WAKE FOREST
UNIVERSITY
SCHOOL of LAW

February ___, 2018

Department of Labor
Employee Benefits Security Administration
Office of Regulations and Interpretations

Re: RIN 1210-AB85 -- Association Health Plans

The Health Law and Policy Program as Wake Forest University is devoted to independent scholarship that informs and improves health care public policy. I write as the Program's founding director, and as a Professor of Law and Health Policy. In this role, I have studied health insurance market regulations for a quarter of a century, including pooled purchasing arrangements such as Association Health Plans, which I have studied off and on since 1995. This research has been funding by the National Institutes of Health and by prominent foundations, and my relevant research findings have been published in leading peer-reviewed journals, such as the *New England Journal of Medicine* and *Health Affairs*. The research on which I draw also led to my being elected as a member of the National Academy of Medicine. And, I am also a Nonresident Senior Fellow in Economic Studies at the Brookings Institution.

On behalf of the Health Law and Policy Program at Wake Forest University, I submit the following comments on various points raised by the proposed rule:

AHPs' Ability to Reduce Costs

The proposed rule is premised throughout on the theoretical ability of AHPs to reduce the cost of health coverage, "all else equal." However, there is no credible published evidence that pooled purchasing arrangements, including AHPs themselves (which have long existed), have been able to do so, and all of the published evidence is to the contrary – documenting that they have not been able to reduce underlying administrative or medical costs.[1]

The proposed rule provides no reasoned explanation why AHPs (which are not a new concept or structure) will be able to reduce coverage costs substantially in the future, through any mechanisms other than risk selection and/or reduction of benefits. In several places, the proposed rule points to two potential cost reduction mechanisms: 1) reduced administrative

[1]M. Hall MA, E. Wicks EK, & J. Lawlor, HealthMarts, HIPCs, MEWAs, and AHPs: A Guide for the Perplexed, *Health Aff.* 20(1):142-53 (2001); Stephen H. Long and M. Susan Marquis, Have Small-Group Health Insurance Purchasing Alliances Increased Coverage? *Health Aff.* 20(1): 154 (2001); E. Wicks & M. Hall, Purchasing Cooperatives For Small Employers: Performance And Prospects, *Milbank Q.* 78(4):511-46 (2000); James R. Baumgardner and Stuart A. Hagen, Predicting Response to Regulatory Change in the Small Group Health Insurance Market: The Case of Association Health Plans and HealthMarts, *Inquiry* 38(4): 351-364 (2002).

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costs; and 2) increased bargaining power over medical costs. Neither is likely to occur to a substantial extent, for the following reasons.

- Although large groups have greater economies of scale than small groups, this translates, at the maximum, to a potential for only about 5 percent savings. Across the board, insurers have already substantially reduced administrative costs in recent years, such that administrative costs in the individual market are now less than 15 percent of premium, compared with about 10 percent of premium in the group market.[2] Completely eliminating this differential is not feasible, however, because AHPs themselves entail additional administrative costs and sales commissions that are not present in the more direct sale of coverage. Thus, as an outer limit, administrative savings of more than 2-3 percent appear to be highly unlikely, and unsupported by any evidence.
- Regarding bargaining power over medical prices, AHPs are similarly unlikely to substantially reduce costs. The plans sold through AHPs use the same networks of providers that health insurers or TPAs form for their other customers, and thus typically employ the same reimbursement schedules. A single group, in theory, can form its own provider network with separate pricing, but doing so requires a large investment of resources, offsetting any potential savings, and any single group is highly unlikely to receive better pricing than an entire book of business represented by a larger carrier or TPA. In short, there is no reason or experience to think that individuals or smaller employers will receive substantially favorable medical prices by joining a larger group.
- The difficulty of finding substantial savings simply by forming larger groups is reflected in national figures, from the leading representative surveys, showing that premiums paid by large employers are actually no lower than those paid by small employers, for insurance that covers a similar level of benefits. [3]
- The Congressional Budget Office drew from similar evidence in 2000 and 2003 when, in scoring previous AHP proposals, it estimated that there would be no administrative savings for either administrative efficiencies or "market clout."

