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AMERICA'S UNIONS

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Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N–5655
U.S. Department of Labor,
200 Constitution Avenue, NW
Washington, DC 20210
Attention: Definition of Employer—Small Business Health Plans

Re: RIN 1210–AB85

Ladies and Gentlemen:

The American Federation of Labor and Congress of Industrial Organizations ("AFL-CIO") is pleased to submit these comments on the proposed rule regarding the definition of "Employer" under Section 3(5) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), as it relates to Association Health Plans ("AHPs"), and which was issued by the Employee Benefits Security Administration, Department of Labor ("DOL" or "Department").[1]

The AFL-CIO is the democratic, voluntary federation of 55 national and international labor unions that represent 12.5 million workers across the country in all sectors of our economy. We strive to ensure all working people are treated fairly, with decent paychecks and benefits, safe jobs, dignity, and equal opportunities.

Background

An AHP is an arrangement through which health coverage is sold to employers that are members of a group or association of employers. An AHP is a kind of multiple employer welfare arrangement ("MEWA"), which is defined under

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[1] The Notice was published in the Federal Register on Jan. 5, 2018 (83 Fed. Reg. 614) and is available at https://www.gpo.gov/fdsys/pkg/FR-2018-01-05/pdf/2017-28103.pdf.

ERISA as an employee welfare benefit plan, or any other arrangement that is not an employee welfare benefit plan which is established or maintained for the purpose of offering or providing one or more welfare benefits to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries.[2] Whether a group or association of employers is considered to be an employer under ERISA section 3(5) determines whether an AHP or MEWA can be an employee welfare benefit plan, or just an arrangement through which each participating employer purchases coverage provided by its own separate employee welfare benefit plan.

DOL promulgated the proposed rule in response to an executive order in which President Trump directed DOL to "consider proposing regulations or revising guidance, consistent with the law, to expand access to health coverage by allowing more employers to form AHPs."[3] In particular, the executive order provides,

> To the extent permitted by law and supported by sound policy, the Secretary should consider expanding the conditions that satisfy the commonality-of-interest requirements under current Department of Labor advisory opinions interpreting the definition of an "employer" under section 3(5) of [ERISA]. The Secretary of Labor should also consider ways to promote AHP formation on the basis of common geography or industry."[4]

Consistent with that direction, the proposed rule stretches ERISA's definition of employer significantly beyond the bounds of DOL's longstanding subregulatory guidance, making it substantially easier for groups or associations of employers to qualify as an employer for purposes of establishing a group health plan that is an employee welfare benefit plan. Most significantly:

- The proposed rule allows for a group or association that exists solely for the purpose of offering a group health plan offered to its employer members to qualify as a "bona fide group or association of employers" capable of qualifying as such an employer.[5]
- While the proposed rule includes a requirement that there be a commonality of interest among employers that are members of the group or association, determined based on relevant facts and circumstances, this requirement is greatly diluted because commonality of interest can be established merely by (a) employers being in the same trade, industry, line of business or profession, or (b) employers having a principal place of business in a region that does not exceed the boundaries of the same state or the same metropolitan area (even if the metropolitan area includes more than one state).[6]

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[2] The term MEWA does not include multiemployer plans or plans established by a rural electric cooperative or a rural telephone cooperative association. 29 USC Sec. 1002(40)(A). Welfare benefits include a broad range of things: medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services. 29 USC Sec. 1002(40).

[3] Exec. Order No. 13,813, 82 Fed. Reg. 48386 (Oct. 17, 2017).

[4] Id.

[5] Proposed 29 CFR § 2510.3-5(b)(1), 83 Fed. Reg. 635.

[6] Proposed 29 CFR § 2510.3-5(b)(5), (c), 83 Fed. Reg. 635.

- Under specified conditions, a working owner of a trade or business may qualify as both an employer and an employee of the trade or business, thereby permitting self-employed individuals, including sole proprietors, to be part of an AHP.

In addition, the proposed rule imposes specific nondiscrimination requirements with which both a bona fide group or association and any health coverage offered by such a group must comply. These requirements prohibit conditioning employer membership in a group or association based on any health factor of an employee or employees or a former employee or employees of an employer (or any beneficiaries of an employee or former employee). Further, the proposed rule requires compliance with specified requirements for nondiscrimination in rules for eligibility for benefits, as well as in premiums or contributions required of any participant or beneficiary for coverage under the plan. In applying the latter requirements, a group or association may not treat different employer members of the group or association as distinct groups of similarly situated individuals.

The Department Should Revoke or Substantially Delay Moving Forward with the Proposed Rule.

The objective of the proposed rule is to spur an increase in the sponsorship of AHPs. It does this by instituting a dramatic change in how DOL regulates them. This will have wide-ranging implications for millions of working people, the group and individual insurance markets, and the people and employers relying on them.

