February 20, 2024

Submitted via www.regulations.gov

Assistant Secretary Lisa Gomez
U.S. Department of Labor
Office of Regulations and Interpretations
Employee Benefits Security Administration
Attention: RIN 1210-AC16
Room N-5655
200 Constitution Avenue, NW
Washington, DC 20210

Re: Definition of "Employer" – Association Health Plans – RIN 1210-AC16

Dear Assistant Secretary Gomez:

We are a group of former insurance commissioners, former state insurance regulators, and experts on association health plans (AHPs). Many of us signed onto an amicus brief in the D.C. Circuit in the *New York v. Department of Labor* case, in which we supported the District Court's opinion[1] that the 2018 AHP Rule was unlawful and should not be implemented. Our brief focused on AHP fraud and abuse perpetrated by unscrupulous promoters, the instability of self-insured AHPs, and the harms to consumers state regulators have had to address.

For the same reasons that we opposed the 2018 AHP Rule in court, we now support the DOL's proposal to rescind the 2018 Rule in its entirety.

AHP Fraud and Abuse Exists and Has Existed Since ERISA's Enactment

After ERISA was passed, individuals seeking to evade state insurance regulatory oversight used group purchasing arrangements called Multiple Employer Trusts (METS) to argue that these were entities covered by ERISA and that state insurance law did not apply. In 1982, after many multiple employer scams, Congress amended ERISA to clarify that state insurance regulators had authority over Multiple Employer Welfare Arrangements (MEWAs), in addition to DOL having authority over such entities. The clarification helped states with oversight efforts but did not prevent health insurance scams promoted through group purchasing arrangements, including phony and real associations.

Even after ERISA was clarified, there have been several documented cycles of large-scale scams promoted through associations. According to the U.S. Government Accountability Office (GAO), between 1988 and 1991, operators of MEWAs left 400,000 people with medical bills exceeding $123 million. Another cycle of scams occurred between 2000 and 2002. One hundred forty-four entities left 200,000 policyholders with $252 million in unpaid medical bills.[2]

[1] 363 F. Supp. 3d 109 (D.D.C. 2019).
[2] "Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entitles Selling Coverage," GAO-04-312, United State General Accounting Office, February 2004; "Employee Benefits: States Need Labor's Health Regulating Multiple Employer Welfare Arrangements," GAO/HRD-92-40, United States General Accounting Office, March 1992.

Cycles of scams typically correspond to significant increases in premiums.[3] Promoters (often unlicensed) market to small businesses and individuals, offering premiums at prices below what is generally available. Before the ACA, promoters also targeted self-employed people who could not pass medical underwriting or were charged higher rates based on their health. One self-employed person was left with $110,000 in medical bills. Her professional association, the National Writers Union, was duped into buying phony coverage from a nation-wide scam called Employers Mutual, LLC that had 30,000 victims and according to some estimates had owed as much as $54 million in medical claims.[4]

When Nevada insurance regulators became aware of Employers Mutual, LLC, Alice Molasky Arman, former Nevada Insurance Commissioner (1995-2008) issued a cease and desist order against Employers Mutual, LLC in June 2001. The commissioner also had to fight to freeze assets in Nevada banks in order to try to pay some of the unpaid medical claims. Other states, including Alabama, Colorado, Oklahoma, Texas, and Washington, issued cease and desist orders against Employers Mutual, LLC by December 2001. In 10 months, Employers Mutual, LLC collected more than $16 million in premiums from more than 30,000 people in all 50 states and the District of Columbia.

Florida regulators shut down many AHP scams and filed criminal charges against some promoters. For example, Florida brought criminal charges against Carmelo Zanfei and William Paul Crouse, operators of an Indiana-based entity called TRG Marketing, LLC. This unlicensed entity refused to pay claims totaling millions of dollars for more than 7,200 Floridians. Zanfei and Crouse plead guilty to charges of racketeering and unlawful transaction of insurance in 2005.[5]

Between 2001 and 2003, Florida's Department of Financial Services shut-down 10 unlicensed entities, initiated administrative actions against approximately 80 agents, and brought criminal charges against six promoters of unlicensed insurance entities.[6]

AHPs Have Been Used as a Way to Misrepresent Products and to Induce Consumers into Believing that They Were Purchasing Comprehensive Health Insurance

The state insurance departments took action against many AHPs for misrepresenting the products they were selling. Some AHPs made claims that their "much cheaper" products were "just as good a major medical health insurance," when in fact the AHP product was a bundled package of excepted benefit or other non-major medical products. These "bundled" AHPs products typically include a variety of excepted benefit policies, such as "mini-med," accident only, hospital indemnity, and cancer/specified disease, and/or short-term, limited-duration plans or medical discount cards.

