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March 6, 2018

The Honorable Preston Rutledge
Assistant Secretary of Labor
Employee Benefits Security Administration Office of Regulations and Interpretations
Room N–5655
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

Re: Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans (RIN 1210–AB85)

Dear Assistant Secretary Rutledge:

Anthem, Inc. (Anthem) appreciates this opportunity to comment on the Department of Labor's (DOL's) proposed Association Health Plan (AHP) rule ("Proposed Rule"), published on January 5, 2018 (83 Fed. Reg. 614).

Anthem is one of the nation's leading health benefits companies, serving over 73 million people through its affiliated companies, including more than 40 million within its family of health plans. As a committed participant in the individual, small group, and large group health benefits markets, we look forward to working with the DOL to explore how AHPs can provide more affordable health benefits to consumers, while protecting consumers from fraud and unpaid medical bills.

Anthem supports the Administration's commitment to a health care system that provides high-quality care at affordable prices, particularly for small businesses. Small businesses in particular struggle with the escalating cost of coverage, and the market is in need of creative solutions and coverage vehicles that can provide coverage at affordable prices. As we work towards that goal, we want also want to ensure any new vehicles have appropriate protections in place to mitigate the potential fraud and other unintended potential outcomes.

As described in our top recommendations below, we believe DOL should modify the Proposed Rule in a number of areas to preserve the existing association health coverage that businesses choose, while ensuring that newly created AHPs will provide stable, financially sound, affordable health coverage to small businesses, particularly those that may not have previously offered coverage to their employees. Following our top recommendations captured in the Executive Summary is a longer section with further detailed comments.

Executive Summary

1. Preserve current association arrangements

Anthem supports the goal of ensuring affordable coverage vehicles exist for small employers, and we support expanding the options that are available. However, we are very concerned that the proposed regulation would place new restrictions on *existing* AHPs, working against the goals of the Administration. Anthem strongly believes that *current* association health coverage (where a bona fide association sponsors a single group health plan for its members) should not be restricted by new AHP requirements, particularly those provisions that will increase costs for existing groups. In a number of states, a large number of employers of varying sizes have chosen to join bona fide associations, driven by affordable health coverage offered to them as one of the benefits of joining the association. Many of the current bona fide associations have had stable membership – and have sponsored group health benefit plans for members – for many years. Requiring current association health benefits coverage to conform to new rules will upset the stability of those arrangements and will deprive employers of the association health coverage they have chosen to maintain for years. As explained in more detail below, to allow groups to "keep what they have," we strongly suggest that the Administration permanently grandfather existing associations to give them the ability to continue to operate under existing federal and state rules and continue to enroll new groups under the existing health benefit plans.

2. Promoting market stability and mitigating fraud

Additionally, rather than permitting new associations to form solely for the purposes of providing their members with health benefits, the DOL should align its regulation with the Public Health Service Act's[1] (PHSA) requirements for bona fide associations. Specifically, the Final Rule should adopt the PHSA criteria requiring an association to have been actively in existence for at least 5 years, and that the association must have been formed and maintained in good faith for purposes other than obtaining insurance. Aligning the Final Rule with these existing legal requirements will

[1] 42 U.S.C. §300gg-91, et seq.

promote a stable regulatory environment for associations that now choose to sponsor a group health plan for their employer members.

3. **Allow health insurers to own or control AHPs**

For decades, health insurance issuers have provided valuable administrative and other services to group health plans offered by bona fide associations and other Multiple Employer Welfare Arrangements (MEWAs). Anthem believes that health insurers should be allowed to continue to provide those valuable services, as well as be permitted to own or control AHPs. This will allow health insurers to use their considerable experience to help ensure optimal options exist for small employers and to deter the fraud and abuse that has plagued MEWAs for decades. We understand that allowing this will require Prohibited Transaction Exemptions (PTEs).

4. **Limit AHP membership to small employers**

Since a primary policy goal of the Proposed Rule is to allow small businesses to experience the advantages of a large group health plan, the DOL should focus this regulation on providing additional choices to small employers, rather than large employers and working owners (sole proprietors). This approach will reduce enrollment "churn" between the individual and small group markets, thus reducing the uncertainty that can lead to the need for higher rates.

5. **Preserve and enhance the ability for states to regulate AHPs for solvency**

Because there has been a history of fraud and failure in certain MEWA health benefit arrangements over the last 30 years (as explained in more detail below), Anthem we strongly support state solvency requirements to provide one mechanism to inhibit fraud and other potential abuses in the new AHP environment.

6. **Assign an effective date allowing for adequate preparation for AHPs, states, and health insurers that provide products/services to AHPs**

Because the Proposed Rule does not assign a specific effective date for the Final Rule, by law, it will take effect 60 days after issuance of the Final Rule. As explained in more detail below, such a prompt effective date will not afford AHPs, states, or health insurers sufficient time to make the appropriate adjustments, set up necessary structures and develop and price products and benefits. Anthem believes that the Final Rule should not take effect until January 1 of the first full calendar year falling at least 12 months from publication of the Final Rule. Assuming the Final

Rule is issued in the summer of 2018, the Final Rule's effective date would thus be January 1, 2020.

Detailed Comments

1. **Preserve current association health benefits arrangements [§2510.3-5(b)]**

Issue: The Final Rule will impose numerous new requirements upon the *existing* bona fide associations that sponsor a single group health plan for their members.

Recommendation: The Final Rule should allow for the permanent grandfathering of single group health plans sponsored by bona fide associations that predate the issuance of the Final Rule and allow those associations to continue to enroll groups under their existing construct that complies with federal and state rules.

Rationale:

The bona fide association requirements in the PHSA[2] have been in existence since 1996. In the time since enactment, bona fide associations have formed to provide their employer members in the same trade or industry with membership benefits, such as informational seminars, webinars and training, compliance assistance, government relations resources, and insurance benefits for health, life, property, and mortgage. Some of these bona fide associations have offered health benefits to their members for 30 to 40 years, and their membership provides a stable and predictable population to allow health insurers to appropriately price the health benefits plan the bona fide association has selected. These associations operate in many states under specific frameworks established through state law and regulation.

These stable and long-established bona fide AHPs should be grandfathered, be allowed to continue to operate under state and federal rules, and not be forced to move to a new AHP arrangement with very different requirements under the Final Rule. This will allow employers and their employees to "keep what they have."

