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Jeanne Klinefelter Wilson
Deputy Assistant Secretary
Employee Benefits Security Administration
Department of Labor
Room N-5655
200 Constitution Avenue, NW
Washington D.C. 20210

Re: RIN 1210-AB85: Definition of "Employer" Under Section 3(5) of ERISA – Association Health Plans Proposed Rule
83 Fed. Reg. 614 (January 5, 2018)

Dear Deputy Assistant Wilson:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the proposed rule implementing changes to the Employee Retiree Income Security Act's (ERISA's) definition of "employer" for purposes of determining when employers may join together to form an Association Health Plan (AHP). ACS CAN is the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society and supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

ACS CAN supports efforts to reduce the number of uninsured Americans. Having adequate and affordable health insurance coverage is a key determinant in surviving cancer. Research from the American Cancer Society shows that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.[1]

We have opposed previous federal initiatives to encourage the growth of AHPs because these plans promote the growth of products that do not provide comprehensive coverage, could damage the non-AHP individual and small group markets, and inadequately address issues of plan solvency and regulatory oversight, especially in light of the long record of AHP fraud and solvency problems. As discussed in more detail below, we outline several concerns we with have with the proposed rule in its current form. We believe this proposed rule should not be finalized until the needs of the patient community have been met.

AHP Coverage Could be Less Comprehensive: The health plans sold by AHPs are currently regulated mostly as either individual or small group coverage and are therefore subject to consumer protection

[1] E Ward et al, "Association of Insurance with Cancer Care Utilization and Outcomes," *CA: A Cancer Journal for Clinicians* 58:1 (Jan./Feb. 2008), http://www.cancer.org/cancer/news/report-links-health-insurance-status-with-cancer-care.

standards provided under the Affordable Care Act (ACA). The proposed rule could seriously erode the affordable comprehensive coverage now available in most states' individual and small group markets that is so critical to cancer patients and survivors. Exempt from any benefit and cost-sharing standards, AHPs could offer products lacking prescription drug coverage or rehabilitation services. These products could leave critical gaps in coverage (e.g., the plan could cover only generic drugs and a limited set of branded products) and could require very high deductibles and coinsurance.

Expanding AHPs Could Lead to Market Segmentation: Because the AHPs would no longer be subject to the Essential Health Benefit (EHB) requirements or the state benchmark requirements that define the scope of those benefits, these plans would fuel market segmentation. The premiums for AHP products would likely be lower than for ACA-compliant plans, not because of any AHP administrative efficiencies, but because of the more limited benefit packages. As a result, younger and healthier individuals would be attracted to enroll in AHPs, leaving older, sicker, and costlier individuals in the individual and small group products that are subject to the ACA's stricter consumer protection and other market requirements. The adverse selection spiral experienced by those non-AHPs, could lead the plans to charge increasingly higher premiums, making them unsustainable. It is for these reasons that the National Association of Insurance Commissioners,[2] the National Governors Association,[3] and the American Academy of Actuaries[4] have also been historically opposed to AHPs.

Past Experience with AHPs: We are also concerned about the proliferation of AHPs because of their history of fraud and financial instability. For a long time, these products were not traditionally subject to the same state insurance solvency and licensing requirements that allowed regulators to maintain necessary oversight.[5] If an AHP lacked the financial resources to pay claims, then enrollees were left with no coverage and high out-of-pocket costs. Even in cases of well-meaning AHP sponsors, insolvencies led to millions of dollars in unpaid claims.[6]

Our concern about the potential for a new wave of AHP fraud and solvency problems arises out of the open question regarding the authority of the federal government and the states to regulate AHPs under the Department's outlined policy framework, a critical issue that we discuss in further detail later. The preamble notes that the Department of Labor has enforcement authority to issue a cease and desist order when a Multiple Employer Welfare Arrangement (MEWA), a type of AHP, engages in fraudulent or other abusive conduct and to issue a summary seizure order when a MEWA is in a financially hazardous condition.[7] Called into question in the Request for Information and elsewhere in the proposed rule's preamble is the continuation of the existing state role in regulating MEWAs, especially those that are not fully-insured and thus more likely to encounter solvency and fraud problems. The Department

