Wisconsin Medical Society
Your Doctor. Your Health.

March 1, 2018

Office of Regulations and Interpretations
Employee Benefits Security Administration
Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
Attention: Definition of Employer – Small Business Health Plans RIN 1210-AB85

RE: Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans; RIN 1210-AB85

Comprised of more than 12,800 physicians, residents and medical students, the Wisconsin Medical Society (Society) is the largest association of medical doctors in Wisconsin. It is our mission to improve the health of the people of Wisconsin by supporting and strengthening physicians' ability to practice high-quality patient care in a changing environment. One way the Society achieves this mission is through providing health insurance coverage for our members via our association health plan (AHP) offered under our Wisconsin Medical Society Welfare Benefit Trust (Trust). Given this interest, the Society, on behalf of the Trust, appreciates the opportunity to offer comments to the Department of Labor (DOL) regarding proposed rule RIN 1210-AB85.

The proposed rule would change the definition of "employer" under Section 3(5) of the Employee Retirement Income Security Act (ERISA), for the purposes of allowing employers to form and join AHPs. The rule as it is proposed significantly impacts the operations of the Trust and its member physicians who obtain insurance through the Society's bona-fide AHP.

The proposed rule attempts to expand the use and utility of AHPs, and offer employers a means to acquire and provide health insurance to their employees and their families. The Society applauds DOL's efforts to increase the availability of affordable coverage for small businesses. However, the changes in the proposed rule would disrupt and threaten the Trust's ability to continue to provide coverage to its members through its AHP. Chief among the concerns of the Society and the Trust are: the rule's pricing components, lack of a transition period and/or grandfathering status, confusion regarding the preemption of federal and state law, and the potential weakening of patient protections. Regarding these concerns, the Society submits the following comments on changes to 29 CFR Part 2510, RIN 1210-AB85.

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History of the Society's Association Health Plan
The Society has a long history in health insurance for our members. In 1946, the Society founded Wisconsin Physician Service (WPS), which operated as a component of the Society until 1977. From 1977 to the passage of the Affordable Care Act (ACA), Society members, their employees and families had access to a unique health plan designed for the Society. With the adoption of the ACA, the Society reorganized its health plan to ensure compliance with DOL's bona-fide association health plan rules. The Wisconsin Medical Society Association Health Plan Trust launched on July 27, 2016, with 2017 being its first plan year under the new ACA structure. As of March 1, 2018, the Trust's AHP covers 1,136 people from 22 unique employers with 433 total employees. The Society's AHP allows small practice physicians to acquire and provide coverage to their employees and their families. In doing so, it allows small practices to compete with larger groups to attract and maintain quality physicians.

Pricing Components and Nondiscrimination Provisions
The ability to appropriately price participating employers in an AHP is critical to its financial solvency and its ability to offer affordable coverage to its members and their employees. Each employer applying for participation in an AHP needs to be accurately priced so that the AHP can assess the appropriate level of risk for all participants. The proposed rule would circumvent the risk assessment process through its nondiscrimination provisions. In doing so, the proposed rule would harm the competitiveness of existing bona-fide AHPs by prohibiting them from accurately assessing the risk of current and new AHP members. The proposed nondiscrimination provisions threaten the financial stability of existing AHPs and create structural issues that could lead to future insolvency.

The proposed rule's nondiscrimination provisions would effectively remove an AHP's ability to price the risk of employer members looking to join. The Society recognizes and appreciates DOL's efforts to ensure that those wishing to obtain insurance coverage are not unfairly discriminated against, and can obtain access to coverage. The Society's AHP has never, and will never deny coverage to members and their employees who wish to participate. Nor does our AHP deny coverage on the basis of any pre-existing conditions or health factor as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), or the Affordable Care Act (ACA). Our AHP is a valuable service that we created to provide our members and their employees with access to affordable and adequate insurance.

However, the Trust's ability to provide coverage that is both affordable to our members and financially responsible is contingent upon our ability to individually price each member group. The success of an AHP depends upon its ability to accurately assess the risk of its individual component parts (participating employers), otherwise it risks failure and insolvency, hurting not just the AHP itself, but its members and ultimately their employees. Large group private insurers apply the same practice when pricing and offering insurance products to businesses. In its current form the non-discrimination provisions of the proposed rule place existing and future AHPs at a structurally competitive disadvantage with large group insurers and plans offered on the health insurance exchanges. Further, the new and restrictive nature of the proposed nondiscrimination provisions hinders the rule's intent to expand access to fiscally responsible AHPs.

To remedy this issue, the Society proposes that DOL modify its proposed rule to allow AHPs to accurately price the risk of their component participating employers, and avoid financial insolvency. The Society supports efforts to ensure that no one is denied coverage due to a pre-existing condition and supports existing patient protections as defined by the ACA. AHPs can be a way for small businesses to acquire adequate coverage, but they are of no use if the plans they purchase are not financially sound

and viable. In order to maintain a viable and competitive environment for AHPs, DOL should ease its nondiscrimination requirements, specifically as proposed in §2510.3-5(d)(4) and §2510.3-5(d)(5) Example 4. Rather, the Society proposes that DOL adopt language and requirements similar to 29 CFR 2590.702(c)(2)(iii) Example 1. In doing so the Society holds that patient protections and nondiscrimination requirements will be maintained, while allowing existing AHPs to accurately and appropriately price the risk of participating members.

