March 6, 2018

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

ATTN: Definition of Employer – Small Business Health Plans RIN 1210-AB85

Dear Sir or Madame:

On behalf of the United Hospital Fund (UHF), an independent, nonprofit, health care philanthropic and research organization headquartered in New York State, I am writing with regard to the above-captioned regulation For the past ten years, my work at UHF has focused on New York State's public and private insurance markets, featuring detailed analysis of the individual and group markets, including enrollment, morbidity, health plan financial data, and state and federal laws and regulations affecting these markets, particularly the Affordable Care Act (Samples of recent publications are available at http://uhfnyc.org/publications/880618 ; http://uhfnyc.org/publications/881265 ; http://uhfnyc.org/publications/881127 ; http://uhfnyc.org/news/881256). Following are my comments:

1. The regulation should be withdrawn

The regulation should be withdrawn because it would do irreparable harm to New York's individual market – finally stabilizing due to the ACA – and small group market, which is very fragile at this point. Since 1992, New York has had in place a pure community rating regulatory framework in both the individual and small group markets; no rating variations are permitted based on age, sex, health status, group size, or occupation. The ACA set similar baselines for the nation, granting states significant discretion to set their own standards. In addition, New York has a tradition of requiring comprehensive benefits, currently embodied in the ACA essential health benefits benchmark plan chosen, which includes benefits that are not statutorily required in large group coverage. New York does not permit noncompliant, so-called "bare bones" or limited benefit coverage. Finally, New York defines its small group market as 1-100 employees. Taken together, these features – which New York adopted under the statutory discretion granted it under the ACA – coupled with the proposed AHP regulation, would make the individual and small group markets here a target-rich environment for AHP sponsors looking to siphon off healthier risks. And, the proposed rule provides them with an endless number of tools to undercut ACA-compliant individual and small group coverage as part of large-group or self-funded AHPs.

Despite the nondiscrimination provisions of the regulation, AHP sponsors targeting individuals and small groups in New York could: 1) market individual or group association coverage that is less costly because it avoids geographic areas with higher incidence of disease or higher costs; 2) market association coverage to groups of under 50 employees which have healthier members and would benefit from being part of an experience-rated large group; 3) market association coverage to employers with 51-100 employees with healthier workers, or workforces with younger worker or more males, using large group experience rates; 4) market association coverage to employer groups with

lower risk occupations, using the readily available North American Industrial Classification or Standard Industrial Classification codes that are used to underwrite large group coverage; 5) market association coverage to self-employed individuals who are younger, male or work in lower-risk occupations; 6) market reduced benefit (i.e., with limited or no prescription drug benefit) association coverage to healthier individuals, which would be much less costly, and unacceptable to individuals with medical needs; and 7) market reduced benefit association coverage to small groups with healthier workers, which would be unacceptable to groups with higher medical needs; and 8) market group association coverage which facilitates the dumping of high-cost employees into the individual market. Distressingly, these association plans would in effect be self-cleansing, since employer groups with higher medical needs for whom low-cost, low-benefit coverage is no longer sufficient , would always be free to return to higher-benefit ACA-compliant coverage, relying on guaranteed issue laws for individuals and groups.

The operation of the AHP scheme on New York's individual and small group markets is entirely predictable, and has been described in many other real-life examples, and by many respected commentators and experts, such as in the testimony on the regulation by the American Academy of Actuaries. New York's markets would be rent asunder, with healthier individuals gravitating to cheaper, lower-benefit association coverage, and healthier small and mid-size groups shifting to lower-cost association group coverage, as adverse selection creates increasing cost-pressures in the non-AHP markets. While the individual market, as the source of ACA Advanced Premium Tax Credits, would likely limp along with increasingly higher premiums and smaller participation in the off-Exchange segment, the small group market would likely implode and comprehensive benefit coverage would likely no longer be available to the small groups that need it. In a very real sense, the AHP regulation violates the provisions in the ACA that preserve state discretion for individual and small group markets, by creating a shadow AHP market which would leave current insurance standards and consumer protections untenable.

2. The regulation should be delayed until the DOL provides additional data that is the basis for its decision.

We support a Freedom of Information Act Request filed on March 1, 2018 by the Georgetown University Health Policy Institute Center on Health Insurance Reforms and a coalition of other groups seeking a range of data that is absolutely necessary for the complete evaluation of the proposal. This data would greatly enhance the ability of affected parties to discern the impact of the regulation, and sift through a wide variety of complex enforcement and administrative issues. At the very least, the implementation of this regulation should be delayed until affected parties have the ability to analyze and evaluate this data.

3. DOL should conduct a public hearing before implementing the regulation.

The AHP regulation is extraordinarily complex, as it involves ERISA considerations, insurance markets in all 50 states, and many other complex state/federal enforcement issues. While the ability to comment on the regulation is important and welcome, this issue lends itself to a full public airing with give-and-take from interested parties.

4. The proposed rule opens the door to fraud

The proposed rule opens the door to fraud and scams. The AHP market has a long history of attracting bad actors and being susceptible to fraud. This proposal not only does not include any standards or processes to minimize potential fraud, but it actually creates opportunities for fly-by-night promoters to set up scams.

There is a long, well documented history of scams and fraud promoted through AHPs. Promoters use ERISA as a shield to evade state oversight and enforcement. In the 1970s after ERISA was enacted, promoters claimed that ERISA preempted states from regulating multiple employer entities like associations. At that time DOL believed that it only had authority over ERISA plans and that multiple employer entities were not ERISA plans. DOL did not act. States tried but were challenged by promoters asserting ERISA as a shield arguing preemption. In 1982 a Republican-led effort clarified ERISA to say that both states and DOL have authority over AHPs. The 1982 amendment was intended to remove ambiguity over preemption. It gave states full authority over multiple employer entities like associations but exempted collectively bargained arrangements (union plans) from state authority. Promoters continued to look for ways to evade state oversight and some promoters set up fake unions and argued ERISA preemption. For example, an entity called International Workers' Guild (IWG) left thousands of people in 32 states with $25 million in unpaid medical bills. Generally the 1982 amendments worked well and enabled states to effectively go after scams but promoters of scams continue falsely to claim ERISA preemption (BNA Report 2003).

