KAISER PERMANENTE®

March 6, 2018

Employee Benefits Security Administration
U.S. Department of Labor
Room N-5655
200 Constitution Ave., NW
Washington, D.C. 20210

Submitted electronically via http://www.regulations.gov

Re: *Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans*

To Whom It May Concern:

Kaiser Permanente appreciates the opportunity to provide comments to the Department of Labor ("DOL") Notice of Proposed Rulemaking, *Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans* (the "NPRM")[1]. Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to nearly 12 million members in eight states and the District of Columbia.[2]

Kaiser Permanente expresses significant concern regarding the approach taken in the NPRM. We are generally concerned that promoting markets parallel to those regulated by the Patient Protection and Affordable Care Act of 2010 ("ACA") – reflected in the NPRM and the recent Internal Revenue Service Notice of Proposed Rulemaking, *Short-Term, Limited-Duration Insurance*, 83 Fed. Reg. 7437 (Feb. 21, 2018) – materially undermines the protections, affordability, comprehensive coverage, transparency and stability of regulated markets upon which consumers have come to rely.

We believe that DOL can better advance the goal of enhancing consumer choice by amending the NPRM in the following ways:

- **Clarifying that the NPRM does not displace traditional state regulatory authority.** DOL should clearly state in its final rule that it does not intend to pre-empt state authority over AHP offerings, including fraud, abuse, benefits and coverage disclosures and solvency regulation. We are concerned that the NPRM fails to provide meaningful guidance to

[1] *Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans*, 83 Fed. Reg. 614 (Jan. 5, 2018).

[2] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, independent physician group practices that contract with Kaiser Foundation Health Plan, or one of its health plan subsidiaries, to meet the health needs of Kaiser Permanente's members.

stakeholders regarding when states – versus DOL – retain the final word on regulation of AHPs. State regulators understand their markets and are in the best position to protect state residents from fraudulent behavior by unscrupulous actors.

- **Limiting commonality of interest to lines of industry.** We believe that the role of AHPs most closely aligns with the concept of similarly situated employers banding together to obtain health coverage. Employers within the same professional community are more likely to face similar challenges in the provision of health coverage to employees, and therefore identify coverage that comprehensively meets employee needs unique to an industry. We do not view that interest as extending to otherwise unrelated employers who simply operate in physical proximity.

- **Maintaining existing *bona fide* purpose requirements for association formation.** Kaiser Permanente views DOL's traditional *bona fide* purpose prerequisite to association formation as an important safeguard against the risks of fraud and insolvency that have arisen with past efforts to expand AHP coverage. In our view, permitting associations to form without any preexisting, legitimate purpose – for the sole purpose of obtaining low-cost (and relatively non-comprehensive) coverage exposes consumers to the risk of much-needed care being uncovered or forgone entirely. Demonstrating a preexisting, *bona fide* basis for association apart from provision of health coverage is critical to averting use of AHPs as possible vehicles of fraud or illusory coverage in the commercial insurance markets. Our experience in markets with previously widespread AHP availability can easily result in higher costs for consumers due to fraudulent business practices.

- **Excluding "working owners" and certain classes of former employees from eligibility for AHP coverage**. DOL's proposed abandonment of its traditional interpretation of "employer" as reflecting a common law employment relationship, means sole proprietors would be eligible to band together for purposes of obtaining AHP coverage. The NPRM also does not contain adequate limitations on the ability of former employees to obtain coverage through such arrangements. Nor does the NPRM contain any meaningful attestation as a prerequisite to eligibility. In each case, the impact on the risk composition of the regulated individual and small group markets will be deleterious. We urge DOL to consider maintaining its current interpretation – upon which issuers opting to participate in the regulated individual and small group markets have long relied – to maintain the viability of those risk pools.

  Recent data – and our own experience in markets where AHP coverage proliferated – does not support DOL's conclusion that "AHPs may also help contain costs by creating a stable risk pool that may enable AHPs to self-insure rather than purchase insurance from commercial issuers." A recent Avalere analysis concluded that the NPRM, if adopted, would have the opposite effect on the regulated markets and the consumers remaining there. Avalere found that individual market premiums could rise up to 4 percent with small group rates increasing up to 2 percent; the expected shift of healthier enrollees from regulated markets would increase risk scores in the regulated markets – and cause nearly 140,000

Americans to lose coverage before 2022.[3] In our own experience, states such as Washington experienced similar market degradation with widespread AHP availability.

- **Applying regulated market non-discrimination rules to AHPs.** Kaiser Permanente supports the comments of America's Health Insurance Plans ("AHIP") that additional non-discrimination provisions need to be delineated in the final rule. Both the member employers and the association should be subject to non-discrimination rules. By creating a parallel market with little oversight, we believe that much of the proposed rule sets the stage for pretextual discrimination.

Below are Kaiser Permanente's specific recommendations for changes to the NPRM:

Establishing Associations for Sole Purpose of Obtaining Health Coverage

DOL has proposed a series of regulatory changes that would expand the circumstances under which employers could establish AHPs. The most notable change is allowing AHPs to be organized for the sole purpose of offering health insurance to members that share commonality of professional or geographic interest, even across state lines. Under the NPRM, DOL would expand eligibility while largely retaining its existing regulatory approach to governance and functional member control of AHPs. While DOL notes that the NPRM "could greatly increase association coverage options available to American workers," we do not believe the analysis ends with choice alone.