Effective Dates and Transition Periods

The proposed rule makes note that its provisions will be effective immediately upon its implementation with no transition periods or grandfathering exemptions. This puts the Society and its AHP in an untenable position in that our AHP could be immediately out-of-compliance with the enactment of the new regulations. The Society proposes that DOL incorporate either a transition period to allow existing AHPs to change their structure to comply with the new rules or create a "grandfathering" exemption for existing AHPs so they can remain operational.

In creating a transition period, the Society suggests that DOL allow existing AHPs to have a minimum of three years from the implementation date to become compliant with the new regulations. Such a transition will provide existing AHPs an opportunity to evaluate their business model and comply with the new regulations. As it pertains to a "grandfathering exemption," the Society recommends that DOL consider an effective "grandfather" date of December 31, 2017. This date will allow existing bona-fide AHPs to remain operational while at the same time prohibit new AHPs from forming under the old regulations. The Society urges DOL to consider both the transition and grandfathering suggestions to help existing bona-fide AHPs maintain compliance and operation.

Preemption of State and Federal Laws

The proposed rule mentions that DOL is soliciting comments on how it should apply and define geographic and metropolitan areas where an AHP could operate in multiple states (e.g., New York City and Kansas City). The rule makes note that it would allow a given AHP to operate in multiple states where a defined metropolitan area exists. However, the rule is unclear on the extent to which federal preemption would alleviate traditional barriers to providing insurance across state lines. Would an AHP operating in a geographic or metropolitan area in multiple states be required to comply with regulations of each state or only one state?

Of particular concern is the issue of self-insurance. Multiple states, including Wisconsin, currently prohibit AHPs from self-insuring. In a situation where competing AHPs are operating in a defined geographic or metropolitan area, a plan that is domiciled in a state that does not allow self-insurance would be at a competitive disadvantage with a plan that is domiciled in a state that does allow self-insurance. Further, the lack of guidance on preemption could create a potential "race to the bottom," and an uneven playing field and risk selection,[1] whereby less robust AHP products are offered to members[2] while creating the potential for AHPs to "cherry pick" its members.[3]

To alleviate these concerns, the Society recommends that DOL include in its guidance that AHPs operating in multiple states abide by the regulations of the state in which the plan is being utilized, and not the state in which the plan is domiciled. Under this condition, an AHP would have to abide by the

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[1] American Academy of Actuaries, March 8, 2017, https://www.actuary.org/files/publications/AHPs_HR1101_030817.pdf.

[2] Katie Keith, "The Association Health Plan Proposed Rule: What It Says And What It Would Do" *Health Affairs*, January 5, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180104.347494/full/.

[3] National Association of Insurance Commissioners, February 28, 2017, http://www.naic.org/documents/health_archive_naic_opposes_small_business_fairness_act.pdf.

regulations of each state in which the plan operates. The Society also urges DOL to consider having its rule preempt state insurance regulations in states that would otherwise prohibit the operation of self-insured AHPs. Doing so is necessary to allow AHPs from states that do not otherwise permit self-insurance to compete on a level playing field with AHPs from states where self-insurance is allowed. The Society also suggests that DOL consider limiting the scope of its proposed AHP changes to allow plans to operate only in an intrastate, but not an interstate manner.

Patient Protections

A principal argument for easing the regulations on AHPs is that it would allow potential members to acquire lower-priced insurance coverage than can be found through the individual marketplace or group market. The Society supports efforts to expand access to coverage and create robust competition in the broader insurance market. However, the Society is concerned that AHPs could be used as a vehicle to circumvent the patient protections provided by the ACA. Prominent associations such as the Society and its Trust are governed by their members and would not risk their reputation or membership value by offering inferior or inadequate insurance plans. Associations like the Society, which exist for reasons other than insurance, have a vested interest in maintaining the patient protections necessary to care for their members, their employees, and their families. However, the Society recognizes that not all actors pursuing AHPs may be as judicious and instead may pursue risk arrangements and benefit plans that are not as comprehensive or adequate. The Society cares deeply about the health and well-being of all patients and does not want patients acquiring inadequate coverage that may compromise the level of care they seek and need. The Society urges DOL to maintain and codify in its proposed rule the patient protections of the ACA, so that coverage is at least as adequate and affordable as stipulated by the ACA as of December 31, 2017. This includes, but is not limited to coverage for pre-existing conditions, community rating provisions, guaranteed issue, and no caps on coverage.

The Society thanks DOL for the opportunity to comment on the proposed changes to 29 CFR Part 2510, RIN 1210-AB85. We look forward to being a partner in creating an environment where AHP members can continue to acquire adequate and affordable coverage for their employees and their families.

Sincerely,

Clyde "Bud" Chumbley, MD
CEO Wisconsin Medical Society