March 3, 2018

Office of Regulations and Interpretations
Employee Benefits Security Administration
United State Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

ATTN: Definition of Employer – Small Business Health Plans—RIN 2010-AB85

On behalf of TriNet, we appreciate the opportunity to provide comment on 29 CFR Part 2510, RIN 1210-AB85, the department's proposed rule addressing the definition of employer under section 3(5) of ERISA – Association Health Plans. TriNet agrees with the administration's stated position that Association Health Plans (AHPs) have the potentialto help reduce the overall cost of health coverage for small to mid-size businesses by placing small businesses on equal footing with large businesses. In concept, Association Health Plans (AHPs) have the potential to help reduce the overall cost of health coverage for small to mid-size businesses while simultaneously ensuring that health coverage "spend" provides more benefit for every dollar. Through proper clarification of existing ERISA law, AHPs will allow groups of employers increased bargaining power with health networks (hospitals and doctors) as well as with pharmacy benefit providers (formularies and drug companies) while also creating new economies of scale, administrative efficiencies and a more efficient allocation of plan responsibilities. By transferring the obligation to provide and administer the benefit programs from small participating employers, who may have little expertise in these matters, to the AHP plan sponsor, AHPs have the potential to truly achieve the administration's stated goals: To put America's small businesses on a level playing field with large businesses by ensuring that the rules for both are equal

TriNet believes changes contained in proposed rule RIN 1210-AB85 meant to operationalize the administration's high-level vision falls short in two critical areas, raising significant doubt on whether Association Health Plans in practice will be able to leverage a consistent and predictable set of rules (both at the Federal level and at the State level) that places them on-par with the current regulatory structure afforded to large group plans under ERISA.

1100 San Leandro Blvd., Suite 400 • San Leandro, CA 94577
Phone 866.344.6688 • **Fax** 510.352.6480 • TriNet.com

Duality of Federal and State Regulation (ERISA Preemption)

Under the proposal, the Department of Labor has stated that AHPs that meet the regulation's conditions would have a ready means of offering their employer-members--and their employer members' employees--a single group health plan subject to the same State and Federal regulatory structure as other ERISA-covered employee welfare benefit plans. While this statement is technically accurate when viewing AHPs along with all other employer plan sponsors under section 3(5) when applying federal ERISA standards, the failure of the rule to distinguish AHPs that meet the conditions under this rule from the generic definition of Multiple Employer Welfare Arrangements (MEWAs) ensures that AHPs will not be treated under the same regulatory structure as all other ERISA-covered employer sponsored plans as the rule uniquely subjects AHPs to additional state regulatory requirements. Instead of enjoying the same levels of federal ERISA preemption afforded to other employer plan sponsors in section 3(5), the rule subjects AHPs to both federal regulation (under this rule and ERISA) as well as state regulatory authority under the existing MEWA provisions contained in ERISA. In doing so, the rule cedes much of the oversight and final rulemaking authority to each of the 50 states, leaving the relative success or failure of AHPs up to the states. This approach not only deviates markedly from the current treatment of large employers under existing federal regulations, but also serves as a significant deterrent for AHPs to achieve the size and scale on a nationwide basis to allow small employers to compete and enjoy a level playing field with their large employer counterparts.

While the proposed rule states that AHPs CAN sponsor benefit plans on a fully insured or non-fully insured basis, consistent with all other ERISA-covered employers in section 3(5), the duality of state-based regulation afforded by the rule's treatment of AHPs as MEWA plans concurrently allows each state to separately regulate either the components of the health coverage itself if the plan is fully insured or regulate the AHP specifically if the plan is non-fully insured, including the ability for states to prohibit non-fully insured MEWA plans in their state. This degree of existing state regulatory authority of MEWAs, if applied as proposed in the rule, will undoubtedly stifle the potential for widespread growth of AHPs across state lines and all but eliminate the ability of AHPs to use alternative funding structures as an effective mechanism to significantly innovate plans, leverage health networks and pharmacy benefit providers and compete on a level, nationwide playing field with large employers who have no such restrictions.

Under the proposed rule, assigning existing MEWA treatment to AHPs instead of treating these new AHPs as if they were a single employer plan could require fully-

insured plans to meet up to 50 different state regulatory requirements--all unique to AHPs--that will materially add to the cost, administration and complexity of such fully insured plans. Even more severe, under the proposed rule, states would also have the ability to significantly regulate non-fully insured AHP plans, including the ability to either prohibit them all together or require such plans to be licensed on a state-by-state basis as an insurance company. To be clear, today well over half of all states have already exercised their authority under ERISA to significantly restrict, punitively regulate or prohibit non-fully insured MEWA plans. Absent a change to the proposed rule to treat AHPs as if they were single employer plans under ERISA rather than MEWA plans, these prohibitions would apply to AHPs on day one and all but deny the ability for a scalable, multi-state AHP solution.