There have been several documented cycles of large-scale scams. According to the GAO, between 1988 and 1991, multiple employer entities left 400,000 people with medical bills exceeding $123 million. The most recent cycle was between 2000 and 2002, as 144 entities left 200,000 policyholders with $252 million in unpaid medical bills. (GAO – March 1992; GAO- February 2004) Cycles of scams typically correspond to significant increases in premiums (Kofman BNA 2003[1]). Promoters market to small businesses and individuals, offering premiums at prices below what is generally available. According to a federal judge, one such entity established rates by "averaging sample rates posted on the internet and then reducing them…to compete with other providers." (BNA Report, page 17). Before the ACA, promoters also targeted self-employed people who couldn't pass medical underwriting or were charged higher rates based on their health. One self-employed person was left with $110,000 in medical bills. (2 statements from victims below[2]) Her professional association, the National Writers Union was duped into buying

[1] Kofman M, K Lucia, and E Bangit, Proliferation of Phony Health Insurance: States and the Federal Government Respond, BNA Plus (2003).

[2] Examples of victims of association health plan scams: "Joan Piantadosi, a small business owner bought health insurance from Employers Mutual LLC through an association for herself, her family, and her employees. She was left with more than $500,000 in unpaid medical bills for her husband's treatment during the time she was covered by Employers Mutual LLC. On top of that, her husband needed a liver transplant to live. In her own words, "[W]e were informed that since we lacked insurance coverage, we would have to pay a deposit of $150,000 before my husband could enter the hospital's Liver Transplant Inpatient program. We simply did not have $150,000 to cover the deposit. Consequently, my husband was removed from the recipient list. Like the preceding months, the next two weeks were an emotionally tumultuous time for us. We feared, among other things, that my husband might die while we were attempting to deal with the predicament of being uninsured despite having paid premiums to what appeared to be a legitimate health insurer."

"Judy Coburn thought that she had insurance through the National Writers Union (NWU), a professional association for journalists. NWU contracted with Employers Mutual to sell coverage to its members. Judy only lost $12,000 (some in premiums, the rest she borrowed to have eye surgery). Unfortunately, Judy now has

phony coverage from a nation-wide scam called Employers Mutual LLC that had 30,000 victims and according to some estimates had owed as much as $54 million in medical claims. (Kofman BNA 2003). Promoters of scams set up fake associations and also sell through established professional and trade associations.

Since the ACA was enacted, there has been less fraud because affordable coverage became available, for small businesses prices became more affordable, and underwriting became illegal. When the demand is low, supply of phony insurance is low. Nonetheless, there are always promoters looking to scam small businesses and individuals.

The DOL proposal adds new ambiguity to ERISA that will be used by promoters to evade state oversight. For example, the proposal would permit an AHP to operate in a metropolitan area that crosses into multiple states (29 CFR 2510.3-5(c)). The proposal does not say that each state has jurisdiction. Promoters will use this new ambiguity to evade state oversight.

In addition to new ambiguity, the proposal includes specific changes that will make it easier for promoters of scams to set up shop. Overturning decades worth of guidance, the proposal under 29 CFR sections 2510-3.5(a) and (b) would allow entities to form for the sole purpose of offering health coverage. Furthermore, there is no requirement that an entity be in existence for any period of time. These entities can spring up with ease and target unsuspecting small businesses and self-employed people. Unlike AHP legislative proposals that required AHPs to have a legitimate purpose other than selling health insurance and be in existence for three years. DOL's proposal has neither requirement and would have the unintended consequence of inviting fly by night scams. Furthermore, unlike states that license and certify entities to help keep convicted felons and fly-by-night promoters out of the insurance business, DOL does not certify or license ERISA plans. The proposal creates new preemption ambiguity, has no real standards, and has no regulatory framework to license or certify entities to keep bad actors out. This proposal would make it easy to create fly-by-night entities masquerading as legitimate AHPs and would lead to proliferation of scams.

This concern is compounded by DOL's Request for Information, which suggests that DOL is considering creating broad exemptions from state regulation, which if implemented would leave AHPs unregulated and promoters of scams with free rein, and ultimately consumers without anywhere to turn when they are scammed out of premiums and left with hundreds of millions of dollars in medical bills.

In the preamble, DOL acknowledges the fraud that has been present in the AHP market for years, but DOL has not proposed any solutions to minimize the risk to consumers. The DOL proposal would promote the proliferation of AHPs and create uncertainty about who has authority to regulate, the combination of which would increase the risk to consumers and reduce the likelihood that a state regulator would be able to intervene to protect consumers. DOL should not proceed with this proposal until it has given due consideration to the harm that consumers would be exposed to if phony AHPs were allowed to proliferate and it has implemented adequate protections for consumers. As proposed DOL appears to be simply wishing the fraud problem away, but it has not taken any steps to practically address this known problem.

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permanently impaired vision in one eye because she could not get her surgery in time to save her vision. So unlike other victims, she is lucky that she does not owe hundreds of thousands of dollars to her physicians. Unlike other victims, however, she will never recover her vision." From Kofman M. Association Health Plans: Loss of state Oversight means Regulatory Vacuum and More Fraud. Summer 2005. Georgetown University Institute for Health Policy. https://hpi.georgetown.edu/ahp.html

DOL needs to ensure that state authority to continue to regulate AHPs is clear and unimpeded. State regulation in this area is essential to combat the fraudulent actors that will flood the AHP market if this proposal is finalized.

