Office of Regulations and Interpretations, Employee Benefits Security Administration, Room N-5655, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210, Attention: Definition of Employer – Small Business Health Plans RIN 1210-AB85.

To whom it may concern:

I am submitting comments on the Notice of Proposed Rule-Making published January 4, 2018 that would expand Association Health Plans (AHPs) under ERISA based on my several decades of work as a consultant to state health policy makers and insurance regulators on issues of access to health care and insurance coverage. I have grave concerns about the legal and policy wisdom of this proposed federal regulation, specifically about how it is likely to undermine the stability of state individual and small group insurance markets, potentially limit access to socially important health care services and consumer protections, and open up more opportunities for fraud and mismanagement by AHPs. The proposal also raises questions about the authority of state insurance regulators to continue their important consumer protection responsibilities. And an overarching concern is how little the NPRM includes information about the many legal and policy issues it raises, information that is available from the Department of Labor's own records and the health policy research on prior experience with various types of Multiple Employer Welfare Arrangements.

As noted below, I support the Freedom of Information Act request by the Georgetown University Center on Health Insurance Reforms (CHIR) and also urge the Department to hold a public hearing to collect additional information in developing the regulation.

I. Undermining Insurance Market Stability

Several provisions of the proposal will seriously jeopardize states' small group and individual insurance markets. First, allowing sole proprietors with no employees to be classified as 'employers' under ERISA who could join an AHP (which may not even be authorized under ERISA, as noted by other commenters) creates the incentive for risk selection by these individuals. And permitting individuals to self-certify their work status exacerbates the opportunity for fraudulent AHP enrollment.

Furthermore, allowing AHPs to operate under different market rules than state individual and small group markets creates instability.[1] An AHP offering coverage less expensive than that in a state's individual market (which will result primarily from benefit design that limits or eliminates essential health benefits or imposes higher cost sharing on selected benefits, as the NPRM acknowledges) encourages healthier individuals and small firms with healthier employees to exit the state's individual market while leaving sole proprietors and small employers with employees needing more comprehensive coverage in the individual risk pool, destabilizing that market, potentially leading to the notorious insurance 'death spiral.' The concentration of medical expenses in a tiny fraction of the population provides especially strong Incentives for AHPs to attract the best risks (healthiest enrollees).[2] And, as discussed below, despite the proposal's nondiscrimination provisions, AHPs will have many opportunities to set AHP membership criteria and craft health coverage to discourage higher risk enrollees and attract those with lower health risks, for example, by carefully drawing geographic

[1] Wicks, Elliot K and Hall, Mark A. "Purchasing Cooperatives for Small Employers: Performance and Prospects." *The Milbank* Quarterly 78(4) (2000); Hall, Mark A., Wicks, Elliot K., and Lawlor, Janice S. "HealthMarts, HIPCs, MEWAs, and AHPs: A Guide for the Perplexed." *Health Affairs* 20:1 (2001).

[2] Miller, Tom. "The Concentration and Persistence of Health Care Spending." *Regulation* 40(4) (2017).

boundaries or targeting certain industries or professions to the exclusion of others and by setting premiums based on gender, age, and/or group size, as the proposed rule would permit. As pseudo 'large employer groups,' AHPs would not be subject to single risk pool requirements or participate in risk sharing arrangements to which insurance issuers are subject under the Affordable Care Act (ACA) (and many state insurance laws), designed to minimize uneven risk selection in the small group and individual markets. If AHPs proliferate, sole proprietors and small firms can exacerbate risk selection by moving in and out of various associations as premiums fluctuate, consistently destabilizing these markets. [3] A notable example of the problem of regulating AHPs differently from individual and small group markets was the failure of regulated insurance markets in Kentucky due to several factors, including state exemption of AHPs from community rating and other reforms.[4]

And while the proposal prohibits AHPs from discriminating in enrollment on the basis of health factors, in a small firm where most employees are healthy and seek lower premiums with less coverage, the employer has an incentive to move less healthy employees needing more care into the individual market. If the AHP plan doesn't meet minimum-value standards (i.e., as required by the ACA), employees are eligible for subsidized coverage in the individual market, which gives employees offered such a plan a choice between a very cheap, employer-subsidized plan or a comprehensive government-subsidized plan that is more attractive if they know their health care costs in the coming year are likely to exceed the premium savings. A midyear renewal date can increase the opportunity to game the system. This intensifies the risk segmentation, making coverage even cheaper within the AHP and more expensive in the regulated markets.

