pennsylvania
INSURANCE DEPARTMENT

March 6, 2018

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

Submitted electronically via http://www.regulations.gov

Re: Proposed Rule: RIN 1210-AB85

Dear Mr. Secretary:

The Pennsylvania Insurance Department (the Department) appreciates the opportunity to submit these comments on the notice of proposed rulemaking titled, "Definition of 'Employer' Under Section 3(5) of ERISA—Association Health Plans." (83 F.R. 614 et seq., Jan. 5, 2018). We acknowledge that it is a laudable goal to seek to increase access to affordable health coverage; however, we have concerns about increased potential for consumer harm both immediately, and in the near future, as the ripple effect of the proposed changes begin to affect market stability, insurers, and the provider community. Our comments, which are grounded in Pennsylvania's significant enforcement history, focus on those areas within the proposed rule that, if finalized as drafted, would result in greater barriers to high-quality coverage and decreased affordability.

Pennsylvania's Experience with Associations

Pennsylvania has extensive experience with associations securing health coverage for their members, and a brief overview of this history may provide context for our comments. Associations can choose to fully insure or self-fund the health care coverage they offer. If fully insured, the insurers from whom associations purchase coverage are subject to state regulatory requirements. Pennsylvania law permits a legitimate association of employers, such as a Chamber of Commerce, to purchase insurance on a group basis from a licensed insurance entity. In this case, the Department has the authority necessary to protect consumers and ensure solvency through the licensing process for the insurance entity. State authority over self-funded Multiple Employer Welfare Arrangements (MEWAs) is another matter.

In the late 1970s through the early 1980s, certain entities exploited ERISA's federal preemption of state law, claiming that certain AHPs, as MEWAs, were "employee benefit plans" exempt from state insurance laws. This allowed for "sham" MEWAs to claim exemptions from state insurance laws. The states had the burden of showing, factually, that the MEWAs themselves were not really true "employee benefit plans" in order to regulate their activity within a state. This is a very fact- and labor-intensive inquiry. Because of the issues involving sham, self-funding MEWAs avoiding regulation in Pennsylvania and other states, ERISA was amended in 1983 to expressly permit states to apply their insurance laws to MEWAs to allow states to regulate them to the extent state laws are not inconsistent with Title I of ERISA.

After joint regulation of MEWAs between the federal Department of Labor (DOL) and state Insurance Department was established, Pennsylvania formulated a dedicated MEWA Task Force in the early 1990s to tackle the issues regarding an uptick in sham MEWAs. Pennsylvania litigated numerous cases; obtained suspension, seizure and liquidation orders against illegal MEWAs; and revoked the licenses of agents who sold policies for these entities. The Department looked into many different problematic MEWA scenarios, including bogus union plans, illegitimate allegedly fully insured association plans (i.e., a stop loss carrier was used to "drop down" and provide first dollar coverage or coverage above a very low deductible) and questionable "church plans." Ultimately, many consumers were left without coverage and very little support. With no guaranty fund to pay unfunded claims, the Insurance Department did what it could to provide guidance. Even with state intervention, millions of dollars in unpaid claims remained. This situation was not unique to Pennsylvania. As noted in a 2004 GAO report, states reported that unauthorized entities had at least $252 million in unpaid claims nationwide from 2002-2004.[1]

Because of solvency issues and the potential for consumer harm, as noted above, Pennsylvania still prohibits most self-funded MEWAs. Specifically, if a group of employers were to join together to self-fund the health care coverage they provide to their employees without first securing a license, it would be considered unlicensed insurance activity and a violation of state law.[2] This regulatory approach is for the benefit of the employees who would purportedly be covered by the self-funded scheme.

The proposed rule confirms that Pennsylvania's regulatory structure overseeing MEWAs would remain. However, DOL's proposed revisions could create ambiguity for stakeholders. To avoid potential confusion, we recommend that DOL explicitly affirm in the final rule that the changes in no way limit the ability of states to regulate MEWAs, insurers offering coverage through MEWAs, and insurance producers marketing such coverage to employers. Clarification that states retain full authority to establish and enforce solvency standards for all MEWAs, and comprehensive licensure requirements for non-fully insured MEWAs, will allow for a better understanding of the regulatory framework overseeing MEWAs for all stakeholders. We also encourage the DOL to affirm that states retain full authority under ERISA's saving clause to regulate the terms of the insurance coverage that may be offered to fully insured MEWAs.

