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Blue Cross and Blue Shield Plans

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The Honorable Preston Rutledge
Assistant Secretary of Labor
Employee Benefits Security Administration Office of Regulations and Interpretations
Room N–5655
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

Submitted via the Federal Regulations Web Portal, http://www.regulations.gov

RE: Definition of 'Employer' under Section 3(5) of ERISA—Association Health Plans (RIN 1210–AB85)

Dear Assistant Secretary Rutledge:

The Blue Cross Blue Shield Association ("BCBSA") appreciates the opportunity to provide comments on the Proposed Rule: "Definition of 'Employer' under Section 3(5) of ERISA—Association Health Plans," as issued in the Federal Register on January 5, 2018 (83 Fed. Reg. 614; Proposed Rule).

BCBSA is a national federation of 36 independent, community-based, and locally operated Blue Cross and Blue Shield Plans that collectively provide healthcare coverage for one in three Americans. For more than 80 years, Blue Cross and Blue Shield companies have offered quality healthcare coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

BCBSA shares the Department of Labor's (DOL) desire to increase choice, competition, and affordability in the small employer health insurance market. However, we are concerned that key provisions in the Proposed Rule – namely the relaxation of sponsorship requirements and commonality of interest standards for association health plans (AHPs), coupled with the inclusion of employers with no common-law employees ("working owners") – will harm the existing options available to small businesses in both the small group and association markets. As the DOL considers expanding the availability of AHPs, care must be taken to establish an effective regulatory framework that will not undermine the coverage for the more than 14 million

people in the small employer health insurance market or the stability of legitimate association plans that exist today.

History illustrates the need for a strong regulatory framework for coverage sold to small employers. After the enactment of ERISA, scam operators proliferated in the association market claiming to be exempt from state regulation under ERISA. Recognizing this problem, Congress amended ERISA in 1983 to allow states to protect small employers.[1] It has taken decades for the DOL and state regulators to create a workable regulatory framework that supports legitimate associations that meet the requirements of current federal guidance as additional options for small group employers. During this period, thousands of employees were left with hundreds of millions of dollars in unpaid claims (see the detailed comment letter attached).

Despite this history, legitimate associations are an important source of health insurance coverage for small employers across the country today in a small employer market that has been relatively stable. While some of the provisions of the Proposed Rule protect this stability – for example the inclusion of nondiscrimination requirements and the continued ability of states to regulate association coverage – other provisions threaten it and increase the likelihood that illegitimate associations will enter the market, disrupting coverage for small businesses and their employees through legitimate associations and the small employer health insurance market.

For example, we are concerned that the Proposed Rule would allow associations to be formed for the sole purpose of sponsoring group health plans that would be exempt from many of the standards that apply in the small group market today. The DOL argues that these changes would free associations from regulatory burden and result in lower premiums. The more likely outcome is that the Proposed Rule’s relaxation of sponsorship requirements and commonality of interest standards would fragment the market. Sophisticated operators might use associations as a way to circumvent current requirements that have added to the relatively stable small group market, driving up costs for small employers, particularly those with older workers and/or in higher cost industries. Unfortunately, these bad actors in the association market are not likely to have the interests of their members in mind in the same way as large employers and legitimate associations.

Below is a summary of key issues BCBSA has identified for the DOL’s consideration as the Department determines the best method for expanding access to AHPs and simultaneously protecting the stability of the small group and association markets. More detailed comments are included in the attached document.

First, BCBSA recognizes the importance of two key provisions of the Proposed Rule, and urges the DOL to maintain and strengthen these provisions in the Final Rule:

- **Continued state regulation:** Continuing to allow states to directly regulate AHPs, especially those that are self-funded, is critical to ensuring adequate oversight of health plans offered to small employers, assuring the stability of the existing small group market, and avoiding scam operations that have plagued coverage offered through

[1] ERISA § 514(b)(6) (29 U.S.C. § 1144(b)(6)).

multiple employer welfare arrangements (MEWAs) to small employers in the past. It is equally critical to allow states to regulate the insurance coverage sold to AHPs and to establish a framework of greater consumer protection should they choose to do so. In our detailed comments, we recommend additional clarifications to eliminate any ambiguity about state regulatory authority.

- **Prohibition on discrimination against employers with high-cost claims:** The DOL included important provisions prohibiting discrimination in determining eligibility to participate in an AHP and rating based on health factors. These provisions are intended to mitigate risk selection and to distinguish genuine employment-based AHPs from commercial enterprises masquerading as AHPs that may occur with the relaxation of current sponsorship requirements. While these provisions would alleviate some of the adverse selection that could undermine the small employer health insurance market, they are not adequate on their own and must be coupled with additional standards for bona fide associations. Our detailed comments provide specific suggestions.

However, we continue to have significant concerns about several proposed provisions that would open the door for illegitimate associations, undermine stability in the small employer and individual markets, and harm consumers:

- **Opening the door for cherry picking and fraud involving illegitimate associations:** The Proposed Rule would allow AHPs to form for no purpose other than offering health coverage and would not require that the association be in existence for a period of time prior to offering health coverage. This would open the door for illegitimate associations that focus only on attracting healthy groups as they have no other affiliation with their members, leaving behind only sicker groups in the small group market. Relaxing sponsorship requirements also would greatly increase the potential for fraud and insolvencies. Scam operators who are not currently affiliated in anyway with small employers would be able to form an AHP quickly and easily, and attempt to circumvent state regulation by claiming exemption under ERISA. The failure to include adequate sponsorship requirements would undermine the stability of the small group market and existing bona fide associations that are working to provide stable coverage that is meaningful to their members.

- **Undermining the individual market through inclusion of working owners:** The Proposed Rule would expand eligibility for participation in AHPs to self-employed individuals (“working owners”) who do not employ other individuals. Movement of relatively healthier working owners – who may not currently need costly services covered by fully regulated plans – into AHPs would threaten individual market stability and potentially threaten the viability of associations with membership criteria that include both small employers and the self-employed. Further, the Rule would allow AHPs to rely on self-certification from working owners to determine eligibility for participation, introducing additional opportunities for fraud and abuse.

- **Jeopardizing the stability of the small employer health insurance market:** Despite nondiscrimination requirements based on health factors, newly formed associations may

still be able to rate products and impose eligibility restrictions based on other factors such as gender, age, and group size that would help them to attract healthier members. In addition, these new associations could exclude certain benefits, making their products less attractive to older and/or higher-cost groups. As a result, premiums would increase for small employers that purchase coverage in the traditional insurance market. Without adequate sponsorship requirements, it would be easy for brokers, associations, and insurers to segment the small group market using industry and other permitted rating factors.

- **Providing inadequate quantitative analysis:** Executive Order 12866 requires that agencies provide both quantitative and qualitative review of the costs and benefits of proposed regulatory changes. The justification and support provided by the DOL in the Preamble to this Proposed Rule does not meet these requirements. BCBSA urges the DOL to conduct and publicly release a more robust, quantitative analysis of how this Proposed Rule would impact premiums and the number of uninsured before finalizing the rule. As it stands, DOL simply has not met its burden of demonstrating that the benefits of the Proposed Rule outweigh its costs.

- **Not specifying an effective date:** Finally, we note that the Proposed Rule does not indicate the DOL’s intentions for an effective date for the Final Rule. BCBSA recommends that the Final Rule not be effective until January 1st of the first full calendar year to fall at least 12 months from the issuance of the Final Rule. Given the magnitude of the proposed changes, this lead time is necessary to ensure proper implementation of the new AHP requirements.

We appreciate your consideration of our comments. If you have any questions or want additional information, please contact Chelsea.Ruediger@bcbsa.com.

Sincerely,

Kris Haltmeyer
Vice President, Legislative & Regulatory Policy
Office of Policy & Representation

DETAILED COMMENTS ON "Definition of 'Employer' under Section 3(5) of ERISA—Association Health Plans"

Part 2510—Definitions of Terms Used in Subchapters C, D, E, F, G, and L of this Chapter

1. Bona fide group or association of employers (§ 2510.3-5(b))

Issue # 1: Allowing Associations to Form Solely to Provide Health Coverage

Under current guidance, bona fide associations must have business/organizational purposes and functions unrelated to the provision of benefits.[2] The proposal would greatly relax current standards by allowing associations to form for no other purpose than to provide health coverage.

Recommendation:

The Final Rule should clarify that associations must be formed for substantial purposes beyond providing health coverage and that they must be offering meaningful benefits to their members other than health insurance. Further, the DOL should align with the Public Health Service Act (PHSA) requirement that associations be in existence for at least five years prior to being considered "bona fide."[3]

Rationale:

Many existing AHPs are sponsored by well established, legitimate associations with a vested interest in protecting the welfare of their members and preserving their own reputations. These associations have offered health insurance coverage along with a host of other benefits such as education and training, conferences, discounts, other insurance programs, and advocacy for their members' business interests. Allowing associations to form for no purpose other than offering health coverage to their members opens the door for less legitimate associations that offer plans attractive to only the healthiest, lowest-cost small employers and individuals.

Having these basic sponsorship requirements – i.e., requiring that associations be formed for reasons other than providing health coverage and requiring associations to have been in existence for at least five years – is critical because small employers and individuals are not sophisticated purchasers of health coverage and are vulnerable to fraud. Small employers may be drawn to the slick marketing of an association that has no other purpose than to offer health insurance and whose true purpose is only to generate revenue for the AHP's founders. And the Proposed Rule provides no effective DOL enforcement mechanism to police these new "health insurance only" associations.

Small employers often lack resources for services that a large employer has such as education, training, advocacy, discounts for trade related vendors, etc., and frequently join associations to

[2] See, e.g., DOL Advisory Opinion 2001-04A. Available electronically at: https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/2001-04a.
[3] See 42 U.S.C. § 300gg-91(d)(3)

obtain these additional benefits. Small businesses have also used these associations to provide health benefits to their employees. When the small employer purchases health insurance through an association along with other employers, they become what ERISA defines as “multiple employer welfare arrangements” (MEWAs), arrangements established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers, or to their beneficiaries.[4] The associations that would be subject to the Proposed Rule are MEWAs.