5. AHP insolvencies will put consumers and providers at risk

The Regulatory Impact Analysis Operational Risks Section (RIA) begins by admitting that "Historically, a number of MEWAs have suffered from financial mismanagement or abuse, often leaving participants and providers with unpaid benefits and bills." (FR631) The preamble continues by describing how both state insurance regulators and the DOL have devoted substantial resources to detecting, correcting and prosecuting wrongdoers. DOL then cites (in footnote 51FR631) a Gov't Accountability Office study, GAO-92-40, for a history of the abuses these types of entities have inflicted on individuals and families. DOL also cites in the same footnote two articles that present the regulatory difficulties and the financial and medical harm that these entities cause when they fail. The analysis, however, fails to discuss these studies or make any attempt to quantify the likely costs of easing the ability to form AHPs. A discussion of such costs should include the losses likely to be incurred by employers, employees, insurance issuers, and health care providers. In addition, any useful cost-benefit analysis should take into account the cost of additional resources likely to be needed by State and Federal governments for monitoring AHPs and enforcing State and Federal standards. DOL should also explain how it plans to conduct oversight to identify and prevent fraud and insolvencies.

AHPs have a long history of insolvencies. Self-insured AHPs are inherently less stable than state regulated insurance companies because solvency requirements are lower and AHP operations are higher risk operations compared to traditional insurers. The DOL proposal to allow for the proliferation of AHPs, including AHPs that choose to assume insurance risk, would expose members of AHPs to the risk of an AHP insolvency and potentially millions of dollars in unpaid medical bills.

There are numerous examples of professional and trade AHPs becoming insolvent. For example, Sunkist Growers, Inc. a licensed MEWA in California, covering 23,000 people became insolvent in 2001 after collecting over $30 million in premiums. At the time of its bankruptcy the plan owed around $11 million for unpaid medical claims. (California HealthCare Foundation 2003 Issue Brief) An insolvency of the New Jersey Coalition of Automotive Dealers left 20,000 people with $15 million in unpaid medical bills. The Indiana Construction Industry Trust, which had been in existence for over 40 years, became insolvent in 2002 leaving over 22,000 people with more than $20 million in unpaid medical bills. (Commonwealth Fund 2004 Issue Brief)

Approximately 20 states have licensing standards specifically for self-insured AHPs (Turbulent Past 2005). All other states reported requiring self-insured AHPs to be licensed as insurance companies. Compared to traditional insurers, self-insured AHPs are at greater risk of becoming insolvent when claims exceed their reserves. States with special licensing schemes for AHPs apply lower solvency standards, such as reserve requirements, to AHPs than to traditional insurers. Low reserves make it harder for AHPs to avoid insolvency resulting from mismanagement or even just large unexpected claims.[3] For example, an AHP in Michigan became insolvent due to unexpected claims from two premature babies. (Commonwealth Fund Brief) Furthermore, generally AHPs cannot participate in guaranty funds and the

[3] "Group Purchasing Arrangements: Implications of MEWAs," California Health Care Foundation, July 2003, Page 5. Available at http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20H/PDF%20HIMUbriefMEWAs.pdf

application of receivership laws can be unclear. Different from an insurer, when an AHP becomes insolvent, covered people are stuck with unpaid medical bills. When there is joint and several liability, then participating employers are assessed and are responsible for any unpaid medical bills. This exposes participating employers to significant financial risk. State receivership laws, which allow insurance departments to take over financially failing insurance companies, sometimes exclude AHPs or are unclear. Without a receivership, an AHP ends up in bankruptcy court, where consumers line up with other creditors. Different from receiverships, outstanding medical claims do not receive priority status in bankruptcy court.[4] When self-funded AHPs become insolvent, their members' medical bills go unpaid, leaving consumers with huge debts for medical care debt and harming medical providers when those debts are not paid.

Many states that license/certify self-insured AHPs invest significant resources to prevent problems and detect problems early. For example, to try to prevent problems like unqualified management, there are background checks on senior management prior to receiving authorization to operate a self-insured AHPs. Self-insured AHPs require more state regulator resources for financial oversight than traditional insurers because solvency standards are lower for AHPs and because of the higher risk associated with AHP operations – typically not diversified and membership may not withstand being assessed any shortfall of the AHP (employers can leave or may become bankrupt from an assessment). One state devoted one FTE per AHP it licensed. This included monthly examinations of AHP financial condition – state regulators on-site reviewing AHP books. States also require prior approval of rates. This helps to ensure that rates are adequate and not artificially low. Inadequate rates can mean an insolvency when claims are higher than what is collected in premiums to pay the claims. (Commonwealth Fund, March 2004; Journal of Insurance Regulation, Spring 2005.)

The DOL proposal's stated purpose is to encourage the growth of AHPs and more AHPs means more insolvencies. Under proposed 29 CFR 2510-3.5(a), an AHP could be created for the sole purpose of offering health coverage. This is equivalent to setting up an insurance company without the type of standards that apply to insurance companies to ensure that promises are kept, bills are paid, and consumers are protected. This proposal contradicts Congressional intent articulated with the passage of the Erlenborn amendment:

> "It has come to our attention, through the good offices of the National Association of Insurance Commissioners, that certain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA covered plans. For instance, persons whose primary interest is in the profiting from the provision of administrative services are establishing insurance companies and related enterprises…They are no more ERISA plans than any other insurance policy sold to an employee benefit plan."
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> House Committee on Education and Labor, Activity Report of Pension Task Force (94th Congress 2d Session, 1977) quoted in Cong. Rec. (daily ed. May 21, 1982) (statement of Rep. Erlenborn).

DOL proposes some minimal standards for AHPs under 29 CFR 2510-3.5(b), such as an AHP must have some formal organizational structure, and employers must have some level of control over the AHP (for example, by electing the board of directors). The proposal, however, includes no standards similar to those found in state insurance regulatory frameworks, such as qualifications for people who set these up and operate AHPs. The requirement that employers have some control is not a sufficient substitute for qualified professional management of entities that are essentially health insurers. Small business owners

[4] California Health Care Foundation, July 2003, page 5.

and sole proprietors are not generally not in the position to determine whether the persons setting up and running the AHP have the needed skills and experience or to provide adequate oversight of the AHP's operations.

Also, the proposed limited standards will not ensure that AHPs are financially stable. There are no solvency standards under ERISA that AHPs would have to meet. The proposed standards do not even address the financial soundness of these entities. Moreover, by suggesting that AHPs would be able to operate across state lines (83 FR 619), the proposal creates confusion regarding states' ability to continue to regulate Furthermore while DOL claims that states will continue to have oversight, the RFI included in the preamble to the NPRM indicates that DOL is contemplating class and individual exemptions for self-insured AHPs from some aspects of state oversight.

