



Christine L. Owens
Executive Director

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www.nelp.org

NELP National Office
75 Maiden Lane
Suite 601
New York, NY 10038
212-285-3025

Office of Regulations and Interpretations
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave. NW, Room N-5655
Washington, DC 20210

Washington DC Office
2040 S Street NW
Lower Level
Washington, DC 20009
202-640-6520

Re: Notice of Proposed Rulemaking, *Definition of Employer Under Section 3(5) of ERISA – Association Health Plans*, 83 Fed. Reg. 614 (Jan. 5, 2018), RIN 1210-AB85

To Whom it May Concern:

California Office
2030 Addison Street
Suite 310
Berkeley, CA 94704
510-982-5945

Washington State Office
317 17th Avenue South
Seattle, WA 98144
206-324-4000

The National Employment Law Project (NELP) submits these comments in response to the Department of Labor’s Employee Benefit Security Administration’s (DOL) proposal to change its longstanding guidance on what kinds of “employer associations” may be treated as an “employer” sponsor of a multiple employer “employee welfare benefit plan” and a “group health plan” as those terms are defined in Section 3(5) of the Employee Retirement Income Security Act (ERISA).¹ NELP is a non-profit research and policy organization that for more than 45 years has sought to ensure that America upholds the promise of opportunity and economic security for all its workers. NELP is especially concerned that this proposed rule, if finalized in its current form, will have a disproportionate negative effect on low-wage workers.

NELP strongly opposes the rule in its current form. The proposed rule will open the door to widespread fraud and abuse by creating Association Health Plans (AHPs)² which will exist for the sole purpose of providing largely unregulated health insurance. It would exempt AHPs from the Affordable Care Act’s (ACA) consumer protections that apply to small groups and individuals. It would permit AHPs to discriminate on the basis of age, sex, occupation and a variety of other factors. It would allow AHPs to cherry pick only good risks to cover, thereby undermining the state regulated markets and putting millions of sicker individuals at risk of losing their health insurance. Because this proposal arises under ERISA, which preempts state action in many areas, states may be powerless to protect their residents with state legislative and regulatory actions.

¹ Notice of Proposed Rulemaking, Definition of “Employer” under Section 3(5) of ERISA- Association Health Plans, 83 Fed. Reg. 614 (January 5 2018) RIN 1210-AB85.

² Association Health Plans, as proposed by the NPRM, are a new subset of Multiple Employer Welfare Associations (MEWAs) so historical studies of MEWAs are highly relevant to the NPRM.

In addition to these policy concerns, NELP has serious concerns about the legality of the proposal. The DOL's regulatory impact analysis (RIA) admits that in the past these types of entities have "suffered from financial mismanagement or abuse, often leaving participants and providers with unpaid benefits and bills."³ Despite the fact that the DOL has a wealth of information in its files, there is no discussion of data concerning the history of failure of these types of entities or any analysis of the cost to participants and beneficiaries when they experience partial or total collapse, whether through fraud or mismanagement. The failure to present any data regarding these issues, when DOL has such information readily available,⁴ seriously undermines the cost-benefit analysis and likely makes a final rule arbitrary and capricious. In addition, any final rule that would expand access to arrangements that DOL admits has a history of fraud and abuse, must, at a minimum, incorporate additional protections for plan participants and beneficiaries in order to avoid being arbitrary and capricious.

Finally, the DOL's proposed concept of AHPs is in violation of the ACA. The ACA is designed to ensure that all Americans have access to comprehensive health insurance. For small employers and individuals, it accomplishes that goal through consumer protections, most particularly the essential health benefits (EHB) requirements imposed upon health insurers. For large employers there are no requirements imposed upon insurers. Instead, to assure comprehensive health insurance, the ACA imposes requirements upon the larger employers themselves through the "employer mandate" in the tax code. DOL's proposal would allow small employers and individuals, who are not subject to the employer mandate of the tax code, to band together to obtain health insurance without any consumer protections, and, as such, conflicts with the text and purpose of the ACA.

