



February 20, 2024

The Honorable Julie Su
 Acting Secretary
 U.S. Department of Labor
 200 Constitution Avenue NW
 Washington, DC 20210

Re: Proposed Rescission of Association Health Plan Final Rule (RIN 1210-AC16)

Dear Acting Secretary Su:

Thank you for the opportunity to submit comments on the Department of Labor’s (“DOL” or the “Department”) proposal to rescind the 2018 “Definition of Employer—Association Health Plans” final rule (the 2018 AHP Rule).

The undersigned organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health

conditions. Our breadth enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion.

In March of 2017, our organizations agreed upon three overarching principles¹ to guide any work to reform and improve the nation’s healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit (EHB) package.

In 2018, in response to an executive order to use the regulatory process to circumvent the consumer protections of the Affordable Care Act (ACA),² the prior administration authorized a new breed of employer association: one that could offer, to individuals and small businesses, coverage that was exempt from the consumer protections that apply to individual and small-group coverage. This outcome was achieved by redefining the term “employer,” under the Employee Retirement Income Security Act of 1974 (ERISA), to mean something far broader than ever previously understood. The Department’s definition of “employer” codified in the 2018 AHP rule is at odds with both the text and purpose of ERISA and, before it was invalidated by a federal court on these very grounds, jeopardized consumers’ access to affordable, comprehensive coverage.³ We believe it is appropriate and necessary for the Department to rescind this rule and we offer the following additional comments in strong support of its proposal to do so.

Federal Law Does Not Support the Use of Association Coverage as a Regulatory Loophole

The Health Insurance Portability and Accountability Act (HIPAA) created, and the ACA strongly reinforced, a federal regulatory framework that recognizes and draws critical distinctions between three separate markets for health coverage. These markets — individual, small-group, and large-group — are defined based on the status of the entity receiving the coverage, and different rules, intended to safeguard the end user of that coverage, apply in each.

The mere fact that health coverage is offered to individuals and/or employers by way of an association of which they are members does not license such coverage to ignore the consumer protective rules that otherwise apply to it. Under ERISA and the Public Health Service (PHS) Act, AHP coverage ordinarily must be regulated without regard to the association. Rather, the legal obligations that attach to such coverage are based on the status of each member who actually receives it, just as if the coverage had been obtained directly. Individual association members must receive coverage that satisfies all the rules and protections applicable to individual market

¹ Partnership to Protect Coverage, Consensus Healthcare Reform Principles, Available at: <https://www.protectcoverage.org/ppc-consensus-healthcare-reform-principles>.

² Executive Order 13813, 82 Fed. Reg. 48385.

³ *New York v. United States Department of Labor*, 363 F. Supp. 3d 109 (D.D.C. 2019).

coverage; small business members must receive coverage compliant with all small-group market rules, etc., as if the association did not exist.⁴

This analysis is different only where the facts and circumstances demonstrate that the association itself is acting as an “employer” under ERISA. As the Department well knows, the ERISA statute is focused on employment-based benefit arrangements, and the existence of an association that properly fits within ERISA’s ambit — known as a “bona fide” association — has been described by federal regulators as a “rare” event.⁵ Only in the unlikely case that an association is bona fide does it gain authority under ERISA to sponsor coverage, an AHP, that may be treated as a single group health plan and regulated based on the combined size of all of the association’s employer-members. Critically, AHPs offered by large bona fide associations (generally, those that have more than 50 plan participants, when membership is aggregated across the association) qualify as large-employer coverage and are exempt from the various consumer protections applicable to individual and small-group coverage — including EHB and premium rating rules and the single risk pool requirement — but that do not apply to large groups.

The 2018 AHP Rule Conflicts with ERISA

Bona Fide Associations

It has been “rare” that an association will qualify as “bona fide” under ERISA because the text of the statute limits such associations to those acting “in the interest” of its members in relation to an employee benefit plan. This language and the statutory scheme in which it fits have long been understood to confer bona fide status only where there is a cohesive relationship between association members sufficient to demonstrate that the association itself will act — as an employer would — in the interest of the employees who receive the benefits it’s sponsoring. This has long been the Department’s understanding, as articulated in guidance requiring, among other things, that a bona fide association have business purposes unrelated to the provision of benefits (the “business purpose” standard) and that its members share some commonality of interest and genuine organizational relationship, again, unrelated to the provision of benefits (the “commonality of interest” standard). And it has been the understanding of the courts, which have both upheld DOL’s criteria and warned that a more permissive approach — one that would allow essentially commercial insurance ventures to

⁴ CMS Letter to Virginia Governor and Insurance Commissioner re: HB 768/SB335 (2022), Preliminary Determination (May 31, 2023); CMS Insurance Standards Bulletin, Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations (Sept. 1, 2011) (the “2011 Guidance”); CMS Insurance Standards Bulletin Transmittal No. 02-02, Application of Group and Individual Market Requirements Under Title XXVII of the Public Health Service (PHS) Act When Insurance Coverage is Sold To, or Through, Associations (Aug. 2002); see also 45 CFR. § 144.102(c). This regulatory framework is sometimes referred to as the “look through” doctrine.