> **Example:** While the proposed rule would allow employers to band together if they have a principal place of business within a region that does not exceed the boundaries of the same State or the same metropolitan area (even if the metropolitan area includes more than one state), the application of state law to an AHP in the Greater NYC/TriState region illustrates the complexity of building a scalable plan. While New Jersey law permits non-fully insured MEWA plans in their state following regulatory approval, New York law requires a non-fully insured MEWA to be licensed as an insurance company and prohibits out-of-state non-fully insured MEWA plan from being sold, while Connecticut treats any non-fully insured MEWA as an illegal operation under state guidance.
>
> New Jersey: http://www.nj.gov/dobi/division_insurance/mewaapps.htm
>
> New York: http://www.dfs.ny.gov/insurance/ogco2003/rg031107.htm
>
> Connecticut: http://www.ct.gov/cid/lib/cid/HC-43.pdf

TriNet suggests that, if the administration seeks to give AHPs a legitimate opportunity to succeed, the department consider adding additional language in section (b) of the proposed rule that would clarify that Association Health Plans that meet the criteria established in this rule would be treated as a single employer plan sponsored by the Association Health Plan. Doing so would not only eliminate the duality of federal/state regulation as noted above, but would also allow the rule in practice to carry out the department's own position as published in Section 1.12: Regulatory Alternatives, which states, *"Nonetheless, DOL recognizes that well-managed self-insured AHPs may be able to realize efficiencies that insured AHPs cannot. In light of this potential, and considering the enforcement tools that the ACA added to DOL's arsenal, DOL elected to allow AHPs to continue to self-insure under this proposal."*

Application of HIPAA/ACA Nondiscrimination Rules

The overall success and viability of an Association Health Plan and its ability to leverage size and scale to help reduce the overall cost of health coverage for small to mid-size businesses will largely be dependent on its ability to garner enough members to create a stable risk pool in the first few years. Much of this will be dependent on whether the AHP can access both demographic and historical data on new groups joining the association to rate them accurately. While the proposed rule does permit AHPs to use age, gender and geography as variable factors in rating each group (similar to the small group market), it applies HIPAA/ACA Nondiscrimination rules to the aggregated association, instead of allowing the AHP to use health status experience as a rating factor at the individual group level. This application of the HIPAA/ACA Nondiscrimination rules stands in stark contravention to existing rules applicable to large employers and undermines a basic tenant of pricing based on insurance risk in the private market.

Under current law, the HIPAA/ACA health non-discrimination rules generally prohibit health discrimination *within* groups of similarly situated individuals, but they do not prohibit discrimination *across* different groups of similarly situated individuals. In layman's terms, this means that large employers today can rate different groups of employees across the company differently provided each identified group meets certain criteria and the overall purpose of creating separate groups is not driven by health status factors of individuals or locations. Employers can segment these groups for risk purposes if they are consistent with its usual business practices. In reality, this means that large employers can use factors such as full-time versus part-time status, different geographic locations of facilities, membership in a collective bargaining unit and different occupations of their workforce to segment their employee population into different groups of similarly situated individuals. Doing so allows them to rate each group differently and also allows them to use health status factors and claims experience of each group as part of its rating and pricing.

The proposed rule does not allow AHPs to enjoy the same discretion as large businesses and prohibits AHPs from treating each business that participates in the AHP as a separate group of similarly situated individuals for application of HIPAA/ACA health non-discrimination. While large businesses, like a drug company, are permitted to treat one facility in Scarsdale, NY that houses chemists, doctors and clerical workers separately from another facility in Buffalo, NY that houses factory workers, machinists and warehouse personnel under the existing nondiscrimination law, the AHP rule would prohibit similar treatment. By contrast, the rule would ignore that a small pharmaceutical engineering firm in Scarsdale, NY and a small medical equipment distribution company

in Buffalo, NY who are both participating in the same AHP are different groups of similarly situated individuals within the AHP. By ignoring the reality of these two different groups and prohibiting the use of health status or claims data as a differentiating factor to rate each of these groups, the rule by nature is promoting cost shifting and subsidization, similar to what is required under the Affordable Care Act.

In fact, prior to the passage of the ACA, private market health insurers used health status and claims data as a core component of rating employers in the small group market (this is still used today in the large group market). In passing the ACA, health insurance experts knew that eliminating this fundamental component of risk management was contrary to private market success. Further, they knew that creating "Exchanges" that featured standardized benefit options that restricted insurers' ability to base premiums on their enrollees' health status would ultimately lead to one of two outcomes: Plans that enrolled a sicker-than-average enrollee population would be in danger of losing money, while plans that enrolled relatively healthier enrollees would probably be overpaid. Ultimately, if too many plans lost money, some could go out of business, and the overall system could be seriously destabilized.