As described in more detail below, NELP opposes the proposed regulation and urges that DOL hold a public hearing so that stakeholders can fully air their concerns.

The Proposed Rule opens the door to fraud and scams.

As the DOL admits in the proposed rule, MEWAs have a long history of scams and fraud.⁵ Not only does this proposal fail to impose any standards or oversight that might minimize potential fraud, but it actually creates additional opportunities for fraudulent AHPs to be created and operated. The history of fraudulent MEWAs is well documented.⁶ Fraud occurs in multiple ways. As the DOL has recognized:

³ 83 Fed. Reg. at 631.

⁴ See, e.g., Employee Benefits Security Administration, Fact Sheet: MEWA Enforcement, <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mewa-enforcement.pdf> (listing numerous civil and criminal Multiple Employer Welfare Associations (MEWAs)).

⁵ "Historically a number of MEWAs have suffered from financial mismanagement or abuse, often leaving participants and providers with unpaid benefits and bills." 83 Red. Reg. at 631.

⁶ Health Insurance Scams: How Government Is Responding and What Further Steps Are Needed Mila Kofman, Kevin Lucia, and Eliza Bangit Health Policy Institute, Georgetown University (2003), available at: <http://www.commonwealthfund.org/publications/issue-briefs/2003/aug/health-insurance-scams--how-government-is-responding-and-what-further-steps-are-needed>, U.S. Gov't Accountability Office, GAO-04-312, "Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage," February 2004, available at <http://gao.gov/new.items/do4312.pdf>.

“MEWAs are sometimes knowingly marketed using attractive but actuarially unsound premium structures. Some plans generate large administrative fees for their promoters. These high fees are often paid before any claims are paid, leaving insufficient funds available to pay for the benefits promised by the promoters.”⁷

Promoters of these types of scams set up fake organizations or unions that dissolve when claims need to be paid.

Several provisions of the proposed rule would actually make it easier for fraudulent AHPs to market their plans. In fact, DOL admits that the additional flexibility afforded AHPs under this proposal could introduce more opportunities for abuse.⁸ Reversing decades of DOL guidance on MEWAs, this proposal does not require AHPs to have a legitimate purpose other than selling health insurance. The existing protections should be retained and any final rule should require AHPs to have a legitimate purpose other than simply selling health insurance. The proposal also eliminates the existing requirement that the association establishing the plan “exercise control over the program both in form and in *substance*”.⁹ Nominal control is a common feature of associations sponsoring fraudulent MEWAs. Nor is there any requirement that these groups be in existence for a set amount of time before they market their plans. All of these safeguards should be in any final rule. The DOL has a responsibility to assure that an association sponsoring a plan actually represents the interests of the employer members against those that would treat the plan as a simple commercial enterprise, or even worse, a fraudulent scheme designed to make money for its promoters. Nothing in this proposal that can be expected to achieve that.

Despite the assertion in the preamble that “The rule is intended to cover genuine employment based relationships, not to provide cover for the marketing of individual insurance masquerading as employment based coverage,”¹⁰ the proposal also allows self-certification of self-employed status. Yet fraudulent MEWAs have long gained access to the individual market by allowing employers to self-certify their employer status. The proposal contains no penalty for falsely certifying self-employed status. Moreover, after paying premiums, if and when a self-certified employer files a claim, nothing in the proposal prevents these plans from investigating the self-employed status and denying the claims because the certifier can’t document their self-employed status. Any final rule should contain enforceable provisions to assure that AHPs are available only to individuals who can verifiably meet the test for self-employment when enrolled and from time to time thereafter.

