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March 6, 2018

The Honorable Preston Rutledge, Assistant Secretary
Employee Benefits Security Administration, U.S. Department of Labor
Room N-5655, 200 Constitution Avenue NW
Washington, D.C. 20210

RE: Definition of “Employer” Under Section 3(5) of ERISA – Association Health Plans (RIN 1210-AB85) – Commonwealth of Massachusetts Comments

Dear Assistant Secretary Rutledge:

We are writing on behalf of the Massachusetts Division of Insurance (DOI) and Massachusetts’s State-Based Marketplace (the Commonwealth Health Insurance Connector Authority or “Health Connector”) to offer comments in response to the Department of Labor (DOL) Notice of Proposed Rulemaking (NPRM) titled “Definition of ‘Employer’ Under Section 3(5) of ERISA-Association Health Plans” (83 FR 614). Together, our agencies serve as stewards of health insurance for 765,000 Massachusetts residents covered in Massachusetts’s “merged” nongroup and small group market, which includes over 245,000 Massachusetts residents covered through the Health Connector. We appreciate the DOL accepting comments on this proposed regulation and inviting dialogue with states on this topic.

I. Massachusetts Insurance Market Background

The Commonwealth of Massachusetts has a history spanning several decades of bipartisan, innovative health insurance expansion efforts and tailored approaches to regulating its health insurance market to meet local market needs and priorities. In the 1990s, Massachusetts implemented reforms requiring guaranteed issue coverage to small employers and also to individuals (nongroup). In 2006, Massachusetts enacted landmark health reform legislation that resulted in the highest rate of health

coverage in the nation – currently at 97.5%.¹ The Massachusetts model embodied a bipartisan spirit of shared responsibility, calling on consumers, employers, insurers, providers, and a state and federal partnership to join together to support coverage expansion. Starting in 2010, Massachusetts implemented the additional reforms of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act or ACA) and in 2012 enacted legislation to promote health care quality and cost-containment. Because of these efforts, the Commonwealth enjoys one of the most competitive health insurance markets in the country with nine carrier groups offering coverage, and residents' access to high-quality health coverage and care is strong. We were recently identified as the healthiest state in the nation by United Health Foundation.²

A unique feature of Massachusetts's insurance market, particularly germane to our comments on this proposed rule, is its merged market for individuals and small employers with 50 or fewer employees. Massachusetts merged its nongroup and small group markets in 2007, as part of the implementation of state health reform, such that rates are based on the collective experience of the merged market and the same health products are available on a guaranteed issue basis to all nongroup and small groups in Massachusetts. Over time, the merged market has evolved in Massachusetts to feature a blend of typical merged market characteristics and some remaining characteristics of a typical small group market– but importantly, it shares a common risk pool, ensuring greater stability and insurer participation for all.

Given these unique market features and long-standing experience overseeing our local health insurance market in a way that meets our residents' needs, we respectfully offer the following comments.

II. Massachusetts Comments

We have concerns about many features of the proposed regulation and the impact the final rule could have on Massachusetts's merged market, if adopted as proposed. Without active state regulatory oversight, we anticipate that the changes to the definition of "Employer" Under Section 3(5) of ERISA, as envisioned by the NPRM, will result in (1) weakening of consumer protections that have long been a hallmark of Massachusetts's health care market, (2) deterioration of our merged market's longstanding stability and competitiveness, (3) higher premiums for individuals and small groups in our merged market, and (4) increased consumer confusion, fraud, and insolvency.

For these reasons, we urge DOL to issue a final rule that clearly recognizes existing state government authority to regulate their local markets so as to prevent any degree of confusion among market participants. While we share the DOL's interest in promoting affordability of coverage for small employers, in Massachusetts, evidence suggests that rising premiums for small employers are driven by escalating unit costs, an area in which we are devoting resources and about which we welcome collaboration with federal partners. However, to the extent that there may be interest in changing

¹ U.S. Census Bureau, "Health Insurance Coverage in the United States: 2016" (Sept. 2017), at: www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf.

² United Health Foundation, "2017 Annual Report: America's Health Rankings" (Dec. 2017), at: https://assets.americashealthrankings.org/app/uploads/ahrannual17_complete-121817.pdf.

purchasing channels for small employer coverage, we believe those goals are best pursued by states in the context of insurance markets that are locally regulated and offer a level playing field. For example, Massachusetts has already developed an alternative state-based pathway to the Association Health Plan concept, allowing the formation of group purchasing cooperatives for small employers that are subject to state regulations and rules, thereby avoiding many of the concerns raised by the proposed regulation. States should retain this ability to serve as “laboratories of democracy,” crafting their own regulatory approaches to AHPs.

