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March 6, 2018

The Honorable R. Alexander Acosta
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Submitted electronically to www.regulations.gov

Re: Definition of Employer under Section 3(5) of ERISA-Association Health Plans [EBSA-2018-0001; RIN 1210-AB85]

Dear Secretary Acosta:

The FAH is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members are diverse, including teaching and non-teaching, short-stay, rehabilitation, long-term acute care, psychiatric, and cancer hospitals in urban and rural America, and they provide a wide range of acute, post-acute and ambulatory services. Many of our members contract with health insurers in the small group and individual markets for health insurance and we strongly support regulatory changes that would increase access to meaningful coverage for individuals in those markets and caution against regulations that would undermine the stability or availability of meaningful coverage in those markets. We believe that it is important for the Department of Labor (DOL) to consider the concerns of direct providers of patient care. To that end, we are pleased to provide DOL with our views in response to the above referenced notice of proposed rulemaking (Proposed Rule), which was published in the *Federal Register* on January 5, 2018 (83 *F.R.* 614).

The Federation urges the Department of Labor to withdraw its proposed definition of "Employer" under section 3(5) of ERISA. The proposed definition, which would be applicable to employers and self-employed individuals purchasing health coverage through certain groups or associations, would destabilize health insurance markets for individuals and small groups. The instability would come about because the rule would create opportunities and incentives for

increasing risk segmentation. If finalized, the rule would also provide incentives for plans to reduce the generosity of health care benefits jeopardizing affordable access to meaningful coverage for those individuals who need health care the most.

Under the Proposed Rule, small employers and self-employed individuals would be able to purchase insurance through a group such as a professional or trade association, and, together with other employers or self-employed individuals buying coverage through that group, be considered a single employer under ERISA. If together those employers employ 50 or more individuals, then in most states, the plan could be considered a "large employer plan."[1] Under federal law, coverage offered by large employers is exempt from a set of standards and consumer protections that insurance offered to small employers and individuals must otherwise meet. Specifically, by being considered a single large group, association-sponsored coverage could avoid important consumer protections including minimum benefit standards, annual and lifetime limits on cost sharing, rules that limit underwriting of premiums, single risk pool requirements, and participation in risk adjustment.

Different Rules for AHPs Would Destabilize Health Insurance Markets

If finalized, a different set of rules related to health benefits and premium rating would apply to coverage offered to small employers and individuals through Association Health Plans (AHPs) versus those purchasing coverage in the traditional small group and individual health insurance markets. Insurance experts and actuaries have long advised, and experience has borne out, that the key to healthy health insurance markets is that insurers compete to enroll the same participants while operating under the same rules.[2] For there to be fair competition, consistent rules must apply across the board to all coverage offered within a market. That consistency (i.e., level playing field) prevents certain insurers from being inappropriately advantaged and others from being unfairly disadvantaged.

Under the Proposed Rule, however, qualifying group and association-sponsored coverage could avoid requirements to cover minimum essential health care benefits including annual and lifetime limits on cost sharing, and would not be subject to rules that limit the underwriting of premiums. The result would be an environment where plans offered through associations are able to operate under rules that are more advantageous to attracting and enrolling healthy individuals while other remaining health plans would be subject to protections that are more likely to appeal to high-risk individuals.

As is well-documented, medical expenses are concentrated in a small percentage of the population, so an AHP operating under the regulatory framework established by the Proposed Rule that could avoid even just the top 1 percent of medical spenders could potentially save 25 percent of total costs. AHPs, like any insurer, could be expected to take every opportunity to

[1] Four states have adopted a definition of small group market that includes employers with a workforce of up to 100 employees. In those states, it appears that AHPs with employers that collectively employer 100 or more individuals would be able to be considered a single employer.

[2] Letter re: Markup of H.R. 1101, the Small Business Health Fairness Act of 2017, American Academy of Actuaries, March 8, 2017, https://www.actuary.org/files/publications/AHPs_HR1101_030817.pdf; An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes, American Academy of Actuaries, January 2017, https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

avoid bad risk. But by providing AHPs with extra risk selection tools and withholding those same tools from other health insurers, it would leave the regular individual and small-group markets to absorb a greater share of higher-cost patients, threatening that market's basic stability.

Associations could further take advantage of the looser restrictions by underwriting premiums offered to certain small employers to discourage enrollment of less appealing groups: they could offer coverage only in geographic areas where they determine healthier individuals reside, and they could manipulate the health care benefits they offer in ways that make their coverage unappealing to individuals who need access to more comprehensive health care. This segmenting of risk would result in higher and increasing premiums for individuals left out of associations which could spiral over time: ever worsening adverse selection that would destabilize the non-AHP products.