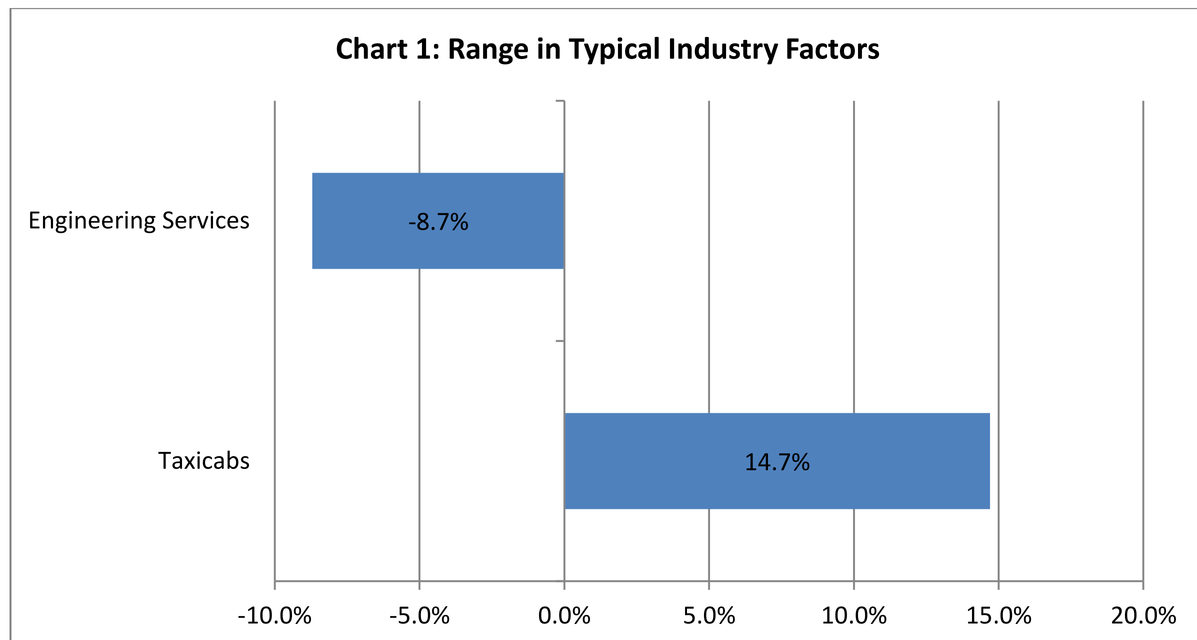
In the past, ERISA preemption arguments were used by MEWA operators to circumvent regulation and led many small businesses to fall victim to numerous scams claiming to offer low-cost “group” benefits. Widespread fraud and insolvency prompted Congress in 1983 to allow states to regulate MEWAs.[5] For fully-insured MEWAs, the statute “…exempts from ERISA preemption any state laws that require the maintenance of specified levels of reserves and contributions in order for such an arrangement to be considered adequately funded.” However, for not fully insured MEWAs, the statute “…exempts from ERISA preemption any state laws that regulate insurance that are not inconsistent with ERISA.”[6] Following the 1983 amendments, DOL issued dozens of advisory opinions clarifying the scope of these rules and state regulatory authority over MEWAs.

Even with state authority to regulate these plans, bad actors continue to enter the market. Between 1988 and 1991, failures involving MEWAs left small businesses and their employees with over $123 million in unpaid claims and 398,000 participants without insurance coverage.[7] Between 2001 and 2003, four fraudulent health insurance companies, run through associations, “left nearly 100,000 people with approximately $85 million in unpaid medical claims and without health coverage.”[8] In Tennessee, a fraudulent association operated from 2008-2010 before being shut down by the Department of Commerce and Insurance. Reports estimate that victims incurred losses of over $7 million.[9] In 2014, South Carolina shut down a self-insured, fraudulent MEWA after it became clear it was not financially solvent. Ultimately over 500 small businesses were left on the hook for medical claims incurred by their employees[10]. More recently, the DOL issued a cease and desist order in November of 2017 for a fraudulent association in Illinois that at its height had 14,000 participants and left $26 million in unpaid claims.[11] In issuing this order, the DOL – for the first time – used specified authority granted to it in 2010 as part of the Affordable Care Act through the rules of section 521 of ERISA. It is ironic that at the same time

[4] *See* ERISA § 3(40) (29 U.S.C. § 1002(40)).
[5] ERISA § 514(b)(6) (29 U.S.C. § 1144(b)(6)(i)).
[6] ERISA § 514(b)(6) (29 U.S.C. § 1144(b)(6)(ii)).
[7] Government Accountability Office (formally General Accounting Office), “Employee Benefits: States Need Labor’s Help Regulating Multiple Employer Welfare Arrangements,” March 1992 available at: http://www.gao.gov/assets/220/215647.pdf.
[8] Kofman, Mila; Lucia, Kevin; and Bangit, Eliza, “Health Insurance Scams: How Government is Responding and What Further Steps are Needed.” August 2003 available at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2003/aug/health-insurance-scams--how-government-is-responding-and-what-further-steps-are-needed/kofman_insurancescams_ib_665-pdf.pdf.
[9] *The Tennessean,* “More guilty pleas, death in Springfield-based, multi-million dollar fraud case,” January 19, 2018 available at: https://www.tennessean.com/story/news/local/robertson/2018/01/19/more-guilty-pleas-death-springfield-based-multi-million-dollar-fraud-case/1049596001/.
[10] Greenville News, “State Takes over South Carolina Health Co-Op.” November 2014 available at: https://www.greenvilleonline.com/story/news/health/2014/11/25/state-takes-south-carolina-health-co-op/70117286/. *See also:* South Carolina Department of Insurance http://www.doi.sc.gov/840/SCHC.
[11] The Department of Labor, “U.S. Department of Labor Obtains a Temporary Restraining Order to Protect Participants and Beneficiaries of Failing MEWA,” November 8, 2017 available at: https://www.dol.gov/newsroom/releases/ebsa/ebsa20171108

DOL is fostering *new* associations with no specific enforcement strategy, it is finally using the enforcement tool Congress gave it several years ago for *existing* MEWA fraud.

In addition to the increased risk of insolvencies and fraud, allowing associations to form for the sole purpose of providing health coverage also puts the stability of the small employer health insurance market at risk. One way in which these less legitimate associations are likely to destabilize the market is to fragment the market based on industry. Prior to the ACA, industry factors were commonly used in the small group market to set rates. For example, Standard Industry Code (SIC) 8711, Engineering Services, has an industry rating factor of .913 and SIC 4121, Taxicabs, has a 26 percent higher industry factor of 1.147 in a sample rating manual, a difference that would result in taxi cab drivers paying a significantly higher premium. AHPs could be structured with eligibility criteria that target lower-cost industries such as Engineering Services with lower rates. As these groups leave the ACA small group market, the ACA small group rates would increase. Chart 1, below, illustrates the wide range in industry factors.



It is likely that illegitimate associations would target lower-cost groups thus leaving only higher-cost groups in the small group single risk pool or with the long established, legitimate associations. As risk in the new association “sours,” operators of illegitimate associations could either increase premiums – causing significant churn between markets – or close the associations down entirely and start new ones, creating more instability. This type of activity would run counter to the DOL’s stated goal of enabling “AHPs to assemble large, stable risk pools.”[12] Legitimate associations, on the other hand, have a vested interest in ensuring the financial health of the businesses they represent, including their members’ health benefits costs.

[12] 83 Fed. Reg. 614, 628.

Despite these concerns, the DOL has not outlined an enforcement strategy in the Proposed Rule. States currently enjoy broad authority to regulate MEWAs.[13] The Proposed Rule indicates that it is not the DOL’s intention to “modify the States’ authority to regulate health insurance issuers or the insurance policies they sell to AHPs,”[14] which we interpret to mean that DOL is not considering any changes to current interpretations regarding state regulatory authority. Given the long history of fraud, financial instability and insolvency of MEWAs/AHPs, maintaining broad state authority to regulate these plans is essential.[15]

The Final Rule should not limit or create any ambiguities about state authority to regulate the insurance coverage sold to AHPs. It is critical that states continue in their traditional role of regulating the business of insurance and protecting consumers. Given the potential for multi-state AHPs under the Proposed Rule, the Final Rule should outline an enforcement strategy including details on how the DOL will supplement and assist with state efforts to ensure that only legitimate associations are offering health insurance coverage to small businesses.

Finally, requiring that an association be in existence for at least five years helps to ensure that associations are legitimate, that they have a vested interest in serving their members and are acting in their best interest, and that they have a professional reputation to protect, thus significantly reducing the potential for fraud. Further, associations that meet the five year criteria are far less likely to have solvency problems. Where possible, BCBSA encourages the DOL to rely on existing standards, such as this current time-in-business requirement in the PHSA, to protect consumers from fraudulent associations.

Issue # 2: Ensure Adequate Funding for DOL Enforcement

Given the high potential for fraud and abuse, it is critical that DOL have adequate funding for oversight of AHPs. Recognizing this, the President’s FY2019 budget included additional funding for the Employment Benefits Security Administration for enforcement. Below is the text from the President’s budget:

> **Makes Health Insurance More Affordable for Small Businesses.** The President’s Executive Order “Promoting Healthcare Choice and Competition Across the United States” directed the Secretary of Labor to expand access to health coverage by allowing more employers to form Association Health Plans (AHPs), arrangements under which small businesses may band together to offer competitive and affordable health insurance to their employees. The Budget supports this initiative by increasing funding for the

[13] The Department of Labor, “MEWAS Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation.” Revised August 2013. Available at: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf. See also, Lucia, Kevin and Corlette, Sabrina, “Association Health Plans: Maintaining State Authority is Critical to Avoid Fraud, insolvency, and Market Instability.” January 24, 2918 available at: http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority.

[14] 83 Fed. Reg. 614, 625.

