Office of Regulations and Interpretations, Employee Benefits Security Administration, Room N-5655, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210, Attention: **Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans** (29 CFR 2510, RIN: 1210-AB85 Document Number: 2017-28103)

To Whom It May Concern:

I am submitting comments on the Department of Labor's proposed rule seeking to expand the use of association health plan (AHP) coverage from three perspectives:

1) as founder and CEO of the Center of Capital & Social Equity, an organization that promotes both market efficiency and inclusion of all citizens in benefiting from economic activity and growth. Thus, the Center supports health and labor policies that cover all Americans in a delivery system with a lower cost;

2) as a leading health policy analyst and researcher in the field of ERISA (the Employee Retirement Income Security Act of 1974), health coverage, and association health plan impacts; and

3) as citizen whose family members have greatly benefited from health plan coverage of mental illness and drug treatment services.

From all three of these perspectives, the Department's proposed rule raises serious concerns.

First, the proposed rule could seriously undermine ERISA's purpose of ensuring that promised employee benefits are delivered in a financially stable environment. Without major revisions, the proposed rule could also subvert the Affordable Care Act's (ACA's) fundamental goal of increasing access to health coverage for all Americans. Treating AHPs as large employer plans without specific and strong federal benefits and solvency standards will result in more uninsured employees and families, and more ERISA plans lacking coverage for people that need it the most. These people include employees and family members needing treatment for mental illness, drug treatment, maternity care, high-cost medications, and even hospital care. By considering AHPs to be large employer plans, the proposed rule would presumably exempt them from the ACA's minimum benefit standards; therefore, AHPs could offer coverage that lacked mental health, pharmacy or other benefits – even hospital coverage as was the case with "mini-med plans" for which

hundreds of ERISA employer and union plans were granted waivers for several years during the transition to more comprehensive ACA benefit standards.

As many analyses show, AHPs could pressure and destabilize insurance markets by offering stripped-down coverage. In the proposed rule, there is no mention of how DoL would actually implement its authority to ensure the solvency of AHPs, though the Department rightly discusses how Multiple Employer Welfare Arrangements (MEWAs) have a troubled past that has required more than one revision to ERISA. AHPs, of course, are a type of MEWA.

Also missing is whether, and how, AHPs considered large employers would meet ACA minimum actuarial value standards. (See: https://www.irs.gov/affordable-care-act/employers/minimum-value-and-affordability "In general, under the employer shared responsibility provisions, an applicable large employer (ALE) member may either offer affordable minimum essential coverage that provides minimum value to its full-time employees (and their dependents) or potentially owe an employer shared responsibility payment to the IRS.") A related question is how an AHP that is a large employer would be held accountable under the ACA's pay-or-play coverage requirements, and how penalties for failing to offer coverage to member group employees would be determined and apportioned.

The proposed rule does require an AHP to have a governing body to help ensure financial integrity. The rule should further specify that AHP board members and executives are fiduciaries under ERISA, and, similar to joint union/management boards of Taft-Hartley trusts, should be held personally liable for misuse of AHP funds, or negligence.

I live in Fairfax County, Virginia and am a member of two groups advocating for improved mental health/drug treatment services locally and regionally – the National Alliance on Mental Illness and the NoVA (Northern Virginia) Mental Health Forum. Allowing the merchandizing of AHPs that could lower costs by eliminating mental health/drug treatment coverage would harm thousands of families in our region – even as national concern rises over the opioid epidemic and the need for improvements to our mental health system that has been discussed in the wake of mass shootings in schools and other places. The National Rifle Association, the National Restaurant Association, and thousands of other associations are headquartered in this region. Many already offer minimum benefit plans (e.g., short-term coverage and cancer coverage) on their web sites; adding AHPs to the mix would only hasten a race to the bottom that would destabilize the availability of affordable coverage in state-regulated markets and in the federal

exchange serving Virginia. This likely result stands in stark contrast to the Department's stated intent of broadening affordable coverage for employers and employees.

Analyses of similar AHP proposals in the past (including two I have authored or co-authored, cited below), many studies by the actuarial profession, and a new study done by Avalere all show that AHPs with stripped-down benefits operating alongside more regulated markets will result in: 1) market churning as low-risk groups move to the least regulated market; 2) higher prices in traditional state-regulated markets; 3) a probable loss of coverage for those with excluded benefits; and 4) a rise in the number of uninsured.