This proposal contains no safeguards to minimize the acknowledged damage that fraudulent MEWAs have inflicted on participants and their beneficiaries in the past. By requiring only minimal qualifications for offering an AHP, the DOL is opening the door to entities creating AHPs with the explicit purpose of defrauding small employers and individuals. Under the DOL’s proposal, fraudulent scams can come into existence quickly and easily and target unsuspecting small business and individuals. This proposal would ultimately leave

⁷ See *supra* note 4.

⁸ 83 Fed Reg. 632.

⁹ *Id.* At 617.

¹⁰ *Id.* At 622.

consumers at significant financial risks as they may face large unpaid claims for their health care or evaporating insurance coverage when their AHP goes out of business. Having admitted that the types of entities it is proposing to expand have a history of fraud and abuse, any final rule that does not include the current protections that the Department is proposing to eliminate, and include new stronger protections, would be arbitrary and capricious.

The Proposed Rule contains no meaningful standards to prevent AHPs insolvencies.

MEWAs have a long history of insolvencies.¹¹ The proposed Rule's stated intent is to expand the existence of and access to AHPs, but without meaningful protections in place to prevent financial insolvencies; more AHPs will mean more insolvencies. In particular, self-insured MEWAs have a troubled history of insolvency. They choose to assume insurance risk, but are less stable than state-regulated insurance companies due to their lower reserve requirements. Low reserves make it harder for these MEWAs to avoid insolvency when there is mismanagement, or even just larger than expected claims. For example, even though California has the highest surplus requirement for self-insured MEWAs, in 2001 Sunkist Growers, a licensed MEWA in California that covered 23,000 individuals became insolvent. Despite the fact that it had collected \$30 million in premiums, it owed \$11 million in medical claims.¹² Another example of the perils of self-insured MEWAs (and the proposed AHPs) is the Indiana Construction Industry Trust. It covered 790 employers and 22,000 employees. It was in operation since the 1960s and fully insured until 1999 when it became self-insured. It became insolvent 3 years later when it owed \$20 million in unpaid claims while having only \$1 million in assets.¹³ Unlike an insurance company, when a MEWA (including the proposed AHPs) becomes insolvent, covered beneficiaries are responsible for the unpaid medical bills, often resulting in financial ruin. In addition, hospitals must find ways to finance the uncompensated care, usually in the form of higher fees imposed on insured patients. If this proposed rule is finalized, it must include provisions such as an upfront approval process to assure actuarial, reserve and other solvency standards and other insurance type standards that would minimize the possibility of AHP insolvency.¹⁴

The Proposed Rule would strip participants and beneficiaries in AHPs of the consumer protections in the ACA, which will allow AHPs to discriminate on the basis of age, sex occupation and a variety of other factors through structuring of benefits, eligibility and marketing.

DOL is proposing to apply the nondiscrimination rules that apply to group health plans under 29 CFR 2590.792 to prohibit AHPs from discriminating based on health status related factors against employer members or their employees and dependents. This requirement is an essential protection for employers and their employees and DOL must retain it in any final rule. Moreover, DOL should require this of all AHPs. AHPs currently in operation should also be required to fully comply with nondiscrimination requirements immediately and without exception.

¹¹"MEWAS: The Threat of Plan Insolvency and Other Challenges" Mila Kofman, Eliza Bangit and Kevin Lucia, The Commonwealth Fund, March 2004, available at <http://www.commonwealthfund.org/publications/issue-briefs/2004/mar/mewas--the-threat-of-plan-insolvency-and-other-challenges>.

¹² Id.

¹³ Id.

¹⁴ If the DOL concludes it does not have such authority, it should withdraw the proposed rule until it receives such authority from Congress.

However, the nondiscrimination requirement contained in the proposed rule is an insufficient protection because an AHP can engage in other practices that result in discrimination against people with medical needs. The proposal exempts AHPs from ACA consumer protections designed in part to protect people with preexisting conditions. An AHP would be exempt from essential health benefits, rate reforms, guaranteed issue and single-risk pool requirements. Consequently, an AHP can simply avoid covering individuals and businesses where the participants are known to have medical needs. Using benefit design, an AHP can attract healthier groups only, including offering coverage without maternity, mental health benefits, and expensive prescriptions. People who need such coverage would not enroll in AHPs.

