FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

February 20, 2024

The Honorable Lisa Gomez
Employee Benefits Security Administration
Department of Labor
200 Constitution Ave. NW
Washington, DC 20210

RE: RIN 1210–AC16 – Proposed Rescission of AHP Final Rule

Submitted electronically via Regulations.gov

Dear Assistant Secretary Gomez,

As a leading national, non-partisan voice for health care consumers, Families USA appreciates the opportunity to comment on recission of the Department of Labor's 2018 rule entitled "Definition of Employer—Association Health Plans." Central to Families USA's mission is a commitment to guaranteeing that families and individuals throughout the nation have access to high-quality, affordable, comprehensive health coverage and care that improves overall health. Association Health Plans (AHPs) sold to self-employed people and small businesses undermine that essential goal and represent a considerable threat to the health and financial security of families and individuals across the country.

Families USA strongly supports the recission of the 2018 rule. The regulation was designed to increase the formation of AHPs and allow them to be sold to individuals and to proliferate among small businesses, thereby undermining the critical consumer protections provided under the Affordable Care Act (ACA). Rescinding the rule will keep protections in the ACA and other applicable laws in place for "working owners" with no employees, and unrelated employers and employees in the same geographic location with no other trade or industry commonality.

The U.S. District Court for the District of Columbia ruled in State of New York, et. al v. United States Department of Labor that portions of the 2018 rule are unlawful pursuant to ERISA and the matter remains stayed pending recission of the rule. We agree with the court's ruling, as explained in depth in our opposition to the 2018 proposed rule and in amicus briefs in State of New York, et al. and City of Columbus, et al. v. Trump, et al. These documents also describe in detail how AHPs can pose significant potential harm to the American people, as AHPs: (1) have a history of fraud and insolvency; (2) fail to provide ACA Essential Health Benefits; and (3) may split and harm risk pools. We will briefly summarize these issues below.

AHP's History of Fraud and Insolvency

Prior to the ACA, AHPs attracted individual and small business customers who thought they provided affordable coverage. However, upon trying to access their benefits, consumers often learned that AHPs had misrepresented their products – they did not actually cover the services people needed and in many cases the plans did not pay their claims, leaving consumers to foot the bill.

Families USA has witnessed fraud within this industry for many years, and authored the 2010 report Buyer Beware: Unlicensed Insurance Plans Prey on Health Care Consumers. The report details one such scam that moved from state to state from 2008 to 2010, harming customers in at least 23 states during that time period. People joined an association in order to get good prices on health insurance, were led by marketing materials to believe they would be buying comprehensive policies, and then learned that their claims were not being paid. The association at the center of the scam changed its name frequently (known at various times as American Trade Association, Smart Data Solutions, Serve America Assurance, Affinity Group Benefits Association, National Trade Business Alliance of America, National Alliance of Associations, to name a few) and defrauded consumers of millions of dollars. Even though state regulators were well aware of this scam, they could take no action until there had been a complaint launched in their own state.

This was far from an isolated case. The preamble to the proposed rescission of the 2018 rule cites other waves of fraud and insolvencies, meticulously documented by GAO and by federal and state regulators, that left hundreds and thousands of people with millions of dollars in unpaid health care bills.[1] More recently, misuse of funds in the Medova/Lifestyles Health Plans arrangement affected 35,000 employees in 38 states as of 2020.[2]

Individuals and small businesses who purchase AHPs are exposed to extreme financial risk. These plans are highly susceptible to insolvencies as they are often exempt from state insurance reserve laws, do not participate in reserve funds, and are subject to lower solvency standards than traditional insurers.[3] In effect, this is equivalent to setting up an insurance company without standards. Had the courts not intervened and the 2018 rule gone into effect, the proliferation of AHPs would have resulted in the significant promotion of insurance arrangements exempt from financial oversight and at serious risk of insolvency and fraud. Such plans leave unsuspecting enrollees with high unpaid medical claims.

Failure to provide ACA Essential Health Benefits

The Affordable Care Act enacted specific health insurance benefit standards and required individual and small group markets to cover 10 Essential Health Benefits (EHBs).[4] If enacted, the 2018 rule would allow AHPs to bypass this requirement by treating businesses consisting of only working owners (that is, self-employed individuals) as well as small groups to be part of associations that are treated as a large group for purposes of health insurance. These large groups do not have to adhere to the same standards, effectively allowing small employers and individuals to once again be exposed to inadequate coverage, limited health care accessibility, poorer health outcomes, and financial risk. Without federal standards, benefits for mental health care, maternal health, and pediatric dental are particularly likely to be omitted from insurance

coverage, as they were before passage of the ACA and as they still are in plans not subject to that law's regulations.[5] AHP rules should not be used as a subterfuge to undermine this crucial protection.

