ConsumersUnion®

THE ADVOCACY DIVISION OF CONSUMER REPORTS

March 1, 2018

The Honorable R. Alexander Acosta
Secretary, U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Ms. Jeanne Klinefelter Wilson
Deputy Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

RE: Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans (RIN 1210-AB85)

Dear Secretary Acosta:

Consumers Union, the advocacy division of Consumer Reports,[1] appreciates the opportunity to comment in response to the proposed rule, RIN 1210-AB85, Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans.

Consumers Union supports efforts to improve affordability and access to health coverage for all consumers. But, lowering the guardrails around Associated Health Plans (AHPs) and encouraging employers and individuals to enroll in these plans is not the best way to increase access to affordable quality healthcare and coverage; it will, instead, exacerbate the affordability issues and expand the number of underinsured. According to the proposed rule itself, "While the impacts of this proposed rule, and of AHPs themselves, are intended to be positive, on net, the incidence, nature and magnitude of both positive and negative effects are uncertain."[2] It is our position, and that of a broad range of stakeholders, from patient groups[3] to providers[4] to insurance experts,[5] that the negative effects of

[1] Founded in 1936, Consumer Reports is an expert, independent, nonprofit organization whose mission is to work for a fair, just, and safe marketplace for all consumers. Using more than 50 labs, its auto test center, and survey research center, the non-profit organization rates thousands of products and services annually. Consumer Reports has over 8 million subscribers to its magazine, website, and other publications. Its policy and advocacy division, Consumers Union, works for health reform, food and product safety, financial reform, and other consumer issues in Washington, D.C., the states, and the marketplace.

[2] Proposed rule at p. 626.

[3] For example, in the letter *Health Insurance Changes Could Put Meaningful Health Coverage Out of Reach of Patients*, (October 12, 2017), cosigned by American Cancer Society Cancer Action Network, American Diabetes Association, American Heart Association, American Liver Foundation, American Lung Association, Arthritis Foundation, Crohn's and Colitis Foundation, Cystic Fibrosis Foundation, Epilepsy Foundation, Lutheran Services in America, March of Dimes, Muscular Dystrophy Association, National Health Council, National Multiple Sclerosis Society, National Organization for Rare Disorders, United Way Worldwide, Volunteers of America, and WomenHeart: The National Coalition for Women with Heart Disease.

expanding the footprint of AHPs clearly and by far outweigh the positives. As our comments articulate, below, this proposed rule:

- jeopardizes access to affordable, comprehensive, coverage for millions of small business employees;
- undermines the individual and small group markets;
- puts into question states' regulatory autonomy and long-term ability to tailor consumer protections; and
- offers misleading choice instead of real solutions;

A better approach would be to press forward with plans to stabilize the individual and small group markets and to expand affordability programs to more Americans. Association Health Plans are not inherently problematic but the AHP market in the past has attracted unscrupulous actors, those looking to make a quick profit and take advantage of consumers and small employers. Fraudulent schemes have left both consumers and providers with unpaid claims, and AHPs that have achieved lower price tags through lower value coverage left consumers underinsured when they needed care. Thus, Consumers Union approaches the expansion of these plans with extreme skepticism. This is particularly so when, as in the proposed rule, safeguards imposed as a result of AHP scandals of the past are eliminated.

If this proposed rule is finalized, we urge the Department to retain current safeguards that ensure that AHPs operate under the same standards as the insurance market with which they will compete, and that the role of states in protecting their citizens from risky association health plans be clearly and solidly settled. We also urge you to strengthen the nondiscrimination provisions. Both are critical to reducing the negative impact that the proposed rule is likely to have on insurance markets and individual consumers, if the rule is finalized.

Under this proposed rule, millions of employees could lose the affordable, comprehensive, coverage on which they rely.

There are 57.9 million small business employees in the United States.[6] Many of these employees' access to coverage and care is jeopardized by this proposed rule. Under current laws and regulations, employer- sponsored health insurance must meet baseline standards set by the Affordable Care Act (ACA), and employees not eligible for affordable "minimum value" employer-sponsored health insurance may qualify for a premium tax subsidy for an ACA-compliant product on the individual health insurance market. This proposed rule would at once eliminate the baseline standards and could affect the availability of a subsidized alternative.