Since MEWAs long have been plagued by financial mismanagement and fraud and the Department and state regulators have extensive experience investigating and correcting MEWA wrongdoing[7], the Department possesses

- Extensive information, data, statistics and other documents related to its enforcement and compliance efforts regarding MEWAs.
- Evaluations of past policy initiatives, regulations, legislation and potential legislation that involved either the regulation of MEWAs or an alteration of of the definition of "employee welfare benefit plan" under ERISA that might have expanded the number of MEWAs considered to be single employee welfare benefit plans.

As others and we noted in a separate comment letter submitted March 1, 2018[8], this information, which is highly relevant to this rulemaking, has not been made public or been incorporated in any meaningful way into the discussion or the regulatory impact analysis accompanying the proposed rule.

Release of the requested information, data, statistics and evaluations and inclusion of the missing analyses, presentations and discussions in a notice of proposed rulemaking are essential to ensuring the proposed and final rules take into account the Department's experience and that the

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[7] 83 Fed. Reg. 631.
[8] Letter from Kevin W. Lucia, Research Professor, Ctr. on Health Ins. Reforms, Georgetown University, *et al.*, to Tim Hauser, Dep'y Asst. Sec'y for Program Operations, US Dep't of Labor (Mar. 1, 2018).

Department's regulatory impact analysis is not arbitrary and capricious. Unless and until the Department provides this information, we urge the Department to revoke or substantially delay moving forward with the proposed rule.

The Department Fails to Address Adequately the Impact of AHP Mismanagement and Fraud on Working People.

We are deeply concerned that the proposed rule will expose millions of working people to losses from AHPs due to financial mismanagement and fraud and believe the Department has failed to properly account for and mitigate this risk of loss in the proposed rule.

AHPs have a long history of insolvencies. Self-insured AHPs are inherently less stable than state-regulated insurance companies are because solvency requirements are lower and AHP operations are higher-risk operations compared to traditional insurers. There are numerous examples of professional and trade AHPs running out of money and leaving working people and their families with unpaid medical claims.

The AHP market also has a long, troubled history of attracting bad actors and being susceptible to fraud, with promoters using ERISA as a shield to evade state oversight and enforcement. There have been several documented cycles of large-scale scams. According to the Government Accounting Office, the most recent cycle was between 2000 and 2002, when 144 entities left 200,000 policyholders with $252 million in unpaid medical bills, only 21 percent of which were recovered.[9] Promoters market to small businesses and individuals, offering premiums at prices below what is generally available through legitimate market players, through fake associations as well as established professional and trade groups.

While the Department acknowledges that the proposed loosening of requirements for AHPs "could introduce more opportunities for mismanagement or abuse, increasing potential oversight demands on the Department and State regulators,"[10] the Department does not 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 the federal and state 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. The Department also 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

The Department describes the proposed criteria that must be met by an association sponsoring an AHP as being "intended to ensure that associations sponsoring AHPs are bona fide employment-

[9] U.S. General Accounting Office, *Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entities Selling Coverage*, GAO-04-312 (Feb. 2004) p. 4, *available at* https://www.gao.gov/assets/250/241559.pdf.
[10] 83 Fed. Reg. 632.

based associations and likely to be resistant to abuse."[11] It also characterizes these criteria as largely duplicating existing sub-regulatory guidance regarding AHPs.[12] The Department, however, does not offer any rationale or analysis based on the extensive record of enforcement actions by the federal and state governments as to why these pre-existing criteria are sufficient to protect against mismanagement and abuse. For example, DOL does not demonstrate how these kinds of organizational structure and control features have in fact distinguished legitimate, successful MEWAs from those that have been fraudulent or mismanaged.

The proposed rule lays out a much more permissive framework than allowed under current DOL guidance. In particular, the Department would allow associations and groups formed solely for the purpose of sponsoring and promoting AHPs to qualify as employers, commonality of interest established merely by geographic proximity or a common trade, industry, line of business or profession, and the participation of self-employed individuals. As a result, there will be very little, if any, real commonality of interest amongst participating employers, rendering membership in an association nothing more than a commercial transaction. Unfortunately, this missing common bond—an organizational purpose beyond the delivery of benefits that is shared among member employers—is what is most likely to act as a check on abusive and harmful practices by those actors who may be promoting and administering AHPs under DOL's proposed rule.

Given these shortcomings, it is troubling that the proposal 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 organizational structure and control criteria are not a sufficient substitute for qualified professional management of entities that are essentially health insurers. Small business owners and sole proprietors are not generally in the position to determine whether the persons setting up and running an AHP have the needed skills and experience or to provide adequate oversight of an AHP's operations.

Also, the proposed limited standards will not ensure that AHPs are financially stable. Moreover, by suggesting that AHPs would be able to operate across state lines, the proposal creates confusion regarding states' ability to continue to regulate them, a feature that some AHP promoters inevitably will use to evade state oversight. Furthermore, while the Department claims that states will continue to have oversight, the request for information 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.

