March 2, 2018

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—Small Business Health Plans, RIN 1210-AB85

Submitted electronically to www.regulations.gov

Re: Definition of Employer under Section 3(5) of ERISA-Association Health Plans [EBSA-2018-0001; RIN 1210-AB85]

Dear Sir/Madam:

On behalf of the American Nurses Association (ANA), we are pleased to comment on the Employee Benefits Security Administration's (EBSA) Proposed Rule regarding the availability of Association Health Plans (AHPs) to consumers. ANA advocates for universal access to a standard package of essential health care services for all citizens and residents. While we certainly support efforts to expand access to healthcare coverage and to stabilize the individual health insurance marketplace and the American health care system writ large, we believe that this particular proposed rule would have adverse consequences which would in the end, not achieve that aim. We alternatively propose that the Trump administration work with the United States Congress to enact lasting policies which stabilize the health care system.

The American Nurses Association (ANA) is the premier organization representing the interests of the nation's 3.6 million registered nurses (RNs), through its state and constituent member associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions including essential self-care, and provide advice and emotional support to patients and their family members. ANA members also include the four advanced practice registered nurse roles (APRNs): nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-

midwives (CNMs) and certified registered nurse anesthetists (CRNAs).[1] ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.

This proposed rule makes a number of changes related to the formation and functioning of AHPs in response to President Trump's October 12, 2017 Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States," which directs the Secretary of Labor to consider proposing regulations or revising guidance to expand access to health coverage by allowing more employers to form AHPs and be treated as single large employers. These proposed changes include:

1) Allowing AHPs to form for the sole purpose of offering health coverage;
2) Allowing sole proprietors and self-employed individuals to join AHPs; and
3) Allowing AHPs to use a similar geographic area (i.e., a state or metropolitan area) as a commonality of interest to form an AHP.

This proposed rule also includes a non-discrimination provision which applies to healthcare coverage offered through AHPs. This non-discrimination provision:

1) Prohibits a group or association from conditioning membership on any health factor of an employee;
2) Prohibits the group or association from discriminating with respect to eligibility for benefits or in setting premiums or contributions; and
3) Prohibits the group or association from treating different employer members of the group or association differently from other employer members who are within similarly situated groups (this distinction crucially still allows distinctions across age groups, different types of industries, and geographic areas, and could also vary on the basis of gender).

This proposed rule would in effect allow for the creation of a greater number of and larger AHPs. Many of these AHPs would qualify as large group health insurance plans regulated under the Employee Retirement Income Security Act of 1974 (ERISA). Under existing law large group health insurance plans – which the Affordable Care Act (ACA) leaves largely untouched – are

[1] The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

not required to adhere to the ACA's requirement for small group and individual health insurance plans to provide coverage for the ACA's essential health benefits, nor are they required to adhere to the ACA's requirements for small group and individual health insurance plans with respect to risk adjustment, risk pooling, or limitations on premium ratings.

The proposed rule provides the tools for AHPs to "cherry pick" the best risk populations from the individual and small group markets for insurance. By enrolling only populations with the healthiest risk profiles, it leaves traditional individual and small group markets in peril of instability and escalating cost. The tools provided under the proposed rule for AHPs to use to undermine risk spreading include:

- Selecting for younger and relatively healthy members by excluding some of the essential health benefits from coverage options. For example, AHPs could exclude coverage for insulin or all prescription drugs, maternity care, certain types of mental health services, cancer treatments, etc. So while the non-discrimination provisions technically prohibit AHPs from excluding coverage for pre-existing conditions, allowing AHPs to be considered large employers and thereby exempt from EHB requirements provides a way to use benefits policy to select for healthier enrollees. AHPs could also choose to provide only bare bones coverage in order to only appeal to the healthiest of groups. These policies leave those needing health care the most to rely on an increasingly unstable market as it experiences worsening adverse selection and declining numbers of participants.
- Charging significantly higher premiums based on age, gender, occupation, or other rating factors. The proposed non-discrimination provisions provide that AHPs could not set eligibility policies or charge premiums that vary based on health status. But by allowing AHPs to be considered large employers and thereby exempt from other ACA rules related to setting premiums, AHPs can nevertheless use pricing (rating) policies to discourage enrollment among older individuals, women, those in higher risk occupations, or those who have held policies for more than a year.
- Excluding coverage in certain geographic areas where the health or risk profile of the population is determined to be less appealing. The proposal allows self-employed individuals and small groups to form an AHP together whether or not they have a shared business interest as long as they are geographically co-located within a state or metropolitan area. The rule does not define those concepts, nor ensure that the AHP offers coverage in contiguous areas throughout a state or metropolitan area. The lack of specificity provides another tool for AHPs to avoid offering coverage in areas in which

they find residents' risk profile to be less attractive, for example where the population is older or is more likely to have chronic health conditions.

Taken together, the tools provided to AHPs under the proposed rule would all but ensure that people who most need health coverage are likely to be left in the traditional health insurance market where more generous benefits are required. Premiums in that market will rise, encouraging more of the healthiest to migrate to AHPs which, in turn, will drive up the cost of the traditional products even further. This "adverse selection spiral" will create increasing instability and threaten the continued existence of health insurance for those individuals. It is for these reasons that the National Association of Insurance Commissioners,[2] the National Governors Association,[3] and the American Academy of Actuaries[4] have also been historically opposed to AHPs. Coverage offered through AHPs would potentially be beneficial to those lucky enough to be young and in good health, but would have a devastating impact on those who are older or have one or more medical conditions.