To prevent this from happening, the ACA required the use of risk adjustment in the small group market to reallocate premium income among health insurers to account for differences in their enrollees' aggregate health conditions, and therefore the likely cost of paying for their care. This government intervention to "force" an outcome was solely based on the ACA's policy decision to restrict the use of health status and claims data as a prudent rating factor to accurately price to risk. The proposed AHP rule attempts to mirror the components of the ACA market reforms through restricting the use of health status factors at the separate group level but does nothing to replace the government-mandated risk adjustment payments that were designed as a stopgap under the ACA when they took away the ability to use prudent insurance rating principles. Simply stated, by restricting AHPs ability to use health status and claims data at the small business group-level without having a similar government run risk adjustment program to prevent against insolvency, the proposed AHP rule not only puts AHPs at a disadvantage over large businesses as stated earlier, but it also puts AHPs at a disadvantage over the current ACA-mandated small group market. While health insurers are provided an economic safety net by government imposed risk adjustment payments as a trade-off for abandoning prudent underwriting and rating in the Exchange-based small group market, AHPs are required to forgo prudent underwriting and rating with no such promise.

As proposed, we believe the application of the HIPAA/ACA Health Nondiscrimination provisions to AHPs will fail to serve the stated goals of the Administration. AHPs have the potential to allow groups of employers increased bargaining power to create economies of scale, administrative efficiencies and a more efficient allocation of plan responsibilities. These efficiencies will allow the AHP to negotiate lower administrative

costs for by all plan participants (which is one component of insurance premium) but should not be mistaken as a substitute for prudent risk-based pricing (which is the other variable component of insurance premium). Restricting prudent risk-based assessment and pricing variability at a small business group level (similar to a similarly situated group) not only runs in stark contrast to the current treatment of large employers under the law, but without the artificial government safety net of mandated risk adjustment payments as exists in today's small group market, the proposed rule will almost certainly limit the success that the private market can provide through an AHP solution.

TriNet agrees with provisions contained in paragraph (d)(1) of the proposed rule that would ensure that AHPs do not restrict membership based on any health factors. Additionally, we agree with paragraphs (d)(2) and (3) of the proposed rule that requires AHP compliance with HIPAA/ACA health nondiscrimination surrounding eligibility for benefits and premiums. In order to provide for substantially equal treatment with current large employer rules and provide for a more actuarially sound basis for private market-based success, we request that the department consider amending (d)(4) as follows:

> In applying the nondiscrimination provisions of paragraphs (d)(2) and (3) of the section, the group or association may ~~not~~ *only* treat different employer members of the group or association as distinct groups of similarly-situated individuals *if, subject to an anti-abuse provision for discrimination directed at individuals, the employer members could otherwise be distinguished based on a bona fide employment-based classification.*

We disagree with the department's assertion that treating an AHP as an employer under section 3(5) of ERISA for purposes of sponsoring a single group health plan is undermined by treating its employer groups as distinct groups of similarly situated individuals. In fact, not only is this treatment consistent with the current law's permissive application for large, multi-state, multi-division corporations, but it is also consistent with the approach adopted by states that have regulated successful Association Health Plans (e.g., Indiana, Ohio and Washington).

Additionally, we disagree with the Department's view that an employer-by-employer risk rating undermines the statutory aim of limiting plan sponsors to employers and to entities acting in the interest of employers. With the advent of the ACA, health insurance has become a more complex, regulatory-driven puzzle for both individuals and employers alike. In this environment, large employers have uniquely benefitted from both the flexibility already afforded to them inside of ERISA as well as through their size and economic means to drive innovative approaches to aggregate larger risk pools, negotiate with providers and insurers to reduce administrative costs and rationalize diverse employee populations spread across diverse regions and job classifications to provide more affordable and innovative insurance solutions to their employees. Larger

employers too have notably used sophisticated approaches, including risk-based rating approaches *across* different groups of similarly situated individuals.

As noted throughout our comments, we agree with the department's overall stated goals of this proposed rule: *"The goal of the proposed rule is to allow AHPs to leverage advantages available to large employers to assemble large, stable risk pools, pursue administrative savings, and offer small businesses more, and more affordable, health insurance options."* As such, we believe it continues to be critically important to extend these same advantages to AHPs to allow them to drive innovation for the benefit of all of its members.

Once again, we appreciate the opportunity to provide comment on 29 CFR Part 2510, RIN 1210-AB85, the department's proposed rule addressing the definition of employer under section 3(5) of ERISA – Association Health Plans. We appreciate the work of the department in considering our comments and recommendations on these critical items in an effort to help achieve a final rule that provides the certainty and common-sense guidelines for Association Health Plans to provide a robust, competitive and thriving private-market solution for small business across the country.

Sincerely;

Todd J. Cohn

Todd J. Cohn
Vice President, Insurance Services and
Regulatory Affairs

1100 San Leandro Blvd., Suite 400 • San Leandro, CA 94577
Phone 866.344.6688 • **Fax** 510.352.6480 • TriNet.com