Also, an AHP could discriminate in rates, charging women higher rates than men, charging smaller businesses higher rates than larger businesses, charging businesses in certain industries higher rates, and charging older people higher rates without limit. Rating practices would result in only healthier groups being covered through an AHP. Furthermore, an AHP could engage in marketing practices targeted at attracting healthier people. An AHP could avoid a geographic area where there is a high incident of cancer rates, heart disease, and diabetes and thereby avoid covering sicker populations. Geographic location could also be used to engage in discriminatory redlining practices. An AHP could limit membership to a specific industry that has lower claims than other industries. Under this proposal small business with a workforce that is older or is disproportionately women would be the most disadvantaged, as would any industry that has a high utilization of health care services.

These and other discriminatory practices would be allowed because AHPs would be exempt from EHB, rate reforms, and guaranteed issue requirements. NELP is especially concerned that individuals and small employers would not necessarily have coverage that includes benefits such as maternity care, prescription drugs, mental health and substance use services. As proposed, the rule puts the economic stability and health of plan participants and their beneficiaries at risk by allowing employers to offer limited coverage that fails to meet the needs of their employees. A small employer, for example, with a relatively healthy workforce might offer an AHP with low premiums and limited benefits, which would return many employees back to pre-ACA levels of coverage. If an employee or their beneficiary later develops a serious health condition such as cancer or requires hospitalization – they could suddenly find that necessary care or treatment is not covered. In that situation, individuals will be faced with the choice of paying large amounts of their own money out of pocket or foregoing needed medical care. Low income workers enrolled in these plans would be especially affected because they simply do not have the income to pay large medical costs out of pocket. To ensure that AHPs provide essential benefits and are not engaged in discriminatory practices, in addition to the proposed non-discrimination standard, any final rule should apply the ACA's consumer protections including essential health benefits, rate reforms, guaranteed issue and single-risk pool requirements.

The Proposed Rule will lead to risk segmentations threatening the stability of the small group and individual markets.

The proposed rule would exempt AHPs from the ACA's single-risk pool requirement. This means that it is inevitable that AHPs will take every opportunity to tailor their coverage and their membership criteria to attract better risks and avoid worse risks. That will leave the regular individual and small-group markets to absorb a greater share of much-higher-cost patients, threatening their basic stability.

As MEWA's have done in the past, AHPs will cherry pick the healthiest businesses and people to cover, while leaving older and sicker people and small businesses in certain high risk industries to rely on state regulated markets. Like any risk pooling entity, AHPs will have a great deal to gain by avoiding the high risk cost subscribers. They will tailor their coverage and their membership criteria to attract only better risks. For instance, the NPRM allows AHPs to form based merely on geographic units of whatever size and proximity they choose. They can form based on a particular zip code or census tract whose residents have desirable populations and to avoid people or groups that are expected to have higher claims. They can cherry pick only good risks through the design of their covered benefits, for example, excluding expensive drugs for chronic illness. That will leave the regular individual and small group markets having to absorb a greater share of much higher costs patients. As the American Academy of Actuaries has noted this practice will challenge and destabilize the already overburdened state regulated small group (small business) and individual private health insurance.¹⁵

AHPs already have a history of harming regulated markets through risk segmentation. A leading example is 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 AHPs, 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.¹⁶

This undermining of the ACA small group and individual markets is inevitable since one of the stated goals of the proposed rule is to provide a less expensive alternative to plans that meet minimal actuarial value requirements and provide all benefits that have been deemed essential. Healthy people will have every incentive to leave the more regulated more expensive marketplace, leaving those sicker individuals who remain in those marketplaces with large and possibly unaffordable increases in premiums. Many people will be left with no health insurance options. For example, in an analysis recently released, it was projected that if the proposed AHP rule is finalized, premiums would rise in the current ACA individual (3.5%) and small group (0.5%) markets relative to current law, largely due to healthier enrollees shifting into AHPs. As a result of those premium increases an additional 130,000 additional individuals will become uninsured.¹⁷