⁵ See the 2011 Guidance at 3.

qualify as bona fide under ERISA — would “twist the language of the statute and defeat the purposes of Congress.”⁶

In our view, the prior administration failed to heed this warning when it promulgated the 2018 AHP Rule. That rule codified a new test for achieving bona fide status that, in a fatal departure from the Department’s longstanding approach, failed to ensure a sufficient protective nexus between the association, as a plan sponsor, and the recipients of the benefit plan, in whose interest the association must act. The administration’s new test instead used a hollowed-out version of the business purpose standard that allowed associations to achieve bona fide status under ERISA even if they were created for the sole purpose of delivering health benefits. Indeed, as the Department now recognizes, the 2018 AHP Rule’s approach to this issue was so untethered from the statute that an association could qualify as bona fide even if its viability as an organization — its ongoing existence — depended entirely on it continuing to sponsor an AHP.

Equally troubling, the 2018 AHP Rule rendered the commonality of interest standard a virtual nullity, by blessing groups whose members shared nothing but broad geographic proximity. As the Department explains at length in its proposal to rescind, common geography is no substitute for a commonality of employer interest. The former gave an ERISA greenlight to agglomerations of wildly dissimilar businesses with different or even potentially conflicting needs and priorities.⁷ Yet providing coverage to such a diverse pool of recipients within a geographic region is functionally the same as what commercial health insurers do by offering coverage within a (geographic) service area. Mere shared existence within a service area does not evoke in any meaningful way the sort of employment-based relationship on which ERISA is premised. What is needed, by contrast, is a commonality of *interest* among members, which gives assurance the association will act, employer-like, in the interest of the people whose coverage it is sponsoring.

Working Owners

The 2018 AHP Rule expanded the definition of “employer” under ERISA in an additional way, by asserting that a sole proprietor without any employees nevertheless could be classified as an employer. We respectfully disagree: you can’t be in an employment relationship with yourself. The prior administration took that highly counterintuitive position to implement a policy preference for encouraging the growth of coverage products that would siphon individuals out

⁶ *MDPhysicians & Assocs., Inc. v. State Bd. Of Ins.*, 957 F.2d 178, 185 (5th Cir. 1992); see also *Gruber v. Hubbard Bert Karle Weber, Inc.*, 159 F.3d 780 (3d Cir. 1998); *Wisconsin Educ. Ass’n Ins. Tr. v. Iowa State Bd. Of Pub. Instruction*, 804 F.2d 1059 (8th Cir. 1986).

⁷ As the federal court that evaluated the 2018 AHP Rule observed, the geographic commonality test would have been satisfied by a group of California businesses consisting of a “restaurateur in Oakland, a physicians practice group in the Hollywood Hills, an almond farmer in the Central Valley, an importer in Long Beach, a technology company headquartered in San Diego but doing business primarily in New York, and a Fresno fast-food franchise,” despite there being “no unique bonds, interests, needs or regulatory schemes” among them. *New York*, 363 F. Supp. 3d at 133 (internal quotations omitted).

of the ACA-regulated individual market. That policy preference — harmful on the merits, as we will discuss — was inconsistent with the text and purpose of ERISA and the ACA; with ERISA’s implementing regulations; with court decisions interpreting the terms “employer” and “employee;” and with common sense.⁸ The Department is right to reexamine this aspect of the 2018 AHP Rule, too, and, for the many reasons it provides in the proposed rule, wholly justified in rescinding it.