[4] Both the American Hospital Association and the American Medical Association have voiced opposition to expanding access to AHPs, stating doing so would "[d]estabilize the individual and small group markets, leaving millions of Americans who need comprehensive coverage to manage chronic and other pre-existing conditions" (AHA statement, October 12, 2017); and that expanding AHPs and short-term plans "may weaken important patient protections and lead to instability in the individual health insurance market" (AMA statement, October 12, 2017).
[5] For example, the American Academy of Actuaries issued a statement on October 12, 2017, cautioning the potential risks and effects of expanding AHPs and short term plans.
[6] Small Business Administration, *Small Business Profile*, (2017).

Dropping the essential health benefits (EHBs) requirement will lead employees offered only an AHP product to discover that the insurance offered by their employer likely fails to serve their needs. For example, before the ACA essential health benefits standards were established:

- The vast majority of plans in the individual market did not cover maternity care. In fact, only 12 percent of plans in the individual market covered this benefit.[7] Even among plans that covered maternity services, the coverage was not always comprehensive or affordable. One study found that several plans charged a separate maternity deductible that was as high as $10,000, and some plans had waiting periods of up to a year before maternity care would be covered.[8]
- One in five people enrolled in the individual market lacked coverage for prescription drugs.[9] Prescription drugs are vitally important to individuals with HIV, hepatitis, cancer, multiple sclerosis (MS), epilepsy and many other conditions. Rolling back coverage of prescription drugs means individuals and families would not be able to access the medicine they need to prevent or manage ongoing health conditions.
- Mental health coverage was often excluded from plans, or was very limited.[10] It is estimated that over 32 million people gained access to coverage for mental health services, substance use disorder treatment or both benefits under the ACA.[11]

The proposed rule harks back to those days. It puts the economic stability and health of consumers at risk by allowing employers to offer limited coverage that fails to meet the needs of individuals and families. Small business owners make many important decisions in the course of managing their business. One of those decisions is whether to offer healthcare coverage, and what type of coverage they can afford to pay for given other competing financial obligations. The rationale on which an employer would base that decision will likely differ from that of an employee with a cancer diagnosis, pregnancy, or a chronically ill child. For those employees, the only way to obtain comprehensive coverage would be to enroll in a separate individual policy.[12] Unfortunately premium tax subsidies may not be available to some who go that route,[13] putting quality coverage and care outside their reach. To correct this, we urge the Department to amend current regulations to permit an individual who declines an employer-sponsored AHP to be deemed eligible for premium tax subsidy based on income.

Finally, the proposed rule appears to put the ACA rating protections at risk as well. The ACA prohibits premium rating to be based on anything other than age (in bands), family size, geography, and tobacco

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[7] National Women's Law Center, *Turning to Fairness: Insurance Discrimination against Women Today and the Affordable Care Act*, (2012).
[8] *Id*.
[9] The Commonwealth Fund, *Eliminating Essential Health Benefits Will Shift Financial Risk Back to Consumers,* (March 15, 2017).
[10] *Id*.
[11] U.S. Department of Health & Human Services, *Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans*, (February 2013).
[12] This is only an option for employees whose employer does not offer insurance with minimum essential coverage (MEC).
[13] An employee who is offered job-based coverage that meets requirements under the employer mandate – i.e. the minimum value standards and affordability requirements – does not qualify for a premium tax subsidy. Because this determination is based on minimum value, an actuarial calculation, an AHP product could meet the actuarial requirement and be deemed qualifying coverage though it offers inferior coverage to an ACA-compliant product, but still disqualify the employee from premium tax subsidy eligibility.

use (if permitted by the state). Prior to the ACA, rating on gender, for example, was rampant, with women being charged more than men. Although the proposed rule would protect individuals from being charged more because of their gender, employers in industries that tend to have higher percentages of female employees could be charged higher premiums, which would ultimately be passed down to their employees. Similarly, the age and industry of employers could be considered as part of rate setting, leading to higher premiums for employers with older employees or in certain industries because these factors can be used as a proxy for higher health care utilization and/or employees with less-than-perfect health.

