Colorado Consumer Health Initiative

March 6, 2018

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

Mr. Preston Rutledge
Assistant Secretary, Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

RE: Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans (RIN 1210-AB85)

Dear Secretary Acosta and Assistant Secretary Rutledge,

The Colorado Consumer Health Initiative (CCHI) appreciates the opportunity to comment on the proposed rule, Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans. CCHI is a statewide, non-profit, nonpartisan membership organization, dedicated to ensuring access to comprehensive, affordable, and equitable health care for all Coloradans. Through our members' members, we represent over 500,000 Coloradans. A core part of our work has focused on private insurance, and ensuring a stable private health insurance marketplace.

CCHI has deep concerns that the proposed rule on association health plans (AHPs) will weaken the individual and small group markets that are critical sources of coverage for people with pre-existing health conditions. The effect of the rule will be lower costs and more choices for some small employers, but would increase cost and limit choice for all other employers and individuals in less-than-perfect health. Moreover, the history of AHPs is one of fraud and insolvency – leaving consumers with unpaid medical bills and no health coverage. In Colorado, we have worked hard with our Division of Insurance (Division) and other stakeholders to ensure availability of quality health care plans that cover what consumers need, and we are concerned this rule could undermine those efforts.

If the Department of Labor ("the Department") moves forward with finalizing this rule, we strongly urge you to maintain the nondiscrimination provisions. We also strongly

oppose any effort to limit states' authority to regulate AHPs. Both are critical to stem the damage that the proposed rule will cause for insurance markets and consumers themselves.

I. AHPs have a history of fraud and insolvency.

For the 30 years prior to the Affordable Care Act (ACA), AHPs were frequently used as a vehicle for selling fraudulent insurance coverage. Scams initially flourished after Congress exempted AHP arrangements from state oversight in 1974 through the Employee Retirement Income Security Act (ERISA).[i] The operators of these fraudulent AHPs targeted small businesses and self-employed people, and then collected premiums for non-existent health insurance, did not pay medical claims, and left businesses and individuals with millions of dollars in unpaid bills and patients without health insurance coverage.[ii] AHPs would often set up headquarters in one state with limited regulatory oversight and market policies to businesses and consumers in other states with more robust regulation, thereby bypassing those states' more protective rating and benefit standards.[iii]

In 1982, Congress responded to widespread fraud by amending ERISA to clarify states' authority to regulate association health plans and multiple employer welfare arrangements (MEWAs).[iv] Because of this broad authority, many states limited the potential risks, including fraud, insolvency, and market segmentation, associated with the expanded AHP market.[v] Even with increased oversight, fraudulent insurance sold through associations remained a problem. Between 2000 and 2002, 144 operations left over 200,000 policyholders with over $252 million in medical bills.[vi] Four of the largest operations left 85,000 people with over $100 million in medical bills.[vii] For consumers and patients, the results were disastrous: some victims were forced into bankruptcy; others have lifelong physical conditions as a result of delayed or foregone medical care.[viii]

AHPs also have a history of financial instability and insolvency. There are no federal financial standards to guarantee that AHPs will remain financially stable. We are extremely concerned that the proposed regulation will once again leave consumers and patients in AHP arrangements with insufficient coverage, unpaid medical bills, and lifelong health implications – just as AHPs did before the ACA provided more oversight and protection.

II. AHPs will weaken the individual and small group markets.

The Department states that the proposed rule will provide additional opportunities for employer groups or associations to offer coverage alternatives to small businesses that are more affordable than insurance currently available on the individual and small group market. The only way, however, that the coverage will be more affordable is if it has fewer protections against fraud and insolvency, covers fewer benefits, or siphons healthier individuals and small groups from other markets.

As part of ACA implementation, the Centers for Medicare and Medicaid Services (CMS) issued guidance to bring AHPs in line with the standards and consumer protections in the ACA. CMS required that health insurance policies sold through an association to individuals and small employers must be regulated under the same standards that apply to the individual or the small-group market.[ix] Because of this guidance, known as the "look through" doctrine, the coverage was required to comply with the ACA's protections for people with pre-existing conditions and other standards such as the essential health benefits (EHBs).

The proposed regulation would create an uneven playing field between AHPs and the individual and small-group markets. Because the rule would subject AHPs to substantially weaker standards than ACA-compliant plans, AHPs could be structured and marketed to attract younger and healthier people, thus pulling them out of the ACA-compliant small-group market and leaving older, sicker, and costlier risk pools behind. If healthier individuals and small groups are syphoned from the individual and small group markets, costs will increase and plan choices will decrease for employers and individuals remaining in those markets. Consumers in need of comprehensive coverage, including those with pre-existing conditions, and consumers with incomes too high to qualify for subsidies, would face rising premiums and potentially fewer plan choices.