DOL's proposal to encourage AHPs to proliferate, does not provide any indication that it would be able or willing to protect consumers from insolvencies. To the contrary, evidence shows that DOL is unable to perform appropriate oversight currently. In 1996, Congress empowered DOL to require AHPs to register with it and file information annually. A 2004 study found that 100 of 700 filings had missing information, conflicting information, and inaccurate information such as fake NAIC numbers. Some falsely claimed that they did not have to file. There was no evidence that DOL ever reviewed the filings. For example, the Indiana Construction Industry Trust reported doubling in size in one year. Such rapid growth is usually an indication of a solvency issue. This association became insolvent one year later leaving 22,000 with $20 million in medical claims. (Journal of Insurance Regulation, M-1 Study.) There is a fine of $1,000 per day if AHPs do not file or filed information is not complete. It is unclear whether DOL has ever used this authority to fine delinquent AHPs.

A more recent example of the inadequacy of DOL enforcement efforts and resources is found in the 2016 M-1 filings. One entity reports on its 2016 Form M-1 that DOL has been investigating it since January 2011. It is unclear why an investigation would be ongoing for 5 years. This entity reports covering approximately 10,000 participants (total covered lives unknown) nationwide (M-1 filings DOL database). For a complete discussion of enforcement and oversight concerns, see section 7.

The proposed weak AHP standards will no doubt lead to the establishment of many new AHPs. The lack of protections to ensure solvency, and DOL's checkered record of oversight of the simple AHP M-1 registration/reporting requirement will allow individuals with limited or no expertise in health plans or operating an association to offer coverage through AHPs, which will increase the risk for consumers. Until DOL is able to address these concerns, DOL must put these regulations on hold.

6. Nondiscrimination provisions alone are insufficient to protect consumers and preserve stable markets

DOL is proposing to apply the nondiscrimination rules that apply to group health plans under 29 CFR 2590.702 (1996 HIPAA non-discrimination standards for ERISA covered group health plans in Part 7 of Title 1 of ERISA) to prohibit AHPs from discriminating based on health status related factors (health factors) against employer members or employers' employees or dependents. As proposed, this would prevent AHPs from using health factors to determine eligibility for benefits or in setting premiums. Health factors include: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. We applaud this proposal, as it is essential to help protect both employers and their employees from discrimination based on health status. We strongly encourage DOL to retain this requirement in final rule. We support this provision applying

to all AHPs, regardless of when in time they were established. AHPs currently in operation should be required to fully comply with nondiscrimination requirements, without exception and without delay.

However, the 1996 nondiscrimination standards are insufficient 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 (EHB), rate reforms, guaranteed issue and single-risk pool requirements. Consequently, an AHP can simply avoid covering people and businesses with medical needs. Using benefit design, an AHP can attract healthier groups. For example, an AHP could offer coverage without maternity, mental health benefits, and expensive prescriptions. People who need such coverage would not enroll in AHP coverage. 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 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. Its geographic location can also be used to engage in redlining practices. An AHP could limit membership to a specific industry that has lower claims than other industries. All of these and other discriminatory practices would be allowed because AHPs would be exempt from EHB, rate reforms, and guaranteed issue requirements.

To ensure that AHPs are not engaged in discriminatory practices and to prevent cherry-picking, in addition to the proposed non-discrimination standard, the final rule should apply EHB, rate reforms, guaranteed issue and single-risk pool requirements. The single-risk pool requirement is an important way to ensure that AHPs where they exist do not result in a segmented market. Failure to extend these protections to AHPs, in addition to protections against discrimination based on health status, will expose employers and their employees to discriminatory practices, including discriminatory rating and marketing practices. Failure to extend these protections will also place the regulated health insurance markets in jeopardy, as AHPs would be free to cherry pick healthy consumers out of the regulated markets, leaving those markets to fail as the risk pool worsens and premiums spiral out of control. See section of market segmentation for a detailed discussion.

The request for comments asks whether nondiscrimination standards "would create an involuntary cross-subsidization across firms that would discourage formation and use of AHPs." It is important to put this question in context, because "involuntary cross-subsidization" is simply a disparaging term for what is more commonly known as "modified community rating."

Indeed, cross-subsidization, which is another name for risk pooling, is the essence of insurance. People without significant losses pay premiums that are intended to be used to pay other people's claims (plus expenses and expected profit for the entity that takes on the risk and pays the claims).

Even if you define cross-subsidization more narrowly, as a situation where some insureds are charged more than their actuarial cost so that others can be charged less, it still occurs in voluntary insurance markets for various reasons, including the impossibility of perfect underwriting, the inefficiency of devoting too many resources to trying too hard to come close, and the value of renewability benefits. Even for term life insurance, where premiums are generally completely deregulated, young healthy consumers voluntarily pay far more than the actuarial value of the policy in early years in return for the right to continue buying the same product many years later, after the premium rate has become far less than the actuarial value of the policy.

For health insurance, the laws have made a similar form of cross-subsidization mandatory. To a large degree, community rating laws simply correct for a variety of market failures and make available a product that most Americans have demonstrated that they want, both at the ballot box and in the marketplace – insurance that provides comprehensive benefits, with affordable cost sharing, that you can renew even after you get sick, with limits on the rate that costs increase as you age, and the ability to keep these protections in place when you change your job or the choice of plans on the individual market changes. (Large-employer coverage does not contradict my premise that most Americans put their money where their mouths are and actually buy affordable community-rated coverage when it's available. This insurance is experience-rated at the employer level, but it's community-rated at the plan participant level, and it's only sold to employers with enough employees that the law of large numbers mitigates the impact of employer-level experience rating.)

The community rating system does go beyond replicating what an ideal voluntary market would be able to provide. In particular, it provides protection to people with congenital health risks who would have been uninsurable at any age in a fully voluntary market. But there is a broad-based consensus that extending these protections to the entire population is a matter of fundamental fairness. Community rating is now the established law of the land (in the case of Medicare Part B, full community rating, and for more than 50 years!), and the only serious debates in Congress last year were over whether to make changes at the margins, such as the permissible degree of age variation, not whether to abolish it entirely.