Massachusetts’s specific recommendations include:

1. The final rule should explicitly recognize states’ continued ability to regulate AHPs that take the form of Multiple Employer Welfare Arrangements (MEWAs), including regulating MEWA employer-participants at the participant level according to state law, thereby reducing any possible market confusion about continued state regulatory authority. Such state oversight is critical to market stability and preventing fraud, abuse, and insolvency.

Since the 1945 passage of the McCarran Ferguson Act (15 U.S.C. §§ 1011-1015), states have served as the primary regulators of the business of insurance, ceding to federal regulation only in specific instances designated by Congress. This understanding is preserved in the federal Employer Retirement and Income Security Act of 1974 and subsequent amendments (ERISA). Under ERISA § 514(b)(2), state laws that regulate insurance are “saved” from federal preemption. Consistent with this goal, Congress amended ERISA in 1982 to explicitly permit state regulation of MEWAs. Under ERISA § 514(b)(6), fully-insured MEWAs may be subject to any state insurance law governing reserve or contribution levels, and any requirements necessary to ensure compliance with those requirements, such as licensing. If the MEWA is self-insured, a state may regulate the plan under any state law not inconsistent with ERISA.

The Commonwealth of Massachusetts takes the firm position that nothing in the proposed rule limits this authority. As permitted by ERISA, state law expressly describes the state’s ability to regulate MEWAs, requiring insurance licensure of any entity offering health products through a MEWA. Additionally, MEWA health plans offered to small employers in Massachusetts are considered a “separate group health plan with respect to each employer maintaining the arrangement.”³ Under this state statute, the DOI has the authority to implement the insurance code with respect to AHPs where they are acting as MEWAs, including requiring these entities to register with the state, meet solvency requirements, and comply with merged market rating rules where applicable to AHP participants. Moreover, as described more fully below, state law requires any small group purchasing cooperatives to meet merged market insurance rules, except where limited rating flexibility has been granted by the Center for Consumer Information and Insurance Oversight and the Commonwealth.

Under previous 2011 guidance, it has been clear that Massachusetts could continue to apply state rules to MEWAs, reviewing the underlying facts and circumstances of the “employer” relationship to

³ Mass. Gen. Laws, ch. 176J, § 1.

determine whether it is “bona fide” in nature, as well as applying state merged market law to the individual employer-participants where applicable. These standards have been important in protecting Massachusetts consumers against the risk-redlining that could occur if out-of-state entities attempt to market coverage to Massachusetts employers that is not consistent with state coverage standards. It is thus important that Massachusetts and other states have the flexibility to define employer as best fits their own markets and that state laws continue to apply to all entities that provide health plans through AHPs to a state’s individuals and/or small employers.

Massachusetts is aware of historical instances of AHPs that attempt to circumvent state laws, capitalizing on perceived ambiguity to operate in the shadows of DOL and DOI oversight. Ample evidence suggests state oversight is critical to preventing fraud and abuse among MEWAs/AHPs, including in Massachusetts. Historically, there have been instances where certain consultants have promoted fraudulent health plans through AHPs, either through bona fide or phony professional associations, to unsuspecting consumers. Further, where states have not interceded in a timely fashion, AHPs have a long history of financial instability and insolvency, yielding instances where enrollees’ claims exceeded the association’s resources, exposing providers to unpaid claims and consumers to medical debt.⁴

While Massachusetts has prevailed over such predatory business practices in the past, this type of case-by-case enforcement is resource-intensive—often requiring engagement of multiple agencies as well as the state Office of the Attorney General over the course of many years—and it exposes consumers to considerable risk during the pendency of investigation and resolution. As such, there must be no room for ambiguity in the final rule. It is critical that states maintain broad authority to regulate AHPs in order to protect consumers, providers, and health insurance markets. State DOIs are positioned to limit the potential risks, including fraud, insolvency, and market segmentation, which may be associated with AHP proliferation. We urge DOL to issue a final rule that recognizes the importance of state-based regulation of AHPs so market participants are in no way unclear about ongoing state authority and market rules.

Recommendation: We urge DOL to include text, in the final rule itself as well as in the preamble, which clarifies that AHPs serving as MEWAs continue to be subject to state authority and oversight. In addition, if the final rule maintains the proposed expansion of the definition of employer, the rule should be clear that states may continue to apply their own local definitions of employer, as needed to enforce state insurance laws that may be more protective of consumers than federal law.

2. The final rule should clarify that AHPs may not engage in rating practices that are a pretext for discrimination on the basis of health status, deferring in instances of ambiguity to state insurance law.

⁴ See, e.g., “MEWAs: The Threat of Plan Insolvency and Other Challenges” (March 2004), at www.commonwealthfund.org/usr_doc/kofman_mewas.pdf.

The proposed rule explicitly prohibits AHPs from discriminating on the basis of health status, an important protection that we strongly support. However, the proposed rule also introduces the potential for discriminatory rating and benefit practices, if the currently proposed nondiscrimination standard is not strengthened and clarified.