Allowing AHPs whose entire purpose is only to offer health insurance is also ill-advised because it creates additional incentives for risk-segmentation. Although the proposed rule would nominally require employers to manage an AHP's operations, given the limited time and nonexistent expertise in health coverage on the part of small firm principals, these employer members are unlikely to actively oversee AHP operations. So rather than 'bona fide' employer organizations (the long-standing standard), AHPs are likely to be managed in fact by third parties with potentially self-interested if not malicious, motives, as discussed below. The only way to avoid these inevitable market disruptions is for the regulation to require that AHPs cover all ACA essential benefits and meet guaranteed issue, risk adjustment, and minimum actuarial value standards, and that insurers include these plans in their single risk pools, in other words, consumer protections that exist in the individual market.

The request for comments asks whether nondiscrimination standards "would create an involuntary cross-subsidization across firms that would discourage formation and use of AHPs." The expression "involuntary cross-subsidization" is simply a disparaging term for what is commonly known as "modified community rating," which is another name for risk pooling, the essence of insurance. People without significant losses pay premiums that are intended to be used to pay other people's claims (plus expenses and expected profit for the entity that takes on the risk and pays the claims). And even if cross-subsidization is defined more narrowly as charging some insureds more than their actuarial cost so that others can be charged less, it still occurs in voluntary insurance markets for various reasons, including the impossibility and inefficiency of perfect underwriting and the value of renewability of benefits.

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[3] Kofman, Mila and Polzer, Karl. *What Would Association Health Plans Mean for California: Full Report.* California HealthCare Foundation. Oakland, CA (2004).

[4] Nichols, George.. *Health Insurance Reform in the 1990s: A Kentucky Perspective.* Kentucky Department of Insurance (1999). Kirk, Adele. "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts." *Journal of Health Policy, Politics, and Law* 25:1 (2000).

State and federal community rating laws correct for a variety of market failures and make available a product that most Americans have demonstrated, both at the ballot box and in the marketplace, that they want – insurance that provides comprehensive benefits, with affordable cost sharing, that is renewable even after one is ill, with limits on the rate that costs increase with age, and the ability to keep these protections in place due to job changes. As a matter of fundamental fairness and sound public policy, community rating goes beyond replicating what an ideal voluntary market would be able to provide: it affords protection to people with congenital health risks who would have been uninsurable at any age in a fully voluntary market. Community rating is now the established law of the land, and the only serious debates in Congress last year were over whether to make changes at the margins, such as the permissible degree of age variation, not whether to abolish it entirely.

Thus, even though nondiscrimination standards might be branded as "involuntary cross-subsidization," it is entirely appropriate for AHPs to be subject to nondiscrimination standards that are equivalent to the standards applicable to all other health plans sold to small employers and self-employed individuals. DOL does not have the power to enact by regulation a measure that is more extreme than anything Congress recently considered, debated, and rejected.

II. Limiting access to socially important health care services

The NPRM asserts that employers should be able to purchase health coverage benefits that they desire. But the essence of any insurance is to pool risks. Because individual consumers know more about their personal health status and risk than any insurer or other third party, allowing choice to purchase health coverage without basic benefits standards entirely undermines the ability of a health plan to pool risks. By aggregating small employers into an AHP and thereby avoiding the small group and individual essential health benefits requirements in the ACA, this proposal creates incentives for employers and sole proprietors to avoid purchasing services they believe they might not need and undercuts the objective of the ACA to pool risk broadly and to assure that Americans have access to socially valuable health care services. An unfortunately timely and obvious example is the importance of substance abuse and mental health services, which are particularly necessary to address the current opioid epidemic. These and other services such as prescription drugs, rehabilitation services, maternity care, and an array of preventive care services may not be what a particular small employer or sole proprietor would choose to buy for himself or herself. But they are mandatory under the ACA precisely because they are appropriate and necessary for some. And everyone in these insurance markets should share in their cost. The proposed regulation will not result in "high quality coverage," as the NPRM alleges.

The NPRM hypothesizes that aggregations of small firms will act like large firms that generally offer comprehensive benefits. But this assumption misconstrues the differences in health coverage decision-making by large and small employers: large employers offer health plans that cover the broad range of services to meet the overall and varying needs of their large number of employees. Small firms are able to pick coverage tailored to the potentially idiosyncratic needs of a small number of workers.