Thus, even though nondiscrimination standards might be branded as "involuntary cross-subsidization," it is entirely appropriate for AHPs to be subject to nondiscrimination standards that are equivalent to the standards that apply to all other health plans sold to small employers and self-employed individuals. Not only is it appropriate, anything else would defy the laws that the Executive Branch has the duty to execute faithfully. DOL does not have the power to enact by regulation a measure that is more extreme than anything Congress recently considered, debated, and rejected.

This is equally true for material differences between the nondiscrimination standards in AHPs and the nondiscrimination standards Congress requires. For example, if insurers are required to sell individual and small group health plans in the traditional market with a maximum age variation of 3:1, and are permitted to sell the same plans to the same customer base using AHPs with a maximum age variation of 5:1, the only stable pricing structure that is possible will have 5:1 age rating across the population as a whole. The traditional market will either wither away or will compete on equal terms for the high end of the age curve and abandon the low end by setting unaffordable prices.

7. Risk segmentation would undermine the individual and small group markets

We share the concern held by many others that freer availability of AHPs will lead to destructive segmentation of healthier from sicker people (see Comment from Prof. Mark Hall for a more detailed discussion). As noted below, AHPs have a history of harming regulated markets through risk segmentation, and risk segmentation is virtually inevitable, for the following reasons. Due to the well-documented concentration of medical expenses in a small percentage of the population, avoiding even just the top 1 percent of medical spenders can save almost 25 percent of total costs, in any given health risk pool.[5] Thus, like any risk pooling mechanism, AHPs have a great deal more to gain by avoiding a few very high cost subscribers than by including features that are attractive to a broader swath of the population.

[5] See Tom Miller, The Concentration And Persistence Of Health Care Spending, 40(4) *Regulation* 28 (Dec. 2017).

This iron law of health care expenditures means that it is highly likely that AHPs will take every opportunity to tailor their coverage and their membership criteria to attract better risks and avoid worse risks. And doing that will leave the regular individual and small-group markets to absorb a greater share of these much-higher-cost patients, threatening their basic stability. In fact older studies analyzing congressional AHP proposals show that between 19% and 52% of small businesses would move to AHPs and prices for small businesses left in regulated markets would increase as much as 23%.[6] The impact of the DOL proposal would be much more severe now because the older studies were done when individual and small group markets did not have guaranteed issue, adjusted community rating, single risk pool and EHB standards.

Despite the obvious potential of AHPs to segment better from much worse risks, the proposed rule speculates, in several places, that this will not happen because unhealthy people have just as much reason to seek the advantages of AHPs as do healthy people. This claim is a *non sequitur*, even if it were true. The issue of risk segmentation arises because healthy people are seeking the additional advantages of the costs they can save if they can get into an AHP that has very few unhealthy people. Unhealthy people might, hypothetically, have some interest in joining a particular AHP, but they won't, if they're smart shoppers, have any interest in signing up for an AHP with a low actuarial value, or one that fails to cover the particular costly drugs and treatments that their condition requires. This makes that particular AHP even more attractive to healthy people than it already was.

The notion that we can depend on AHPs not to offer skimpy coverage is disingenuous, since one of the stated goals of the program (see Pages 60-61 of the Preamble) is to provide a less expensive alternative to plans that must meet minimum actuarial value requirements (56% under the latest regulations) and provide all benefits that have been determined to be "essential." It is certain that healthy people will leave regulated "more expensive" coverage. And that's what risk segmentation is all about. If AHPs are not intended to be a vehicle for skimpy coverage, then the Proposed Rule should be revised to prevent them from selling skimpy coverage.

AHPs will likely segment the market both by appealing differentially to healthier groups, and also to healthier individuals *within* groups. As long as an AHP avoids offering what the ACA defines as "minimum value" or bronze level coverage, then individual employees are free to seek richer coverage through the subsidized individual market. This below-minimum value coverage can easily be structured in a way (coupled with a health savings or reimburse account) that meets needs of healthier workers/families but discourages enrollment by sicker people. This is similar to the widely-criticized practice of "lasering" that once prevailed in the unregulated small group market.[7] By allowing AHPs to reinstate these discredited practices, the proposed rule creates a vehicle for employers to more easily "dump" their sicker workers or families onto the publicly-subsidized individual market, without having to make the employer responsibility payment that the ACA otherwise would assess on large groups that might deploy this tactic.

Additionally, there are many other ways an AHP can segment insurance markets. One obvious way is through "redlining," another long-discredited practice. Redlining is the pejorative term applied to techniques by which insurers (of various types, including life, property, etc.) illegally refuse to sell, or selectively market, in certain locations based on the economic or racial profile of the population. The

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[6] Mila Kofman & Karl Polzer,What Would Association Health Plans. Mean for California? (Calif. Health Care Foundation, Jan. 2004), https://www.chcf.org/wp-content/uploads/2017/12/PDF-AHPFullReport.pdf .

[7] Amy Monahan, Saving Small-Employer Health Insurance, Iowa Law Rev. 98:1935 (2013).

proposed rule explicitly allows geographic (and thus socioeconomic) redlining, by allowing AHPs to form merely based on geographic units of whatever size and proximity they choose. Thus, the proposed rule allows an AHP to form based on a particular zip code or census tract, or to "cherry pick" the particular micro-areas that have the population features considered most desirable, without even needing, necessarily, for the covered areas to be contiguous. In addition, AHPs can use rating practices as well as marketing to attract desirable populations and to avoid groups and individuals expected to have higher claims.[8]

The proposed rule also allows similar forms of cherry-picking through the design of covered benefits, including, for instance, whether to cover expensive drugs for chronic illnesses. The proposed rule reasons that, in fact, most large employers do not offer skimpy coverage, and it speculates that, therefore, AHPs also will be unlikely to skimp in order to segment risks. However, there is a major structural difference between AHPs and ordinary employer groups that causes them to behave differently. AHPs are an open invitation for self-employed people and small businesses to pick their insurance group based on the particular coverage they want. In contrast, people covered by large employer plans simply accept the insurance their employer chooses. Large employers cover the full range of services that many or most people want, so that, when they hire, the benefits are comprehensive enough to satisfy most everyone. Thus, large group insurance is not tailored to particular health needs, whereas unregulated individual and small group insurance is.