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[2] National Association of Insurance Commissioners, Consumer Alert: Association Health Plans are Bad for Consumers, available at http://www.naic.org/documents/consumer_alert_ahps.pdf.
[3] National Governors Association, Governors Oppose Association Health Plans, May 2004, available at https://www.nga.org/cms/home/news-room/news-releases/page_2004/col2-content/main-content-list/governors-oppose-association-hea.html.
[4] American Academy of Actuaries Letter to John Boehner, Chairman, House Committee on Education and the Workforce, April 28, 2003, available at http://www.actuary.org/pdf/health/ahp_042803.pdf.
[5] Kofman M, Bangit E, Lucia K, MEWAs: The Threat of Plan Insolvency and Other Challenges, Commonwealth Fund, May 2004, available at http://www.commonwealthfund.org/usr_doc/kofman_mewas.pdf.
[6] Id.
[7] 83 Fed. Reg. at 617.

appears to be considering a final rule that would provide a sweeping federal preemption of state authority in this arena. We are very concerned about any policy that would weaken the states' role in regulating AHPs.

The Department of Labor would need far greater resources than it has had in the past or currently exists to fully monitor AHPs in all 50 states and provide for effective enforcement where noncompliance issues arise. ACS CAN strongly urges the Department to follow current law and reaffirm the authority of the states to regulate AHPs more generally. We note that state regulators are often on the front lines of consumer complaints and can be in a better position to monitor what is happening in their markets.

PROPOSED REGULATION

A. Employers Could Band Together for the Single Purpose of Obtaining Health Coverage

The proposed rule seeks to allow employers to band together for the express purpose of offering health coverage if they are: (1) in the same trade, industry, line of business, or profession; or (2) have a principal place of business within a region that does not exceed the boundaries of the same State or the same metropolitan area.

We note that the preamble discusses at length how this proposed policy would help small businesses reduce their health care costs, but at the same time, the Department declined to limit the policy only to small employers. In fact, the preamble notes that it expects minimal interest from large employers given that they already enjoy market advantages, nevertheless "there may be some large employers that may see cost savings and/or administrative efficiencies in using an AHP as a vehicle for providing health coverage to their employees."[8] We are concerned that allowing large employers to join together to form an AHP – either with other large employers and/or a mixture of large and small employers – would segment the market further and would siphon younger, healthier individuals into these products and away from the individual market. We strongly urge the Department to disallow large employers from forming an AHP.

Under the proposed policy, an AHP could sell across state lines if the businesses to which membership was offered shared some common geographic area. It also seems likely, however, that AHPs could market across state lines to the extent that they meet the other commonality of interest provision, that is, that they are in the "same trade, industry, line of business or profession." To the extent that the rule was to permit a state to impose solvency and other standards on these plans, as we urge, it is unclear which state would have jurisdiction over the AHP. If an AHP were formed in the greater Washington, D.C. area, it is unclear whether the state insurance regulators in Maryland, D.C., and Virginia would have joint jurisdiction. If an AHP selling to real estate brokers across the country was domiciled in Georgia, would other states' insurance laws apply to that AHP? Or, as it appears possible under the preamble language, would any or all state laws be preempted from applying to the AHP coverage or would the application of state law be limited to only that state in which the AHP was primarily domiciled. The potential for problems to arise would be significant. AHP participants might discover that they have no recourse under state law to obtain benefits due under the terms of the AHP and federal law and oversight would seem to be minimal as outlined in the preamble.

[8] 83 Fed. Reg. at 620.

B. The Group or Association Must Have an Organizational Structure and Be Functionally Controlled by Its Employer Members

The proposed rule would require that the group or association have a formal organizational structure with a governing body and have by-laws or other indications of formality and that the group control its functions and activities.

We are concerned that this proposal is not sufficient to address concerns regarding the financial solvency of the AHPs. The proposed rule does not impose any federal solvency requirements to ensure that entities have sufficient resources to prevent financial failure. These solvency requirements exist to ensure that a health insurer is able to pay claims when their enrollees experience high health care claims, such as when an enrollee is diagnosed with cancer. If an AHP has insufficient reserves to pay claims, the AHP risks folding, thus leaving enrollees suddenly with no health coverage and potentially liable for any medical expenses that have been incurred.