The Department notes the history of instability which has occurred when states established uneven regulatory environments for health coverage, but does not offer any solutions or proposals to counter such instability. Real-life examples of market failures include:

- Kentucky's individual market collapsed during the 1990's after the state implemented a set of reforms that included more advantageous laws and regulations applicable to association plans. In that state, enrollment in association-sponsored plans increased and the disadvantaged insurers were left in the more stringently regulated market. Within two years, the state was forced to reverse its reforms.[3]
- California's uneven regulatory environment contributed to the downfall of that state's purchasing pool for small employers. The pool was subject to more stringent and disadvantageous rules as compared with other insurers. The result was instability and ultimately failure of the pool. Even though "PacAdvantage" grew to a large size, it ultimately failed because of adverse risk selection. "People with higher medical costs enrolled in PacAdvantage, while lower-risk people obtained coverage outside the exchange [pool] where they could find less expensive insurance. This drove up premiums inside the exchange, causing healthier people to drop out. This is known in the insurance business as a classic ""death spiral.""[4]

Access to Comprehensive Health Coverage Will Decline

The rule, if finalized, would also allow for "cherry-picking" through the design of covered benefits. Because AHPs could avoid the minimum benefit standards that apply to other coverage for individuals and small groups, they could offer bare bones benefit plans in order to attract only the healthiest of groups. AHPs could, under the Proposed Rule, eliminate coverage for prescription drugs, or avoid covering maternity care, cancer care, or certain services for mental illness for example. Those individuals most in need of health care or are expecting to

[3] Hall, M., "States have already tried Trump's health-care order. It went badly." *Washington Post*, October 13, 2017, https://www.washingtonpost.com/opinions/states-have-already-tried-trumps-health-care-order-it-went-badly/2017/10/13/7b090d88-af93-11e7-a908-a3470754bbb9_story.html?utm_term=.f0d917c06d63; Hall, M., The Geography of Health Insurance Regulation, Health Affairs, March/April 2000, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.19.2.173.

[4] Lee, P., Grguina, J., What People Don't Know about Health Insurance Exchanges, Health Affairs Blog, August 12, 2009, https://www.healthaffairs.org/do/10.1377/hblog20090812.001727/full/.

need expensive health care interventions are most likely to be most adversely affected. Premiums for coverage that includes those services is likely to sky-rocket. Over time, only those with the highest health needs and expenses would remain in the regulated market. Coverage of hospital services could be greatly compromised, thus leading to increasing underinsured and rising hospital bad debt. This outcome explicitly undercuts the critical public health goals that were embodied in existing market regulations.

Increases Uncertainty in Insurance Markets

Uncertainty in the regulatory environment can have a deleterious effect on premium adequacy and stability. Unfortunately, the Proposed Rule, instead of improving clarity around the regulatory authority of AHPs under existing law, adds more confusion about which states' laws and regulations apply to different types of AHPs and under which circumstances. We expect that this uncertainly will likely raise legal challenges which will only escalate the uncertainty for health care insurers and providers in these markets. Areas in which this rule increases confusion include:

Lack of Clarity on States' Authority. AHPs have a history of plan failures due to underfunding and fraud. One of the underlying causes of that past has been a regulatory framework that is confusing – states' regulatory authority over different types of AHPs has been unclear. Bad actors have taken advantage of that lack of clarity to assert that their plans cannot be regulated by states. The Department, while issuing helpful guidance in 2013, has not been able to completely erase the uncertainty over regulatory authority of AHPs and, in particular, the lack of clarity around plans offered to markets that cross state boundaries.

The Proposed Rule presents an opportunity to address the uncertainties, in particular those that have the effect of encouraging fraud and plan failures due to insolvencies. Unfortunately, while the Proposed Rule describes, in the preamble, the consequences of such confusion it proposes no clarifications nor offers guidance that would eliminate those areas of confusion. The proposal instead adds to the uncertainties of the regulatory landscape. It proposes new rules that allow for self-attestation in areas that should be subject to oversight to prevent fraud. It asserts its authority to further preempt state laws and oversight of AHPs without indicating how that authority can be used more effectively in the past and requests feedback on doing so in future rules. The Federation strongly opposes the Department using its flexibility to further preempt states' oversight over AHPs.

Self-attestation. The Proposed Rule would allow individuals to "self-attest" that they qualify as "working-owners" of their own business and as such, qualify for AHP enrollment. We expect that this provision would exacerbate the instability and market segmentation of the individual market for insurance. There would be strong incentives for healthy individuals to falsely claim that they are working owners. For these people, joining an AHP would not be a genuine employment-based benefits decision, but simply an insurance-shopping choice of whether to purchase their coverage through the regulated non-AHP individual market, or instead through the unregulated AHP market. FAH recommends development of a framework to audit the self-attestations to ensure individuals are not gaming the market to their perceived benefit at the expense of the stability of the individual insurance market.