Recommendation: Kaiser Permanente urges DOL to retain its current approach to defining commonality of professional interest. The NPRM does not provide extensive description of DOL's thinking regarding what constitutes sufficiently similar lines of trade or industry.

Recommendation: We urge DOL to impose more robust verification mechanisms for association membership. Proof of solvency or a durational minimum of incorporation are two approaches that help ensure AHPs possess the necessary organizational reliability to pay claims within the scope of covered services.

Recommendation: We urge DOL to impose more robust governance restrictions on AHPs. If DOL expands eligibility and formation flexibilities, it must consider whether revising requirements that AHPs act "in the interest of" their membership is necessary. Stronger minimum membership or functional control/governance disclosure requirements would be an appropriate approach that does not impose significant, additional regulatory burden on AHPs. We urge DOL to consult with state regulators on the appropriate scope of new federal AHP governance requirements.

Recommendation: We urge DOL to impose individual market-like limitations on AHP formation and employer enrollment periods for AHPs. Such restrictions could mitigate concerns that members could use the AHP framework as a vehicle for gaming.

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[3] *Association Health Plans: Projecting the Impact of the Proposed Rule*, Avalere, http://go.avalere.com/acton/attachment/12909/f-052f/1/-/-/-/-/Association%20Health%20Plans%20White%20Paper.pdf (Feb. 28, 2018).

Limiting Coverage to Employer Members, Working Owners and Employees

DOL proposes to include additional classes of persons within those eligible to form AHPs; specifically, "working owners". Under DOL's proposal, sole proprietors could become eligible for membership after satisfying 30 hours of personal services to the trade or business per week or 120 hours of service per month or earned income from such trade or business that equals the cost of coverage under the plan and a lack of eligibility for other group insurance. Performers of *de minimis* commercial activities would remain ineligible as a check against fraud and abuse.

Recommendation: Kaiser Permanente supports AHIP's comments that the statutory definition of "employer" should not be altered to include "working owners" who lack employees. In addition, we oppose allowing former employees and extended family members of employers to be eligible to participate in an AHP. We urge DOL to study alternatives that make the existing regulated market more attractive to sole proprietors. For example, we have urged the executive and legislative branches alike to identify ways to make the small business tax credit used in the SHOP program more attractive to small business owners.

Health Nondiscrimination Protections

DOL has proposed to deviate from previous approaches in determining when large versus small group rules would apply to AHPs. Previously, DOL would apply small group rules if the AHP comprised members each meeting the small group definition in a particular state. Under the NPRM, if the AHP *entity* meets a state's definition for large group status, large group rules apply. The NPRM remains otherwise vague on applicability of certain ACA market rules to AHPs.

Recommendation: We urge DOL to clarify in the final rule that ACA nondiscrimination market rules apply to AHPs regardless of group size classification. Among the rules most critical for ensuring both market stability and consumer protections are:

- Prohibition of discrimination based on health status;
- Guaranteed availability;
- Guaranteed renewability;
- Prohibition of retroactive rescission of coverage;
- Maximum waiting period limit;
- Dependent coverage to age 26;
- Prohibition on pre-existing condition exclusions;
- Prohibition on lifetime and annual limits for any covered essential health benefits coverage; and
- Internal appeals process.

With respect to age rating, we recommend DOL pursue policies that, to the extent possible, retain the regulated markets' age bands to prevent adverse selection. Regarding guaranteed issue, we urge DOL to take steps to provide a more stable risk pool by requiring AHPs to abide by the same rules as regulated markets to prevent gaming; e.g., introduction or exclusion of certain

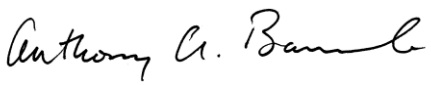
professional classes at time of enrollment (or potentially even mid-year) based upon unexpectedly high claims submitted by association members.

By including these clarifications, DOL would remove significant ambiguity that could result in a complicated, two-tiered nondiscrimination enforcement mechanism under which consumers receive entirely different levels of coverage protections based upon opaque association design mechanisms. We do not believe consumers would benefit from such ambiguity, and believe it promotes additional disruption to the risk pool.

Recommendation: We urge DOL to clarify that AHP coverage lacking access to Essential Health Benefits ("EHBs") does not qualify as Minimum Essential Coverage. Maintaining EHB requirements in AHP coverage helps better protect the right of consumers to obtain comprehensive benefits packages, and ensures that AHPs do not offer lower cost coverage with the inappropriate trade-off of uncovered maternity and behavioral health services. We note that the present opioid crisis generates the need for immediate and downstream treatment to which Americans deserve predictable, affordable access.

We appreciate the opportunity to comment on the NPRM. If you have questions or concerns, please contact Christopher Kriva at (510) 267-7619, Christopher.Kriva@kp.org, or me by phone at (510) 271-6835, or Anthony.Barrueta@kp.org.

Sincerely,



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