III. AHPs should not be allowed to sell junk insurance and charge higher premiums to businesses based on employees' age, gender, or industry.

Currently, AHPs are regulated by the "look-through" doctrine set forth in 2011 guidance from CMS.[x] This guidance has the effect of looking through the association to understand who is purchasing coverage through an AHP, and then to determine regulation of the insurance products. AHP products sold to individuals are considered to be individual market insurance and AHP products sold to small employers are considered to be small group market insurance. The insurance products are then subject to the same requirements and consumer protections that exist in those markets under the ACA.

The proposed regulation would not apply the "look-through" doctrine to AHPs. As a result, an AHP would be treated as a single plan providing large employer coverage, and therefore exempted from the individual and small group market protections. For example, plans offered to working owners and small employers would be exempt from the requirement to provide EHBs. Individuals and small employers would not necessarily have coverage that includes benefits such as maternity care, prescription drugs, and mental health and substance use services.

We are extremely concerned that this will take consumers and patients back to pre-ACA days, when plans frequently failed to meet the needs of individuals and families. For example, before the ACA:

- The vast majority of plans in the individual market did not cover maternity care. In fact, only 12 percent of plans in the individual market covered this benefit.[xi] Even among plans that covered maternity services, the coverage was not always comprehensive or affordable. One study found that several plans charged a separate maternity deductible that was as high as $10,000, and some plans had waiting periods of up to a year before maternity care would be covered.[xii]
- One in five people enrolled in the individual market lacked coverage for prescription drugs.[xiii] Rolling back coverage of prescription drugs means individuals and families would not be able to access the medicine they need to prevent or manage ongoing health conditions.
- Mental health coverage was often excluded from plans, or was limited.[xiv] It is estimated that over 32 million people gained access to coverage for mental health services, substance use disorder treatment or both benefits under the ACA.[xv]

In Colorado, our Division implemented a thoughtful and inclusive process of defining our EHB package, which included input from organizations representing consumers with various health care needs. We do not want this rule to undermine the work done in our state to ensure insurance plans are meeting state and federal law and providing access to the care that Coloradans need.

The proposed rule puts the economic stability and health of consumers at risk by allowing employers to offer limited coverage that fails to meet the needs of individuals and families. A small employer, for example, with a relatively healthy workforce might offer an AHP with low premiums but that also provides limited benefits. If an employee later develops a health condition such as cancer or HIV, or requires hospitalization – they could suddenly find that necessary care or treatment is not covered.[xvi]

While the proposed rule prevents health status rating of separate employers, the rule appears to allow groups or associations to base premium rates on any other factor, including gender, age, industry and other factors actuaries create to estimate health care utilization. Plans would be exempt from the rating protections that apply to individual

and small group markets. Small businesses with a workforce that is older, disproportionately women, or in industries that are believed to attract high health care utilizers would suffer the most.

Currently, because of the ACA protections, plans are prohibited from basing premiums on anything other than age (within a 3:1 ratio for adults), tobacco use, family size, and geography. As one example of problematic rating practices before the ACA took effect, 92 percent of best-selling plans on the individual market practiced gender rating, costing women approximately $1 billion a year.[xvii] While the proposed rule would protect *individuals* from being charged more because of their gender, it appears that employers with higher rates of female employees could be charged higher premiums, which would ultimately be passed down to their employees. Similarly, the age and industry of employers could lead to higher premiums for employers with older employees or in certain industries because these factors can be used as a proxy for higher health care utilization and/or employees with less-than-perfect health.

We strongly recommend that the Department continue to apply the "look-through" doctrine, rather than treat AHPs as large group plans. If an AHP is offering coverage to individuals, including working owners, or small employers, the plans should be required to meet standards and protections set forth in the ACA.

IV. States must retain authority to regulate multiple employer welfare arrangements (MEWAs).

While the Department states that the proposed rules do not alter existing ERISA statutory provisions governing MEWAs, we are concerned that the proposed rules will have the result of preempting existing and future efforts by states to regulate MEWAs. The proposed rules' new framework allowing many more AHPs to be treated as large, single employer plans invites new insurance scams by creating confusion about states' enforcement authority over AHPs. In the past, promoters of fraudulent health plans have used this type of regulatory ambiguity to avoid state oversight and enforcement activities that could have otherwise quickly shut down scam operations.[xviii]

We urge the Department to clarify that ERISA single employer AHPs, including those that cover 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. This will maintain states' ability to protect consumers from the potential ramifications of fraudulent or insolvent AHPs, and to manage their insurance markets.

Finally, we oppose any proposal that would exempt AHPs from state regulation. States have long taken the lead in addressing AHP insolvencies and fraud and maintaining competitive markets, and any attempt to preempt state authority would harm consumers.

