AMERICAN ACADEMY *of* ACTUARIES
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March 5, 2018

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
U.S. Department of Labor
200 Constitution Ave. NW
Washington, DC 20210

Re: **RIN 1210-AB85**—Definition of ''Employer'' Under Section 3(5) of ERISA—Association Health Plans

To Whom It May Concern,

On behalf of the Individual and Small Group Markets Committee of the American Academy of Actuaries,[1] I would like to offer comments in response to the Department of Labor's (DOL) proposed rule that would broaden the ability for association health plans (AHPs) to be treated as large groups and for self-employed individuals to be eligible for AHPs. In a previous comment letter[2] we offered considerations that we believe should be made when analyzing the potential impacts of defining AHPs more broadly. This comment letter addresses more directly on the policy implications of the proposed rules and highlights the potential effects of broadened AHP eligibility on the stability and sustainability of the existing ACA-compliant individual and small group markets.

To be sustainable, the ACA-compliant markets require sufficient enrollment numbers and a balanced risk profile. They also require a stable regulatory environment that facilitates fair competition, with health plans competing to enroll the same participants operating under the same rules.[3] If one set of plans operates under rules that are more advantageous to healthy individuals or groups, market segmentation will result. Individuals and groups will migrate to the plans more advantageous to them. In other words, plans that have rules more amenable to less

[1] The American Academy of Actuaries is a 19,000 member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
[2] Individual and Small Group Markets Committee of the American Academy of Actuaries, "Considerations Related to Modeling the Potential Impact of Association Health Plans," (letter), Feb. 8, 2018.
[3] Health Practice Council of the American Academy of Actuaries, "Steps Toward a More Sustainable Individual Health Insurance Market," (issue brief), April 2017.

healthy individuals or groups will suffer from adverse selection. In the absence of an effective risk adjustment program that includes all plans, upward premium spirals could result, further threatening the viability of the plans more advantageous to less healthy individuals or groups.

Under current law, regulations, and guidance, AHPs follow the rules pertaining to the units they are enrolling. In other words, AHPs that enroll small groups must follow the small group ACA rules; AHPs that enroll individuals must follow the individual market ACA rules. These rules include prohibiting coverage denials or higher premiums for individuals or groups with pre-existing health conditions, benefit coverage requirements, and cost-sharing limits. Each state and market also uses risk adjustment and a single risk pool to help ensure that plans are appropriately compensated for the risks they bear, thereby reducing incentives for insurers to avoid higher-risk individuals and groups.

In contrast to the individual and small group plans, large groups have more flexibility regarding rating rules and benefit coverage requirements. For instance, premiums for large group coverage can vary based on the expected health costs of the group—age factors can exceed the 3:1 limits currently required in the ACA individual and small group markets; industry, group size, and health status factors—prohibited in the individual and small group markets—are allowed in the large group market.[4] The proposed nondiscrimination rules would prohibit the use of health status factors for rating each member employer. Nevertheless, AHPs would be allowed to use other large group rating factors that are not allowed in the individual and small group markets. Market segmentation and adverse selection for ACA compliant plans could result. AHPs could offer lower premiums to healthier and/or younger enrollees, deteriorating ACA markets and raising ACA premiums as healthier groups leave ACA plans for AHP plans.

This comment letter provides information on the potential implications of broadening AHP eligibility on the ACA small group and individual markets.

## Impact on the ACA small group market

**Which large group rules would apply?**

The proposed rule indicates that an AHP would be rated based upon the aggregate size of all employer-members. If an association's members represent in total more than 50 employees (or 100 in states that define small groups as having up to 100 employees), it would be governed by large group rules, subject to the proposed nondiscrimination provisions. We note that the proposed rules are not clear on what is allowed with respect to rate variations, plan design limitations, benefit requirements, annual open enrollment and special enrollment periods, guaranteed availability and renewability of coverage, and rate review requirements. Uncertainty on allowable practices can increase the potential for abuse and raise concerns about whether a level playing field exists. Relatedly, clarification is needed on whether a state may regulate AHPs based on the size of each employer-member under its authority to regulate multiple employer welfare arrangements (MEWAs) as granted by ERISA.[5]

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[4] While rating factors such as age, gender, industry, and health status can be used in the development of large group rates, these factors are aggregated for the group as a whole. Within the group, rates for individual employees rarely vary by age or gender and never vary by an employee's or dependent's health status.

