michigan dental
ASSOCIATION
YOUR CONNECTION TO ORAL HEALTH

March 6, 2018

Submitted Electronically via: ***www.regulations.gov***

Office of Regulations and Interpretations, Employee Benefits Security Administration
Attn: RIN 1210–AB85
Room N–5655
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

RE: Comments on Proposed Regulations to Facilitate the Formation of Small Business Health Plans

To Whom It May Concern:

The Michigan Dental Association ("MDA") respectfully submits these comments in response to the Notice of Proposed Rulemaking ("NPRM"), clarifying the definition of "employer" under Section 3(5) of the Employee Retirement Income Security Act ("ERISA") for purposes of establishing a "Small Business Health Plan" ("SBHP"). The MDA is supportive of the Department of Labor's (the "Department") efforts to provide more flexibility so small employers and self-employed individuals with no employees (referred to as "working owners") can form SBHPs. However, one of the Department's proposals – if finalized – would have a devastating impact on existing health plans like the MDA's Michigan Dental Health Plan Trust (the "MDA Health Plan"), a self-insured group health plan through which we offer health coverage to our dentist members, their employees, and dependents.

Importantly, the MDA is currently considered a "bona fide group or association of employers" as defined under existing Department guidance. The proposed modifications to the "commonality of interest" test would *not* change the MDA's status as a "bona fide group or association of employers" for purposes of ERISA. However, one of the proposed "nondiscrimination protections" – the prohibition on developing different premium rates for different employer members of an SBHP based on "health claims experience" – would place a significant strain on the MDA's ability to provide quality and affordable health care to our dentist members, their employees, and dependents. Put more bluntly, this proposed nondiscrimination protection would likely force the MDA Health Plan into insolvency, thus requiring the MDA to discontinue our group health plan coverage; a result we do not believe the Department intends.

The below comments discuss the various nondiscrimination protections included in the NPRM, focusing specifically on why the MDA believes that the inability to "experience-rate" employer members (i.e., develop different premium rates for different employers members)

3657 OKEMOS ROAD • SUITE 200 • OKEMOS MI 48864-3927 • 517.372.9070 • FAX: 517.372.0008 • MICHIGANDENTAL.ORG

would adversely impact the MDA Health Plan. We respectfully request that the Department *remove* this proposal from the final regulations.

I. The Proposed Nondiscrimination Protections

The proposed regulations establish four different nondiscrimination protections applicable to SBHPs. If an "employer group" fails to satisfy any of these nondiscrimination protections, the group would fail to be considered a "bona fide group or association of employers," even in cases where the employer group satisfies the "commonality of interest" and "control" tests.

A. The Nondiscrimination Protection Under Subsection (d)(1) – Participation In an "Employer Group" Cannot Be Denied Based on a "Health Factor" of an Employee or Working Owner

Under the first proposed nondiscrimination protection, an employer group cannot refuse other employers and/or working owners from participating in the group (and by extension participating in an SBHP) on account of any "health factor" of an employee, a former employee, or the working owner.

The MDA is supportive of this nondiscrimination protection, and this is a practice that MDA adheres to today. That is, eligibility for membership in the MDA is based on whether the prospective member is a dental office operating in the State of Michigan. We do *not* base eligibility in the MDA on any health factor of the dentist or his or her employees (if any). Similarly, the MDA Health Plan provides health coverage to any dentist members, their employees, and dependents that are interested in enrolling in the plan, irrespective of any health factor.

B. The Nondiscrimination Protections Under Subsections (d)(2) and (d)(3) – Eligibility for Benefits and Premiums Cannot Vary Based on a Particular Participant's "Health Factor"

Under the second and third proposed nondiscrimination protections, the premiums for SBHP health coverage – and eligibility for benefits covered under the plan – cannot vary based on a particular participant's health factor.

We are also supportive of these nondiscrimination protections, and the MDA Health Plan already complies with these rules today. As the Department knows, these are requirements that currently apply to existing group health plans. And as a group health plan, the MDA Health Plan does *not* develop premiums or define eligibility for benefits based on any health factor of a particular plan participant.