To safeguard against these issues, the Department should continue to apply the "look-through" doctrine, rather than treat AHPs as large group plans; if an AHP is offering coverage to individuals, including working owners, or small employers, the plans should be required to meet standards and protections set forth in the ACA for the individual and small group markets, respectively.

- Response to the Department's request for comments on the nondiscrimination requirements, including how they balance risk selection issues with the stability of the AHP market and the ability of employers to innovate and enter voluntary coverage arrangements.[14]

  The Department's proposal to apply the Health Insurance Portability and Accountability Act of 1996 (HIPAA) nondiscrimination provisions in §2590.702(a) and § 2590.702(b) to AHPs could shield consumers from some of the discriminatory practices exercised by AHPs of the past. However, these provisions are not enough. Within the framework proposed here remain a number of troubling loopholes. Under this proposal, AHPs would be exempt from EHB, rate reforms, and guaranteed issue requirements – all intended to protect those with pre-existing conditions. The fact is that AHPs would be able to structure benefits, eligibility, and marketing in order to attract groups that lean toward healthy, younger, and male members, meaning that they would disfavor groups that skew toward less healthy, older, and female members. Under the rules proposed, AHPs could avoid undesirable risk via de facto discriminatory practices, such as avoiding covering certain benefits, (for example: specialty drugs, mental healthcare, or maternity benefits), or engaging in marketing practices targeted at attracting healthier people. An AHP could avoid a geographic area where there is a high incidence of cancer rates, heart disease, and diabetes and thereby avoid covering sicker populations. Geographic limitations can also be used to engage in redlining practices. An AHP could also limit membership to a specific industry that has lower claims than other industries. All of these, and other practices with discriminatory impacts would be allowed.

  All things considered, this rule would have the effect of advancing AHPs – products with a very troubled history – while undermining the individual and small group market, and prioritizing the preferences of some small business employers over the interests of their employees. To be sure, we encourage the Department to retain its proposal to apply the HIPAA nondiscrimination provisions to AHPs in the final rule. We also support this provision applying to all AHPs, regardless of when in time they were established. But, to more meaningfully prevent discrimination, the Department should also strengthen the protections in this provision by preventing groups or associations from varying premium rates to different employer members

[14] Proposed rule at 624.

based on gender, age, zip code or other geographic identifier, industry, or other factor that may be used to vary rates based on expected health care utilization. The final rule should also apply EHB, guaranteed issue and single-risk pool requirements to AHPs.

- Response to the Department's request for comments on whether any notice requirements are needed to ensure that employer members of associations, and participants and beneficiaries of group health plans, are adequately informed of their rights or responsibilities with respect to AHP coverage.[15]

  It is critically important that consumers receive all pertinent information available in order to make the best decision for themselves and their families. Rigorous notice requirements are necessary to ensure that the self-employed, employers, employer groups, and employees know if the AHP they are considering is less comprehensive than health plans available to them in the individual or small group markets. We suggest that this notification requirement includes a comparison of the differences between the AHP and ACA-compliant plans on the small group and individual market, such as a comparison of AHP coverage benefits to ACA essential health benefits (EHBs), and explicitly states in boldface type what benefits are not covered by the AHP. This notification will be especially valuable at the point when employers select whether to change their employee benefits from comprehensive ACA-compliant insurance to an AHP. The Department should also clarify that all notice requirements that apply to group health plans apply to plans under this regulation, including notice of appeal rights, summary of benefits and coverage, and summary plan descriptions. Finally, it is important that AHPs be required to provide notice to employer groups and potential beneficiaries if plans do not meet standards for minimum value. This will ensure that employer groups and employees know that the plans have lower value than ACA-compliant options in the individual or small group markets. Further, if the AHP does not meet minimum value, the employees and their dependents must be made aware of their right to receive coverage through the health insurance marketplaces, potentially with premium tax credits based on their income.