[5] Employee Retirement Income Security Act of 1974 (ERISA).

We believe additional clarification is needed regarding how the proposed rule would interact with the ACA's employer mandate. Under the employer mandate, large employers are subject to financial penalties if: 1) they do not provide coverage that meets affordability and minimum value requirements and 2) any employees obtain subsidized coverage on the Exchange. Since the association is not the employer, but rather acting on behalf of employer-members, clarification is needed as to whether the AHP is subject to the employer mandate. It is our understanding that the employer mandate would apply to each employer-member separately, but we would like confirmation of that. If the employer mandate applies to each employer-member separately, employer-members with 50 or fewer employees are not subject to the employer mandate. Since there appears to be no other mechanism to enforce minimum value requirements in the large group market, application of the mandate at the employer-member level may provide AHPs significant flexibility to craft ultra-lean benefit designs. This would lead to the risk of potential anti-selection in ACA risk pools if AHPs are not also required to offer coverage that meets the minimum value requirement. While we believe AHPs would be subject to the same maximum out-of-pocket requirement as ACA plans, AHPs may be able to place annual visit limits on services to create leaner benefit packages, if not prohibited by state law.

**Impact of reducing benefit coverage rules**

By allowing AHPs to offer coverage under large group rules, the proposed rule would exempt AHPs from the ACA's essential health benefits requirements (EHBs) and related restrictions. As noted previously, the employer mandate subjects large employers to financial penalties if they do not offer coverage that meets affordability and minimum value requirements and if any of their employees obtain subsidized coverage on the Exchange. If the mandate is not intended to apply to the association as a whole but rather to each employer-member separately, we note that AHPs may not provide benefits similar to EHBs in the following areas.

- It is our understanding that even if not subject to EHB requirements, the Pregnancy Discrimination Act of 1978 requires that health insurance offered by employers with over 15 employers must include maternity benefits. If this is the case, some groups enrolled in the AHP may be required to cover maternity and others will not. It is unclear whether this requirement would apply to all groups within an AHP or only those with 15 or more employees.
- Mental health and substance abuse treatment parity requirements apply only when health insurance coverage includes those benefits. ACA-compliant plans in the individual and small group markets must cover these benefits due to the EHB requirements, but AHPs may not be required to cover mental health and substance abuse.
- Under the ACA, annual dollar limitations are not allowed for covered EHBs, and any service limits applied must result in a benefit that is actuarially equivalent to the state EHB package in order for a plan to still be considered as providing EHBs. This requirement may not apply to AHPs. AHPs may be able to place service limits on certain EHB services without consideration of actuarial equivalence and offer leaner plans than required in the ACA market.
- Drug formularies can be a powerful tool for controlling costs, but can also result in plans that do not cover drugs essential for certain classes of high cost members' conditions. ACA EHB requirements attempt to mitigate the potential for discrimination by requiring minimum drug counts by class, but AHPs would not be subject to these requirements.

- A similar concern applies to rehabilitative and habilitative services, autism treatment requirements (to the extent not required by a state), and pediatric dental and vision coverage required under ACA. AHPs could make coverage be unappealing to certain classes of potential enrollees by not covering services in these areas.

In general, although more benefit design flexibility could increase plan choice and reduce premiums among AHP plans, benefit design differences between AHPs and ACA plans could cause market fragmentation. AHPs could design plans more attractive to lower-cost small groups, leading to adverse selection and higher premiums among ACA small group plans.[6]

**Impact of more flexible premium rating rules**
Because they would be treated as large groups, AHPs would have more flexible rating rules. Due to this increased flexibility, AHPs could offer lower premiums for lower-cost groups and higher premiums for higher-cost groups. As a result, AHPs could benefit from positive selection—that is, they would attract a lower-cost enrollee population. In contrast, ACA plans would be subject to adverse selection—they would attract a higher-cost enrollee population, which would lead to higher ACA premiums.