III. Potential for Fraud and Financial Mismanagement

The NPRM acknowledges that over many years some MEWAs (particularly those purporting to self-insure health coverage) have been vehicles for financial mismanagement and sometimes fraud, leaving consumers with millions of dollars in unpaid medical claims. The NPRM cites as references only two very old GAO reports, while recent evidence in the Department's own records illustrates the continuing

problem of these mismanaged arrangements.[5] And other legal and policy research has described these problems with MEWAs in the past.[6]

While even legitimate trade associations have become insolvent due to mismanagement and limited insurance expertise of their self-insured health plans,[7] allowing AHPs to exist solely for the purpose of offering health insurance is an invitation to the creation of risky entities and Ponzi schemes, which nominal participation in and control by small employers are unlikely to prevent. And while (as of 2005) just over half of state laws require self-insured AHPs and other MEWAs to meet all insurance licensing standards, others impose lower solvency requirements and generally do not include AHPs in guaranty funds that protect enrollees' claims in the case of insolvency.[8] Federal regulations to encourage AHP formation should include adequate financial surplus, reserves and stop loss requirements to guard against insolvency.

It is very likely that these financial shenanigans will blossom again with the new crop of AHPs encouraged by the proposed rule. As small group coverage and individual coverage become more expensive, the temptation to succumb to fraud is greater. DOL MEWA enforcement declined after 2013 precisely because the ACA provided affordable coverage to small groups and especially individuals. Small employers could leave their employees to the individual market without serious concern for their welfare.

As discussed below, state insurance regulators have actively pursued this fraud and mismanagement and must remain fully authorized to continue in partnership with the Department of Labor. A 2004 study of state MEWA enforcement reported that to avoid the many potential AHP financial problems one state assigned a full FTE for each of its licensed AHPs.[9]

The Department should not only include all previous research about MEWA/AHP regulation in its NPRM but should have surveyed state insurance regulators for recent enforcement practices and experience. Furthermore the Department must include in its analysis the costs of predictable increased enforcement at both the state and federal levels. It must, for example, estimate the need for many more federal agency staff to respond to the likely increase in consumer complaints and AHP financial disasters, information that is entirely missing from the proposal, as well as the costs likely to be incurred by employers, employees, and health care providers when AHPs fail to pay claims. A 2005 Congressional Budget Office analysis of a bill to authorize AHPs reported that the Department of Labor would need to hire well over 100 new employees and spend more than $100 million over ten years to monitor AHPs and take action when they failed. The administration's FY 2019 budget proposes only 15 additional FTE for small group health plan policy, oversight, and enforcement activities, far below a level needed to meet these growing responsibilities.

In the ACA, Congress gave DOL additional tools to address fraud and abuse related to AHPs by adding new sections 520 and 521 to Title I of ERISA, which gives DOL a much needed oversight and enforcement tool. DOL has been authorized to act under these provisions since 2010, but to date it has

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[5] U.S. Department of Labor, Employee Benefits Security Administration. *Fact Sheet: MEWA Enforcement.* March 2013.

[6] Kofman, Mila and Libster, Jennifer. "Turbulent Past, Uncertain Future: Is it Time to Re-evaluate Regulation of Self-Insured Multiple Employer Arrangements?" *Journal of Insurance Regulation* 23(5) (2005).

[7] Kofman and Libster, note 6.

[8] Kofman and Libster, note 6.

[9] Kofman and Lipster, note 6.

not issued regulations to implement section 520. A DOL Office of Inspector General Report from September 30, 2011[10] noted EBSA's failure to implement this provision which "authorizes the Department to determine standards, or issue orders, regarding when persons providing insurance through MEWAs are subject to State law as a means to prevent fraud and abuse." EBSA noted in its response to the Inspector General's report that it would move forward with issuing regulation and implementing this provision. I urge DOL to begin the rulemaking process and to implement this critical authority under section 520 prior to moving forward with any proposal that would result in the proliferation of AHPs.

IV. Impact on State Authority to Regulate MEWAs

States have more than a century's history of regulating insurance, authority specifically sanctioned by Congress in the McCarran-Ferguson Act of 1946. Regulating health insurance includes an array of standards such as setting premium rates, financial reserves to assure that medical claims can be paid, guaranty funds in the case of insolvency, benefits mandates, and grievance resolution procedures at both the insurer and state agency levels. In its 1982 Erlenborn amendments to address financial problems with MEWAs, Congress explicitly allowed states to regulate insured MEWAs regarding financial solvency but more broadly to regulate self-insured MEWAs under state law in all respects not inconsistent with ERISA, unless the Secretary of Labor exempts MEWAs from state oversight.