Many people and small businesses were duped. Some associations told consumers that by joining the association, they were becoming employees of the association and could get less expensive coverage. For example, between 2006 and 2015, former Montana Insurance Commissioner John M.

[3] Amicus Brief filed by Former Insurance Regulators in State of New York v. Department of Labor, D.C. Circuit Court of Appeals (July 22, 2019) at 12.
[4] *Id.* at 13.
[5] Attorney General of the State of Florida, Office of Statewide Prosecution 2005 Annual Report (March 1, 2006) at 6-7, available at https://legacy.myfloridalegal.com/webfiles.nsf/WF/MRAY-6MHMJP/$file/AnnualReport2005.pdf.
[6] Gallagher, Posey Announce Felony Charges against Operators of Unlicensed Insurance Entity, Florida Department of Financial Services Press Release, April 14, 2003.

Morrison (2000-2007) and former Montana Insurance Commissioner Monica J. Lindeen (2008-2016) initiated many investigations, filed multiple oversight actions and issued cease and desist orders against AHPs that were engaged in unlicensed activity regarding the sale of health plans and/or misrepresented the coverage sold to people, including sole proprietors and small employers.[7]

Even Legitimate AHPs Have a History of Financial Instability and the Risk of Insolvencies Requires Extensive Monitoring by States

AHPs have a long history of insolvencies. Self-insured AHPs are inherently less stable than state regulated insurance companies. Approximately 20 states have licensing standards specifically for self-insured AHPs.[8] All other states reported that they require self-insured AHPs to be licensed as insurance companies.

Compared to traditional insurers, self-insured AHPs are at greater risk of becoming insolvent when claims exceed their reserves. States with special licensing schemes for AHPs apply lower solvency standards, such as reserve requirements, to AHPs than to traditional insurers. Low reserves make it harder for AHPs to avoid insolvency resulting from mismanagement or even just large unexpected claims.[9] For example, an AHP in Michigan became insolvent due to unexpected claims from two premature babies.[10] The 2018 Rule would have promoted the proliferation of AHPs, including AHPs that choose to assume insurance risk, effectively increasing the number of members of AHPs exposed to the risk of AHP insolvency and potentially millions of dollars in unpaid medical bills.

Even when regulated by states, the risk of AHP insolvency is considerable. There are numerous examples of legitimate, state-licensed professional and trade AHPs becoming insolvent. An insolvency of the New Jersey Coalition of Automotive Dealers left 20,000 people with $15 million in unpaid medical bills.[11] According to former California Insurance Commissioner Dave Jones (2011-2019), in 2001, Sunkist Growers and Packers Benefit Plan Trust collapsed, "… forcing tens of thousands of workers to switch insurance and leaving nearly 5,000 medical providers with unpaid bills…The plan covered 23,000 subscribers. When they collapsed, the plan owed 4,800 medical providers an estimated $10 million in unpaid claims."[12]

Association health plans that self-insure successfully for years may still experience volatility and insolvency. For example, the Indiana Construction Industry Trust had provided health insurance for its members for over 30 years before becoming insolvent.[13] Former Indiana Insurance

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[7] Office of the Montana State Auditor. Commissioner of Securities & Insurance. *In the Matter of United National Workforce Association, et al*, Case No. INS 2006-71; *In the Matter of Consolidated Workers Association, Inc.*, Case No. INS-2008-55; *In the Matter of Independent Electrical Contractors*, Case No. INS.-2008-3; *In the Matter of the National Better Living Association*, Case No. INS-2009-70; *In the Matter of the National Alliance of Associations, National Trade Business Association, et al.*, Case No. INS 2007-79; and *In the Matter of Health Insurance Innovations*, Case no. INS-2015-348. Available at: https://csimt.gov/legal-actions/

[8] Amicus Brief filed by Former Insurance Regulators in State of New York v. Department of Labor, D.C. Circuit Court of Appeals (July 22, 2019) at 15.