The 2018 AHP Rule Undermined Federal Coverage Protections for Individuals and Small-Groups, Jeopardizing Care for the Patients We Represent

By straying from the text and purpose of ERISA, the 2018 AHP Rule placed consumers, including the patients we represent, at unnecessary risk. History suggests these risks, and the harms that flow from them, would have been far greater, had the rule not been promptly struck down by a federal court in 2019.⁹

ERISA-covered AHPs, and multiple employer welfare arrangements (MEWAs) more generally, have a poor track record of delivering the benefit they promise. The National Association of Insurance Commissioners has described a long history of fraud and abuse by promoters of these arrangements and has noted that “[e]ven well-intentioned [plans have been] notoriously prone to insolvencies.”¹⁰ As the Department observes in the proposed rule, the financial mismanagement and abuse that has “disproportionately” afflicted these arrangements have saddled employees and their families with unpaid medical claims and a loss of access to needed care. The 2018 AHP Rule acknowledged these problems. However, instead of seeking to mitigate the dangers of fraud and insolvency, the rule codified lax standards that made it easier for unscrupulous actors to exploit these arrangements — or for simply negligent operators to mismanage them — to the detriment of consumers.

Moreover, and of fundamental importance to the patients we represent, these AHPs endanger consumers because they are free to ignore several of the core consumer protections that apply to coverage issued to individuals and small groups. These arrangements can charge consumers higher premiums based on a range of factors, including gender, age, occupation, and industry — characteristics that, taken individually or in combination, can serve as proxies for health status. While individual and small-group plans are prohibited from manipulating premiums based on these considerations (or strictly limited in their ability to do so) because of the risk of

⁸ See, e.g., *Yates v. Hendon*, 541 U.S. 1, 21 n.6 (2004); *Marcella v. Capital Districts Health Plan, Inc.*, 293 F.3d 42 (2d Cir. 2002); *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982); 42 U.S.C. § 300gg-91; 29 U.S.C. § 1002(6); 29 CFR § 2510.3-3.

⁹ See M. Kofman, “Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud,” Georgetown University Health Policy Institute (2005); M. Kofman, E. Bangit, and K. Lucia, “MEWAs: The Threat of Plan Insolvency and Other Challenges,” The Commonwealth Fund (March 2004); GAO, “Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage” (February 2004); A. Kirk, “Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts,” *Journal of Health Politics, Policy and Law* (February 2000).

¹⁰ NAIC Comment Letter re: Definition of Employer Under Section 3(5) of ERISA (Mar. 6, 2018).

discrimination, ERISA-covered AHPs, armed with the regulatory flexibility their promoters tout as a key feature, can use all of these factors and more to effectively exclude entire classes of beneficiaries with higher rates of illness and disease.

This flexibility likewise enables AHPs to structure their benefit designs and provider networks in ways that are inadequate to the needs of people with preexisting conditions. ERISA-covered AHPs are not subject to EHB requirements and therefore can exclude coverage for medically necessary prescription drugs or other medically necessary care for individuals with chronic conditions. And, because they are exempt from most network adequacy standards (including all federal network adequacy requirements for marketplace coverage), they may limit access to providers in a manner that causes beneficiaries to incur high out-of-network costs or forgo care.

ERISA-covered AHPs pose risks to the many consumers who do not enroll in them, too — risks exacerbated by a rule designed to encourage these arrangements to proliferate. By leveraging the regulatory advantages they enjoy, compared to individual and small group coverage, these products can siphon away healthy individuals from those markets. Indeed, as DOL knows, risk segmentation is very much the point. Of course, a consequence of this cherry-picking of risk is that the individual and small group markets are made smaller, and left with a larger proportion of individuals with preexisting conditions than they would have had otherwise. This, in turn, leads to higher premiums and the real risk of fewer plan choices for the people who depend on these markets to access comprehensive coverage.

All of these consumer risks were made far worse by the 2018 AHP Rule. We thank the Department for its attention to these dangers and support rescinding the rule.

Federal Regulators Should Codify Pre-2018 Standards for Evaluating Association Coverage

We appreciate the Department’s proposal to rescind the 2018 AHP Rule. We also support the proposed rule’s careful explanation of DOL’s pre-2018 approach to evaluating whether an association is bona fide under ERISA. We urge the Department to codify this longstanding guidance in regulation. We also request that DOL work with its counterparts at the Department of Health and Human Services to ensure codification of the longstanding “look through” approach to regulating association coverage under the PHS Act and the ACA.

Thank you for the opportunity to provide these comments. If you have any questions, please contact Bethany Lilly with The Leukemia and Lymphoma Society at bethany.lilly@lls.org.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association

American Kidney Fund
American Lung Association
Arthritis Foundation
Cancer Support Community
CancerCare
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Muscular Dystrophy Association
National Alliance on Mental Illness
National Bleeding Disorders Foundation
National Coalition for Cancer Survivorship
National Eczema Association
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Pulmonary Hypertension Association
The Leukemia & Lymphoma Society
WomenHeart