Bona fide associations should have the choice of maintaining their current health benefits arrangement if they believe it best suits their members. Bona fide associations, their employer members, and health insurers have relied upon decades of DOL regulations, Advisory Opinions, and other Agency guidance to form health benefits arrangements that are most beneficial to and desired by employers. Bona fide associations and health insurers thus have substantial reliance

[2] 42 U.S.C. §300gg-91, et seq.

rights upon longstanding DOL policy that should not be disrupted absent good reasons for changing that policy.[3]

In order to allow current association members to keep their choice of health benefits and allow them to maintain the health benefits that they have and want, the DOL should grandfather the existing health benefits arrangements of bona fide associations rather than them to change and meet the new requirements of the Final Rule. To ensure these associations can continue to thrive, they must also be able to add new groups into the association framework.

2. **Ensure New AHPs that Form do not Harm Consumers or the Market**

Issue: The Proposed Rule would permit new associations to be formed solely for the purpose of furnishing health benefits to their members.

Recommendation: The DOL should align the requirements in its Final Rule with the PHSA's requirements for bona fide associations, which require, among other criteria, an association to have been actively in existence for at least 5 years and formed and maintained in good faith for purposes other than obtaining insurance. Alignment of the PHSA and the Employee Retirement Income Security Act (ERISA) rules will promote stability across the market as well as deter fraud and abuse.

Rationale:

The PHSA's requirements for bona fide associations have been in existence since 1996.[4] The PHSA, and its corresponding regulations, state that:

> The term "bona fide association" means, with respect to health insurance coverage offered in a State, an association which—
>
> (A) has been actively in existence for at least 5 years;
>
> (B) has been formed and maintained in good faith for purposes other than obtaining insurance;

[3] The Supreme Court has recently reiterated that although an agency is free to change its existing policies, it must provide a reasoned explanation for the change. Encino Motorcars LLC v. Navarro, 136 S. Ct. 2117, 2125 (2016). As part of that reasoned explanation, "an agency must also be cognizant that longstanding policies may have 'engendered serious reliance interests that must be taken into account'", id. at 2126, because failing to consider reliance interests may be arbitrary and capricious and thus invalidate the rule. Smiley v. Citibank (South Dakota) N.A., 517 U.S. 735, 742 (1996).

[4] Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, Aug. 21, 1996, 110 Stat. 1936, Section 102(a).

(C) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(D) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

(E) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(F) meets such additional requirements as may be imposed under State law.[5]

Allowing new AHPs to form for the sole purpose of offering health coverage is likely to contribute to market instability and potential solvency issues. If an association does not have the proper resources to offer viable health coverage, consumers could be at risk of having coverage that is not stable Aligning ERISA AHP requirements with requirements for bona fide associations currently in the PHSA would help ensure that new AHPs are capable of offering stable coverage to consumers, which we believe is DOL's primary goal.

Issue: Given the history of certain MEWAs committing fraud, we are concerned that allowing new associations to be formed solely to provide health benefits has the potential to attract bad actors to establish entities with the purpose of committing fraudulent actions.

Recommendation: If the Final Rule permits new associations to be formed solely for the purpose of furnishing health benefits to their members, then the DOL must adopt guardrails to protect AHP members, plan participants, and plan beneficiaries from bad actors and fraud.

Rationale:

The Proposed Rule correctly points out that over the past 30 years, some MEWAs have not paid claims due to fraud. The damage that MEWA fraud has done to consumers is considerable. One state's Attorney General considered MEWA fraud as having "the potential to become the most sophisticated and profitable white-collar crime in America" due to its "high profit and very low risk crime under the existing laws … [A]n operator with virtually no capital can go into the ERISA trust benefit business and become a very rich person by cheating people out of their premiums and face almost no chance of going to jail."[6]

[5] 42 U.S.C. §300gg-91(d)(3); 45 C.F.R. §144.103.

[6] Testimony of Tyrone Fahner, Attorney General, State of Illinois (former Assistant U.S. Attorney and former Director of Illinois Department of Law Enforcement), before the Subcommittee on Labor Management Relations of the Committee on Education and Labor House of Representatives, March 5, 1982, at 6. (128 Cong. Rec. 30356).

Between January 1988 and June 1991, fraudulent MEWAs left at least 398,000 participants and their beneficiaries with over $123 million in unpaid claims and many other participants without insurance. During that period, more than 600 MEWAs failed to comply with state insurance laws, and some violated criminal statutes. Many officials did not quantify the problem, but those who did estimated that (1) MEWAs failed to pay claims for at least 398,324 participants and their beneficiaries and (2) unpaid claims totaled at least $123.6 million. Of 34 states trying to recover money on behalf of participants and their beneficiaries, 18 had recovered an estimated $9.6 million as of December 31, 1990.[7] Moreover, despite federal and state regulation, MEWA fraud persisted in the 2000s, harming thousands more consumers.

There are many more similar instances of MEWA fraud, as outlined in a recent article in *The New York Times*.[8] Importantly, despite the ACA granting DOL new cease and desist powers over MEWAs,[9] fraud in MEWAs persists to this day. In November, 2017, the DOL for the first time exercised its new authority by obtaining a cease and desist order on an Illinois MEWA, and the receiver terminated the plan on December 21, 2017, leaving $26 million in unpaid claims incurred by 14,000 participants and beneficiaries spread out across more than 560 employers in 36 states.[10] The plan funds were offshored to Bermuda where they could not be recovered.

Anthem is concerned that without appropriate federal and state regulatory oversight of AHPs, MEWA fraud will increase. Should the DOL decide to proceed with allowing new associations to form solely for the purpose of providing health benefits to members, it is imperative that the Final Rule include additional protections that, in combination and if well-enforced, could serve to deter bad actors and to inhibit fraud in newly formed associations designed to offer health benefits. The DOL and state insurance regulators must coordinate their efforts in enforcing these guardrails so that employers and consumers are protected from criminal behavior.

Thus, Anthem recommends several policy fixes that, taken together, could reduce the potential for and incidence of fraud in AHPs. These recommendations include:

[7] U.S. General Accounting Office, Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements, GAO/HRD-92-40 (1992), found at https://www.gao.gov/products/HRD-92-40

[8] R. Pear, "Cheaper Health Plans Promoted by Trump Have a History of Fraud," New York Times (October 21, 2017), found at https://www.nytimes.com/2017/10/21/us/politics/trump-association-health-plans-fraud.html

[9] ERISA Section 521, 29 U.S.C. §1151.

