March 6, 2018

Jeanne Klinefelter Wilson
Deputy Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW, Room N-5655
Washington, DC 20210
Submitted via www.regulations.gov

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

Dear Ms. Wilson:

The Alliance of Community Health Plans (ACHP) is pleased to comment on the Proposed Definition of "Employer" Under Section 3(5) of ERISA–Association Health Plans (29 CFR Part 2510; 82 *Federal Register* 614) issued by the Employee Benefits Security Administration of the Department of Labor (hereinafter referred to as "the Department").

ACHP is a national organization of innovative health plans and provider groups leading the nation towards a value-based health care financing and delivery system. Members are non-profit organizations or subsidiaries of non-profit health systems. They provide coverage and care for more than 19 million Americans in 30 states and the District of Columbia in the commercial market and exchanges and for Medicare, Medicaid, and federal, state and local public employees.

Member plans have been grounded in their communities for decades and, as non-profit organizations, do not enter or exit markets based solely on financial considerations. They are characterized by close relationships with providers either through integrated structures or carefully managed networks. This is an important consideration as the proposed rule on Association Health Plans (AHPs) risks creating an uneven regulatory playing field and segmenting the risk pool to the detriment of consumers served by community-based and regional health plans. **ACHP believes strongly that federal and state rules should create a uniform regulatory environment in which plans compete on cost and quality instead of engaging in favorable risk selection and unfair marketing practices.**

ACHP shares the Department's goal of improving access to affordable health insurance for individuals and small businesses. Association Health Plans can increase options for coverage when they are organized for specific industries, are regulated by the state in which they operate and

1825 Eye Street, NW, Suite 401 | Washington, DC 20006 | p: 202.785.2247 | f: 202.785.4060 | www.achp.org

include solvency requirements and consumer protections. In Minnesota, for example, AHPs have provided coverage for the agricultural industry which might otherwise not be available. That law clearly establishes state regulatory oversight and includes strict structural guidelines and consumer protections.

In brief, our concerns are:

- Proposals for AHPs and the sale of insurance across state lines would destabilize already precarious health insurance markets for individuals and small employers.
- AHPs would be subject to fewer consumer protections and would be exempt from requirements assuring a minimum level of coverage.
- AHPs likely would enroll the most favorable risks (healthier, younger individuals), further fragmenting the risk pool and driving up costs for families needing, and employers offering, comprehensive coverage. A stable market requires a broad risk pool to spread risks and lower costs.
- Past experience has shown the proliferation of organizations and insurance products with a long history of plan failures, fraud and abuse.
- The proposed rule calls into question the role of states as the primary regulators of self-insured as well as fully-insured AHPs.
- The proposed rule is not likely to significantly expand the availability of insurance coverage and may increase federal costs as individuals become newly eligible for federally subsidized health insurance.

We believe that AHPs as structured under the proposed rule would undermine the ability of community-based, high quality health plans such as our members to continue providing comprehensive and integrated health care to those we serve. Additional information on our concerns is below.

1. AHPs and Adverse Selection

The proposed rule would create an uneven, two-tiered regulatory environment for health coverage that could destabilize individual and small group health insurance markets.

Under the Department's approach, existing rules and regulations would apply to traditional health plans and a separate, looser set of rules would apply to plans offered through groups of employers or associations. Over time, the uneven regulatory landscape would further segment health risk in the affected markets and increasingly undermine stability.

Under the proposed rule, plans offered to groups of employers and sole proprietors through associations would be treated as a single employer plan. They would be exempt from a number of federal rules applicable to non-grandfathered, individual and small group health insurance: required coverage of Essential Health Benefits, premium rating limitations, prohibition on exclusions for pre-existing conditions, risk adjustment and other requirements designed to promote fair competition while protecting consumers. AHPs could exclude key benefits, lower limits on annual coverage and raise deductibles. They would not be considered part of the same rating pool or participate in the risk adjustment program in which individual and small group issuers are required to participate.

AHPs would likely engage in favorable risk selection because they could eliminate benefits and protections important to higher-risk individuals and they would not share in the spreading of costs

for those individuals – a key element of a healthy, sustainable insurance market. Lower-risk groups could obtain more favorable rates within the AHP market and higher-risk groups would cluster in the non-AHP market.[1] The resulting adverse selection would drive premiums for non-AHP coverage increasingly upward. Over time, this segmentation would affect the ability of community-based health plans to continue to provide coverage to their entire populations.