The DOL notes in the rule that interested stakeholders have an opportunity to present views on the implications and significance of this proposal in light of sound public policy. (83 F.R. at 623). Based on Pennsylvania's extensive history with MEWA enforcement efforts, we are convinced that it is not sound public policy to create regulatory ambiguity that would invite associations to avoid effective regulatory oversight by the Department. An association's failure to provide comprehensive benefits that state lawmakers have determined should be provided to employees would be detrimental to Pennsylvania consumers. More critically, MEWAs may jeopardize the financial wherewithal with which employees' claims are to be paid. Uniform insurance standards and oversight activities allow for a level playing field, which supports a competitive market. Assurances that oversight activities will be supported give states the ability to ensure issuers are financially sound. There is no assurance, if AHPs are removed from state regulation, that there can or will be sufficient actuarial analysis of the risk being undertaken, adequate funding and reserves, or

[1] U.S. Gen. Accounting Office, GAO-04-312, Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entities Selling Coverage 4 (2004).
[2] *See* 40 P.S. §§ 46, 47 requiring an association to obtain a certificate of authority from the Insurance Department before engaging in the business of insurance, and imposing monetary penalties for those operating without a certificate of authority.

appropriate (i.e., not excessive) levels of administrative expenses. While the proposed rule confirms that Pennsylvania's regulatory structure would remain, we nonetheless entertain public policy discussion of how the proliferation of MEWAs could be harmful if encouraged.

Formation of Associations

The proposed rule would allow associations to be formed for the sole purpose of purchasing insurance or providing self-funded coverage, which is a violation of Pennsylvania state law.[3] Not only does Pennsylvania state law prohibit formation of an association solely for the purpose of obtaining insurance, it also requires that an association must have been in active existence for at least two years.

Proponents of AHPs may argue that an AHP formed solely to provide health care coverage presents no more risk than does a self-funded large single-employer group. But there is more risk. A large employer with ongoing business operations has countervailing pressures that an AHP does not have. A large employer, if it is to stay in business and satisfy its shareholders, must protect its reputation, and must treat its employees in a manner that will assure the continuity of its workforce. An AHP formed for the sole purpose of providing some level of health care coverage, on the other hand, has none of those concerns. Unlike a business operation, an AHP formed for the purpose of providing health care coverage has no reason for its existence other than to collect money and pay for health care claims, and it is but a few short steps for administrators of an AHP either to miscalculate the financial costs and be forced into liquidation or insolvency, or, with less noble intentions, to yield to the temptation to skims funds from its accounts and then walk away from its promises of coverage.

The proposed rule would also loosen existing commonality of interest requirements to allow associations to form simply based on membership in the same trade, industry or profession; or on geographical area, i.e., the principal location of the business being within the same state or the same metro area. While Pennsylvania law does not specifically address commonality of interest beyond the requirement to be "organized [and] maintained in good faith for purposes other than that of obtaining insurance", the implications of allowing cross-state sales of insurance via the metro area commonality requirement are of great concern. If a self-funded MEWA were permitted to form in a neighboring state and to sell to Pennsylvania association members under the metro area provision, Pennsylvania regulators would not have the ability to assist a Pennsylvania resident if problems arise with the other state's association, including claim denials, or, worse yet, in the event of insolvency or fraud.

As noted above, the provisions in Pennsylvania state law are intended to protect consumers from sham MEWAs that could leave employers and their employees with unpaid claims. Any attempt to call into question state laws that govern the formation and availability of AHPs would put Pennsylvania consumers at risk.

The DOL seeks comment on whether or not it would be helpful to have more clarification regarding the definition of a metropolitan area, as well as comments about whether or not associations could manipulate geographic classifications to avoid offering coverage to certain populations. (83 F.R. at 620). We suggest that the DOL should provide a specific definition of metropolitan area. As above, attempts to limit state authority,

[3] *See* 40 P.S. §756.2(a)(2).

particularly when there is evidence that an association has manipulated the metropolitan area provision to avoid certain state laws, would put Pennsylvania consumers at risk.

