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Definition of Employer Under Section 3(5) of ERISA-Association Health Plans

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Definition of Employer Under Section 3(5) of ERISA-Association Health Plans

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General Comment

My firm is a 40 year Insurance specific technology company and Third Party Administrator of health plans as well as a licensed health insurance agency. Fortune names our firm as one of the top 100 fastest growing companies in 2017 and Forbes calls us #6 fastest growing tech firm in the US. Our firm supports numerous verticals for their benefit needs, i.e. financial organizations and businesses, blue collar, ethnic and social specific (LGBT), Medical professions, engineering, etc.

The association health plan strategy is a great strategy to help improve the current state of benefits especially to small businesses and for individuals. We support 100% the small employer component and we represent potentially 30 million members of organizations that can form associations or are already associations who desire to take advantage of an AHP branded under their association and powered by the top health carriers nationally. The branded affiliation is key to growing member base.

Our biggest concern lies with the many associations who desire to leverage an AHP, but are more of an "individual" member association and not an association of small businesses.

Our request and comments are the following 3 statements:

(1) Stay the course with current design for AHPs as a result of small businesses forming under one.

(2) Add to the order: Most important addition needed to the Executive order is to allow members of an association who have the relationship tie of ALL being a member in good standing of the association to also qualify for that association's benefits. For example, an LGBT Association who all share the common tie of LGBT, some of which may be small business owners, but most are just individual members should also be able to form an association and qualify to have their own AHP accordingly. This should also be formed WITHOUT state geographical lines being drawn and instead allow for a national association. The health carrier(s) sponsoring these plans may be a national carrier OR be required to be regional and state by state. Either will work.

(3) Do not hold the Association financially liable for the health benefits produced meaning if a carrier defaults on a plan or files bankruptcy the association guidelines and operating practices agreed to and signed by the members would not hold the association liable for any healthcare related costs to its members so in short the AHP WOULD NOT be structured as a self- funded design. The AHPs MUST stay fully funded, paid for by each member monthly as a group health plan and all risk is held by the health carrier(s) and/or the re-insurer. It would however be required by the association management to procure another health carrier and AHP to replace a plan that terminates, provide a Short Term Medical alternative or perhaps a COBRA designed fail over to another carrier and to offer in some capacity the ability for the association members in this situation to purchase "individual" health plans.