AHPs can be expected to behave much more like the unregulated individual and small group markets, prior to market reforms, than like the large group market, in this regard. They have every reason to form more limited coverage packages that appeal distinctively to particular demographics or health profiles – thus undercutting critical public health goals embodied in existing market regulations. Unlike regulated markets, AHPs, as proposed, are not subject to any minimum benefits requirement, nor is there a risk adjustment mechanism to discourage AHPs from avoiding higher risks.

The risk segmentation that AHPs will produce in these and other ways would threaten the stability of individual and small group markets. This threat is not mere speculation or simply a question of differing opinions. Wider use of AHPs previously caused actual substantial harm to regulated markets in several states, prior to tightening standards for bona fide status.[9] A leading example is the market collapse that occurred in 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 associations, 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.[10]

The seriousness of this threat to regulated markets is also documented by thoughtful opinion letters and issue briefs written by the leading expert authorities in the country. The American Academy of Actuaries, for instance, has warned that AHPs "would result in market fragmentation and threaten the viability of the

[8] For documentation and description, see Mark A. Hall, Elliot Wicks and Janice Lawlor, HIPCs, MEWAs, and Association Health Plans: A Guide for the Perplexed, *Health Aff*. 21(1):142 (Jan. 2001).
[9] See note 3.
[10] 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).

insured market,"[11] and the National Association of Insurance Commissioners (NAIC) has issued a "Consumer Alert" warning that "Association Health Plans are Bad for Consumers" because they "threaten the stability of the small group market."[12] More recently, the NAIC has advised Congress that AHPs "would actually harm consumers by further segmenting the small group market"; they "would encourage AHPs to 'cherry-pick' healthy groups by designing benefit packages and setting rates so that unhealthy groups are disadvantaged. This, in turn, would make existing state risk pools even riskier and more expensive for insurance carriers, thus making it even harder for sick groups to afford insurance."[13]

The proposal runs counter to the Congressional intent to prevent market segmentation through the ACA's risk adjustment program, which currently moves resources from insurers that attract low cost enrollees to insurers that cover enrollees with higher medical costs. Insurers that continue to cover individuals and small groups through the ACA compliant individual and small group market will not only be left with higher cost populations after AHPs cherry-pick the healthiest enrollees, they will also be deprived of the full benefit of the risk adjustment mechanism that Congress intended.

The market segmentation effect of the proposed rule will also be more dramatic because it will allow self-employed "working owners" access to AHP coverage based on mere self-attestation that they are in fact "working owners." It is likely that there will be widespread attempts by healthy individuals to claim falsely that they meet "working owner" requirements. This will serve to dramatically further risk segment the individual market.

The proposed rule provides no citations or documentation for the contrary, wishful thinking that AHPs will avoid market disruption by promoting risk pooling or minimizing risk segmentation. Virtually all logic, experience, and unbiased expert opinion contradicts this naïve optimism.

Furthermore, there is no solid basis for the proposed rule's speculation that AHPs will generate substantial efficiencies. In fact the Congressional Budget Office assumed no administrative savings for either administrative efficiencies or "market clout" in analyzing the impact of congressional proposals (CBO 2000 and 2003). Experience shows that associations don't actually reduce administrative expenses but add to those by replicating functions that insurers already perform like marketing and enrollment. (W. Wicks & M. Hall, Milbank Q.). Contrary to DOL's claim, association coverage adds to administrative costs.

DOL fails to provide any evidence to support any of its assertions and if the proposal is finalized, there is substantial evidence that AHPs will segment the market and lead markets to collapse. If the DOL goes forward with the proposal, then it apply to AHPs guaranteed-issue, EHB, rate reforms, single risk pool requirements applicable to individual and small group markets, minimum actuarial value requirements, and risk adjustment. This is the only way to prevent market segmentation.

[11] https://www.actuary.org/content/association-health-plans-0
[12] http://www.naic.org/documents/consumer_alert_ahps.pdf
[13] http://www.naic.org/documents/health_archive_naic_opposes_small_business_fairness_act.pdf

8. Both State and Federal oversight of AHPs should be strengthened and supported

Strong oversight of AHPs is essential because of a long and well-documented history of AHP insolvencies and fraud. Since ERISA was enacted, Congress has expanded DOL's oversight authority several times and has given DOL new enforcement tools. In 1982 Congress amended ERISA to clarify that both DOL and states have authority to regulate AHPs. In 1996 Congress granted DOL authority to require AHPs to register (MEWA registration or Form M-1 requirement). In 2010, Congress granted DOL new oversight authority including cease-and-desist authority to shut down insolvent or fraudulent AHPs administratively without first having to go to court. While all of these federal enforcement tools are important, none compare to the enforcement authority that states have – and use. Further, while DOL has some enforcement tools, it lacks adequate staffing or funding to conduct meaningful oversight. And even if DOL gained resources, it is very unlikely that DOL could ever replace or replicate state regulation and oversight: Federal oversight is reactive, while state oversight is proactive.

Compared to DOL's lackluster record, generally states have a strong record of effective oversight – in cases of both insolvencies and scams. For self-insured AHPs, states either require licensure as an insurer or have AHP-specific laws with lower reserve and capital requirements than for other issuers. (Journal of Insurance Regulation, Spring 2005.)Registration or licensing requirements, including background checks to keep convicted felons from operating self-insured AHPs, help mitigate risk of mismanagement. Depending on the financial strength of AHP in their states, state regulators use varied approaches. For example, in the 1990's one state conducted monthly financial exams to monitor AHP stability and act quickly when financial condition erodes. That state's insurance department assigned the equivalent of one full-time employee to each self-insured MEWA in the state.[14]

In contrast with states' strong oversight record, there is no evidence that DOL is performing oversight. Although AHPs must register with DOL, there is no evidence that DOL conducts regular reviews or takes actions based on filings. For example, the Indiana Construction Industry Trust reported doubling in size in one year--explosive growth that usually points to a solvency issue. DOL did nothing. Just one year later, the association became insolvent leaving 22,000 members with $20 million in medical claims. (Journal of Insurance Regulation, M-1 Study.) In 2016 an entity reported in its M-1 filing with DOL that the entity had been under investigation for five years, since 2011. It is concerning that the organization was investigated for five years with no apparent corrective action by DOL. This entity reports covering approximately 10,000 participants (total covered lives unknown) nationwide (M-1 filings DOL database).