The proposed rule asserts that AHPs will avoid market disruption by promoting risk pooling or minimizing risk segmentation and that concerns to the contrary are speculative.¹⁸ But DOL provides no citations or analysis or documentation for this conclusion. The DOL speculates that AHPs "may deliver

¹⁵"Issue Brief: Association Health Plans," American Academy of Actuaries, February 2017, available at <http://actuary.org/content/associationn-health-plans-0>.

¹⁶ 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).

¹⁷ Association Health Plans: Projecting the Impact of the Proposed Rule; Avalere Health 02.28.18, available at http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1519833539_Association_Health_Plans_White_Paper.pdf.

¹⁸ 83 Fed. Reg. at 626-29.

sufficient administrative savings to offset the additional costs of insuring an older or less health population.”¹⁹ But as the preamble asserts numerous times, the purpose of expanding access to AHPs is to reduce premium costs. To the extent an AHP experiences administrative savings, they are much more likely to be used to reduce their AHP premiums even further, instead of using the savings to enroll higher risk groups.

The Proposed Rule would hamper state enforcement by creating ambiguities in ERISA preemption.

Historically, promoters and others have established and operated questionable AHPs as vehicles for marketing health benefits to employers for their employees while representing that the arrangements are exempt from state insurance laws. In response to that, a Republican-led effort in 1982 amended ERISA to clarify that both states and the DOL can regulate AHPs in order to provide oversight and fraud protections for businesses and consumers. The DOL proposal creates new preemption ambiguity. Under this proposal, State oversight efforts will be severely hampered and in some cases foreclosed because of the possibility of ERISA preemption. NELP strongly opposes preemption of state regulation and any final rule should clearly address the continuation of the states right to regulate AHPs.

The proposal fails to clearly articulate that states can continue to regulate AHPs. State consumer protections such as rate reforms, guaranteed issue and single-risk pool requirements that keep markets stable are at risk. While, the proposal would permit an AHP to operate across state lines it does not address which, if any states, would have jurisdiction, and does not clearly articulate that all states would continue to have regulatory authority over such plans. While the preamble to the proposed rule states that it is not altering existing ERISA statutory provisions, existing statutory provisions allow for state regulation that is not inconsistent with the federal approach. Therefore, it is not clear if a state’s attempt to regulate by, requiring AHPs to provide essential health benefits and/or applying other small group rating rules could be preempted as inconsistent with the federal rule. Moreover, in the Request for Information (RFI) that accompanies the proposed rule, DOL appears to be signaling that it is considering whether to use its Section 514(b)(6)(B) authority to issue individual or class exemptions for AHP that are otherwise subject to state regulation.²⁰ An exemption would preempt state regulation leaving AHPs virtually unregulated, giving scams free license to proliferate, and consumers nowhere to turn when they are left with unpaid medical bills. At best if preemption is not clear, it will likely be litigated for many years as states attempt to keep private markets from imploding.

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's essential that DOL implement the additional tools to address fraud and abuse related to AHPs that Congress gave to it in the ACA.²¹ DOL has been authorized to act under Section 520 of ERISA since 2010, but it has not issued regulations to implement this provision. A DOL Office of Inspector General Report from September 30, 2011 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

¹⁹ Id at 628.

²⁰ 83 Fed. Reg. 625.

²¹ Section 520 of ERISA, 29 U. S. C. 1150.

means to prevent fraud and abuse.”²² DOL should begin the rulemaking process and implement this critical authority prior to moving forward with any proposal that would result in the proliferation of AHPs.