[15] ERISA section 520 authorizes the DOL to promulgate regulations regarding standards, or issuing orders, when persons providing insurance through MEWAs are subject to state law in order to prevent fraud and abuse. The DOL stated in 2011 that it would propose regulations and implement ERISA section 520, but to date the DOL has taken no action on this issue. The DOL should start work on such rulemaking as soon as possible, to ensure that regulations under ERISA section 520 can be finalized concurrently with any final rule on association health plans.

Employee Benefits Security Administration to develop policy and enforcement capacity to expand access to AHPs.[16]

Recommendation:

The Final Rule should not become effective until Congress has appropriated additional funding for DOL oversight of expanded access to AHPs.

Rationale:

Given the past history of abuse of AHPs, it is logical that the Final Rule not become effective until the DOL has adequate funding to ensure proper oversight. The President’s FY2019 Budget recognizes this need by including a request for AHP enforcement funding. Implementing AHPs before the DOL has adequate funding would increase the potential for fraud and abuse.

Issue # 3: Prohibiting Health Insurance Issuers from Forming an Association

The Proposed Rule would require the association to not be a health insurance issuer described in ERISA section 733(b)(2), or owned or controlled by an issuer. However, no definition of “control” is provided, leaving ambiguity as to the allowable role of issuers in an AHP.

Recommendation 1:

The Final Rule should clarify that issuers are not prohibited from providing existing services to associations, such as assistance with plan development, marketing, ASO services, or participation on the association board.

Rationale:

Issuers often provide significant assistance to associations in the administration of their association coverage, including plan design, marketing, billing, etc. In addition, issuers sometimes have employees participate on the association’s board. For example, it is not uncommon for an employee of an issuer to sit on the board of a local association such as one sponsored by a local Chamber of Commerce. The Rule should clarify that these types of activities are not viewed as “control.”

In addition, BCBSA encourages the DOL to clarify how this provision interacts with state law. For example, the Final Rule should explicitly state that the DOL continues to defer to states as to whether an entity is a health insurance issuer.

[16] Fiscal Year 2019 - Efficient, Effective , Accountable An American Budget, Page 77

2. Commonality of Interest (§ 2510.3-5(c))

Issue # 1: Using Common Geography to Form an Association

Under current guidance,[17] bona fide associations must include employers from the same industry or trade. The Proposed Rule would allow associations to include employers from either the same "trade, industry, line of business or profession" or based on common geography. This approach is inconsistent with decades of DOL guidance and fails to ensure that the employers and employees who participate in the plan are tied by a common economic or representational interest.

Recommendation # 1:

The Final Rule should **only** allow AHPs of unrelated employers to form on the basis of common geography if the association exists for substantial purposes beyond providing health coverage, has been in existence for at least five years, and is offering meaningful benefits to their members other than health insurance.

Rationale:

A robust commonality of interest standard protects the integrity of the group to which an association is providing health insurance. In the Preamble to the Proposed Rule, the DOL asserts that "allowing formation of such an organization based on either common industry or geography…could greatly increase association coverage options available to American workers."[18] While it may be true that the proposal would increase the *quantity* of options available to small businesses, it is also important to consider the *quality* of options available and the potential for abuse. Relaxing both the bona fide association requirement that an AHP exist for reasons other than to obtain insurance and the commonality of interest standard to include common geography would pave the way for bad actors to enter the association market. These associations would take advantage of the large group market's less stringent rating and benefit requirements to attract healthier groups away from the small group market since they have no other affiliation with their members than providing insurance.

Under the proposal, employers with better than average health risk, and therefor lower costs, would be able to meet the minimal commonality of interest criteria by creating targeted associations. For example, these associations could be as specific as two employers in the same building or same geographic area who form an association of "employers located at [description of the specific geography]". This is redlining taken to an extreme level. Allowing this level of selectivity undermines the concept of risk pooling in the small group market that has existed since the states' and the National Association of Insurance Commissioners' (NAIC) efforts at small group reform in the 1990's that ultimately led to the protections in the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

[17] See, for example, DOL Advisory Opinion 2001-04A. Available electronically at: https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/2001-04a.
[18] 83 Fed. Reg. 614, 620.

The proposal would also introduce significant instability within the existing association market, especially for well-established associations, because the employers with the lowest-cost groups would move to newly formed associations established to target lower-cost groups through their association eligibility criteria, thus leaving only the higher-cost groups with the long-established legitimate associations. Operators of illegitimate associations could close their current associations risk pool when the risk "sours" and start a new association and risk pool, creating more instability. This behavior would run counter to the DOL's stated goal of enabling "AHPs to assemble large, stable risk pools."[19]

Throughout the Preamble, the DOL makes a distinction between the AHPs allowed under the Proposed Rule and "AHPs…more akin to traditional insurers selling insurance in the employer marketplace."[20] However, allowing AHPs to sell insurance to employers based solely on shared geography is indistinguishable from a traditional commercial insurance arrangement offered to employers in the group market in a state.

Recommendation # 2:

The geographic areas in which an AHP offers coverage should be contiguous within a state or MSA.

Rationale:

Requiring AHPs to offer coverage in contiguous areas within a state or MSA and not allowing them to selectively omit certain areas would reduce the potential for discriminatory practices such as redlining.

Recommendation # 3:

The DOL should consult with the NAIC on the complexities of an AHP offering coverage in multi-state MSAs and only include this provision in the Final Rule if, after consultation with the NAIC, the DOL finds that it does not diminished the ability of states to have proper oversight.

Rationale:

With the exception of MEWAs that meet the current commonality of interest requirements, health insurance coverage offered to small employers is subject to the laws of the state where the small employer is located. Allowing multi-state AHP coverage with the relaxed sponsorship requirements in the Proposed Rule raises questions that should be addressed in the Final Rule such as in which state the situs of the contract is located. Working with the NAIC to identify these issues prior to issuing the Final Rule likely would lessen problems with the initial implementation.

[19] 83 Fed. Reg. 614, 629
[20] 83 Fed. Reg. 614, 623.

Recommendation # 4:

The Final Rule should include a requirement that the situs of the insurance contract or arrangement, including the contract or arrangement for a self-insured AHP, is where the association is headquartered. In addition, this location must be a physical location and not merely a post office box.

Rationale:

Since AHPs may qualify as "large groups" they should be treated the same as large employer groups as it relates to situs of the contract. Generally, group insurance coverage is issued to the employer where the company is headquartered, or where it has a principal place of business, such as a large plant that might be better serviced by a local health plan. Tying the situs of the AHP contract to a physical location would increase the ability of both federal and state regulators to investigate any improprieties and help reduce the potential for fraud that would be associated with a PO Box.

Issue # 2: Impact on Large Group Market

As drafted, the Proposed Rule would include large employers that are in MEWA arrangements that would be considered as AHPs under the new rule, depending on how they are structured. These large employers already have the benefit flexibility available to large groups and can be rated based on their specific group's experience, but benefit from pooling their experience together to obtain more stable rates over time. Because the Proposed Rule's non-discrimination provisions apply to all size employer groups in an AHP, not just those with 50 employees and under, the premium for these large employer's specific groups can no longer vary based on claims experience as their pooling arrangements are currently structured. This will result in healthier large groups leaving these arrangements.

Recommendation:

The Final Rule should not apply to association coverage sold to large employers.

Rationale:

While the Proposed Rule is applicable to all size employers, its focus is on providing small businesses more affordable alternatives. The Preamble indicates that the DOL "believes providing additional opportunities for employer groups or associations to offer health coverage to their members' employees under a single plan may, under the conditions proposed here, offer many small businesses more affordable alternatives than are currently available to them in the individual or small group markets."[21]

As drafted, large employers that are in MEWAs that would be considered an AHP under the new rule would actually lose flexibility. Given the intent is to make coverage more affordable,

[21] 83 Fed. Reg. 614, 619

these large employers should not be subject to the new rule and its more flexible eligibility criteria; rather they should be governed by the current, long-standing requirements.

3. Nondiscrimination (§ 2510.3-5(d))

Issue #1: Rating and Eligibility for Association Health Plans

The Proposed Rule’s nondiscrimination provisions build on existing nondiscrimination provisions applicable to group health plans under HIPAA, as amended by the ACA, with an additional clarification addressing how to apply those rules to association coverage. The association may not restrict membership in the association itself based on any health factor. The group health plan sponsored by the association must comply with the rules at 29 C.F.R. § 2590.702(b) with respect to nondiscrimination in eligibility for benefits, as well as 29 C.F.R. § 2590.702(c), with respect to nondiscrimination in premiums or contributions required by any participant or beneficiary. In applying these provisions, the association may not treat different employer members of the association as distinct groups of similarly situated individuals. Nothing in the rule prohibits issuers from using experience to set the overall level of rates for AHPs.

Under the Proposed Rule, health status is not a permitted rating factor for setting rates for different employer members of an association. It appears, however, that other rating factors, which are currently not allowed in the small group market, could potentially be used at the employer member level, resulting in adverse selection that would increase prices and potentially destabilize the non-AHP small group market.

In the Preamble to the Proposed Rule, the DOL clarifies that the nondiscrimination provisions were included to address concerns that the relaxation of commonality-of-interest and bona fide association requirements may lead to adverse selection.

Recommendation # 1:

BCBSA strongly supports the nondiscrimination provision prohibiting health status/claim experience from being used to restrict membership, eligibility for benefits, or to distinguish rates between employer members of an AHP that is subject to the requirements of the Final Rule. This provision should be retained in the Final Rule for small employers and working owners, if the latter are eligible for AHP coverage in the Final Rule.

Rationale:

BCBSA is concerned with the impact of expanding the ability of newly formed AHPs to provide insurance under different rules for enrollees who would otherwise be covered in the small group and individual markets. When participants have choices of plans governed by different sets of rules, particularly requirements related to setting premiums, adverse selection occurs.

Unlike individual and small group market plans, large group market and self-insured plans are not subject to several significant ACA market reforms including:

- Modified community rating (PHSA § 2701; 42 U.S.C. § 300gg).
- Coverage of essential health benefits package (PHSA § 2707(a); 42 U.S.C. § 300gg-6).
- Single risk pool (ACA § 1312(c); 42 U.S.C. § 18032).
- Risk adjustment (ACA § 1343; 42 U.S.C. § 18063).