C. The Nondiscrimination Protection Under Subsection (d)(4) – Premiums for a Particular Employer Member Participating In an SBHP Cannot Vary By a "Health Factor" of an Employee

The fourth proposed nondiscrimination protection provides that an employer group "may not treat member employers as distinct groups of similarly-situated individuals." This essentially means that an employer group sponsoring an SBHP cannot develop different premium rates for different employer members based on the health claims experience of the employer members (i.e., the SBHP *cannot* experience-rate its employer members).

The MDA urges the Department to remove this proposal from the final regulations. As stated above, we believe that this proposed nondiscrimination protection would force the MDA to discontinue the MDA Health Plan. A result we do not believe the Department intends.

1. *Allowing Experience-Rating Would Not Render the Nondiscrimination Protections Ineffective*

In the preamble of the proposed regulations, the Department explains that if an association could treat different employer members as different bona fide employment classifications, the first three nondiscrimination protections discussed above could be ineffective, as SBHPs could offer membership to all employers meeting the association's membership criteria, but then charge specific employer members higher premiums based on the health status of those employers' employees and dependents. The MDA strenuously disagrees that treating employer members differently based on health claims experience would render the above stated nondiscrimination provisions ineffective.

With respect to prohibiting employer groups from denying membership based on any health factor of a prospective employer member's employees (as set forth under subsection (d)(1)), we do *not* believe that this nondiscrimination protection would be rendered ineffective if an SBHP could develop premiums based on health claims experience. Rather, in cases where a prospective employer member may employ employees who utilize a significant amount of health care (i.e., a "high-medical-utilizer"), due to the fact that this employer *cannot* be denied membership in the employer group because of these high-medical-utilizers, this employer may benefit from joining the group by finding more affordable health coverage through the SBHP (even in cases where the SBHP experience-rates its premiums).

More affordable premium rates will likely be available to an employer with high-medical-utilizers because – on account of experience-rating – the SBHP will be able to attract employer members with "healthy" employees (by offering these employers a lower premium rate). The fact that these healthy risks may now be a part of the SBHP, these healthy risks are able to offset the exposure the high-medical utilizers may pose to the risk pool. This allows the SBHP to develop competitive premium rates for the employer with high-medical-utilizers, notwithstanding the fact that this employer's premiums may be higher than employer members with healthy employees. In other words, by allowing an SBHP to develop different premiums for different employers, the SBHP will be able to offer competitive premium rates that *both* employers with healthy employees *and* employers with high-medical-utilizers may find attractive, which not only benefits the employer member (from a financial perspective), but also its employees (especially those employees who may be high-medical-utilizers because they may now have access to affordable and quality health coverage).

With respect to the prohibition against varying premiums and eligibility for benefits based on any health factor, as the Department knows – currently – self-insured and fully-insured "large group" health plans develop their premium rates based on experience-rating. And, the current law prohibition against varying premiums or eligibility for benefits based on any health factor of a particular participant is in *no* way rendered ineffective by virtue of the existing experience-rating practice. In other words, the current practice of developing premiums based on health claims experience – which is universally adopted by self-insured and fully-insured "large group" plans – does *nothing* to change or inhibit the effectiveness of the current law requirements that premiums and eligibility for benefits cannot be different for particular participants based on any health factor. Allowing employer groups sponsoring an SBHP to engage in the practice of experience-rating will similarly do *nothing* to change or inhibit the effectiveness of the nondiscrimination protections set forth in subsections (d)(2) and (d)(3).

2. *Allowing Experience-Rating Would Not Undermine the Status of a "Single-Employer Plan" Nor Would It Conflict With the Requirement To "Act In the Best Interest" of Employees*

In the preamble of the proposed regulations, the Department seems to believe that if an SBHP is able to develop different premiums for different employers based on health claims experience, this would undermine the status of the SBHP being considered a "single employer plan." The Department's belief appears to stem from its concern that by allowing employer-by-employer risk-rating, SBHPs would simply devolve into commercial-type-insurance entities that are no different from commercial insurance carriers under-writing risk. In this case, the Department feels that this result is too far removed from ERISA's statutory aim of limiting plan sponsors to employers "acting in the best interest" of their employees.