[10] See http://www.receivermgmt.com/AEUBenefitPlan.htm

(1) The Final Rule should require the person(s) who create the association to pass a criminal background check.

In the health care sector, there is a high rate of fraudulent actors re-offending. Thus, a criminal background check of the person or persons establishing a new association would provide federal and state authorities with valuable information. Although not foolproof, failure to pass a criminal background check should be grounds to disqualify anyone from forming a new association with the intent to provide health benefits to members.[11]

(2) Registration of new associations with the DOL and with state departments of insurance would give federal and state regulators knowledge of new entities that are providing health benefits.

New associations that seek to sponsor group health plans should be required to register not only with the DOL, as is currently required for MEWAs,[12] but also with all state departments of insurance in those states where the association plans to market. Registration should be required before the association engages in any marketing of health benefits to potential employer members. A registration requirement will help state regulators know what AHPs intend to offer coverage to their citizens and will assist regulators in responding to consumer complaints.

(3) The situs of the health plan should be the headquarters of the association, located at a physical address rather than a P.O. Box.

In health care fraud, a typical tactic includes utilization of a post office box as the alleged address of the business. Any new association should have a headquarters located at a physical address, which will also establish the situs of the plan.

(4) States should continue to have the ability to regulate the solvency of AHPs, in order to ensure that AHPs have adequate funds to cover claims liabilities.

While all states plus the District of Columbia regulate MEWAs in some fashion, the level of regulation varies by state. One key protection against MEWA fraud is the efforts of state insurance regulators to monitor MEWAs for solvency. Before the effective date of the Final Rule, the DOL should work with the National Association of Insurance Commissioners (NAIC) to develop standard solvency requirements and quarterly financial reporting that could be used by

[11] See 29. U.S.C. §1111 (persons convicted of certain crimes prohibited from holding positions relative to employee welfare plans).
[12] See ERISA Section 101(g), 29 U.S.C. §1021(g).

states to ensure that AHPs and other MEWAs operating in their jurisdictions would be financially sound and not harm consumers. We discuss this guardrail in more detail below.

Issue: New association options create an increased likelihood of enrollment "churn" between markets, which increases uncertainty and drives up the cost of health benefits.

Recommendation: The DOL should adopt reasonable enrollment restrictions designed to promote market stability and avoid excess churn between markets.

Rationale:

While Anthem has concerns from a fraud perspective about the Proposed Rule allowing new associations to be created solely to provide health benefits to their members, we are also concerned about the impact on the insurance and health benefits markets that these new entities will potentially have due to movement between markets. One of the important policy goals of the Proposed Rule is to establish a stable risk pool in AHPs (which the DOL asserts will lower costs), and unless reasonable enrollment restrictions in AHPs are implemented, this policy goal may not be achieved.

Because of guaranteed availability, when the Final Rule is issued, small businesses will be able to move their benefits between the ACA insured market and the AHP insured or self-funded market with relative ease. It is not difficult to imagine a scenario where a small business experiencing higher premiums in the ACA market finds an AHP with lower premiums (whether due to a less rich benefits package, or because of a lower-risk pool of employers). The small business then moves its benefits to the AHP. Then, if AHP rates become more expensive over time for any reason, seeking rate relief, the small business then terminates coverage with the AHP and moves back into the ACA insurance market.

Should small businesses have the unfettered ability to move between markets without restrictions, a number of challenges are likely to emerge, including challenges faced by consumers associated with benefits, networks, and formularies potentially differing significantly between the markets. Additionally, actuaries will face difficulty pricing the cost of coverage in either market, due to the unpredictable populations in each, leading to higher rates associated with higher levels of uncertainty.

Additionally, should movement between markets drive up costs in the ACA individual market, those higher costs will drive up the cost of the second lowest cost silver plan, resulting in higher advance premium tax credits, and thus higher cost to the U.S. Government.

Therefore, in order to control churn to some extent, the Final Rule should place reasonable enrollment restrictions on AHPs designed to promote the stability of their membership and enrollment in the group health plan. For example, AHPs should be required to have an annual open enrollment period, similar to practices established for large employers. Setting an open enrollment period will promote stability by setting limits on when small businesses can take up AHP coverage, rather than allowing coverage to start at any month during the year.

Also – assuming establishment of an open enrollment period – the AHP should be required to establish limits on when employers can join the association and enroll in health benefits, to avoid situations where employers join the association shortly before the open enrollment period. For example, the Final Rule could specify that AHP bylaws must provide that employer members can only join the association up to 6 months before the open enrollment period begins. Alternatively, the DOL could consider requiring AHPs to implement a waiting period before employer groups are eligible for AHP coverage, to prevent gaming. Finally, the Final Rule could require AHPs to have a "lock-in" period for benefits, mirroring legislation introduced in Wisconsin[13] that would require a three-year lock-in period where small businesses would be required to stay with the AHP.

3. Allow health insurers to own or control Association Health Plans [§2510.3-5(b)(8)]

Issue: The Proposed Rule prohibits a health insurance issuer to be, own, or control a "bona fide group or association of employers."

Recommendation: If the final rule allows AHPs to be created solely for the purpose of providing health benefits, the DOL should modify this provision to permit health insurance issuers to own or control a "bona fide group or association of employers."

Rationale:

Anthem does not construe the Proposed Rule as limiting or affecting a health insurer's ability to provide administrative services to a self-funded AHP or health insurance to a fully-insured AHP. The Proposed Rule, however, contains no discussion as to the rationale for prohibiting health insurers from being, owning, or controlling an AHP. Given the expertise that health insurers have in the market, if the rule is finalized to allow AHPs to be created solely for the purpose of providing health benefits, allowing for ownership and control of an AHP would conceivably allow for more options for small employers.

Health insurer involvement in AHPs, even extending to AHP ownership and control, could help AHPs succeed long-term and protect an AHP's employer members as well as plan participants

[13] See Wisconsin Assembly Bill 920, found at https://docs.legis.wisconsin.gov/2017/related/proposals/ab920-engrossed/_12.

and beneficiaries. Health insurers possess the comprehensive ability to administer health care claims; retain large amounts of reserves to protect new AHPs from financial insolvency; offer deep provider discounts;[14] provide effective care management based upon the most recent medical studies; offer and administer employee wellness programs; provide antifraud programs; design benefits based on institutional knowledge of what is most effective and efficient for consumers; and navigate complex federal and state laws, regulations, and sub-regulatory guidance concerning health benefit plans.