[9] Amicus Brief filed by Former Insurance Regulators in State of New York v. Department of Labor, D.C. Circuit Court of Appeals (July 22, 2019) at 16.

[10] *Id.*

[11] *Id.*

[12] D. Jones, Comments regarding proposed rule, Definition of "Employer" Under Section 3(5) of ERISA_ Association Health Plans, 83 Fed. Reg. 614 (Jan. 5, 2018), California Insurance Department (March 6, 2018).

[13] Amicus Brief filed by Former Insurance Regulators in State of New York v. Department of Labor, D.C. Circuit Court of Appeals (July 22, 2019) at 17.

Commissioner Sally Baker McCarty (1997–2004) reports about her experiences with the Indiana Construction Industry Trust:

> The Indiana Construction Industry Trust (ICIT) was a Multiple Employer Welfare Arrangement operating in Indiana in which relatively small construction trade businesses were able to pool resources to buy health insurance for their employees. The plan was able to assert ERISA exemption but the federal government did not assertively exert its authority over ICIT. When I began to receive complaints that the plan was not paying its claims, the Indiana Insurance Department became involved. After investigation, I learned that, due to weak federal oversight, the plan's principals had been extending membership to non-construction-related industries to grow the fund. They did so to cover up their embezzlement of more than $400,000 in premiums collections. The money was used to purchase a Florida condo, a boat, and luxury cars. The Department closed down the plan and aggressively pursued all responsible individuals and entities (principals, agents, attorneys, legal and board malpractice insurers). The DOI was able to recover $24 million in funds to pay claims. Eventually, the U.S. Department of Labor became involved, and two ICIT principals were sentenced to federal prison for sentences of 30 and 37 months.

Former Montana Insurance Commissioner Monica J. Lindeen (2008–2016) reports that between 2015 and 2017, at least three licensed MEWAs in Montana voluntarily shut down their health plans primarily because of their own concerns about remaining solvent and their strong motivation to protect employees from unpaid claims. According to Commissioner Lindeen, these were MEWAs that had properly obtained licensing, were following applicable laws and were long-standing associations of professionals who were in the same trade. These MEWAs were managed by experienced insurance professionals, and the plans utilized well-established, reputable and adequate networks of hospitals and healthcare providers.

AHPs cannot participate in guaranty funds and the application of receivership laws can be unclear. When a licensed insurer becomes insolvent, usually a state's guaranty fund will pay most of the claims. Different from an insurer, when an AHP becomes insolvent, covered people are stuck with unpaid medical bills. When there is joint and several liability, then the AHP can assess participating employers and they are responsible for any unpaid medical bills. This exposes participating employers to significant financial risk.

Many small employers do not have the financial resources to bear this risk. State receivership laws, which allow insurance departments to take over financially failing insurance companies, sometimes exclude AHPs or are unclear. Without a receivership, an AHP ends up in bankruptcy court, where consumers line up with other creditors. Different from receiverships, outstanding medical claims do not receive priority status in bankruptcy court.[14] When self-insured AHPs become insolvent, their members' medical bills go unpaid, leaving consumers with huge debts for medical care and harming medical providers when those debts are not paid.

Many states that license or certify self-insured AHPs invest significant resources to prevent problems and detect problems early. For example, to avoid problems like unqualified management, states require background checks on senior management prior to receiving authorization to operate

[14] California Healthcare Foundation, Insurance Markets: Group Purchasing Arrangements: Implications of MEWAs, July 2003, available at https://www.chcf.org/wp-content/uploads/2017/12/PDF-HIMUbriefMEWAs.pdf.

a self-insured AHP. Self-insured AHPs often require greater state regulator resources for financial oversight than traditional insurers because solvency standards are lower for AHPs. One state devoted one full-time employee per AHP it licensed. This included monthly examinations of AHP financial condition, which required state regulators on-site to review AHP books.