Based on a quick review of some 2016 M-1 filings, it appears that some filings contain incorrect or incomplete information. These problems are consistent with the DOL 2014 report on M-1 Filings.[15] DOL has had since 1996, when Congress gave DOL authority to require AHPs to register, to establish an effective oversight program to protect businesses and individuals covered through AHPs. Yet after more than 20 years there is not a single action or evidence that anyone at DOL even reviews the filings on a regular basis, much less takes action based on the self-reported information from AHPs. DOL has itself admitted that there is a high M-1 noncompliance rate and estimated that in 2003 fewer than half of existing MEWAs registered with DOL.[16] Yet, while there is a fine of $1,000 per day if AHPs do not file

[14] "MEWAs: The Threat of Plan Insolvency and Other Challenges," The Commonwealth Fund, Kofman, Bangit, and Lucia, March 2004.

[15] U.S. Department of Labor (DOL): Employee Benefits Security Administration (EBSA); Office of Policy and Research (OPR) Contract 2 Deliverable 5.2: Analysis of Form M-1 Data for Filing Years 2010-2013.

[16] Reporting by Multiple Employer Welfare Arrangements, Federal Register 68, No. 68 (April 9, 2003): 17495, 17498.

or file incomplete information, there is no evidence that DOL has ever used its authority to fine delinquent AHPs. Given the troubling history of AHPs, DOL should conduct in internal review of M-1 filings, take appropriate enforcement actions, and implement appropriate oversight procedures before finalizing a rule that will guarantee proliferation of AHPs and put employers and workers at risk.

Additionally, states have oversight and enforcement resources that DOL simply does not have. DOL generally investigates plans only after they establish a pattern of failing to pay claims. Thus, by the time DOL acts, consumers have already been harmed. States have numerous tools that allow them to conduct regular oversight and intervene before consumers are harmed. These tools include background checks for operators/management of AHPs, financial and market conduct examinations, form reviews, rate reviews, etc. Thanks to the broker community, states also have "eyes and ears" on the ground to quickly identify bad actors who promote fake insurance. States also have and use enforcement tools, including cease-and-desist authority and state receivership laws. States have vigorously pursued bad actors in the AHP market and have been able to act earlier and quicker than DOL, better protecting consumers from harm. (See BNA Fall 2003.)

Historically, DOL has been slow to take action against insolvent or fraudulent AHPs, in part because it did not have cease-and-desist authority, and it relied on states to shut down bad actors. (GAO 2004). During the 2000 scam cycle, states issued cease and desist orders against 41 entities, while DOL shut down three entities. (GAO 2004.) DOL was granted cease and desist authority in 2010, under the ACA, but has only used its new authority once, in 2017. During this same period, one state, Florida, has taken three enforcement actions against AHPs.[17] See detailed discussion of state oversight relating to scams in the section titled "AHP Fraud."

Given the history of fraud and insolvencies of AHPs, it is critical for DOL to address questions of oversight and enforcement. In 2007, the GAO found that DOL had a ratio of one employee conducting oversight or enforcement activities for every 8,000 plans.[1] When Congress considered legislating standards for AHPs, DOL testified that it can review plans under its jurisdiction once every 300 years.[18] Before proceeding to finalize the proposed rule, 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. 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.[19] Importantly, since DOL's proposal goes further to expand the proliferation of AHPs than the 2005 AHP bill, DOL would need even more staff to regulate effectively. EBSA, DOL's office charged with oversight of AHP plans, has recently experienced attrition, and DOL is also under a hiring freeze, making it even more challenging to meet the increased oversight and enforcement need created by this proposal. EBSA has an estimated 750 people responsible for health and pension plans. Only a small fraction are investigators. By comparison, state insurance departments have an estimated 11,209 employees and for FY 2018, a total of $1,417,145,120 budget.[20]

[1717] See Florida Office of Insurance Regulation, Actions Against Unlicensed Entities. Available at https://www.floir.com/Sections/MarketInvestigations/ue_regulatory_entities.aspx.

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

[19] "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.

[20] National Association of Insurance Commissioners, "2016 Insurance Department Resources Report," Vol, One, June 2017, Table 7, page 29.

The President's Budget for Fiscal Year 2019[21] proposed $189,500,000 for EBSA to cover all functions of the office, including oversight and enforcement for both health plans and pensions. The proposed budget has $2 million for a mere "15 new FTEs for Small Business Health Plan, or Association Health Plan (AHP), assistance to provide interpretive guidance, enforcement, oversight activities, and compliance assistance initiatives ensuring Small Business Health Plans are adequately funded and that fiduciaries comply with their obligations of prudence and loyalty." FY 2019 Department of Labor Budget in Brief, available at https://www.dol.gov/sites/default/files/budget/2019/FY2019BIB.pdf (page 20).

States have historically been better positioned to conduct oversight and enforcement activities to protect consumers from fraud and mismanagement. It is essential for states to continue regulating. Unfortunately, the proposal establishes new obstacles and fails to consider the financial impact of the proposal on states. DOL should review how the proliferation of AHPs would impact state oversight and enforcement resources before finalizing regulations.

The oversight concerns are compounded when viewed in light of the preemption issues raised by DOL's RFI. In the RFI, DOL requested information on use of its section 514 authority to issue individual or class exemptions for MEWAs that are otherwise subject to state regulation. It is well documented that DOL has neither the resources nor the expertise to serve as the sole regulator. DOL should not take action to prevent states from regulating.