The strategy of excluding health insurers from involvement with a new health insurer-like entity like AHPs has been tried in the recent past, with negative consequences to consumers and the market. The ACA established the Consumer Operated and Oriented Plan (CO-OP) program.[15] The CO-OPs were intended to be nonprofit, tax-exempt health insurance issuers that would offer Qualified Health Plans in the individual and small group markets in the states where they were licensed. The CO-OPs were intended to create competition for established health insurers, which in theory would drive down the cost of health insurance. Thus, an established health insurance issuer could not become a CO-OP, nor could it be involved in CO-OP formation or even CO-OP governance.[16] The ACA prohibited established health insurers from owning, controlling, or even providing any valuable guidance and experience to these newly formed health insurers.

Excluding established health insurers from CO-OP involvement was likely one of the factors that contributed to failures that harmed consumers. As of this writing, of the 24 original CO-OPs formed, all but four have collapsed.[17] (One CO-OP, in Vermont, was never licensed.[18]) The others have all closed their doors since 2014. In some states, CO-OP failures were not covered by a state guaranty fund, meaning that consumers and health care providers were left with the unpaid claims after the CO-OP became insolvent.

Permitting health insurers to own or to control an AHP would allow health insurance company expertise and financial backing (in the case of ownership) to support AHPs, particularly those that are newly-created, should DOL allow that in the Final Rule. In the situation where a new AHP is created and a health insurer can control it by involvement in the AHP's governance, health insurer involvement in AHPs could contribute to stability and deter fraud and abuse. Moreover, allowing health insurers to own AHPs could provide a great deal of credibility to the new AHP program, which could help AHPs flourish and grow. If new associations are permitted to form solely for the purpose of providing health benefits to their members, health insurer involvement will be even more important. DOL therefore should not prohibit health insurers from owning or controlling AHPs.

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[14] Although the Proposed Rule posits that AHPs will recognize significant savings from their ability to directly contract with providers, current bona fide associations seldom if ever do this, and we are skeptical that newly formed AHPs will develop sufficient market power to directly contract with providers and obtain deep provider discounts similar to health insurers.

[15] ACA Section 1322, 42 U.S.C. §18042.

[16] 42 U.S.C. 18042(c)(2)(A) and (c)(3)(B), 45 C.F.R. §156.515 (2)(v) [referencing 45 C.F.R. §156.510(b)(1)(i)].

[17] https://www.healthinsurance.org/obamacare/co-op-health-plans-put-patients-interests-first/

[18] http://www.dfr.vermont.gov/press-release/vermont-health-co-op-fails-state-insurance-standards

Anthem understands that permitting health insurers to own or control AHPs will likely require DOL to establish one or more administrative class exemptions from the prohibited transaction provisions of ERISA.[19] As is evident from our comments above, Anthem is greatly concerned about the increased opportunities for fraud in the new AHP program. Allowing health insurers exemption from prohibited transactions would serve to protect the interests of AHPs, plan participants, and plan beneficiaries from fraudulent activities. DOL should consider publishing in the *Federal Register* a Request for Information with opportunity for public input on specific ideas for class exemptions, similar to DOL's actions with respect to the Fiduciary Rule.[20]

Alternatively, should the DOL retain this provision without change, Anthem recommends that the term "control" be clearly and narrowly defined so as not to hinder the valuable services and guidance that health insurers currently provide to their bona fide associations that sponsor group health plans, and would anticipate providing to newly formed AHPs. For example, the DOL could look to the Internal Revenue Service definition of control, which implies a majority ownership interest.[21]

4. AHP membership should be limited to small employers

a. Exclude working owners from eligibility to form or join AHPs [§2510.3-5(e)]

Issue: The Proposed Rule would permit both working owners and employer groups of all sizes to join or form AHPs.

Recommendation: The Final Rule should limit participation in AHPs to small employers.

Rationale:

There is a legal barrier to the ability of working owners to form or join AHPs that are insured. There is an irreconcilable conflict between the language of the Proposed Rule and the statutory language in the PHSA, and the Proposed Rule cannot amend the PHSA.

A statute grants an agency the authority to promulgate regulations that interpret statutory language. The DOL has the authority to issue regulations under ERISA; however, not to issue regulations interpreting the statute under the jurisdiction of another federal agency. Here, the Proposed Rule changes how the term "employer" is used for ERISA group health plan purposes, and the Preamble suggests that this change will also be applied under the PHSA.[22] The DOL

[19] 29 U.S.C. §1106.
[20] See, e.g., 82 Fed. Reg. 7336 (January 19, 2017) and 82 Fed. Reg. 31278 (July 6, 2017).
[21] See IRC §368(c).
[22] *See, e.g.*, Preamble to the Proposed Rule, 83 Fed. Reg., 614, 619 (Jan. 5, 2018) ("These stakeholders opined that the AHP structure would give them increased negotiating power to bargain for lower premiums for their employees, as well as the ability to purchase coverage that would be less expensive because it would not be subject to some of the regulatory requirements applicable to the small group market but not the large group market. … Under the

cannot alter the definition of "employer" as that term has been used in the PHSA; only the Department of Health and Human Services (HHS) can change its interpretation of and guidance under the PHSA. In addition, because of the disconnect between the Proposed Rule's ERISA definition of "employer" and the PHSA definition of "employer," it is unclear that even if HHS wished to adopt DOL's definition that HHS has the same interpretative flexibility that the DOL has. The result is that working owners without employees would not be able to join or form insured bona fide association health plans, unless Congress modifies the PHSA definition to align with the ERISA definition in the Proposed Rule.

The Proposed Rule would amend Section 3(5) of ERISA such that a "working owner" would be considered to be an employer that can join or form a bona fide association.[23] However, the PHSA, the statute that governs insured bona fide associations, defines "employer" as follows:

> The term "employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974, **except that such term shall include only employers of two or more employees.** [Emphasis added.][24]

Reading the Proposed Rule and this PHSA section together, the definition of an employer would exclude working owners who did not employ two or more employees. Sole proprietors without employees, or self-employed individuals, would thus be ineligible to join an AHP that is insured (but would be able to join self-funded associations).