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[2] M. McCue, M. Hall M, & X. Liu, Impact Of Medical Loss Regulation On The Financial Performance Of Health Insurers, *Health Aff*. 32(9):1546-51 (2013); M. J. McCue and M. A. Hall, How Have Health Insurers Performed Financially Under the ACA's Market Rules? (Commonwealth Fund, October 2017), http://www.commonwealthfund.org/publications/issue-briefs/2017/oct/health-insurers-perform-financially-aca-market; M. Abraham, P. Karaca-Mandic, & K. Simon, How has the Affordable Care Act's Medical Loss Ratio Regulation Affected Insurer Behavior? *Med. Care* 52(4):370-7 (2014).

[3] Kaiser Family Foundation, 2017 Employer Health Benefits Survey, https://www.kff.org/report-section/ehbs-2017-section-1-cost-of-health-insurance/; U.S. Bureau of Labor Statistics, Measuring the generosity of employer-sponsored health plans: an actuarial-value approach (June 2015), https://www.bls.gov/opub/mlr/2015/article/measuring-the-generosity-of-employer-sponsored-health-plans.htm.

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The limited ability of AHPs to achieve true economic efficiencies means that these efficiencies are highly unlikely to offset or counteract the negative effects, discussed below, that AHPs are likely to generate.

AHPs' Ability to Avoid Market Regulations

If AHPs are to reduce coverage costs substantially, this can happen only by their ability to avoid existing regulation of the individual and small group markets, as outlined by the comments from the American Academy of Actuaries.[4] Among these regulations are requirements that individual and small-group carriers cover maternity care, for instance, or that they avoid setting their rates based on gender or occupation. These regulations serve important public policy goals that the proposed rule fails to fully consider. For instance, not mandating maternity coverage tends to make the price of optional maternity coverage unaffordable, resulting in a market that fails to cover maternity coverage even for those who desire having it. Obviously, lack of maternity coverage has serious consequences for fetal and maternal health, which are matters affecting public health and welfare, and not simply matters of personal consumption. And, this is but one of many other troubling possibilities, backed by existing real-world experience.

The proposed rule reasons that, in fact, most large employers do not offer skimpy coverage, and it speculates that, therefore, AHPs also will be unlikely to skimp. However, there is a major structural difference between AHPs and ordinary employer groups that causes them to behave differently. AHPs are an open invitation for self-employed people and small businesses to pick their insurance group based on the particular coverage they want. In contrast, people covered by large employer plans simply accept the insurance their employer chooses. Large employers cover the full range of services that many or most people want, so that, when they hire, the benefits are comprehensive enough to satisfy most everyone. Thus, large group insurance is not tailored to particular health needs, whereas unregulated individual and small group insurance is.

AHPs can be expected to behave much more like the unregulated individual and small group markets, prior to market reforms, than like the large group market, in this regard. They have every reason to form more limited coverage packages that appeal distinctively to particular demographics or health profiles – thus undercutting critical public health goals embodied in existing market regulations.

There are two ways to lessen this problem: 1) mandate minimum benefits that AHPs must cover; or 2) require that AHPs exist for reasons other than insurance and have fairly narrow eligibility criteria, so that AHPs cannot form, and employers cannot join them, simply to obtain unregulated insurance.

Differentiating AHPs from the Mere Commercial Insurance Arrangements

The proposed rule correctly recognizes the need to differentiate AHPs from mere commercial insurance arrangements, in order to preserve the integrity of ERISA's employer-sponsored

[4] https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00106.pdf .

domain. However, three aspects of the proposed rule undercut this goal: 1) including sole proprietors, 2) allowing AHPs to form primarily for the purpose of offering insurance, and 3) allowing AHPs to be based merely on geographic location.

As written, the proposed rule would allow anyone with Schedule C income of just a few thousand dollars to purchase through an AHP, as long as they are not eligible for employer-sponsored insurance elsewhere (e.g., through another job or their spouse). Importantly, the recent tax reform law will cause many more employed people to establish themselves as also having independent business income, in order to receive reduced "pass through" business income tax rates. For these people, who plausibly number in the millions, joining an AHP will not be a genuine employment-based benefits decision, but simply an insurance-shopping choice of whether to purchase their coverage through the regulated individual market, or instead through the unregulated AHP market.

