules would apply to employers participating in associations. We urge the Department to consider the effectiveness these rules have if only applicable to employers and not the association itself. Both the member employers and the association should be subject to non-discrimination rules. Further, in creating a parallel market with little oversight, we believe that much of the proposed rule sets the stage for pretextual discrimination. DOL should make every effort to develop a final rule that reduces the likelihood of the type of discrimination these provisions are intended to prevent.

The final rule should be clear which non-discrimination rules apply. That list should include sufficient guardrails to ensure that discrimination based on health status does not take place when

¹¹ Miller, T. "The Concentration and Persistence of Health Care Spending." *Regulation*. Vol. 40, Issue 4. (December 2017) p. 28

differentiating premiums among member employers, including through pricing consumers with health conditions out of the market. Additional clarity would be helpful regarding both *which* non-discrimination rules will be applied and enforced and *how* such application and enforcement will occur.

Among the rules most critical to ensuring both market stability and consumer protections, which the ACA requires for all large group plans and should affirmatively acknowledge as applying to AHPs in the final rule:

- Prohibition of discrimination based on health factor (45 CFR 147.110)
- Guaranteed availability (45 CFR 147.104)
- Guaranteed renewability (45 CFR 147.106)
- Prohibition on retroactive rescission of coverage (45 CFR 147.128)
- Maximum waiting period limit (45 CFR 147.116)
- Dependent coverage to age 26 (45 CFR 147.120)
- Prohibition on pre-existing condition exclusions (45 CFR 147.108)
- Prohibition on lifetime and annual limits for any covered essential health benefits (45 CFR 147.126)
- Internal appeals process (45 CFR 147.136)

Even with applying some non-discrimination rules to AHPs, we are concerned the proposed rule creates an uneven playing field by exempting association plans from many of the requirements that large group insurance plans and self-funded ERISA plans would be subject. Insurers are particularly interested in clarity in the final rules as to how market rules governing guaranteed availability would apply in this context, and whether those rules would exclusively apply to the insurer or also to the association.

While the proposed rule does contain an explicit prohibition on discrimination based on health factors, the rule does not limit premium variations or membership determinations that are effectively pretextual based on health status. The absence of these limits would allow an association to offer premium rates that are substantially higher to a small business expected to have higher risk compared to more favorable, lower-risk businesses.

Additional non-discrimination protections in a final rule could guard against the type of discrimination the proposed rule appears set on preventing. Through rate discrimination, an AHP could charge women higher rates than male employees, charge certain labor-intensive industries more than those less intensive, and older employees substantially more than younger employees.

As previously noted, an AHP could restrict membership to geographic areas that are known to have statistically higher rates of diseases such as cancer, heart disease, or diabetes. In extreme cases, the proposed rule would allow these restrictions to be microtargeted in a way that less affluent neighborhoods of a given city could be excluded. Explicit prohibitions on varying premiums for small group employers that participate in an AHP based on industry, age, geography, or gender would help guard against this phenomenon and mirror the protections small employers would see in their traditional market.

To avoid disruption and protect against pricing anti-selection, the rule should allow for large employers who participate in an AHP to vary premiums based on the available factors and standards of the large group market in that state and under the PHSA. For example, large group employers may vary premiums based on overall experience; this should be preserved and applied for AHPs that enroll large group employers to maintain equity across markets.

The proposed rule would apply the non-discrimination rules to the association itself, not the member employer. Consequently, we believe the proposed rule would allow member employers to determine which employees may be eligible for AHP participation, allowing for discrimination on the basis of an individual's health status.

The final rule should refine this application of the non-discrimination provisions while clarifying that differentiation of premiums applies to individual member employers. However, it does not change the rules that apply in the large group market that allow issuers to use experience rating to determine premiums for the overall association health plan if the AHPs membership qualifies it for large group status.

Existing AHPs operated by legitimate sponsors in compliance with current state and federal laws may comprise a substantial portion of the insurance market in certain States. For these sponsors, the additional non-discrimination rules may impact rating such a way that in existing AHPs facing substantially higher premiums and some bona fide associations may decline to offer health coverage altogether. With additional feedback from interested stakeholders, we hope DOL can find a solution that ensures existing, bona fide associations may continue to offer competitive health benefits to their members.

We urge DOL to consider the impact of these new rules on those associations and ways to mitigate disruption. Possible options include a transition period during which existing associations would be subject to existing requirements rather than the new non-discrimination rules or allowing for terms under which an association that exists as of the issue date of the final rule to be treated as grandfathered and exempted from the new requirements indefinitely (or as long as the association remains in force). Due to the potential for significant disruption to existing AHPs, it is important that this question be more carefully considered by stakeholders. Therefore, it would be beneficial for DOL to issue a subsequent Request for Comments that addresses the issue of compliance for existing associations.

Recommendations:

- DOL should establish clear regulatory enforcement mechanisms for non-discrimination mechanisms of MEWAs, particularly if multi-state MEWAs are permitted under the final rule.
- The Department should clearly identify the particular rules, with references to the Code of Federal Regulations, that will apply to Association Health Plans. Among the protections that should be included are: Prohibition of discrimination based on health factor; Guaranteed availability; Guaranteed renewability; Prohibition on retroactive rescission of coverage; Maximum waiting period limit; Dependent coverage to age 26; Prohibition on pre-existing

condition exclusions; Prohibition on lifetime and annual limits for any covered essential health benefits; Internal appeals process

- The final rule should clarify what employment-related factors would be permissible (classification of employee, length of service, office location, etc.)
- The final rule should apply the non-discrimination rules to both the association and member employers.
- The final rule should clarify that the burden of compliance with nondiscrimination and rating rules is on the association, not the issuer, and be clear that nothing in the rule alters existing large group rules governing experience rating by issuers.
- The final rule should include explicit prohibitions on discrimination at the level of the employer or association on the basis of age, gender, geography and industry. AHPs should be permitted to differentiate premiums for member employers based on allowable factors for existing markets.
- DOL should consider the impact of imposing new non-discrimination rules on existing association health plans and solicit stakeholder feedback with a subsequent Request for Comments.