In the preamble the Department recognizes past solvency and fraud problems with Multiple Employer Welfare Arrangements (MEWAs) but glosses over the potential for these problems to multiply under the far less stringent organizational requirements specified in the proposed rule. This concern is magnified to the extent that states, which require issuers of insurance to meet capital and reserve requirements, are prevented from regulating AHPs.

C. Group or Association Plan Coverage Must be Limited to Employees of Employer Members and Treatment of Working Owners

The proposed rule would require that only employees and former employees (including dependents) may participate in the health plan sponsored by the association.

More concerning though is the inclusion in the proposed rule of working owners (self-employed individuals) as eligible entities for coverage under AHPs based solely on their self-certification. The proposed policy is inconsistent with ERISA as a law created to protect employees of private sector firms, since a working owner may not have any employees.[9]

In addition, the proposed policy could dramatically increase the likelihood that the individual insurance market, including the Qualified Health Plans (QHPs) selling through the ACA marketplaces, would experience severe adverse selection and become unsustainable. AHPs would draw healthier individuals away from the ACA-compliant individual market products, turning the latter into the coverage of last resort for those in need of more comprehensive benefits. Together with the repeal of the shared responsibility (individual mandate) requirement under the Tax Cuts and Jobs Act, signed into law in late 2017, this measure would make it impossible over a few years' time for ACA-compliant plans to retain sufficiently large and balanced risk pools to survive.[10] (Federal costs would also grow substantially to cover the increased QHP premiums for those eligible for the ACA's premium subsidies.)

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[9] Both ERISA regulation 29 CFR 2510.3-3 and the Public Health Service Act (42 U.S.C. § 300gg-91) make clear that employer-owners without any employees would not qualify as employees.

[10] The Congressional Budget Office (CBO) estimated 13 million additional people would be uninsured by 2026 as a result of the repeal of the individual mandate. CBO, "Repealing the Individual Health Insurance Mandate: An Updated Estimate," November 2017, available at https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf.

Moreover, because AHPs would be exempt from the current law requirement for a single risk pool and risk adjustment, no mechanism would exist to require their participation in the spreading of risk that helps offset the losses of ACA-compliant plans (including QHPs. As the ACA-compliant individual and small group markets became more expensive, less well-meaning entities would likely form AHPs in an effort to make a quick profit off of consumers seeking lower-cost alternatives.

D. Nondiscrimination Protections

The proposed rule would prohibit the group or association from restricting members in the association itself based on any health factor of an employee (including former employees and family members). Health factors include health status, medical condition (both physical and mental illness), claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, and disability.

We are pleased that the proposed rule would not allow the group health plan sponsored by the AHP group or the AHP to exclude enrollees based on a health factor, including their health history. We believe that an individual's health status and health history should not be taken into account for purposes of determining eligibility for health coverage or cost-sharing associated with benefits provided under the plan.

However, we are concerned that the while the proposal would prohibit health discrimination *within* groups of similarly situated individuals, it would not prohibit discrimination *across* different groups of similarly situated individuals.[11] For example an AHP could impose different rates based on age (the 3 to 1 limit under the ACA would not apply), gender, industry, group size and geography. It could also charge an employer with higher rates of females higher premiums or an employer with a relatively younger workforce lower premiums. An AHP seeking to achieve favorable selection would face few constraints on its ability to fashion and price products that attract the lowest-cost, lowest-risk enrollees. We are concerned that this provision provides a back-door way for an AHP to use health status to determine premiums.

The Department requests comment on whether its proposed non-discrimination rules would result in involuntary cross-subsidization across firms that would discourage AHPs from forming. We strongly urge the Department to ensure that guaranteed issue, guaranteed renewability, adjusted community rating, a single risk pool and risk adjustment, all required under the ACA's individual and small group markets and applicable today to most AHPs, continue to apply to AHPs. A separate and weaker set of federal minimum standards, such as envisioned by this proposed rule, would invite the kind of risk segmentation that we have already described, greatly limiting the affordable coverage options for individuals with preexisting health conditions like cancer or a history of cancer, or are older or have other risk factors, such as employment in a high-risk industry.

[11] 83 Fed. Reg. at 624.

