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Managed
Health Care

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VIA ELECTRONIC MAIL

Office of Regulations and Interpretations
Employee Benefits Security Administration
U.S. Department of Labor (DOL)
ATTN: RIN 1210-AB85
Room N-5655
200 Constitution Avenue NW
Washington, DC 20210
http://www.regulations.gov

Re: DMHC COMMENTS ON DOL PROPOSED RULE: DEFINITION OF EMPLOYER—SMALL BUSINESS HEALTH PLANS (RIN-1210-AB85)

Secretary R. Alexander Acosta:

The Department of Managed Health Care (DMHC) regulates health care service plans in California. The DMHC exercises jurisdiction over health plans that collectively have more than 26 million covered lives, or over 95 percent of the commercial and public enrollment in the state.[1] The DMHC is the nation's largest state health insurance regulator. The DMHC enforces the consumer protections codified in the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act, at California Health and Safety Code §§1340, et seq). The Knox-Keene Act balances the goals of ensuring consumer access to the best possible health care at the lowest possible cost, and protecting consumers from an unstable health care delivery system caused by financially unsound health plans.

We submit for your consideration the following comments on the January 5, 2018, proposed rules (Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans).

Troubled history of MEWAs

The proposed rule, as a whole, raises serious concerns for the DMHC. As noted in the preamble, Association Health Plans (AHPs) are a form of Multiple Employer Welfare

[1] California Health Care Foundation (CHCF), California Health Insurance Enrollment by Section, 2013-2015 (May 23, 2016) <http://www.chcf.org/articles/2016/05/ca-2015-health-insurance-enrollment>.

Arrangement, or MEWA.[2] MEWAs have a troubled history, plagued with insolvencies and fraud. For instance, a MEWA may claim to be fully insured, but instead of using the premiums it collects from its member employers to pay a contract with a licensed health care insurer, it will instead funnel money to its promoters before shutting down.[3] The DOL itself notes in its fact sheet on MEWA Enforcement that a bad-actor MEWA may use "actuarially unsound premium structures to generate large administrative fees for the promoters," then pay itself these fees before paying out claims, leaving the MEWA insolvent.[4] When, at the request of Congress, the United States General Accounting Office (GAO) studied the prevalence of entities not authorized to sell insurance from 2000 to 2002, 80 percent of the entities the GAO found "characterized themselves as associations, professional employer organizations, unions, single-employer ERISA plans, or some combination of these arrangements."[5]

As the regulator of health care service plans in California, the DMHC would regulate those health care service plans that contract with a fully insured AHP. Fraudulent MEWAs claiming to be fully insured can and have caused significant harm to their participants. As recently as 2013, the DOL itself noted that it "has devoted significant resources to investigating and litigating issues connected with abusive MEWAs..."[6] The DMHC opposes expanding access to AHPs because it will expose more consumers to the dangers posed by unscrupulous or insolvent MEWAs.

Market Instability and Segmentation

The proposed rule threatens the viability and stability of the small group and individual markets. By expanding the circumstances under which an AHP is considered a single employer under ERISA, the proposed rule would allow small groups and sole proprietors to buy plans in the large group market instead of the individual and small group markets. If these AHPs are indeed as advantageous to these market segments as the DOL intends, healthier groups and sole proprietors will likely exit the small group and individual markets, leaving those markets with unstable risk pools and ever-rising premiums, ultimately leading to a premium spiral.

While the proposed rule's preamble downplays the possibility of destabilization,[7] there is no evidence for that assertion. The preamble acknowledges that the individual market,

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[2] 83 Fed. Reg. 614, 617, fn. 4 (Jan. 5, 2018).

[3] U.S. Gen. Accounting Office, *Rep. to Congressional Requesters, Private Health Insurance: Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage,* 31-37 (Feb. 2004) (hereafter GAO Report).

[4] U.S. Department of Labor, Employee Benefits Security Administration, *Fact Sheet, MEWA Enforcement* (March 2013) (hereafter MEWA Factsheet).

[5] GAO Report, *supra,* at 11.

[6] MEWA Factsheet, *supra.*

[7] *See* 83 Fed. Reg., *supra,* at 628-629. "Some stakeholders argue that pursuit of lower prices based on non-health factors would lead, for example, younger association members to join AHPs but might lead older members to remain in the individual and small group markets. This argument, however, depends on the assumption that pricing flexibility is the principal or only advantage available to AHPs. In fact, as outlined above, AHPs have the potential to create

in particular, may be especially susceptible to adverse selection,[8] and the large group market rules will allow for AHPs that are cheaper because they are not subject to key consumer protections.[9] The self-insured and partially insured markets have even fewer consumer protections. The lack of consumer protections in the large group market also suggest that disproportionately healthy groups and individuals will seek AHP coverage, leaving the less healthy consumers – who need the ACA's protections – in the destabilized individual and small group markets.