Limitations on Coverage

DOL states that the principal objective of this proposed rule is to expand access to less expensive large group coverage. The proposed rule would not change AHPs but would expand the number and types of employers who can access AHPs as large group products, which, as noted, may offer less robust coverage and provide have fewer consumer protections than individual and small group products. Through reduced restrictions on commonality of interest and the treatment of sole proprietors as "working owners," the large group threshold would be far easier to cross than in the past. DOL specifically invites comment on whether working owners who join an AHP are genuinely engaged in a trade or business. In order to protect against fraud and abuse, either from individuals inappropriately joining associations or from associations trying to recruit ineligible individuals, PID recommends that the final rule include a definition of working owners and clearly outline the documentation necessary to substantiate claims that a working owner is genuinely engaged in a trade or business.

In addition to fraud and abuse concerns, increased access through associations to large group plans that offer limited coverage to consumers would have an immediate negative impact on consumers due to confusion, as well as downstream consequences in terms of uncompensated care, medical bankruptcies, and problems with access to coverage.

Despite being promoted as a way to expand access to "affordable, high-quality" coverage, coverage offered to large groups through associations is not subject to minimum standards such as essential health benefits and prescription drug coverage requirements. We agree that premiums may or could likely be lower for these plans, but lower premiums are a result of fewer benefits. With fewer benefits covered, people who have existing medical conditions will be driven to ACA-compliant plans, which will create an *ad hoc* high-risk pool, driving up premiums and driving out competition. Even for the healthier individuals who take advantage of access to self-funded AHPs, ERISA prevents the application of existing state mandates, so consumers expecting coverage that at least complies with minimum requirements applicable in their homes state may find themselves lacking adequate coverage for basic or crucial health care needs. As association-member employees find that they do not have coverage for these needs, they will likely return to the individual market creating a sicker risk pool and further destabilization.

Moreover, the proposed rule is silent on the applicability of a variety of non-benefit consumer protection provisions, including, for example, what rights an employee will have to secure comprehensive coverage mid-year upon learning of inadequacies of the AHP coverage relative their health needs. Sufficient consumer protection requires continued enforcement of state law and of ACA provisions that apply generally to the large group market, including:

- guaranteed availability;
- guaranteed renewability;
- prohibition on pre-existing condition exclusions;
- maximum out-of-pocket limits;
- lifetime and annual dollar limits on covered Essential Health Benefits (EHBs);
- prohibitions on rescissions;

- coverage of preventive health services;
- Summary of Benefits and Coverage (SBC) documents and notice of material modification requirements;
- appeal and external review rights; and
- primary care and emergency service requirements.

Limitations on Health Nondiscrimination Provisions

In response to the DOL's solicitation of "comments on the proposed nondiscrimination requirements, including how they balance risk selection issues with the stability of the AHP market and the ability of employers to innovate and enter voluntary coverage arrangements," (83 F.R. at 624), we suggest that the proposed rule does not go far enough.

We recognize the clear language that prohibits discrimination based on health status; however, under the proposed rule, AHPs would still be permitted to discriminate based on gender, industry, or age (unchecked by the ACA age-bands), each of which may be a proxy for discriminating based on health status. Thus, the articulated prohibition could, in effect, be illusory, providing no true protection from discrimination. AHP rates for women and older workers could easily climb out of reach, thus incentivizing formation based on factors that exclude those who would pose a greater risk. This will likely result in the healthiest individuals choosing AHPs, and leaving sicker individuals to seek coverage in the existing individual and small group markets, which would necessarily be priced higher, with increasingly higher individual and small group premiums year-over-year due to adverse selection. Not only would the rule make it possible for associations to discriminate based on health status via numerous other means, but it also fails to balance risk selection issues with the stability of health insurance markets generally. In light of the destabilizing effect these protections would have in their current form, we suggest that additional protections be included to ensure a level playing field for all and to minimize the destabilizing impact this proposal would have on our insurance market.

Further, to the extent this proposed change to the definition of "employer" is only meant to apply in the context of AHPs, and associations do form in such a way to avoid high-cost members, we expect continued application of state and federal civil rights and equal opportunity laws will be critical.