By establishing an association group that is treated as a large employer, especially a self-insured AHP that would be a self-funded MEWA, small employers may avoid compliance with several federal health insurance reforms that would ordinarily apply to small group health plans. This means that the MEWA could be structured in ways designed to attract healthier employer groups and discourage enrollment by less healthy employer groups. The Proposed Rule would allow new associations to form associations in a manner that targets the best risk, underscoring the need for the nondiscrimination provisions to be maintained in the Final Rule.

The Proposed Rule partially addresses these concerns in § 2510.3-5(d), which requires compliance with existing regulations prohibiting discrimination based on health status for employer membership in the MEWA, eligibility for benefits, or in premiums paid by participants or beneficiaries.[22] Without these nondiscrimination protections for AHPs formed under the new requirements, adverse selection would be even greater – shifting less healthy, higher-cost groups to coverage that is subject to insurance reforms while healthier groups would be in these newly formed AHPs.

The adverse selection impact of not having to comply with the same insurance market rules as the insured market would be particularly large if DOL did not adopt the nondiscrimination provisions and an AHP were allowed to offer lower rates to the healthiest small employer groups, including working owners. If this were allowed, AHPs subject to the new requirements could be structured to cherry pick the best risks from the existing ACA small group and individual markets by offering lower prices (as compared to ACA market rates) for lower-risk groups and higher prices for higher-risk groups. This would result in the healthiest small groups and working owners leaving the ACA markets and subsequent rate increases for the persons remaining in the ACA small group and individual markets. This would have a destabilizing impact on the ACA individual and small group markets, which are required to comply with adjusted community rating rules.

While it's important that this apply to small employers that are members of an AHP, as noted above, large employers in an AHP should be allowed to base rates based on currently available factors in the large group market, including the large employer's overall experience, in a manner consistent among the member large employers. Offering different protections to small and large employers within an AHP will provide the least disruption in the respective markets and guard against pricing anti-selection.

Some commenters may suggest that this adverse selection could be mitigated by imposing limits on how much the rates may vary for health in AHPs, such as the plus or minus 25 percent that was in the NAIC's Small Group Health Insurance Availability Model Act (and in many states'

[22] *See* 29 C.F.R. § 2590.702.

small group rating laws) prior to the ACA. However, adverse selection would still occur as the healthiest small employer groups would opt for coverage through an AHP where they receive the lower price due to health rating while higher-cost groups would continue to enroll in ACA coverage.

Later in our detailed comments, we recommend that the DOL consider allowing states with a high concentration of existing AHP enrollment to grandfather in existing AHPs.

Recommendation # 2:

BCBSA recommends that small employers obtaining coverage through AHPs (unless grandfathered per our suggestion later in this letter) should be subject to the rating factors currently used in the ACA small group market to establish their specific premium within the association. Further, the DOL should clarify the factors that are permissible for distinguishing rates between small employer and sole proprietor members of an association.

Rationale:

As mentioned under Recommendation 1, BCBSA is concerned about the potential for adverse selection between AHPs and the ACA markets, particularly from new associations formed solely for the purpose of offering insurance. While the nondiscrimination provision would prohibit using health status to set rates for small employer members in an AHP, under large group rating rules, AHPs could potentially use other non-health rating factors to distinguish rates between small employer member groups; for example, age, gender, group size, location, and other employment related factors.

We recommend that AHPs subject to the Rule’s relaxed standards be limited to the same rating factors as ACA markets when differentiating premiums for small employers purchasing coverage through AHPs. More specifically, the age rating scale should be the 3:1 age curve, the AHP rating areas should correspond to the ACA rating areas, gender rating should not be used, and tobacco and wellness factors should have limits consistent with those currently in place in the small group market.

Limiting premium differences based on age and prohibiting gender rating would ensure that AHPs are not able to skim the youngest, lowest-cost small groups and working owners from the ACA markets, increasing costs for older small groups and working owners. The charts below show the percentage difference by age between actual claims cost curves and the CMS 3:1 age curve, assuming the same distribution of enrollees by age.[23]

Chart 2, below, shows that actual claims on a unisex basis are more than 30 percent less than the CMS 3:1 age curve for those ages 21 and 22. This provides a significant advantage to an AHP targeting young people and would result in higher prices for older workers.

[23] https://www.soa.org/resources/research-reports/2013/research-health-care-birth-death/. Data from Chart 5

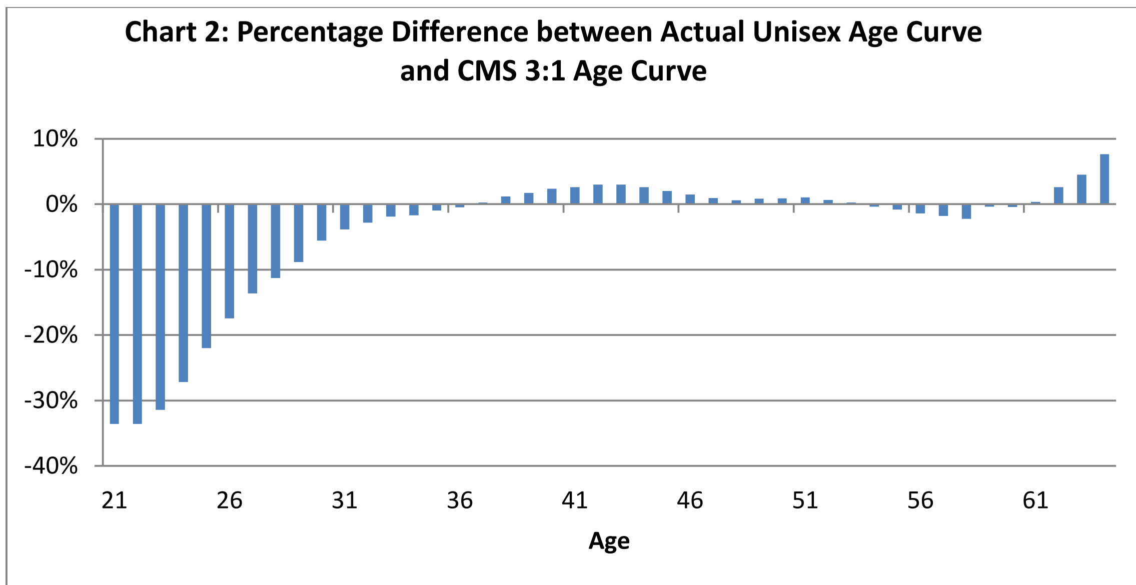
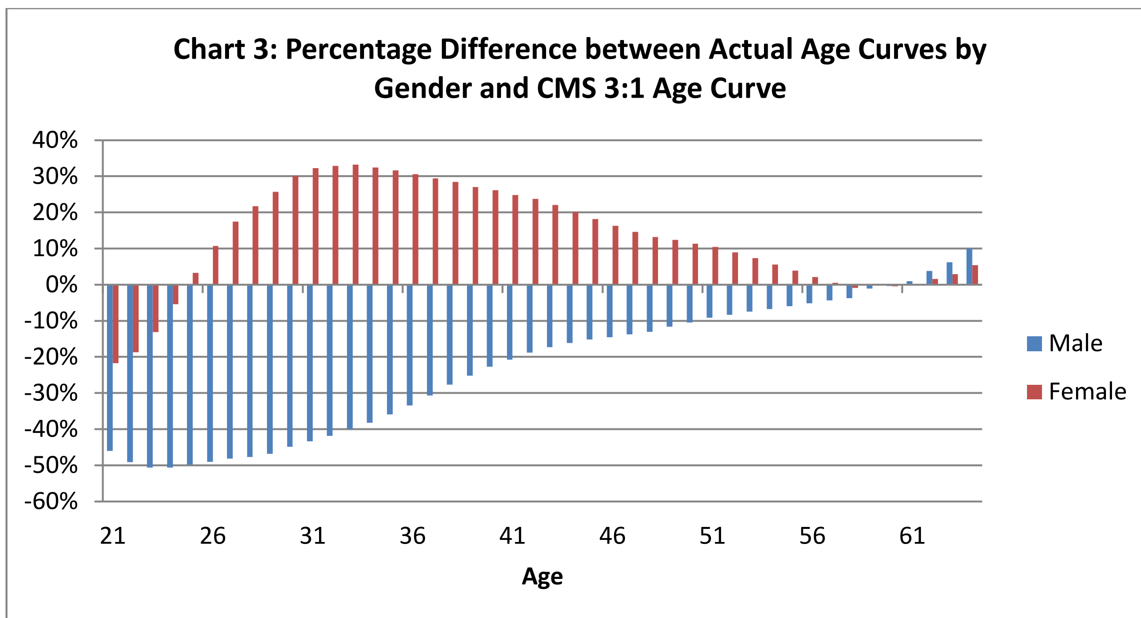


Chart 3 illustrates the difference in claims cost separated by gender and age. If gender rating were also allowed, young males would experience an even larger decrease compared to the CMS 3:1 age curve. Females over age 25 have higher claims costs than the CMS 3:1 age curve. Young males ages 23-24 have claims costs that are more than 50 percent below the CMS 3:1 age curve. At age 32, claims costs for females are 33 percent higher than the CMS 3:1 age curve and claims costs for males are 42 percent below the curve.



The difference in premiums could be expected to be even greater if the morbidity and age distribution of the AHP and ACA pools are different.

We also recommend that the rating areas for small employers purchasing coverage through AHPs correspond to ACA rating areas. Otherwise, AHPs could subdivide larger rating areas that contain a mix of higher- and lower-cost counties and offer lower prices in the low-cost counties. In addition, AHPs should not be able to offer larger wellness discounts or a higher rating factor for tobacco use than is allowed under the ACA.