The DOL expects the "potential" for administrative savings will mitigate any risk of adverse selection in the small group and individual markets.[10] However, the American Academy of Actuaries has noted that AHPs would not necessarily be able to achieve the "critical mass of enrollment needed to negotiate the deep provider discounts that large health maintenance organization and insurance companies currently obtain."[11]

The stability of the individual and small group markets is critical to their continued viability, for consumers and insurers alike. Accordingly, the DMHC requests the DOL delay issuance of a final rule until it can more fully review and report on the detrimental impact on the individual and small group markets resulting from the expansion of AHPs.

States retain authority to regulate insurance products

States historically have regulated the health coverage sold within their borders. It is critical that the rule explicitly preserve this traditional state role of regulating the business of insurance. The DMHC was pleased to learn from the preamble that "[t]he proposed rules also would not modify the States' authority to regulate health insurance issuers or the insurance policies they sell to AHPs."[12] In order to fully realize this goal, the DMHC requests the DOL add a section to the rule to reflect this statement.

Inadequate Anti-Discrimination Provisions

The proposed nondiscrimination rule prohibits health discrimination within groups of similarly situated individuals, but it does not prohibit discrimination across different groups of similarly situated individuals, which could be used as a pretext for health-related discrimination. AHPs may use benefit designs, membership requirements, location of employees, and other factors to discriminate. While employers would not be able to charge higher premiums between different employees based on claims experience, the proposed rule allows AHPs to set rates based on bona-fide

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significant efficiencies that could lower premiums across the board. An AHP that realizes sufficient efficiencies may offer attractive prices even to less healthy groups. In that scenario, less healthy people would also have an incentive to leave the individual and small group market, potentially balancing out any exodus of healthy people from these markets."

[8] *Id.* at 630.

[9] *Id.* at 628.

[10] *Id.* at 628, 631.

[11] American Academy of Actuaries, *Issue Brief: Association Health Plans,* https://www.actuary.org/files/publications/AssociationHealthPlans_021317.pdf (last visited Feb. 26, 2018).

[12] 83 Fed. Reg., *supra*, at 625.

employment-based classifications (part-time vs. full-time), geography or industry. For example, because the proposed rule does not define "region," an AHP may create a "region" that is simply the higher income area of a single city. Income may serve as a proxy for health-related discrimination, and an AHP may then charge lower rates for this "region." While the stated nondiscrimination provisions are important, they still leave room for unfair and unequal treatment, which may result in further market segmentation. Therefore, the DMHC requests that states be allowed to ensure that AHPs comply with existing state nondiscrimination provisions.

"Working owner" provisions

This rule would permit sole proprietors to buy large group coverage with an AHP. As previously noted, if healthy sole proprietors opt for large group coverage through AHPs in large enough numbers, their exit could destabilize the individual market. Further, while the proposed rule noted that "[t]he rule is intended to cover genuine employment-based relationships, not to provide cover for the marketing of individual insurance masquerading as employment-based coverage,"[13] its "working owner" provisions are wholly inadequate to serve this goal. Proposed new section 29 CFR 2510.3(e)(2) sets forth the ownership, wage, income and working hour requirements for a sole proprietor to qualify as a "working owner" such as to gain access to membership in an AHP.[14] Yet, the only safeguard for ensuring a sole proprietor actually meets these standards lies in a written representation from that sole proprietor, so long as the association does not have "knowledge to the contrary."[15] A simple written statement from the purported working owner is not enough to prevent individuals from posing as "working owners" as defined by the proposed rule. While the DMHC shares the DOL's goal of expanding health coverage options, individuals are not large groups. The different markets for individuals and large groups, as well as the law governing their operation, have evolved to reflect this reality. The "working owner" provisions increase the odds of individuals gaining inappropriate access to large group coverage that otherwise would be unavailable to them. It is important to prevent this inappropriate access in order to preserve the integrity of the traditional individual market, and to ensure individuals receive coverage with consumer protections appropriate for their status as individuals.

Delay in implementation

For the reasons stated above, the DMHC has significant concerns about the proposed rule, and opposes its finalization. Because this rule could have a major impact on the California health coverage market, if this rule is finalized in any form, the DMHC requests the DOL delay the effective date until 2020. This will allow state policymakers time to thoroughly assess the effect of this rule on state health coverage markets, and allow them to make any legislative and regulatory adjustments necessary. This will increase the chances that the rules are appropriately implemented with minimal

[13] *Id.* at 622.
[14] *Id.* at 635.
[15] *Id.*

disruption to the marketplace, that California consumers are protected, and that states retain their traditional role in regulating health insurance.

Thank you for considering the DMHC's comments.

Sincerely,

Shelley Rouillard
Director,
California Department of Managed Health Care