The MDA disagrees with the Department's view. The MDA is an employer member organization that has sought to be considered a "bona fide group or association of employers" so the MDA Health Plan can be treated as a "single employer plan." As the Department knows, to be considered "bona fide," the health plan sponsored by the employer group *must* be "controlled" by its employer members. In the case of the MDA and the MDA Health Plan, our members actively "control" the Plan through a Board of Trustees made up of employer members that are elected by all of the employer members participating in the Plan.

Importantly, these employer members "act in best of interest" of their employees in accordance with ERISA's fiduciary responsibilities. And, contrary to the Department's belief, developing different premiums for each employer member based on their health claims experience is actually done in furtherance of "acting in the best interest" of the employees covered under the MDA Health Plan. For example, if the MDA Health Plan did not develop different premium rates for particular employer members, the MDA Health Plan would likely go insolvent, and the employees currently covered under the Plan would lose their health coverage.

As a result, to ensure that affordable and quality health coverage is consistently made available to employees of MDA employer members, the MDA Health Plan is required to experience-rate employer members to maintain its solvency. In our opinion, pursuing policies that would ensure the long-term viability of the MDA Health Plan is by definition "acting in the

best interest" of employees participating the Plan because, again, without experience-rating, MDA would no longer be able to offer health coverage.

In addition, by experience-rating different employer members, the MDA Health Plan is able to attract employer members with "healthy" employees who are then able to offset the health risks associated with high-medical-utilizers. This means that high-medical-utilizers can enjoy a competitive premium rate for affordable and quality health coverage, which is in no doubt in these employees' "best interest." And, healthy employees can also enjoy a competitive rate relative to the existing small group market, which again, is in these employees' "best interest."

3. *Allowing Experience-Rating Would Not Result In SBHPs Operating Like Commercial-Insurance-Type Entities*

Related to the above discussion, the Department makes clear that it is concerned that SBHPs may serve as commercial-insurance-type arrangements, as opposed to employer-based arrangements. Actually, the Department appears to justify the development of the prohibition against experience-rating on its belief that by allowing SBHPs to risk-rate employer members, the SBHP would be akin to a commercial insurance carrier. But, as discussed above, because an employer group sponsoring the SBHP will have a "common bond" – along with the requisite "control" over the SBHP – even if the SBHP engages in experience-rating, this practice will in no way corrupt the SBHP, because the employer members sponsoring the plan will continue to "act in the best interest" of their employees receiving coverage under the SBHP. And, as discussed more fully below, allowing SBHPs to develop different premium rates for different employer members (1) will ensure that SBHPs are sustainable over the long-term, (2) it will prevent existing SBHPs from going insolvent, and (3) it will encourage the formation of new SBHPs.

4. *SBHPs Would Be Placed At a Competitive Disadvantage If SBHPs Cannot Develop Different Premiums for Different Employer Members*

In our opinion, it does not appear that the Department understands the competitive nature of providing health insurance. Without the ability to experience-rate employer members, SBHPs will be placed at a competitive disadvantage relative to commercial insurance carriers.

It also appears to us that the commercial insurance carriers have argued the opposite – that they would be the entities placed at a competitive disadvantage if SBHPs were permitted to develop different premiums for different employer members. We come to this conclusion based on how the ACA reformed the "small group" market. As the Department knows, the ACA small group market reforms prohibit the development of premiums based on the health claims experience of a small employer. Instead, premiums for small group plans may only vary by age, tobacco, geography, and family size.

It is our belief that the commercial insurance carriers argued that if SBHPs were able to engage in employer-by-employer risk-rating (which the ACA prohibited for these commercial carriers), then SBHPs would be able to market their health coverage to small employers, and

unfairly gain market-share to the detriment of the commercial insurers. In response, it appears that the Department developed a nondiscrimination protection that essentially mirrors the premium rating practices now permitted in the ACA's newly reformed small group market (i.e., *no* employer-by-employer risk-rating).