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[11] 83 Fed. Reg. 632. The criteria called out by in the Department's analysis are: (a) the group or association has a formal organizational structure with a governing body and has by-laws or other similar indications of formality appropriate for the legal form in which the group or association is operated; (b) the functions and activities of the group or association, including the establishment and maintenance of the group health plan, are controlled by its employer members; (c) the AHP's member companies control the AHP; and (d) only employer members may participate in the AHP and health coverage is not made available other than to or in connection with a member of the association.

[12] 83 Fed. Reg. 620.

DOL should not proceed with this proposal until it has given due consideration to the harm that working people would be exposed to if fraudulent or mismanaged AHPs were allowed to proliferate and it has implemented adequate protections. The Department should reconsider its proposal to permit AHPs to be sponsored by employer associations or groups established solely to do so with no common bond beyond geographic proximity or a common industry or profession.

The Department Fails to Account Adequately for the Impact of Increased Risk Segmentation and Adverse Selection on the Small Group and Individual Markets.

Under the proposed rule, market forces generally favor groups and individuals with lower-than-average health care costs compared to their respective community-rated risk pools seeking out their own separate risk pools, so it is likely AHPs will mostly enroll individuals with lower costs and the community-rated small group and non-group markets will retain individuals with higher-than-average costs.[13] This segmentation of healthier people from sicker people will increase the costs of coverage for those remaining in the small group and non-group markets, potentially destabilizing or even destroying them in some states.

The Department states that it "believes that under this proposal AHP's adherence to applicable nondiscrimination rules and potential for administrative savings would mitigate any risk of adverse selection against individual and small group markets."[14] This belief, however, is not substantiated by any meaningful analysis of the interplay between the limited nondiscrimination rules that have been proposed, the avenues for discrimination that still would be open, how AHPs could use more flexible rating rules and more flexible benefit design rules resulting from the proposed rule to attract a lower-cost population[15], and the overriding economic forces driving

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[13] A senior representative of a major independent insurance broker described the impact of the proposed rule in the following way:

> Some associations might benefit substantially from the new rules. This is particularly true if their employer-members' risk profile in the aggregate is more favorable than the profile of the community risk pool in which they are currently lumped. Certain professions (or even unrelated groups of professions in the same state or metro area) that boast better-than-average health risk profiles, for example, might see significant reductions in health insurance costs by purchasing coverage through an association.
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> Other associations' members, however, might reflect risk profiles that are worse than the community-rated risk pools in which they might now be buying or shopping for coverage. Pulling those members into their own risk pool would make little sense in that case.

Edward Fensholt, "Association Health Plan Proposed Rules Create Opportunities," https://www.lockton.com/insights/post/association-health-plan-proposed-rules-create-provocative-planning-opportun (last visited Mar. 4, 2018).

[14] 83 Fed. Reg. 631.

[15] *See generally* Letter from Barbara Klever, Chairperson, Individual and Small Group Markets Committee, American Academy of Actuaries, to US Dep't of Labor (Feb. 9, 2018) (discussing the rating factor and plan design considerations that should be made when when analyzing the potential impacts of the proposed rule on individuals, employer groups and the individual and small group health insurance markets).

AHP sponsors, employers and individuals to behave in ways that will result in positive and adverse selection when given the opportunity to do so.

The Department argues that the experience with large group employer health plans suggests AHPs will not engage in the kinds of behaviors that are likely to drive the segmentation of risk pools, but it fails to account for the unique aspects of AHPs under the proposed rule. For the first time, AHPs will be permitted to be a single group health plan even when the group or association of employers is a single-purpose entity, existing solely to sponsor the AHP. This creates a vastly different dynamic from the current situation in which a group plan is incidental to the plan sponsor and its relationship with employees and, in the case of a multiple employer plan, participating employers. This changed dynamic is heightened by the proposed rule's deeming of self-employed individuals to be employees.

The Proposed Nondiscrimination Requirements Are Necessary but not Sufficient.

The Department is proposing to apply the nondiscrimination rules that apply to group health plans pursuant to HIPAA to prohibit AHPs from discriminating based on factors related to health status against employer members or employers' employees or their dependents. As proposed, this would prevent AHPs from using health factors to determine eligibility for benefits or in setting premiums.[16] Including these requirements in any final rule is essential to protecting both employers and their employees from discrimination based on health status. Further, we urge the Department to apply this provision to all AHPs, regardless of whether they were established prior to the effective date of a final rule.

The nondiscrimination standards, however, are insufficient because an AHP can engage in other practices that result in discrimination against people with medical needs. In particular, an AHP can use rating flexibility, benefit design, and flexibility in establishing common bond according to geographic proximity or trade, industry, line of business or profession to drive positive selection and exclude or deter unwanted, higher-cost groups. In light of this, it is critical that the Department reconsider its proposal to treat single-purpose associations and groups of employers with no commonality (other than location or trade, industry, line of business or profession) as bona fide groups eligible to sponsor employee welfare benefit plans.

[16] Health factors include: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.

The AFL-CIO appreciates the opportunity to comment in response to the notice of proposed rulemaking. If you have any questions or concerns about these comments or need any additional information, please do not hesitate to contact me.

Very truly yours,

/s/ Shaun C. O’Brien

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