- AHPs would not have to follow the ACA's small group rating rules, meaning that age ranges greater than 3:1, gender, industry, and group size could be considered when developing rates for AHPs. In addition, AHPs could use different geographic rating areas than ACA plans. As a result, AHP premiums could be more attractive to lower-cost groups with ACA premiums more attractive to higher-cost groups.
- Many states currently do not have rate review/approval authority over the large group market. In these states, there is no mechanism to ensure the rating factors used by an AHP are actuarially justified.
- If the DOL were to issue self-funded AHPs a "class exemption" from certain state insurance laws, self-funded AHPs may be able to avoid state regulatory authority on rating rules.

## Impact on the ACA individual market

Many of the factors that would affect the ACA small group market would also affect the ACA individual market. In particular, the greater rating and benefit design flexibility and exclusion of AHPs from the risk adjustment program make AHPs more attractive to lower-risk individuals. Higher-risk individuals will be more attracted to ACA plans, leading to higher premiums and deterioration of the ACA individual market.

The proposed rules change the definition of "employer" under ERISA to include self-employed individuals without common law employees. Allowing self-employed individuals access to

[6] Transitional plans (often referred to as "grandmothered plans") provide an example of what can happen when it becomes advantageous for lower-cost individuals to be covered by noncompliant plans. In states that permitted individuals and small groups to retain their pre-ACA plans, lower-cost individuals and groups were more likely to do so because they could face lower premiums. Higher costs among ACA-compliant plans were the result. In the individual market in particular, greater presence of transitional plans was associated with greater losses in 2014. http://www.milliman.com/uploadedFiles/insight/2016/2263HDP_20160712(1).pdf

AHPs would affect the ACA individual market membership and morbidity level. If self-employed individuals were given the option of a lower-premium AHP, the ACA-compliant individual market could deteriorate, leading to higher ACA premiums. While AHPs would be available to all self-employed individuals meeting the eligibility requirements, it may be even more advantageous to those who are healthy and do not need the more comprehensive benefits offered in the ACA market. This includes enrollees who are young and currently subject to 3:1 age rating, or work in industries that are healthier on average and therefore could face lower premiums in an AHP. Adverse selection against the ACA single risk pool could result, leading to higher premiums for those remaining in the ACA plans. Allowing individuals to participate in an AHP only if they are self-employed, as opposed to allowing all individuals to be eligible to join an AHP, would limit the adverse selection risk to the ACA-compliant individual market. In other words, this proposal is less harmful to the ACA market than if any individual could join an AHP. Nevertheless, self-employed individuals make up a sizeable share of the individual market.[7]

Under the proposed rules, so-called "working owners" would have to fulfill specific conditions (in addition to either the industry or geography criteria common to all members) to be eligible for coverage under an AHP. Specifically, they would be required to work at least 30 hours per week or earn at least as much wage income as the cost of the coverage, and not have access to other subsidized coverage through the individual's or spouse's employer. The proposed rules would allow the AHP to rely on "written representations from the individual" that they meet these requirements. This leaves it up to the AHP to determine how thoroughly to enforce the requirements. If enforcement is weak and relies solely on the written representations, it may be easier for individuals to leave the individual ACA market to join AHPs, further disrupting the ACA pool. Weak enforcement could result in enrolling individuals in the AHP that do not meet all of the requirements but are willing to provide a written representation saying they do. A difference in enrollment rules, such as open enrollment and special enrollment requirements, between the ACA and AHP markets could further complicate estimating the risk pools in the ACA market and the AHP market.

The ACA individual market could deteriorate and result in higher premiums not only because lower-cost individuals would be more likely to enroll in an AHP, but also because AHP enrollees who later develop health problems could re-enroll in an ACA plan during a subsequent open enrollment period or potentially during a special enrollment period. For example, individuals might find lower premiums through an AHP in part because fewer benefits are covered by the AHP. If the individual's health status deteriorates and those benefits become important, they can return to the ACA pool in worse health, subject to the open enrollment and special enrollment requirements. The increase in premiums could be particularly harmful to unsubsidized enrollees.

