blue of california

March 6, 2018

Jeanne Klinefelter Wilson
Deputy Assistant Secretary
Office of Regulations and Interpretations
Employee Benefits Security Administration, Room N–5655
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Submitted electronically.

RE: Definition of Employer—Small Business Health Plans.

Dear Ms. Wilson:

Blue Shield of California ("Blue Shield") appreciates the opportunity to respond to your Definition of "Employer" under Section 3(5) of ERISA—Association Health Plans Proposed Rule. Blue Shield is a nonprofit health plan that offers health benefits coverage to individuals and groups throughout the State of California. As a nonprofit, Blue Shield's mission is to increase the number of insured Californians, improve health care quality, and provide higher-value care at an affordable price. Blue Shield provides coverage in the individual and group markets, covering approximately 4 million Californians. That enrollment is a result of a focused effort to provide high-value care at an affordable price. The stability of all health insurance markets is key to continuing to provide affordable access to Californians and people across the country.

The Department of Labor's proposed rule on Association Health Plans (AHPs) aims to make the formation of AHPs easier and to expand their enrollment, with the rationale that this will make affordable health insurance coverage available to more small employers. However, these arrangements do not serve to "bend the cost curve" to sustainably lower the cost of care. Instead, they merely lower the cost of insurance for some by raising the cost for others. This transfer of costs does not create a sustainably affordable health care system—it merely would allow certain groups to profit at the expense of others.

Additionally, this proposal risks repeating mistakes of the past. We appreciate the Department's recognition that AHPs and Multiple Employer Welfare Arrangements (MEWAs) have a very problematic history. The Department correctly recognized that, "Historically, a number of MEWAs have suffered from financial mismanagement or abuse, often leaving participants and providers with unpaid benefits and bills." This is particularly true in California, where hundreds

of thousands of Californians who thought they had insurance were left with unpaid claims. AHPs, including MEWAs, proliferated following the passage of ERISA in the 1970s. These plans were often able to market attractive rates, in part because they were held to less stringent licensing requirements than those imposed on traditional insurers. As a result, they were at far greater risk of becoming insolvent and have been continually plagued by financial instability and fraud.

These problems became evident to federal regulators in the 1980s, prompting Congress in 1983 to amend ERISA to provide increased state regulatory authority over MEWAs. However, even this action did not fully address the problems. A 1992 GAO report concluded that, "MEWAS have proven to be a source of regulatory confusion, enforcement problems, and, in some instances, fraud. Between January 1988 and June 1991, MEWAS left at least 398,000 participants and their beneficiaries with over $123 million in unpaid claims and many other participants without insurance. More than 600 MEWAS failed to comply with state insurance laws, and some violated criminal statutes."[1]

Considering this history, the principles of Federalism require that states be permitted to maintain control of their insurance markets, particularly where a state wants to be more protective of its consumers. The Proposed Rule on AHPs does not propose to change this critical balance, nor should it. In contrast, the rule warns that the "[o]perational risks [of expanding AHPs] may demand increased Federal and State Oversight." It is essential that the federal agencies not overrule decades of on-the-ground experience states have in regulating their markets. Each state may have unique circumstances that warrant a particular approach to the complicated implications of enabling AHPs. This is even more true where AHPs can involve out of state actors beyond the reach of state regulators and consumer protections. To facilitate proper state control, the agencies should explicitly clarify that nothing in the rule is intended to preempt any state law or regulation affecting a MEWA or insurance contract in that state and continue to provide states full oversight of their markets to the extent permitted under ERISA.

Shifting Risk but Not Lowering Costs:

The small group market in California is stable with relatively moderate premium increases.[2] Contrary to the statements in the Proposed Rule,[3] premium increases in the small group market in California were extremely volatile before the Affordable Care Act (ACA). Since the ACA market rules took effect, premium increases in the small group market have moderated significantly.[4] We have strong concerns that any advantage to employers participating in AHPs will come at the expense of the broader small group market.