In enacting the PHSA, Congress specifically limited the term "employer" to those with two or more employees. Moreover, the PHSA is under the jurisdiction of the Secretary of HHS.[25] An agency only has rulemaking authority under its authorizing statute. Therefore, the DOL does not have the authority to, in effect, amend a statute within HHS' jurisdiction by issuing a regulation.[26] And while HHS has authority to interpret the PHSA, and has issued guidance regarding associations, it cannot remove the Congressional limitation "except that such term shall include only employers of two or more employees."

In addition to the PHSA, the ACA market definitions also would not allow insured AHPs to treat working owners without employees as a group rather than individual market participants. The

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proposed rule, AHPs that buy insurance would not be subject to the insurance "look-through" doctrine as set forth in the CMS 2011 guidance; instead, because an AHP under the proposed rule would constitute a single plan, whether the plan would be buying insurance as a large or small group plan would be determined by reference to the number of employees in the entire AHP.")

[23] §2510.3-5(b).

[24] 42 U.S.C. §300-gg-91(d)(6).

[25] 42 U.S.C. §§201(c), 202.

[26] 45 C.F.R. §144.103 defines "employer" as having the meaning given the term under section 3(5) of ERISA, which states, "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." However, HHS has heretofore not considered a sole proprietor, whether working or not, as an employer, and the PHSA statutory definition would govern.

ACA states that a "small employer" "means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year."[27] If an employer, including a working owner, employs no employees, the employer is included in the individual market.[28] Furthermore, the U.S. Supreme Court has stated that "[c]ourts agree that if a benefit plan covers only working owners, it is not covered by Title I [of ERISA]". [29] Therefore, allowing working owners to be considered both employers and employees would be contrary to long-established case law.

If, however, despite these legal hurdles, should DOL decide to retain working owners' ability to join or form AHPs in the Final Rule, that rule must contain antifraud protections to ensure that the validity of working owners. Working owners should be required to prove that they have been in business at least 3 years prior to applying to join an AHP. The Final Rule should also require working owners to provide actual evidence of their business, such as supplying federal tax returns or other documentary evidence, rather than the mere certification included in the Proposed Rule. The Final Rule must provide that this documentary evidence must be verified and/or audited by parties external to the AHP, such as the DOL, state regulatory authorities, and any health insurer providing health insurance benefits to the AHP. Finally, the Final Rule should provide that health insurers providing health insurance to an insured AHP are to be held harmless if fraudulent working owners enroll.

b. Exclude large employers from eligibility to form or join AHPs

Issue: A primary policy goal of the Proposed Rule is to give small businesses the advantages that large employer groups have, by allowing them to join or form AHPs.

Recommendation: The Final Rule should not permit large employers to join or form AHPs, so that the primary benefit of AHPs is experienced by small employers.

Rationale:

We agree with the Proposed Rule which posits that small employers will enjoy a net positive effect in joining in AHPs. Since the ACA was fully implemented, small employers have faced challenges, especially because issuers and group health plans in the small group market have been required to comply with many ACA market reforms, which can be costly and administratively burdensome. Moreover, due to smaller risk pools, some small employers have encountered health coverage that is prohibitively expensive. We therefore support the proposal to change the "look through" provisions of the current regulatory framework (i.e., disregarding the association and looking to the underlying employer group size to determine whether coverage is large or small group), to allow small employers to form AHPs that would be treated

[27] 42 U.S.C. §18024(b)(2).
[28] 42 U.S.C. §18024(a)(2).
[29] Yates v. Henden, 541 U.S. 1, 21 n. 6 (2004).

as large employers at the association level. We believe the ability to join AHPs – and having those AHPs considered large group coverage – will result in a marked improvement in the small group market. Allowing small employers to form AHPs would potentially improve choice and affordability of coverage, as well as give small employers increased negotiating power to bargain for lower premiums for their employees, because of economies of scale.

With respect to their group health plans, large employers already enjoy the posited benefits that proponents attribute to AHPs, including scale, greater bargaining power, and fewer ACA requirements with which their health plans need to comply. In addition, large employers have a relatively stable employee workforce, meaning that their risk pool is less volatile year-over-year, and their health benefits can be priced more accurately based on aggregate risk. Moreover, large employers already can, and do, join bona fide associations that sponsor single group health plans; therefore, they can already realize the benefits of association coverage in the current regulatory environment. Thus, while allowing small employers to form AHPs would significantly improve stability, coverage options, and affordability, extending this option to large employers would not do much to improve the health benefit options large employers already have.

Additionally, allowing large employers as eligible AHP members will also tend to bring about churn in the large group market as well. Focusing the Proposed Rule on small employers will promote large group market stability.

5. **Preserve and clarify state regulation of AHPs**

Issue: The Proposed Rule is unclear as to the limits of DOL and state enforcement of AHPs.

Recommendation: Until such time as the DOL is provided adequate and stable funding of its enforcement activities relative to AHPs, states should take a leading role in enforcement of AHPs, particularly with respect to their solvency.

Rationale:

It could be said that many self-funded MEWA failures over the past 30 years were attributable not to lack of rules, but lack of effective enforcement of those rules. We are concerned that may also be an issue with these new requirements. Therefore, the Final Rule should be very clear that states continue to have the ability to enforce state laws that apply to AHPs. In addition, DOL should explicitly encourage states (through a Memorandum of Understanding or otherwise) to work with DOL to investigate and help develop cases regarding AHP enforcement at the federal level, to assist DOL in its enforcement duties.

The Proposed Rule does assert that DOL will provide enhanced enforcement of AHPs requirements, but it does not call for appropriation of funds for enforcement of the Final Rules.

However, the recently-released White House's Fiscal Year 2019 Budget Proposal would increase DOL funding to support and enforce AHPs.[30] The budgetary language states:

> **Makes Health Insurance More Affordable for Small Businesses.** The President's Executive Order "Promoting Healthcare Choice and Competition across the United States" directed the Secretary of Labor to expand access to health coverage by allowing more employers to form Association Health Plans (AHPs), arrangements under which small businesses may band together to offer competitive and affordable health insurance to their employees. The Budget supports this initiative by increasing funding for the Employee Benefits Security Administration to develop policy and enforcement capacity to expand access to AHPs.

As of this writing, it is uncertain whether Congress will appropriate the requested funding for DOL policymaking and enforcement of AHPs. Until such time as Congress appropriates funds for DOL enforcement of AHPs, states should remain the primary regulators of the health insurance issuers that fully insure AHPs. Moreover, states should retain the ability to enforce any applicable state laws regarding both fully-insured and self-funded AHPs.