Notice Requirements

The DOL invites comment on whether notice requirements are needed to assure that participants and beneficiaries have adequate information regarding enrollees' rights and responsibilities with respect to AHP coverage. (83 F.R. at 624-25). Our response is, unequivocally, yes, substantial notice requirements are needed. Association members must be made aware, not only of the limits in their coverage, e.g., lack of benefits to which they have become accustomed, but also of the limits to their rights, such as ineligibility to switch to comprehensive medical coverage when their AHP is not meeting their medical needs. Additionally, members need to be aware that self-funded MEWAs are not covered by state guaranty associations - should a self-funded AHP become insolvent, the members will be responsible to pay any unpaid claims.

The Administration should also provide a framework to grant states additional resources to support education and enforcement efforts. Within the last two years, the Pennsylvania Insurance Department suspended the licenses of seven agents who had knowingly misrepresented limited benefit plans as having comprehensive

benefits that are compliant with the ACA. Additional investigations are still ongoing. Given the potential for similar misrepresentations about benefits and coverage under AHPs, clear disclosure requirements, as well as enhanced education and enforcement, will be necessary to protect consumers from harm.

Timing Concerns

The DOL indicates that this proposal would "offer many small businesses more affordable alternatives than are currently available to them in the individual or small group markets," and may "prompt some small businesses with insured health plans to switch from their existing individual or small group policies to AHPs." (83 F.R. at 619). Such disruption to the health insurance market without sufficient time for states to put in place enforcement tools and resources likely would be disastrous for consumers, regulators, and individual and small group insurers.

As proposed, this rule would increase access to AHPs and encourage their use as an alternative to the more expensive and comprehensive individual and small group plans that comply with the ACA's minimum consumer protections. The American Academy of Actuaries has warned that this construct:

> would fragment the market as lower-cost groups and individuals would move to establish an AHP, and higher-cost groups and individuals would remain in traditional insurance plans. Such adverse selection would result in higher premiums in the non-AHP plans. Ultimately, higher-cost individuals and small groups would find it more difficult to obtain coverage.[4]

In Pennsylvania, we continue to experience upheaval due to uncertainty and last-minute substantive changes to market requirements. As our regulated community and consumers have tried to adjust for these last-minute changes, including risk corridor budget neutrality, repeal of the individual mandate, and concerns regarding the non-payment of CSR payments, the result has been increased rates and consumer confusion. Given the disrupting effect this rule would have on the individual and small group markets, if this rule is finalized as proposed, we encourage the DOL to delay the effective date of this rule to give regulators, legislators, insurers, and other stakeholders an opportunity to be thoughtful in its implementation. At the state level, there is a clear need for regulatory and/or legislative action to prepare markets for potential insolvencies, greater risk to consumers, and a shift in risk pools that will result in higher premiums. The insurance industry will need to adjust their business plans, including marketing, benefit designs, and rates to account for enrollment shift and adverse selection. Providers, as well as consumer advocacy groups, will need time to understand and respond to a flood of new, less-comprehensive coverage, a return to more uncompensated care, and confusion around what is covered and what is not. We respectfully request that implementation of this rule be delayed until 2020 at the earliest.

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In sum, if this rule is finalized as proposed, it will create more problems than it will solve. While we support expanding access to affordable coverage, the policy implications of expanding access to substandard coverage through AHPs is well-documented as an inappropriate strategy that has long relied on a lax regulatory structure.[5] If provisions in this rule are finalized as proposed, the potential for adverse selection resulting from

[4] American Academy of Actuaries. *Issue Brief: Association Health Plans* (Feb. 2017), *at* https://www.actuary.org/content/association-health-plans-0.
[5] *See, e.g.*, Owcharenko, Nina. Making Association Health Plans a Success, Heritage Foundation Backgrounder, No. 1824 (Feb. 14, 2005).

the expansion of AHPs will negatively impact the stability and affordability of the traditional individual and small group markets and will result in significant consumer harm.

We appreciate your consideration of our comments. If you have any questions or would like more information, please do not hesitate to contact me.

Sincerely,

Jessica K. Altman
Acting Commissioner

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