If AHPs use factors consistent with the ACA to differentiate premiums for small employer/working owner member employers as we recommend, it would help ensure that they compete based on adding value through administrative expense savings and the ability to get better network discounts rather than by taking advantage of the ACA rating restrictions to target the lowest-cost individuals and groups. We note that even with these restrictions, AHPs still may be able to attract healthier small group and working owners based on their eligibility criteria or use of other non-health rating factors which would increase the cost for those who remain in the ACA risk pool. In particular, industry factors have commonly been used in small group rating pre-ACA. For example, as noted earlier, Standard Industry Code (SIC) 8711, Engineering Services, has an industry rating factor of .913 and SIC 4121, Taxicabs, has a 26 percent higher industry factor of 1.147 in a sample rating manual. AHPs could be structured with eligibility criteria that target industries such as Engineering Services with lower rates. As these groups leave the ACA small group market, the ACA small group rates would increase.

Issue# 2: Compliance with Nondiscrimination Provisions

Bona fide groups and associations, as well as the health coverage offered by them, are required to comply with the nondiscrimination provisions in the Proposed Rule. However, the Rule does not specify the party that is responsible and liable for compliance.

Recommendation:

BCBSA recommends that the DOL clarify that associations, rather than insurers, are responsible and liable for compliance with the nondiscrimination rules for fully insured arrangements when the insurer does not administer or set the rates at an employer member level.

Rationale:

Under existing guaranteed issue laws and regulations, insurers appear to be required to quote any AHP that applies for fully insured coverage. For association business today, in some instances the insurer quotes one rate for the entire association and the association determines the amount that each employer member contributes toward the premium and administers the billing. In this situation, the insurer does not have control over how the premium is allocated to each employer member and should not be responsible for compliance.

4. Dual Treatment of Working Owners as Employers and Employees (§ 2510.3-5(e))

Issue: Eligibility for Working Owners

The DOL proposes to allow “working owners,” such as sole proprietors and other self-employed individuals, to participate in AHPs. Specifically, the Proposed Rule would allow working owners to be treated as both employers who can participate in an AHP and employees who can be covered by the AHP. The Proposed Rule would permit an AHP to consist entirely of working owners.

The Proposed Rule includes a definition of “working owner” that, in part, requires that the individual either work at least 30 hours per week or 120 hours per month providing services to the trade or business, or has earned income from such trade or business that at least equals the working owner’s cost of coverage for participation in the group health plan. The Proposed Rule would permit the group or association sponsoring the group health plan to rely on written representations from the individual seeking to participate as a working owner as a basis for concluding that these conditions are satisfied.

Recommendation # 1:

The Final Rule should not allow working owners to participate in AHPs.

Rationale:

Allowing working owners such as sole proprietors and other self-employed individuals to participate in AHPs, and even permitting an AHP to consist entirely of such individuals, would upset decades of DOL guidance and court decisions and is in tension with the statute itself.

ERISA’s definition of an “employee welfare benefit plan” is premised on the existence of an employer/employee relationship: it defines an “employee welfare benefit plan” as a plan established or maintained by an “employer” for the purpose of providing benefits to its participants (i.e., its “employees” or “former employees”). In *Nationwide Mutual Insurance Company v. Darden* (503 U.S. 318 (1992)), the Supreme Court held that whether an individual is an “employee” for purposes of ERISA generally must be determined by applying common law principles. Working owners and self-employed individuals have no common law employees, and therefore do not qualify as “employers” under *Darden*. As the statute makes clear, ERISA regulates plans maintained by *employers* for *employees*; it does not regulate plans maintained by business owners with no employees, such as a plan comprised entirely of working owners.

Permitting working owners to participate in AHPs is also a significant departure from past DOL guidance. In advisory opinions over the past 40 years, the DOL has consistently taken the position that where membership in a group or association is open to anyone engaged in a particular trade or profession regardless of employer status (such as working owners and self-employed individuals), and where control of such group or association is not vested solely in

employer members, such group or association is not a group or association of employers within the meaning of section 3(5) of ERISA.[24]

The DOL cites Advisory Opinion 99-04A, the Department’s regulation at 29 CFR 2510.3-3, and the Supreme Court’s decision in *Yates v. Hendon,*[25] as support for its approach, but none of these provides support for its position. In Advisory Opinion 99-04A, the regulation, and *Yates*, a business owner participated in a plan with other common law employees. The guidance recognizes that it would be unlikely that Congress would have intended that owners not be able to participate in the plans they establish for their employees. Here, in contrast, the DOL proposes to allow business owners to participate in plans for which there are no employees that have a common law relationship with the owner. Indeed, the DOL contemplates permitting an AHP to consist entirely of working owners – a plan with absolutely no common law employees. This is a far cry from an employment-based plan. Even where a working owner participates in an AHP with unrelated persons that may have a common law employment status to their actual employer, there is no employment-based nexus for that working owner.

Simply put, unlike Advisory Opinion 99-04A, 29 CFR 2510.3-3, and *Yates*, where there was a clear employer-employee relationship between an owner and the common law employees, and allowing the owner to participate in the plan did not undermine ERISA’s focus on the employment relationship, here, the DOL cannot attribute the employer-employee status of other employers to the working owners and self-employed individuals, because there is no employer-employee relationship to regulate. Without common law employees, there is no employment nexus and ERISA is inapplicable. In fact, the Court in *Yates* recognized as much, explaining that “if a benefit plan covers only working owners, it is not covered by Title I.”[26]

The DOL also cites Internal Revenue Code § 401(c), which treats working owners as having dual employer-employee status, as support for its proposal. However, to the extent the Code recognizes dual status, it is only relevant for that particular section of the Code, and not for section 3(5) of ERISA, which has no particularized statutory accommodation. Had Congress wanted that result, it could have done so in section 3(5) of ERISA, but did not.

Additionally, the Proposed Rule would amend Section 3(5) of ERISA to define a “working owner” as an employer who can join or form a bona fide association.[27] PHSA § 2791 (42 U.S.C. § 300-gg-91), the statute that governs insured bona fide associations, defines “employer” as follows:

> …“employer” has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(5)], except that such term shall include only employers of two or more employees.

[24] *See, e.g.,* DOL Adv. Op. 79-49A; 81-51A; 82-50A; 82-59A; 83-15A; 83-41A; 83-53A; 84-11A; 84-24A; 84-43A; 86-08A; 86-26A; 87-01A; 87-02A; 87-11A; 88-07A; 89-21A; 89-26A; 90-01A; 90-19A; 91-42A; 94-07A; 95-01A; 2003-13A.
[25] 541 U.S. 1 (2004).
[26] 541 U.S. 1, 21 n.6.
[27] § 2510.3-5(b).

In enacting the Public Health Service Act, Congress specifically defined the term “employer,” and the definition is not ambiguous. Moreover, the PHSA is under the jurisdiction of the Secretary of Health and Human Services.[28] An agency only has rulemaking authority under its authorizing statute. As such, the DOL has no authority to issue rules that would in effect amend a statute that is within HHS’ jurisdiction.[29]

Finally, the DOL includes a requirement that to be considered a “working owner” the person must work at least 30 hours per week or at least 120 hours per month providing personal services to the trade or business. The Preamble states that this provision was included to ensure a legitimate trade or business exists. However, this standard is virtually un-auditable as there are no records, such as payroll tax records that exist for true employees, which are used to determine eligibility in the group market.

Recommendation # 2:

If the DOL determines that it will allow participation by working owners, the Final Rule should:

1) Include provisions that allow AHPs to exclude working owners;
2) Retain the requirements for minimum hours worked and income;
3) Include a verification or audit process, administered by the DOL, to confirm that participating working owners meet eligibility requirements;
4) Include a requirement that the sole proprietor has been in business for at least 2 years;
5) Clarify that issuers will be held harmless in the event of fraudulent enrollments of working owners; and,
6) Clarify that issuers may verify working owners meet eligibility requirements.

Rationale:

If the DOL takes the unprecedented and legally questionable step of allowing working owners to participate in AHPs, an additional regulatory framework would be needed to protect the integrity of the AHP risk pool and deter fraudulent enrollments.

First, the Final Rule should make clear that the AHP is permitted to exclude working owners. The Preamble to the Proposed Rule indicates that “an AHP…could be comprised of participants who are common law employees, common law employees and working owners, or comprised of only working owners.”[30] It does not, however, clearly state that the association may define eligibility for participation based on status as a working owner. Further, the Proposed Rule, while prohibiting the establishment of eligibility rules that discriminate on the basis of a health factor, does allow AHPs to establish eligibility rules based on bona fide employment-based classifications, including (but not limited to), part-time or full-time status, geography, or industry

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[28] 42 U.S.C. §§ 201(c), 202.

[29] 45 C.F.R. § 144.103 defines “employer” as having the meaning given the term under section 3(5) of ERISA, which states, “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.” However, HHS has never considered a sole proprietor, whether working or not, as an employer, and the PHSA statutory definition would apply.

[30] 83 Fed. Reg. 614, 622.

type. The DOL should clarify that the AHP could exclude working owners, because this is a bona fide employment-based classification.

The DOL, in consultation with HHS, should also clarify that issuers, separate and apart from the association, may establish uniformly applicable and non-health based rules for eligibility to enroll in an AHP, and that guaranteed issue requirements would not apply where the association does not have any eligible individuals. This is an important clarification so that issuers retain control over their AHP business and are not forced to offer coverage to any and all types of associations

Because the claims experience of working owners has historically been materially higher than the small group risk pool as a whole, the inclusion of working owners in an AHP's risk pool could make the association less competitive versus associations that do not include working owners. Mandating that associations that have members who are working owners have to offer coverage to them would create an un-level playing field, particularly if new associations are allowed to form solely for the purpose of offering health insurance.

In addition, if the DOL allows working owners and other self-employed individuals to participate in AHPs, the Final Rule should include a verification process to ensure that working owners meet eligibility requirements, to be administered by the DOL. Self-certification is not sufficient "to ensure that a legitimate trade or business exists"[31] as is indicated in the Proposed Rule. Unfortunately, the DOL did not include in the regulatory impact analysis the costs associated with the additional staff and/or staff time that would be needed to fulfill this function.

To aid in ensuring that working owners that join AHPs meet eligibility requirements, BCBSA recommends that the DOL include a requirement that the working owners have been in business for at least two years before joining the AHP.