The best way to reduce this degradation of market boundaries is to eliminate AHP eligibility for self-employed people or "family businesses." A fallback would be to eliminate the income test for self-employment, and instead rely only on the requirement of devoting at least 30 hours of effort a week to the business enterprise, coupled with not having other substantial employment. Based on substantial experience in a number states, however, the latter approach would entail substantial documentation requirements through tax and payroll records in order to avoid fraud and abuse.[5]

Becoming "merely a commercial insurance-like" arrangement is also threatened by the weakening of the standards for commonality of interest, to allow AHPs established primarily for the purpose of offering insurance. Indeed, establishing an AHP for this purpose is virtually a definition of a merely commercial insurance arrangement, since this proposal eliminates the requirement that an AHP have any other purpose other than offering insurance.

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[5] See, for instance, page 16 of Mark A. Hall & Elliot Wicks, An Evaluation of Colorado's Small-Group Health Insurance Reform Laws (Dec. 1998), https://www.phs.wakehealth.edu/public/pub_insurance/PDF/colorado.pdf ("In other states, insurers increase their scrutiny of the eligibility criteria for micro groups by demanding tax and payroll documentation, because they believe there is a much greater potential for fraud, discussed more below. In Colorado, however, the only documentation that law allows insurers to demand of self-employed applicants is an affidavit stating the business is real. As a result, there is a widespread belief among insurers, and to a lesser but significant extent by agents, that many people purchasing as a one-life group are not legitimate businesses. This concern is much greater in Colorado than in other states we have studied."); and p. 19 of Mark A. Hall & Elliot Wicks, An Evaluation of Florida's Small-Group Health Insurance Reform Laws (Dec. 1998), https://www.phs.wakehealth.edu/public/pub_insurance/PDF/florida.pdf ("Insurers respond that problems of group legitimacy and subscriber cheating are indeed much greater with one-life groups. They observe that it is much easier for one high-risk person or a family to create a fictitious business simply to obtain insurance than it is for larger groups of unrelated individuals. One insurer maintains that fraud of this sort is rampant in parts of Florida, and that agents are facilitating this fraud.").

Further adding to this dilution of true employer sponsorship is allowing AHPs to form based merely on geographic location. In the past, industry participants and observers have mocked the notion of "air breather" associations – those that purport to have a commonality of interest but in fact require nothing more than dependency on oxygen.[6] By requiring nothing more than broad geographic proximity, the proposed rule would codify this very absurdity.

The solution is to restrict commonality of interest to a distinct industry, trade or profession.

AHPs' Threat to Risk Pooling

Despite the obvious potential of AHPs to undermine risk pooling, the proposed rule speculates, in several places, that this will not happen because unhealthy people have just as much reason to seek the advantages of AHPs as do healthy people. The seriousness of the threat to regulated markets is documented, however, by thoughtful opinion letters and issue briefs written by the leading expert authorities in the country. The American Academy of Actuaries, for instance, has warned that AHPs "would result in market fragmentation and threaten the viability of the insured market,"[7] and the National Association of Insurance Commissioners (NAIC) has issued a "Consumer Alert" warning that "Association Health Plans are Bad for Consumers" because they "threaten the stability of the small group market."[8]

More recently, the NAIC has advised Congress that AHPs "would actually harm consumers by further segmenting the small group market"; they "would encourage AHPs to 'cherry-pick' healthy groups by designing benefit packages and setting rates so that unhealthy groups are disadvantaged. This, in turn, would make existing state risk pools even riskier and more expensive for insurance carriers, thus making it even harder for sick groups to afford insurance."[9]

The proposed rule provides no citations or documentation for the contrary, wishful thinking that AHPs will avoid market disruption by promoting risk pooling or minimizing risk segmentation. Virtually all logic, experience, and unbiased expert opinion contradicts this naïve optimism. Several aspects of the proposed rule make this speculation highly implausible, and validate the almost universal concerns expressed by the leading authorities.

First, as noted above, there is no solid basis for the proposed rule's speculation that efficiencies achieved through AHPs will offset their incentives to avoid worse health risks. Despite existing for decades, AHPs have no track record of substantially reducing underlying administrative or medical costs, nor is there a good basis for assuming that they have this potential now, to any greater extent.

[6] Mark A. Hall, HIPAA's Small-Group Access Laws: Win, Loss, Or Draw?, *Cato J.* 22(1):71-83 at p. 75 (2002).