REGULATORY IMPACT ANALYSIS

1.3 AHP's Potential Impacts

The proposed rule's stated goal is to facilitate the establishment of more AHPs in order to make more, and more affordable, health coverage options available to more employees of small businesses and their dependents.[12] However, even the rule itself notes that "[w]hile the impacts of this proposed rule, and AHPs themselves, are intended to be positive on the net, the incidence, nature and magnitude of both positive and negative effects are uncertain. Among factors impacting uncertainty, as cited in the proposed rule, are legislative proposals to repeal and replace the ACA, state's ability to regulate AHPs, and interaction with related initiatives including the short-term limited duration policies."[13]

Given the amount of uncertainty, we question the wisdom of allowing the proliferation of AHPs or whether it would be wise to delay the implementation of any proposed changes until such time as efforts to provide more stability to the individual market have been permitted to take effect. We caution that the impact analysis conducted by the Department is incomplete. The repeal of the individual mandate penalty beginning in 2019 is expected to have a significant impact on the individual market and the proposed rule failed to include any analysis regarding the extent to which the interaction of those policies would affect the viability of the individual market.[14] In addition, we note that other efforts by the Administration – such as the recently released proposed rule on short-term limited duration policies[15] – will also have a profound impact on the individual market and should be taken into account for purposes of determining the impact on the individual market.

1.5 Increased Choice

The proposed rule notes that AHPs would not be subject to the individual and small group market rules, and thus "would enjoy greater flexibility with respect to the products and prices they could offer to small businesses."[16] We are concerned that the proposed rule would allow AHPs to offer coverage that does not include the Essential Health Benefits (EHBs) or the state EHB benchmarks that define their scope.

Moreover, it appears that AHPs may also be exempt from the ACA's Minimum Essential Coverage and maximum out-of-pocket cost limits by virtue of the proposed rule's definitional changes. As a result, an AHP could offer lower-cost coverage than non-AHPs simply by not covering expensive cancer drugs or any prescription drugs or could cap the number of hospital days or offer no inpatient hospital coverage. Exemption from the ACA's 60 percent minimum essential coverage requirement could give rise to AHP coverage that actually pays for very little of an enrollee's health care expenses.

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[12] 83 Fed. Reg. at 626.
[13] 83 Fed. Reg. at 627.
[14] Recent analysis by Avalere estimates higher premiums in both the individual and small group markets and an increase in the number of uninsured Americans relative to current law. Avalere, "Association Health Plans: Projecting the Impact of the Proposed Rule," Feb. 28, 2018, available at http://go.avalere.com/acton/attachment/12909/f-052f/1/-/-/-/-/-/Association%20Health%20Plans%20White%20Paper.pdf.
[15] Internal Revenue Service, Employee Benefits Security Administration, and Department of Health and Human Services, Short-Term, Limited Duration Insurance, Proposed Rule, 83 Fed. Reg. 7437 (Feb. 21, 2018).
[16] 83 Fed. Reg. at 628.

Thus, AHPs could impose high enrollee cost-sharing on benefits likely to be expensive to insure or to attract higher-risk enrollees. While technically enrollees might be insured, the insurance offered to them would be inadequate to meet their needs, leaving them exposed to a significant amount of out-of-pocket costs. Enrollees who signed up for an AHP assuming that they were healthy and in little need of health care could find themselves uninsured for critically-needed health care in the event of a serious illness, like a cancer diagnosis.

Moreover, to the extent that plans offered by AHPs do not meet the Minimum Essential Coverage requirements, an individual who needs or wants to leave their AHP to enroll in an ACA-compliant plan (for example to access more comprehensive coverage or because their AHP has become insolvent and stopped paying claims) would likely not be given a special enrollment period to do so, and would have to wait till open enrollment, thus resulting in a gap in coverage.

The selection dynamics created by this proposed rule would inevitably lead to a severe segmentation of the private insurance market, jeopardizing the adequacy and affordability of coverage for those Americans most in need of health care. Should the rule be finalized in its current form, the ACA-compliant plans, especially the QHPs, could be significantly weakened, experiencing declining numbers of participants that would undermine the spreading of risk. As stated earlier, to the extent that AHPs draw the healthier and younger enrollees, the non-AHPs (especially the QHPs selling through the marketplaces) would likely become insurers of last resort, vulnerable to a death spiral undermining their viability. Especially in the absence of the enforceable individual mandate, healthier individuals and small groups will either migrate to AHPs or go uninsured.