Finally, we recommend that issuers be held harmless in the event that fraudulent enrollments of working owners are uncovered. In addition, because the issuer has the insurance risk of adverse selection related to fraudulent enrollments, the Final Rule should explicitly allow issuers to verify eligibility. This would include allowing the issuer to require a working owner to provide past tax returns similar to how issuers require employment tax information to verify employee eligibility for small employers.

5. Justification and Support for the New Interpretation (Preamble)

Issue: <u>Inadequate Quantitative Analysis</u>

The Preamble to the Proposed Rule suggests that the DOL itself is not clear that this Proposed Rule is either justified or necessary, and that the DOL does not have sufficient data to determine if it is sound policy or to provide a reasoned analysis for the departure from its prior precedent. The DOL states that "while the impacts of this Proposed Rule and of the AHPs themselves are

[31] 83 Fed. Reg. 614, 622.

intended to be positive on net, the incidence, nature and magnitude of both positive and negative effects are uncertain…”[32] While the proposal may result in lower costs for some businesses, it has the potential to be disruptive to many of the more than 14 million people who currently purchase small group coverage.

Recommendation:

Prior to finalizing the rule, the DOL should model the impact of the proposal to ensure that “on net” the impact is positive. As part of this analysis, the DOL should estimate the change in premiums in both the AHP and non-AHP market (both on average and at the employer group level) and the impact on the uninsured rate. In addition, the DOL should extend the comment period to allow this additional data to be taken into consideration in rule making and the public comment process.

Rationale:

Among the various statutory provisions that the DOL relies upon to support this change in rulemaking, ERISA § 505 (29 U.S.C. § 1135) provides that “the Secretary may prescribe such regulations as he finds *necessary or appropriate* to carry out the provisions of this subchapter [subchapter I, which includes the definition changed by this rule]” (emphasis added). On the issue of AHPs specifically, the President directed the DOL to “consider proposing regulations or revising guidance, consistent with law … [and] [t]o the extent permitted by law and *supported by sound policy*.”[33] (Emphasis added). Although agencies are free to change prior interpretations, including prior rules, such changes should be explained with a “reasoned analysis,” or risk a court concluding that the new rule is arbitrary and capricious.[34] In “explaining its changed position, an agency must also be cognizant that longstanding policies may have ‘engendered serious reliance interests that must be taken into account”[35] (internal citations omitted).
In this case, there is over 40 years of policy and guidance from DOL that employers forming MEWAs have relied upon and the Proposed Rule, if adopted as written, could negatively impact how some of these MEWAs operate in the future.

In addition, as the DOL recognizes in its proposal, Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, *if* regulation is necessary, to select regulatory approaches that maximize net benefits. In this assessment, agencies should quantify both costs and benefits. In other words, in order to determine if a rulemaking is even necessary, an agency should assess and quantify the costs and benefits of the proposal. In this case, the DOL has, in its own characterization, provided a mostly qualitative assessment of this proposal's potential impacts, rather than quantifying the costs and benefits of the proposal, because the DOL does not currently have sufficient data to quantify the costs or benefits.

[32] 83 Fed. Reg. 614, 626.
[33] Executive Order 13813, October 12, 2017 (emphasis added).
[34] *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515-16 (2009).
[35] *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125–26 (2016), 579 U.S.

Just a few examples from the Preamble help demonstrate that the DOL itself appears unsure of the necessity or benefits of the Proposed Rule. For instance, in the Preamble to the Proposed Rule, the DOL opines that "AHPs *may* offer small businesses comparable coverage [to the coverage currently available] at lower prices," and that AHP's "*may, under favorable circumstances*" provide small businesses the same economies of scale from which larger businesses often benefit in the provision of health coverage to employees (emphasis added). But the DOL notes that "the net impact of this proposal on efficiency in this interface (and on associated social welfare) could be positive or negative." The DOL also says that "it *may* be advantageous to allow more small businesses to combine into large groups for purposes of obtaining or providing health insurance," and that "AHPs *might* offer small businesses some of the scale and efficiency advantages typically enjoyed by large employer plans" (emphasis added). And, the DOL asserts, "While the impacts of this Proposed Rule, and of AHPs themselves, are intended to be positive on net, the incidence, nature and magnitude of both positive and negative effects are uncertain." Further, the data that the DOL does rely upon to justify its policy choices, as the DOL recognizes, is often thin. For example, the DOL requests "comments and data that will allow the impacts of the rule to be quantified, and that will enable it to more fully assess the Proposed Rule's effects."[36]

This suggests that the DOL is uncertain whether a new rule is justified or necessary. It further suggests that rather than finalizing a new rule that reverses long-standing interpretations without sufficient evidence and data to support the policy change, the DOL should seek the necessary information and data to determine whether this change in policy is likely to have the salutary effects that the DOL hopes. By conducting its own modeling and allowing additional time so that relevant parties can submit their modeling of the potential impacts, the DOL would have the opportunity to gather sufficient information for determining whether the proposal – in its current form – is justified and worth the potential risks of significant disruption of the small group market.

In 2003, Mercer Risk, Finance & Insurance ("Mercer") published a study that refutes many of the claims the DOL makes in the Preamble.[37] In particular, Mercer found that proposed AHP legislation would increase the number of uninsured and segment the small group market based on health status. Further, premiums would increase for small employers overall, in particular for those in the traditional small group market. While AHP premiums could be less expensive, the study found that this would be a result of risk selection rather than administrative efficiencies. There are differences between the proposed legislation that prompted the 2003 study and today's Proposed Rule that should be noted. Most importantly, the report was conducted prior to the passage of the ACA, so issuers in the small group market were not required to use modified community rating, nor were they required to cover EHBs. Additionally, the proposed legislation included more stringent sponsorship requirements than are included in the Proposed Rule. Despite these differences, the results of the study illustrate the potential impacts of the Proposed Rule and point to the need for additional quantification.

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[36] 83Fed. Reg. 614, 627

[37] Fritchen, Beth; Bender, Karen; Mercer Risk, Finance & Insurance, "Impact of Association Health Plan Legislation on Premiums and Coverage for Small Employers." June 2003 available at: http://web.archive.org/web/20120403231739/http:/www.nsba.biz/docs/mercer_ahp_report.pdf.

Specific to the Proposed Rule, while it is early for interested parties to have completed modeling the impact of the changes, Oliver Wyman has completed an analysis of the impact on the District of Columbia’s (the District’s) individual and small group markets, specifically for those members covered under ACA plans. For the small group ACA market, Oliver Wyman estimates range from an increase in average claim costs of +0.2% to +25.8%, depending upon the assumptions that are employed. For the individual ACA market, Oliver Wyman estimates range from an increase of +1.1% to +10.9%.[38] While increases of this level are concerning, increases in others states will almost certainly be much higher because the District’s exchange include members of Congress and their staff who have no choice but to purchase their coverage through the District’s exchange.

Supporting these analyses, the American Academy of Actuaries and the actuarial firms Oliver Wyman and Milliman have all recently stated that relaxing standards for AHPs would result in fragmented risk pools and higher prices for firms with less healthy employees due to risk segmentation.

- **American Academy of Actuaries**: “Such a development would fragment the market as lower-cost groups and individuals would move to establish an AHP, and higher-cost groups and individuals would remain in traditional insurance plans. Such adverse selection would result in higher premiums in the non-AHP plans. Ultimately, higher-cost individuals and small groups would find it more difficult to obtain coverage.” [39]

- **Oliver Wyman**: “Pulling healthier groups into AHPs would leave less healthy groups behind in the ACA small group market. Since AHPs would not be required to pool their risk with the ACA market, either directly in setting premiums or through risk adjustment, this would require increased premium rates in the ACA market. The result could be a bifurcated market where healthier groups join AHPs and less healthy groups purchase ACA coverage, assuming there is at least one carrier that remains active in the ACA small group market. Similarly, if young, healthy working owners leave the individual ACA market for AHPs, the health of the remaining members in that market could deteriorate.”[40]

- **Milliman:** “If AHPs are allowed to operate under a different set of rules than the ACA small group market… a separate market will form with the potential advantages of risk selection. This favorable selection by AHPs will conversely mean negative selection for the ACA small group and result in upward pressure on ACA-compliant small group premium rates.”[41]

[38] Ryan Schultz, Oliver Wyman, Letter to Mila Kofman, DC Health Benefit Exchange Authority, February 21, 2018.
[39] American Academy of Actuaries. “Issue Brief, Association Health Plans” February 2017 available at http://www.actuary.org/files/publications/AssociationHealthPlans_021317.pdf
[40] Diana Welch, FSA, MAAA; Tammy Tomcyzk, FSA, MAAA; Beth Fritchen, FSA, MAAA; Shari Westerfield, FSA, MAAA; Oliver Wyman Health Transform Care, “Trump Administration Proposes Rule to Expand Association Health Plans”, January 17, 2018 available at http://health.oliverwyman.com/transform-care/2018/01/trump_administration.html?utm_source=ExactTarget&utm_medium=Email&utm_content=Trump-admin&utm_campaign=HLS-Newsletter
[41] Fritz Busch, FSA, MAAA; Erik Huth, FSA, MAAA; Nick Krienke, ASA, MAAA, JD; Jason Karcher, FSA, MAAA; Milliman White Paper, “Law and Executive Order, A look at how President Trump’s executive order on healthcare impacts the ACA’s small group and individual markets”, November 2017 available at http://us.milliman.com/uploadedFiles/insight/2017/law-and-order.pdf

Given that numerous respected experts believe that AHPs would result in higher prices for less healthy groups, the impact of the current proposal should be modeled and quantified before finalizing the rule to truly understand the overall impact on pricing for various small employers and the number of uninsured.

In addition, one of the justifications for the Proposed Rule is that the ACA has caused individual and small group insurance premiums to increase significantly. Specifically, the Proposed Rule says:

> “The ACA has caused individual and small group insurance premiums to increase significantly. In part as a result of this increase, health insurance available in the large group market is now typically less expensive, all else equal, than coverage in the small group or individual market.”