At the outset, the rule is unclear about which nondiscrimination rules apply, referencing HIPAA nondiscrimination and ACA Section 1557 rules but failing to note other federal laws that act to bar health status nondiscrimination in the large group market, such as guaranteed issue and renewability; limits on coverage rescission, waiting periods, lifetime and annual cost caps; and appeals processes. The applicability of these and other large group standards to AHPs should be clarified in the final rule.

In addition, the rule should further clarify when an eligibility or rating standard would be considered impermissible discrimination based on health status. While we appreciate the examples listed in the proposed rule, we are concerned that the proposed rule may be read inappropriately to permit eligibility or rating requirements that operate as subterfuge for health status discrimination—such as unrestricted age rating, unrestricted industry or geographic rating, or gender rating in contravention of civil rights laws that would typically apply to employers. Moreover, the proposed rule does not state clearly enough that nondiscrimination standards apply to both the AHP itself and its member-employers. These issues should be corrected in the final rule.

Again, Massachusetts expects to continue to enforce its merged market rating rules to the full extent permitted under law—including applying prohibitions on health status rating at the member-employer level for MEWAs—but notes this potential for discrimination because it would require significant state resources to stamp such practices out.

Recommendation: We support DOL's prohibition on health status discrimination, but seek clarification as to how this prohibition would be applied to prevent population-based redlining. In addition, as described above, there should be no ambiguity regarding states' authority to continue to enforce state rating practices at the employer-participant level.

III. Market Impact if Recommendations Not Adopted

1. The proposed rule could increase premiums by over 10% in the first year alone, with additional premium increases to follow. These premium increases could increase federal expenditures.

The concerns identified above are not speculative. Given Massachusetts's concerns with the proposed regulation and AHPs' long history of risks to consumers and destabilizing impact on state insurance markets, our agencies engaged an independent actuarial firm, Oliver Wyman, to evaluate premium impact to our merged market if AHPs not clearly subject to state regulation were to be introduced in Massachusetts.

The results indicated that merged market premiums could rise by over 10% next year alone due to over 40% of the state's lower-risk small businesses exiting the market, with additional premium increases to follow in later years. This downward spiral could be exacerbated by any number of factors, in some instances escalating to as much as a 15% increase in merged market premiums within the next year.

This is a most concerning possibility. It is inconsistent with DOL's stated goals of bringing affordability and competition to small employers, and it is certainly inconsistent with our guiding principles for the Massachusetts insurance market. Moreover, any premium increase resulting from these higher premiums would be expected to increase federal outlays for advance premium tax credits available to eligible low-income members through the Health Connector, given our merged market and shared risk pool. DOL should reconsider the implementation of any action that would have such a deleterious impact on state insurance markets and lead to higher federal liability.

2. State-specific market features underscore the critical need for local flexibility and independent state authority.

The risk of negative impacts to Massachusetts residents is heightened by singular features of the Commonwealth's insurance market that demonstrate the need for continued state management of local health insurance markets.

In Massachusetts, our nongroup and small group markets share a merged risk pool, meaning that the expected premium impact that AHPs would introduce to our small group market, without continued independent state regulation, would not only affect 455,000 Massachusetts residents covered through small employers in the merged market, but also 310,000 nongroup market participants, including over 245,000 individuals enrolled in coverage through the Health Connector. Of that population, approximately 200,000 are obtaining federal advance premium tax credits, which as noted above would be expected to increase with any premium increases resulting from market destabilization, increasing federal outlays.

In addition, Massachusetts's health care reform law includes a state individual mandate, in effect since July 1, 2007, which provides standards for the coverage that adult residents are required to carry in order to avoid a possible penalty via the state income tax process. Coverage that meets Massachusetts Minimum Creditable Coverage (MCC) requirements must include critical benefits like maternity care, prescription drug coverage, mental health services, etc.⁵ MCC rules also stipulate that a plan cannot be considered MCC if it includes annual caps on spending or if cost-sharing exceeds state standards. These state standards have been essential to Massachusetts's success in achieving near-universal coverage. However, to the extent that AHPs attempt to enter the Massachusetts market with subpar coverage, these entities could expose unknowing consumers to state tax penalties. In Massachusetts's regulated insurance market, the DOI and Health Connector have been able to minimize this risk

⁵ For more information on the Commonwealth's Minimum Creditable Coverage standards, see www.mahealthconnector.org/wp-content/uploads/rules-and-regulations/956CMR5.00.pdf.

through regular communication with market participants about the kind of coverage that satisfies the individual mandate and MCC. To the extent that national AHPs attempt to operate outside of this local framework, they may increase the risk of confusion and penalties for Massachusetts residents who inadvertently select AHP coverage that does not meet MCC.