Furthermore, AHPs and other multiple employer welfare arrangements (MEWAs) have had a subpar track record with respect to fraud and financial solvency – so much so that Congress took action in 1983 to clarify that states have regulatory authority over MEWAs and AHPs; this clarification still did not eliminate the problems which had previously abounded with respect to these arrangements. The ACA included even stronger language on MEWAs and AHPs, which imposed expanded reporting requirements and criminal penalties on MEWA fraud and gave the Secretary of Labor additional authority to take immediate action to close a MEWA determined to be in a financially hazardous condition.

Despite these actions, state regulatory authority over AHPs that are MEWAS continues to be unclear especially with respect to those offered across state boundaries. The proposed rule not only does not add clarity in these areas but adds to the uncertainty by suggesting that DOL may go further to pre-empt the application of state laws to AHPs. This track record of instability and consumer fraud combined with unclear legal and regulatory authority is troubling and puts both the physical and financial health of consumers at risk. If anything, states' regulatory oversight should be supported and expanded. States have had a relatively strong oversight

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[2] National Association of Insurance Commissioners, Consumer Alert: Association Health Plans are Bad for Consumers, available at http://www.naic.org/documents/consumer_alert_ahps.pdf.
[3] National Governors Association, Governors Oppose Association Health Plans, May 2004, available at https://www.nga.org/cms/home/news-room/news-releases/page_2004/col2-content/main-content-list/governors-oppose-association-hea.html. [SEE ALSO citations cited at 623.]
[4] American Academy of Actuaries Letter to John Boehner, Chairman, House Committee on Education and the Workforce, April 28, 2003.

record while DOL's history of oversight with respect to AHPs has been lackluster. Despite receiving annual reporting from AHPs, there is no evidence that DOL conducts regular oversight based on the findings or ensures the findings are accurate, and it has been slow to take action against insolvent or fraudulent AHPs. The oversight concerns have resulted in a long history of plan failures and fraud. These include:

- As recently as November of 2017, DOL was working to close down operations of a failing MEWA that covered 14,000 enrollees in multiple states. Premium contributions from employers enrolled in the coverage were being pooled and transmitted to offshore accounts. The Department identified more than $26 million in processed but unpaid claims for medical services.[5]
- In 2016, the Department filed suit against a Florida woman and her company to recover $1.2 million that it said had been improperly diverted from a health plan serving dozens of employers. The defendants concealed the plan's financial problems from plan participants and left more than $3.6 million in unpaid claims, the department said in court papers.[6]
- A licensed MEWA in California, covering 23,000 people, became insolvent in 2001. It collected over $30 million in premiums and owed around $11 million for medical claims when it failed.
- New Jersey's Coalition of Automotive Retailers, a MEWA that covered 20,000 people, became insolvent in 2002. At the time it had $15 million in outstanding medical bills.
- The Indiana Construction Industry Trust, in operation since the 1960s became insolvent in 2002.The trust insured approximately 790 employers and 14 association groups covering over 22,000 employees and their dependents. At that point it had less than $1 million in assets and more than $20 million in unpaid claims.[7]

ANA is not opposed to the expansion of AHPs, *per se*. One of ANA's core principles of health system transformation is to ensure universal access to a standard package of essential health care services for all citizens and residents. We believe, however, based on the points made above, that expanding AHPs in the manner described under EBSA's proposed rule would not achieve that goal. Expanding AHPs as large single employer plans would exempt them from some of the ACA's most important consumer protection requirements, including the important requirement that small group and individual health insurance plans provide coverage for the ACA's essential health benefits. This proposed rule also throws decades of EBSA guidance and

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[5] "U.S. Department of Labor Obtains a Temporary Restraining Order to Protect Participants and Beneficiaries of Failing MEWA," https://www.dol.gov/newsroom/releases/ebsa/ebsa20171108 .
[6] Pear, Robert, October 21, 2017, "Cheaper Health Plans Promoted by Trump Have a History of Fraud," New York Times, https://www.nytimes.com/2017/10/21/us/politics/trump-association-health-plans-fraud.html.
[7] Kofman, Mila, et al., MEWAs: The Threat of Plan Insolvency and Other Challenges, Health Policy Institute, Georgetown University, http://www.commonwealthfund.org/usr_doc/kofman_mewas.pdf

judicial opinions out the window in favor of an expedient policy option. As such, the EBSA proposed rule, as written, would allow AHPs to provide bare bones coverage options and enable them through their exemption from other individual and small group health insurance requirements to select for younger and healthier individuals and to essentially price out older and less healthy individuals. Such a coverage mechanism is leagues away from ANA's vision of universal access to a standard package of health care services for all citizens and residents and we oppose its implementation.

ANA alternatively recommends that the Trump administration more broadly work with the United States Congress on bipartisan solutions to strengthen the nation's existing individual health insurance marketplace, restore crucial Cost-Sharing Reduction payments which benefit low-income consumers, and take meaningful steps to ensure lower healthcare costs overall (including lower premium and prescription drug costs). ANA has previously voiced its support for proposals such as that offered by Sen. Lamar Alexander (R-TN) and Sen. Patty Murray (D-WA) to stabilize the individual health insurance marketplace, thereby providing American consumers of all ages and health status with stable and affordable coverage options and in effect reducing the federal government's costs.

ANA welcomes an opportunity to further discuss the issue of Association Health Plans, essential health benefits, and universal access to comprehensive healthcare coverage for all American citizens and residents. If you have questions, please contact Mary Beth Bresch White, Director, Health Policy (marybreschwhite@ana.org).

Sincerely,

Cheryl A. Peterson, MSN, RN
ANA Vice President for Nursing Programs

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President

Associations signing on to this letter:

Indiana Nurses Association
Kentucky Nurses Association
Montana Nurses Association
New Hampshire Nurses Association
New Jersey Nurses Association
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