Lack of definition of metropolitan area. The Proposed Rule would allow associations of employers with no legitimate business connection to form if they are geographically co-situated within a metropolitan area. The Proposed Rule does not define what is meant by a metropolitan area but does seek feedback on whether additional specification should be provided. If the Department proceeds with finalizing the rules, we strongly recommend that it provide a definition of a metropolitan area that would eliminate the ability of AHPs to use geography as a tool to only offer coverage in particular areas where health risk may be viewed to be more desirable. By allowing AHPs to form merely based on geographic areas of whatever size and proximity they choose, we would expect AHPs to "cherry pick" the particular micro-areas that have the population features considered most desirable. They could conceivably form based on a particular zip code or census tract, or cover areas that are not contiguous in an effort to selectively market to perceived attractive health risk.

<u>History of past abuse and failure of multiple employer welfare arrangements (MEWAs) should discourage their proliferation through AHPs</u>

The history of plans sponsored by associations and groups of employers is marred by repeated plan insolvencies and fraud. Such failures have left millions of Americans without coverage and with unpaid medical bills. A small sample of the long history of MEWA failures include:

- As recently as November of 2017, the Department was working to close down operations of a failing MEWA that covered 14,000 enrollees in multiple states. Premium contributions from employers enrolled in the coverage were being pooled and transmitted to offshore accounts. The Department identified more than $26 million in processed but unpaid claims for medical services.[5]
- In 2016, the Department filed suit against a Florida woman and her company to recover $1.2 million that it said had been improperly diverted from a health plan serving dozens of employers. The defendants concealed the plan's financial problems from plan participants and left more than $3.6 million in unpaid claims, the department said in court papers.[6]
- A licensed MEWA in California, covering 23,000 people, became insolvent in 2001. It collected over $30 million in premiums and owed around $11 million for medical claims when it failed.
- New Jersey's Coalition of Automotive Retailers, a MEWA that covered 20,000 people, became insolvent in 2002. At the time it had $15 million in outstanding medical bills.
- The Indiana Construction Industry Trust, in operation since the 1960s became insolvent in 2002.The trust insured approximately 790 employers and 14 association groups covering over 22,000 employees and their dependents. At that point it had less than $1 million in assets and more than $20 million in unpaid claims.[7]

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[5] "U.S. Department of Labor Obtains a Temporary Restraining Order to Protect Participants and Beneficiaries of Failing MEWA," https://www.dol.gov/newsroom/releases/ebsa/ebsa20171108 .

[6] Pear, Robert, October 21, 2017, "Cheaper Health Plans Promoted by Trump Have a History of Fraud," New York Times, https://www.nytimes.com/2017/10/21/us/politics/trump-association-health-plans-fraud.html.

[7] Kofman, Mila, et al., MEWAs: The Threat of Plan Insolvency and Other Challenges, Health Policy Institute, Georgetown University, http://www.commonwealthfund.org/usr_doc/kofman_mewas.pdf.

A former DOL employee, speaking about AHPs under existing rules adds "They operate in a regulatory never-never land between the Department of Labor and state insurance regulators."[8] As noted above, the Proposed Rule expands on that landscape by adding confusion, embracing self-attestation, providing additional tools for bad actors, and indicating that it will go further to pre-empt states' attempts to regulate these organizations.

II. Improvements Necessary Should the Rule Be finalized

DOL should clarify that states' laws are enforceable.

The Proposed Rule's modifications to ERISA regulations do not appear to extend to the regulatory provisions affecting the application of state law as provided under section 514 of ERISA. As the Proposed Rule's preamble notes, ERISA section 514, its implementing regulations and Department guidance, including advisory opinions, have reserved to the states the ability to regulate the business of insurance and, in the case of MEWAs, which is a type of AHP, to regulate those that are not fully-insured. Further, the proposal's *Federalism Statement* says "If an AHP is not fully insured, then under section 514(b)(6)(A)(ii) of ERISA, any state insurance law that regulates insurance may apply to the AHP to the extent that such state law is not inconsistent with ERISA." Because of the history of AHP fraud and financial instability, Congress and the Department have recognized the need for state oversight, especially with respect to self-insured MEWAs, and has clarified that the scope of state authority in this domain is broad.[9]

Given the emphasis in the Proposed Rule on ways in which the growth of AHPs may be inhibited by their existing regulatory requirements, however, we are concerned that the Department is contemplating changes to preempt state authority. Such a policy could open the floodgate to AHP problems, leaving AHP enrollees vulnerable to health and financial insecurity. To avert this possibility, the Department should clearly state that ERISA single-employer AHPs, including those covering people in more than one state, would have to comply with all state laws in states in which they operate and continue to be subject to state oversight and regulation.