VIII. Role of Licensed Insurers (29 CFR 2510.3-5(b)(8))

In defining “employer,” the proposed rule expressly excludes health insurance issuers from owning and controlling a group or association plan. (“The group or association is not a health insurance issuer described in section 733(b)(2) of ERISA, or owned or controlled by such a health insurance issuer.”) While ownership of the association plan by the members of the group or association is essential to ensuring that the association acts in the best interest of members, the requirement should not be construed in such a way that prohibits licensed health insurers from acting as the third-party administrator (TPA) of a self-funded plan. Today, many associations rely on licensed insurers to serve as the TPA for their self-funded AHP. While we do not believe the Proposed Rule intends to change this, we believe that explicit clarification will help ensure that experienced, reputable TPAs may continue to serve association clients.

We are concerned that the absolute nature of the language used in the proposed rule would effectively exclude licensed insurers that have decades of experience administering large group and self-funded plans from being active players in this process. In an environment where we are very concerned about the opportunities for fraud from bad actors, experienced and accountable organizations should be welcomed into the process rather than excluded.

Recommendation:

- The final rule should allow for licensed issuers of health insurance to act as the third party administrator of an AHP.

IX. Authorities Superseded

The proposed rule makes reference to certain pre-existing authorities, namely sub-regulatory guidance and advisory opinions issued by DOL or the tri-agencies. Absent further clarity, there is

concern that associations, employers, and issuers will be uncertain with which existing regulatory guidance they must continue to comply. This is essential for compliance departments to have certainty that activities conducted after the effective date are in compliance with the new regulations.

Recommendation:

- The final rule should state which specific advisory opinions, sub-regulatory guidance, or final regulations the newly issued rule is superseding.

X. Effective Date

The effective date of a final rule must allow sufficient time for States, exchanges, issuers, and employers to price future coverage appropriately and assess their legal and regulatory environments. If a final rule takes effect that closely resembles the proposed rule, the impacts on individual and small group coverage would be significant and the makeup of the unified risk pools in each state would be dramatically altered.

Stakeholders need ample time to develop an actuarial model of the risk pool and price insurance products appropriately. In particular, employers of all sizes will be impacted and require a planning window of up to 24 months to enter into benefit contracts. Additionally, States will need sufficient time for their legislatures to draft and enact legislation in response to a new federal rule that dramatically alters the nature of their insurance markets.

Recommendations:

- The effective date of the rule should be no sooner than January 1, 2020, or at least eighteen (18) months after the issue date (if later) to allow for adequate and appropriate transition planning.

XI. Treatment of Financial Health and Wellness Products (HIPAA Excepted Benefits)

The proposed rule invites comments on “whether an individual must not be eligible for other subsidized group health plan coverage under another employer or a spouse’s employer.” We appreciate this concern and believe that employees who are eligible for major medical coverage through an employer or a subsidized Qualified Health Plan should not be eligible for AHP coverage. However, we urge DOL to craft a final rule that distinguishes between major medical coverage and HIPAA excepted benefits, which do not qualify as Minimum Essential Coverage (MEC).

Congress, in drafting the Health Insurance Portability and Accountability Act of 1996 (HIPAA), recognized the distinction between comprehensive medical coverage and other group health products that should not be subject to the same requirements. Congress expressly excepted an array of benefits from HIPAA’s new federal requirements for health insurance. These “HIPAA-excepted benefits” include: dental coverage; vision coverage; disability income protection; long-term care coverage; Medicare supplemental coverage; and ancillary health coverage (e.g., critical illness, specified disease, and hospital indemnity coverage).

The proposed requirement that a working owner must not be eligible to participate in any subsidized group health plan maintained by any other employer of the individual or their spouse in order to be eligible to participate in an AHP inappropriately confuses excepted benefits with medical coverage that qualifies as MEC. In recent years, requirements that are meant to apply to major medical coverage have occasionally been erroneously applied to these products. To ensure that these popular options continue to be available to consumers, the final rule should not prohibit AHP coverage merely because the individual is eligible for other group coverage consisting solely of excepted benefits, nor should it limit one's ability to enroll in excepted benefit coverage by reason of access to major medical coverage through an AHP.

We would also note that the proposed rule does not impact the treatment of non-major medical coverage as an excepted benefit under HIPAA or the PHSA. The final rule should make it clear that it does not impose requirements of a large group insurance plan on an excepted benefit product that is an individual market product merely because it is sold through an AHP. Excepted benefit individual market products sold through the workplace are not group products if the involvement of the employer is limited as provided in DOL regulations for "voluntary" arrangements. The result should not change merely because the product is marketed through an AHP.

Recommendations:

- The final rule should preserve the statutory role of excepted benefits under HIPAA and the ACA so that any such coverage should not impact AHP eligibility.
- The final rule should clarify that an Association Health Plan that includes an excepted benefit product does not therefore transform the product into group health insurance.