Under the proposed rule, health status could not be considered in setting premium levels, but AHPs could set premium levels based on age, geography and type of industry, among other factors, while non-AHP plans would remain subject to more restrictive rating rules. These provisions would provide another tool for AHPs to price plans in ways that appeal to lower-risk individuals and avoid enrolling higher-risk individuals.

2. Impact on the Individual Market

The Department's proposal to allow sole proprietors to join an association only for the purpose of purchasing health insurance and for an association of such sole proprietors to be considered a single large-employer plan would increase the risk of instability in the individual market.

Because the individual insurance market is relatively small, broad risk spreading is even more essential than in the small employer or large group market. If sole proprietors are able to enroll in AHPs, fewer individuals would remain in the traditional individual market – further reducing the ability to spread risk. The Department suggests that AHPs would be able to reduce costs by taking advantage of economies of scale. Health coverage for a group of self-employed individuals is unlikely, however, to achieve economies of scale. Marketing, enrollment costs and underlying drivers of health care costs for self-employed individuals buying through an association are not likely to be different from individuals buying alone. Lower costs, if they arise, are more likely to be related to lower benefits and risk segregation introduced by the other provisions of the rule as described above.

3. Interstate sale

Permitting the sale of AHPs across state lines does not account for the difficulty of establishing provider networks, further segments the risk pool and obscures accountability for consumers.

While the purchase of insurance across state lines has been promoted as a way to increase availability of insurance and reduce costs, existing statutory provisions to encourage such interstate sales have not been embraced because the approach is inherently problematic. Current law permits two or more states to enter into a "health care choice compact" to provide a regulatory structure to sell insurance across states lines. Only six states have enacted such laws (RI, WY, GA, KY, ME, OK) and, as of mid-2017, none had entered into agreements with other states to sell across state lines. Insurers historically have not sought to sell across state borders for a number of compelling reasons. Perhaps most important is that negotiating, establishing and maintaining favorable contracts with providers is a major challenge even in states where plans already operate. Out-of-state plans with no current market share in a state would encounter even greater difficulty in establishing a provider network – a significant barrier to market entry.

[1] NAIC Consumer Alert—Association Health Plans are Bad for Consumers
http://www.naic.org/documents/consumer_alert_ahps.pdf

If this rulemaking moves forward, the Department should take into account how to ensure adequate access to providers when an AHP established in one state has few or no provider relationships in other states. While ACHP plans vary from closed HMOs to fully contracted networks, all have invested significantly in developing close, productive working relationships with local providers – a key to their success. Allowing AHPs domiciled in states with fewer regulations to compete against those whose successful business models rely upon a local presence would further exacerbate the concerns raised by an uneven playing field, undermining the stability of community-based and regional plans and the health care gains of their communities.

Selling AHP coverage across state lines further exacerbates the problem of unstable and segmented risk pools noted above: AHPs operating in states with fewer regulatory requirements could aggressively select the healthiest risks in a more highly regulated state. Healthier consumers might have greater access to cheaper and less comprehensive coverage, but sicker individuals and people with pre-existing conditions would face significantly increased costs and less choice. Consumers would not easily know where to appeal adverse plan decisions or file disputes. Even if they did, the other state's regulators and elected officials would have little incentive to assist an individual who is not a resident of their state.

4. Potential for Fraud, Abuse and Plan Failures

The proposed rule would increase the likelihood of AHP failures and insolvencies. States should retain regulatory oversight of AHPs and MEWAs.

In recent years, the Department has worked to improve oversight of AHPs by clarifying federal and state regulatory roles and implementing stronger reporting and other oversight requirements. As recently as 2017, the Department was engaged in targeting plans offered to groups of employers such as those proposed in the rule to root out fraud, prevent plan failures and halt "unscrupulous promoters who sell the promise of inexpensive health benefit insurance, but default on their obligations."[2]

The Department has identified instances in which plan managers have been found to divert premiums for their own personal use.[3] For example, the Department worked to close down operations of a plan provided to a group of employers in which contributions from employers and employees for health insurance were pooled and transmitted to offshore accounts. In that instance, the Department identified more than $26 million in processed but unpaid claims for medical services.[4]

Past insolvencies among AHPs and Multiple Employer Welfare Arrangements (MEWAs), a type of AHP, have been related to weaker state and federal solvency and licensing requirements when compared to the requirements that apply to traditional insurance. AHPs that do not meet minimum

[2] "U.S. Department of Labor Obtains a Temporary Restraining Order to Protect Participants and Beneficiaries of Failing MEWA," https://www.dol.gov/newsroom/releases/ebsa/ebsa20171108 .
[3] Pear, Robert, October 21, 2017, "Cheaper Health Plans Promoted by Trump Have a History of Fraud," New York Times, https://www.nytimes.com/2017/10/21/us/politics/trump-association-health-plans-fraud.html.