DOL asserts that requirements in proposed 29 CFR 2510.3-5(b) for a formal AHP organizational structure and control by employer members, are intended to ensure that AHP sponsors are bona fide employment-based associations not prone to abuse. However, DOL admits that the flexibility afforded AHPs under this proposal could introduce more opportunities for mismanagement or abuse and thus increase the potential oversight demands on the Department and state regulators (83 FR 632). DOL cites new enforcement and reporting provisions added by the ACA to help reduce the rate of financial collapse in AHPs—but DOL offers no evidence that it is actually using these tools to protect consumers from AHP insolvencies.

It is also important to note that proposed 29 CFR 2910.3-5(e) raises significant oversight and enforcement concerns, by allowing individuals to simply self-certify compliance, without any review for compliance. DOL has not supported this with any data from its experience conducting oversight and enforcement against AHPs. DOL has not provided any data or analysis on the cost of fraudulent or financially unstable AHPs to their members. DOL has acknowledged that Congress has repeatedly intervened to address AHP fraud, but DOL has failed to provide any data on its experience identifying and intervening against fraudulent or insolvent AHPs. The failure to provide any data on its oversight and enforcement activities and the impact of fraud, insolvency, and noncompliance on AHP members is a significant failure of this proposal. DOL should provide data on its oversight and enforcement activities, as well as details on how it would address oversight and enforcement, before proceeding with this proposal.

Finally, Congress gave DOL additional tools to address fraud and abuse related to AHPs by adding new section 520 to Title I of ERISA (Section 6604 of the ACA). Section 520 gives DOL a much needed oversight and enforcement tool. DOL has been authorized to act under this provision since 2010, but to date it has not issued regulations to implement this provision. A DOL Office of Inspector General Report

[21] https://www.whitehouse.gov/wp-content/uploads/2018/02/budget-fy2019.pdf

from September 30, 2011[22] 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 means to prevent fraud and abuse." [DOL OIG 2011 Report, Page 4.] EBSA noted in its response that it would move forward with issuing regulation and implementing this provision. We strongly encourage DOL to begin the rulemaking process and to implement this critical authority under section 520 prior to moving forward with any proposal that would result in the proliferation of AHPs.

9. State preemption must be rejected

The proposal raises many questions about preemption. We oppose preemption of state laws and would consider any attempt by DOL to preempt states through this rulemaking as a usurpation of Congress' lawmaking authority. Any effort to preempt states through this rulemaking would be in conflict with clear Congressional intent. The 1982 Erlenborn amendment 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.

Furthermore, we are concerned that DOL's proposal to change more than 40 years of ERISA interpretation creates new ambiguity. Historically, entities seeking to evade state oversight and state standards used ERISA as a shield and exploited exceptions and ambiguity to challenge state actions. To head-off such ERISA abuses, DOL should clearly state that ERISA single employer AHPs, including, the ones 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.

Finally, DOL has raised the possibility of taking action under Section 514(b)(6)(B) in this request for information, which could be used to exempt a class or an individual AHP that is an employee welfare benefit plan from state insurance regulation. As noted above, we strongly oppose any proposal that would limit state's ability to regulate AHPs. 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 revoke the exemption for fraud and abuse - a remedy Congress expressly provided. Congress amended ERISA in 2010 specifically providing DOL with new tools to address fraud and abuse related to AHPs. DOL should promulgate a proposed rule for section 520 for public comment and ensure that section 520 is fully implemented prior to exercising its authority under section 514(b)(6)(B) to exempt as a class or individually AHPs from state oversight.

10. Provisions for "Working Owners" without employees violate the ACA

The proposed rule allows "working owners" without any employees to receive coverage through association health plans. These plans will presumably in most instances be considered large group plans as they will have more than 50 enrollees. Individual working owners who participate in them will, therefore, be deprived of the special protections Congress extended to individual market participants through the Affordable Care Act. They will also, of course, no longer be part of the individual market

[22] "Further Action by EBSA Could Help Ensure PPAC Implementation and Compliance," Department of Labor ,Office of Inspector General - Office of Audit, September 30 , 2011. https://www.oig.dol.gov/public/reports/oa/2011/09-11-003-12-121.pdf

single risk pool. To the extent that associations "cherry pick" healthier individuals to participate in their plans—as they have in the past—this will increase premiums for individuals who retain individual market coverage.

The Public Health Service Act (42 USC 300gg-91) defines employer to mean: "The term "employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002 (5)], except that such term shall include only employers of two or more employees." This strongly suggests that employer-owners without any employees would not qualify as employees.

ERISA regulation 29 CFR 2510.3-3, adopted in 1975 and in force at the time the ACA was adopted, provides: "For purposes of this section:(1) An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and (2) A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership."

In the preface to the proposed rule, DOL relies on the Supreme Court's decision in Yates v. Hendon, 541 US 1 (2004), which held that self-employed working owners could be plan participants, to support its position that working owners can get small group coverage (or participate in large group coverage through an association) even if they have no other employees. Yates in fact asked a different question—assuming that an owner offers a plan that covers its employees in a plan, can the owner also be a participant. This is the question the Yates Court answered, but is not the question raised by the DOL AHP rule, which addresses the question of whether owners who have no employees can participate in group health plans. On that question, the Supreme Court acknowledged that "Courts [in three circuits] agree that if a benefit plan covers only working owners, it is not covered by Title I," and that this position was taken by the Solicitor General's brief submitted as Amicus Curiae

The cases cited by Yates recognize the long-standing position of the federal agencies that an ERSIA plan had to have at least one employee participant other than the owner to be a group health plan. For example, 42 USC 300gg-21(d), which allowed partners in partnerships to be participants in group health plans, recognizes that self-employed individuals can only become plan participants if one or more employees are eligible to be participants in the plan as well as the partner.

Congress in adopting the ACA, with its special protections for individual market participants, was aware of this body of law and meant to retain it. The ACA includes definitions of the individual, small group, and large group market (42 U.S.C. 18024) that continue to recognize that owners of businesses who have no employees cannot qualify for group coverage (although it permitted small group coverage for groups that included only one employee other than the owner). The proposed rule, therefore, violates the ACA.

Thank you for your attention to this matter,

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