While we acknowledge that the price of health insurance (and health care services) is higher than anyone would like, the above statement does not appear to be accurate. For example, the Medical Expenditure Panel Survey (MEPS) for 2016 shows lower premiums for small groups (50 employees or less) as compared to groups with 50 or more employees (see Chart 4 below).[42]

Chart 4: Average Total Single Premium (in Dollars) per Enrolled Employee at Private-Sector Establishments that Offer Health Insurance by Firm Size and State: U.S., 2016

Total	Number of Employees						
	Less than 10	10-24	25-99	100-999	1000 or more	Less than 50	50 or more
6,101	6,340	6,100	5,786	6,084	6,174	6,070	6,108

In addition, the Kaiser Family Foundation 2016 Employer Survey shows an increasing gap between the average annual premiums for covered workers with family coverage by firm size from 1999 to 2016. Kaiser reported that small firms (3-199 workers) had an average family coverage premium of $17,546 compared to $18,395 for large firms (200 or more workers).[43]

Again, given the discrepancy between the justification in the Proposed Rule and available data, including data from HHS’s Agency for Healthcare Research and Quality, additional analysis is warranted before finalizing the Proposed Rule.

6. Treatment of Existing AHPs (Preamble)

Issue: <u>Transition Period/Grandfathering for Existing AHPs</u>

The Preamble explains that existing AHPs would be required to meet all the conditions in the Proposed Rule, including the HIPAA/ACA nondiscrimination rules prohibiting health status rating

[42] Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality. Table II. C.1 available at https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2016/tiic1.pdf
[43] Kaiser Family Foundation. 2016 Employer Health Benefits. p. 36 available at http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey. See exhibit 1.13.

on an employer by employer basis, to continue to be treated as the ERISA section 3(5) employer sponsor of a single ERISA plan.[44] DOL requests comments on whether additional provisions should be added to assist existing employer associations – including MEWAs that do not currently constitute AHPs – in making adjustments to their business structures, governing documents, or group health coverage to become AHPs under the Final Rule.

Recommendation:

The Final Rule should clarify that existing associations that are treated as employer sponsors of a single ERISA plan would be provided, at a minimum, a transition period to come into compliance with the new requirements. In addition, the DOL should allow AHPs in states with a high concentration of existing AHP enrollment to be grandfathered if compliance with the rule would cause significant disruption of existing small employer coverage based on the following criteria:

1) The AHP meets the Department's current standards to be considered an single, ERISA-covered group health plan at the association level, including that the association:
   - Was formed for a purpose other than to provide health insurance coverage to its members;
   - Has a commonality of interest (*i.e.*, members of the same industry or trade) beyond geography; and
   - Meets the Department's employer-member control standards.

2) The AHP must have been formed on or before, and must be offering health insurance coverage to its members on, the date of the issuance of the Proposed Rule (January 5, 2018).

3) The state in which the AHP is offered meets one of the following standards:
   - As of the date of issuance of the proposed rule, AHPs have consisted of no less than 30 percent of the small group market within such state; or
   - The Department of Insurance or applicable state department or agency with authority to regulate insurance within the state, certifies to the DOL that applying the rule to AHPs operating in the state as of January 5, 2018, would cause significant disruption to small employers purchasing coverage in the state.

Rationale:

Issuers have reasonably interpreted the HIPAA/ACA nondiscrimination rules to allow rating differences between employer members of an AHP based on health status/claim experience. Applying the HIPAA/ACA nondiscrimination rules at the association or plan level as proposed would disrupt the current market practices of some associations. In order to minimize disruption and ensure smooth implementation of the AHP regulation for existing associations, there should be an appropriate transition period. For example, the first plan year beginning 12 months after the regulation is effective.

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[44] 83 Fed. Reg. 614,622

If the DOL is considering allowing existing AHPs to be grandfathered into current requirements, we suggest a state-by-state approach. Some states have large, existing association markets. To avoid disruption of these thriving markets, we recommend that the DOL allow grandfathering for existing AHPs based on the criteria above.

7. Preserving State Authority to Regulate AHPs (Preamble)

Issue: State Oversight

Nothing in the Proposed Rule suggests that state law is otherwise preempted with respect to the proposed AHPs. However, this policy is not explicitly stated. In addition, the DOL asks for comments on the relevant merits of possible exemption approaches under ERISA section 514(b)(6)(B) relating to exempting self-insured MEWAs from state regulation.

Recommendation # 1:

The Final Rule should state clearly and unequivocally that state authority to regulate the policies issued to AHPs and MEWAs are preserved under the Rule.

Rationale:

States are in the best position to prevent harm and take enforcement action against fraudulent and abusive MEWAs.[45] There is nothing in the Proposed Rule that suggests that state law is otherwise preempted with respect to the proposed AHPs.[46] For more than 30 years, the DOL and the courts have interpreted ERISA to permit states to regulate the insurance policies issued to MEWAs, and also the MEWAs themselves. If the DOL were to change its position on this issue, it would need to engage in another round of notice-and-comment rulemaking.[47]

It is well settled that states can regulate the insurance policies sold to ERISA plans, including MEWAs. Thus, if states wish to impose additional standards on health insurance sold to bona fide AHPs, they are clearly free to do so. States could apply their own mandates to such coverage, or generally require the insurer to “look through” to the group size of participating employers, regardless of whether the coverage is “large group” for purposes of the PHSA’s market standards.

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[45] For a discussion on state and federal regulation of self-insured MEWAs see, Kofman, Mila; Libster, Jennifer, “Turbulent Past, Uncertain Future: Is It Time to Re-evaluate Regulation of Self-Insured Multiple Employer Arrangements?” Journal of Insurance Regulation, Spring 2005, Volume 23, No 3, pp 17-33. And Kofman, Mila; Lucia, Kevin; Eliza, Bengit; Pollitz, Karen, “Association Health Insurance: Is It Time to Regulate this Product?” Journal of Insurance Regulation, Fall 2005, Volume 24, Issue 1, pp 31-45.

[46] *See* 83 Fed. Reg. 614, 625: “The Proposed Rules would not alter existing ERISA statutory provisions governing MEWAs. The Proposed Rules also would not modify the States’ authority to regulate health insurance issuers or the insurance policies they sell to AHPs.”

[47] *See Environmental Integrity Project v. E.P.A.,* 425 F.3d 992, 996 (D.C. Cir. 2005) (“[A]n agency's Proposed Rule and its final rule may differ only insofar as the latter is a ‘logical outgrowth’ of the former”).

Section 514(a) of ERISA provides that any state law or regulation that “relates to” an employee benefit plan covered by ERISA is preempted. But ERISA’s insurance saving clause then “saves” from preemption any state laws that regulate insurance.[48] Under established Supreme Court precedent, laws that directly regulate insurers, rather than plans, constitute state laws regulating insurance that are saved from ERISA preemption under the “savings” clause.[49]

Indeed, this is the DOL’s established view in the context of MEWAs. In a 2011 Advisory Opinion, the DOL states that the MEWA preemption scheme “should not be confused with a state’s ability to apply its insurance laws directly to the insurer that issues insurance to a MEWA.”[50] Another advisory opinion in 2007 indicates that “even in the case of a fully insured MEWA, ERISA would not limit any state in which the MEWA’s insurance risk is resident or located or to be performed from enforcing state insurance law requirements directly against the insurance company, insurance service or insurance organization insuring the MEWA.”[51]

The deemer clause does not prevent this result. The deemer clause provides that neither an employee benefit plan nor a trust created pursuant to such a plan “shall be deemed to be an insurance company ... or to be engaged in the business of insurance ... for purposes of any law of any state purporting to regulate insurance companies [or] insurance contracts.”[52] Regulating what is otherwise characterized as health insurance coverage under *both* federal and state law sold to insured MEWAs would not trigger the deemer clause. Laws regulating health insurance policies sold to insured MEWAs do not turn a self-insured ERISA plan into an insured ERISA plan. They instead impose additional health insurance standards on the health insurance coverage purchased by associations. As such, for deemer clause purposes, state regulation of health insurance coverage is clearly distinguishable from state regulation of stop loss insurance issued to an *employer* that sponsors a self-insured plan.

In addition, state regulation of insurance policies sold to MEWAs is not generally preempted by the PHSA. The PHSA provides that state laws are not preempted unless the state law “prevents the application of a requirement of this part.”[53] Well-settled HHS guidance makes clear that state law “prevents the application” of the PHSA – and is therefore preempted – only if “the State law makes it impossible for a party to comply with [the PHSA].”[54] If a state law “simply permits but does not require an issuer to do something that is prohibited under [the PHSA], the state law would not be applicable. The issuer simply could not take advantage of the more generous state law provision.”[55]

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[48] ERISA § 514(b)(2).
[49] *See, e.g., Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (holding that a Massachusetts statute setting forth mandatory minimum health care benefits for inclusion in general insurance policies was “saved” from preemption, because “regulation regarding the substantive terms of insurance contracts falls squarely within the saving clause….”).
[50] *See, e.g.,* DOL Adv. Op. 2011-01A
[51] DOL Adv. Op. 2007-06A
[52] ERISA § 514(b)(2) (29 U.S.C. § 1144(b)(2))
[53] PHSA §§ 2724, 2762 (42 U.S.C. §§ 300gg-23, 300gg-62).
[54] HHS Insurance Standards Bulletin 00-03 (June 2000); HHS Insurance Standards Bulletin 00-04 (Aug. 2000); HHS Insurance Standards Bulletin 00-05 (Nov. 2000).
[55] HHS Insurance Standards Bulletin 00-03 (June 2000) available at: https://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_00_03_508.pdf.

A wide range of state laws are preserved because of states’ ability to regulate the insurance policies sold to MEWAs. This would include state “look-through” rules that apply state-level small group insurance rules to participating small employers provided they do not prevent the application of a PHSA requirement. It would also include state extraterritoriality laws that apply a state’s insurance law to any policy that covers residents in the state.

Given the long history of fraud, financial instability, and insolvency of AHPs, maintaining broad state authority to regulate these plans is essential. The Final Rule should not limit or create any ambiguities about state authority to regulate the insurance coverage sold to AHPs. It is critical that states be able to continue in their traditional role of regulating the business of insurance and protecting consumers and providers.