(See: "What Would Association Health Plans Mean for California," Kofman & Polzer, 2004, California Health Care Foundation, https://www.chcf.org/wp-content/uploads/2017/12/PDF-AHPFullReport.pdf;

"Preempting State Authority To Regulate Association Plans: Where Might It Take Us?," Polzer, 1997, National Health Policy Forum, GWU, https://www.nhpf.org/library/issue-briefs/IB707_10-15-97_AssocPlanRegulation.pdf;

"Association Health Plans Projected to Enroll 3.2M Individuals," Mendelson, Sloan, and Brooker, 2018, Avalere, http://avalere.com/expertise/life-sciences/insights/association-health-plans-projected-to-enroll-3.2m-individuals?utm_source=pressRelease&utm_medium=Twitter&utm_campaign=02-28-2018 .)

For these reasons, I conclude that the Department should extend the period for comment and address the issues identified above before moving forward. Please note that the Center on Capital & Social Equity is a signatory on a coalition letter calling on the Department to withdraw or substantially delay this proposed rule. The coalition made this demand in conjunction with a Freedom of Information Act request, stating the DoL failed to provide critical information, data, and statistics from its own files detailing the history of financial abuses associated with AHPs and other types of MEWAs. (The letter can be found at: https://georgetown.app.box.com/s/90t3u3b0s59cfs5yg59j3nhyw0vtcnbk.)

Finally, please see my comments below on specific provisions of the rule.

Sincerely,

Karl Polzer

CEO, Center on Capital & Social Equity – www.inequalityink.org

Founder, NoVA Mental Health Forum - https://www.facebook.com/groups/249057865516670/?multi_permalinks=418574615231660&notif_id=1520130960270416&notif_t=feedback_reaction_generic&ref=notif

Comments on specific provisions:

"AHPs are an innovative option for expanding access to employer-sponsored coverage (especially for small businesses). AHPs permit employers to band together to purchase health coverage. Supporters contend that AHPs can help reduce the cost of health coverage by giving groups of employers increased bargaining power vis-à-vis hospitals, doctors, and pharmacy benefit providers, and creating new economies of scale, administrative efficiencies, and a more efficient allocation of plan responsibilities (as the AHP effectively transfers the obligation to provide and administer benefit programs from participating employers, who may have little expertise in these matters, to the AHP sponsor)" https://www.federalregister.gov/d/2017-28103/p-15

Comment: **AHPs probably won't achieve administrative savings** compared with large employer plans. Yes, large employer plans have significantly lower administrative costs and more bargaining leverage than small employer plans (better able to self-insure, lower costs of **sales and support because they're dealing with one client not many,** etc.) But AHPs would not have the same advantages as large employers because they are internally unstable and not as cohesive as large employers. Despite being declared large employers by the government, AHPs still would be "clumps" of individuals and small employers. AHPs would will still have to market to many entities and manage and communicate with separate employee groups. They

would also have to manage and price for variability internally (not all members would have equal risk – some might have high risk employees, some low). This brings up another issue: how will AHPs manage this internal variation: will they be able to risk-rate between difference member groups or individuals – seems rather labor intensive? Also, how will AHPs exert bargaining leverage with providers for benefits they **don't cover** – as stated above, these plans may not cover essential benefits?

"This proposed regulation would define the term "group or association of employers" under ERISA section 3(5) more broadly, in a way that would allow more freedom for businesses to join together in organizations that could offer group health coverage regulated under the ACA as large group coverage. principal objective of the proposed rule is to expand employer and employee access to more affordable, high-quality coverage."

Comment: As noted above, most actuarial analyses show that promoting AHPs will do the opposite: over the years, it will result in less comprehensive coverage and more uninsured.

"The Affordable Care Act established a multipronged approach to MEWA abuses. Improvements in reporting requirements, together with stronger enforcement tools, are designed to reduce MEWA fraud and abuse. These include expanded reporting and required registration for MEWAs with the Department prior to operating in a State. The additional information facilitates joint State and Federal efforts to prevent harm and take enforcement action. The Affordable Care Act also strengthened enforcement by giving the Secretary of Labor authority to issue a cease and desist order when a MEWA engages in fraudulent or other abusive conduct and issue a summary seizure order when a MEWA is in a financially hazardous condition.[5"

Comment: The Department needs to fully develop its new enforcement authority before promoting AHPs, which have a long

history of fraud and financial instability that has often required the Department to respond, often with enforcement tools that are not adequate.