The proposed rule makes note of these concerns, yet dismisses them by stating that these risks "may be small, however, relative to the benefits realized by small businesses and their employees that gain access to more affordable insurance that more closely matches their preferences."[17] The Department is seemingly suggesting that a concern about the lack of adequate and affordable coverage options to those in the individual market is outweighed by lower premiums provided to small businesses (even though these premiums would be lower because coverage would not be as comprehensive). From a cancer perspective, affordable health insurance premiums are important but equally important are the adequacy of the benefits provided under the plan.

1.6 Risk Pooling

The proposed rule indicates that AHPs would not be part of the risk adjustment program that seeks to minimize risk for insurers in the individual and small group market. Rather, the Department suggests that such programs are not necessary given that AHPs would be subject to non-discrimination policies outlined above. However, we again note that non-grandfathered health insurance coverage and the insurers selling that coverage in the remaining individual and small group markets would have to meet federal minimum requirements related to rating, a single risk pool, the EHBs, and participation in the risk adjustment system. They would have to shoulder the effects of adverse selection through these risk pooling measures; AHPs, on the other hand, would be exempt from sharing in any of the costs associated with that adverse selection. The proposed application of a non-discrimination rule that allows AHPs to rate on factors other than those that are defined to be health-status related would create an extremely un-level playing field for insurers, likely leading most if not all to exit the marketplaces.

[17] 83 Fed. Reg. at 628.

In response to concerns that AHPs could siphon younger and healthier individuals by offering lower-priced products, the Department suggests that pricing flexibility would be the only advantage provided to AHPs and suggests that an AHP may realize sufficient efficiencies that would enable it to offer lower premiums even to less healthy individuals. Yet the Department offers no evidence to support its theory.

The plans sold through the AHPs use the same network of healthcare providers as health insurers or third-party administrators (TPAs) and thus the likelihood is low that an AHP, even with a large number of participants, would be able to achieve more discounted prices than these issuers. If an AHP seeks to contract directly with providers in order to achieve discounted prices, it would require an enormous investment of resources to establish that network and again, seems unlikely to achieve deeper discounts than insurers or TPAs. Moreover, there are administrative costs associated with establishing and operating an AHP and they would have to be reflected in its premiums. For these reasons, when asked to estimate AHP proposals introduced in Congress, the Congressional Budget Office has concluded that they would not likely lead to significant increases in health insurance coverage, including for small businesses.[18]

1.7 Individual and Small Group Markets

We are concerned that the proposed rule seems to suggest that its intent is to shift individuals from marketplace coverage to coverage through an AHP, noting that many individuals who are enrolled in marketplace coverage could become eligible for an AHP. The proposed rule incorrectly suggests that "the ACA creates significant incentives for some people to wait to purchase insurance until an enrollment period that occurs after they have experienced a medical need." The ACA was designed to ensure that as many individuals as possible were enrolled in coverage and in fact contained a provision that imposed a fine on individuals who failed to maintain coverage. Also as the Department is aware, the Department of Health and Human Services has severely curtailed an individual's opportunity to enroll in marketplace coverage outside the annual open enrollment period, much less create a special enrollment period for individuals who have a medical need.

In fact, the proposed rule notes that the "Department considered the potential susceptibilities of individual and small group markets to adverse selection under this proposal" but notes the "ACA's requirement that essentially all individuals acquire coverage and the provision of subsidies in Exchanges may reduce that susceptibility."[19] The individual mandate was repealed in recent legislation, thus negating the Department's arguments.

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[18] Congressional Budget Office, Small Business Health Fairness Act of 2005 (H.R. 25), cost estimate (Apr. 2005), available at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/62xx/doc6265/hr525.pdf; Congressional Budget Office "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts," (January 2000), available at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/18xx/doc1815/healthins.pdf.

[19] 83 Fed. Reg. at 630-631.

Conclusion

On behalf of the American Cancer Society Cancer Action Network we thank you for the opportunity to comment on the proposed rule. If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Policy Principal, Access and Quality of Care at Anna.Howard@cancer.org or 202-585-3261.

Sincerely,

Christopher W. Hansen
President
American Cancer Society Cancer Action Network