## Other Considerations

### Impact of not being included in risk adjustment

Although AHPs could structure benefits, rates and eligibility criteria to target the healthier small groups, AHPs would not be part of the single risk pool and would not be included in the risk

[7] Emilie Jackson, Adam Looney, and Shanthi Ramnath, "The Rise of Alternative Work Arrangements: Evidence and Implications for Tax Filing and Benefit Coverage," Department of Treasury, Office of Tax Analysis Working Paper 114, January 2017.

adjustment system. There would be no transfer of funds from AHPs to the ACA market to reflect the different underlying risks between these segments. Premiums for AHPs will reflect the overall health status of their risk pool and could continue to diverge from ACA premiums if they attract better risks than in the ACA market. While including AHPs in risk adjustment is not currently being proposed, we note that it would be difficult to effectively risk adjust between the ACA market and AHPs. The potentially large differences in underlying benefits between ACA and AHP coverage would make risk adjustment extremely difficult to implement.

**Provider payment rates and administrative costs**

AHPs not closely associated to large issuers are unlikely to negotiate the same level of deep provider discounts that large issuers currently negotiate, due in large part to the fact that they are not likely to obtain a critical mass of enrollees in a given geographic location that is of similar size to those issuers. It is reasonable to expect that AHPs will "rent" networks and pay access fees that depend in part on market leverage and savings. Some of these networks are owned by issuers that rent them out to smaller issuers, and the discounts secured by many rental networks are not at the same level as those enjoyed by the larger issuers that own these networks. AHPs associated with large issuers may have discounts equivalent to the issuer's commercial business, but the discounts would not be expected to be greater than discounts found in the commercial market.

It will also be difficult for AHPs to achieve administrative efficiencies greater than those experienced by issuers. An AHP will still be required to perform monthly billing for each group and premium collection functions for each small group and sole proprietor that it covers. Enrollment functions including issuance of enrollee ID cards will still be required to be performed at the employee level, and benefit booklets and policy forms/certificates will need to be maintained for each plan that is offered. Based on medical loss ratio (MLR) reports, large group coverage across all carriers nationwide experienced roughly a 90 percent MLR in 2016, while small group coverage experienced roughly an 86 percent MLR. These numbers show that large groups used about four cents less of every premium dollar on non-claims expenses. Both markets have a fairly high average MLR compared to the required minimum MLR.[8] Achieving a decrease in administrative expenses may be less likely given the similarities between an AHP and a large insurer in the small group market. Since AHPs will be considered large group, clarification is needed that they will be subject to the large group minimum MLR of 85 percent.

**AHPs that cross state lines**

The proposed rule would allow AHPs to meet the commonality of interest requirement if all employers and sole proprietors participating in the AHP are (1) from the same industry, trade, line of business or profession, or (2) have a principal place of business that does not exceed the boundaries of the same state or metropolitan statistical area (MSA), which could encompass parts of more than one state. Therefore, AHPs that are established by meeting either the first requirement, or are comprised of employers and sole proprietors having a principal place of business within the same MSA, have the potential to be marketed to employers and sole proprietors in more than one state.

[8] Required minimum MLR is 80 percent for the small group market and 85 percent for the large group market. MLR is not an ideal method to measure administrative cost levels. MLRs may be high due to poor claim experience or inadequate premiums.

Cross-state marketing of AHPs raises concerns of an unlevel playing field. The ACA harmonized many of the rules that apply to the individual and small group markets across states. Under the proposed rule, an AHP could be established in a state with less restrictive issue and rating rules relative to other states, and then offer rates developed under those rules in other states. At the same time, individual and small group plans that are not part of the AHP would be subject to the requirements of the state in which the plans are offered. This could lead to a fragmentation of the markets, and in some cases, these differences could be significant. For example, in states that require community rating, an AHP operating under rules of another state could offer rates that vary by age, allowing it to attract the younger groups and sole proprietors while putting upward pressure on the individual and small group ACA rates offered by carriers subject to the community rating requirements. This could threaten participation in the ACA market in these states, making it more difficult for small groups with higher-cost enrollees and individuals with health problems to obtain coverage.