- Response to the Department's request for information on how best to ensure compliance with ERISA and ACA standards that would govern AHPs and on any need for additional guidance on the application of these standards or other needed consumer protections.[16]

  The wording of this question, "how best to ensure compliance with ERISA and ACA standards *that would govern AHPs,*"[17] suggests that some of ERISA and the ACA may no longer govern AHPs. If so, that would be highly problematic for consumers. Holding AHPs to the same, full standards as ACA-compliant insurance products is necessary to protect consumers from the pitfalls of AHPs prior to when adequate safeguards were implemented. Holding AHPs to these same standards ensures fair market competition and promotes individual and small group market stability. We therefore strongly urge the Department to maintain the current standard for ERISA and ACA governance over AHPs rather than to lower even a fraction of the protections created by these two laws. In addition to maintaining the current federal framework for

[15] Proposed rule at 624.
[16] Proposed rule at 625.
[17] Proposed rule at 625 (emphasis added).

protecting consumers against unscrupulous AHPs, we also press the Department to clearly demarcate the broad authority of state insurance regulators over AHPs, whether the AHPs are based in the state or selling in the state from other jurisdictions.

Expansion of Association Health Plans would undermine the individual and small group markets.

If, as expected, healthier consumers are diverted to AHPs, the consumers who remain in the individual and small group health insurance markets will experience higher premiums and destabilized insurance markets.[18, 19] As the American Academy of Actuaries explains, a "key to sustainability of health insurance markets is that health plans competing to enroll the same participants must operate under the same rules."[20] The Affordable Care Act (ACA) did just that, placing most AHPs under the same ACA consumer protections as other individual or small group plans,[21] and requiring them to abide by relevant state rules. As a result, very few AHPs compete with traditional insurance and those that do operate on an even pitch. This proposed rule threatens to reverse this, fragmenting the market and leaving consumers with chronic or costly healthcare conditions – and the federal government, when premium tax subsidies are paid – to shoulder spiraling insurance premiums. With 23 million self-employed entrepreneurs[22] newly eligible to buy in to AHPs under this rule, the threat is clear. This hazard is described as "speculative" within this proposed rule,[23] but Consumers Union and the broad range of other experts cited throughout this letter, from actuaries to insurance commissioners, perceive it as a near-certainty.

In addition, by permitting AHPs to sell coverage to small employers without meeting the minimum value standards of the ACA, the proposed rule seems to make a compelling argument for AHPs to structure themselves as a vehicle for small employers to redirect their costlier employees – such as those who are older or have chronic conditions – into the individual market. This would intensify risk segmentation, making coverage even cheaper within the AHP and more expensive in the regulated markets. It would also transfer the burden to subsidize healthcare coverage from employers on to the federal government. This is because, if the employer only offers to employees an AHP that fails to meet minimum-value standards, then employees are eligible for federally subsidized health insurance coverage in the individual market. In this way, employers could pay less in insurance premiums for their employees, and employees will have a choice: a cheap employer-subsidized plan coupled with potentially massive financial risk of a five-figure deductible, or a comprehensive government-subsidized plan that is especially attractive to employees who know their healthcare costs in the coming year will likely exceed premium savings. The ACA sought to prevent precisely this scenario by requiring all small group insurance to have a minimum actuarial value of 60% and requiring all large employers to pay a substantial penalty if their plans failed to meet this standard and any of their employees chose to exercise the right this gave them to buy subsidized coverage in the Exchange. This proposed rule would

[18] American Academy of Actuaries, *Issue Brief: Association Health Plans*, (February 2017).
[19] The National Association of Insurance Commissioners, *Consumer Alert: Association Health Plans Are Bad for Consumers*, (undated). TheNAIC has warned that AHPs "threaten the stability of small group markets."
[20] American Academy of Actuaries, *Issue Brief: Association Health Plans*, (February 2017).
[21] Health Affairs, Implementing Health Reform: Association Health Plans, September 1, 2011. Because some AHPs are treated as a single ERISA plan – a narrow definition set by HHS for an association of employers that meets certain requirements – not all AHPs are held to ACA consumer protections for the individual and small group market (such as essential health benefits and rate standards).
[22] In 2017, the Small Business Administration reported 23,836,937 nonemployer firms out of 29,643,319 total small firms. Small Business Administration, *Small Business Profile*, (2017).
[23] Proposed rule at 628.

undermine a well-designed system by giving small employers the right to buy into the benefits of "large group" status without taking on the burdens.