While the Proposed Rule indicates that states' regulatory authority over MEWAs is not affected, the DOL also requests comments on whether it should create a class exemption for self-funded MEWAs to preclude state regulatory authority. The Final Rule should clearly pronounce that the broad state regulatory and oversight authority that states currently have over AHPs and MEWAs (including self-funded MEWAs) is preserved. This will allow states to maintain the important role they play in protecting consumers and markets as the AHP market expands. In fact, states may wish to enhance their regulatory authority over AHPs in the following areas:

- **Registration.** As previously discussed, AHPs should be required to register with state departments of insurance so that state regulators are initially aware that AHPs will be operating in their states.

- **Solvency and Oversight.** Prior federal legislation implementing AHPs contained substantial solvency requirements for these new health plans, recognizing a Congressional desire to protect employers and consumers from fraud and the financial loss of unpaid claims. For example, H.R. 1101 (115th Congress) would have established specified levels of reserves, surplus and stop loss coverage for AHPs, and would have required self-funded AHPs to contribute to a new federal guaranty fund. DOL would have been charged with overseeing the financial stability of self-funded AHPs.

[30] Fiscal Year 2019 Budget Proposal, at 77, found at: https://www.whitehouse.gov/wp-content/uploads/2018/02/budget-fy2019.pdf

Similarly, states could require an AHP to maintain reserves and surplus and to obtain stop loss coverage for catastrophic claims. States could establish market standards to assess the financial health of AHPs. States could require AHPs to file quarterly financial reports with the state, to ensure that the state has frequent regulatory updates on the AHP's solvency. States could also conduct oversight of AHPs through market conduct and financial examinations.

We believe states are best equipped to manage the health and solvency of their markets, particularly in an area that has historically encountered enforcement issues. Explicitly acknowledging that states continue to have the authority to enforce state laws regulating AHPs and MEWAs would eliminate confusion and ensure consistency across states once this rule is finalized.

6. **Assign an effective date allowing for both AHPs and health insurers that provide products/services to AHPs to adequately prepare for the new AHP requirements.**

Issue: The Proposed Rule has not specifically stated an effective date; therefore, by law it will become effective 60 days after issuance of the Final Rule.

Recommendation: The DOL should assign an effective date for the Final Rule that is no sooner than January 1 of the first full calendar year falling at least 12 months from publication of the Final Rule.

Rationale:

Both associations and health insurance issuers need adequate preparation time to comply with and make necessary adjustments that reflect these new requirements, and 60 days from the date of the Final Rule does not provide adequate time to implement the necessary changes to ensure robust coverage options. A more reasonable effective date would also ensure that states have sufficient time to introduce legislation enacting or, in some cases, improving their solvency oversight of AHPs, which could help ensure market stability. As mentioned above, we recommend that the DOL work with the NAIC to develop solvency standards and quarterly financial reporting that states can use to ensure AHPs and other MEWAs are financially sound. Collaboration to develop these requirements is crucial and will take longer than 60 days after the Final Rule is released.

First, as demonstrated by several studies, the details in the finalized AHP regulation will impact rates (potentially significantly) in the fully-insured small group market (and individual market if working owners are included). Given the timing of 2019 rate filings and likely timing of the final rule, it will be too late to adjust rates for the 2019 rate filing. Thus, without ability to make mid-

year rate adjustments, an effective date that does not provide time to adjust rates will result in significant harm to the market.

Second, associations will need time to formalize their governance and financial structures. The long list of tasks for a new association seeking to create a new AHP would include: creating the legal association entity; marketing to employer groups to join the association; creating a formal organizational structure and governing board; drafting and finalizing by-laws; nominating and electing officers and directors; discussing with the governing board and voting on the health benefits to be included in the association's group health plan; engaging an actuary skilled in health benefits pricing to determine the required funding for a self-funded group health plan, or contracting with a health insurer to quote a rate for the new AHP; seeking quotes for stop-loss insurance, and more. A newly formed association could not possibly accomplish all these tasks within several months after issuance of the Final Rule. Assuming that the Final Rule is issued in the summer of 2018, and given that current employer health coverage tends to renew on January 1, the earliest that a new (or health insurer owned or controlled) association could reasonably implement its new group health plan would be January 1, 2020.

Third, many state legislatures will want to amend their statutes to account for the federal policy changes contained in the AHP rule, and it will be too late for states to act in their 2018 sessions for 2019.

Issue: Irrespective of the effective date of this regulation, robust new AHP options will not likely be in place until 2020.

Recommendation: The DOL should work with HHS to extend the transitional relief policy so that small employers can continue their existing affordable coverage options until AHPs are fully operational.

Rationale:

As stated above, irrespective on the effective date of this final rule, it will take time for new robust AHP options to form. The DOL may have concerns about this timing because small employers need more affordable health coverage right now. There is a step that could be taken by DOL's sister Agency, HHS, which could partly ameliorate this concern. HHS could extend the transitional policy several years (i.e., through the end of 2020) to maintain existing relief to small employers that have maintained pre-ACA coverage. Anthem urges DOL to work with HHS to accomplish this goal, which will help avoid the disruption that would take place if these employers are forced to shop for new, more expensive, coverage at the end of 2018.

Under the ACA, for plan years beginning on or after January 1, 2014, health insurance issuers were required to meet a number of insurance market reforms, including provisions dealing with modified community rating, single risk pool, guaranteed availability, guaranteed renewability, pre-existing condition exclusions, discrimination based on health status, provider non-discrimination, Essential Health Benefits (EHBs), and participation in approved clinical trials. On November 13, 2013, in recognition of the likely negative impact on individuals and small businesses that already had health insurance and wanted to keep it, HHS issued a letter to state insurance commissioners announcing a transitional relief program adopted specifically pursuant to HHS's enforcement authority. The transitional relief permitted coverage issued under previous market rules in the individual and small group markets issued after the ACA's effective date (and therefore not eligible for formal grandfather treatment) to be renewed for policy years starting between January 1, 2014, and October 1, 2014, and to continue in force until September 2015, without meeting the ACA's insurance market reforms that became effective for plan or policy years beginning on or after January 1, 2014.[31]