To some extent, states may have the ability to mitigate these selection concerns. This effect may be limited by a state's regulatory approach. For instance, New York says it has regulatory oversight except in very limited circumstances. While the argument is not recent, the regulatory environment appears to be unchanged concerning the issues presented, and so employers in New York would generally still be subject to the rules and restrictions of the New York small group market even if they purchase coverage through an AHP. (See New York State Department of Financial Services, "Opinion Re: Multiple Employer Welfare Associations (MEWA)," Nov. 12, 2003.) As such, states that wish to avoid this practice may be able to create a similar regulatory structure, taking advantage of the limited pre-emption of state insurance laws, particularly for partially insured and self-insured MEWAs.[9]

**Timing of AHP expansions**

The proposed rule does not include an effective date. Premiums for 2018 ACA-compliant plans are finalized and in effect. These premiums were developed assuming current AHP rules. If the effective date occurs at any time during 2018, premiums for ACA-compliant plans could be understated to the extent that healthier ACA plan enrollees switch to AHPs, worsening the risk profile of the ACA-compliant markets. Insurers are not allowed to submit mid-year premium changes in the individual market or modify small group rates for groups that enrolled earlier in the year under current rules.[10] ACA premiums could be inadequate as a result.

Even if mid-year rate changes were allowed, such changes would be extremely difficult to implement. Resource constraints for insurers and regulators could make it difficult to simultaneously develop and approve revised rates for 2018, especially on a condensed timeline, alongside the 2019 rates. State laws and regulations typically require rates and coverage to be effective for a period of 12 months. An additional complication is that if mid-year rate changes are allowed, a mid-year open enrollment period or special enrollment periods might need to be

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[9] Kevin Lucia and Sabrina Corlette, "Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability," The Commonwealth Fund, Jan. 24, 2018.

[10] Insurers can already change small group rates quarterly for new business and renewal business. Therefore, for any new or renewal group business beginning after a change to AHP rules, the change can be incorporated into the rates as long as the changes are known far enough in advance.

provided so that individuals could reassess their options. Like mid-year rate changes, an additional open enrollment period or special enrollment periods would be very difficult to implement.

If the rule is not finalized before insurers must finalize rates for 2019, we suggest that insurers should be given an opportunity to adjust 2019 individual and small group rates to reflect the impact of the expansion of AHPs. Insurers are already beginning the process of developing ACA market premiums for 2019; initial rates will likely need to be filed during the spring or early summer of 2018 depending on the state.[11]

**AHP Solvency and Consumer Protections**

Governmental authority for regulating AHPs would need to be clearly defined. Absent this clarification, it is likely that no entity will bear the sole responsibility for regulating AHPs or that there will be conflicting regulations. The rule provides that AHPs will be subject to the current MEWA regulatory requirements, which would make states the primary regulators. However, the DOL is asking for comments about possible exemption approaches under ERISA. The history of MEWAs is instructive. Self-funded MEWAs had no clear regulatory authority, as initially it appeared that ERISA exempted them from state-level regulatory oversight. Multiple MEWA bankruptcies resulted, and consumers had limited avenues for redress. Eventually, the federal government issued a written clarification of earlier amendments to ERISA authority over MEWAs. If regulatory authority for AHPs is not clearly specified, they could suffer the same fate as MEWAs, leaving many without health coverage due to insolvencies. Surplus requirements for self-funded AHPs should be similar to the minimum requirements for health risk-based capital developed by the National Association of Insurance Commissioners.

It is important to recognize the need for AHPs to adhere to state-level consumer protection laws, which require network adequacy and appeal processes for denied services. While AHPs may save money if they do not have to bear the costs of these consumer protections, AHP enrollees may not realize they lack these protections until the time of claim, when it is often too late for recourse.

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We appreciate the opportunity to provide these comments and would welcome the opportunity to speak with you in more detail and answer any questions you have. If you have any questions or would like to discuss further, please contact David Linn, the Academy's senior health policy analyst, at 202.223.8196 or linn@actuary.org.

Sincerely,

Barbara Klever, MAAA, FSA
Chairperson, Individual and Small Group Markets Committee
American Academy of Actuaries

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[11] Samara Lorenz, "DRAFT Bulletin: Proposed Timing of Submission of Rate Filing Justifications for the 2018 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2019", Center for Consumer Information and Insurance Oversight, Nov. 27, 2017.