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[1] GAO, "Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements," March 1992. Available at: https://www.gao.gov/assets/220/215647.pdf.
[2] The average premium increase for 2018 was 4.0 percent. *See* National Trends in Individual and Small Group Market Premiums, DMHC Financial Solvency Standards Board Meeting, January 23, 2018.
[3] The Proposed Rule states that "the ACA has caused" small group premiums to increase.
[4] *See* Kaiser Family Foundation Annual Survey of Employer Health Benefits for 2016, Exhibit 1.16. Available at: http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey. The

While the Proposed Rule suggests that costs to small employers can be reduced through "administrative efficiencies" and "economies of scale" offered by AHPs, there is no evidence showing real savings from these mechanisms. As the Proposed Rule notes, some AHPs might offer less comprehensive benefits with higher administrative costs. Instead, carriers selling AHPs will engage in various schemes to risk-select, including offering coverage with reduced benefits, offering only bronze-level coverage, or targeting certain industries with lower risk. Syphoning off healthy populations and good risk from the overall market doesn't lower costs; it just shifts costs.

In addition, as noted in the Proposed Rule, AHPs organized as large groups are exempt from the risk adjustment program that serves to redistribute financial benefits resulting from selection. The risk adjustment program is an important check on intentional risk stratification strategies by small group carriers. By allowing carriers to design benefits to attract a healthier population—and then exempting them from risk adjustment—the Proposed Rule magnifies the benefits of intentional risk selection strategies that the ACA rules attempted to marginalize. If AHPs really are designed to reduce costs through efficiencies, they should be required to participate in the risk adjustment program to ensure that they are not simply benefiting from adverse selection. This would allow AHPs to retain any material benefits from administrative efficiencies or market power, while controlling for intentional selection.

AHPs in California—A History of Fraud and Failure:

The Proposed Rule acknowledges the problematic history of AHPs and their pattern of fraud and failure. This history played out to the detriment of hundreds of thousands of California consumers, leading the state legislature to step in and impose regulations to mitigate the damage and prevent future abuses. Given this history, the Proposed Rule lacks a valid factual basis to limit a state's authority over its own markets. We agree with the Department that "the flexibility afforded AHPs under this proposal could introduce more opportunities for mismanagement or abuse, *increasing potential oversight demands on the Department and State regulators*."[5] (emphasis added). We feel strongly that the states must maintain their ability to regulate these arrangements and that any additional federal preemption of state oversight would be contrary to the historical evidence presented in the rule. The final rule should explicitly clarify that nothing in the rule is intended to preempt any state law or regulation affecting a MEWA or insurance contract in that state.

The Proposed Rule notes that Congress acted to "curb MEWA abuse" by passing reforms that recognized it is both "appropriate and necessary for states to be able to establish, apply, and enforce state insurance laws with respect to MEWAs." The Proposed Rule further notes that the

ACA market rule with the biggest premium impact was member-level rating, which created a shift between employer groups but did not increase the aggregate premiums in the small group market.

[5] The Proposed Rule cites this risk twice, noting later that, "Operational risks may demand increased federal and State oversight."

ACA "established a multipronged approach to MEWA abuses" to facilitate "joint state and Federal efforts to prevent harm and take enforcement action." It would be contrary to this Congressional direction to circumscribe the ability of states to protect their markets.

In addition, the historical evidence supports a strong role for state and federal regulators. California residents were impacted by several significant and widely publicized MEWA failures during the 1980s and early 1990s. According to a GAO report, by 1991 an estimated 200,000 Californians were affected with approximately $45,000,000 in unpaid claims.[6] The next year, a State Senate Committee held a hearing on insurance practices including MEWAs and found widespread violation of California's insurance laws by plans attempting to operate under the federal exemptions provided by ERISA. Consequently, California passed legislation in 1994 that restricted the ability of new MEWAs to form and to offer health care benefits within the state.[7] That state law also required MEWAs to meet certain financial requirements.