- Response to the Department's request for comments on the impact of these proposals on the risk pools of the individual and small group health insurance markets, and for data, studies or other information that would help estimate the benefits, costs, and transfers of the rule.[24]

  The proposed rule threatens to weaken the small group and individual market risk pools as small employers and individuals who claim self-employment move to AHPs and away from their currently assigned risk pool. If this proposed rule is finalized, AHPs would be offered alongside other small group and individual market plans. However, the AHPs would operate under different rules. Past experience shows this is likely to lead to cherry-picking, adverse selection, and increased costs for sicker individuals and small businesses.[25] Put another way, this would lead to health risk being segmented with the less healthy consumers outside the AHP risk pool. This position is supported by a number of sources, including the Congressional Budget Office (CBO). In 2003, the CBO concluded "As relatively low-cost firms are attracted to the new AHP market, the average costs and thus the premiums facing firms in the state-regulated market would increase."[26] This finding was issued again two years later, in the CBO score for H.R. 525 Small Business Health Fairness Act of 2005. A core, long-held Consumers Union principle is to support broad pooling of risk as fairer and more cost-effective for consumers.[27] We do not support lower rates for healthiest consumers at the expense of older or sicker consumers.

- Response to the Department's request for comments on the concerns that AHPs will be more likely to form in industries with younger, healthier employees, as employers and their employees receive greater access to more affordable coverage than is available in the individual and small group markets.[28]

  The proposed regulation would create an uneven playing field between AHPs and the individual and small-group markets. Because the rule would subject AHPs to substantially weaker standards than ACA-compliant plans, the plans could be structured and marketed to attract younger and healthier people, thus pulling them out of the ACA-compliant small-group market and leaving older, sicker, and costlier risk pools behind. If healthier individuals and small groups are syphoned from the individual and small group markets, costs will increase and plan choices will decrease for employers and individuals remaining in those markets. Consumers who need comprehensive coverage, including those with pre-existing conditions, and consumers with incomes too high to qualify for subsidies, would face rising premiums and potentially fewer plan choices.

[24] Proposed rule at 625.
[25] In 2003, the CBO concluded "As relatively low-cost firms are attracted to the new AHP market, the average costs and thus the premiums facing firms in the state-regulated market would increase." Congressional Budget Office Cost Estimate, H.R. 660 Small Business Health Fairness Act of 2003, July 11, 2003. This finding was issued again two years later, in the CBO score for H.R. 525 Small Business Health Fairness Act of 2005.
[26] Congressional Budget Office Cost Estimate, H.R. 660 Small Business Health Fairness Act of 2003, July 11, 2003.
[27] Consumers Union, *Congress Should Take an Evidence-Based, Consumer-Centric Approach to Health Reforms,* (2017).
[28] Proposed rule at 628.

- Response to the Department's suggestion that "An AHP that realizes sufficient efficiencies may offer attractive prices even to less healthy groups" and that "AHPs have the potential to create significant efficiencies that could lower premiums across the board."[29]

  The Department fails to justify either its suggestion that AHPs will achieve sufficient efficiencies or that AHPs will use efficiencies to offset premiums and offer AHP membership to less healthy enrollee groups. It is more likely that AHPs will achieve savings by taking on a carefully curated risk pool and by covering less costly care. Furthermore, Consumers Union generally rejects the notion that insurers, and by extension AHPs, will forward the fruits of efficiencies on to consumers as there is very little incentive for them to do so.

This proposed rule jeopardizes states' regulatory autonomy and long-term ability to tailor consumer protections.