V. Individuals and small businesses must be notified if AHPs are not meeting minimum value or providing all the EHBs.

We appreciate the Department's request for information about required notices. AHPs should be required to provide notice to employer groups and potential beneficiaries if plans do not meet standards for minimum value. This will ensure that employer groups and employees know that the plans are less comprehensive than health plans available in the individual or small group markets. Further, if the AHP does not meet minimum value, the employees and their dependents must be made aware of their right to receive coverage through the health insurance marketplaces, potentially with premium tax credits based on their income. Similarly, AHPs should be required to notify employer groups and potential beneficiaries of any EHBs not covered by their plans.

The Department should also clarify that all notice requirements that apply to group health plans apply to plans under this regulation, including notice of appeal rights, summary of benefits and coverage, and summary plan descriptions.

VI. Existing law should be retained to prevent fraudulent entities from creating AHPs.

Proposed regulation §2510.3-5 (b) allows a bona fide group or association of employers to exist for the *sole* purpose of offering health insurance, reversing decades of guidance that protect employers, beneficiaries, and insurance markets. Allowing a bona fide group or association to exist for the sole purpose of offering health insurance opens the door for fraud and financial insolvency. By requiring only minimal qualifications for offering an AHP, the Department is opening the door to entities creating AHPs with the explicit purpose of defrauding small employers and individuals as AHPs could more easily establish and quickly expand across state lines. The Department should retain existing law that a group or association cannot exist solely for the purpose of sponsoring a group health plan.

VII. The Department should retain the commonality of interest test.

Proposed regulation §2510.3-5 (c) significantly weakens the commonality of interest test, which is meant to show a commonality of interest among the employers participating in

the AHP. The existing commonality of interest test prevents groups and associations from circumventing protections that apply to the individual and small group markets by requiring that associations be established for a purpose other than offering insurance. The proposed commonality of interest test eliminates that requirement and would instead allow association to be based on member employers' line of business or trade, or on geography, regardless of industry. The proposed test is so broad that employers with no common interest will be allowed to join together as an AHP, opening the door to fraudulent entities to offer coverage.

The Department should retain the existing commonality of interest test based on facts and circumstances. If the commonality of interest test is changed, additional factors should be required beyond shared geographic location or industry in order to limit the ability of groups or associations to form without any true commonality of interest among employers. With regard to shared geography, the final rule must prevent arbitrary definitions of shared geography that allow AHPs to exclude higher cost areas.

VIII. Individuals and small businesses must be protected from discrimination.

We are pleased that the proposed rule applies the HIPAA nondiscrimination provisions in §2590.702(a) and §2590.702(b) to AHPs. The nondiscrimination provisions prevent AHPs from discriminating based on health status related 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. We applaud this proposal, as it is essential to help protect both employers and their employees from discrimination based on health status. We urge the Department to retain this requirement in final rule. Further, this provision should apply 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, we remain concerned that 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 to protect people with preexisting conditions. An AHP would be exempt from EHB provisions, rate reforms, guaranteed issue and single-risk pool requirements. Using benefit design, an AHP can attract healthier groups. For example, individuals and small employers would not necessarily have access to coverage that includes maternity, mental health benefits, and expensive prescriptions. 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. An AHP could also engage in marketing practices targeted at attracting healthier people.

For these reasons, the Department should strengthen the protections in this provision by preventing groups or associations from varying premium rates to different employer members based on gender, age, zip code or other geographic identifier, industry, or other factor that may be used to vary rates based on expected health care utilization. The final rule should also apply EHB, guaranteed issue and single-risk pool requirements to AHPs.

Failure to extend these protections, in addition to protections against discrimination based on health status, to AHPs will expose employers and their employees to discriminatory 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.

IX. "Working owners" should not be allowed to join AHPs.

The proposed rule allows working owners to join AHPs providing ERISA plans. In 2016, 31 percent of the individual or small group market was self-employed.[xix] This rule effectively allows those individuals to join AHPs that function as large group employer plans. As a result, AHPs will be able to design and market plans to cherry-pick healthy individuals out of the ACA-complaint individual market, resulting in increased rates and decreased choice in the individual market.

In addition, the broad definition of AHPs means that they do not have to confirm that an individual is actually a "working owner"; this opens up the ability for any individuals, regardless of whether they are true "working owners" to purchase coverage through an AHP. The Department should not allow associations to have working owners qualify as both an employer and as an employee as this will bring instability to the individual market.

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For all of the reasons described above, CCHI has serious concerns that the proposed rule will not protect consumers and will undermine the stability of the private insurance market. We urge the Department to reconsider the approach set forth in the proposed rule.

Thank you for this opportunity to comment on the proposed rule, Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans. If you have any

questions about our comments, please contact Debra Judy at djudy@cohealthinitiative.org.

Sincerely,

Adela Flores-Brennan
Executive Director

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