The result was significant relief for many of our members, particularly for those who would have experienced significant rate increases in the ACA market. In recognition of the ongoing burden of these requirements on individuals and small groups, and in light of the continuing instability in the insurance markets, HHS, relying on its discretionary enforcement authority, subsequently extended the transitional policy on three separate occasions. Extension of transitional relief was one of the first actions taken by HHS under the Trump Administration, when it issued a bulletin in February 2017 allowing coverage to continue through the 2018 calendar year.[32]

Immediately upon taking office, the President issued an Executive Order (January EO)[33] directing the Secretary of HHS and other Executive department and agency heads to exercise their authority and discretion to, among other things:

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[31] CMS Letter to State Insurance Commissioners (Nov. 14, 2013), available at https://www.cms.gov/cciio/resources/letters/downloads/commissioner-letter-11-14-2013.pdf

[32] See Extension of Transitional Policy through October 1, 2016, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf ; Extension of Transitional Policy through Calendar Year 2017, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/final-transitionbulletin-2-29-16.pdf; Extension of Transitional Policy through Calendar Year 2018, available at https://www.cms.gov/CCIIO/Resources/Regulations-and Guidance/Downloads/Extension-Transitional-Policy-CY2018.pdf

[33] Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal, January 20, 2017, available at https://www.gpo.gov/fdsys/pkg/FR-2017-01-24/pdf/2017-01799.pdf

- Waive, defer, grant exemptions from, or delay the implementation of any ACA provision or requirement that would impose an economic burden on, among others, individuals, families, patients, recipients of health care services, and purchasers of health insurance, and
- Afford states more flexibility and control to create a freer and open health care market and cooperate with them in implementing health care programs.

Anthem agrees with the objectives identified in the January EO and believes that it is critical that states have the flexibility to provide their citizens with access to high-quality, affordable health care options. Since 2014, Anthem members have continually found value in their transitional plans and have renewed them as permitted by state rules and guidelines. A vast majority of consumers renewing transitional plans do not qualify for premium subsidies under the ACA. If transitional plans are no longer available, individuals and small groups currently covered under these plans will likely have few, if any, affordable alternative health care options. Extending the transitional relief will continue current affordable health benefits for individuals and small groups until they have an opportunity to join an AHP. DOL should work with HHS to achieve this objective.

Additionally, if the DOL does move forward with an effective date that is sooner than our recommendation above, and if current associations are not grandfathered, Anthem believes that current bona fide associations that sponsor single group health plans should not be required to comply with the Final Rule until their first renewal date after the effective date, to allow adequate preparation time.

7. Do not expand the "commonality of interest" requirements to permit AHPs to form in a metropolitan area that includes two or more states [§2510.3-5(c)(2)]

Issue: The Proposed Rule expands the "commonality of interest" requirements for employer members of a group or association beyond the same trade or industry, to having a principal place of business in the same state or in the same metropolitan area, even if that metropolitan area includes more than one state.

Recommendation: The DOL should not expand "commonality of interest" to include employers having a principal place of business in the same metropolitan area. However, if the DOL decides to retain this provision, Anthem recommends that it consult with the NAIC to resolve state jurisdictional questions, such as which state's rating rules will apply.

Rationale:

The definition of "employee welfare benefit plan" in ERISA is grounded on the premise that the person or group maintaining the plan is tied to the employers and employees that participate in the plan by some common economic or representation interest or genuine organizational relationship unrelated to the provision of benefits.[34]

Anthem believes that expanding the commonality of interest requirement to allow employers with a principal place of business in the same state to join AHPs could allow well-established and reputable organizations like Chamber of Commerce to take advantage of the new health coverage choice that AHPs potentially represent. A same-state expansion would also make it easier for a state regulator to monitor AHPs in its jurisdiction.

The same is not true for allowing AHPs to operate in a multi-state metropolitan area. Expanding AHPs to involve employer members in two or more states increases the operational and legal complexity of the arrangement. Allowing AHPs to operate across states would likely be burdensome for states and could expose AHPs to potential abuse. For instance, this expansion could create a circumstance in which a single state would not have all the information required to ensure each member is a legitimate employer in the metropolitan area, and no safeguards would exist to ensure that only eligible employers could join a particular AHP. Moreover, since states are the primary regulators of health insurance issuers, for fully-insured AHPs, health insurance issuers would have to navigate different requirements in different states. Furthermore, in some circumstances, an issuer may be licensed in one state in the metropolitan area but not in another. Therefore, we believe limiting the geography of an AHP to a single state creates consistency and prevents the opportunity for abuse.
However, if the DOL decides to retain this provision, Anthem recommends that it consult with the NAIC to resolve state jurisdictional questions, such as which state's rating rules will apply.

8. Clarify the Nondiscrimination and Rating Requirements [§2510.3-5(d)]

Anthem fully supports the health nondiscrimination requirements in the Proposed Rule that would continue current HIPAA nondiscrimination protections that prohibit an AHP from restricting membership in the AHP itself and prohibit discrimination based on eligibility for benefits. For new AHPs that are not grandfathered and formed for the purpose of providing

[34]DOL Advisory Opinion 2008-07a, at 3, found at https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/2008-07a

health insurance, Anthem believes it is important to have a level playing field between the AHP market and the ACA market to mitigate adverse selection between the markets.

Issue: The health nondiscrimination provision will need to be enforced properly to ensure a level playing field.

Recommendation: The Final Rule should clarify whether the DOL or state departments of insurance, or both, have regulatory authority to enforce the nondiscrimination provisions.

Rationale: As we indicated above, we are concerned that the DOL will not currently have adequate funding to effectively enforce the Final Rule provisions, including the nondiscrimination requirements. Since state regulators are most familiar with their local markets, and are more accessible to receive complaints or warnings, the DOL should grant authority to the states to enforce the nondiscrimination provisions in the event that the DOL is not able to do so.

Issue: Although the Proposed Rule does not permit associations to use health status to set rates for small employer members, associations could use other rating factors, such as gender, age, geography, and group size to distinguish rates between employer groups.

Recommendation: The Final Rule should ensure a level playing field by being clear about what rating factors are permissible and by limiting the permissible AHP rating factors for new, non-grandfathered AHPs to the factors currently permitted in the ACA market, specifically age, geography and tobacco rating factors, and wellness credits.

Rationale: In order to ensure a level playing field with the non-AHP market, the Proposed Rule should only allow new, non-grandfathered AHPs to use rating factors that are currently permissible in the ACA small employer market.

