Department of Labor NPRM RIN 1210-AB85,

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

Comment Submitted by Marilyn Dahl

I oppose the proposed revision of the definition of "employer" under ERISA section 3(5) and urge the Department of Labor (DOL) to withdraw this ill-conceived proposal. The NPRM quotes Executive Order 13813 as stating that ‘‘[i]t shall be the policy of the executive branch, to the extent consistent with law, to facilitate the purchase of insurance across State lines and the development and operation of a healthcare system that provides high-quality care at affordable prices for the American people." The NPRM further notes that the Executive Order directs DOL to consider revising regulations or guidance to permit more employers to form Association Health Plans (AHPs). (83 FR 614)

In 2013 DOL said the following about Multiple Employer Welfare Associations (MEWAs), of which AHPs are a subset: "For many years, promoters and others have established and operated multiple employer welfare arrangements (MEWAs), also described as “multiple employer trusts” or “METs,” as vehicles for marketing health and welfare benefits to employers for their employees. Promoters of MEWAs have typically represented to employers and State regulators that the MEWA is an employee benefit plan covered by the Employee Retirement Income Security Act (ERISA) and, therefore, exempt from State insurance regulation under ERISA’s broad preemption provisions. **By avoiding State insurance reserve, contribution and other requirements applicable to insurance companies, MEWAs are often able to market insurance coverage at rates substantially below those of regulated insurance companies, thus, in concept, making the MEWA an attractive alternative for those small businesses finding it difficult to obtain affordable health care coverage for their employees. In practice, however, a number of MEWAs have been unable to pay claims as a result of insufficient funding and inadequate reserves. Or in the worst situations, they were operated by individuals who drained the MEWA’s assets through excessive administrative fees and outright embezzlement** [emphasis added].... Recognizing that it was both appropriate and necessary for States to be able to establish, apply and enforce State insurance laws with respect to MEWAs, the U.S. Congress amended ERISA in 1983, as part of Public Law 97-473, to provide an exception to ERISA’s broad preemption provisions for the regulation of MEWAs under State insurance laws. While the 1983 ERISA amendments were intended to remove Federal preemption as an impediment to State regulation of MEWAs, it is clear that MEWA promoters and others have continued to create confusion and uncertainty as to the ability of States to regulate MEWAs by claiming ERISA coverage and protection from State regulation under ERISA’s preemption provisions. Obviously, to the extent that such claims have the effect of discouraging or delaying the application and enforcement of State insurance laws, the MEWA promoters benefit and those dependent on the MEWA for their health care coverage bear the risk. The Patient Protection and Affordable Care Act (ACA) established a multipronged approach to MEWA abuses. Improvements in reporting, together with stronger enforcement tools, are designed to reduce MEWA fraud and abuse. These include expanded reporting and required registration with the Department of Labor prior to operating in a State. The additional information provided will enhance the State and Federal governments’ joint mission to prevent harm and take enforcement action. The ACA also strengthened enforcement by giving the Secretary of Labor authority to issue a cease and desist order when a MEWA engages in fraudulent or other abusive conduct and issue a summary seizure order when a MEWA is in a

financially hazardous condition." (MEWAs – A Guide to Federal and State Regulation, DOL, August, 2013, pp. 3-4)

In summary, by DOL's own analysis, some MEWAs have been prone to fraud, have been able to offer lower prices through the avoidance of regulatory requirements, and were of such concern that Congress in 2010 enacted legislation to strengthen their oversight. There is no acceptable rationale for the fact that DOL is now proposing to facilitate the formation of AHP MEWAs by relaxing the long-standing requirement for members of MEWAs to share a true commonality of interest, and would instead allow such "commonality" to be established merely by a shared location in a common geographic area which may be designated by the AHP, so long as it does not go beyond the boundaries of a state or a "metropolitan" area (presumably a metropolitan statistical area is intended????). DOL also proposes that a working, self-employed individual who does not have any employees reporting to him/her could simultaneously be considered an employee, and thus eligible to join an AHP. The proposed §2510.3-5(3) would establish only vague requirements for an AHP to have some "formal" structure and §2510.3-5(4) would establish only weak member "control" of the AHP through "regular" elections of governing representatives. These vague requirements would not hinder the development and promotion of just the sort of AHPs that raised concern within DOL as recently as 2013.

This proposal constitutes an open invitation to the formation of under-funded, ill-governed AHPs that would in all likelihood offer shoddy coverage, since these plans would not be subject to the coverage requirements for the small employer and individual insurance markets that Congress enacted in 2010. It seems designed, moreover, to undermine the stability of the small employer and individual insurance markets. As with so many of the regulatory proposals and administrative actions being taken by the current Administration, this NPRM seems designed to return the United States to the completely dysfunctional health insurance market conditions that pre-dated enactment of the Affordable Care Act in 2010, i.e., market segmentation, lack of guarantees of good coverage, lack of standardization of plan benefits to ensure not only good coverage, but also to facilitate true comparison shopping, and thus true competition, rather than sham competition based on the prices of non-comparable products. All of this resulted prior to 2010 in a steadily growing number of individuals without insurance, endangering not only the health of those individuals, but also the stability of the hospitals and health care providers that furnish care. It is a disgrace that DOL would abandon its decades-long interpretation of the requirements of ERISA Section 3(5) with respect to MEWAs, thereby placing potentially millions of Americans at risk.