DOL does not have – and has never had – the resources to go after scams, fraud and mismanagement. Between 2000 and 2002, association scams left more than 200,000 people without health insurance and with more than \$252 million in unpaid medical bills.²³ States shut down 144 scams compared to only 3 shut down by DOL.²⁴ When Congress was considering legislating standards for AHPs, DOL testified that it can review plans under its jurisdiction once every 300 years.²⁵ In 2005 the Congressional Budget Office estimated that the AHP expansion legislation under consideration then would require DOL to hire an additional 150 employees and spend an additional \$136 million over 10 years to properly oversee the expansion yet the President’s Budget for Fiscal Year proposed a mere \$2 million for 15 additional FTEs to provide “interpretative guidance, oversight activities and compliance assistance” for the proposed expansion of AHPs.²⁶ In order to prevent fraud and mismanagement in the future and especially in light of this clearly inadequate budgetary proposal, any final rule should clearly state that ERISA single employer AHPs, including ones that operate across state lines, will continue to be subject to state oversight and regulation.

The RIA does not adequately take into account the costs and benefits associated with expanding access to AHPs.

As discussed above, the Regulatory Impact Analysis Operational Risks Section begins by admitting that “[h]istorically, a number of MEWAs have suffered from financial mismanagement or abuse, often leaving participants and providers with unpaid benefits and bills” and cites studies that detail the history of abuses.²⁷ However, the analysis contains almost no quantitative discussion of the costs to participants and beneficiaries when these entities collapse either through fraud or mismanagement. While DOL attributes this failure to several listed uncertainties, DOL does not even attempt to analyze the data it cites.²⁸

The DOL has publically stated in its MEWA Fact Sheet that it “has devoted significant resources to investigating and litigating issues connected with abusive MEWAs created by unscrupulous promoters who sell the promise of inexpensive health benefit insurance, but default on their obligations. Particular emphasis has been put on identifying ongoing abusive and fraudulent MEWAs, and working to shut down such

²²U. S. DOL, Office of the Inspector General “FURTHER ACTION BY EBSA COULD HELP ENSURE PPACA IMPLEMENTATION AND COMPLIANCE,” page 4, September 30, 2011, available at <https://www.oig.dol.gov/public/reports/oa/2011/09-11-003-12-121.pdf>.

²³ U.S. Gov’t Accountability Office, GAO-04-312, “Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage,” February 2004, available at <http://gao.gov/new.items/do4312.pdf>.

²⁴ Id.

²⁵ Testimony of Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration, Senate Labor and Human Resources Committee, October 1, 1997.

²⁶ FY 2019 Department of Labor Budget in Brief, available at <https://www.dol.gov/sites/default/files/budget/2019/FY2019BIB.pdf>, (page 20).

²⁷ 83 Fed. Reg. 631.

²⁸ Id. at 627.

operations.”²⁹ DOL also proudly presents examples of recent civil and criminal enforcement actions taken against such entities. In a 2013 Press release, it indicated that “EBSA has been involved in many cases where MEWAs have been operated by individuals who drained them of their assets through excessive administrative fees or outright embezzlement, leaving participants and their families with unexpected, unpaid health care bills.”³⁰ It has on its website over 75 press releases announcing the results of civil or criminal actions against fraudulent or mismanaged MEWAs.³¹ As recently as November 2017 DOL issued a press release that it had obtained a temporary restraining order against a MEWA that had more than \$26 million in unpaid claims. At its height, this MEWA covered approximately 14,000 participants and beneficiaries. These participants worked for more than 560 employers in 36 different states.³² Yet, DOL does not analyze this data as part of the NPRM, nor does it put these investigations into context and discuss how DOL will safeguard against an increase in these investigations. It neither presents nor analyzes the data it already possesses from current and past investigations.