Our concerns about the erosion of state authority to regulate AHPs are reinforced by the questions raised by the Department in its "Request for Information." In that section, the Department signals that it is considering to use its section 514 authority to issue individual or class exemptions for MEWAs that are otherwise subject to state regulation. The FAH opposes any measure that would weaken, let alone, preempt state regulation of AHPs. As we have already noted, when the states have recognized their clear authority to regulate in this arena, they

[8] Pear, R., "Cheaper Health Plans Promoted by Trump Have a History of Fraud."

[9] The 1982 Erlenborn amendment to ERISA gave states broad authority over entities that cover two or more employers and the preemption standards applicable to group health plans, as added by Congress to ERISA through HIPAA and reaffirmed by the ACA, all support the authority of states to regulate in this area. Moreover, the Department advised states that in its review of section 514 of ERISA, the ability of states to regulate the insurance sold to AHPs that are MEWAs and to regulate non-fully insured MEWAs is broad. Department of Labor, *MEWAs Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation*¸ revised August 2013, https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf.

have demonstrated effective oversight. As noted above, the resource limitations of the Department to be an effective regulator on its own, without state participation, have been well documented. Once their authority to regulate AHPs was clearly established, the states achieved a better track record of AHP oversight, often preventing major problems from developing and when they do, addressing AHP insolvencies and fraud and maintaining competitive markets. We would view any attempts by the Department to issue class or individual exemptions from state regulations for AHPs, which again is signaled in the Request for Information, as extremely misguided.

Oversight Requirements must be enhanced and DOL requires sufficient resources to conduct oversight.

In 2007, the GAO found that DOL had a ratio of one employee conducting oversight or enforcement activities for every 8000 plans.[10] When Congress considered legislating standards for AHPs, DOL testified that it can review plans under its jurisdiction once every 300 years.[11] When Congress considered an AHP bill in 2005, CBO estimated that the legislation would have required DOL to hire 150 additional employees and spend an additional $136 million over 10 years to properly oversee an expansion of AHPs.[12] Before proceeding to finalize the Proposed Rule, at a minimum, DOL should review each state's approach to regulating AHPs to learn what types of oversight are necessary to prevent and mitigate AHP insolvencies and fraud and how those activities can be executed given DOL's current staffing levels.

Non-discrimination rules are important but insufficient

The Proposed Rule includes several provisions that seek to protect people from discrimination by AHPs. Under the rule, an AHP cannot reject enrollees or set their premiums based on health factors. FAH believes these protections are essential but they are far from sufficient. Under the Proposed Rule, an AHP or insurer of AHP coverage, could still discriminate in terms of eligibility, enrollment, premiums and benefits based on a large number of other factors because it would not be subject to the federal minimum standards that apply to non-grandfathered health insurance sold in the individual and small group markets. For example, as drafted, the rule would allow AHPs to structure eligibility rules, benefit designs and marketing practices that would have the effect of being discriminatory against people who need such coverage – women who are pregnant, people with cancer, or people needing mental health services, for example. The AHP could charge higher premiums for people who are older, female, work in professions or live in neighborhoods that are deemed high-risk or who have been enrolled for longer than others.

[10] U.S. Government Accountability Office, "Employee Benefits Security Administration: Enforcement Improvement Made but Additional Actions Could Further Enhance Pension Plan Oversight," January 2007, https://www.gao.gov/assets/260/255488.pdf.
[11] Testimony of Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration, Senate Labor and Human Resources Committee, October 1, 1997.
[12] "H.R. 525: Small Business Health Fairness Act of 2005," Congressional Budget Office, April 8, 2005, Page 6. Available at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/62xx/doc6265/hr525.pdf.

As noted above, the geographic location of coverage could be used to redline locations where there is a high incidence of cancer, heart disease or diabetes – a roundabout way to discriminate against people based on health status.

To ensure that AHPs are not engaged in discriminatory practices, in addition to the proposed non-discrimination standard, the final rule should apply the Affordable Care Act's Essential Health Benefit requirements, rate reforms, guaranteed issue (which includes marketing standards) and single-risk pool requirements.

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Thank you for the opportunity to comment on the Proposed Rule. Should you have any questions regarding these comments please do not hesitate to contact me or my staff at (202) 624-1500.

Sincerely,