The 2018 AHP Rule Would Have Opened the Door to More Fraud and Abuse

The 2018 Rule's stated purpose was to encourage the growth of AHPs, and more AHPs means more fraud and insolvencies. The 2018 Rule included specific changes that would have made it easier for unscrupulous promoters to set up scams and by creating new regulatory ambiguity, would have made it harder for state regulators to find and shut down such scams. We support DOL's current proposal to rescind the 2018 Rule. This rescission is grounded in decades of federal and state experience related to AHP failures, fraud, and insolvency and is necessary and appropriate.

The 2018 Rule Would Have Interfered with State Oversight

The 2018 Rule would have added new ambiguity to ERISA and state jurisdiction that could have been used by promoters to evade state oversight. The ability to evade state regulation is particularly problematic because, as the preamble to DOL's current proposal to rescind the 2018 rule states, "available [DOL] oversight resources are extremely limited and fraudulent operations resist detection until claims go unpaid, significant damage can be done before the Government even receives a complaint about an arrangement, making it difficult for regulators to mitigate damages and stop bad actors."[15]

By allowing AHPs to "operate across state lines," the 2018 Rule created confusion regarding states' ability to establish regulatory jurisdiction.[16] While the 2018 Rule established some minimal standards for AHPs under 29 C.F.R. § 2510-3.5(b), those standards were so broad as to be essentially meaningless and none were similar to those found in state insurance regulatory frameworks, such as background checks for people who set up and operate AHPs.

In contrast to DOL's limitations, states have numerous tools that allow them to conduct regular oversight and intervene before consumers are harmed. These tools include background checks for operators and management of AHPs, financial and market conduct examinations, form reviews, rate reviews, etc. Thanks to the broker community, states also have "eyes and ears" on the ground to quickly identify bad actors who promote fake insurance. States also have and use enforcement tools, including administrative cease-and-desist authority and state receivership laws. States have vigorously pursued bad actors in the AHP market and have been able to act earlier and quicker than DOL, better protecting consumers from harm.[17]

DOL's current proposal to rescind the 2018 Rule is necessary to mitigate the jurisdictional ambiguities it created. Those ambiguities impede state insurance regulators' efforts in stopping fraud and insolvencies. We recommend:

- Finalizing the proposal to rescind the 2018 Rule;

[15] Definition of "Employer"—Association Health Plans, 88 FR 87968, at 87973 (December 20, 2023).
[16] *See* National Association of Insurance Commissioners, State Jurisdictional and Extraterritorial Issues White Paper: States' Treatment of Regulatory Jurisdiction Over Single-Employer Group Health insurance, (2009), at 9, available at http://www.naic.org/documents/committees_b_jurisdictional_issues_states_treatment_reg_jurisdiction.doc.
[17] Amicus Brief filed by Former Insurance Regulators in State of New York v. Department of Labor, D.C. Circuit Court of Appeals (July 22, 2019) at 28.

- Memorializing through regulation DOL's sub-regulatory guidance including its informational letters to insurance regulators and its guidance found in the DOL booklet *MEWAs, Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation*.
- Strengthening pre-2018 standards to help prevent fraud and insolvency. This is important given a long history of fraud and insolvency even under the pre-2018 regulatory framework.

Conclusion

We strongly support DOL's proposal to rescind the 2018 Rule in its entirety and urge the DOL to finalize its proposal expeditiously. We appreciate your consideration of our comments.

Former Insurance Commissioners and NAIC Presidents

Brian Atchinson, former Superintendent, Maine Bureau of Insurance, former President, National Association of Insurance Commissioners

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Earl Pomeroy, former Commissioner, North Dakota Insurance Department, former President, National Association of Insurance Commissioners

Sandy Praeger, former Commissioner, Kansas Insurance Department, former President, National Association of Insurance Commissioners

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Other Experts on AHP Fraud and Abuse

Sabrina Corlette, J.D. author of dozens of papers relating to the regulation of private health insurance and insurance marketplaces.

Kevin Lucia, J.D., M.P.H. authored 10 publications on AHPs; expert on AHP fraud and abuse.