Every piece of data and all information relating to the past failures of MEWA’s that the Department possess or is aware of must be put into the public proposal so a serious scrutiny of all the costs and benefits can be undertaken. DOL has readily-available data regarding the number of prior failures, the loss of premiums paid for no insurance coverage, the number of participants and beneficiaries whose medical claims were not paid and the amount of unpaid medical claims in each failure and in total over the years since the enactment of ERISA. DOL’s failure to reveal and analyze this type of information undermines the cost benefit analysis in the NPRM. This alone likely renders any final rule arbitrary and capricious.³³ The combination of a lack of a data presentation, any analysis of the past failures of these entities and, as discussed above, the lack of safeguards to guard against fraud and mismanagement after this proposed expansion makes it even more likely that any final rule will be arbitrary, capricious, and an abuse of discretion. On March 1st, a coalition of stakeholders, including Georgetown University’s Center on Health Insurance Reforms (CHIR) asked the DOL to withdraw or substantially delay the proposed regulation.³⁴ This demand was made in conjunction with a Freedom of Information Act (FOIA) request, because, as discussed above, DOL has failed to provide critical information, data, and statistics from its own files detailing the history of financial abuses associated with AHPs. NELP urges that the NPRM be withdrawn and reissued only after the FOIA request is answered and with an analysis of any data the DOL has knowledge of or has in its possession.

Allowing Associations of Small Employers and/or Individuals to be treated as Large Groups violates the structure and Purpose of Affordable Care Act.

²⁹ MEWA Enforcement Fact Sheet, U.S. Department of Labor, Employee Benefits Security Administration, March 2013.

³⁰ <https://www.dol.gov/opa/media/press/ebsa/EBSA20130383.htm>.

³¹ <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/enforcement/healthcare-fraudyet>.

³² <https://www.dol.gov/newsroom/releases/ebsa/ebsa20171108>.

³³ See generally *Michigan v. EPA*, 135 S. Ct. 2699 (2015); *National Association of Home Builders v. EPA*, 682 F. 2d 1032 (D.C. Cir. 2012).

³⁴ <http://chirblog.org/coalition-demands-crucial-information-association-health-plan-rulemaking/>.

The ACA was designed to ensure that all Americans have access to comprehensive health insurance. Prior to the ACA individuals with health insurance might develop a condition that needed health care coverage but could discover that their insurance did not cover the kind of medical attention they needed. The ACA addressed this issue and promoted comprehensive coverage by targeted regulation in different segments of the insurance market. In the individual and small group market, it imposed consumer protections, most notably specific EHBs, on health insurers selling in those markets.³⁵ In the large group market, it took a different approach. It imposed requirements not upon insurers, but upon employers themselves through the employer mandate in the tax code. While the tax code does not require that large employers offer each of the EHBs, it requires the same actuarial level of benefits imposed in the small group and individual markets.³⁶ Thus while large employers have more flexibility in determining which particular benefits to cover they must achieve the same costs standards as the small group and individual markets. In other words, they cannot exclude too many benefits that are part of the EHB package, and to the extent they do exclude a benefit, they must offer more generous coverage for other benefits. Thus, all employees will have coverage that meets a meaningful standard of comprehensiveness.

This proposal completely undermines the mandate of comprehensiveness. It reduces the breadth of coverage for participants in AHPs. It creates a group health plan, which has neither the small group and individual plans consumer protections, nor the large employer's comprehensiveness mandate. The ACA is structured precisely to avoid this outcome and therefore the proposal violates the ACA. In order to remedy this, any final rule must require AHPs to provide the consumer protections of the small group and individual markets.

Conclusion. For these reasons, we urge the Department to reconsider its proposal and leave the 2011 regulation intact. We also request the Department hold a public hearing so that stakeholders can fully share their concerns. Please contact Judy Conti at 202-640-6517 if you have questions about these comments.

Sincerely,



Christine Owens
Executive Director

³⁵ 42 U.S.C. 18022(a).

³⁶ 26 U.S.C. 4980H(b).