[7] https://www.actuary.org/content/association-health-plans-0

[8] http://www.naic.org/documents/consumer_alert_ahps.pdf

[9] http://www.naic.org/documents/health_archive_naic_opposes_small_business_fairness_act.pdf

Even if AHPs could achieve some genuine cost savings, the added costs of attracting just a few higher risk subscribers would quickly swamp any possible efficiency gains. Due to the well-known concentration of medical expenses in a small percentage of the population, avoiding even just the top 1 percent of medical spenders can save almost 25 percent of total costs, in any given health risk pool.[10] Thus, AHPs, like any risk pooling mechanism, have a great deal more to gain by avoiding a few very high cost subscribers than by including features that are attractive to a broader swath of the population. This iron law of health care expenditures means that it is highly likely that AHPs will take every opportunity to tailor their coverage and their membership criteria to attract better risks and avoid worse risks.

One obvious way AHPs could do this under the proposed rule is through the long-discredited practice known as "redlining." Redlining is the pejorative term applied to techniques by which insurers (of various types, including life, property, etc.) illegally refuse to sell, or selectively market, in certain locations based on the economic or racial profile of the population. The proposed rule explicitly allows geographic (and thus socioeconomic) redlining, by allowing AHPs to form merely based on geographic units of whatever size and proximity they choose. Thus, the proposed rule allows an AHP to form based on a particular zip code or census tract, or to "cherry pick" the particular micro-areas that have the population features considered most desirable, without even needing, necessarily, for the covered areas to be contiguous. In addition, AHPs can use rating practices as well as marketing to attract desirable populations and to avoid groups and individuals expected to have higher claims.[11]

The proposed rule also opens the door to similar forms of cherry-picking through the design of covered benefits, including, for instance, whether to cover expensive drugs for chronic illnesses. Moreover, AHPs will likely segment the market not only by appealing differentially to healthier groups, but also by discouraging sicker members *within* groups. As long as an AHP avoids offering what the ACA defines as "minimum value" or bronze level coverage, then individual employees are free to seek richer coverage through the subsidized individual market. This below-minimum value coverage can easily be structured in a way (coupled with a health savings or reimburse account) that meets needs of healthier workers/families but discourages enrollment by sicker people. This is similar to the widely-criticized practice of "lasering" that once prevailed in the unregulated small group market.[12] By allowing AHPs to reinstate these discredited practices, the proposed rule creates a vehicle for employers to more easily "dump" their sicker workers or families onto the publicly-subsidized individual market, without having to

[10] See Tom Miller, The Concentration And Persistence Of Health Care Spending, *Regulation* 40(4): 28 (Dec. 2017).

[11] For documentation and description, see Mark A. Hall, Elliot Wicks and Janice Lawlor, HIPCs, MEWAs, and Association Health Plans: A Guide for the Perplexed, *Health Aff*. 21(1):142 (Jan. 2001).

[12] Amy Monahan, Saving Small-Employer Health Insurance, Iowa Law Rev. 98:1935 (2013).

make the employer responsibility payment that the ACA otherwise would assess on large groups that might deploy this tactic.

The risk segmentation that AHPs will produce in these and other ways would threaten the stability of individual and small group markets. This threat is not mere speculation or simply a question of differing opinions. Wider use of AHPs previously caused actual substantial harm to regulated markets in several states, prior to tightening standards for bona fide status.[13] A leading example is the market collapse that occurred in Kentucky in the 1990s. Kentucky implemented market reforms but exempted AHPs from these reforms, including rating reforms. This resulted in healthy people seeking coverage through associations, which were not community rated. This left unhealthy people to seek coverage in the regulated markets. Carriers began canceling health insurance policies and fleeing the state, leaving a decimated market. Over 20 carriers left the market, leaving two carriers, one of which had experienced $30 million in losses over the prior 20 months.[14]

The solution to this set of problems entails the combination of measures previously mentioned. To ensure that AHPs form and compete based on their ability to achieve genuine efficiencies and value in health care coverage, the rule must restrict AHPs' ability to operate primarily as a mechanism to simply shop for insurance. That entails a much more focused and concrete concept of "commonality of interest," a requirement that AHPs do not exist primarily for the purpose of selling insurance, and additional limits on their ability to engage in various risk selection and segmentation strategies outline in this letter, which are based not just on logic and unbiased expert opinion, but also on hard learned experience.

Thank you for this opportunity to comment.

Sincerely,

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[13] See note 3.
[14] Kentucky Department of Insurance, Health Insurance Reform in the 1990's: A Kentucky Historical Perspective (April 1997); Adele Kirk, Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts, *J. Health Pol. Pol'y & L.* 25:133 (2000).