IV. Alternatives to Federal AHP Proposal that Better Address Risks

Massachusetts harbors no objection to the concept of small group purchasing arrangements where purchasing collectives are subject to all the same market rules and do not foster confusion for market participants. As noted above, Massachusetts respectfully offers for DOL's consideration an example from Massachusetts's market that shows how small group purchasing cooperatives can be facilitated without creating unequal playing fields and risking market segmentation, destabilization, and weakening of consumer protections. State group purchasing cooperatives, a local variation of AHP coverage, mitigate some of the concerns traditionally associated with AHPs via state oversight and protections. To the extent DOL promulgates final rules without incorporating Massachusetts's suggestions, we ask that DOL consider allowing states with alternative forms of small group purchasing to waive out of the federal AHP concept outlined in the proposed rule.

By way of background, these "small business group purchasing cooperatives" (or "cooperatives") were introduced in Ch. 288 of the Acts of 2010 in response to employer stakeholder interest in leveraging greater health insurance purchasing power for small employer groups. Employer stakeholders sought an opportunity to negotiate with insurers for less costly coverage. The legislation passed by the state Legislature recognized this interest, but balanced it with provisions intended to protect consumers and maintain the integrity of the merged market.

The state law authorized the creation of up to six small business group purchasing cooperatives, three of which are currently operating today. With the exception of a carefully managed premium rating discount, these cooperatives must follow the same insurance market rules that apply to small groups to ensure that the cooperatives do not draw selectively draw younger/healthier groups away from the merged market, thereby driving up premiums for the older/sicker groups that remain. These cooperatives must also offer wellness benefits and follow other rules designed to address the Commonwealth's policy goals. (See *Appendix A*).

Importantly, to the extent that the needs of Massachusetts's small employers change, the Commonwealth has the opportunity to adjust its statutory framework to meet these needs. For example, the state Legislature has considered bills in recent years to expand the number of employers eligible to participate in these cooperatives, or permit similar entities to form cooperatives via professional employer organizations. In each instance, the state Legislature has considered the merits and made decisions in light of local market considerations. Similarly, our agencies have engaged for several years in successful dialogue with federal agencies to ensure a stable approach to premium discounts associated with the state cooperatives.

Massachusetts expects that these locally-driven strategies can continue to operate in lieu of the proposed AHP changes, and urges DOL to consider that states are best equipped to consider such alternatives. In the event that DOL fails to accept our other recommendations, we suggest that the final rule should, at minimum, give states a pathway to opt out of the federal framework where the state can demonstrate that an alternative form of small group purchasing is in place.

Recommendation: We suggest that the final rule recognize states' ability to implement their own state-specific variations of association coverage. In the event that DOL fails to accept our other recommendations, we suggest that the final rule should, at minimum, give states a pathway to opt out of the federal framework when the state can demonstrate that an alternative form of small group purchasing is in place. Massachusetts suggests that this could take the form of a state waiver process.

V. Effective Date of Any Proposed Rule

Whether or not the DOL promulgates final rules that incorporate Massachusetts's suggestions, we ask that the DOL consider delaying the effective date of this rule until at least 2020. Merged market carriers are in the midst of developing rates for the 2019 calendar year and any effective date prior to 2020 will significantly impact the 2019 rates that carriers will submit for state review. Delaying the effective date of any such rules until 2020 will enable states to work with carriers about the appropriateness of assumptions to be used in 2019 rate filings.

Thank you for the opportunity to comment on these proposed rules. The Commonwealth of Massachusetts stands ready to assist if we can be of service in further developing these comments to meet shared goals of a stable insurance market that meets the needs of small employers.

Sincerely,



Gary D. Anderson
Commissioner
Massachusetts Division of Insurance



T. Louis Gutierrez
Executive Director
Massachusetts Health Connector

Appendix A: Comparison of State and Federal Employer Purchasing Models

Element	MA Small Group Purchasing Cooperatives	Federal AHPs, if Concurrent State Jurisdiction Is Restricted or Ambiguous in Final Rule
Purchasing power	Allows small groups to band together to collectively negotiate with insurers	Allows small groups to band together to collectively negotiate with insurers
Guaranteed availability	Must offer coverage in accordance with guaranteed issue/renewability, and without pre-existing condition exclusions	Unclear whether prohibition on health status nondiscrimination would require guaranteed availability and prohibit pre-existing condition exclusions
Benefits	Must offer Essential Health Benefits and all state-required benefits	Not required to meet Essential Health Benefits or most state benefit requirements
Rating rules	Must meet state rating rules, except for allowable cooperative discount negotiated with insurers and overseen by the state	Other than prohibition on health status rating, can charge different populations different rates
Network access	Must meet state network adequacy requirements and other state rules, such as those encouraging cost-saving network structures	Not subject to state or federal network adequacy rules
General oversight	Must register with state DOI and subject to all state insurance laws, including licensure and solvency requirements	Must register with federal DOL, though particular standards are unclear