Ratcheting back states' ability to regulate AHPs sold in their jurisdiction does not allow states to identify and address the unique needs of their citizenry. Although states would continue to adopt solvency and other financial or licensure requirements for AHPs, it is foreseeable that state regulators that assert other regulatory oversight will be challenged in court, stretching state resources (both time and money), with consumers continuing to be victimized while lawsuits make their way through the legal system. In addition, whether and to what extent states can adopt other regulatory standards—such as network adequacy requirements, minimum loss ratios, or essential health benefits—is far from certain. Although the proposed rule's preamble suggests states will retain their long-held authority to regulate insurance and health plans in their jurisdiction, three provisions in the proposed rule seem to significantly curtail that authority: 1) the requirement that state regulation not be "inconsistent" with ERISA; 2) DOL's authority to exempt AHPs, individually or by class, from state insurance regulation; and 3) the implied curtailment of state authority by allowing sale of AHPs across state lines.

Finally, AHPs will have the opportunity to sell across state lines, adhering only to the rules of the least regulated state. This would challenge the viability of many state-based markets,[30] and render regulators powerless to protect their constituents. Prior to the 1983 act of Congress that clarified states' authority to regulate association health plans and multiple employer welfare arrangements (MEWAs), AHPs would often set up headquarters in one state with limited regulatory oversight. Then, they would market policies to businesses and consumers in other states with more robust regulation, thereby bypassing those states' more protective rating and benefit standards, claiming jurisdiction of the headquarter state with a weaker regulatory scheme.[31] Consumers cannot afford to return to those days of limited oversight.

To avoid that real threat of a race to the bottom in terms of regulatory oversight, we urge the Department to clearly confirm that states will retain authority over AHPs for their residents in all facets, from finances to minimum coverage standards, and everything in between. The Department must also ensure that states have time prior to the resurgence of AHPs to review current state laws that might apply to AHPs, and fill gaps in their regulatory framework as needed.

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[29] Proposed rule at 628.
[30] American Academy of Actuaries, *Issue Brief: Association Health Plans*, (February 2017).
[31] Commonwealth Fund, *Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability*, (January 24, 2018).

- Response to the Department's request for information on the relative merits of possible exemption approaches under ERISA section 514(b)(6)(B), 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.[32]

  Section 514(b)(6) of 29 U.S.C. §1144(b)(6) was added to ERISA because some MEWAs, which include AHPs, were avoiding state solvency requirements.[33] This revision to ERISA clarified that MEWAs were subject to some if not all state insurance laws.[34] The health insurance market in the years leading up to the 1983 revision of ERISA were stressful and unstable for consumers who, for one reason or another, enrolled in MEWAs such as AHPs. In the years since, the problems associated with AHPs lingered, necessitating the added safeguards implemented via the ACA. There is no evidence, either in historical experience or in the proposed rule itself, that these precautions – which protect consumers and providers alike – are unnecessary. Instead, it is clear that exemptions to the approaches under this section of ERISA will undermine the stability of the insurance markets and likely take power from the states that are in the best position to protect and serve their residents.

Association Health Plans offer misleading choice instead of real solutions.

Association Health Plans are far from a policy solution that would improve coverage options and make premiums more affordable. Instead, AHPs are characterized by a legacy of failure, so much so that over a decade ago, our organization warned readers to be wary of AHPs, as many were "bogus health insurance plans [that] left tens of thousands of people without coverage and millions in unpaid medical bills."[35] While some consumers enrolled in AHPs fully understanding the benefit limitations, some AHPs defrauded consumers about benefits.[36] In either case, consumers holding policies for AHPs that became insolvent were left abruptly uninsured and providers stranded with unpaid claims.[37] For these reasons, the National Association of Insurance Commissioners (NAIC), has warned that AHPs "provide inadequate benefits and insufficient protection to consumers."[38] Legislative protections via ERISA and the ACA curtailed risks associated with AHPs, but some bad actors remain.[39]