Using the ACA 3:1 age rating limit and prohibiting gender rating would ensure that AHPs are not able to form associations with the youngest, healthiest small groups and working owners from the ACA small employer and individual markets. Due to the age and gender rating restrictions in the ACA, member premiums do not always align with expected claim costs. Premiums for young males are higher than their expected average claim costs while premiums for young females are significantly less than their expected average claim costs. If AHPs are permitted to rate employer members based on their participants' genders and actual ages, they would be incentivized to establish AHPs that attract young males. If young males leave the non-AHP market to join AHPs, premiums would necessarily increase in the ACA market since the lower-cost young males are no longer subsidizing the higher-cost members.

Furthermore, the rating areas for the AHP market should correspond to rating areas for the small employer and individual ACA markets. Without this limitation, AHPs could choose to offer coverage only in the lower-cost counties of a rating region or charge higher rates in the higher-cost counties of the rating region. This practice would result in lower-cost employers and working owners migrating to the AHP market while the higher-cost members would choose to stay in the ACA market.

In addition, AHPs would have an unfair advantage over ACA issuers if they were able to offer larger wellness discounts which would attract healthy employers to the AHP market. Similarly, AHPs offering coverage with higher tobacco rating than is allowed under the ACA would incentivize tobacco users to stay in the ACA market.

If AHPs use factors consistent with the ACA to differentiate premiums for small employer and working owner members, as we recommend above, it would help ensure a level playing field and that they compete based on adding value through economies of scale and administrative efficiencies rather than by taking advantage of the ACA rating restrictions and skimming lower-cost individuals and groups from that market.

Issue: The Proposed Rule seems to permit associations to use employment-related rating factors.

Recommendation: The Final Rule should clarify the permissible employment-related rating factors such as current employee vs. former employee, salaried vs. hourly, length of service, etc.

Rationale: In order to promote compliance with the regulation and establish a level playing field for all participating AHPs, the Final Rule should clarify which employment-related factors are permissible.

Issue: The Proposed Rule is unclear as to which entity (AHP or insurer) must comply with nondiscrimination and other rating rules.

Recommendation: The DOL should clarify that AHPs, rather than insurers, are responsible and liable for compliance with the nondiscrimination rules for fully insured arrangements when the AHP determines the rates at the employer member level.

Rationale: In instances where the insurer quotes one rate for the entire association and the association determines the amount that each employer member contributes toward the premium and administers the billing, the insurer does not have insight into nor control over how the premium is allocated to each employer member and should not be responsible for compliance.

9. **Do Not Deviate from ERISA's Longstanding Structure of Participants and Beneficiaries, By Making "Family Members or Other Beneficiaries" Eligible for AHP Coverage [§2510.3-5(b)(6)]**

Issue: The phrase "family members or other beneficiaries" in the Proposed Rule is undefined, ambiguous, and could add a class of individuals eligible for health coverage that would likely drive up the cost of AHP benefits.

Recommendation: The Final Rule should strike the term "family members or other beneficiaries" and preserve the term "beneficiaries."

Rationale:

While ERISA defines "participant" and "beneficiary,"[35] the phrase "family members or other beneficiaries" is undefined and hence ambiguous. "Family members or other beneficiaries" could mean relatives of the full-time employee or his/her dependents, such as grandparents, grandchildren, aunts, uncles, cousins, stepparents, step-grandparents, etc. Due to the expansive nature of potential individuals who could be considered eligible for coverage under this undefined phrase, it would be difficult for a health insurer to price products with no firm idea of which family members could be covered under the AHP. Moreover, including individuals other than the traditional ERISA participants and beneficiaries as eligible for coverage under the AHP could markedly drive up the cost of AHP coverage, defeating one of the policy goals of the Proposed Rule. Eligibility for AHP coverage could also interfere with a family member's eligibility for other public programs, such as grandparents over 65 who are Medicare-eligible, or even an individual's eligibility for subsidized individual market insurance in the Exchange. This type of potential harm to consumers should be avoided.

Additionally, providing health benefits to individuals other than legal dependents as defined in the Internal Revenue Code could result in unintended federal and state tax consequences for employers, AHP participants and AHP beneficiaries. In general, an employer may deduct the cost of health benefits provided to its employees. Similarly, an employee incurs no tax penalty for health benefits extended to the employee's legal dependents.[36] Unless the Internal Revenue Code is amended to provide favorable tax treatment of health benefits for "family members or other beneficiaries," both employers and employees would be required to include in their gross

[35] 29 U.S.C. §1002(7), (8).

[36] For a similar analysis of the tax treatment of health benefits provided to children under age 27 pursuant to the Affordable Care Act, see IRS Notice 2010-38, found at https://www.irs.gov/pub/irs-drop/n-10-38.pdf .

income amounts paid for that coverage.[37] The DOL potentially did not anticipate the tax consequences involved with proposing to expand AHP coverage to "family members or other beneficiaries," and so that phrase should not be included in the Final Rule, while the ERISA term of art "beneficiaries" should be retained.

10. **Consider the unintended consequences of expanding the ERISA definition of "employer" [§2510.3-5(a)]**

Issue: The Proposed Rule expands the ERISA definition of "employer," a term that was established over 40 years ago. There may be unintended consequences of expanding the definition that the DOL may not have considered.

Recommendation: The DOL should carefully consider the unintended consequences of expanding the ERISA definition of "employer" in the Final Rule, and should clarify the application of other laws to AHPs.

Finally, there are many questions attributable to the proposed expansion of the ERISA definition of "employer" that the Proposed Rule does not resolve. Would the rule impose new COBRA administrative duties upon small employers that they may not have the capacity to perform? (And how does this potential added administrative burden align with the Proposed Rule's assertion that in an AHP, small employers' administrative burdens will be reduced?) What are the cost implications of the Medicare Secondary Payer (MSP) rules as applied to AHPs – would the MSP rules tend to drive up the cost of coverage, given that the AHP benefits would be primary? Would the AHP be responsible to deliver a Summary of Benefits and Coverage to plan participants, or would the ERISA summary plan description suffice? These questions should be addressed and guidance given to stakeholders in the Final Rule.

[37] See I.R.C. §§106 and 152(f)(1).

Conclusion

We value the partnership that we have developed with the DOL and welcome the opportunity to discuss our recommendations for AHPs. Should you have any questions or wish to discuss our comments further, please contact Judith Langer at (414) 276-7467, or Judith.a.langer@anthem.com.

Sincerely,

Anthony Mader
Vice President, Public Policy