[4] U.S. Department of Labor, https://www.dol.gov/newsroom/releases/ebsa/ebsa20171108.

solvency standards are at greater risk of becoming insolvent when claims suddenly or unexpectedly exceed their ability to pay.[5]

AHP and MEWA failures also were exacerbated by ambiguity on the circumstances in which state solvency standards and consumer protections applied. Bad actors were able to avoid oversight by both state insurance departments and the Department of Labor by taking advantage of this lack of clarity in the statute and regulations.

As the American Academy of Actuaries points out in its issue brief of February, 2017, "to avoid increased solvency risk, AHPs would need clearly defined regulatory authority and solvency requirements."[6] Should the Department finalize the rule, we urge it to clarify existing areas of uncertainty on the role of federal *versus* state regulation and enforcement and address ambiguity in the proposed rule. The rule should assign clear accountability and responsibility for monitoring reserves and solvency of all AHPs.

The rule would allow employers with "a principal place of business in the same metropolitan area" to be considered to have a common interest so that they may be defined as a single employer. The rule does not define "principal place of business" or the "same metropolitan area." Without a more specific definition and safeguards, this language could provide opportunities for AHPs to use geography as a tool to discourage enrollment of high-risk individuals and small businesses by limiting their service areas and provider networks to selective parts of a metropolitan area.

The Department indicates in the preamble to the proposed rule that it would not make changes to the regulation of MEWAs at this time. It does not attempt to clarify remaining ambiguities over regulatory oversight and raises new concerns by reducing barriers to entry for AHPs and increasing ambiguity about which states' rules apply and when. The Department leaves open the possibility that it could interpret a state law's application to an AHP operating in that state as inconsistent with its revised requirements. **In response to its request for feedback, we urge the Department to affirm state regulatory oversight over AHPs and MEWAs**. States should remain the primary regulators of self-insured as well as fully-insured AHPs. This is especially critical given the lack of federal financial standards for AHPs or a robust program for their fiscal oversight.

5. Impact on the Uninsured and Increased Federal Costs

The proposed rule is not likely to significantly expand the availability of insurance coverage.

ACHP shares the Department's goal of increasing access to affordable health insurance coverage. We note, however, that independent estimates of past legislative proposals, including those of the Congressional Budget Office, have concluded that AHPs are unlikely to result in significant increases in small firm coverage. For every small employer that may gain cheaper health insurance through an AHP, many more will find their insurance to be more expensive, leading some to drop coverage altogether.[7]

---

[5] Kofman, Mila, et al., MEWAs: *The Threat of Plan Insolvency and Other Challenges,* Health Policy Institute, Georgetown University, http://www.commonwealthfund.org/usr_doc/kofman_mewas.pdf
[6] American Academy of Actuaries, https://www.actuary.org/content/association-health-plans-0
[7] "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts," Congressional Budget Office, January 2000, https://www.cbo.gov/sites/default/files/106th-congress-1999-2000/reports/healthins.pdf.

The proposed rule is likely to increase federal costs as individuals become newly eligible for federally subsidized health insurance.

Under current law, if an employee is not offered coverage which meets a test for "minimum value," then the employee is able to purchase coverage through the state's exchange. Based on his or her income, the individual could qualify for a subsidy for that coverage. Under the proposed rule, small employers buying coverage through an AHP would be able to obtain plans with fewer benefits since the Essential Heath Benefits requirements would not apply. As a result, more workers and their dependents could become eligible to receive a premium subsidy tax credit toward a plan issued on the state's Exchange. Some of those individuals may be expected to choose that option, especially if they need access to Essential Health Benefits. Thus the proposed rule would likely increase federal costs without significantly expanding coverage.

With few advantages of AHPs and the high risk of introducing additional instability in the small group and individual marketplaces, ACHP recommends that the Department not finalize the proposed rule. We suggest that other policy approaches, such as establishing a federal reinsurance program for the ACA-compliant individual and small group markets, would be far more effective in promoting affordable coverage options.

Thank you for your consideration of ACHP's comments. If we can answer any questions or provide additional information, please contact Howard Shapiro, Director of Public Policy, at hshapiro@achp.org.

Sincerely,

Ceci Connolly
President and CEO