Even with state legislation restricting MEWA formation in California, employees living in California continued to be financially damaged by MEWAs, many by arrangements claiming to be exempt from state regulation. Thousands of Californians were left with millions of dollars in unpaid medical bills. Below we describe just a few of the many examples:

- Rubell-Helm Insurance Services: In the early 1980s, the partners used the money intended to provide medical benefits to pay themselves excessive salaries and to buy personal luxury items. The company attempted to use ERISA to avoid state regulators by claiming federal exemption from regulation.[8] When the company went out of business, it was reported to have left $10 million in medical claims unpaid.[9]

- Atlantic Health Plan: Beginning in 1990, Edward Zinner and his associates marketed and administered two health insurance plans, the Atlantic Plan and the American Plan, that received millions in subscriber premiums. While Zinner's health plans were based in

[6] United States General Accounting Office (GAO), *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*, March 1992, GAO/HRD-92-40, Appendix III, Table III.1, available at: https://www.gao.gov/assets/220/215647.pdf.

[7] INS Code Section 742.24. This law required all MEWAs to file applications for certificates of compliance by November 30, 1995, or cease operating in California. It also authorized the California Department of Insurance to set fiscal solvency standards, imposed upon MEWAs the same mandates for health insurance imposed on regulated health insurers, and required MEWAs to cover only employers in a similar trade, profession or industrial association.

[8] Fraud and Abuse in Employer Sponsored Health Plans: Hearing Before the Permanent Subcomm. on Investigations of the Senate Comm. on Governmental Affairs, 101st Cong. 3 (1990) (statement of Senator Nunn), available at: http://njlaw.rutgers.edu/collections/gdoc/hearings/9/90602184/90602184.html.

[9] *Los Angeles Times*, "Health Insurance 'Pyramid' Scams Examined: Hearing: Authorities tell a Senate panel that Irvine-based Rubell-Helm Insurance Services is among firms under scrutiny for allegedly taking premiums and not paying large, legitimate claims." May 16, 1990, available at: http://articles.latimes.com/1990-05-16/business/fi-362_1_health-insurance.

Virginia, one-third of the Atlantic Plan's premiums came from California.[10] When selling the plans, Zinner falsely claimed that the plans were properly insured, that they had sufficient reserves to pay claims, and that they were exempt from state regulation. He and his associates used the funds held in trust for payment of health benefit claims for personal business debts, entertainment expenses, no interest/no term loans, and personal lines of credit. Zinner eventually pled guilty to a variety of charges including racketeering, mail and wire fraud, and making false statements.[11]

- Sunkist Growers, Inc.: The collapse of Sunkist's SGP Benefit Plan Inc., a California licensed MEWA, in 2001 forced tens of thousands of employees to find new health plans and left nearly 5,000 medical providers with unpaid bills. Sunkist had collected over $30 million in premiums and was estimated to owe approximately $11 million for medical claims.[12]

Contrary to DOL's notion that expanding access to AHPs will lead to increased availability of affordable health insurance coverage, history has shown that the lack of regulation of AHPs makes room for unscrupulous and/or negligent actors to hurt hard-working individuals seeking lower premiums. As thousands of Californians have already discovered, AHP insolvency means that medical bills go unpaid and families get saddled with huge expenses, leaving them vulnerable to bankruptcy. Beyond those directly affected, insolvent health plans hurt the entire market. Physicians and hospitals are faced with accounting for uncompensated care, leading to higher provider fees for other insured patients and higher insurance premiums for all.

Conclusion:

Thank you for the opportunity to comment on these proposed rules. We would welcome the opportunity to discuss any of these issues with you at your convenience.

Sincerely,

Andrea Chasin

Andy Chasin
Policy Director
Blue Shield of California

[10] Tillman, Robert: *Broken Promises: Fraud by Small Business Health Insurers,* Northeastern University Press, 1998, pgs. 61-62. Google Books, https://books.google.com.
[11] United States Department of Labor, Office of Inspector General, Semiannual Report to Congress, October 1, 1994-March 31, 1995, pg. 19, available at: https://www.oig.dol.gov/public/semiannuals/33.pdf.
[12] *Los Angeles Times,* "Sunkist's Health Plan Collapses." January 4, 2002. Available at: http://articles.latimes.com/2002/jan/04/business/fi-sunkist4.