Recommendation # 2:

The Final Rule should state clearly and unequivocally that state authority to regulate self-insured AHPs is preserved under the Rule.

Rationale:

It is also well-settled that if an ERISA welfare plan is a MEWA, states may apply their insurance laws with respect to the plan to the extent provided in ERISA section 514(b)(6)(A) (29 U.S.C. 1144(b)(6)(A)). Indeed, the DOL and at least two courts of appeals have found that this section serves to provide an exception to the “deemer clause,” by permitting states to directly regulate MEWAs as insurance companies, subject to few limitations.[56] The DOL has taken the position that while ERISA section 514(b)(6)(A) imposes some limitations, “these limitations should have little, if any, practical effect on the ability of States to regulate MEWAs under their insurance laws.”[57]

Under ERISA section 514(b)(6), if the MEWA is self-insured, it may be subject to state insurance laws that are “not inconsistent with” Title I of ERISA. The DOL, in its MEWA guide and advisory opinions, has construed the phrase “inconsistent with” Title I of ERISA very narrowly, such that a law is only “inconsistent with” Title I of ERISA if it makes compliance with ERISA impossible. For example, a state insurance law that would require an ERISA-covered plan to violate ERISA’s fiduciary standards (such as making imprudent investments) would be inconsistent with the provisions of Title I.

On the other hand, the DOL takes the position that a state insurance law generally will not be deemed “inconsistent” with the provisions of Title I if it requires ERISA-covered plans that are MEWAs to meet more stringent standards of conduct, or to provide more or greater protection to plan participants and beneficiaries than required by ERISA.[58] The DOL has expressed the view that any state insurance law which sets standards requiring the maintenance of specified levels of reserves and specified levels of contributions will generally not be “inconsistent” with the

[56] *See* DOL MEWA Guide; *Atl. Healthcare Benefits Tr. v. Googins,* 2 F.3d 1 (2d Cir. 1993); *Fuller v. Norton*, 86 F.3d 1016, 1024 (10th Cir. 1996).
[57] *See* DOL MEWA Guide.
[58] *See* DOL MEWA Guide.

provisions of Title I. The DOL also has expressed the view that a state law regulating insurance which requires a license or certificate of authority or which subjects persons who fail to comply with such requirements to taxation, fines and other civil penalties, including injunctive relief, would not in and of itself be “inconsistent” with the provisions of Title I for purposes of Section 514(b)(6)(A)(ii).[59]

In addition, at least two courts of appeals have agreed that states can broadly regulate self-funded MEWAs as insurance companies. In *Atlanta Healthcare Benefits Trust v. Googins,* the Second Circuit held that Connecticut could regulate self-funded MEWAs as insurance companies to the extent “not inconsistent with” ERISA, and ruled that Connecticut’s laws requiring licensing and registration of MEWAs were not “inconsistent with” ERISA.[60] The Tenth Circuit reached a similar conclusion, and quoted the DOL’s Advisory Opinion 90-18A as support for its conclusion.[61]

As a result, states can still broadly regulate self-insured AHPs (to the extent not inconsistent with Title I of ERISA). This could include prohibiting the sale or offering of self-funded AHPs in the state, or only permitting self-funded AHPs to be sold or offered in the state if they meet some or all of the requirements applicable to carriers.

Recommendation # 3:

The DOL should not use its authority under ERISA section 514(b)(6)(B) to exempt certain individual or classes of self-insured MEWAs that otherwise constitute a single ERISA plan from the special rules authorizing state regulation.

Rationale:

A class exemption from state oversight for self-funded MEWAs would erode the primary mechanisms of enforcement and consumer protection currently in place at the state level and pose a significant risk of harm to potentially millions of American consumers. Congress recognized that in order to protect consumers, state oversight of MEWAs was critical and in 1983, amended ERISA to affirm states’ authority to regulate these types of arrangements. This was a direct response to widespread fraud and insolvency of MEWAs.[62] States currently have broad regulatory authority and oversight of MEWAs, including activities related to licensing and registration, financial solvency, state-mandated benefits, rate and form approval, and market conduct and financial examinations. These regulatory and enforcement tools limit the potential risk of insolvency and ensure that operators in the state serve the interests of consumers.

The DOL does not have the resources to address MEWA fraud and abuse or directly regulate what are effectively insurance companies forming under ERISA. If the DOL took on this

[59] *See* DOL Adv. Op. 90-18A.
[60] 2 F.3d 1 (2d Cir. 1993).
[61] *See Fuller v. Norton*, 86 F.3d 1016 (10th Cir. 1996) (Colorado law requiring licensing of MEWAs was not “inconsistent with” ERISA).
[62] To further prevent MEWA abuses, the ACA expanded reporting and registration requirements for MEWAs, imposed criminal penalties on fraudulent marketing (ERISA §§ 501(b) and 519), and gave the Secretary authority to issue cease and desist orders against MEWAs (ERISA § 521).

authority, it would require an entirely new framework for regulating the solvency and market conduct of these arrangements that, in our opinion, the DOL would be unprepared and ill-equipped to implement effectively. Exemption from state regulation for self-funded MEWAs could undermine the insurance market and recreate the potential for fraud and insolvencies that the DOL and the states have recognized as pervasive and worked hard to address over the last three decades.

Further, if the DOL chooses to use its authority to exempt self-insured MEWAs from state regulation, a new Proposed Rule would be required. The DOL would need to provide specifics on a class certification process, with more stringent requirements than currently exist under ERISA, in order to protect consumers and allow ample time for public comment.

8. Benefit Requirements

Issue: <u>Floor for Benefits Coverage</u>

Applicable large employers (ALEs) are required to offer coverage that is affordable and meets the minimum value (MV) standard of 60 percent in order to avoid penalties under the employer shared responsibility provision of the ACA. However, small employers who are not ALEs are not subject to these penalties. As a result, there would be only minimal federal benefit requirements for coverage offered to small employers through an AHP (i.e., no lifetime or annual limits, preventive care, maximum out-of-pocket limit) which has the potential to result in adverse selection between the AHP and ACA risk pools and abuse by illegitimate associations.

Recommendation:

BCBSA recommends that AHPs be required to offer plans that provide minimum value, as defined in 45 CFR §156.145, Determination of minimum value.

Rationale:

As mentioned previously, BCBSA is concerned with the impact of expanding the ability of AHPs to provide insurance under different rules for enrollees who would otherwise be covered in the small group and individual markets as this would result in adverse selection between the AHP and ACA risk pools. Under the Proposed Rule, AHPs with more than 50 total employees generally would not be subject to the essential health benefit (EHB) requirements, and small employers purchasing AHP coverage would not be subject to the employer responsibility provision penalties. This leaves AHP coverage issued to small groups in a regulatory void, with minimal requirements for benefits. We recognize that DOL may find the elimination of EHB requirements desirable; however, having virtually no benefit requirements, especially when coupled with the relaxation of sponsorship requirements, raises the potential for abuse and selection against the traditional insurance market.

A minimum value requirement would place a floor on the allowed benefit designs for AHPs while providing the same flexibility that is provided to large employers. When evaluating MV, a large

employer is not required to cover all categories of benefits, but the value of the benefits that are included in the employer’s plan is measured against the cost of providing all categories of benefits on a standard population. To meet the MV standard, a plan must provide benefits and cost-sharing such that it covers 60 percent of expected costs of all categories of benefits. In addition, to meet MV, the plan must include substantial coverage of inpatient hospital and physician services. If DOL prefers to provide a lower standard of coverage for AHPs, AHPs could be required to provide plans with an MV of at least 50 percent; however, in no case should there be no benefit standard for AHPs. Doing so would open the potential for abuse by illegitimate associations and could leave employees facing massive medical bills for services they thought would be covered.

9. Enrollment Opportunities

Issue: <u>Eligibility Requirements</u>

No restrictions are included in the Proposed Rule as to when small employers and working owners may obtain insurance from an AHP.

Recommendation:

The Final Rule should include a requirement that each AHP establish an annual open enrollment period and only allow small businesses and working owners to enroll in coverage during that time. Alternatively, the Final Rule could state that insurers are allowed to require an AHP to limit enrollment to certain periods, including an annual open enrollment period.

Rationale:

Just as large employers set limitations on when employees can enroll in their employer-sponsored health coverage programs, AHPs should be required to do the same. The AHP and ACA markets, as discussed above, are likely to have significantly different rates and benefit options under the DOL’s proposal. Without limitations on when a small business or sole proprietor may enroll in coverage via an AHP, significant churn could result. This is particularly worrisome for working owners, who might move in and out of the AHP market depending on their healthcare needs at the time if they are not restricted to purchasing coverage during an annual open enrollment period. Issuers will be developing rates for their AHP business on an annual cycle. If small businesses and working owners can come and go from the AHP as they please, the task of predicting costs and setting accurate rates for AHP business will be complicated.

10. Effective Date

Issue: <u>Effective Date is Unclear</u>

The Proposed Rule is silent on when the Final Rule would be effective.

Recommendation:

BCBSA recommends that the Final Rule be effective on January 1st of the first full calendar year to fall at least 12 months from the date of publication of the Final Rule.

Rationale:

Given the magnitude of the proposed changes, at least 12 months lead time is necessary to ensure proper implementation of the new AHP requirements. Following the issuance of the Final Rule, the DOL will need to update and develop new guidance. Issuers will need adequate time to digest and appropriately implement the guidance as well as develop rates for both the individual and small group markets, taking into consideration changes to the ACA risk pool as a result of the Final Rule. Additionally, some states will likely choose to pass legislation and/or promulgate rules to ensure adequate oversight of these new AHP products.

Additionally, should the DOL proceed with the proposal that working owners are eligible to purchase AHP coverage, the DOL should consider that the policy year for individual market products coincides with the calendar year. This means that premiums which will be filed in the spring of 2018 will be in effect the entire year of 2019 and any changes to the number of working owners who purchase coverage in the individual market will have a significant impact on the adequacy of these rates.