"With respect to insured coverage, whether coverage is offered in the individual, small group, or large group market affects compliance obligations under the Affordable Care Act and other State and Federal insurance laws. For example, only individual and small group market health insurance coverage is subject to the requirement to cover essential health benefits as defined under section 1302 of the Affordable Care Act.[7] Moreover, the risk adjustment program, which transfers funds from plans with lower-risk enrollees to plans with higher-risk enrollees, applies only to health insurance issuers offering coverage in the individual and small group markets, not the large group market.[8] The single risk pool requirement, which requires each health insurance issuer to consider the claims experience of all individuals enrolled in plans offered by the issuer in the individual market to be in a single risk pool, and all its individuals in the small group market to be members of a single risk pool, also applies only in the individual and small group markets, not the large group market.[9] In addition, the health insurance premium rules that prohibit issuers from varying premiums except with respect to location, age (within certain limits), family size, and tobacco-use (within certain limits) apply only in the individual and small group markets.[10] Finally, the Medical Loss Ratio (MLR) provisions, which limit the portion of premium dollars health insurance issuers may spend on administration, marketing, and profits establish different thresholds for the small group market and the large group market.[11] Self-insured group health plans are exempt from each of these obligations regardless of the size of the employer that establishes or maintains the plan. These differences in obligations result in a complex and costly compliance environment for coverages provided through associations, particularly if the coverages are simultaneously subject to individual, small group, and large group market regulation."

Comment: If the Department treats AHPs as large employers, it should specify what type of benefits or actuarial value test AHPs must meet. It also should specify how AHPs not meeting those standards **will be penalized under the ACA's pay**-or-play provisions.

"The Department is also interested, for example, in comments on whether there is any reason for concern that associations could manipulate geographic classifications to avoid offering coverage to employers expected to incur more costly health claims."

Comment: AHPs would be able to manipulate geographic classifications at every geographic boundary by stripping out benefits required by neighboring jurisdictions.

"the proposed regulation would not restrict the size of the employers that are able to participate in a bona fide group or association of employers. The Department expects minimal interest among large employers in establishing or joining an AHP as envisioned in this proposal because large employers already enjoy many of the large group market advantages that this proposal would afford small employers. However, the Department anticipates that there may be some large employers that may see cost savings and/or administrative efficiencies in using an AHP as the vehicle for providing health coverage to their employees."

Comment: If joining an AHP is a way for a large employer to avoid minimum actuarial standards and ACA coverage requirements, large employers will be lining up.

"The proposal would require that the group or association have a formal organizational structure with a governing body and have by-laws or other similar indications of formality appropriate for the legal form in which the group or association operates, and that the group or association's member employers

control its functions and activities, including the establishment and maintenance of the group health plan, either directly or through the regular election of directors, officers, or other similar representatives."

Comment: This governing body and its individual members should have a fiduciary duty to the plan and members. Members of the body should **be held accountable under ERISA's fiduciary standards, much** like board members of Taft-Hartley trusts, and should be personally liability for fiduciary breaches.

"Thus, self-insured MEWAs, even if covered by an exemption, would remain subject to State insurance laws that provide standards requiring the maintenance of specified levels of reserves and contributions as means of ensuring the payment of promised benefits. While beyond the scope of this proposed rulemaking, the Department is interested in receiving additional input from the public about the relative merits of possible exemption approaches under ERISA section 514(b)(6)(B). The Department is interested both in the potential for such exemptions to promote healthcare consumer choice and competition across the United States, as well as in the risk such exemptions might present to appropriate regulation and oversight of AHPs, including State insurance regulation oversight functions."

Comment: Undercutting state authority in any way regarding self-**insured plans doesn't make sense in the context of the 1983** Erlenborn amendments, which allow increasing levels of state regulation of MEWAs depending on their level of insured funding and plan cohesion. The logic of these amendments seems to be: the more insured the funding and federal protections, the less need for state oversight: So, currently, for fully insured MEWAs, states can only apply solvency/financial type regulation and ERISA takes care of the rest; for self-insured MEWAs, states can apply the full array of insurance rules, **just so long as they don't interfere with ERISA** protections (such as they are); and for MEWAs that are not ERISA plans, states can ban them, do whatever they want. Eliminating state

consumer protections for self-insured MEWAs in the middle of this **progressive scheme doesn't make sense**, and does not indicate an interest in protecting plan participants and ensuring financially stable **benefits (ERISA's purpose)**. Rather it smacks of helping ERISA plan sub-contractors, who are a force behind this proposed rule, to make sales.

"The Department requests comments on how it can best use the provisions of ERISA Title I to require and promote actuarial soundness, proper maintenance of reserves, adequate underwriting and other standards relating to AHP solvency."

Comment: If it proceeds with this proposed rule, DoL should develop AHP solvency rules and enforcement tools similar to what state insurance departments use. It should consult the NAIC before moving forward.