Additionally, the 2018 rule would allow for de facto discrimination based on health status, geographic location, and other factors. Associations, especially those formed mainly to sell health insurance, could construct benefits that will be attractive to lower-risk populations in good overall health while avoiding operating in geographical areas with sicker populations.

Potential to split and harm risk pools

The potential for harm if the 2018 rule went into effect goes beyond the individuals and small employers who might purchase AHPs: It would further split risk pools, driving up costs for small businesses that continue to buy comprehensive coverage.

The Affordable Care Act requires that insurers pool all individual market enrollees in a state together, as well as either pooling all small group market enrollees or merging small and individual market enrollees together to set prices for products (45 CFR 156.80 and 42 U.S.C. § 18063). This helps create a level playing field that protects people who buy a particular product from spiraling prices based on health status. If AHPs were allowed to siphon off small businesses and individuals from state risk pools, particularly by "cherry-picking" lower risk customers, it would drive up prices for those that remained in the ACA regulated products.[6]

In addition to supporting recission of the 2018 rule, we recommend codifying pre-rule guidance and note other administrative measures that the agency could take to help purchasers determine the legitimacy of either an AHP or another type of Multiple Employer Welfare Arrangement (MEWA) and the risks of purchasing coverage through it.

We recommend codifying the guidance that states only a bona fide association can establish a MEWA that is covered under the Employee Retirement Income Security Act (ERISA) if (1) the group or association has a business or organizational purpose unrelated to provision of insurance; (2) Employers share a commonality of interest unrelated to insurance; (3) Employers that participate exercise direct or indirect control over the benefit program in form and substance;[7] and (4) In determining whether an association is bona fide, regulators must consider the following factors: how members are solicited, who participates, how it was formed (Were there preexisting relationships of members? What powers, rights, privileges do members have as employers? Who controls and directs the benefit program? To what extent was their common interest outside of benefit provision?).

Although the Department of Labor (DOL) was able to implement its guidance on bona fide associations for many years prior to the 2018 rule, codifying the guidance would make it easier for the public to find and rely on it if they experienced a problem or had questions about the legitimacy of a particular association health plan. It would also help prevent the advancement of state legislation that goes against these principles, such as Virginia HB 768/SB 335 (2022), which impermissibly allowed an association of realtors to purchase coverage as if they were a large group.[8]

Families USA makes the following recommendations to strengthen regulation of AHPs:

- **Regulations should specify that AHPs are subject to the administrative requirements of Title I of the Affordable Care Act and, when applicable, administrative requirements of ERISA, including claims and appeals, summary plan descriptions (SPDs), and other notices.**
- **AHPs should be regulated both by DOL and by the states where the employer members are located**. Associations should not be allowed to sell health plans in regions smaller than a census track, as that would effectively allow them to red-line neighborhoods based on health status and socioeconomic status. If associations cross state lines and provide benefits to small groups, the small group health plans should be subject to laws in each state where there are members, as well as to DOL regulation and oversight. AHPs should be required to receive state approval before they can cover participants in that state.
- **DOL and states should vigorously enforce requirements to "look through" associations to determine if they should be following individual market or small group market rules.** When associations offer coverage to small groups, the small group rules apply; and when associations offer coverage to individuals, the individual market rules apply. Some states explicitly provide this in their laws, and DOL should work with all states to enforce this requirement.[9]
- **DOL should expand on non-discrimination requirements** to ensure that associations that provide AHPs do not have discriminatory membership criteria. They should not discriminate based on health status or age (often a proxy for health status). Further, they should not discriminate in the rating and underwriting of coverage across those factors.
- **DOL should produce consumer education materials that will help employers better understand the risks of obtaining insurance through a MEWA**. Materials should include an explanation of how to determine if a MEWA is legitimate, and how to determine if action has been taken against a particular MEWA in any state or federally.
- **DOL should update standardized disclosures tied to MEWA benefits.** Disclosures should describe how MEWAs are different from traditional comprehensive coverage, that M-1 forms are filed with the Employee Benefits Security Administration and are accessible to the public online; and explain that the insurance company listed on an M-1 form might only be serving as an administrator under the contract and the benefits may not be fully insured by that company. Each health plan participant should receive notice explaining what benefit requirements and consumer protections apply to the plan, as well as how to contact the relevant insurance department and the Employee Benefit Service Administration of DOL regarding any problems.
- **DOL should be adequately staffed to review M-1 filings.** It should regularly report to Congress and the public on its staff capacity to review M-1s and oversee all MEWAs, including AHPs.