But ironically, in an attempt to ensure that SBHPs are subject to similar premium rating practices as commercial carriers in the small group market, the Department is detrimentally impacting existing SBHPs, and calling into question whether SBHPs will be formed in the future. This is due in large part to the fact that commercial insurance carriers have greater scale relative to SBHPs. In other words, SBHPs can only cover a finite number of "lives" under their plan. Which means, the risk pool of SBHPs are going to be small relative to commercial carriers who have access to a much greater number of lives on account of under-writing coverage for small employers that are not part of a "bona fide group or association of employers."

For example, the MDA Health Plan covers 4,000 lives. The number of lives in the State of Michigan's small group market appears to be in the millions. Importantly, one commercial insurance carrier holds a large majority of the market-share in Michigan's small group market, which means that this dominant carrier has a much bigger risk pool of employees of small employers compared to the MDA Health Plan (e.g., hundreds of thousands of lives compared to 4,000 lives). Even those commercial carriers who have a smaller percentage of the market-share in Michigan's small group market will also have a bigger risk pool relative to the MDA Health Plan.

As a result, if the MDA is not permitted to develop different premium rates for different employer members, the MDA Health Plan would not be able to compete with these commercial insurance carriers because we would not be able to attract enough lives – especially "healthy" lives – to create a sustainable risk pool. Instead, the MDA Health Plan's risk pool would likely deteriorate as these commercial carriers will likely reduce their premium rates as a means to coax away MDA Health Plan employer members. In our opinion, the current commercial insurance carriers operating in Michigan's small group market are in a superior position because most if not all of these carriers can sustain losses – as they increase their own market-share – and make up for these losses over the long-term due to their sizable reserves. A luxury that the MDA Health Plan does not enjoy.

Even if SBHPs become the preferred choice for health coverage among small employers in a particular State's small group market, we do *not* believe that the ability to experience-rate employer members will result in "cherry-picking" small employers with good health risks over small employers employing high-medical-utilizers (a scenario that it appears the Department is trying to prevent through the development of this nondiscrimination provision). This is because the SBHP – as an employment-based arrangement – will be "acting in the best interest" of its employer members and their employees, taking the necessary steps to provide affordable and quality health coverage to each and every employer member (who, as discussed above, cannot be denied membership in an employer group because of their employees' health status).

In other words, an SBHP is not going to "price" its employer members out of the SBHP coverage, thereby leaving small employers with high-medical-utilizers to the commercial

insurance carriers. Instead, SBHPs are going to balance the health risks covered under their plan in such a way where the premium rates work for both small employers with healthy employees and small employers with high-medical-utilizers.

5. *The Department Is Expanding the Criteria That Must Be Met to Be Considered a "Bona Fide Group or Association of Employers"*

The Department asks whether this particular nondiscrimination protection represents an expansion of current regulations. We answer this question in the affirmative. For example, under the Department's existing guidance, to be considered a "bona fide group or association of employers," the group of employers must meet both the "commonality of interest" and the "control" tests. While the proposed regulations modify the "commonality of interest" test, the proposal does not change the requirement that these two tests must be met to be considered "bona fide."

However, as stated above, the proposed regulations provide that the consequence for failing to satisfy this particular nondiscrimination protection is the failure to be considered a "bona fide group or association of employers," even in cases where the employer group satisfies the "commonality of interest" and "control" tests. As a result, an argument can be made that by imposing this nondiscrimination provision, the Department is creating a third "test" that must be met in order to be considered a "bona fide." Whether this is an inadvertent – or intended – result, this additional criteria will have an adverse effect on existing employer groups – like the MDA – sponsoring an SBHP. It is highly likely that this additional criteria will also discourage SBHP formation in the future.

***

Thank you in advance for considering these comments. Please do not hesitate to contact me with any questions, or if I can serve as a resource on these very important issues.

Sincerely,

Craig A. Start

Craig Start