[32] Proposed rule at 625.
[33] American Bar Association, *ERISA Basics: Preemption (Update),* (undated).
[34] Which state laws apply to each MEWA depends on whether the MEWA is fully insured or non-fully insured.
[35] Consumer Reports, *Phony Health Insurance*, (July, 2003). The story noted that fraudulent sales and financial instability left consumers on the hook for $65 million in unpaid medical bills.
[36] Commonwealth Fund, "Association Health Plans: Maintaining State Authority is Critical to Avoid Fraud, Insolvency, and Market Instability," (January 24, 2018).
[37] *Id*.
[38] National Association of Insurance Commissioners, *Consumer Alert: Association Health Plans are Bad for Consumers*, (undated).
[39] For example, in April, 2017, Massachusetts reached a $2.9 million settlement with Kansas-based Unified Life Insurance Company over allegations that the insurer engaged in deceptive practices, such as making false promises that certain services were covered that were not.

The Department acknowledges the risk that AHPs may not operate in the interest of consumers,[40] and suggests that the Department will have to commit additional resources to AHP oversight. Given competing demands on the Department's time and budget, we are not confident that the level of oversight needed to ensure consumers are protected will be possible, regardless of good intent. In addition, oversight will fail consumers if it is based on inadequate standards.

- Response to the Department's request for comment on whether the final rule, if adopted, should also recognize other bases for finding a commonality of interest.[41]

  The final rule, if adopted, should impose more constraints on the commonality test than in the proposal, not fewer. As drafted, the commonality test simply requires employers be in the same industry or profession, regardless of geography, or be in a geographically limited area, such as a single state or metropolitan area. This broad definition already allows for cherry picking of lower risk industries, professions, and geographic areas, as described above. Furthermore, it is so permissive as to practically promote sale of AHPs across state lines. Sale of AHPs across state lines is something to be wary of, for the reasons cited above. In 1983, Congress took the step to amend the Employee Retirement Income Security Act of 1974 (ERISA) in order to make clear the power of states to exercise broad authority over MEWAs,[42] of which AHPs are one. Congress took this step because experience demonstrated that MEWAs without adequate oversight and constraints were harmful for consumers. We see no evidence that would indicate that the threat has changed. Therefore, the Department should both reconsider expanding the commonality test and reject suggestions to recognize other bases for commonality of interest that do not clearly indicate how the benefit of broadening the definition counteracts the risks to consumers.

- Response to the Department's request for comments on the benefits of AHPs offering wider choices including less comprehensive policies as well as any risk of adverse effects on individual or small group markets.[43]

  The "wider choices" likely to be offered by carriers are likely to be inadequate to truly insure consumers against the health risks they face across the span of their lives. Small businesses can already purchase coverage through AHPs. These AHPs are currently regulated by the states, just like other insurance in the small group market. Yet, AHPs have not proliferated because of the limitations put on them to protect would-be enrollees. This is precisely why some interests have lobbied for a proposed rule like this one. The preferential rules included in this proposal will fuel the growth of AHPs; it is unclear what, if any, new benefits enrolled members would gain. Concurrently, that preferential status will most certainly destabilize the individual and small group markets, causing premiums in those markets to soar for the reasons discussed throughout these comments.

[40] Proposed rule at p. 633, stating "Historically, self-insured MEWAs have been particularly vulnerable to financial mismanagement and abuse. MEWA promoters sometimes have used self-insurance both to evade State oversight and to maximize opportunities for abusive financial self-dealing, often with highly negative consequences for their enrollees."
[41] Proposed rule at 619.
[42] The Commonwealth Fund, *MEWAs: The Threat of Plan Insolvency and Other Challenges*, (March 2004).
[43] Proposed rule at 628.

Conclusion

We believe this proposed rule will leave millions of consumers and patients in AHP arrangements with insufficient coverage, unpaid medical bills, and lifelong health implications – just as occurred with AHPs before the ACA provided more oversight and protection – while millions more consumers will lose access to affordable, comprehensive, insurance coverage. Given the foregoing expressed concerns, we strongly urge the Department not to move forward with finalizing the rule. If the Department elects to do so, we urge the Department to reconsider each proposal and to finalize only those that uphold states' strong regulatory authority and the consumer protections achieved through the 1983 amendment to ERISA and the passage of the Affordable Care Act.

Sincerely,

Dena B. Mendelsohn
Senior Senior Attorney