AHPs, under the current rule, present a grave concern for the health and welfare for all Americans, along with jeopardizing the stability of the health insurance market. Rescinding this

rule is vital to upholding individuals' and families' rights to comprehensive and affordable health care coverage. Beyond AHPs' troubling track record of fraud and insolvency, they also sidestep Essential Health Benefits requirements, critical for safeguarding the well-being of Americans. The widespread adoption of such plans introduces substantial risks to health, healthcare access and the overall stability of comprehensive individual and small group coverage. **For these reasons, Families USA strongly supports rescission of this 2018 regulation designed to expand the formation of Association Health Plans.**

Thank you for considering these comments. For further information, contact Cheryl Fish-Parcham, cparcham@familiesusa.org.

Sincerely,

Yael Lehmann

Interim Executive Director

Families USA

[1] The Notice of Proposed Rulemaking cits(1) U.S. Gov't Accountability Office, GAO–92–40, "States Need Labor's Help Regulating Multiple Employer Welfare Arrangements.", March 1992, at *https://www.gao.gov/assets/220/215647.pdf;* (2) U.S. Gov't Accountability Office, GAO–04–312, "Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage." Feb. 2004, at *https://www.gao.gov/new.items/d04312.pdf;* and (3) Kofman, M. and Jennifer Libster, "Turbulent Past, Uncertain Future: Is It Time to Re-evaluate Regulation of Self-Insured Multiple Employer Arrangements?", Journal of Insurance Regulation, 2005, Vol. 23, Issue 3, pp. 17–33.

[2] US Department of Labor News Release, "Federal Court Appoints Independent Fiduciary as Claims Administrator of Medova Arrangement," April 12, 2021, https://www.dol.gov/newsroom/releases/ebsa/ebsa20210412; see memo from Chamber Business Solutions to Tennessee Chamber of Commerce, September 11, 2019, as an example of Medova Healthcare/Lifestyle Health Plans marketing to an association, https://issuu.com/kychamber/docs/tn_program_proposal__002_

[3]Employee Benefits Security Administration, US Department of Labor, "Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation," April 2022, https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf; California Health Care Foundation, Group Purchasing Arrangements, Implications of MEWAs, July 2003, https://www.chcf.org/wp-content/uploads/2017/12/PDF-HIMUbriefMEWAs.pdf

[4] https://www.cms.gov/marketplace/resources/data/essential-health-benefits#:~:text=The%20Affordable%20Care%20Act%20requires,hospitalization%3B%20(4)%20maternity%20and

[5] Amici Curiae, Families USA et al, State of New York v. DOL, op cit; National Women's Law Center, , Nowhere to Turn: How the Individual Health Insurance Market Fails Women ,June 2008, https://nwlc.org/wp-content/uploads/2015/08/NWLCReport-NowhereToTurn-81309w.pdf; Families USA et al, Short-Term Plans Do Not Cover Life-Saving Mental Health and Substance Use Treatment, 2018, https://familiesusa.org/wp-content/uploads/2018/06/STP-and-Mental-Health_Factsheet_0.pdf;

[6] 42 U.S.C. § 18063; Mark Hall and Michael McCue, Experiences Under the ACA Suggest Association Health Plans Could Harm the Small-Group Insurance Market, Commonwealth Fund, December 2018, https://www.commonwealthfund.org/blog/2018/experiences-under-aca-suggest-association-health-plans-could-harm-small-group-insurance; CBO, Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028, May 2018, p. 10, https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53826-healthinsurancecoverage.pdf

[7] Department of Labor Advisory Opinion 2007-06A, August 16, 2007, https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/advisory-opinions/2007-06a#:~:text=The%20employers%20that%20participate%20in,with%20respect%20to%20the%20program.

[8] Letter from Chiquita Brooks LaSure, Administrator, CMS, to Glen Youngkin, Governor and Scott While, Insurance Commissioner, Virginia, May 31, 2023.

[9] E.g, CA Code Chapter 700 Section 3 and California Department of Managed Health Care All Plan Letter, 19-024, https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2019-024%20(OLS)%20%20Association%20Health%20Plans%20.pdf?ver=2021-05-07-095619-167, DC Code 31-3101.01.