The proposed regulation complicates state authority when an AHP operates in more than one state. A final regulation must indicate explicitly that small employer AHPs, including, the ones covering people in more than one state, must comply with all state laws in states in which they operate and continue to be subject to state oversight and regulation.

In response to the Department's request for information on the issue of whether to grant exemptions to self-insured MEWAs, I urge you not to remove states from their important role protecting consumers. Besides solvency oversight, states have adopted consumer protection standards that can be applied to self-insured MEWAs, for example requiring health insurers and managed care plans to process consumer complaints (including independent medical review where health plans refuse to cover a medical service), assure adequacy of provider networks, and provide sufficient information for consumers to use their care and coverage appropriately. Furthermore, state insurance regulatory agencies themselves play a vital role in accepting and resolving complaints from individual consumers – and states have a much greater capacity to do so than the Department's national and regional offices. [11]

The Department of Labor has a poor track record in MEWA oversight. It does not routinely review Form M-1 filings or follow up when those are incomplete or suggest potentially suspicious behavior. And unlike state insurance regulators' authority to conduct ongoing market conduct review, the DOL typically initiates enforcement action only when a health plan is failing to pay claims.

As noted above, if the U.S. Department of Labor is expected to increase its capacity to oversee and prosecute AHP mismanagement and fraud, these costs must be identified in the NPRM and included in the administration's budgets. But even an expanded DOL capacity to oversee AHPs will never match

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[10] "Further Action by EBSA Could Help Ensure PPAC Implementation and Compliance," Department of Labor ,Office of Inspector General - Office of Audit, September 30 , 2011. https://www.oig.dol.gov/public/reports/oa/2011/09-11-003-12-121.pdf

[11] Butler, Patricia A. and Polzer, Karl. *Regulation of ERISA Plans: The Interplay of ERISA and California Law.* ISBN 1-932064-04-4. California Health Care Foundation. Oakland, CA. (2002)

states' enforcement resources. It is therefore imperative that states retain the full authority to oversee AHPs authorized by ERISA and continue to coordinate with DOL enforcement staff.

In its request for information, DOL has raised the possibility of acting under Section 514(b)(6)(B) to exempt a class of AHPs or an individual AHP that is an employee welfare benefit plan from state insurance regulation. As noted above, I strongly oppose any proposal that would limit states' ability to regulate AHPs. If DOL is considering proposed rulemaking under section 514(b)(6)(B), it should first fully implement Section 520 of ERISA. If DOL is going to exempt AHPs from state oversight, it is essential that DOL not apply any such exemption with respect to fraud and abuse - a remedy Congress expressly created. DOL should promulgate a proposed rule for section 520 for public comment and ensure that section 520 is fully implemented prior to exercising its authority under section 514(b)(6)(B) to exempt as a class or individually AHPs from state oversight.

Conclusion

The NPRM's nondiscrimination standards provide important safeguards to minimize the opportunity for AHPs to sell health coverage explicitly only to healthy individuals. But while necessary, those provisions are entirely insufficient to avert the serious risks to the stability of individual and small group insurance markets. The proposed rule would send state individual insurance markets back to days before state health insurance reforms of the 1990s, entirely inconsistent with the objective of the ACA to stabilize these markets.

The NPRM provides no evidence for many of its premises and conclusions, information about which is necessary for commenters to respond to the proposal. For example, it baldly asserts that AHPs can lower health coverage premiums for small firms. Reducing coverage of socially important benefits might lower premiums, albeit at a significant social cost. But research on the ability of AHPs and other employer purchasing group arrangements like MEWAs to reduce overhead or achieve administrative economies of scale does not support that optimism. [12] Evidence from past experience with these employer purchasing groups also suggests little likelihood of obtaining significant discounts from medical care providers.[13] The Department's own records contain a great deal of information on experience with MEWA performance and mismanagement and this information should have been included in the NPRM. I support the Freedom of Information Act request by CHIR. Until this information is available to the public to allow more informed comments on the proposed regulation's impacts, this rule-making should not go forward. I also urge DOL to hold a public hearing as part of its collection of information about the proposed rule. Such hearings have traditionally been granted when requested.

Respectfully submitted,

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[12] Wicks and Hall and Hall, Wicks and Lawlor, cited in footnote 1.
[13] Letter from Karen Bender, American Academy of Actuaries, to Virginia Foxx, Chair, House Committee on Education and the Workforce, U.S. House of Representatives. March 8, 2017.